WOMEN, MEDICINE AND SOCIETY IN 18th AND 19th CENTURY - A FOCUS ON INDIA

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CERTIFICATE

Certified that the dissertation entitled "Women, Medicine and Society in 18th and 19th Century - A Focus on India" submitted by SAROJ DHINGRA is in partial fulfillment for the degree of MASTER OF PHILOSOPHY of this University. The dissertation has not been submitted for any other degree of this University or any other University, and it is her own work.

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INTRODUCTION

INTRODUCTION

In India, the sex ratio (number of women to 1000 men) has steadily declined. In 1901, it was 972 which declined to 946 in 1951. It further declined to 933 in 1981 and to 929 in 1991. This has happened despite a lot more attention being paid to improving women's status by the Government machinery. The explanations offered are slower improvement in female mortality and a poor health-status compared to men.

In 1974, the Ministry of Education & Social Welfare set up a Committee on Status of Women in India. This Committee expressed its concern for women, stating: "While improvement in the status of women was a pledge made by policy makers...with changing social and economic condi tions...various new problems relating to advancement of women...have emerged."[1]

It further commented: "There is a wide gap between stated social objectives and achievements, between legal framework and empirical realities...while opportunities have widened immensely...enabled women to forge ahead...for the others this was not the case...."[2]

In the year 1980, *ICSSR-ICMR Committee on Health for All: An Alternative Strategy*, commented: "...development has adversely affected women...their employment status has

deteriorated...."[3].

As regards health status of women, it admitted that "...public health services have reflected social attitudes in regarding all women as mothers or potential mothers....Health Services for women and children can only be improved if associated with substantial change in their social status."[4]

In 1994, Draft National Population Policy expressed its conviction that `development which is not equitable is not sustainable'. Its major concern was with gender inequality and the discrimination against women.[5]

It appears that even though women have been a concern of policy makers, indicators of women's health status have not shown the desired progress.

The Draft Population Policy espouses the cause of women through better education and job opportunities and improved health care. It underlines the need for improved status, nutrition and health for women. There seems to be recognition that social status of women cannot be altered in isolation, that improvement in social status is necessary to bring about desirable change in the health status of women. Having made this important and crucial diagnosis, Draft Population Policy also took up issues of Population, Poverty and Environmental degradation. Without examining the

resource distribution in different classes, it put forward a simplistic relationship between limited resources and increasing numbers of the poor.

As a result when it came to recommending specific interventions, the measures proposed treated women in isolation. The efforts suggested were assumed to improve their welfare without changing social and political structures. The approach remained, at best, confined to welfare where women were passive recipients and at its worst, exploitative where women were the targets of new reproductive technologies.

For limiting the population growth, the Draft Policy suggested undemocratic measures like cutting off of employment and promotional avenues for those with more than two children or early marriages. (It even suggested that to promote small family norms, help of Army could be sought and one's right to stand for *Panchayat* elections should be denied if one had more than two children.)

We note then an inherent contradiction, that is, while the reality is too harshly apparent to be ignored, the State still continues to attempt to curtail its efforts at any serious interventions which will actually affect women's status and their health.

This contradiction in the State's handling of women's

problems is further borne out by researches in the field. Since independence, a lot of literature has come out which has recognised women's role in households, agriculture, industry and other aspects of the economy. Kalpana Bardhan (1985) points out that agriculture sector forms the largest single sector which employs women, followed by construction and informal sector in urban areas - domestic service, garbage disposal.[6] At the same time it (agriculture) is a low paid sector. Nata Duvvury points out that 2/3 of female agriculture labourers are below the poverty line according to NSS. Study by Sen & Sen Gupta (1983) illustrates how development efforts and health programmes do not necessarily reach every family or individual member within these families equally. Women and little girls tend to benefit least of all from such efforts. There are various studies which highlight health hazards associated with women's traditional work at home[7] and in the informal sector[8]. Aggarwal (1983) estimates from his study of Gujarat homes that exposure to three hours of work in the kitchen is equivalent to smoking roughly 20 packets of cigarettes per day.

There are various studies which show women's important role in home based industries (Chatterjee 1987, Lalitha V 1987, Mehrotra Deepti 1983, Marje Anagha 1983, Awachat 1989).[9]

These studies reveal that women are not outside but very much within the production domain of even the traditional economic analysts. There are feminist critiques of the traditional understanding of `worker' itself where the `invisible hand' at work is recognised [10] and the predominance of women and children in the unorganised sector is highlighted.

It is then obvious that what happens to the economic structure will have serious implications for women. On the one hand, Government takes note of women's productive roles, recognises the need to improve their status and emphasizes the need for women's education, employment, nutrition and health; on the other hand, Government's new economic policy necessitates Structural Adjustment Programmes. Nata Duvvury shows that traditional industries such as coir, handloom and handicrafts, etc., which employ women are today in crisis because of the SAP package.[11]

Report of the Commonwealth Expert Group on Women & Structural Adjustment pointed out that women's welfare has suffered disproportionally from SAP, given the multiplicity of women's roles. Women face special trade-off in the use of their time given the overall balancing they have to perform between different activities. At the same time, the social support network - including health and public distribution system - is cut back as part of `fiscal

discipline'. In reality then, all welfare measures suggested by the Committees concerned with women are being overruled by the SAP. The question then arises, what allows the decision makers to get away with strategies which are so apparently contradictory?

Our assumption is that policy is both a statement of intent as well as a framework within which strategies are developed and programmes initiated. The people responsible for framing policy do so partly in response to their own perceived interests as members of a particular class and partly due to their ideological understanding of social processes.

An example of this contradiction is the universal recognition of the fact that maternity and child health in the post-1947 period in India was very poor. Despite this, the MCH programmes were never really seen by planners as an end in themselves. They were always treated as a means of some other objective. The emphasis on maternal health has seen many ups and downs. Bhore Committee regarded maternal and child health services as an integral part of general health services. While it regarded women as independent actors whose concerns must be addressed on their own, the later health policy documents viewed women only as agents of reproduction, biologically and socially.[12]

The first UN Advisory Mission of 1966 made a

categorical recommendation that MCH activities should be sacrificed so that resources and personnel are free to promote birth control.[13] In 1969, Maternal & Child Health was again placed with family planning as it was observed that without Maternal Health Services, family planning targets could not be achieved.[14] Maternal Health was used as a vehicle and it was clear that the vehicle itself has to be in order to deliver.

It was only in the 70s that the welfare approach to women acquired some respectability. However, this approach very soon melted into population control policy where welfarism became a mere slogan. Despite the lessons of the 70s, the approach to family welfare remained highly technocentric. It was assumed that poverty (basic cause of under-development) can be reduced by simply limiting fertility by widespread dissemination of contraceptive knowledge and technology to women. Today, within the health care system, the scope of maternity services has been broadened to include reproductive health. In practice, the emphasis is on hormonal, long acting, injectable contraceptive technologies, propagated by multinational agencies, which give control to providers rather than users of technology. [15]

Evolution of policy and strategies reveal very clearly on which side official policy is biased. There are visible

gaps between social reality and planners' perceptions. The fact that they have been allowed to continue to pursue anti-women strategies in the name of welfare, can be explained only through societal attitudes towards women as well as perception of the professionals within it.

In this dissertation, we therefore, address, ourselves to how society at large and the modern medical system in particular, have approached the problem of women and health. We attempt to develop an overview of this issue over 18th and 19th century and trace the roots of the tradition which is so clearly manifest in our policies.

We examine the position of women in India historically and show how their secondary status was often used for various political and economic interests of the State at the cost of women's progress and liberation.

We then also examine the origin of health services for women and show that while concern for the poor state of women and philanthropic attitudes were not absent, very often the reasons for the beginning of these efforts had very little to do with the problem of women of India. The British professional interests, gender conflicts and political prorities played a key role.

We also examine the understanding and attitudes of the medical profession itself and the way it tackled women's

health.

The two major British influences on women's issues in India have been: (i) the welfare movement in Britain and the Women's movement in the West; and (ii) the growth of modern medicine in Britain highly influenced the genesis of health services in India as both the providers and decision makers were of the view that allopathy is superior to traditional systems and used their power to establish this in reality.

The dissertation, therefore, examines the growth of women's movements, social perceptions regarding women, and maternity services in the West. This is necessary because, in the 18th and 19th century, Indian social life was very significantly influenced by the events in Britain.

Review of literature reveals that the problem of health and health services by and large has been tackled within the bio-medical framework. There is paucity of literature on social dimension of evolution of services as well as the understanding of women's health from a social perspective. The studies either focus on social status of women or legal status. There is rarely a meeting ground between social analysts and the analysts of the medical system. Therefore, this dissertation makes an attempt to study social attitudes regarding women at a given time and their links between with the then existing health care system and medical

professionals. As our dissertation illustrates the role of science and medical establishment in moulding attitudes towards women has been significant.

Primarily the study is based on historical texts reviewed by other scholars and a review of literature on women and health services. We have attempted to extract information relevant to our problem, collate it and sometimes provide re-interpretation of the reality in a framework that was different from the ones used by authors of the source.

There are different approaches to study women's issues. Women's problems have been analysed within different frameworks. The liberal feminists in their analysis have challenged the myth of a biological basis of women's oppression, but do not seriously challenge the social and economic hierarchy. They also see the medical system as reflecting the sexual hierarchy of society with a male monopoly of upper level jobs, but do not question the hierarchichal organisation of health care. They, in their approach, demand equal opportunities and equal pay.[16]

The other approach to analyse women's problems is of Radical Feminists. They see the patriarchal family as the major and most oppressive force in society. This approach served to expose the operation of paternalist ideology and the structure of women's oppression in society. They also

see medical profession as imitating patriarchal society. They work to disseminate information and knowledge about medicine specially about women's sexual and reproductive functions. This led to setting up of self-help centres in US and Europe.[17]

The third approach to understand women's issues is through the use of historical and dialectical materialism. It sees patriarchy as both supporting and strengthening capitalism. It assumes that no one characteristic of the medical system can be analysed in itself, but must be seen in relation to the entire social structure and its institutions, and the economic order in which it is rooted. This Marxist Feminist approach is also critical of the sexist bias of medicine and the emphasis on 'scientific' base which itself has an inherent class and sex bias.[18]

The framework of analysis in our dissertation falls into the third category. In fact we have adopted our frame work from Ruth Belier. We have tried to show that for an analytical account of the position of women in a particular period, it is essential to study socio-economic context of that particular period as this affects the social group differently. We have tried to locate women's issues in the larger socio-political environment rather than focusing on women or their problems in isolation.

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CHAPTER ONE

STATUS OF WOMEN - A HISTORICAL ACCOUNT

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This chapter puts together the status and position of women as reflected by the reviewers of historical texts. Our concern is women through time. We only attempt to summarize available information on women's status and highlight contradictions as they evolve in different periods.

We focus on two basic questions:

i) status of women in the ancient Indian texts,

ii) the influence of Buddhism, Jainism and Islam on some practices *vis-a-vis* women.

Even though in the intervening Mauryan, Gupta and other empires changes did occur, the ancient texts remained at all periods of time the guiding force for religious code of conduct and for retaining the hold of religious autocracy.

There exists a stream of analysts who believe in the glorious past and in the undermining of the ancient Indian society because of the contact of various invasions it suffered both materially and culturally. Our review infact reveals that while the later Vedic texts became more and more restrictive where women were concerned, the influence of other religions was not always negative and at times forced the religious autocracy to contain its influence by

incorporating some of its practices.

I. Ancient Period

There are two separate sources of information on the Indian past: the historical which consists of archaeological evidence and evidence derived from Vedic literature, and the traditional, consisting of the stories in the *Puranas*, the latter being composed at a later date than the Vedic.[1]

The traditional account in the *Puranas* was collected many centuries later (between 500 B.C. and A.D. 500). *Rig Veda* was originally composed prior to 1000 B.C. The remaining Vedic literature - the *Sama*, *Yajur* and *Atharva* Vedas - is of later date. The historical reconstruction of Aryan life and institution is based on this literature.[2]

A. Pre-Aryan India and Its Women

The progress of civilization was often linked with Aryan race, and redemption of man with Aryan superman. The absence of any living monument or literature of pre-Aryan India, strengthened the belief in the fiction of a wild pre-Aryan India.[3]

These beliefs received a shock by the archeological discoveries of the early decades of the 20th C. It was discovered that Aryans who conquered south-eastern Europe, the Middle East and India, were, semi-barbarous type, more-war-like but less civilized. Those Aryans who moved to

south-east of Europe, came to be known as Greeks, while the Persians who conquered Mesopotamia came under the cultural influence of the Babylonians. That branch of Aryans who made in-roads into India and settled down in Punjab, came in contact with what is now known as the Indus Valley Civilization.

Two cities Mohanjo-daro and Harappa, believed to be the Metropolitan centres which controlled a pre-historic Indian empire, were unearthed in the Sind-Punjab region. It is generally held that the Aryan invasion of India was responsible for destruction of the Indus Valley Empire.[4] Our knowledge of the Indus Valley people is very meagre. The Indus Valley people knew the art of writing. Very little information can be gleaned from the evidence concerning the marriage laws and customs of those people, of the position of their women in society. The many figures of goddesses discovered would suggest that the popular deities of the pantheon were females.[5]

The importance of mother worship in religion, the abundance of female figurines with rich ornaments, would indicate that society was more favourable to women than to men.[6] Uma Chakravarthy opines that importance of bronze statue of the dancing girls could be interpreted as the continued importance of women's special relationship with reproduction and may also be seen as an acceptance of their

sexuality.

Evidence for the Harappan civilization has not been analysed from the gender point of view but there is some indication of the emergence of social stratification, with a class of people who laboured and others who wielded power and occupied the citadels in the structures that have to be excavated.[7]

B. Women in the *Vedas*

The earliest known literary composition of the Indo-Aryans are the hymns of *Rig Veda*. The composition is essentially religious in character. Based mainly on Rig-Vedic and on the other three *Vedas*, a vast body of literature known by the name `Vedic literature' developed in India.

The Rig Vedic Aryans were semi-nomads who had no great religious system. For them, the needs of life on earth were all important; they tilled the soil, breed cattle and fought their enemies with a vigour.

For them, women were no ornaments but co-partners in life; they had no use for weaklings and the sickly and an exuberance of vitality and vigour guided them in forming their institution of marriage and family life.

Child marriage was unknown in this period. Widows were

not expected to remain single in memory of their dead husbands. The early Aryan could ill afford to let the fertility of their women go waste, as the needs of building up the numerical strength of the family and clan was paramount. The widow being a member of the family was married to her husband's brother.[8]

A girl after marriage, went and lived in her husband's house. Marriage was generally arranged by parents, the bride was a full grown girl. Consummation took place on the fourth night after marriage. The bride was adorned with ornaments.

There are many passages in the *Rig Veda* describing the beauty and charm of women, of men vying with one another for the favour of the fair ones, of courtesans displaying their histrionic talents in public, and of eloquent women taking part in the deliberations of the assemblies of clans. "The wife is the home", says one hymn. In another hymn, Usha, the goddess of dawn, is described as a blooming beauty, dressed in superb finery revealing her splendour on a public stage. According to Max Muller, the hymn throws a curious light on the social character of Vedic times as it presupposes two classes of wives - not necessarily simultaneous, however, a housewife who stays at home and is not much seen and a wife who appears in public and takes part in society and conversation of the *Sabha*, the assembly room.

There is evidence, however, that indicated that the desirability of having learned daughter was not entirely lost sight of.

It would appear that during the age of the *Upanishads* (one of the text of later-Vedic period - metaphysical writing attached to *Vedas*), women were not debarred from the study of the *Vedas;* learned Rishis, as a rule, initiated their wives into sacred sciences. Even *Sudra* wives enjoyed this privilege[9] Dayanand also believed that in ideal society of the Vedic period women lived in an idyllic existence, fully participated in all areas of public life.

Women also took part in the intellectual and spiritual life of the community. Education was restricted to upper castes.[10] Women as professional dancers were not looked down by society but were sought after by heroes and gallants. Urvashi was a dancer whom King Pururavas married. According to Chakravarti, *Rig Veda* reflect an explicit relationship of women and sexuality. This is an aspect which is specially associated with demoniac women or with *apsaras.* While demoniac women are a threat to men and to their rituals, the *apsaras* are free from male control and even set stringent conditions for any long term cohabitation with men.

Rig vedic Aryans were patriarchal[11] and man had almost absolute power over his wife and children. But Uma

Chakravarti is of the opinion that the patriarchal family had established a certain degree of control over Aryan women. Their position in pastoral economy, with household playing an important part in production, ensured the recognition of their presence in society, especially in the performance of rituals. But the custom of *Niyoga*, which was the privilege of affinal male kinsmen, indicates that control over female sexuality was firmly established. *Niyoga* combines the utilization of the reproductive potential of women, but under rules laid down by men, to further cultural norms which privilege them.[12]

Illegitimacy, the bane of patriarchal society is as old as Rig Veda since hymns indicate considerable stigma attached to illegitimate children. Uma Chakravorti shows that while there is no special value attached to chastity, the example of the maiden who abandoned her child (indicating definite notion of legitimate reproduction) reiterates that patriarchal control over women was institutionalized.

Of the four *Vedas*, the *Rig Veda* is the most ancient and original. The other two *Vedas* - *Sama* and *Yajur* were compiled by arrangement of some of the hymns of *Rig Veda*, mainly for the purpose of sacrifices and rituals in certain order and sequences.

The fourth *Veda*, known as *Atharva*, is a later addition. It has an individuality and originality of its own, though

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it contains many of the hymns of the *Rig Veda*.

The central feature of Aryan religious life was sacrific. Small oblations were restricted to domestic sacrifice.[13] The religious ideas embodied in the *Atharva Veda* had a direct bearing on the change of attitude of society towards women. In patriarchal society, the importance of son is recognized all round. Besides notions of ceremonial purity were fast advancing among Indo-Aryans as the caste system developed.

Women were beginning to be considered generally impure, and particularly so during their menstrual periods, pregnancy and child birth. Besides, "below her navel, a woman is always unclean". Such impure creatures were not competent to perform the highly clean and spiritual function of offering oblations to the pure soul of the dead.[14] These highly intricate eschatological notions, while raising the importance of male, lowered the position of women. A women was considered important only as long as she was able to bear sons. As for daughters, the gods were requested to give them elsewhere. One prayer in *Atharva Veda* is "give daughter elsewhere but here a son".[15]

A curious notion developed in later Vedic literature, that embryos were essentially male, and the birth of daughters were due to the perverse activities of malignant spirits who during the course of development of the fetus turned

it into female.

