

Women Physicians as Vital Intermediaries in Colonial Bombay

MRIDULA RAMANNA

The pivot around which the improvement of maternal health revolved was the Indian woman doctor and her growing presence from the 1900s was to be seen at hospitals and welfare centres in the Bombay presidency, promoting knowledge of more hygienic birthing methods and safe infant care. These women physicians, graduates of the first five decades of the Bombay University were not only influential in coping with the serious public health challenge of maternal mortality, their excellent standard of professional skills was much appreciated and became a role model for the younger generation of women doctors.

This paper focuses on Indian women doctors, products of the first half century of women's medical education, of the Bombay University (BU). When Cama hospital (CH), was started in 1886 in Bombay city for the exclusive use of women and children, and to be managed by women doctors, the neighbouring Jamsetji Jejeebhoy hospital (established in 1845) tried to "annex" the donation made by Pestonji H Cama. But the founders of the Medical Women for India Fund (MWIF), whose objectives were both the establishment of the CH and the opening of medical education to women in 1883, were insistent that there be no compromise on the aims.¹ Further, the Indian Medical Service, (IMS) which manned all top posts in the medical establishment, did not want women doctors to be free from male supervision, and contended that without the control of civil surgeons there would be laxity. But again, the view of the MWIF founders prevailed and the doctors of CH were allowed to report directly to the surgeon general of Bombay presidency.

Edith Pechey Phipson, first medical officer (MO) at CH, shortly after her arrival in India, petitioned for the creation of a new department of medical women, which would be exclusively for Europeans first and would later include Indians. She urged, most importantly, that they should be on the same footing as their male counterparts, in respect of salary, since she and her colleagues received lower salaries and perquisites, but the government of India would have none of it.² Only in 1914, was the Women's Medical Service (WMS) created.

A review of facilities for women in early 20th century Bombay, has shown that the growing presence of Indian women doctors, inevitably led to a rise in the numbers of women patients, who constituted around 20 per cent of the total number of patients, in hospitals and dispensaries.³ Most of these women were graduates of Grant Medical College (GMC 1845) and served in the cities of Bombay presidency and in some of the princely states. Women's health was a space left to them by both British and Indian male doctors, their competitors being British women physicians. The Association of Medical Women of India (AMWI), founded in Bombay in 1907, initially voiced the demands of the latter for parity with their male counterparts, and lobbied for more positions. While Indian women were members of this body, most of them continued to hold intermediate level posts in hospitals, for four decades after the introduction of medical education. Only in 1928 was Jerusha Jhirad appointed MO at CH. Now, their voices were heard in public forums.

What issues did they take up and what were their social concerns? They were associated with reformist bodies,

Mridula Ramanna (mridularamanna@hotmail.com) is with the department of history, SIES College, Mumbai.

disseminating information on hygiene, sanitation, and safer birthing practices, and played a role in women's organisations like the All India Women's Conference (AIWC). Birth control was promoted as a means of combating maternal mortality and poverty. Efforts to promote family planning made a modest beginning in these years. Geraldine Forbes has examined some of these issues, with reference to Bengal, while Sarah Hodges' edited volume deals with the debates around reproduction.⁴

Career Profiles

A look at these profiles begins with four medical women, who were not BU graduates, but who are important to any discussion on women medics of western India. Even before the first woman physician graduated from the Bombay University, the celebrated Anandibai Joshi had completed her MD at Women's Medical College of Pennsylvania, Philadelphia, in 1886. Joshi was appointed resident physician of the women's ward at a Kolhapur hospital, but never took charge of her position, as she died soon after returning to India. Less well known is Gurubai Karmarkar, who also trained at Philadelphia, and is an example of an Indian "medical missionary". After her return to India, in 1893, she served the American Marathi Mission, for 23 years. The mission's objective was clear; medical mission work was to be "the master key to open doors and hearts alike to the advance agents of a Christian civilisation".⁵

Motibai Kapadia who trained in Britain, on her return, in 1889, took charge of the Victoria Jubilee hospital, Ahmedabad, a post she held for 30 years. Rakhmabai, the daughter of Dr Sakharan Arjun, came into the public eye when her husband, Dadaji Bhikaji filed a legal suit for the restitution of conjugal rights in 1884. The separation was settled through a compromise in 1887. Two years later, Rakhmabai went abroad for medical studies, encouraged by Pechey Phipson, and qualified for the MD in Brussels in 1894, and later trained at the London School of Medicine for Women (LSMW). She is said to have moved in "high social circles", while in England and met then British prime minister William Gladstone, poet Alfred Tennyson and the wife of Bertrand Russell the philosopher-writer. On her return to India, she worked at CH, for eight months as house surgeon. She then served at the Morarbhai Vajrabhushandas hospital, Surat from 1895-1917, and was chief doctor to the princely states of Saurashtra based at Rajkot, from 1918-30. Her popularity was legion and during the plague and influenza epidemics she worked selflessly and was subsequently awarded the Kaiser-I-Hind medal.

From the GMC, Annie Walke, a Goan, was the first to qualify in 1888. She worked at CH, as assistant to Pechey Phipson, but died young during the plague epidemic, in 1898. Hence Freny Murzban nee Cama (1892)⁶ the second Indian graduate, is better known. (The graduation dates of GMC students are indicated in brackets) Freny Cama began her career in CH, but seems to have fallen out with her English bosses, and later worked in the Dufferin hospital, Patiala.

Service and Efficiency

By 1913, 66 women, including Europeans, Eurasians, Parsis, Indian Christians, Hindus and Jews, had secured the Licentiate of Medicine and Surgery (LMS) degrees from GMC. Some of them

served at CH, where it is easier to trace their careers, while it is more difficult with others who took to private practice. It is significant that some of these women continued a family tradition.