Further elaborate ceremonies began to develop for ensuring the birth of sons. Pumsavana (male producing) ceremony even now performed by the Hindus in the third month of gestation, might have its origin here.[16]

The Aryan who loved his soul was compelled to marry. The importance of sons were emphasized at every step. In the story of Harishchander, who had one hundred wives and no sons, the learned Brahmins of his Court reveal to him the greatness of a son: "The father pays a debt to his son and gain immortality when he beholds the face of his son who is born to him".[17]

Though the *Atharva Veda* depreciates the birth of daughters, we don't find any mention of infanticide. The text is generally unfavourable towards women with their ideas of ceremonial purity. There are texts which make a mention of `disposing' of unwanted daughters during infancy by abounding them.[18]

There is a mention, that a wife should take her meals after her husband has finished his, and the wife who does not answer back to her husband even under great provocation is praiseworthy; elsewhere, a disobedient wife is enjoined to be taught obedience by physical force.[19]

Sterility in women was considered an evil and the

continued bearing of daughters a worse evil. In either case, it became obligatory for a man to marry again and raise sons to himself. In case of impotent men, ingenious expedients were invented to invest the impotent with sons. The brother or near relative of the unfortunate man was appointed for raising sons to him; in the absence of these, the services of the learned *Brahmins* were obtained. (Mahabharata story supports this notion).

For one thing, injunctions of these texts were not binding on all Indo-Aryan and local usages and customs have always had over-ridding effect on written ordinances. Uma Chakravorti points out that there was essential stratification between women of conquered tribe and women of subjugated indigenous tribe. Their roles and their place in society were different.[20]

C. Women in *Puranas* and *Dharam Shastras*

There are many law books among the Hindus. Of all the law books, the Code of Manu is considered the most authoritative. Even the medieval law books of Burma, Indonesia and other countries of South Asia formulated their laws on the pattern of the Code of Manu, and in most of these countries, as in India, the origin of law is ascribed to Manu.

Every law giver including Manu, says, "in childhood, a

women is to be dependent upon her father, in youth on her husband and in old age on her son, a women is never fit for independence". According to *Dharam Shastra*, a woman only merges into man as a river merging into ocean. A woman of the lowest birth is worthy of honour after being merged into a man of higher rank.

Three persons, a wife, a son and a slave, are declared by law books to have no wealth exclusively of their own. In marriage while a man's eligibility was judged by his intellectual and spiritual accomplishments, the girl's desirability was solely dependent upon her physical attractions.

According to the law giver, a good wife is not born but made. A wife was always to be taught her place; if out of misplaced affection, she was allowed to have her own way, "She becomes uncontrollable like a disease neglected."[21]

Some contradictions are also found in Hindu codes. In Manu, as well as in other law books, there are passages exhorting men to honour women and keep them contented and happy, lest misfortune should overtake.

A woman, according to some passages was always pure, "The moon has conferred on her purity, the Gandharvas sweet speech, fire the most exalted state of holiness, therefore women are most holy. If a women commits adultery, she gets

purified by her menses."[22]

Manu permitted widow remarriage in certain passages and prohibited it in others. Manu's objection to widow remarriage was that a gift could be given away only once. Widow remarriage was strictly prohibited for higher three castes. Ramabai also quotes Manu and shows how the wife is classified with cows, mares, camels, she goats and ewes.

Custom of sati was more prevalent among *Kshatriyas*. One of the *Puranas*, *Padma Purana*, speaks highly of sati but prohibits it to the Brahmins as this would amount to Brahminicide. The impetus sati received after the decline of Buddhism in India must be seen against the background of the aggressive spiritualism that was rising in the country under the aegis of Brahminism.

Woman is also described by many derogatory attributes by Manu. She is called fickle-minded, sensual, seducer, trickery, impure, thoughtless, inconsistent and cruel. It is believed since women are fickle-minded so chastity among women was very important. To save and protect it needed a man.[23]

It appears that, perhaps as caste system established itself, the society became much more stratified and control over women's sexuality became necessary in the interest of the stability of the larger socio-economic structure. It is

in contrast to Rig Vedic period (as mentioned on page-20) where chastity was not considered that important though legtimate reproduction was much more acceptable. It indicates that control over women's sexuality became necessary in later Vadic period as mentioned in *Atharva Veda* and Manu. These again refer to period later than *Rig Veda*.

Saroj Gulati points out that the rules regarding chastity and devotion to the husband were laid down particularly for women of higher castes. Probably women of lower castes were not bound by the same laws. The actual practices among the poor was more varied and perhaps less constraining for women.

In short, women has a long history of many faces. The image of women has undergone many changes over a period of time. The image of women is not consistent but her expected rights and duties are fairly clear. She is viewed only in specific roles. The close and sustained association of the child with the woman's body is emphasised in number of ways. By idealising the quality of sacrifice in a mother and by eulogising her motherhood, religion binds a woman to the home and to her rule of creating and nurturing. She is given high status in society as a mother and this high status is accorded to her by the sacrifices she makes.

On the one hand, women are regarded as the embodiment of purity and spiritual power, and on the other hand, they

are viewed as being essentially weak and dependent creatures who are in need of constant guardian and protection of man.

Religion as a system of beliefs and rituals undoubtedly accords an inferior and dependent status to women.

In pre-historic societies, the reproductive power of women and their sexuality was accepted as an inherent part of their being and posed no problem. Slowly it gave way to a system requiring stringent controls and women's sexuality had to be organised and ordered by parental power in emerging clan-based societies to serve new social and political arrangement organised by men of dominant classes.

Evidence from *Rig Veda* is extremely significant as it reflects an essential stratification within women, between women of the conquering tribes (Aryans) and women of subjugated people (enslave). Their roles and their place in society were different. Rig Vedic society witnessed a continuing struggle between the Aryan and the indigenous tribe.

The notion that the essential nature of women is vested in their sexuality is dealt with most explicitly by Manu, the most prominent ideologies of the brahminical system. The most revealing statement that Manu makes in the context of women's extended nature points out:

"Knowing their disposition, which the Lord of creatures laid on them at creation (i.e. their reproductive power, their sexuality, their essential nature), every man should most strenuously exert himself to guard them". (Manu IX.16)

These rules and obligations by and large were confined to upper caste women. Women of lower caste were bound by customary laws. As Uma Chakravarti shows that the purity of women has a centrality in brahminical patriarchy because the purity of caste is contingent upon it and the structure that came into being has shaped the ideology of upper castes and continues to be underpinning of beliefs and practices extinct today.

II. Women in The *Artha Shastra* (4th - 3rd C. B.C.)

The Artha Sastra was written by Chandra Gupta Maurya (4th-3rd C.B.C.), the first Indo-Aryan emperor so far known to history. Chanakaya was the man behind Chandra Gupta's political expansion and *Artha Sastra* is a work of his genius.

The first book of *Artha Sastra* deals with the efficient management of the harem, as the greatest danger to the state was the king's harem and not foreign armies or internal rebellion.

Women also contributed to the security force for the personal safety of the king. There was another class of women kept for splendour of the Court, pageants and for the pleasure of the king. These are mentioned in the *Artha Sastra* by not very respectable epithet of prostitutes.

One of the important state officials mentioned in the *Artha Sastra* was the superintendent of prostitutes. Special laws were in force to regulate the relations between prostitutes and their clients. As a rule, punishment for most of the offences were fines. "When, however, a prostitute murders her paramour, she shall be burnt alive or thrown in water".

The age of consent was 12 years for girls and 16 years for a boy. Marriage was fixed when the girl was about this age. The ceremony took place immediately after menstruation. It was obligatory for a man to get his daughter married before passing of her 7th menses. According to Kautilya, intercourse between an unmarried girl who had passed her seventh menses was not punishable as her father has lost his authority over her in consequence of having deprived her so long of the result of her menses. Here again, we come across the idea that wasting of fertility of women was sinful. Kautilya, like Manu, ordained that a girl who remained unmarried for three years after her first menses, could marry a man even outside her caste at her own

choice, as her father had completely failed in his duty towards her.

III. Women in Buddhism and Jainism (6th Century B.C.)

In the 6th century B.C., we find the Brahminical religion based on *Vedas* flourishing in northern India. Elaborate rituals and sacrifices have been established. The caste system had become the most important feature of Indian society and the Brahmins had the exclusive privilege of studying Vedic texts and performing ceremonies for the benefit of humanity in general and the Indo-Aryan in particular.

Both Buddhism and Jainism marked a revolt against the pretension of Brahmins. The founder of both were Kshatriyas, princess of ruling class. Both were contemporaries hailed from East India, where the old clans had not submitted to the intellectual and spiritual supremacy of Brahmins who were dominant in the Gangetic plain. In the literature of Buddhists and Jains, we find the Kshatriyas often mentioned as the first caste and superior to the Brahmins.[24]

Buddhism

From the time of Ashoka, Buddhism was the dominant religion till the 8th century of the Christian era when it received a serious set back by the rising tide of Hindu revival.[25]

Buddhism does not consider woman as evil or as solely responsible for sensuality in the world. Yet she can be an obstruction in the path of deliverance. Woman is physically weak and dependent but mentally as good as man.[26]

Mother as a self-sacrificing and benevolent figure is very much present in Buddhist thought. Despite her intellectual parity, woman is definitely considered as inferior to man in the monastery as well as in society.

From the ancient Buddhist literature, we find that as early as the time of Buddha, the courtesan had come to occupy a very high position in Indian society. While the Artha Sastra deals with the subject from the point of view of a secular statesman and legislator, in Buddhist literature we get some idea of social position of the courtesan and the attitude towards her. The profession was not looked down upon, on the contrary considered a regular, useful desirable occupation. The story of famous Amrapali justifies this point.[27]

Though Buddhism in India is now confined to certain hill tribes of Himalayan region with Tibetan affinities, it was the most important religion in India and has left its indelible mark on Hindu religion and society. The Brahmins who were during the Vedic period great sacrificers and soma drinkers, emerged in Buddhist period as vegetarian and

teetotalers.[28]

Jainism

Jainism has much in common with Buddhism: it rejected the sanctity of *Vedas*, the superiority of the Brahmins and the sacramental notion of marriage, and considered all sex relations in and out of wedlock, as inferior to celibacy. Jainism, however, did not obtain the stature and popularity of Buddhism in India.

As a way of life Jainism lays great stress on self-denial, restraint of passion and a life of renunciation for both men and women. As a socio-religious organization the Sangh comprises (religious organizations) of both monks and nuns as well as both male and female lay followers. A woman has a legitimate position in the congregational life. She can occupy a position of leadership in which she deals with matters of practical concern. But the female ascetic appears to have suffered from certain handicaps in matters of seniority between monks and nuns.[29]

Jainism prescribes suitable patterns of moral conduct for ascetic as well as domestic life. Marriage is not obligatory for a girl in the same sense as it is in Hinduism, for the religious path is open for her.

Polygamy is not forbidden. There is no sanction for widow remarriage, for a life of self-restraint is greatly

valued. Divorce and widow remarriage are, however, found customarily practised among certain sections.

In the context of the family, chastity in women is greatly valued. Motherhood is respected but a childless women does not find her future absolutely dark.

Though Jainism spread throughout India under Ashoka's grandson, Samprati, it does not seem to have much appeal to the masses because of its exacting views on popular occupations.

During the three cornered fight - the Buddhism, the Hinduism and the Jainsism, which reached its culmination in the 8th and 9th century, Jainism escaped the fate of Buddhism by making many concessions to Brahminism. It recognized the supremacy of the brahmin rituals.[30]

IV. Women and Islam

The earliest Muslim invasion of India dates back to 650 A.D.[31] The conquest of Prithviraj's Kingdom in 1190 A.D. and establishment of the Delhi Sultanate was the beginning of the continuous Muslim rule in India until the coming of the British.[32]

The first phase was characterized by repeated invasions, exploitation of wealth and returning to their home or

establishment of short term rules, before the establishment of its continued empire in India.

Muslims brought and added their own set of norms and attitudes towards women to those already existing.

Marriage in Islam derives its legitimacy from the *Shariat* and is a contract. There are certain broad outlines within which the terms of contract operate. There is no ban on widow remarriage and even divorce is allowed. But the contract of marriage gives unequal rights to man and woman. Religion provides for free consent of both parties in the *nikah*, but in practice, it is a mere formality, as far as the girl is concerned. Similarly widow remarriage and divorce are generally frowned upon, specially among the middle and upper class, even though they are permissible in Islam.

The right of repudiation of marriage contract is with the husband. Polygamy is permitted in Islam. The text (Kuranic injunction) is not very clear but generally accepted interpretation is that limited polygamy is permitted.[33]

Women's rights to inheritance provided in Islam are significant. Islam introduced share for wife, daughter, mother, sister and grandmother, "the general rule being that the female was to inherit half of what the corresponding male would inherit".[34]

The Muslim Shariat Law, as it has developed over the centuries placed women in disadvantageous or inferior position in many respects. Many of these disadvantages arise from interpretation of the Kuranic Verse or the saying of Prophet in the light of the cultural norm prevailing in society.[35]

Modesty, decorum and chastity are emphasized in the Kuran and the women are advised not to display their ornaments of beauty. For them it is proper to keep women away from the gaze of outsiders.

During the long and close period of contact with the Hindu culture, the socio-cultural life of Indian Muslims got inevitably coloured by Hindu tradition and values.[36]

The Islamic provisions concerning marriage and divorce were heavily influenced by the local practices. Marriage began to be considered as final and binding for woman. In matters of inheritance, the regional and customary laws began to prevail and the Muslim women like the Hindu women became a non-inheritor.

Same way, *purdah*, a custom which was confined to kings, nobles and merchants, spread to the genteel and the middle classes too. *Purdah* among middle classes of Hindus is generally confined to these places in India where Muslim rule had been prolonged and prominent as in the north.

The convention of *purdah* was so strict that any woman found in public place without veiling her face was taken for a `shameless' woman and her molestation was not considered a serious offense as such. As a result, even non-Muslim women, under Muslim rule, took care to veil their faces when they went out.

While the *purdah* was more strict on the women of nobility than on the middle classes its adverse effects were less marked on former because these women had exclusive pleasure parks, separate ladies amusement/entertainment place; Whereas middle class women could not afford these luxuries and seclusion made these women anaemic and victim of many physical ailments.

The Shariat Law was only "an object of reverence, not a body of law that could be enforced". While there was no formal change relating to the rights and duties of women, there was a considerable change in the attitudes towards these laws.[37]

What becomes obvious is that inspite of some positive/liberal provisions in marriage and inheritance in religious texts, the actual practice has been more favourable to men and the status of women remained low.

Muslims ruled for a long period but their influence on Indian women has not been positive. The positive provisions got over shadowed by the already existing attitudes. It is not to say that Muslim woman had better status before coming in contact with India, but only to stress that the negative aspects of Islamic provisions got prominence and provided support to already existing attitudes and further deteriorated the status of women.

Another important point is that it is the upper class women whether Hindu or Muslim who were subjected to constraints. Among the lower class women the practices were more varied and less constraining. Our reviews of texts thus provides evidence that there was a steady deterioration in the position of women over time. And when the British came to India, the position of women was one of the issues on which they legitimized their superiority.

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CHAPTER TWO

COLONIAL RULE AND INDIAN WOMEN

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This chapter consists of two parts. Part one explores the impact of the British rule on women in India. It focuses on two aspects: i) the debates around some key issues pertaining to women within the larger framework of social reforms, and ii) Indian women's movement or women's involvement in National Movement.

Part two focusses on women in western societies around 18th and 19th century, their protest movements, especially issues taken up by organized women's groups and their relevance to Indian women's movement.

I. Women under Colonial Rule

British came to India as Merchants in search of fortune, as servants of East India company in 18th century. Before 1757, the English East India Company was interested only in making money. It wanted monopoly of trade with India. The company wanted to sell its products at as high a price as possible and buy Indian products as cheaply as possible to maximize their profits.

Apart from investing in trade, the East India Company also required large amount of money to wage wars both in India and on the high seas. A part of this money had to be raised in India. The company did this through local taxa-

tion in its coastal fortified towns such as Calcutta, Madras and Bombay. Gradually it became necessary to expand its territories in India in order to be able to levy more taxes over larger areas and increase their financial resources.

East India Company required direct control over state revenues of the conquered area so as to grab the accumulated wealth of the local rulers, nobles and zamindars.[1]

Upto this point, the British rule did not introduce changes in the administration, the judicial system transport, communication, the method of agriculture or industrial production. The British rule had appropriated large part of wealth and state revenue entirely for its own benefit and for financing its further expansion in India. The British rule was not very different from traditional empires which collected agricultural surplus from its territories, though it was much more efficient in doing so.[2]

R.P. Dutt periodizes this stage as `Merchantilist stage' from 1757-1813, characterized by direct plunder through the investments of surplus revenues in the purchase often at arbitrarily low price.[3]

The Industrial revolution in England dramatically changed the whole pattern of trade after 1813. With the Industrial Revolution Britain had become leading manufacturing and exporting country. The colonial

administration at this point of time was interested in raw material and food stuffs. Besides this, it needed foreign outlet for their manufactured goods. In other words, Britain wanted India as a subordinate trading partner to produce and supply raw material and food stuffs.

The British Indian Government set out, after 1813 to transform Indian administration, economy and society to achieve these ends and to meet financial requirement, there was a search for more Indian collaborators 'system of nomination, representation, etc., were all means of enlisting Indians to work for Imperial code'. The financial and political aspects were really combined in the development of local self-Government.[4]

The Administration was made more detailed and comprehensive to include a large variety of activities apart from tax collection and maintenance of law & order. The Administration also became wider in compass reaching down to the villages so as to draw out agricultural products for exports.

Moreover, the entire legal structure of Indian society had to be overhauled as it was to be based on capitalist commercial relations. Thus came up a new judicial system based on a new corpus of laws and legal codes, such as the Indian Penal Code and the Civil Procedure Code.[5]

A new pattern of economic exploitation of British rule did not mean that the earlier form of exploitation came to an end. Indian Revenue was still needed to conquer the rest of India, and to consolidate the British rule.

The British had introduced two major land revenue and tenurial systems. One was zamindari and other was ryotwari system.

Under zamindari system, old tax farmers, revenue collectors and zamindars were turned into private land lords possessing some but not all of the rights of private property in land. For one, the bulk of rent they derived from the tenants was to be turned over to the government. At the same time they were made complete masters of village community.

Under the Ryotwari, the government collected the revenue direct from individual cultivators, who were recognized in the law as the owners of the land they cultivated. But their right of ownership was limited by the temporary nature of land revenue settlement, and by the high rate of revenue demanded, which often they could not pay.

Whatever the name, it was the peasant cultivator who suffered. They were forced to pay very high rent and for all practical purposes the government came to occupy the position of land lords.

Through after 1901, revenue rates were gradually reduced but by then the agrarian economy had been ruined to such an extent and the land lords, money lenders and merchants had made deep inroads into the village that it was of no practical use to the peasant cultivator.

Thus the impact of British rule led to the evolution of a new structure of agrarian relations that was extremely regressive. New social classes appeared at the top as well as at the bottom of social scale. Landlords, intermediaries and money lenders occupied the top position and tenants, share croppers and agricultural labourers appeared at the lower position.

After 1850, a very large amount of British capital was invested in railways, roads, and to a smaller extent in the tea plantations, coal mines, jute, shipping trade and banking. It became even more important for the British administration to reach out to every nook and corner of India and Indian society. It also became necessary for the British to know the Indian people and their cultural practices. Many Britishers had studied Indian people and their cultural practices.

The Mutiny of 1857, showed them the insecurity of their military power. A more insidious threat was perceived in the appearance of Indians among the official elite.[6]

Through trade, travel and channel of communication the British furthered their economic interests. At the same time, it opened education opportunities for Indian elites in Europe. The intellectual life of Indian people began to undergo changes. It helped Indians not only to take critical look at their society, economy and government, but also to understand the true nature of British Imperialism in India.