Like Rakhmabai, three women of the family of Atmaram Pandurang Turkhud, leading medical practitioner of the 19th century, also qualified as doctors. They were Manak Bahadurji nee Turkhud (1895) whose assistance during the plague epidemic of 1896-97, N H Choksy has acknowledged in his report of the infectious diseases hospital, Violet, who completed her degree from London in 1906, and Kantabai Sadanand (1914) who was appointed house surgeon at CH, in 1915. Avambai Mehta (1901) who served at CH for long years, also had a physician elder sister, who died young. Mehta was designated assistant MO in 1933, her responsibility in this job being considerable, as most maternity cases at the time, were of an emergency nature, since ante-natal work was unknown. Mehta was lauded for her exceptional efficiency as an anaesthetist by Annette Benson, Pechey Phipson's successor at CH.

Cecilia D' Monte (1898) was another long serving graduate, who served as second MO, CH, for 39 years, and MO briefly. She was also associated with the Bombay Presidency Infant Welfare Society (BPIWS) established in 1921. Dosibhai J R Dadabhoy (1904) MD, Licentiate of the Royal College of the Physicians of London (LRCP), Member of the Royal College of Surgeon (MRCS), was the first Indian woman fellow of BU. Trained initially at the Parsi Lying-in hospital, and then in London, at the Royal Free Hospital and LSMW, she was the first Indian woman to complete her MD in tropical medicine (1912). On her return to Bombay, she opened a maternity clinic, was honorary obstetric consultant at CH (1923-36) and at King Edward Memorial Hospital (established in 1926), and pioneered the use of radium in cancer cases among women in India. Dadabhoy was involved with the BPIWS, the Red Cross, and organised the blood transfusion service and blood bank (1942).

Jerusha Jhirad (1912) had her early education at the high school for Indian girls, Poona and completed her matriculation in 1907. Her decision to pursue medicine was due to the impression created by the marvellous recovery made by her sister from a serious illness, under the treatment provided by Benson at CH. She joined GMC, where she won scholarships and prizes. She started general practice in Bombay, since residents' posts were not available to women. Her next endeavour was to get an MD from London, but she found that scholarships were only open to Europeans and Anglo-Indians. Subsequently, she secured a loan scholarship from the house of Tatas, for her MD in Obstetrics and Gynaecology from the LSMW. Six months into her stay there, she was awarded a scholarship of 200 pounds per annum for five years, by the government of Bombay.⁷ She completed her internship at the Garrett Anderson Hospital, London and worked as house surgeon for a couple of years. When Jhirad returned to India, after the first world war, she served at Lady Hardinge College and Hospital, the women's medical school started in Delhi, in 1916, and then as senior surgeon, Bangalore Maternity Hospital. Finding the facilities in the latter limited, she started private practice in Bombay. She worked as honorary surgeon (1925-28) in CH.

Jhirad was the first Indian to serve as MO, 1928-47. Under her guidance, the work of the hospital expanded and undergraduate and postgraduate training facilities for women medical students were provided as she believed that medical facilities and education exclusively for women, would make them more acceptable. She was both fellow and a member of the syndicate of the BU.

Between Two Worlds

Krishnabai Kelavkar (1902) spoke of a cane curtain between male students and herself at Ferguson College, Poona, where she pursued her education before joining GMC. She worked at the Albert Edward hospital for women and children, Kolhapur, for two decades and was awarded the Kaiser-I-Hind medal, for her services as a doctor and in training nurses. The Anglo-Gujarati journal, *Hindi Punch* wrote about her, "She heals the disease quite as well with her drug and her surgical knife as with her sweet smile and her gentle treatment of the patient".⁸

Kashibai Nowrange, who completed her BA from Wilson College and then the LMS (1907) was one of the first few women to set up independent practice. Associated with medical forums and reform organisations, she has been regarded as exemplifying the female intelligentsia, a group fostered by male social reformers to play a mediating role between the separate worlds of male and female.⁹ She was instrumental in getting postgraduate courses run at CH recognised for the MD degree of the university. In 1934, she led a delegation of medical women to provide medical relief to the victims of the Bihar earthquake.

Rani Rajwade (1908) nee Nagutai Joshi, was the daughter of Sir Moropant Joshi, a nationalist, reformer and legislator. A scholarship student and gold medallist at GMC, on completion of the course Nagutai, as she was then known, decided to pursue further studies in England and not marry till she completed her training. Her travelling companion on SS Macedonia was Gopal Krishna Gokhale. He introduced her to Sir Jagdish Chandra Bose, and Romesh Chandra Dutt in England. She cultivated the friendship of leaders of the suffragette movement like Emmeline Pankhurst, and subscribed to a fund, started to help Indian Passive Resisters in South Africa.¹⁰ She obtained her LM (Rotunda), LRCP, (London) and MRCS, (Dublin) and on her return to Bombay in 1912, practised medicine for 14 years. With the help of Dr Gopal Rao Deshmukh she set up her own consulting rooms, nursing home and operating theatre, records her doting mother, Lady Yashodabai Joshi. Nagutai made so much money that she asked her father to retire and offered to fund his trip to the west.¹¹ She married a widower, Ganpatrao Raghunath Raja Rajwade of Gwalior state in 1926 and was very active in public organisations, as will be shown.

Jerbanoo Mistri (1902) was associated with the organisation of infant welfare centres, and penned a small tract in Gujarati, entitled *Baljanam agair matani ane panch varas sudhina balakni mavjat* (*Care of the Expectant Mother and Child up to Five Years*).¹² She was a member of the Indian Prostitution Committee, 1923, where she gave a note of dissent along with three others, against the recommendations for regulation and punishments for prostitution.¹³ Later, she was chairperson, parliamentary sub-committee of Bombay Presidency Women's Council. She was

also concerned with improving standards of cinema films, and worked to improve the condition of women in detention cells and in the two mental hospitals of the presidency.