The conflict over scarce resources in education, administrative jobs lay in the very logic of colonial under development.

Another point was that, the British sense of racial superiority had a significant role in the political and economic restructuring of colonial India. From the British point of view, to exclude Indians from key positions in military and administrative cadre was a rational decision. "Though, Indians in services should be encouraged, there is a point at which we must reserve the control to ourselves, if we are to remain at all", argued Elgin in a letter to Rosenberry in July 1893.[7]

Same way, an apparently trivial demand like holding of simultaneous ICS examination was bitterly opposed. This started in 1863, when an Indian candidate, Satyendranath Tagore was successful in ICS examination. The Civil Service Commissioner reacted in characteristic fashion by manipulat-

ing the marking scheme so as to impede subsequent Indian candidates.

Infact, the British could no longer assert their right to power on the ground of superior knowledge or intellect, instead they turned to the argument of racial superiority. They also repeatedly criticized competition examination for not attracting the best men, those who passed into ICS were often described as bookish, socially inept and physically inadequate.

Such stereotypes fit the classical model of dominance and subordination. Members of the dominant group ascribe to themselves the qualities needed for the tasks which they wish to monopolize.

In the beginning the policies of colonial state encouraged social reforms. Efforts were made to modernize Indian society in order to enable the economic penetration of the country and the consolidation of the rule. To some extent the humanitarian consideration also played some role. But the British slowly withdrew their support from the reforms and gradually came to side with conservative elements in society. In the following section we will focus on these aspects when we discuss debates around some key issues pertaining to women.

In short the British rule and its policies were moulded basically by a combination of greed for more revenue and

desire to encourage certain type of production to maximize their profit. In the process, they introduced new system of revenue collection, modified old system which in turn changed land relations to great extent. A new political and economic life produced a deep impact on social life of the Indian people that was first felt in the urban areas and later penetrated the village.

Through new methods of communication like railways, telegraphs, postal system, development of roads were initiated during the British rule but it destructed the rural and local economic self sufficiency.

On the one hand, it opened opportunities of education for Indian elites but when it posed a threat to British administration they resorted to racial superiority to monopolize control.

A. Women and Colonial Rule

The British and Anglo Indian law had a territorial scope. It ruled over the `public' sphere of land relations, criminal law, law of contract and of evidence. On the other hand there were the Hindu and the Muslim laws which were defined as 'personal' covering persons rather than areas and ruling over the more intimate area of human existence, family relationship, family property and religious life.[8]

Even through the dissertation does not examine reforms in the public sphere, the introduction of zamindari, ryot-

wari system, taxation and labour legislation do reveal British effort to modify these. However, wherever women were concerned very little change took place in their favour even in the area of public sphere. In the area of personal law, many reforms were introduced but economically and socially women remained disadvantaged.

A major force that was acting as a pressure group on the British rulers to introduce reform was the upper middle class elite and the emerging socially and politically conscious polity. It is therefore, important to understand how they were interpreting social issues of those times.

These in one way called for radical changes in personal laws of various communities; hence with the support of Indian liberal and reformers, between 1795-1937, British liberalized the law on six major issues relevant to women. *Sati* was prohibited in 1829, widow remarriage was allowed in 1856, the age of consent of consummation of marriage which was fixed at 10 in 1860, was raised to 12 in 1861. Female infanticide was prohibited under the Acts of 1793, 1804 and 1870 and the child marriage forbidden in 1929.

Pragmatism, however, demanded that the British economic interests be given primacy over radical reformers; hence in contrast to the above reforms, British action in other areas such as restitution of conjugal rights, prostitution and rejection of female suffrage, illustrate that their attitudes and actions were far from purely progressive. The

denial of attention to these was linked with British political and military interests and are explored in later section in greater detail.

Most Hindu Law, apart from that of the brahmins, was unwritten and based on custom, which varied both over time and across cultural and regional and caste boundaries. In contrast, Western law was written and based on the binding force of parliament, applying uniformly to every one and interpreted more rigidly. An obvious reason was the relatively higher cultural uniformity of Britain. To bring Hindu Law into line with the British concept, Warren Hastings, Governor of Bengal decreed in 1772 that brahmin written law should be the sole legal authority of all Hindus.[9]

The effect of this was to subject lower caste women to the strictures previously suffered only by women of higher caste. Brahmin law laid down the severest restrictions on women in order to preserve the purity and property of caste.[10]

This earlier zeal for textualization and codification of traditional law was gradually replaced by a recognition of the importance of the dichotomy between the uniform written law, and varied actual customs, of the invisibility of legislation on laws for women in post-1887 period. There was an implicit grey zone of unwritten law where variation in interpretation was quite substantial within the law courts.

The nationalist response to these British manoeuvres has been analysed by historians. The salient arguments of those who have written on the subject of women under colonial rule are:

i) The colonial past can not be viewed as unproblematic retrospect where all power was on one side and all protests on the other. The colonial power structure compromised with, indeed learnt from indigenous patriarchy and upper caste norms and practices which in certain cases of life, retained considerable hegemony.[11]

ii) During 19th century a particular kind of past was constructed as a context for the construction of a particular kind of womanhood. The image of past itself was a creation of the compulsion of the present (referring to 19th Century). These compulsions determined which elements were highlighted and which receded from the conscious object of concern in historical and semi-historical writings.[12]

iii) In the context of the women's question the entire focus of attention in 19th Century has been on the high caste Hindu women. Whether it was to highlight her high status in the past or reforming her low status in the present (19th Century). The

emphasis on *shastras* in setting the debates in 19th Century, ensured that the only issues taken up about women were those that had a bearing on legal and familial questions.[13]

iv) The social reforms of that period and nationalist response to these reforms indicate that there was a total lack of effort to change relations within or outside the family. The concern with the social conditions of women was hardly an indicator of ideological preference for liberalism in social practices. It was more an expression of certain `acute problems of interpersonal adjustment within the family' on the part of the early generation of western educated males. The very assumption that the early attempts at reforms were principally guided by any ideological acceptance of liberal or rationalist value imported from the west is doubtful.[14]

To understand the social dynamics and how it shaped and constructed reforms, we take two examples of legislative reforms introduced by the British.

Abolition of *Sati*

The legislative prohibition of *sati* was the culmination of a debate during which 8,134 instances of *sati* had been recorded, mainly though not exclusively, among upper caste

Hindus with a high concentration - 63% - in the area around Calcutta city.[15]

Official discourse on *sati* was prompted by deliberation on whether it could be safely prohibited through legislation. Women became critical matter for public discussion in the 19th century, but this does not signify concern for women. Analysis of official discourse makes it evident that arguments in favour of prohibiting *sati* were not primarily concerned with its cruelty or `barbarity' although many official did maintain that *sati* was terrible even as an act of volition.

Social legislation which set out to improve the situation of women, was at times counterproductive.[16] The Regulation of 1812 introduced in Bengal Presidency to curb widow immolation based on the selective use of Shastric interpretation made by pandits, actually led to increase in the number of incidences as the Regulation introduced the invidious category of `illegal' and `legal ' *sati* as opposed to categories of `voluntary' and `coerced' *sati*.[17]

Ram Mohun Roy's first pamphlet on *sati* was published in 1818, five years after the colonial administration had authorised a particular version of the practice and three years after systematic data collection or *sati* had begun.[18]

Ram Mohun Roy's discussion on *sati* is grounded from the beginning in a discussion of scripture. He produces proof

from Manu and Yajnavalkya of the widow's right to live with her natal or marital family on the death of her husband.

The entire debate on the issue of *sati* was based on scriptural interpretation. The orthodox argument was to demonstrate that the East India Company's criminalising of *sati* was based on erroneous reading of the scriptures.[19] The orthodox argument did differ in one respect from that of Ram Mohun and most colonial officials; it assigned a relatively greater weight to custom. Ram Mohun while giving priority to scripture over custom, criticised his opponents for being "driven to the necessity of taking refuge in usage".

The debate was not conducted along lines that are normally held to constitute the modern. It was not a secular discourse of reason positing a morality critical of `outmoded' practices and a new conception of individual right.[20] The discussion of the rights of women as individuals is also absent except insofar as it is posed indirectly in the context of the widow's will.

In fact, debates on women, whether in the context of *sati*, widow remarriage or seclusion of women were not merely about women, but also instances in which the moral challenge of colonial rule was confronted and negotiated. In this process, woman came to represent `tradition' for all participants: whether viewed as the weak, deluded creatures who must be reformed through legislation and education. For the

British, rescuing women became part of the civilizing mission. For indigenous elite, protection of their status or its reform became an urgent necessity to assert their own civilized moorings.

Raising the Age of Consent

The other area which sparked off debate was raising the age of consent and restitution of conjugal rights.

Traditionally, the Hindu marriage sacrament consisted of two components. The first part was wedding ceremony itself and second part was the consummation or 'garbhadhan', literally the impregnation or conception ceremony. It was obligatory to perform it within 16 days of the bride's first menstruation. This later custom was endangered by the age of consent proposal because of the possibility of the bride's reaching puberty during the two crucial years between 10-12 years. This potential threat generated the controversy which brought into focus, a whole complex of women's issues interlinked with the marriage system.[21]

On the legal front, the demand for consent legislation was considerably reinforced by two court cases, exposing different aspects of the question of child marriage which erupted on the national scene. The first of these was the Rukhmabai case in Bombay. 19 year old Rukhmabai (from educated non-Brahmin elite family of Bombay) had been married in her childhood but refused to reside with her husband

on the grounds of socio-economic and personal incompatibility. Her husband filed a suit for the restitution of conjugal right. The case dragged on from 1884 to 1888 (during which Rukhmabai was threatened with a prison sentence) and ended in an out of court settlement in which he relinquished his claim on her. The controversy which raged around the case was a confrontation between the largely traditional society and the reformers who sought to introduce the Western value of choice and compatibility in marriage which presupposed adult marriage.[22]

The restitution of conjugal rights legislation had forced the women to stay in marital home or risk custodial penalties and tied women's sexuality even more firmly to the control of men.[23]

The second incidence was the Calcutta child wife murder case of 1889, involving 10 year old Phulmony (or Phulmonee as in Tanika Sarkar's article). Phulmony of 10 or 11 yrs was raped to death by her husband Hari Mati, a man of 35. Under existing Penal Code provision, however, he was not guilty of rape since Phulmony had been well within the statutory age limit of 10. Phulmony's family referred that Hari, on a visit to their house had stolen into Phulmony's room and had forced himself upon her thereby causing her death. Hari, however, insisted that since marriage, she (Phulmony) had spent at least a fortnight at his house and they had slept together all the time.

The English Judge, Wilson, clearly indicated that he chose to accept Hari's version, thus exonerating him from the charges of culpable homicide. The charge of rape in any case was not permissible since Penal Code provision ruled out the existence of rape by the husband if the wife was above 10 yrs. of age. The judge, built up his case on the hypothetical argument that the couple had slept together earlier and chose to ignore the version given by the women in the girl's family. The law itself was shaped to preserve custom as well as the male right to enjoyment of an infertile female body. In fact, there is an assertion about the continuity in the spirit of law from the time of the Hindu kingdom to the time to British rule. [24]

In the considerably wide spectrum of opinion which was articulated during the entire controversy, three staunch positions emerged:

i) At one extreme was the self-styled orthodox or anti-reform faction;

ii) At the opposite pole was the reformer faction claiming that the ancient texts have been misconstructed and should be rightly interpreted and followed;

iii) Somewhere in the middle, according to Indu Prakash was a third faction, that of the reactionists which

supported limited reforms to be achieved surely and solely through influencing public opinion.

A systematic effort was launched to restore the `Shastras' to their original accuracy and purity and to resolve contradictions on a logical basis. The real issue running through the argument was in the words of Raghunath Rao (reformer), that infant marriages are not sanctioned by the Hindu `Shastras' nor were they in use in India a few hundred years ago. On the contrary, the marriage of undeveloped girls are in way prohibited by them. [25]

The orthodox and the reactionists like Ram Shastri Apte quoted evidence from 14 `Shastras' to prove that `the girl who sees her menses in her father's house(before marriage) is impure, her father is guilty of killing of the embryo.' Logically, this represented the essence of patriarchial thinking since woman's primary function was procreation, every post-menstrual period to be utilised starting with the very first such period in a woman's life.[26]

The reformers' more humane position stressed that distinction between girlhood and womanhood which rested on criteria other than the mere start of menstruation. But this position had to be made credible and palable by distinguishing it in a religious garb and offering counter-evidence from the same 'Shastras'. [27]

The anti reform argument which the British government itself was most vulnerable to was the Proclamation argument (Proclamation of the Queen as ruler of India declared non-interference in religious and cultural matters) which challenged the very constitutional legitimacy of the bill. The Proclamation like the Hindu sacred books was open to variety of interpretations. Salient among them were the government's conflicting duties to refrain from interference in religious matters but to provide protection to women against exploitation. The Government resolved the dilemma in favour of protection; the orthodox charge was that the bill amounted to government's interference in Hindu social and religious matters whereas reformers accused the British Government of being too cautious and even cowardly about introducing reform through law, due to the constant awareness of its own alien status and fear of causing disaffection.[28]

One thing which obviously emerges is how all nationalist medieval reformers agreed to the definition of consent. This was pegged to a purely physical capability, divorced entirely from free choice of partner, from sexual, emotional or mental compatibility. Consent was made into a biological category, a stage when the female body was ready to accept sexual penetration without serious harm. There is a complete identity in patriarchial values between reformers and revivalists.[29] Whatever their broader views, reformers

always had to struggle with a minimalist programme since nothing else would have the remotest chance of acceptability either with legislative authority or with the Hindu society.

Ultimately the Age of Consent Bill drafted by Sir Andrew Scoble to amend Section 375 of the Indian Penal Code was introduced by the Viceroy of India. The age of consent was raised to 12 years in the case of both married and unmarried girls, but in the case of married girls the offence by the husband was made non-cognisable.

These two examples illustrate the constraints of the reformers and the pragmatic posture of the British legislators who decided to work within the constraints of these existing patriarchal religious and social frame. *Sati* was abolished but the nature of the family contract of marriage did not change. Similarily, the age of consent was shifted by just 2 years but child marriage continued thereby the right of men to abuse minor girls was never actually questioned.

Till now, it is quite evident from these debates that history of British rule and the working of British courts in India manifest a distinct tenderness towards the customs and religious observances of the Indian people. Secondly, colonial rule, with its moral civilizing claims, is said to have provided the context for a thoughtful re-evaluation of Indian 'tradition' along lines more consonant with the 'modern' economy and society. This is believed to be the

consequence of India's incorporation into the capitalist world system.[30]

B. Women's Movements and National Movement

The struggle for the upliftment of women in India began in the 19th Century. It was an offshoot of the fight against colonialism and the aspiration for national freedom. Enlightened freedom fighters some of them product of western education, could see parallels between the political impotency of a nation of `men' and an all encompassing oppressiveness of women. These political leaders, social reformers, missionary workers - virtually an all male hegemony - were interested in improving the status of Indian women. They were supported in their struggle by a few emancipated women on a variety of issues that degraded women. By contrast in contemporary times, the effort to improve the status of women has been taken up largely by women themselves. Earlier efforts to improve the status of women and the contemporary women's movement was, to a considerable extent, the product of an idea that had its birth in the West. However, our own historical and cultural experiences have provided a unique momentum and direction.

The 19th century women's movement did not attack the prevalent patriarchal system in anyway. Rather, the attempt was to improve the condition of women within the frame of patriarchy. [The term patriarchy is used not only to refer to the system of familial organization in which the father

as head is vested with primary right, but also to mean *all* the extant economic, social, political and cultural system which *naturally* grant first place to men rather than women.][31]

The social reform movement was perhaps aptly termed a movement for the `uplift' of women - uplift is indeed effected by an outsider.[32] An awareness of their rights was lacking, by comparison, in women in the 19th Century, who were, by and large, at the receiving end of the male patronage. However, efforts were made to improve the lot of women within the framework of patriarchy so that as wives, mothers and daughters they could have a better deal inside the family. This was not a result of sudden outbreak of generosity on the part of men. The social reform movements arose out of the conflict between the needs of an emergent `educated' urban middle class and the norms of the older, feudal family system. In fact, the reforms were an attempt to change the older patriarchial system and bring it in line with material needs of the urban middle class.[33]

Whatever changes have come about since that time in the social and legal position of women, have been through objective socio-economic pressures, rather than clear cut ideology or really autonomous struggle. Mental attitudes and values have consequently changed very much less.[34]

Feminist consciousness around World War I is more closely linked to the women-led movements of the last

decades of the nineteenth century than the earlier male-led reform movements. It is said to have begun in the last decades of the 19th century when Pandita Ramabai, Ramabai Ranade, Anandbai Joshi, Rukmabai and others crossed the bounds of familial and cultural restrictions of a patriarchal society and went abroad to study. They returned with a new awareness of their rights and immediately became involved in raising women's issues in the country. For the first time, women formed independent organizations in 1886, Swarna Kumari Devi started the Ladies Association, Pandita Ramabai started Sharda Sadan in Pune in 1892 to provide employment and education for women. Ramabai Ranade started the Hindu Ladies Social and Literary Club in 1902 and Seva Sadan in 1909 in Pune. The central issue they focused on was education and awareness. Women's education was not confined to debate alone, it took the form of social agitation. Women's Organisations began to set up schools for girls. Annie Besant started an institute for girls in Benaras. Crosswaille Girls School was strated in Allahabad. Some of the women involved in the movement taught in these schools on honorary basis. Apart from formal education, schools held classes in craft such as stitching. Mahadevi Verma, a noted poet was a product of Crosswaille school. Interestingly, she was married at the age of 10, but her father continued her studies. After completion of education, Mahadevi rejected the marriage. This step showed rare courage and needs to be

viewed not only as a personal event but also against the backdrop of the ongoing women's movement.

Along with this, women's journals were started in Madras, Calcutta, Gujarat and Mysore between 1905-1913. These provided impetus to the movement by creating a platform through which women continued to express their views.

Annie Besant, as a leading figure in the national movement, started the Women's India Association with Margaret Cousins in 1917. The objective was to demand women's rights and increase their participation in the national movement. In an attempt to establish an all-India organization for women, the National Council for Women in India was initiated in 1925. In 1926, the Women's India Association brought together several scattered women's groups in the country at a convention and many of them united under the banner of All India Women's Conference. Women's own organisations developed as part of the anti-imperialist movement.