The placements of other early Bombay graduates have been reconstructed on the basis of data not always complete or clear, compiled by the AMWI. Priscilla Soares (1909) ran one of the maternity centres established under the Lady Willingdon Scheme, which was started in 1914 to assist poor women in child birth and infant care. Hirabai Gilder nee Contractor (1906) served initially under Benson at CH, and then set up private practice. She worked for the ambulance and nursing divisions of the Red Cross, for the visually challenged and as a medical inspector at the J J School for girls. Also at CH was A V Dias. Gulbai Doctor (1905) practised in Bombay. The *Bombay Medical Register 1914* lists Navazbai Mehta (1899), Bahooobai Anklesaria (1905), Kathleen Gomes (1907), Saroshbano Khareghat (1911) as medical practitioners.¹⁴

Woman as Healer

Elsewhere in the presidency, Sundarabai Kirtane (1912) was in charge of the maternity ward established in the King Edward Memorial (KEM), Poona in 1915, assisted by nurses provided by the Seva Sadan. Kirtane noted that these facilities owed their origin to a need keenly felt of affording relief to the poor Indian women who "are proverbially shy and shrink from consulting male doctors even if they are suffering untold agonies".¹⁵ Dhun Wadia (1903) and Manekbai Bridgeinspector (1907) served at Ahmedabad, Porochee Dalal, at the Parsi Maternity hospital, Surat, and Mary Edith De Souza (1909) also at Surat.

Serving in other regions were Piroja Bahadurji (1907) Rangoon, Jerbanoo Karani (1906) the Empress Mills, Nagpur, Ursula Marie Lobo (1909) Caibai Moti hospital, Berar, N Mascarenhas nee N Fernandez (1900) civil hospital, Ujjain, and Mathurabai Uchgaokar (1914) Bangalore. Shirin Commissariat (1904) Charlotte Smith (1908) and C F Mendes at the Countess of Dufferin Fund (CDF) hospitals in Allahabad, Sholapur and Sitapur, respectively. In the princely states were Emma Smith (1900) Jamnabai hospital, Baroda, Motebai Thanewala (1902) Maharana hospital, Indore, Ruth Devajee (1913) Zenana hospital, Junagarh, A Taraporewala, Hyderabad (Deccan), and Manak Dadina, KEM hospital, Jammu.¹⁶

The later graduates, included Edith Olivera, wms who served at the Women's Medical School, Agra, Mary Ferreira (1917) Hazel and Myrtle Machado (both 1917) at CH, Lanibai Shamrao Manker (1918) associated with the Pathare Prabhu Mahila Samaj, Saibai Ranade made her mark among the Bhatia community, Gulbai Medhora at the Sassoon hospital, Poona, Gulcheher Surveyor (1918) at Gwalior and Naja Mukadam. Mehra Wadia (1927, MD 1929) was honorary consultant 1931, and MO (1947-58) at CH, succeeding Jhirad. Wadia was also associated with the AMWI and the Bombay Obstetrical and Gynaecological Society.

Margaret Balfour, the first CMO in the WMS, observed that women's entry into medicine was accepted as "suitable and natural" and there was little "sexual prejudice" in India. Once the medical woman became a success, patients came from all over.¹⁷ In an article in *The Journal of the AMWI*, entitled 'Woman as Healer', Hazel Machado, pointed out that it was commonly

believed that the study of medicine for women was unnatural and tended to deaden her feelings and there was something in it that was repugnant to the social order of things. But soon public opinion began to realise that there was ample scope for men and women to share in the “noble work for the welfare of humanity”. She noted that gradually, attendance by a woman doctor on her own sex became the rule rather than the exception.¹⁸

Sometimes, women medical students dropped out midway through their course, for marriage, or they would not pursue their careers despite having qualified. Jhirad asserted that marriage was no bar to medicine. On the other hand, it brought into relief the best qualities of sympathy and fellow feeling. They were suited to serve at ante-natal clinics, infant and welfare centres.¹⁹ Avانبai Mehta had averred, “Let us resolve that we shall not rest till the message of medical relief is carried to the humblest cottage. Few professions offer such unique opportunities for public service such as ours.”²⁰ Dadabhojy who was the first Indian president of the AMWI, pointed out at the golden jubilee of the AMWI in 1957 that the statistics collected from a few states of independent India showed that out of 507 women, 492 were practising part time or full time.²¹

In her review of the obstetric work done at the CH in 1933, Mehta pointed out that women had by then, begun to consider it their “birthright” to come to the hospital for confinement. She found that the third generation of women from families came to her for medical care, with the labour cases increasing from 970 in 1923 to 2,387 in 1932. Mehta detailed the expansion of facilities at CH: training of nurses, through a full-fledged course of three and half years recognised by the Bombay Presidency Nursing Association, (1913) a venereal diseases clinic and a tuberculosis ward. She further described the changes in treatment, from the early 1900s: examination of patients during pregnancy and labour including a check on blood pressure was done by nurses as well as doctors, and any abnormality noted, thereby reducing cases of eclampsia (fever accompanied by fits). In cases of rigid perineum, chloroform was replaced by 1 per cent novocaine injection and a cut was made with scissors so that it would be easy to suture, and in cases of traumatic haemorrhage from the cervix, where formerly the vaginal canal was packed with gauze, now the lacerated cervix was sutured and sepsis thus prevented.

Owing to pressure on accommodation maternity patients were discharged within a week, as soon as the umbilical cord dropped.²² It seems that gynaecology and obstetrics as the only speciality, and women and children as patients, was the forte of the medical woman. While she performed operations of fibroid tumours of the uterus and cystic tumours of the ovary she did not get much general surgery, and was called only for occasional amputations, setting of fractures or for cataracts.²³ Alison Bashford has shown that while it was accepted that women nursed men, it was unacceptable they attended to men as doctors.²⁴

Association of Medical Women of India

In 1906, Benson arranged a meeting of women doctors from different parts of India, who decided they would form themselves into the AMWI (formally established, 1907). The objectives were to promote professional fellowship among its members and to

further the interests of women. It was decided to adopt three methods: (1) holding of meetings at centres, where decisions would be taken by a two-thirds majority, (2) providing and circulating medical literature, and (3) printing and circulating a quarterly journal, priced at three rupees. The annual membership subscription was rupees five. The AMWI prided itself on predating similar associations of medical women in the USA (1915) and in the UK (1917).

To achieve its objective of disseminating information, the AMWI held regular conferences to discuss various issues. The need for studying venereal diseases was recognised and from 1921, short-term courses were organised at Poona. The outcome of the discussions of the 1939 conference was that several large women’s hospitals established paediatric wards. The AMWI brought out *The Journal of the AMWI*, which included book reviews, reports of cases, extracts from the *Indian Medical Gazette*, a list of qualified medical women and job openings. It also carried advertisements of infant foods and tonics to relieve anaemia in mothers, books on nursing and midwifery, hospital steel furniture, surgical instruments, improved stethoscopes, and anaesthetic apparatus.

The list of Indian members of the early years of the AMWI, included 26 from Bombay; 13 Parsi, six Indian Christians, five European and Eurasian, and two Hindu women.²⁵ All the council members were British, Rakhmabai being made a member in 1912.²⁶

Though the CDF had practically benefited British doctors,²⁷ the AMWI was critical of it for not providing satisfactory conditions of work for medical women. The AMWI sought affiliation with the Association of Registered Medical Women of London, for the crusade against the “abuses” of the CDF. Emma Slater (formerly Littlewood, who had served at CH) took an active part in rousing public opinion in England about the need to have a proper organisation of women’s medical work in India. From Bombay presidency, doctors Bernard who served in Poona, and Rakhmabai, urged that such an organisation would improve the status of medical women. In fact there was a complaint about gender prejudice from Lilian Trewby, who was discharged after 17 years of service. She had learnt the local language and had opened a hospital in Amravati, but had not received even thanks from the local commissioner. In her letter to the English branch of the AMWI, she cautioned that women should not come out to India till there was a settled scheme.²⁸ On the other hand, the civil surgeon, Hyderabad, had endorsed the appointment of a woman sub-assistant surgeon, M De Souza on the same scale of pay as her male counterpart.²⁹ The contemporary newspaper, *Indu Prakash* referred to complaints by “female medical employees” against “a lot of male interference and male supervision which is prejudicial to efficiency and of course dissonant with their dignity”.³⁰

Women’s Medical Service

A deputation of the AMWI headed by Benson, presented to the government, Simla in 1909, a scheme for the formation of the WMS, and demanded that there should be women on the central committee of the CDF and a woman medical secretary.³¹ The CDF jointly with the AMWI, made a representation to the secretary of state, Lord Morley in 1910. The attention of the British

press seems to have been focused on both the lack of medical aid to Indian women, and the failure of the government of India to provide this relief. As the British government's response was not definite, a second deputation waited on Morley's successor, Lord Crewe in 1912. Submitting the draft proposals for the WMS, the deputation referred to the strong sentiments against social intercourse between men and women and to doubts that had been voiced whether anatomy classes could be held for women. It was noted sardonically that the government of Bombay had recently announced an increase in dispensaries, in the outlying areas, but if these were put in the charge of women there would be a "scandal", for the lady doctor was in popular parlance, a term of disrepute. They urged the setting up of a medical school for women staffed by women.

The WMS scheme was subsequently sanctioned in 1914, especially to secure personnel for staffing the CDF hospitals, and was reserved for the British, Anglo-Indians and Indians with British qualifications. The first Indian woman in the WMS was Hilda Lazarus (1917) and the first from Bombay was Rakhmabai.

Even as the WMS was being contemplated, Rajwade sent a memorandum, asking that the posts to be created should be reserved for local graduates without distinction of caste or creed.³² She pointed out that if the majority of western women were very sensitive, and found it difficult to overcome prejudice "on the score of difference in race, tradition and religion", it was not surprising thus that the average Indian woman, who was "more" sensitive had a greater aversion to being examined by a stranger, the European male or female doctor. There was consequently greater justification for pressing the claims of Indian women doctors.³³

Some British women doctors felt that their Indian counterparts had inadequate experience compared to them. Hence the *Indu Prakash* warned against "scandals", like with the Indian medical or civil services when all sorts of "ingenious subtleties" were employed to shut out Indians. The paper reminded its readers that "alien" nurses had been imported during the plague epidemics, and were supported by the Indian taxpayer. The *Parsi* echoed these sentiments.³⁴ The *British Medical Journal*, on the other hand, objected to what was regarded, "unfair criticism" in an unnamed Parsi journal, which had commented: "What we want is not the organisation of a corps of a limited number of lady doctors from England, who make a rich living out of their high salaries and a flourishing practice amongst the upper classes of Indian society, but the institution of a large number of Indian medical women who may be in a position to carry medical aid and relief to that large class of women, who are reluctant to take advantage of the hospital managed by male doctors."³⁵

Notwithstanding the issue of keeping Indian women out, British women doctors were themselves not considered fit to do "rough" tasks. At the outbreak of the first world war, the AMWI offered the services of its members to the war effort, but it was not accepted, on the grounds that war was not suited to "female hands". But the opinion seems to have changed in 1917, when the services of medical women were urgently needed. As a result, the government of India constituted a committee of the AMWI and CDF, which included Balfour as a member. Medical women were engaged

as civilian practitioners and, for the remainder of the war, units were maintained at Bombay and Secunderabad.³⁶ During the second world war, conditions were different and Lazarus CMO by then, was given the rank of colonel. India was represented at the international conference of medical women at London, in 1924. Dadabhoy, Jhirad and Lazarus presented a memorandum on behalf of the AMWI to give proper status to WMS officers, following the dissolution of the service, with the IMS in 1949.³⁷ By then all senior officers except for seven out of 38 were Indian.