Votes for women was first raised as an issue in 1917, when a women's delegation, led by Sarojini Naidu, met Montagu, Secretary of State for India, during his visit to discuss Indian demands for political representation. Montagu derided the idea and did not even mention it in his report, but the subsequent Southborn Franchise Report rejected it. The reasons given were that it would be

premature when even so many men were not sufficiently educated to use their rights responsibly[35]. When all the major political groupings in India supported the principle, British were forced to abandon these arguments, but instead of taking action themselves, they put the onus on the new Indian legislatures to decide. The colonial government may have wished to free Indian women but they did not intend to do so by allowing them equal voting rights. It would indeed have been difficult for the British to agree on such a policy in India in 1917-1919 since in Britain, women were not granted the vote until 1928.[36]

In 1929, the Viceroy announced a round table conference to discuss Indian demands for total independence. The All India Women's Conference proposed a three women delegation to put forward its policy of adult suffrage, but the British Government rejected the delegation. In 1932, the Women's organization again demanded representation at the Second Round Table Conference, and were eventually invited to send three representatives to the Parliamentary Joint Select Committee in London. The delegation was scheduled to meet the Committee in July, but the meetings were repeatedly postponed, until they were informed that they could appear before a sub-committee.

The Simon Commission which was appointed to investigate responsible government of India was boycotted by Congress as it comprised of all Britishers and Congress declared the

goal of total independence and published its own report on self government in 1928. As a result of women's organizations' activities, the report fully supported the women's demand for universal adult franchise and at Independence in 1947, the principle was enacted. Meanwhile, the Britishers rejected adult franchise as administratively impossible and instead included in the 1935 Government of India Act the wives and widows of men qualified to vote. Of course, this was rejected by women's organizations on the grounds that they demanded female equality and equal individual rights.[37]

The women's movements in the period of the World War gathered support on three accounts:

i) One was on the basis of history and *Puranas*. Women writers like Rameshwari Nehru sought examples from the Hindu *Puranas* and history to support their argument for the liberation of women. The examples of `Sita, Savitri, Damayanti and Shakuntala' were taken to show that these were not women who lived within the confines of *purdah*. The brave Rajput women who fought and died on the battle field for the country were likewise not women who could be confined to *purdah*. Women often used such arguments for supporting their demand for women's liberation.

ii) The next major source of support that the movement drew upon was the European women's movement. In

1905, in Europe, women were agitating for rights for political participation. The ongoing debate on the role of women in society was put to an effective end by the World War, when all able-bodied men were away at war front and women took on men's responsibilities with complete success. As a result, in England when the War came to an end, the Government had to concede the demands of women's movement. Educated upper middle class Indian women were instrumental in publicizing the role and achievements of European women.

(iii) The third form of significant support for the women's movement came from the national movement for *Swarajya* (Self-Rule). Annie Besant, a major figure in the agitation raised the question that if women are equal to men in every respect then how could there be true *Swarajya* without the full participation of women.

Many women writers expressed these views by writing in journals and newspapers. Rameshwari Nehru and Uma Nehru started *Stree Darpan*, a journal from Allahabad. The questions (questioned patriarchy and women's subordination within the family) which Uma Nehru had raised were not those which were taken up by the Indian women's movements but were raised abroad. The question she raised and the answers she gave, were part of a discourse of the British

women's movement. Indian middle class nationalist women did not attack gender discrimination in a way which would make a dent in male domination and patriarchy, instead they confined themselves to reformist issue.[38]

In spite of her progressive feminism, people like Uma Nehru were not able contribute to the movement to the same extent as Gandhi did.

Gandhi appealed to women as independent individuals. Madhu Kishwar emphasizes that Gandhi's main contribution to the cause of women was "his absolute and unequivocal insistence on their personal dignity and autonomy in the family and society". While he held the traditional symbols of Sita and Draupadi for women to emulate, he gave these symbols a vigorous new life which was worlds apart from the commonly accepted lifeless stereotypes of subservience.[39]

Gandhi stated that men and women are equal. Women have right to freedom to achieve as high office as men. He said that the point of view, that held women unworthy of these rights because they were not educated, was unjust.[40]

Gandhi gave new strength and inspiration to the freedom movement and drew into it women in large numbers. Gandhi had nominated Sarojini Naidu to lead the raid on Dharasana after he and Abbas Tyabji were arrested. In Bombay Kamaladevi Chattopadhyay and Avantikabai Gokhale were among the first women to break the Salt Law. Gandhi did help to raise

consciousness among women and help increase women's participation in National Movement.

There were broadly three stages in the movement for the emancipatíon of women in India - the first stage starting from Ram Mohun Roy, attempting to change conventions and to apply rational and humanitarian criteria. The second stage from mid-19th Century onward the great stress was laid on women's education. The third stage was marked by the entry of women in political field.

In short, women's movement or concern for women's position in society was initiated by men, but later on women themselves took over this task as part of National movement. Most of the women who participated in this movement were those who had been exposed to western education and some of them had personal experiences of oppression. The attempt was to educate women and demand equal rights for women. These attempts have been reformist and did not question patriarchy/power structure. Few women, like Uma Nehru, who dared to raise voice against discrimination and oppression and question women's subordination within family were not successful in getting support of masses though they continued to express their views by way of writting in journals, etc.

But women's organisations were very active in national movement and continued to demand equal rights for women. It is the women's involvement in national movement which gave birth to women's movement in India.

II. Some Aspects of Women's Movements in Western Society

To the extent that early efforts at the emancipation of women were influenced by western ideas and education, the understanding of the genesis of western feminism is important for understanding the nature of feminism in Indian middle class.

Western societies have also undergone changes over a period of time. We would see along with these changes which factors influenced the emergence of feminism.

Infact, Feudal societies existed in early Greece from 5th to 12th Century B.C. and in medieval Europe from late 5th to 14th Century A.D. Although political and economic life was organized by alliance among kin groups, a small minority who possessed military power controlled almost all the landed property and wealth[41].

In the case of Europe, family life differed greatly depending on whether one belonged to the warriors, aristocracy or the labouring serf class. The status of serf was mid way between slavery and personal freedom. Every serf had to work on his land as well on the land of lords/aristocrats. Their labour was a form of tax. They also had to pay little or tenth part of their income to the church and do heavy labour for the manor. For centuries, there was more land than there were peasants to cultivate, so marriage

outside the manor was forbidden. This ensured that children would take over the labour of their parents.

In pre-industrial household the position of men and especially father was supereme in all classes. He controlled marriage and sexual lives as well as the occupation of all members of the household in ways that best supported its economy. The marriage of girls was arranged either by the father or by the master for serf and peasant families. Women played a key role in production as farm houses and individual households were the main unit of production of goods. In Europe, feudalism was replaced by state organised societies between 5th and 16th century.

Industrialization was the main reason for the changes in the family pattern of the household. The England of 18th Century, then the Western Europe and the United States, were the first to undergo shift in social production.

Historically, significent withdrawal of women and children from the world of social labour and public life occurred later in wealthy families of Europe. In 18th, 19th Century, with industrialization, these groups became dominant economically and politically in Europe and America.

Women in these capitalist families became `ladies'. They were leisured like aristocrat women in pre-industrial period. Their lives were confined to the private sphere and defined by domestic function of consumption and reproduc-

tion. Indeed motherhood was the only function that the society recognized for `ladies', until ladies themselves forced a change. The women's movements of the second half of 19th Century and early 20th Century was largely a struggle of upper middle class women to break away from the limits imposed by marriage and mothering role.

These changes in society did not affect women of lower strata in the same way. The nuclearization of working class families increased with industrialization. Women and children had to work as unskilled workers on lower rate of pay and often had to work longer hours. They worked in un healthy and unsafe conditions. It was necessary for women and children of these families to work. Only by pooling their wages could they hope to feed and house themselves. Working class women who needed to supplement their income were handicapped in earning as care of children claimed most of their time. But this did not keep married women out of the labour force. Denying them factory and office jobs did not keep them from working for pay. It simply bound them to unskilled, underpaid work at home and outside.

A. Emergence of Women's Movement

These conditions were the prime source of emerging social movement for the rights of women as capitalist production and class formation produced important changes in their lives.

While freedom from household work was a welcome feature in the lives of the higher income and middle class women, it was not accompanied by freedom to do anything else. This meant women's prescribed role was either of wives or mothers.

Though the movement was restricted at this time to the activities of a minority of educated middle class women, its importance lies in the fact that it sought to deal with the social contradictions that the middle class women were facing.[42]

The specialisation of the family had the differing impact on the middle and working class. The question then arose - would home and family and thereby society suffer or benefit if women, the traditional home maker, be allowed to join political and legal privileges, education and employment? This necessarily involved an exposition and definition of the nature, role and status of women within the perceived needs and aims of a society undergoing changes and stresses.

The beginning of an organized women's struggle was marked by organization of Langham Place group, which in 1856 collected more than 26,000 signatures to press for demanding the reform of the Married Property Act. Two years later, the group started first feminist journal, the *English Women's Journal* which became the official organization of women's movement. The following year, the group started a

society for promoting the employment of women. In 1860, came the Victoria Press, run by and for the women. In 1862 came the Female Middle Class Society. The same year saw the beginning of struggle for admission to degrees at Oxford and Cambridge as well as the Suffragette Struggle. In 1869, it started the struggle for the repeal of Contagious Disease Acts which gave the police power to victimize and harass prostitutes while protecting and legitimising a double standard of sexual morality for their male clients.[43]

Employment of women, whether single or married, outside home generated great deal of debate. Would not work in factories deprive them of the time and environment needed for them to learn domestic skills necessary for setting up home when they married? Who was to look after the family if they continue work after marriage? A host of social problems and crime were seen in the light of these questions.

The middle class women's movement was aware of the problems of working class women and highlighted their distress. They also frequently argued the case for legal re form, better paid jobs, education and the vote, by pointing to the disadvantage that working class women suffered. With the emergence of trade unions, the cooperative movement and revival of the socialist ideas in 1880s, working class women got organized separately in the last quarter of the century. The political character of the working class women's organizations was totally reformist. Trade Union League

(1874), Women's Cooperative Guild (1883) and other allied organisations had their own demands - shorter hours, higher wages and maternity benefits, but other demands were in common with the middle class women's movement, for example right to divorce, education and right to vote.

These organizations formed an important bridge between the women's movement of the middle and the working class. The working class women's organizations were heavily dependant on middle class leadership and support.

On the one hand, middle class leadership supported working class women's demand for shorter working hours, better pay, good working conditions and for provision of child care facilities, on the other hand, with the improvement in the standard of living of skilled workers by the 1970's, it reinforced the ideology of women's place in the home. The prevailing middle class Victorian ethic of home government firmly entrenched within the working class over a period of time. To understand this phenomenon it is necessary to understand the western intellectual ethos within which women were ideologically located.

B. Women as Perceived by Western Philosophers

Changes in society also saw publication of major ideological statement concerning women. The ideological position did not arise in a vacuum, they are embattled positions taken in the wake of social changes.

Though our focus is on changes that were taking place in the 18th and 19th Centuries but no discussion on women would be complete without referring to Plato and Aristotle, who are even today refered back at different points of time. To some extent these provide us the ideological basis of the treatment of women in pre-industrial feudal societies. Even Plato's radical posture was not an expression of freedom but of total subordination.

Plato

The status of women in Athens during the 4th and 5th Century B.C. was little better than that of its slaves. Cut off from the duties and rewards of citizenship and confined to the home, a respectable woman led a life consisting of an endless round of domestic trivia periodically interrupted by the birth of children. Plato wrote his revolutionary proposal for the best possible state *The Republic*.[44]

Women are classified by Plato, as they were by the culture in which he lived, as an important subsection of property. Just as other forms of private property were seen as distructive to society's unity, so private wives, are viewed by Plato, as diverse and subversive in the same way. Thus emerges his most radical proposal calling for the abolition of the nuclear family among certain group and the promotion of society itself as a family in which divisive interests are eliminated.

The women who were eligible to become wives of Plato's contemporaries were valued for silence, hard work, domestic frugality and above all, marital fidelity.[45]

Aristotle

Although a devoted student of Plato, Aristotle represented the orthodox Greek position, which he sought to justify by various means of his philosophical works. "The Generation of Animals" which investigates the reproduction of life and female's role and `Polities' which discusses women's status in society are of particular interest. Aristotle maintains that women is a mutilated or incomplete man, a thesis that has enjoyed a long and persistent history culminating in Freud's thesis about women.[46] The male's contribution to generation is pure and hence more valuable than woman's, although both are necessary, has been stressed by Aristotle. Man contributes the form or essence of the embryo while woman merely provides the nutrition necessary to maintain it, that is, the male creates human life. And ultimately, women lacks rational soul - she is physically weaker and less capable of rational thought, and subordinate to the rule of men.[47]

18th-19th Century

Towards the end of the 18th Century, in the midst of revolutionary fever in Europe, a book *A Vindication of the*

Rights of Women by Wollstonecraft appeared in 1792. This was a response to Rousseau's program for training women. Although an early disciple of his egalitarian views, she objected to his assumption that men's nature and virtues differ from woman's nature and virtues. Wollstonecraft argued, to deny women a full measure of rationality amounts to denying their humanity. Female virtues - passivity, gentleness and sensitivity - can be only pseudo virtues, since they do not proceed from rational activity. She argued against traditional training for girls as these made them empty headed, frivolous, selfish - and such beliefs and practices damage not only women themselves, but also the family and society as a whole. She urged equal rights for women, though addressed herself mainly to the problems of middle and upper class women of her days. John Stuart Mill, Marx and Engels address the plight of lower class women.[48].

The ideological statement concerning women, which originated around the same time, when struggle for women's rights took place in developing capitalist countries, help us to identify the nature of conflict in that particular period. The ideologies emanated in the course of women's struggles were of consequence for women of both middle and the working class.

These ideologies could be divided into two, as Sudesh Vaid has classified: (i)the doctrine of equality and (ii) the doctrine of separate sphere.

The doctrine of equality rests on the premise that women by nature are equal to men and their present inferiority is due to social factors. This is a premise shared by Mill and the socialist of 18th Century.

The doctrine of separate sphere is analogous to contemporary division of labour and depends on the premise that women by nature are radically dissimilar to men. This has two variants. The first is a secular equivalent to the scriptural doctrine on the inferiority and subordination of women. This variant gets scientific treatment in the hands of Darwin. The second variant depends not on the notion of the inferiority of women, but on her superiority in moral and spiritual realm. This variant lends itself to the idea that women have to be protected from the destructive forces of the world outside so that they can fulfill the function appropriate to their nature.

Mills' *The Subjection of Women* (1869) is the classic feminist piece. Written in England during the early years of the 19th Century feminist movement, it provided theoretical foundation for the argument in favour of equality between sexes.[49] Mill supported the drive for recognition of women's rights by consistently applying egalitarian principles, both as utilitarian and as a committed advocate of civil liberties.

On utilitarian's ground, he argued that no society could hope to approach justice so long as half of its people were in a state of subjection. As a committed advocate of civil liberties, he lamented that women were deprived of freedom and dignity.

As an MP, Mills lent his support to Reform Bill (1867) proposing the extension of the franchise to women on the same basis as men. In 1868, he presented a petition on behalf of women demanding the vote. He also supported the campaign for the repeal of the Contagious Disease Act.[50]

For Mills, the emancipation of women requires at a minimum, a full egalitarian extension of the formal rights of political and civil citizenship. Mills, arguing for formal equality of political and civil rights, is aware that while these are necessary conditions these are not in themselves sufficient for full emancipation of women. As long as vestiges of patriarchal despotism survive in marriage and in the family, he argues, so will the subjection of women. The patriarchal family is seen by Mill as the last remaining bastion of despotism and the laws of force surviving fully intact into the heart of modern liberal society.[51]

Engels

In the midst of the Industrial Revolution, with its appalling abuse of the labouring class, emerged a political

philosopher, Karl Marx. Together with Engels, he expounded the philosophy of historical materialism, which held that (1) all social and intellectual relations are ultimately explained by the material conditions of human life, and (2) the most basic material condition is the economic structure (i.e. the modes of production and distribution of goods). Since the most fundamental social relation is that between men and women, the position of women is ultimately explained by economic conditions. Engels attempted a systematic exposition of this in *The Origin of Family, Private Property and the State* (1884), using as his basis the anthropological evidence of Lewis Morgan. He employs Morgan's threefold classification of the stages of history - savagery, barbarism and civilization to demonstrate how women's position deteriorates.[52] In savagery, group marriage, unrestricted sexual freedom prevailed, paternity was unknown, only female line was recognized. With barbarism the pairing of family emerged, and to insure paternity, woman was held to strict fidelity. With civilization monogamy prevailed, and the patriarchal family solidified male supremacy. Hence emerged the first class struggle, the antagonism between sexes.

These socialist ideas were also expressed in response to Mill's proposal for equal right to both the sexes. William Thompson argued "neither an equality of rights and criminal laws, nor of political laws, nor an equal system of morals upheld by enlightened, will solve the problem of women's inequality. What will be necessary is a different

set of social arrangement, where all "possession and means of enjoyment" are held in common and "individual property and competition forever excluded". Only under such conditions would women have the opportunity for equal improvement and use of all their faculties with men.

The importance of these ideas lay not in their immediate practical impact, which was little but in that, unlike Mill, the inequality of women is seen as related to production relations in the economic sphere and that family is placed in a symbolic alliance with these relations.[53]

The most important opposition to Mills ideas came from Darwin. *The Origin of the Species* (1859) was as Darwin himself acknowledged, gives its framework by the co-relation Malthus made between population growth and its potential harmful consequences for the economic well being of society.[54]

Descent of Man (1871) was published three years after Mills *The Subject of Women*. Darwin maintained that there is indeed inherent differences in the nature of men and women, drawing on the analogy of the lower animals. Woman due to her maternal instincts, develops the qualities of tenderness and selflessness which extend to "her fellow creatures"....Man in contrast develops the higher faculties, "reason, invention and imagination". Darwin's theory of instinct and sexual selection placed women in the domain of inferiority.

Darwin's opposition to women's movement takes a definite form. Grounding himself in the theory in which Malthusian competition for scarce resources and aggression in sexual mating are primary features, Darwin not only gives "scientific reasons" for women's inferiority but negates the very possibility of any change since nature can only act according to its laws.[55] His theory supplied and continue to supply simultaneously, in modified forms, support to capitalism and opposition to women's equality[56] and feminist from 1850's onwards were both to contest the idea of `separate' sphere as well as to draw from it.

It is these developments in women's movement in west which influenced women's movement in India. Educated upper class women, after being exposed to western education, were instrumental in publicizing the role and achievements of European women. Women's writings in journals highlighted history of suffragette movement in England. European women's agitation for rights for political participation influenced Indian women. Though, women's movement in India got influenced by women's movement in the west,nationalism provided its own direction. Infact, there seems an absence of any autonomous struggle for women themselves for equality and freedom, unlike the women's movement in 19th and 20th Century Europe. The women's concern during nationalist movement has been reformist. It attempted to improve the status of women within the existing social structure by way

of education, demanding equal rights and participating in political struggle for freedom. It did not attempt to break the bonds of oppression within family except in few individual cases. It is only in the 60's that these issues began to emerge as critical within the women's movement itself.

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CHAPTER THREE

WOMEN, SCIENCE AND MEDICAL ESTABLISHMENT

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Just as philosophers and social scientists constructed images of women within the constraints of the socio-political environment of that time, so did science and medicine. Dispite all their claims of objectivity both science and medicine are based on assumption which taint the image of their subjects that they create. These assumptions reflect the biases that prevail within the social environment of scientists and medical professionals.

Ruth Belier argues that all scientific ideas have an intellectual history of their own: a long line of ideas developing within their social contexts.[1]

Thomas Kuhn wrote *The Structure of Scientific Revolution* in 1962. He was of the view that most historians and philosophers of science no longer view science as progressing historically through better and better theories by which to understand reality. He demonstrates with examples from early modern Europe, that 'old' theories were often discarded and replaced by 'new', not simply because the new theories had better explanatory power but because events within society made the new theory more acceptable. This was often to do with nature of ideological and political changes.[2]

The scientists, like everyone else, are born and raised in a particular culture of beliefs, biases, values and opinions. They are affected in their work by what they hope, believe, want or need to be true. Consequently, all science bear a heavy load of social values. They are linked to the people who create them and to the social concerns of these people.[3]

It would be appropriate here to cite an observation made by an accomplished microscopist, Van Leeuwenhook. Van Leeuwenhook asserted that he had *seen*, under the microscope "exceedingly minute form of men with arms, head and legs complete inside sperm". Rather it was the old concept and tradition, stemming from Aristotle, that women as totally passive being, contribute nothing but an incubator - womb to the developing fetus that springs full blown, from the head of the sperm. One's conceptual framework, a certain state of mind permits one to see and accommodate certain things but not others.[4]

Though there has always been a strong biological determinist thinking in the science of human behaviour, it surfaces itself more clearly at the times of political and social upheavals. (Women's rights movement, antislavery movement, women's organized demand for admission to university courses).

Sociobiology, another field of science, provides important insights into the social behaviour of animals. Sociobiology considers all human behaviour, characteristics, social relationships and forms of social organization to be biologically, genetically and evolutionarily determined. It relies heavily upon the biology of female-male differences. It announces certain characteristics of female and male 'nature' to be universal: why women are genetically predisposed to be 'attached' to home and men to business and profession; why men are aggressive, nasty, fickle and women are faithful and selective. As a final message sociobiology explain the 'naturalness' of rape.[5]

What, then, becomes necessary is to contextualize such advances in science. It becomes necessary to look at socio, political and economic system that gain much in power, privileges and profits for itself and for individual men from the subordinate position of women.

I. Women and Science

Women's innate temperament - maternal, pure, pious, compassionate - underlay the debate by physicians, natural and social scientist and educators. Women's true roles had been recognized as reproduction and motherhood and any attempt to do other than what they were destined by biology and evolution had been subjected to scientific scrutiny.

In the mid-19th Century, the anti-slavery women's rights and suffrage movements were accompanied by a flourishing science of craniology: human brains were weighed and measured and remeasured in an effort to find some index of qualitative inferiority of brains of women enslaves and other blacks.[6] Anatomists in one decade found females to be deficient in the lobe of brain believed to be the 'seat' of intelligence. The next decade had to reverse the measurements, when it was decided that another lobe accounts for men's highest achievements. After futile exercises to demonstrate consistent qualitative differences, the sciences of craniology faded away.[7]

When women were demanding equal rights in Europe in late 19th Century, publication of Darwin's theory about "The Origin of the Species" (1857) and "Descent of Man" (1871) [Mentioned in previous chapter also along with women's movements in the West] appeared around the same time. His two pieces of work describe the mechanisms whereby evolution is effected - natural selection, sexual selection, and inheritance of acquired characteristics. Darwinist thinking views the body politics - the political and social order along with each person's place within it - as having evolved according to Darwinian law of natural selection.

Darwin maintained that as a result of sexual selection women are more self-sacrificing, affectionate, gentle and maternal. Men on the other hand, are more intelligent, competitive, courageous and energetic than women and have great physical strength. Darwin scienticizes women's inferiority and negates the possibility of change as nature acts according to its laws.[8]

As early as 1895, German scientists and physicians were formulating theories of 'racial hygiene' and suggesting medical practices that could weed out the poor, feeble-minded, criminal and other biological 'misfits'. The same philosophy underlying the political program of the New Right in US today, expressed in its efforts to reinforce the patriarchal family and reinstate it as women's exclusive sphere by withdrawing programs for social welfare, removing women from the labour force, bringing their sexuality and reproductivity more fully under state and male control.[9]

Belier points out that ignoring political and social factors in analysing the origin of political and social relationship under the guise of science, is not only use-less, but biologically hazardous. It lends itself to social 'tampering' and to have political programms that attempt at genetic improvements of populations.

II. Women, Medicine and Medical Estabishment

The health status of any group is a dynamic and complex manifestation of social, economic, political, cultural and historical factors. Social class, caste, political power, income and occupation, and the physical environment play as much role in creating or destroying health as hereditary factors, dietary practices and taboos, or germs and viruses.[10]

Similary, medicine, in its conceptual, professional and political dimension, both shapes and is shaped by the cultural circumstances that surround it and give it at any time its particular character.[11]

The image of medicine as morally neutral, essentially 'benign', an activity which merely deploys effective techniques for curing diseases and reducing suffering and pain has been questiond. The 'scientific knowledge' as applied through medicine, is not merely factual knowledge, it also comprises a set of social messages wrapped up in technical knowledge. Medical history traditionally dwell upon history of disease, emphasizing less the political and cultural environment of disease and more the conquest of disease itself.[12] This emphasis coincided with a view of medicine as a progressive influence and carefully served to legitimise interests of the medical profession.

Medicine as a cultural institution has the power to redefine (or medicalize) concepts into the terms of its own discourse. It encompasses not only the conquest of new disease, but also the extension of what has been called the 'bio-medical' model to the non-medical world.[13] It also implies the extension of Western cultural values to the non-Western world. This view is supported by Navarro who believes that if by imperialism we mean extension of international system of domination - by economic, cultural or political means - it is clear that medicine has its place in this definition.[14] A common culture of medicine sustained by the image of science as the universal agent of progress, and scientific medicine as its servant - became the hallmark of European Empires throughout the world.[15]

Satya Mala adds that medicine has played and continues to play a powerful role as a reinforcer and perpetuator of sexist ideology. It has the dubious distinction of shifting justification for sexism from religion to bio-medicine, thereby taking it out of the realm of prejudices and putting it within the confines of "Scientific Objectivity".[16]

We would illustrate these through four major examples:

i) Women were not excluded from medical education and practice in 13th and 14th century. In Medieval period witch hunt was at its peak and many of these were women healers. Though witch hunt was a part of larger

socio-political changes but its impact on women healers was significant.

ii) Secondly, professionalisation in medical field began in late 15th century onwards. It started with changes in economic and political field. From 17th century onwards advancements in scientific field had much to contribute in professionalisation. With this though women continued to be in the medical field, they were confined to much lower ranks.

iii) With advancement in medical and scientific field, normal body functions were medicalized. It provided medical view of pregnancy and women's diseases so as to fit in the prescribed social roles.

iv) And finally State's interest in maternal and child health after world war was not only motivated by the welfare orientation but again was a part of much larger socio, economic and political interests. This is discussed at the end of this section.

A. **Women Healers and Witch Hunting**

For centuries women had been healers to family members, midwives to younger female relatives and neighbours. They learnt their work from old experienced women. They were skilled in making medicine and midwives.

The relative or total exclusion of women from the ranks of the healer by 17th century seems to have been part

of the process of professionalization.[17] At first women were not totally excluded and even the development of universities did not drive them out. The famous medieval medical school at Salerno in the 11th Century accepted men and women among both teachers and students including the well-known women medical teacher, Trotula.[18] (The differenciation between doctors, nurses and midwives is a later development. Earlier, there were either male healers or female healers).

In France and England and with northern Europe generally women were not allowed to study at University. It was the bishops rather than the city authorities who issued licences to doctors[19]. Attempts to est ablish a closed shop, and exclude women seemed to have begun in earnest in Britain in 1421. When a petition from the universities was received and approved by Parliament, recognizing the dangers of allowing 'ignorant and unskilled persons' to practice medicine and surgery.

The situation remained as it was until Henry VIII set about ext ending centralized state power in various spheres, and arranged for the enacting of the Medical Act of 1512.

Practice was to be restricted to those licensed by bishops. The licence depended on both competence and moral suitability, including religious reliability which became

of increasing importance later. Later in Henry's reign the so-called 'Quack Charter' restored the right to practice (by implication without a fee) to 'honest persons...men... (and)...women, whom God hath endowed with the knowledge of...herbs'.[20]

This was the development in City of London. But for most people, who lived in the country life went on much as before. McConaghey (1961) has described some features of medical care in one corner of England. The Bishop of Exeter duly granted licences from time to time. In 1568, he granted two medical practitioners permission for the practice of surgery - one of these was a woman. McConaghey also found that Church wardens kept record of parish payments for treating the sick or injured poor. Many of these payments were made to women.[21]

In 1542, the first law against Witchcraft in England was passed: "The Act Against Conjurors, and Witchcraft and Sourcery and Enchantment". The Act said that witchcraft was no longer a matter to be dealt with by the Church Courts, but had become a serious criminal offence punishable by death.

The people accused of witchcraft included women. Many more women than men were accused of witchcraft and found guilty, shows Hillary Boudillon. The first execution for witchcraft in Britain was in 1479 and before the laws were

repealed in 1735, about 30,000 people died. The majority of these deemed to be witches were women, and many of these were believed to be knowledgeable about herbs and magical means of promoting and destroying health and intervening in child birth.[22]

The women healers and midwife were in danger of being accused of witchcraft because of the charms and rituals used for the treatment despite the fact that treatment/healing of that period involved use of the same magic and ritual. John Locke (1681), who was a Fellow of the Royal Society, wrote about treatment of pain in kidney which involved rituals rather than treatment. Treatment of wounds also involed some rituals (like applying ointment on the sword rather than on the wound).

The objection was not to the type of healing being practised by the wise woman but to the fact that she was an unlicensed healer. People who practised medicine without licence were sometimes accused of witchcraft as they were believed to have got their healing power from the Devil and not from God[23]. The penalty advocated by Church was strange: "If a woman dare to cure without having studied, she is a witch and must die". The exclusive stricture for untrained women let the untrained men go about their healing business without any interference. But all women

accused of witchcraft were not healers and not all women healers were accused of witchcraft.

H.C. Erik Midelfort's study of 1,258 witches' execution in south western Germany during the period 1562 to 1684 shows that 82% of the witches were females. Defenseless old women and lower class midwives were usually the first to be accused in any local outbreak.[24]

All the women who were brought to trial as witches seemed to have one thing in common, i.e., 'the devilish of her tongue'. Women were particularly outspoken and critical of the way in which things were managed in their communities. The witch hunt did not get rid of all women healers, only those who were seen as challenging the control of the State and Church.

The biggest influence on people's thinking about witches came from the writings of two Dominican monks who worked for the Spanish Inquisition. In their book, *Malleus Maleficarum* (The Hammer of the Witches) they wrote that women rather than men were likely to be witches. Women were seen as imperfect human beings and Christian Church taught that women were the cause of bringing sin into the world and were therefore easy targets for the Devil. *Malleus Maleficarum*, the guide book to witch hunting was clearly concerned with the sexuality of women and their intervention in what was termed 'the Veneral

Art". (Veneral Art refers to toxication or poisoning by preying or feeding. This also refers to offering the new born child to the Prince of Devil by raising it up on the pretext of warming it).

A handful of people probably drawn from the ranks of the frustrated and discontented people could not really become a threat to the survival of the propertied and the governing classes[25].

The explanations for the phenomenon of witch craft differ. Ehrenreich and English (1974) argue that persecution of witches was primarily a campaign against women and particularly against women healers[26]. However, Leeson and Gray feel that it is an over-simplification. It is no accident that witch hunt came into increasing prominence along with the violent protests against social and economic inequalities. The Pope gave permission to use torture against witches shortly before the Protestant Reformation, and the witch hunt peaked during 16th and 17th century wars amidst revolutions that put an end to the era of Christian unity[27].

A more plausible explanation therefore comes from Marwin Harris. He points out that the best way to understand the cause of witch mania is to examine its earthly results rather than heavenly intentions. The principal result of the witch hunt system was that the poor

came to believe that they were being victimized by witches and devils instead of princes and popes. The practical significance of the witch mania, therefore, was that it shifted responsibility for the crisis of late medieval society from both Church and State to imaginary demons in human form. Preoccupied with the fantastic activities of these demons, the distraught, alienated, puperized masses blamed the rampant Devil instead of the clergy and the nobility.[28]

The laws against witches were repealed in many countries in the 18th Century. The last treat for witchcraft in England took place in 1712, and in Scotland in 1722. But by that time the witch hunt was repealed, the medicine of the physicians was accepted by the Church and State, whilst the medicine of the wise-woman was regarded as being based on superstitition and ignorance.

Inspite of witch-hunting, the Parish did employ women healers to treat the sick poor and to help at times of out breaks of Plague. In England, the city authorities employed women to do the unpleasant job associated with plague. They worked as searchers, examining bodies for the black spot. The same women who dealt with victims of the plague were also paid to treat the poor who were sick and to deliver the babies of pauper women. The Poor Law Act, passed by Queen Elizabeth in 1601 meant that the sick and

poor had become the responsibility of the local Parish and Parish officials wanted to keep the cost of looking after the poor as low as possible and so employed local wise-women, rather than pay the high fees demanded by university trained doctors.[29]

This strengthens M. Harris' argument, for it shows that the female healers were actually of some utility to the State. It also shows that there was no scientific basis or logic for excluding women from practice. A State that on the one hand hunted women for practising mid wifery, on the other hand used them for running its own hospitals as they could be cheap and effective.

The analysis shows how all through centuries even the earliest efforts at medical practice were deeply influenced by social and political forces.

B. **Professionalisation in Medical Field**

Professionalisation of any field has certain pre-requisites. It requires a special kind of training, recognition, patronage of State and the Church and monopoly of knowledge. To obtain the training the professional guild sets up its own requirement and there is a kind of hegemony that it exercises over new entrants.

Medical profession also has this special nature. It has been granted the right to autonomy - to determine what

its work is, who can do it, and how it should be done. In medicine the right has been granted by the ruling elite, who based their patronage on a recognition of learned content - the scientific body of knowledge on which medicine is based, and on its ability to produce desired results for the public good.[30]

Freidson argues that worthwhile results are essential prerequisites for a service profession like medicine to establish itself or rather, to obtain a legal monopoly.[31] However, in Britain the Apothecaries Act of 1815 and the Medical Registration Act of 1858, were passed long before the profession had proved itself in any demonstrable way.[32]

The establishment of medicine as profession required training. By 13th Century more and more young men of means sought medical training.[33] The Church imposed strict control on the new profession and allowed it to develop only within the terms set by them. The treatment provided by the university trained doctors was no way better than the treatment provided by lay healers or unlicensed healers.

Most of the universities were closed to women even from upper class and licensing laws were established which prohibited practice by unlicensed lay healers. The partnership between Church, State and medical profession reached full bloom in the witch trials also, where he was

called as an medical expert giving an aura of science.[34] He owed his new status not to medical or scientific achievements of his own but to Church and State, he served so well.

By 18th Century, there was increase in university trained doctors. As a result of the work of the scholars and physicians working in the university, peoples' knowledge of Anatomy and Physiology increased. Yet this knowledge did not mean medicine improved or that people had a longer life expectancy. In fact, one 'invention' of the 18th Century, which did increase life expectancy - the use of inoculation against small pox, had nothing to do with peoples understanding of how the body works.[35]

With industrialization, people were cramed into towns near the factories. They lived in small houses, where there was no fresh water supply or sewage system. These conditions were to bring hazards to peoples health. Typhoid and tuberculosis thrived in the new insanitary manufacturing towns. In 1831, a new epidemic 'cholera' spread in Britain.

One of the public health legislators, Edwin Chadwick's interest in this resulted in the 1830's new Poor Law. His Report described the squalers and overcrowing in the industrial towns. He concluded that local government was responsible for improving the conditions. In 1848, the

Parliament passed the first Public Health Act, which set up a Central Board of Health and with Medical Officer.

Public health reforms alone could not remove the ill-health bred in industrial towns. In 1834, the Poor Law of 1601 was amended. Now Parish was to join together to form unions to provide relief for the poor. This affected medical treatment available to them. The Union Surgeon now replaced the Parish Surgeon. Due to stigma attached to poverty, particularly under the New Poor Law, only a minority of the sick poor received their treatment from the Union doctor.

By the same time, French and German scientists brought forth the germ theory of disease which provided rational basis for disease prevention and therapy. So for doctors both science and patronage became available about the same time. This gave boost to establishment of laboratory work in basic sciences with expanded clinical training. Slowly licensing laws and scientific expertise sealed the doctors monopoly on medical practice.

One obvious group outside the control of University physician was midwives. It is not that physicians ignored that area. But until pregnancy and child birth were defined as medical events, midwifery was in no sense a branch or area of interest of medicine as a profession.[36]

i) Growth of Midwifery as a Profession

From the beginning of human kind's existence ill health has been part of common experience. Anyone who lived long might have gained enough experience to advise younger members of the group how to avoid or treat ill health. It was the elder women who were available and who knew most about disease and about helpful remedies. Women who had borne children were also most likely to be midwives of others. Not everyone agrees - Malkin (1961) suggests that 'husbands' were the first specialist, although he gives no evidence other than a passing reference.[37] Hilary Bourdillon shows that from peasant women to Lady of the Manor, women were skilled at making medicines and midwifying during middle ages.

She also mobilizes the evidence to show that when ill, people prayed to god and goddess to help them get better. The deities worshipped were female. She gives examples from Ancient Egypt, Greek and Roman tradition in support of this assertion.

The care of woman in childbirth was part of woman's work throughout the middle ages. A midwife learnt her work by becoming apprentice to an older experienced midwife and the local priest had to swear to the apprentice's good character. Throughout Europe in the Middle Ages, it was the usual practice that women should be attended only by

other women when giving birth. Guides for women's health were written to help midwives in their work. A Medieval Women's Guide to Health dates back to 15th Century[38]

Midwifery, like the other areas of medicine, came increasingly under the control of the Church in the 16th and 17th centuries. As mentioned above, a law was passed in England in 1512, which stated that all midwives had to obtain a licence from the Bishop before they could practise.

Until the 17th Century nearly all midwives were women. But around 1625, a new phrase came into English language: the man-midwife. By the mid 18th Century, the *accoucheurs*, outnumbered the female midwives among the highly paid mid wives employed by the upper class. Among the lower classes, midwives were still mainly women.

These men-midwives or *accoucheurs* were trained in anatomy. They attended one of the Scottish universities or the midwifery course run by experts in London.[39] They were thus better able to cope up successfully with abnormal births involving malpresentations and they were skilled in handling of forceps. Porter and Porter feels that one of the most traumatic events of "women's life was becoming medicalized and placed in the hands of male practitioners and all-male experts".[40]

The main change in the practice of midwifery in the 17th Century resulted from the invention of the delivery forceps by Peter and Hugh Chamberlain. This new technology in child birth paved the way for man midwife.

Many women in labour were reluctant to employ a man midwife. The man midwife was associated with difficult labour where some kind of surgery was necessary.