Reformist and Healthcare Organisations

Women physicians were associated with reformist organisations, which tackled other social problems concerning women. Both Rakhmabai and Nowrange were closely involved with the Arya Mahila Samaj for 40 years. Rakhmabai was the inspiration for Shivgauri Gajjar, the sister of the well known chemist of Surat, G T Gajjar. Shivgauri set up the 'vidhya' (widow) ashram with another orthodox Brahmin woman, Bajigauri Nagar. Rakhmabai also encouraged young Vidyalakshmi, a mother of two, who was estranged from her husband to learn first aid and take up nursing. Vidyaben, as she was referred to assisted Rakhmabai in the Rasulkalji Zenana hospital, Rajkot and soon gained so much confidence that she looked after the local chapter of the Red Cross. Later, when Vidyaben reconciled with her husband she took a conscious decision not to have any more children and was evidently taught ayurvedic preparations for "protection" by her mentor, Rakhmabai.³⁸ Rakhmabai used her contacts with the princely families of Kathiawar to start a fund, to which she contributed all the personal gifts she had received from grateful patients, to promote nursing. She wished to persuade women from "better classes" to take up nursing, since in her own career she had worked most of the time without qualified nurses.

Women were represented on local organisations associated with healthcare, which were unique initiatives in early 20th century Bombay. Nowrange attended the inauguration of the Bombay Sanitary Association, 1904 and spoke at the inaugural of the Anti-Tuberculosis League, 1912. She pointed out that tuberculosis had been wreaking havoc among the poorer classes, especially women, who had to pass most of their time in seclusion. The subject of prevention was vitally connected with sanitation and hygiene, and it was therefore necessary to educate the ignorant masses.³⁹ Kelavkar was the only woman on the central committee of the Bombay Medical Congress held in 1909, though she did not read a paper at the congress. Hazel Machado was a member of the Social Service League, a reformist body (1911), which instructed mill workers on sanitation, hygiene and first aid, and provided medical relief during the influenza epidemic 1918-19, and famine. Myrtle Machado worked at the dispensary, maintained by the League for Combating Venereal Diseases (1916) providing free diagnosis and treatment by "modern methods".⁴⁰

Phirozbai Captain, Gulbai Doctor, S R Singara, and Shirin Commissariat were members of the Bombay Medical Union (established in 1884). Malini Sukhthankar was the first to be appointed "chairwoman" of the school committee of the Bombay municipal corporation. Shakuntala Talpade with Margaret Balfour made an inquiry into the conditions of women mill workers. Among their

suggestions to assist pregnant mill workers, were that light work should be given during the later months of pregnancy, and one free meal and milk should be provided daily. Interestingly, they recommended improvements in the conditions of male workers, which would indirectly help women since they continued to work even during advanced pregnancy because the men gambled or drank away their salaries.⁴¹

At the all India level, Dadabhoi was founder member of the Federation of Obstetrical and Gynaecological Society of India (FOGSI) and served with Lazarus on the health survey and development committee (1942-46) chaired by Sir Joseph Bhore. Jhirad was also a founder member of the FOGSI. Closely connected with the AMWI, she served as its president and was chairperson of the maternity and child welfare advisory committee of the Indian Council of Medical Research, for several years till 1954. She was awarded the MBE (1945) and the Padmashri (1962), by the government of India.

Gentle and Persistent

Medical women were prominent in women's organisations; mainly the AIWC. Rajwade was elected organising secretary, 1930-31, 1932-33, and chairwoman in 1934, 1935 and 1939. On her elevation, Sarojini Naidu welcomed her with these words, "I remember how 25 years ago she had conquered Bombay as Dr Miss Tai Joshi. I christened her the spirit of India. Imagine my pleasure when I find how she has vindicated that prophetic name."⁴² In her presidential address at the 13th session, Rajwade noted that since legislation in social matters aroused too much bitterness, she advocated that the most effective weapon was "voluntary and propagandist effort". Matters of social hygiene, personal hygiene, care of children, nutrition, prohibition and swadeshi could be accomplished through personal contact, "gentle but persistent preaching and example".⁴³

Rajwade initiated a scheme, whereby pamphlets were prepared on a variety of themes. The subjects included hygiene, mohalla sanitation and water supply, illustrated with some physiological charts and models explaining common epidemics, preventive measures, care of the body, first aid, homely remedies and childcare. Other titles were, 'Where to Put the Child to School?' 'Everyday Science', 'Lives of Eminent Indians', and 'Tolerance'. Sukthankar was general secretary for 1939, treasurer (1944) and convener, health subcommittee. In her report of the latter sub-committee, Sukthankar referred to the inadequate responses to questionnaires circulated regarding medical inspection of schools and physical education, but reported that the latter was compulsory in primary and secondary schools and colleges of Bombay presidency. She had arranged for the circulation of a valuable monograph on the nutrition problems faced by women, which had suggested that milk should be added to the diet, and that faulty cooking and storing should be avoided.⁴⁴

Rajwade also undertook a study of the nursing profession and subsequently the resolution of the AIWC, 1941 called for encouragement to nursing through better salary, housing and more extensive training facilities. In the 1944 session, she made a plea for health insurance for every citizen. By this date, infant mortality had declined to 21.8 per 1,000 live births as compared to 12.2 in the UK. She asserted the right of every woman to have

skilled attendance during pregnancy but held that she was not optimistic, for the central government when dealing with health had always raised the question of finance.⁴⁵ The other Bombay doctor active at the AIWC was Gulbai Doctor, who was vice president at the 18th session, 1945.