McKeon and Brown (1955) evaluated several medical developments in midwifery in 18th Century. One was the establishment of lying-in hospitals (the first was in Lon don, in 1749) of which men-midwives were keen advocates. These have increased maternal and infant mortality than to reduces it, as the spread of pueperal sepsis took its dreadful toll. Forceps were associated with high maternal and infant mortality rates, even if occasionally they saved lives. (A century later, Florence Nightingale estimated insitutional MMR as 34/1000 deliveries, more than seven times higher than in domicillary deliveries).[41]

Amongst the poor women midwife was favourite. They were called to deliver babies. In 1902, the Midwives Act required all people calling themselves midwives to be registered. It laid down qualification for midwives. People still carried on using the unqualified midwives because they were cheaper compared to qualified ones.

Doctors were no better trained to delivering babies than midwives were. Throughout the 19th Century the death rate of women in child birth was slightly higher among upper and middle class women who were attended by a doctor, than among the working-class women attended by a mid wife.[42]

Professional self-interests reinforced the reserved club like world of male professionals and led even doctors to resist women in search of new careers. From late 18th Century, male doctors had been encroaching on the midwife's preserve and made it difficult for her to acquire professional qualification.[43]

ii) **Development of Nursing Profession**

Most often, all sick were cared for or nursed at home by those around them.

Economic and social development in 18th and 19th Cen turies created great demand for institutional care, and caused hospitals to be established in many towns. Some were run by religious order and others sponsored by local philanthropists. Their inmates included the chronic sick and dying and cripped, the old and the mad from among the urban poor.

Until late 18th Century doctors were rarely concerned with hospitals to any great extent. Post-revolutionary

France began to take the lead in European Medicine based on extensive clinical and pathological studies of institutionalised patients. Medical students came in to be taught on this 'clinical material' to practise clinical examination and diagnosis and in due course, post-mortem examination.[44] This was to gain more knowledge and experience and thus to be better able to treat their affluent patients.

The sick in institutional care were drawn almost exclusively from these groups whose home circumstances were totally unsuitable for any sort of home nursing - the poor and the destitute. The status of nurse looking after work houses and voluntary hospitals were low. They were badly paid even by the standard of women's wages at that time.

There was other category of nurses, who catered to upper class families. They were mostly respectable married or widowed working class women. They were a kind of superior domestic servant.[45]

By 1860s some hospitals began to recognize that good nursing played an important part in a patient's treatment and they gave medical training to their nurses.

Abel-Smith in *History of Nursing Profession* (1960), documents that demographic changes led to a surplus of single women; those of the working class could find some

occupation in industry, mill, etc., but the despised and shrinking role of governess was open to gentlewomen.[46] Nursing was considered an exclusive of feminine role, as a help mate to the men-doctors. Several hospitals had already made a beginning.[47]

In fact, it was Florence Nightingale's return from successful expedition to Crimean War, which marked the beginning of major changes. She came from upper class family and had to fight against the disapproval of her family.

Florence Nightingale used her friends and contacts in the Government to convince the public and the medical officers of the necessity of good nursing. She spent the rest of her life advising public and the medical officers on matters of public health and hospitals and overseeing the setting up of training hospitals.[48]

Ashley (1976) argues that sex hierarchy in distribution of power in health services is a reflection of male-female relationship in the family.[49] A Doctor who is in the position of authority passes on the instructions which are carried out by the nurse. Her work is more to do with her 'natural function' - caring.

iii) **Women Doctors**

The first woman to get registered as doctor by the

British Medical Association was Elizabeth Blackwell in 1859, who came from USA. In the following year BMA changed its rules and allowed only those people who had studied at a British University to become registered doctors. This new ruling effectively excluded women, because they were not allowed to study at British University.

The other woman Elizabeth Garette who wanted to become doctor, spent sometime training as nurse and attended some lectures given to medical students, until the male students objected to her presence and insisted on her leaving. She studied privately with professors and took a course on midwifery. This enabled her to run a dispensary. She was able to take her final examination in Paris and was allowed to practise as doctor in 1870.

Subsequently, other women were not allowed to follow the same footsteps. The women faced a great deal of opposition and harassment from medical students. They were refused permission to do practical work.

The women's situation was brought before Parliament and prompted debate in newspapers and journals. A Bill was introduced in 1875 which enabled universities to educate and graduate women on the same terms as men.

A common argument against women training to be doctors was that men would be embarrassed to be treated by them and

some men felt that women were not physically capable of doing this work.[50]

Though medical education and training were open to women doctors, they had difficult time practising medicine like their male-counterparts in their own country. In the next chapter we would see how those women doctors choose to work in India which not only provided field training to women but also legitimised colonial government's concern for Indian women who lived in *Purdah* and thereby deprived of western medicine.

III. Medical View of Pregnancy and Women's Diseases

What emerges from the above discussion is that over a period of time medical establishment became the monopoly of males. It tried to drive women out. At the same time, medicine continuously expanded its field to embrace more and more normal body functioning requiring expert attention.

Pregnancy is the most important field which came under medical scrutiny. A particular area of social behaviour (pregnancy) comes to be separated off from social behaviour in general and reconstructed as a specialist, technical subject under some expert authority.[51]

Anna Oakley argues that even antenatal care is both an examplar and a facilitator of the wider social control of

women. She feels that antenatal care may be equated with other forms of social control over women on the basis of what is said by the clinicians and policy makers.[52]

The frame of reference that the doctors apply to child bearing does not entertain the possibility of an equal relationship between the provider and the user of the reproductive care.[53] This kind of relationship classifies the state of reproduction as a medical subject, the state of pregnant women as patients and the measurement of successful outcome in terms of biological mortality rates.[54]

The medical frame of reference evolved with the development of obstetrics and gynaecology as a medical specialization.

Division within medicine - obstetrics, gynaecology, paediatrics, fetal medicine, reproductive medicine - have segmented women's bodies into competing professional clusters and domains of medical work; womanhood and motherhood have become a battle field for not only patriarchal but professional supremacy.[55]

The medical view of women's health went much beyond the risk associated with reproduction. It defined all female functions as inherently sick. Puberty was seen as crisis, menstruation and pregnancy made women indisposed

and menopause was final incurable illness. The doctor's view of women as innately sick does not make them sick or delicate but it does prove a power rational against allowing women to act in any other way.[56]

Padma Prakash points out that medicines 'model' of the normal human being is the upper/middle class male. This makes all women by definition 'abnormal'. Female physiology is considered a complication of basic male physiology especially with reference to reproduction.[57]

To medical men the 'sick' women from upper class were God sent. Here was a patient, who was ill without being 'diseased', in obvious need of the ministration of a medical man, compliant enough to obey every one of the doctors' demands, and wealthy enough to afford the prolonged treatment... an ideal patient. (Satya Mala referring to upper class women of 17th-18th Century who were forced into sedentary life of enforced leisure.[58] The 'cult of invalidism' emerged among upper class women.

In contrast working class women were not paid the same attention though they were subjected to a host of illnesses due to poverty, unhyg ienic living conditions, low wages, etc. It was the upper class women whom medicine considered as inherently 'sick'. Women from lower class were considered strong enough to bear children and work outside home for wages.

As 'scientists' the medical men end up proposing theories that were actually justification of social roles.

Medical theory of women's weakness rested on the basic physiological law: **conservation of energy**. According to this theory, human body contains a set quantity of energy which is distributed to various organs. Ability of one organ could develop at the expense of other by drawing energy away from other organs. The second and most important aspect of this theory is that reproductivity was central to a woman's biological life. The presence of uterus in woman's body makes this competition highly unequal, with the reproductive organs in almost total command of the whole woman.[59] Since reproductive organs drain out most of the energy other organs remain deprived of it.

Porter and Porter opines that during 18th-19th Century domesticity of women was enforced by the formulation of medical and scientific theories which emphasized that women and men are physiologically different. And there is no way women can develop other body functions (specially mental functions) as reproductive organs drain out all their energy.

Dr. F. Hollick (1849) wrote, "the uterus is the controlling organ in female body". To some other medical

theorists it was the ovaries that occupied centre stage. The typical medical view was that "The ovaries... gave women all her characteristics of body and mind. All women's natural characteristics were directed from ovaries, any abnormalities (irritability to insanity) could be attributed to some ovarian disease.[60]

During the 18th Century in particular, a new medical conception of women was formulated. The traditional notion that women were simply feebler version of men was increasingly replaced by the claim., emanating chiefly from medical men, above all, possessing far more delicate nervous system.[61] This rendered them more susceptible to disease, and liable to disorders which men seldom suffered, especially hysteria. Some physicians assumed that women's blood was 'thinner' than man causing nutritional adequacies in the CNS and an inability to store nervous energy - a weakness.[62] In the long run, mental and emotional disease increasingly came to be associated with the female of the species. The 'natural state' in a female is a 'morbid state' in male (Thomas Laywock quoted by Carroll Rosenburg).[63]

This had repercussion for sexuality. It was claimed in medical texts that female sexuality was by its very nature passive. By the Victorian age, extremists were contending that active sexuality in a woman was something

pathological, leading to physical and mental disease (quoted by Porter and Porter). Freud, a psycho-analyst, a product of the later half of Victorian century began his work on treatment of hysteria in women. Freud also held the same view that women are inherently defective but this time it was absence of penis rather than presence of uterus or ovaries in women. Women were still sick, and their sickness was totally predestined again by their anatomy.[64]

Diana Sculby and pouline Bart have examined gynaecological books over a time. They point out that one factor which remained constant over time is 'anatomy is destiny'.It reveals the even text books carry the same message. They act as force, committed to the maintenance of traditional sex role stereotypes, in the interest of men and from the male perspective.[65]

IV. Maternal and Child Health - A Matter of Concern for the State

We now examine how maternal and child health became the concern of the State at the first place. Pregnancy and Childbirth were medicalized in the interests of medical profession and were defined as medical conditions where specialized care was needed, and there were systematic efforts to exclude traditional workers from the field.

For this to happen, two developments took place. First, the personal concept of health replaced the

environmental one. Secondly, child bearing was singled out as an area of concern for the State - one in which it was essential for the State to intervene in the interests of maintaining and improving the quantity and quality of the population.[66]

As a consequence of the decimation of lives in the Great War, there was a strong wave of pronatalism in Europe. The concern with maternity and child welfare in the ensuing period was greatly influenced by eugenicist argument.[67]

In January 1902, an article by Maurice entitled 'Where to Get Men' appeared in *Contemporary Review*. He argued that the general shortage of recruits reported by British Military authorities was due to the fact that few were able to meet the physical requirements necessary for the War Service.

This led to setting up of Inter-departmental Committee on the Physical Determinants of the Population. The Committee made various recommendations for the surveillance and improvement of the nation's health. These included measures to deal with over-crowding, urban slums, and better statistics relating to pregnancy and birth; the registration of still births, infant mortality rates by locality, and the collection of occupational data in relation to infant mortality, especially for mother.

On the other hand, this opinion got support from George Newman who in his Annual Report of the Board of Education for 1913, put that the two basic truths are: (1) that the health of the adult is dependent upon the health of the child, and (2) that the health of the child is dependent upon the health of the infant and its mother.[68]

Newman was of the view that the answer to the problem were education of mother in infant care, provision of better food for infant and mother and attention to the working conditions of poor women.[69]

Oakley on the other hand feels that maternal ignorance and need for educating mothers was not only confined to eugenicists or a handful of policy makers, but was the common feature in most discussions on infant mortality, and in programmes concerned with maternal and child welfare. Oakley further adds that educating mothers was certainly a cheaper solution than the provision of adequate free medical services or improved housing. The zeal with which the latter was promoted probably had more to do with the perceptions of women's social function than with a strictly cost-benefit analysis of different strategies for preserving children's health.[70]

The high MMR also became a matter of concern at the close of the First World War in 1918; one mother died for

every 246 babies born alive.[71] The first Government Report, devoted specifically to maternal mortality, was published in 1924. It was written by Jane Campbell, Senior Medical Officer to the Department dealing with maternity and child welfare. She pointed out that most of the women who died were in the prime of life, and busy 'rearing children for the nation'. Many maternal deaths were associated with the death of the infant too, and many of these were avoidable.

Oakley also pointed out that 'avoidable' was a key word. When a certain category is labelled as avoidable, the health administrator, policy maker or provider is staking out new territory as the legitimate domain of medical care.[72]

In identifying as a priority - the issue of maternal health and survival - women's organisation of that time were also making the point that the deaths of women in child bearing were the tip of the iceberg of women's health. These concerns for women and child health have been highlighted by the working class women's movement as we have already seen in the previous chapter.

The 1918 Maternity & Child Welfare Act enabled the Municipal authorities to aid the funding of maternity and child welfare work. The comprehensive ideal- Maternity and Child Welfare Service included salaried midwives, health

visitors, ante-natal clinics, day nurseries and free and cheap food for mothers and children.[73]

So three kinds of thinking have initiated concern for maternal and child health. One is the eugenicists' concern who had boosted the prestige of mother in their eagerness to improve the quality of population. Francis Galton in 'Hereditary Geneses' (1869) emphasised that great national gains to be made from getting the strong strains in the population to marry earlier and the weak strains in the population to later. His late Victorian disciples were alarmed that the birth rates were falling among the educated class.[74]

The spread of birth control throughout the working class seemed the urgent need to such people and the 20th century expansion in the birth control movement owed much to them.

Brain Harrison points out in this regard that of the 75 members of Eugenic Society, 14 held some kind of official position in the National Birth Control Association (NBCA, ancestor of Family Planning Association).

Secondly, the desire for healthy mothers and children was by no means confined to this lobby. An immense impact on the health of the population have been made by the advent of the welfare state, whose origin owed much to

pressure from women, many of them feminist women. Working class women's movements have emphasized the need for better working conditions for mothers and better child care facilities along with their other demands. This has much to do with humanitarian and secularised pre-occupation with improving the health of the population as a whole.

Thirdly, as we have already observed during 19th century, in all countries, obstetrics and gynecology emerged as specialisation as a reflection of the growth in scientific professionalism and the sophistication of techniques. These developments did not have any immediate impact on women's health but their long term significance was considerable.

The developments in Britain had important repercussion in India. These processes influenced shaping up of women's health care in India. These processes and differences between health services will be explained in the next chapter.

V. Summary:

What has been contended in this chapter is that the period between the 18th and early 19th Century was of decisive importance in recounting the relative identities of men and women, and therby transforming the place and role of women not only within the home and society but also

in medicine. Social attitudes towards women got support from scientific field and this in many ways justified women's subordinate position in society.

Secondly, that medicine and medical practitioners have played a significant role in shaping the broader social destiny of women. The subordinate place of women in pre-modern social order was thereby fixed by a combination of biological and social factors.

The third contention is that medical profession, as it developed, was sustained by the image of science as the universal agent of progress and it was the patronage of Church and State which gave it its status. In fact, it was more to do with the patronage than the scientific and technical superiority.

Fourth is the partnership between Church, State and medical profession that laid down certain prerequistes which were essential to have access to knowledge and licence to practise. This in turn excluded/discouraged acquiring of required knowledge and practise medicine by women as only men of means could afford to enter the field. Scientific progress within the medical field added to the monopoly of knowledge and specialization.

Medical profession as it developed, became a male hegemony and it expanded its scope by defining more and

more of social behaviour in medical terms requiring expert attention. Women's normal physiological functioning, like child birth and menstruation were medicalized, needing attention of medical expert.

State's concern for maternal and child health after world war was not only influenced by welfare orientation of the State but also by a social and political necessity which called for an adequate and healthy work force.

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CHAPTER FOUR

ISSUES OF WOMEN'S HEALTH AND MATERNITY SERVICES IN BRITISH INDIA

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The Indian social system had devised an extremely sophisticated ideological frame to chain women in their piety, purity, loving and caring roles. It used these images to project their highly valued status and thereby sidelined their total dependence and subordination. The British colonisers took full advantage of the situation to restrict areas as well as extent of reforms thereby avoiding conflicts with the male leadership controlling communities. They also established their own civilised image by introducing some reforms without actually compromising their economic interests and the organizational forms required for its optimisation.

Within this overall framework, then, women's health issues were certainly not central to British concerns.

This Chapter explores :

i) The issue of medical legislation for Venereal Disease to unravel British attitudes towards the health and health services for Indian women with special reference to prostitutes.

ii) It mobilises evidence to assess the overall status of health of women of different strata.

iii) It also focusses on the emergence of services in India.

iv) It explores emergence of health services for women.

v) It focusses on training and education of women doctors and midwives.

vi) And finally, it explores implications for maternal health in independent India.

I. Medical Legislation

The British medical presence in India dates from 1600, when a small number of ships's surgeons arrived on board. The East India Company's first fleet. The number of British surgeons in India increased steadily as the Company extended its trading operations, but there was no regular medical establishment until 1763.[1]

The major stimulus to reorganization was company's expansionist policy in mid 18th century East India Company began to set aside special houses for sick employees in the 17th century but not until the end of the 18th century were separate provisions made for the native indigent sick in Calcutta, Madras, Bombay.

Britishers ensured a physical separation between the life of the official elite and that of the Indian people by planning civil stations adjoining but apart from Indian

town. They lived in an ordered environment in spacious houses, enclosed by large gardens.

A similar seclusion was provided for soldiers in cantonments or permanent military camps. The authorities often revealed anxiety at the thought of British soldiers wandering beyond controlled environment of the cantonment where they might be inflicted with infectious disease.[2]

British soldiers seemed to need protection from the dangers of disease thought to be spread by prostitute women. The measures later culminated in an elaborate system of registering prostitutes, inspecting them, and detaining them in hospital if they caught venereal disease. This closely resembled the system established by Contagious Disease Acts which prevailed in England between 1864-1886.

This was the first time health authorities talked of Indian women in relating to health. Here concern was not health of women or prostitutes but health of British soldiers. It was the sexual behaviour of soldiers which embarrassed the authorities. The problem was concisely expressed by Dr. W.J. Moore, Surgeon-General, Bombay in 1886.[3] He began with the premises that physiological instincts must be satisfied in some way or the other; or they must be repressed by force of will aided by severe physical exertion.

The Contagious Disease Act and the Cantonment Act in India were campaigned as in England, though its severity varied greatly from one area to another.

In 1859, the Royal commission on the Sanitary State of the Army in India proposed the way for legislation. Venereal disease was described in their report as the scourge of British troops in India. Many witnesses had recommended that many soldiers be allowed to marry, but in their report the commission alluded vaguely to a possible disadvantage: When a regiment went on active services wives and children left behind might be exposed to temptation and distress.[4]

Similiar argument was presented to the Governor-General's legislative council in 1864 when a Bill was introduced to regularize the administration of civil and criminal justice in military cantonments. One clause provided that local governments could make rules for inspecting and controlling houses of ill-fame and for preventing the spread of VD. The bill duly passed into law as act XXII of 1864.[5]

A special committee was appointed to draw up rules under the Cantonments Act. The committee proposed that prostitutes should be divided into two classes: the first class would consist of 'Public prostitutes frequented by Europeans' the second of 'public prostitutes not so

frequented'. Only first class prostitutes would be subjected to regulation. They would have to register with cantonment authorities and each would be given a 'printed ticket' together with a copy of the rules. She would be medically examined every month, and the result of each examination would be recorded on her ticket. If she caught VD, she would be detained in the lock hospital until she was certified as cured.

A frequent observation had been that soldiers went to women living outside the cantonment and free from military supervision. In Act XXII of 1864 it was, therefore, provided that the new rules could be extended beyond cantonment boundaries.

It was believed by British Officials that India needed a Contagious Disease Act on the lines of English legislature. The main difference was that it was compulsory for prostitutes to register, while in England action could only be taken after a police officer had laid information against a woman. The reason for not entrusting the work to police officer in India was that they could not be trusted. Such developments in Calcutta have been discussed by Kenneth and Harrison.[6]

The bill was duly passed into law as Act XIV of 1868, known as Indian Contagious Disease Act. The provision included the compulsory registration of brothels and

prostitutes, periodical medical examinations and compulsory treatment of prostitutes found to be infected. Also, prostitutes could be forbidden to live in specific areas.[7]

In Bombay, however, there was vigorous opposition as half the cost of running lock hospitals, was to be met from municipals and half from Government fund.[8] Initially this arrangement worked but later on local Government refused to pay and argued that as the Act was intended to protect the soldiers the cost should fall on imperial and not on local revenues. The Government thereupon terminated the working of Contagious Disease Act in Bombay.

Meanwhile in England the Act provoked a protest from Baptist missionary society and women's groups. The missionaries concluded that no considerations of health, economy or expediency can justify or excuse legalised prostitution[9] and the women's group protested against it in 1869 on the grounds that it gave the police power to victimize and harass prostitutes while protecting and legitimising of a double standard of sexual morality for their male clients.[10]

Moreover arrangements in India seemed harsher than those in England[11]. There was no fixed time limit a woman could be detained in hospital and there was no way to appeal against her detention. In 1872 Lord Ripon, Governor-General, decided to reconsider the policy behind the Act. A

committee was appointed for this purpose. One of the members of the committee asserted that the result of the Act were altogether insufficient to justify the expenditure and it was also an interference with the people in their most intimate social relations[12]. In fact, the committee raised several issues. The Act was unpopular, it involved an interference in intimate social relations it was expensive and the money could be better spent on improving the drains and water supplies.

The Act was promptly suspended in Calcutta around 1881-82. The Government of India soon advised the Bombay and Madras Governments to suspend the Contagious Disease Act. Bombay did so, but delaying tactics were attempted in Madras. Madras Government appointed a committee which recommended that instead of suspending the Act, it should be extended with some modifications.

The attitude of British officials towards prostitutes was also evident from Dyer's article. He published an article entitled 'The Infidel Government of India'. He published this article along with a circular of June 1886, advocating the supply of a sufficient number of attractive women together with a document emanating from official commander. The circular memorandum dated 1886 , was addressed to the cantonment Magistrate, Ambala, who was informed that the regimental strength was four hundred, that

they had only six women and needed six more[13].

The uproar that followed these disclosures was enough to enable the Britishers to carry a resolution through the House of Commons in June 1888 to the effect that "mere suspension of measures for the compulsory examination of women, and for licensing and regulating prostitutes in India, is insufficient, and the legislation which enjoins, authorises or permits such measures ought to be repealed".[14]

The circular and the cantonment rules were suspended. Great care was devoted to drafting a new cantonment bill where there was no mention of prostitutes or VD or lock hospital but only mention of hospitals for the treatment of "persons with infections or contagious disease".[15]

The repeal of the Contagious Disease Act did not mark the end of the medical inspection of prostitutes in India. The new Cantonment Act of 1889 incorporated a deliberatecatch-all clause which provided inspection and compulsory treatment of prostitutes.[16]

This was followed by protests by masses in many parts of the Country. In January 1890, the Social Purity Committee of Wesleyan Conference protested to Cross, the Secretary of State that the new Cantonment Act was compatible with the old lock hospital system. Since the new rules merely specified infectious and contagious disease 'the people of

Kausali in public' meeting feared, that their own people (of the respectable class) might be forced into hospitals,[17] but officials provided reassurance to this effect.

What we have discussed so far reveals that the British were primarily concerned about the fitness and satisfaction of their soldiers. It was not the health of women; the main focus was to protect British soldiers from catching Venereal Disease. There was no evidence of the efforts at changing or modifying the behaviour of British soldiers but only putting restrictions on prostitutes.

II. Health Status of Women

The British administration was primarily concerned with the health of military personnel so there were efforts to collect information about their ill-health. As regards health of civilian population and health of the women, not much information was available.

The Health status of any group is a complex manifestation of social, economic, political, cultural and historical factors. We have already observed in our previous Chapters that these factors were not favourable to women.

The earlier concern of British Government is evident from the Royal Commission Report of 1857. It pointed out that mortality rate in British Army were greater than

civilian population. The Royal Commission on Sanitary State of Army in India in 1859, recorded a death rate of 69 per 1000 among British troops.[18]

During the Cholera epidemic in 1857, European troops experienced a Cholera mortality rate of 14/1000 whereas Indian troops died at lower rate of 3/1000.[19]

We have already seen that the Cantonments Act made provision for medical inspection and regulation of brothels and, in 1863, the system was formalised and extended under Contagious Disease Act. There was no concern about women's health.

The urgency with which death registration was introduced owed much to military imperatives and military factors continued to shape its development. Anxiety about the health of troops lay at the heart of Indian Government's attempts to centralize information.

On the one hand, the British generated array of documents on virtually every subject - Settlement Reports, Gazetteers & Census which served as an available and systematic guide to social, economic and political issues, on the other hand, bias and distortion in such material raises question about its extent and value of their use.[20]

Although the Census of 1872 was the first one, but the population count did not relate to the same reference moment

for all parts of the country. A period of six years from 1867 - 1872 was spent taking this Census and it did not cover the entire country.[21]

As regards mortality data, there was no reference to age and sex specific deaths. So not much information about women's mortality rate was available. Alice W. Clark points out that there was clearly very different pattern of excess female mortality by age, among various regions of India. And as mortality conditions improved for every one, they improved more for male than female.[22]

Concern for women's health was a part of non-official activity. And general observation made by missionaries stressed that many more women in India die during pregnancy and children as compared to Britain. There were a number of attempts to remedy the situation by way of providing trained *dais* and women doctors for the Indian women.

Around 1940's, Sub-committee of National Planning Committee on Health (Sokhey Committee) and Health Survey and Development Committee (Bhore Committee) talked of women's health in relation to maternal mortality and stressed maternal and child Health Services.

The Sub-Committee of National Planning Committee pointed out that statistics pertaining to infant mortality and maternal mortality were subject to a wide margin of

error and they did not reflect the full magnitude of the problem. It pointed out that for every 1000 live births, 20 mothers lost their lives and 162 children died of every 1000 children born alive.[23]

Health Survey & Development Committee, commonly known as Bhore Committee has also observed that maternal deaths are very high in British India.[24] Blair Bell estimated that for every woman who died as a result of pregnancy and child birth, 20 suffered from impaired health and lowered efficiency. The report estimated that approximately 200,000 women died annually from causes arising out of child birth in a year in British India. The report also observed high infant mortality and estimated that half of the total deaths at all ages take place among children below 10 years. The report does not highlight sex specific deaths in this age group.

The sex ratio according to 1901 census stood at 972/1000 males and this most often is attributed to high maternal mortality. It ignores the fact that even in reproductive age group, infectious and parasitic diseases, epidemics also cause death in females.

When women's ill-health is viewed in relation to her maternity, it is obvious the services vis-a-vis women focused on this aspect primarily. As regards health services in general, the focus remained on health of military personnel/Army.

III. Health Services in British India

Colonial medical machinery was originally set up to take care of the health of military personnel. The Indian Medical service was an auxillary of the army and even after it had widened its scope to embrace civilian concerns its original organization and outlook was not abandoned. The Indian Medical Service tracing its origin from 1714, served the interests of British Community and grew in direct association with military and political necessity.[25]

In post-mutiny period, the India medical services became the responsibility of British Government. Surgeons in the Indian medical services became commissioned officers, although the Indian military medical service remained distinct from that of the British Army , which had its own medical service - the Army medical Department. (In 1896 the three presidency medical services were amalgamated into a single Indian medical service).[26]

So, in India, allopathic or modern medicine emerged gradually as the professional activity of 'colonial medical service', which formed in turn an arm of the colonial authority.[27]

After introduction of competitive examination in 1855 , the IMS had been opened up to Indians. As the examination

was held in Britain very few Indians actually joined the services until the turn of the century. Yet the presence of Indians, however, few was sufficient to lower the status of the IMS in European eyes, and this was compounded by the fact that Indians allegedly received an inferior professional training.[28]

As the need for medically trained personnel grew, medi cal colleges were established for training of subordinate staff: the Calcutta and Madras Colleges were founded in 1835 and the Bombay and Lahore College in 1845-1860. Although Indian Medical Service Practice was almost exclusively hospital based, a sanitary perspective in these matters was introduced from 1835 by an Indian Medical service office, Sir James Ronald Martin.[29]

The premier cadre among the medical officers who came to India were members of the Army Medical Department (later named the Royal Army Medical corps) deputed for the medical and sanitary care of British troops serving in India. Officers of the Army Medical Department were employed as executive medical officers of British station hospitals. The position of Director of Medical Service was almost always occupied by an Army Medical Department officer, although in theory Indian Medical Service officers were also eligible for this appointment.

The IMS, the other important arm of medical services,

became exclusively responsible for the health of the Indian troops. These IMS officers who were in excess of peace time requirement were lent to the civil government for employment in civil department, and were liable to recall in the event of war.[30] Civil work encompassed Presidency and district head quarters hospital, the health of the police and the inmates of jails and lunatic asylums, and private practice.

The position of IMS was subordinated to the Director of Medical Service, who was the Supreme executive authority and same way provincial sanitary commissioners were also drawn from IMS, who were again only advisors with no executive power.

Officers of the IMS laboured under a double handicap, the low esteem in which medical profession was held in mid Victorian Britain was compounded in India by the seeming indifference of the Colonial administrators[31]. The social standing of the British profession was uncertain, even after the Medical Registration Act of 1858. There was also marked variations in status within the medical profession. The old division between physicians, surgeons and apothecaries was being replaced by new divisions between general practitioners and consultants, and between these with lucrative private practice and those employed by local authorities as poor law medical officers.[32]

The legal status of the Indian Medical profession was equally problematic. The IMS officers found themselves in a position similar to that of British medical men prior to the Medical Registration Act of 1858 : as registered practitioners, they enjoyed legal status in Britain. But in India where there was no registration act until 1912, they faced competition from the practitioners of indigenous medicine. Attempts to introduce legislature similar to that passed in Britain, brought medical men into conflict with the Indian administration, which was more sensitive than the colonial medical profession to the likely political implications of any interference in traditional practices. Only when a significant number of Indians began to qualify in Western medicine, and themselves demanded restrictions on unlicenced practice was the Government prepared to contemplate legislation on British laws.

Thus it was rather insecure, neglected and uneven Service structure that began looking into issues of civilian health and confronted the problem of ill-health of the Indian people.

IV. Emergence of Health Services for Women

We have examined in the previous Chapter the forces that led to the emergence of maternity service in Britain. There were different kinds of pressures.

i) A major shift from environmental handling of health to individual disease treatment. This was under the influence of germ theory and led to strengthening of specialisations and institutionalised care. The emerging professional pressure of gynecologists and obstetricians played a key role.

ii) The interest of the State in maternity became clearer as the pro-natal pressure after the World War I increased and healthy labour force became a priority. Eugenicists' concern for a better breed of human beings was very much a part of this.

iii) Very high level of mortality of young women got State's attention as well. This, in many cases, was associated with death of infants as well.

We will now see how Maternity Services evolved in India and what forces determined their emergence. As we have already shown in the previous Chapter, maternity care constituted the central focus of women's services.

Prior to 1870 there had been few initiatives in the direction, of maternity care. It has often been noted that women were seldom admitted to hospitals or sought medical attention.[33]

Prior to 1885, colonial officials in India devoted little systematic attention and few resources to the health

of Indian women. As observed by many scholars, the chief concern of British health policy was the army, followed by the European community.[34]

The regulation and medical inspection of prostitutes at military cantonments was the first state intervention into Indian women's health.

The first qualified medical woman to provide medical relief to Indian women came from the United States in 1864. Others followed her, after opening of the London School of Medicine and Royal Free Hospital in 1877[35]. In 1874, Mary Scharlieb, later to become a famous London gynecologist, persuaded authorities in Madras to allow women students to attend classes at Madras Medical college[36]. Beginning in the early 1880's, prominent medical women in England - reading missionary reports and Journals - were inspired to take up the cause of providing medical care for women in India.

Fanny Butler was the first qualified medical woman from England to work in India. She was sent out by the Church of England Zenana Missionary Society in 1880, and was stationed at Jabbulpore and than in Bhagalpore.

Miss Elizabeth Bielby came to India in 1875. She already had some medical training and had come with the purpose of relieving the suffering of Indian women. She opened a dispensary and later a small Hospital. Miss Bielby

left India in 1881 to go to England for a full medical training. She found that the major difficulties in India were the "ignorance and prejudices" of the women (Balfour and Young). Elizabeh Bielby (a medical missionary) and Mary Scharlieb were said to be responsible for the queen's concern about the lack of Western medical care for Indian women.

In fact missionary work provided one of the few openings to newly qualified women in Britain and the United States.[37] The initiation of these efforts suggest that the health of women in the British Empire had become an issue of some importance in Britain as well as India.

In fact the changing social circumstances in Britain created a new breed of medical personnel many of whom chose India as the field to carry out their vocation. This was made possible because middle-class women had the eduction, economic opportunities, and personal confidence to take advantage of larger social changes.

Many of the women doctors, 'redundant' in their own society's terms, found a sense of purpose and achievement in the work they did in India. It enabled them to lead an independent, if sometimes hard, life.[38] Moreover, there was some unemployment among doctors in England and government service in India brought them status and future.

The medical women set up a network of hospitals specially for women all over India. These were looked after by women doctors. The official rationale for these segregated institutions was the need to provide relief to Indian women. The zenana hospitals gave women medical practitioners an institutional setting for their autonomous functioning[39]. But women doctors worked under their overt subordination to male medical bureaucracy. For example, the Civil Surgeon was directed by regulations to inspect all Government supported hospitals and dispensaries. This created a delicate situation. The doctors in charge resisted this, as a breach of trust of her patients and secondly the experienced medical women were subjected to the supervision and control by men often less qualified than themselves.[40]

The particular ideology applied to Indian women reflected the wider imperial beliefs regarding gender relations in India. The perceived low status of women in India was a central point of British strategy to project the superiority of Western civilization. British colonial government thus made full use of the weaknesses of India's social fabric. They appeared to be less concerned about Indian woman and this was quite obvious in the medical field as well.

The perceived needs of Indian women for Western medical aid provided by women, became a key argument and a potent

symbol for those interested in increasing British women's opportunities to obtain medical education and employment both in colonies and at home. We may note here that women were allowed entry to medical schools after long debate in 1867.

When women attempted entry into medicine in their own countries, they relied on arguments that emphasized their feminine qualities and interests while seeking to extend them outside the home. This grounding in the 'Separate Spheres'ideology enabled potential opponents to see the medical care of women children as a "suitable field for women."[41]

Around 1876-77, though British women doctors were in profession, they were not in the 'club' as pointed out by Ann Elston. So for medical women's opponents and competitors, the proposal that medical women be sent off to India seemed a welcome opportunity to reduce competitions at home. In addition to employment opportunities, India provided for medical women, clinical and scientitic training that was diffcult for them to obtain in England. Women's lack of access to practical experience after registration was a short coming in their training as no general hospital would offer them house jobs. This point has also been made by Elizabeth Garrotte as mentioned in our previous chapter.

India not only offered employment and training, it also

served most importantly as justification for expanding women's education and training within England itself.

Women physicians lacked confidence due to their subordination to civil surgeons. Establishment of a Women's Medical Service in 1914 - after several years of lobbying by medical women in England and India - did improve, to some extent, the autonomy and working terms and conditions of women physicians. Still women's medical work and women's health issues remained a low priority of the colonial Government. Yet, the National Association was the most important institution in the field of women's health, and the policies it adopted influenced subsequent efforts.

From the Year 1918 onwards certain steps were initiated to improve maternity and welfare. An association was formed in Dufferin's office (Dufferin Fund) for the provision of health visitors and maternity supervisors.

Successive vicereines created their own funds: Lady Curzon established the Victoria Memorial Scholarship Fund in 1903 to train indigenous midwives; Lady Chelmsford formed the Lady Chelmsford All India League for Maternity and Child Welfare in 1920; and Lady Reading opened her Women of India Fund to provide for a Women's hospital in Simla (Balfour and Young). These had service as well as training components and are discussed in detail in the next section.

A major force behind the evolution of services for women was the national movement itself. Not only did the Congress pay special attention to planning welfare for women in its national planning exercise in the 30s but much earlier than that Indian women associated with the emerging movement spoke for their country women. Rameshwari Nehru, Uma Nehru, Pandita Rama Bai and Sarojini Naidu were amongst them.

Our explorations reveal that the events most critical in shaping health services were British Government's concern with the health issues specially of its soldiers. Secondly the gender conflicts in Britain itself helped emergence of Services of women. Thirdly our exploration highlights British prejudices against Indian women who were regarded as ignorant, superstitious and backward behind their *pardah*. Though the Maternity needs of these women were used to establish MCH Services and justify British superiority, they were also a means to resolve the expanding needs of British professional class.

V. Training and Education of Women Doctors & Midwives

Three types of educational efforts were initiated by the British. One to provide practical training to its own women who acquired their medical degrees in Britain; second, opportunities for women to join medical colleges and third, short term training in maternity care to midwives. The

implications of all these were crucial in the maturing of modern maternity services and undermining of traditional practitioners -- the *Dais*.

There were two primary sources for training women doctors, nurses and midwives. One, the independent initiatives of concerned individuals, and the other, steps taken by the British Government through its Indian Medical Services.

The influential social worker Pandit Ramabai Sarasvati testified to the Hunter Education Commission of 1882 that India was in urgent need of women Physicians.[42]

The public concern over health of women, got support of Queen Victoria after the recommendation of Elizabeth Bielby and Mary Scharlieb. Mr. Kittridge of Bombay, proposed to raise funds for British medical women willing to give their services in India. The scheme was supported by several prominent Indian gentlemen and helped to raise enough money to establish a medical course in India.[43]

Kittridge's proposal raised the question of what kind of medical education should be made available to women, and hence of their professional status in relation to male practitioners[44]. Initially, the Government of Bombay approved a three years course specially for women, which was similar to that leading to the licentiateship of the London

Society of Apothecaries, and did not provide special instruction in diseases peculiar to women or in obstetrics. This move was criticised by Bombay Gazette (23rd Feb. 1883, p. 16) which argued that women should be admitted to existing course of instruction including 5 years MB degree.[45]

A compromise was reached in which women were intially admitted to three years diploma and after completion of this they were eligible to study final two years of the degree.[46] The Indian medical Gazette (Jan. 1884) wished sucess to this kind of venture but was of the opinion that women are better fitted for nursing rather than doctoring, and that educated nurses would fulfill the requirements of this country better than full-fledged lady doctors.