Rajwade was appointed chairperson of the sub-committee on women's welfare, under the National Planning Committee (NPC). In her report she referred to the importance of nutrition to good health, and the lack of efforts to tackle the housing problem. She asserted that it was essential to lay down regulations for proper housing from the point of view of public health. A scheme of social insurance contributed to by the state and the individual was recommended. This could include benefits in case of temporary disability, sickness, accident, pregnancy, childbirth, assistance for the care of the newborn, child sickness and old age pension.⁴⁶

Only one million women were enfranchised by the Montford Reforms and voted for the first time in the 1923 elections. Among those elected to the legislatures were women doctors. Along with other women of the AIWC, Rajwade issued an appeal for a commission to be set up to enquire into the disabilities of women in regard to marriage and inheritance. Both she and Sukthankar were among those who gave evidence before the Indian Franchise Commission, presided over by Lord Lothian.⁴⁷

Family Planning

This subject was discussed from the 1920s and birth control was regarded as a means to check the high rates of maternal and infant mortality. In fact, the only article by an Indian doctor in the pages of the AMWI journal, of the early years, was by Mistri on this subject. As a member of the social purity committee, she had looked into the issue of prostitution and had interacted with all sections of the people, medical and lay persons. After deliberations, she said she had come to the conclusion that "until young people, particularly men, were given the training that would teach them to restrain their impulses and instil higher ideals", preventive measures had to be adopted to "control conception". This was not only out of consideration for the woman's health, but also from social and economic considerations which affected the "offspring".⁴⁸

Another advocate was Rajwade, who has been seen by Barbara Ramusack as combining medical training with feminist activism in her unflagging promotion of birth control. In her presidential address to the Oudh women's conference in 1931, Rajwade spoke of the need to limit the growth of population, which could be achieved by proper attention to eugenics, which necessarily involved the practice of regulating births.⁴⁹ Rajwade's proposal to appoint a committee of medical women to recommend means of educating the public to regulate their families was defeated in the 1931 session of the AIWC. In fact, the contrasting views of the Bombay physicians and their Madras counterparts are evident. Sukthankar, while supporting a resolution on birth control at the AIWC in 1933 noted the change in the attitudes of the delegates from the previous year when "we were afraid even to utter the word birth control". She held that "there is nothing in the shastras which injuncts people not to use birth control... If we want our future race to be strong and sturdy, we must see that the vitality of the mother is not stopped by frequent births."⁵⁰

On the other hand, Muthulakshmi Reddi held that birth control was an “unnatural method of limiting the family”, while continence and self-control raised the moral and spiritual nature of man and woman. She advocated the enforcement of the Sharada act so as to postpone the age of marriage for boys and girls. The resolution adopted read, “This conference feels on account of the low physique of women, high infant mortality and increased poverty of the country married men and women should be instructed in methods of birth control in recognised clinics”. It is interesting to note that Reddi objected to the words “birth control clinics” and “married men and women”, and abstained from voting.⁵¹

In 1934-35, the American pioneer Margaret Sanger and the British feminist, Edith Howe Martin toured India. It was observed that except for Bombay and Gujarat other constituencies had not established birth control clinics.⁵² However, as Ramusack has shown even supporters of the movement like Mistri advocated moderation in the propaganda and emphasised the importance of providing information only to married women.⁵³ It was introduced in some of the large hospitals of Calcutta and Bombay by 1936, and was discussed by the AMWI in the all India conference of medical women in 1939, where there was general consensus that the practice of contraception was justifiable when child bearing was likely to endanger the life of the mother and infant.⁵⁴

Jhirad was not for the legalisation of abortion, but for the inculcation of “a healthier frame of mind and a reverential and dispassionate attitude of men and women towards each other”.⁵⁵ Her contention was that children should be educated to develop the right attitude towards sex, inculcating mastery over all passions, and this would develop a highly intellectual nation. Another solution to “sublimate the sex impulse” could be social service organisations to give a “healthy outlet to pent up energies”, and to reduce the “drink evil”.⁵⁶ To Dadabhoy, the question assumed an economic aspect, and she cited the view of the food enquiry committee that for an effective solution of the “food problem” the high rate of the increase of population had to be checked.⁵⁷ In the sub-section entitled ‘Racial Health’ the report of the sub-committee on women of the NPC asserted that the woman as mother of the “race” required special protection of the state. Interestingly, it was averred that “she (woman) has to suffer for the sins of others and any effect on her health has a direct bearing on the health of the child she brings forth”.⁵⁸ This had to be borne in mind while chalking out a programme for the “ensurance (sic) of a physically and mentally healthy race”. This would aim at the gradual eradication of such diseases as caused the degeneration of the race like venereal disease, tuberculosis, leprosy and certain mental disorders.⁵⁹

It was contended that knowledge of birth control enabled a woman to limit her family and to “see that children are not born in conditions in which they can hardly survive”. Abortion was more widespread than was commonly believed, brought about by general ill-health, deficiency in diet, malnutrition and constant pregnancy, because of which women suffered mentally.⁶⁰

Male Proponents of Birth Control

While the discussion around “eugenics” is beyond the scope of this paper, it engaged the discourse of the few male proponents of birth control. The Society for the Study and Promotion

of Family Hygiene was established in 1935 by Dr A P Pillay, who had earlier started the Sholapur eugenics education society, a eugenics clinic in Bombay and a journal, entitled *Marriage Hygiene*. The first women’s free birth control clinic was opened in the mill area of Bombay in the charge of a lady doctor (name not mentioned) who had been trained in contraception by Pillay. Lady Cowasji Jehangir, a reformer associated with this effort, noted that “family limitation” was controversial, but this was meant to give the “poor married Indian woman a chance of enjoying better health for herself and her children by introducing a new science unknown and unheard of by her”, in order to limit her family to the extent that it would leave no injury to her physical health. She clarified that the campaign was trying to advertise that birth control was not the destruction of life, but “spaced babies, happy families and healthy mothers; and that lack of knowledge, prejudice and superstition lead to misery, unhappiness, ill-health, high maternal and infant mortality”.⁶¹

Another advocate was Raghunath Dhondo Karve, professor of mathematics, regarded as the pioneer of modern India’s birth control movement.⁶² In 1921, he wrote *Prevention of Venereal Diseases*, and *Birth Control*. Karve argued that women, not doctors, had inalienable rights to decide when and how many children they would have, and objected to the government’s stand that only for medical reasons could birth control be availed. His wife Malti underwent sterilisation of her own volition. Karve opened a centre for sex consultancy and for the sale of contraceptives, called “Right Agency”, and hoped that from the proceeds of the sale of his books he could bring out similar literature in Marathi. But it did not work out since such writing was considered obscene. In fact, his espousal of family planning cost him his job. He conducted a monthly called *Samaj Swasthya* in Marathi for 25 years, from July, 1927 to his death in 1953.

Karve supported the legislative resolution, moved by Kanji Dwarkadas, that information on birth control should be provided at municipal dispensaries but critics felt that unmarried women would become “immoral” with this information. Karve observed wryly that he expected corporators to have “a little more intelligence”, and mentioned that there was information in his works and in the Gujarati book written by G N Modak of Baroda.⁶³ Another contemporary work entitled *Sex Problem in India* (1927) authored by N S Phadke, professor of moral and mental philosophy, Rajaram College, Kolhapur, with a foreword written by Margaret Sanger, made a plea for “eugenic marriage”.⁶⁴ Phadke held that people suffered from miserable degeneration and the race was void of all stamina, and since wholesale legal prohibition of prostitution had been ruled out, he advocated late marriage and popular education.

The “eugenics” that these male advocates espoused came to be subsumed by family planning, since both agendas agreed that the most pressing problem was poverty, as Sarah Hodges has shown. Pillay’s society merged with a family planning clinic run by the AIWC to become the family planning society, 1940.⁶⁵ Family planning activities were sporadic and ceased when the second world war broke out.

By the 1920s, birth control was also figuring in the newspapers, which carried advertisements, promising a catalogue “containing

various requisites of birth control goods”, supplied by Bakuly & Co, of Calcutta.⁶⁶

Conclusions

Indian women physicians were indeed the vital intermediaries in promoting western medicine and disseminating knowledge about safer births, though this was mainly in the cities and towns. As has been shown, their writings on the causes of maternal mortality reveal more sensitive perceptions of the issues involved than those in the colonial establishment. They had the advantage of knowing the language, customs and the entrenched birthing practices. Hence, they made a more realistic evaluation of the role of the much maligned ‘dai’ (midwife) and recommended her training rather than her outright replacement by the midwife, who was considered alien.⁶⁷ The other dimension, was that women’s and children’s health alone was considered the forte of these physicians. Nevertheless, by the time of the golden jubilee of the AMWI in 1957, Jhirad could record that mixed medical colleges had women not only as professors of obstetrics and gynaecology, but also teaching general medicine, orthopaedics and tuberculosis. As for family planning, their views were moderate and birth control was seen as a means of tackling infant mortality, and poverty.

When the wms was started, Indian women had petitioned that it should be opened to the locally qualified, albeit without

success. They were by no means as vociferous as Indian male doctors who had demanded the Indianisation of the IMS from the 1890s.⁶⁸ That women doctors guarded their space is evident. Jhirad and her colleagues protested against the move to make Lady Hardinge College co-educational, in 1948. Deputations by the AMWI proved ineffective and it was only an injunction against the authorities brought by an ex-student that averted this step. Again in 1956, the Indian Medical Council tried to get the college closed and open a new co-educational college. The AMWI, under the presidency of Jhirad strongly protested and a memorandum was sent to the president, vice president and prime minister. Subsequently, the move was given up, and the cabinet announced that Lady Hardinge would continue as a women’s college.⁶⁹

The struggles of these women are inspiring, working as they did in second rung positions, till the 1920s. They aspired to excellence within the limits imposed by social circumstances. In her review of “obstetrics” at the CH, Avانبai Mehta gave credit to Dadabhy and Jhirad for their high standard of professional work, tact, sympathy and administrative ability and surgical skill, respectively. Their clinics were much appreciated and under their guidance the younger generation was getting equipped “for an independent career”.⁷⁰ These words could sum up what they stood for: professionalism and self-reliance.