Male practitioners were concerned that the inclusion of women in medical profession would lower its status in the eyes of Europeans and in 1883-84, there was intensified campaign for medical registration in India. Despite reservations of IMS officers, the efforts for the training of British and Indian female practitioners began to gain ground.

National Association for supplying Female Medical Aid to the women of India, commonly known as Dufferin fund, got a great deal of publicity. It started with the intention of providing the salaries to British

medical women willing to work in India and scholarships for Indian women wishing to train in Western medicine[47]. The Dufferin fund, establishment was greeted by great enthusiasm and many Indian elite contributed to the fund, but there were some reservations on the part of IMS. The editor of *Indian Medical Gazette* (Jan. 1886) wrote, "we wish it (Duf ferin Fund) every success as promises to provide skilled nurse midwives for Indian women (but) as concerns the education of native girls as doctors, we are not quite so clear or sanguine."[48]

Harrison feels that the impetus behind the fund was not simply humanitarian desire to extend medical relief and knowledge of hygiene to Indian women, but to proselytise western values. Europeans believed that in India deliveries took place in the filthiest conditions and people did not understand the importance of hygiene, technical advancements which were available in hospitals under the supervision of specialists. They continued to patronize traditional birth attendants. So Britishers regarded *zenana* as a bast on of ignorance and superstition.

Our review, In fact, also shows that the impetus had to do with 'acquisition' of maternity, for medicine and economic interests rather than any humaniatarian considerations. The biggest hurdle in this effort was traditional birth attendant who had to be neutralised .

Though the central rationale behind the formation of the Fund was the assertion that the Indian women would not see male physicians, such claims were misleading. Maneesha Lal shows that according to official government statistics for 1886-88 women of all communities and regions did seek aid in the European and male-staffed government hospitals and dispensaries. Though women's attendance was generally less than men or children, or was between 15-20 percent of the total attendance. As far as maternity was concerned women prefered traditional birth attendants.[49]

Maneesha Lal further shows that strict *purdah* (rationale on which Dufferin Fund was established) was observed only in upper-caste and upper class families; the majority of Indian women were not secluded in the house.[50] There was wide variation in the extent to which and the ways in which *purdah* was practised by individual women. Its observance depended on a complex set of factors. Dufferin Fund rhetoric however ignored and underplayed these differences - portraying *purdah* - and thus refusal to consult male physicians - as a characteristic of Indian women in general, and rarely distinguishing women of different religions, clans, castes or region, opines Maneesha Lal.[51]

This again illustrates that the actual reality of Indian women had little to do with the British decision to

have exclusively maternity hospitals. Neither lack of attendance in hospitals nor *purdah* were as widely prevalent as it has been made out. Another possibility that can not be rejected is the fact that the women of the richer classes who did observe *purdah* were perhaps the main target for the expanding British medical profession and the lady doctors could earn their profits only when the barrier of *purdah* was broken through *Zenana* hospitals.

A School was opened in Delhi in 1918, and a large maternity and child welfare exhibition was organised in Delhi in 1920. Lady Chelmsford formed a new association to be called 'Lady Chelmsford All-India League for Maternity and Child welfare'.

In the year 1921, Lady Reading, in spite of delicate health, took keen interest in the working of the different Funds. Apart from looking after activities created by other Funds, she opened her 'Women of India Fund', the object of which was to provide for the Simla Hospital, to forward the interests of the Indian nurses, and to provide an adequate building for the Health Training School, in Delhi[52]. Large donations to the building fund were given by Indian Princes and others and Lady Reading Hospital was opened in 1924 for Women. It also invited women health workers.

The All-India Baby Week was organised in 1924; and

All-India Conference on Maternity and Child Welfare was held at Delhi in 1927; the organising secretaries of all these movements were members of the Women's Medical Service.

The scheme of the Lady Harding Medical College was initiated before the Women's Medical Service. By the time the College was opened the women's Medical Service was in working order and had since provided the upper middle class women as medical staff.

Medical education became the concern of IMS personnel also who tried to follow as closely as possible the latest trends in western science. The former came to include midwifery, Diseases of women and Infant Hygiene. A Chair for Midwifery was created in many of the Medical Colleges and it was held by a Professor of the rank of Lt. Colonel.[53]

One of the much vaunted virtues of the Western Medical system was its emphasis on practical demonstrations. This usually proved a daunting hurdle in the early days of the medical schools as very few Indian women would consent to be delivered by male doctors.

The most direct attempt to obtain access to maternity cases was a proposal to pay women to attend hospital to have their babies, but this was to provide teaching cases for the *dai* classes and for medical students.[54] The Male medical students were unable to attend enough midwifery cases to

fulfill the British General Medical Council's requirements.[55]

The biggest hurdle in the way of the acquisition of maternity for medicine was thought to be the observance of seclusion among upper caste women both Hindu and Muslim. Women in India generally continued to patronise their traditional birth attendants.

This kind of thinking ignored that the traditional birth attendant, *dai*, in Indian situation did more than just deliver the child. She would stay with mother and child for some days and attend to their needs. Washing clothes, burrying the placenta and massaging and bathing the infant were part of her duties.

Male Medical opinion roundly condemned the unclean and muddlesome *dai* as the pernicious evil the Indian women had to be rescued from. Early masculine attempts to train the *dais* had been unequivocal failure. Seasoned *dais* had resented or ridiculed the classes organized by Young Assistant Surgeons, generally raw young men with little practical experience of labour cases.[56]

Many women (missionaries or doctors), however, had successfully organised training classes for *dais*, where they were taught to incorporate the new notions of hygiene with their traditional skills. These training schemes met with

success because of the personal charisma of their organizers who managed to establish a rapport with the *dais*.[57]

Piecemeal and sporadic effect to train indigenous midwives, *dais* had begun in the late 1860's by a few individual civil surgeons and missionaries. In the year 1866 , a civil Surgeon, Dr. Aitchison, opened a class for *dais* at Amritsar, which after ups and down around eighties became the well-known Amritsar Dais School with the help of Miss Hewlett of the Church of England Zenana Missionary Society, one of the first woman pioneers who initiated relief for Indian women.[58]

As more *zenana* hospitals and maternity wards were established, the ranks of women doctors swelled, and there was a small corpus of nurses and midwives trained in the hospitals, the demand for banning the *dai* grew more vociferous. There was a move to register and certify midwives as was done in England and this gained strength after World War I.

For Britishers, *dai* represented an older social order and with modernisation, much women's work was destined to be obsolete. *Dais* were condemned for taking on menial tasks besides the actual deliveries. The more frequent and vehement condemnation, however, was on the grounds of hygiene. The social origin of *dai* and a general belief in the unsanitary nature of Indian habits convinced that

child-birth occurred in filthiest conditions.[59] Westernised Indians were ready to accept this as the germ theory provided a rationale for some tradition taboos. Caste prejudice that assumed those performing lower level occupations were bound to be unclean.

The most vociferous advocates of the elimination of the *dais* were male doctors, who declared it was worthless trying to train them. Guha quotes one of the doctors to highlight their attitude:

'Their intelligence is too low to enable them to appreciate the value of what they are taught and they tend too often to relapse into their old methods. It is the better-class women who are needed.'[60]

However, the Victoria Memorial Scholarship Fund established by Lady Curzon in 1903 had, by 1912, set up centres in 14 different provinces and trained midwives. This contributed to some progress in training Indian womens mid wives.

Training and Education facilities which were started in late 19th and early 20th century clearly indicate that these efforts were motivated by the needs of male doctors in Britain. When it came to view women's health needs the focus was on her maternal role and maternity services. Women doctors from Britain were also instrumental in

publicising need for maternal services in India.

British women doctors got opportunity to practice in India as well as publicise the demand for medical education to women in their own country. Training and education initiatives questioned the capacity and capabilities of Indian women. These attitudes were expressed by the National dailies and Medical Gazette as well.

Medicalization of pregnancy created a need to break the barrier of traditional practices without taking cognisance of its importance and its place in the social reality.

VI. Implications for Maternal Health in Independent India

The implications of the social processes discussed above are critical for our understanding of the nature of MCH services. What emerges very clearly from the discussion is that women's health was viewed only in relation to her maternal role. Maternal Health Services were the obvious outcome of this. The Women's general health was not a matter of State's concern. Practice of *Purdah* was considered a barrier in reaching out to women for maternity services, but this was not talked about in relation to other diseases which were prevalent at that time or in relation to her general health.

Traditional Birth attendant who was a part of social

Traditional Birth attendant who was a part of social structure and played an important role was considered an obstacle and there were efforts to neutralize them. In this effort the male doctors were quite vociferous and at times even the press joined hands. The medical model which was considered "scientific" had a significant role in the undermining of traditional *Dais*.

Attitude towards women reflected a sense of western superiority. Indian women were considered ignorant, superstitious and thus condemned. The very process of professionalization and emergence of obstetrics as a speciality played a key role. No effort was made to appreciate women's differential health behaviour or their medical needs. This was an outcome of the fact that services for women were largely run by British women doctors whose ideological visions saw Indian women as 'natives' and 'aliens' with irrational life styles.

The cultural imperialism was not restricted to the medical profession alone. Nationalists educated and trained in Britain often believed in the 'superior ideas' offered by British intellectuals. Eugenics had Indian supporters. Within the national movement there were voices concerned with improving the race through Maternal and Child Health services. Again race, not women, were the focus of their attention.

These are the trends that characterise the very scaffolding on which Maternal and Child Health Services were constructed. They are apparent in the attitudes of the Indian policy makers and medical professionals in the 1930s who stepped into power after 1947. They were socialized into the model of western medicine through their education and training.[61] Thus what was built later carried the imprints of the professional and elite class visions. We briefly trace it over the 30's and the 40's.

British government's narrow efforts to improve women's health are visible from the Report of Second meeting of Central Advisory Board of Health, Government of India, 1939,[62] Annual Report of the Public Health Commissioner, Govt. of India in 1940,[63], Annual Report of the Public Health Commissioner with Govt of India in 1945.[64] All these reports made reference to the necessity of the appointment of qualified women doctors, training of medical students and midwives in pre-natal and post-natal care and considered traditional *dai* an obstacle to the establishment of a domicillary midwifery service run by trained *dais*. The service component included distribution of tonic, codliver oil and free milk. A lot of stress was laid on good mother craft. Even the National Movement was not free of similar biases as is visible in its planning efforts.

The National Planning Committee of the Indian National Congress had many sub-committees to look into different areas.[65] Three committees which are of special relevance to women are discussed here. These committees in their resolution in 1940 envisaged people-oriented health service and integration of curative and preventive function in a single state agency was urged; but as regards women, these committees came out with some important and interesting resolutions which seem greatly influenced by the prevailing attitudes towards women in the 30's and 40's.

Laxmi Bai Rajwade in **Sub-Committee on National Health** noted that the greatest single cause of Female mortality is child birth - that is brought about by the prevailing customs.[66] She points out (p.162) "that indigenous *dai* is age old practice...and method of their art are totally unscientific...their services are not only inadequate but dangerous." In view of the success of Victoria Memorial Scholarship , she further stresses the need for legislative measures for compulsory registration of *dais* with local authorities.

Sub-Committee on Women's Role in Planned Economy resolved that an organised health service with special maternity arrangement, shall form an integral part of planned economy and for this the indigenous *dai* shall gradually be replaced by trained midwives as soon as

possible.[67] The Committee resolved that eugenic programme should aim at making the race physically and mentally healthy by discouraging marriage of unfit persons and provide sterilization of persons suffering from transmissible diseases of serious nature such as insanity and epilepsy!

Under its Racial Health agenda (p.39), the resolution stressed the need to emphasize the fact that women as mothers of race require special protection of the State. This sub-committee pleaded to the sub-Committee on National Health to chalk out programmes for ensurance of a physically and mentally healthy race and for this maternal and child welfare centres to be opened and indigenous *dais* be replaced by trained *dais* within 10 - 15 years.

Sub-Committee on Population stressed the need to adopt a policy for Family Planning in the interest of social economy, family happiness and national planning. The Committee noted (p.66) that with education, contraceptive practice has been adopted by advanced castes. Birth Control has been adopted by the upper classes, the demand was more for diffusion of its knowledge among masses to prevent the deterioration of the racial make up.[68]

Under the pressure of the National Movement the British Government set up a Health Survey and Development Committee commonly known as Bhore Committee.[69] It considered Maternal

and Child Health service under special services. Maternal & Child Health was one of the special category and the other two were school children and industrial workers.

The Bhore Committee took a much wider view of maternal & child health problem. Apart from emphasizing special care to mothers and children, need for improving socio-economic causes had been stressed. It took note of the fact that only medical measures would not improve the health of women; so efforts have to be directed towards removing socio-economic causes as well.

Though the planners in Independent India accepted its recommendations in principle, in practice they were not fully implemented. Despite the recommendations of Bhore Committee to give special attention to maternal and child health, Maternal and Child Health programmes in India have either been neglected or treated as appendages to the Family Planning Programme.[70] This was possible only because women's health has never been a priority in national policies.

Even in Independent India an important aspect of continuity has been the persistent trends of negative social perceptions and attitudes towards women. This is a major reason for the narrow scope of health policies. The maternal component of health services that got incorporated was less because of social concern for women's health and more for

economic and political reasons. Even the liberal planners tended to have a narrow vision as is evident in the documents produced by the Planning Commission.[71]

During the First and Second Plans, maternal and child health was given priority. But even there, its scope was limited with little focus on other aspects of health that impinge on maternity health. In the sixties, priorities changed and Family Planning Programme got top priority. Maternal and Child Health Services got side tracked and women were the ones who suffered most. Not only they did not get appropriate maternity services but they also became the victims of a target oriented sterilization campaign. This happened because woman's status and her role remained unrecongnized and unimportant in society at large. The contemporary emphasis on reproductive health and population control reflects that the social basis of services has not changed substantially.

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SUMMARY AND CONCLUSION

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After several years of planned development, the status of women still leaves much to be desired. Census of 1991 stand witness to this. This clearly indicates that initial recognition of women's rights which emerged during freedom struggle and were expressed in the Constitution, has run into sand.

Taking off from this point, we have tried to understand women's issues within the historical context to develop an overview of issues over 18th and 19th century. We have tried to locate women's issues in larger socio-political environment which gained much in power by women's subordination and their secondary status.

The first chapter entitled ***Status of Women - A Historical Account***, focusses on status and position of women as reflected by reviewers of history. We have tried to summarize available information on status of women over a period of time and highlight contradictions. This chapter highlights the following:

- The Vedic text has been foremost in shaping the social and religious life of people in general and women in particular.
- Though contact with other religious communities did bring about some change, its influence either remained confined to regional boundaries or got overshadowed by

the prevalent religious autocracy.

- The Brahminical hold remained strong at all periods of time for determining religious code of conduct.
- As society became more stratified, the upper class women were subjected to more stringent measures.
- There was a steady deterioration in the position of women over a period of time and secondary status of women was one of the issues on which British legitimized their superiority.

The second chapter entitled ***Colonial Rule and Indian Women*** explores the impact of British rule on women. It focusses on debates around some key social issues pertaining to women in the larger frame of social reforms. It underlines the following facts:

- The British introduced some reforms by legislating laws for prohibition of *sati*, raising the Age of Con sent of Marriage, prohibiting female infanticide and hence legitimized their civilized image. At the same time their attitudes in other areas were far from progressive.
- These reforms were also greatly influenced by indigenous elites with whom British could not afford to come in conflict. Their need for Indian supporters to further their economic and political interests was greater than their concern for women.
- Welfare movement in Britain also influenced British

Government initiatives in the area of social reforms. Our National movement got influenced by these development as well.

- Women's movement in the West provided impetus to Indian women's movement. Indian women who got educated in Britain were instrumental in initiating reforms in India. By and large their approach was reformist.
- Women's organizations demanding equal rights did not always get support. A section of society opposed these moves. This period also saw publication of ideological statements which highlighted western intellectual ethos within which women were located.

The third chapter entitled ***Women, Science and Medical Establishment*** highlights that as philosophers and social scientists constructed images of women within the constraints of socio-political environment of that time, so did science and medicine. This chapter mobilizes evidence to show that:

- The scientists and medical doctors like any one else are born and raised in a particular culture of beliefs, biases, values and opinions. The conceptual framework which they choose to adopt reflect their values at any given time.
- The image of women or social attitudes towards women also get reflected in scientific and medical field. Some of the social attitudes get scientific treatment

in the hands of scientists and medical professionals.

- Even the earlier efforts at medical practice were deeply influenced by socio-political forces. The witches - intelligent and articulate among poor - were converted into political enemies and scapegoats among others, but at the same time the Church needed women for health care work which no one else did.
- Similarly the professionalization of midwifery was a part of expansion of the medical field to encompass normal body functions and to establish its hold. Infact, midwifery got professionalized when men entered this field. Nursing Profession was the need of institutionalised health care. Nursing was considered most suitable profession for women as it suited their feminine qualities.
- With advancement in medical and scientific field more and more normal body functions were medicalized. Medicalization of pregnancy and cult of invalidism among upper class women necessitated that they be attended by doctors trained in modern medicine.
- At the same time, working women from poor familieswere not considered sick or unhealthy to be treated by specialists. The possible economic interests of medical doctors can not be ruled out in these cases. Rather these women were considered strong enough to bear children and work outside home.

- Maternal mortality rate and puerperal sepsis were high among the upper class women (those attended by trained personnel) than the women in lower class.
- Maternal and Child Health services in early 20th century got State's attention not because of welfarist orientation alone; interests of eugenics and medical professionals shaped these services as well.

The fourth chapter entitled ***Issues of Women's Health and Maternity Services in British India*** highlights that women's health was not really central in British initiatives. It explores the origin of health services for women and shows that:

- The political and economic interests were foremost in their initiatives. The reason for beginning of special services for women had very little to do with problems of women.
- British professional interests, gender conflicts and expansion of medical profession very often shaped the services in India.
- The penetration of British cultural values into Indian elites further strengthened the shape and nature of services.
- Our own National Movement was greatly influenced by these developments and thinking about women. This very clearly emerges from the recommendation of National

Planning Committee of Indian National Congress. These trends characterized the very scaffolding on which Maternal and Child Health service was constructed.

- Though planners in independent India in principle accepted the recommendations of Health Survey and Development Committee, which took wider view of MCH, in practice they were not fully implemented. This was possible because women's health has never been a priority in the Indian social ethos.
- Though there have been significant changes since independence in political and economic structures, the social attitudes and perception about women have changed very slowly. Infact negative social attitudes and perception regarding women are so prevalent that the policy makers and planners - in order to retain their power and the political status quo - have no hesitation in making use of women without fear of political fallouts. Women become targets for population control, their labour is further marginalized by pushing them into the unorganized household sector and their health becomes a means of profit for the fast growing private sector at the cost of general health services including MCH. The MCH service in itself continues to focus on the reproductive functions of women and ignores other dimensions of her health.

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LIST OF ABBREVIATIONS

1.	BMA	-	British Medical Association.
2.	CNS	-	Central Nervous System.
3.	IMS	-	Indian Medical Service.
4.	MMR	-	Maternal Mortality Rate.
5.	MCH	-	Maternal and Child Health.
6.	SAP	-	Structural Adjustment Programme.
7.	VD	-	Venereal Disease.