NOTES

- 1 Mridula Ramanna, *Western Medicine and Public Health in Colonial Bombay, 1845-95*, New Delhi, 2002, p 185.
- 2 General Department Volumes, Maharashtra State Archives (hereafter GD) 50,1887, Pechey/Government of Bombay, January 31, 1885.
- 3 Mridula Ramanna, ‘Gauging Indian Responses to Western Medicine: Hospitals and Dispensaries, Bombay Presidency, 1900-20’ in *Disease and Medicine in India: A Historical Overview*, Deepak Kumar (ed), New Delhi, 2001, pp 233-48.
- 4 Geraldine Forbes, *Women in Colonial India*, New Delhi, 2005; Sarah Hodges (ed), *Reproductive Health in India History, Politics, Controversies*, New Delhi, 2006.
- 5 Reports of the American Marathi Mission, Sholapur, 1921, p 27.
- 6 Bombay University Calendar of 1914.
- 7 GD no 628, 1915, Letter no 380, 1914, October 1, 1914.
- 8 Pickings from the Hindi Punch, July, 1908, p 73.
- 9 Gail Pearson, ‘The Female Intelligentsia in a Segregated Society-Bombay: A Case Study’ in *Women in India and Nepal*, M Allen and S N Mukherjee (eds), Australian National University Monographs on South Asia, 1982 pp 135-47.
- 10 Sushila Nayar and Kamala Mankekar, *As I Remember Her*, India, 2002, p 97.
- 11 Yashodabai Joshi, *A Marathi Saga*, translated, V V Bhide, New Delhi, 2003, p 91.
- 12 Jerbanoo Mistri, *Baljanam Agair Matani Ane Panch Varas Sudhina Balakrii Mavjat*, Bombay, 1930.
- 13 Bombay Prostitution Committee’s Report, in Supplement to the Indian Social Reformer, Vol XXXIII, No 52, August 1922.
- 14 Bombay Medical Register, 1914, Bombay, 1915.
- 15 Report of Managing Committee of KEM, Poona, 1917.
- 16 *Journal of the Association of Medical Women of India* (hereafter AMWI), Vol IX, No 1, May 1921, pp 40-51.
- 17 Balfour and Young, *Medical Women*, p 101.
- 18 Hazel Machado, ‘Woman as Healer’, AMWI, Vol XLXV, No 4, November 1967, pp 53-55.
- 19 J Jhirad, ‘Women in the Medical Profession’, AMWI, Vol XLVIII, February 1960, No 1, p 9.
- 20 AMWI, Vol XLV, November 1957, No 4, p 118.
- 21 AMWI, Vol XLVI, No 1, 1958, p 7.
- 22 Avانبai Mehta, ‘A Short Review of the Progress of Obstetric Work in the Cama and Allbess Hospitals’, written in 1933, AMWI, Vol XLXII, 1964, No 1, pp 2-3.
- 23 Balfour, *Medical Women*, pp 92-93.
- 24 Alison Bashford, *Purity and Pollution Gender, Embodiment and Victorian Medicine*, London, 2000, p 92.
- 25 Welcome Institute for the History of Medicine, London (hereafter WIHM) SA/MWF/File No C147.
- 26 AMWI, Vol III, February 1912, No 5, p 1.
- 27 Maneesha Lal, ‘The Politics of Gender and Medicine in Colonial India: The Countess of Dufferin Fund, 1885-88’, *Bulletin of the History of Medicine*, 1994, 68, p 65.
- 28 WIHM, SA/MWF/File No C 150, letter of June 19, 1912.
- 29 GD, 537, 1917, Government Order No 901, February 9, 1917.
- 30 Report of Native Papers, Bombay Presidency (hereafter RN), *Indu Prakash*, July 9, 1912.
- 31 AMWI, Vol XLV, November 1957, No 4, p 113.
- 32 GD, 1369, 1914, No 5423, July 10, 1914.
- 33 RN, *Indu Prakash*, July 3, 1914.
- 34 RN, *Indu Prakash*, June 5, 1912, *Parsi*, June 7, 1912.
- 35 *British Medical Journal*, August 24, 1912.
- 36 AMWI, Vol XLV, November, 1957, No 4, pp 120-21.
- 37 AMWI, Vol XLV, November, 1957, No 4, p 122.
- 38 Varde, *Rakhmabai*, pp 147-50.
- 39 GD 156, 1912, ‘War on Phthisis: The Bombay Campaign’.
- 40 *Directory of Social Work in the City and Island of Bombay*, N S Savardekar (ed), Bombay, 1926, p 59.
- 41 Margaret Balfour and Shakuntala Talpade, ‘The Maternity Conditions of Women Mill Workers in India’, *The Indian Medical Gazette*, Vol LXV, No 5, May 1930, pp 1-26.
- 42 Margaret Cousins, *Indian Womanhood Today*, Allahabad, 1941, p 162.
- 43 ‘Report of the All India Women’s Conference’ (hereafter AIWC Report), XIIIth session, 1938-39, p 24.
- 44 AIWC Report, XIIth Session, 1938-39, pp 91-94.
- 45 AIWC Report, XVIth Session, 1941-42, pp 181-82, AIWC Report, XVIIth Session, 1944, pp 60-61.
- 46 *Women’s Role in Planned Economy*, p 41.
- 47 Aparna Basu and Bharati Ray, *Women’s Struggle: A History of the All India Women’s Conference, 1927-90*, New Delhi, 1990, p 56.
- 48 AMWI, Vol IX, No 3, 1921, pp 18-20.
- 49 Barbara Ramusack, ‘Authority and Ambivalence: Medical Women and Birth Control in India’ in *Reproductive Health*, p 69.
- 50 AIWC Report, VIIth Session, 1932, pp 95-96.
- 51 Ibid, pp 90-93.
- 52 AIWC Report, Xth Session, 1935, p 53.
- 53 Ramusack, *Reproductive Health*, p 76.
- 54 AMWI, Vol XLV, November 1957, No 4, p 119.
- 55 AMWI, Vol XLXII, November 1961, No 4, p 190.
- 56 AMWI, Vol XLVI, November 1963, No 4, p 120.
- 57 AMWI, Vol XLVI, February 1958, No 1, p 7.
- 58 *Women’s Role in Planned Economy*, p 39, p 175.
- 59 Ibid, pp 40-41.
- 60 Ibid, p 193.
- 61 Lady Cowasji Jehangir, ‘Maternal Welfare Work in Bombay’, *Asiatic*, Vol 33, 1937, pp 764-65, 767.
- 62 J V Naik R D Karve ‘Modern India’s Birth Control Movement Pioneer’, *Freedom First*, No 414, July-September, 1992, pp 23-26; Divakar Bapat, *Upekshit Drashtra*, Bombay, 1971, pp 78-81.
- 63 *Bombay Chronicle*, June 26, 1929.
- 64 N S Phadke, *Sex Problem in India*, Bombay, 1927, p 323.
- 65 Sarah Hodges, ‘Indian Eugenics in an Age of Reform’ in *Reproductive Health*, pp 132-34.
- 66 *Bombay Chronicle*, April 1929.
- 67 Mridula Ramanna, ‘Maternal Health in Early Twentieth Century Bombay’, *Economic & Political Weekly*, Vol XLII, No 2, January 13, 2007.
- 68 Ramanna, *Western Medicine*, pp 217-33.
- 69 AMWI, Vol XLVI, May, 1958, No 2, p 64.
- 70 Mehta, ‘Progress of Obstetrical Work in Cama’ AMWI, 1964, p 10.