NWISA JOURNAL OF SOCIOLOGY
A Peer Reviewed and Refereed Journal ISSN Number 3048-6963 (Online)
Volume 1 Oct 2024

FROM HOME TO MEDICAL SPACES: MISSIONARIES, WOMEN'S HOSPITALS, AND THE REDEFINITION OF *PURDAH* IN COLONIAL DELHI, 1860-1920.

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ABSTRACT

In the social history of medicine, the subject of women's health, pertaining to the bigger presidencies of Calcutta, Bombay and Madras during the colonial period, has been significantly dealt with. However, the same for the district of Delhi is considerably lacking. Though short write-ups do exist, this, in no way, can bridge such a hole in academia. The current article, therefore, uses empirical data to focus on the inception of female healthcare in the region. In doing so, it highlights the role of missionaries and their medical mission, which became an indispensable element in the colonial healthcare structure. With the proliferation of various female hospitals in the given period, a gradual repositioning of medical spaces from home to medical institutions is subsequently evident.

KEYWORDS

Women's Health; Delhi Female Medical Mission; St. Stephen's Hospital; Victoria Zenana Hospital; Lady Hardinge Medical College and Hospital.

INTRODUCTION

Delhi, formerly a district within the Punjab province (1858-1911), later transformed into the heart of British colonial rule in 1911. While there is a substantial body of existing research on the development and planning of urban spaces, especially regarding their significance during events like the 1857 mutiny, partition, post-partition memories, and migration studies, the potential of this locale within the context of 'colonialism and medicine' remains underexplored.

Classic works by Harrison (1994), Arnold (1993), Ramasubban (1982), Pati (2008), and others have extensively deliberated over the role of Western medicine as a 'tool of empire.' Since 1980s, they have deeply analyzed state medicine and public health developments in the Indian colony during the nineteenth and early twentieth centuries. Many have incorporated such studies into the local context, focusing on bigger presidencies of Bengal, Bombay and Madras, addressing exhaustive themes around diseases and colonial measures, medical institutions, western and indigenous medicine, female healthcare, concepts of race, class, sex, gender, etc. (Kumar, Ramanna, Chakraborty, Forbes, Mukherjee, Levine, Kavadi, Blake, Hardiman, Kaminsky, Legg).

Under the rubric of 'gender and empire,' the role of missionaries, writings surrounding the '*zenana*,' and the formation of the Dufferin's Fund has been vital in shaping the politics of women and medicine (Nair, 1990; Baru, 1999; Chawla, 2005; Lal, 1994; Burton, 1996). Like other parts, Delhi too experienced the pioneering efforts of women medical missionaries in founding specialized healthcare and medical institutions dedicated to women. In this respect, the paper distinguishes itself from the prevailing historiography by not only examining missionary accounts to investigate the genesis of women's health and its institutions, but also various government files, gazettes, annual reports, biographies, memoirs, and journals from the Delhi State Archive, National Archive of India, Nehru Memorial Museum and Library and other sources, to argue that these missions had outright casteist and classist agendas, evident in the way dispensaries and hospitals were constructed, and in the selective choice of medical professionals including other staffs for 'certain' women.

THE GENESIS: THE DELHI MEDICAL MISSION AND ST. STEPHEN'S HOSPITAL

During the late nineteenth century, three missions functioned in Delhi. The Baptist Mission, led by Johnson Chamberlain and J.T. Thompson successively, was the first Christian mission (Pascoe, 1901). Subsequently, the Society for the Propagation of Gospel (SPG) and the Cambridge Mission joined forces to carry out what became towards the second half of the century as the 'Delhi Mission' (Punjab District Gazetteers, 1912, pp. 81-83). While these societies operated concurrently, the former didn't garner as much appeal as the latter two.

Amidst the 1857 revolt, a number of missionaries in Delhi lost their lives. Eventually, Thomas Skelton, a Cambridge missionary, collaborated with Ram Chandra (one of the first Delhi converts who happened to be a professor) to reinstate their primary endeavours. The arrival of Robert Winter as head of the SPG in 1860 further fueled their efforts. Assimilation of the Cambridge mission with the SPG however happened with the coming of scholars, Bickersteth, Allnutt and Lefroy in 1877 (Bickersteth, 1899; Martin, 1922). With Robert's death, Allnutt led the mission, expanding it significantly, covering pastoral, evangelical, educational, and medical projects. Preaching extended to rural and suburban areas outside Delhi. Christian converts mainly came from the *'Chamar'* community initially, low-caste leatherworkers residing in the Daryaganj area, and other pockets in Rohtak, Gurgaon, Karnal, and Rewari. Also, educational efforts excelled, particularly for boys, leading to the establishment of esteemed institutions like the St. Stephen's High School and St. Stephen's College. While St. Mary's home, Victoria Boarding and Industrial

schools for girls and women existed, apparently, they 'turned out a few teachers, but, pre-eminently, wives (Winter, 1888).'

At the beginning, missionary works in colonial India were mostly confined to boys/men. Perhaps, this was a deliberate choice on their part to not concentrate on ventures that wouldn't gain quick recognition, since indigenous customs restricted women's presence in the public, let alone expressing their grievances. Also, since most early missionaries were of the opposite sex, they couldn't enter the women's compartments. This didn't mean that initiatives for female were altogether absent. In fact, the introduction of '*zenana*,' mission, mainly, medical and dispensary work, created a huge impact.

The Delhi Female Medical Mission of the SPG and Cambridge Mission was the first of its kind in British India (The Religious Tract Society, 1889), the credit for its inception being attributed to Priscilla Winter, wife of Robert. The idea originated when the 1863-64 cholera epidemics provided her the chance to tend sick *purdah* women at homes and distribute medicine to all classes of women by the banks of the river Yamuna (Connor, 2000). To notice women missionaries in these medical missions possessing diverse and uncertain skills was not uncommon, since formal medical training was primarily reserved for men at the time. Priscilla, for instance, relied on common sense and wisdom gained from her experiences rather than being a formally trained medical professional (Bickers, 1996). Moreover, women missionaries were mostly wives or daughters who supported their husbands and families in their missionary vocation. It was only after 1869 that qualified foreign female doctors came to India.

The flourishing little dispensary work motivated her to press upon the Ladies' Association (Ladies' Association for the Promotion of Female Education in India and other Heathen Countries, in Connection with the Missions of the SPG , 1889, p. 193) of the SPG during her furlough to England, the vitality of funding and delivering female staffs for her *zenana* mission. Upon return, the medical mission officially materialized. It consisted of outdoor dispensary work at Delhi and Karnal districts, the one at Rewari being attached afterwards. Additional services for training nurses and midwives were soon introduced. Home visits were also provided to patients (including Europeans), with male relatives or partners often seeking the doctors' assistance at any moment. Consequently, after operating briefly in a rented space in Chandni Chowk, the government acknowledging the potential such medical centres carried, allocated a suitable location in 1880. Four years later, the foundation stone of the hospital building was laid by the Duchess of Connaught, followed by its inauguration in 1885 by Lady Dufferin as 'St. Stephen's

Hospital for Women and Children,' with a focus on diseases exclusively affecting women and children. Despite its noble mission, the hospital faced growing challenges encompassing hygiene concerns, odors, disruptive noises, increased patients, and the need for better facilities, prompting its relocation to Tis Hazari in 1908.

Apart from Miss Engelmann, a missionary who initially took charge, the hospital had qualified professionals like Dr. Jenny Muller, Dr. Mayo, Dr. Sorabji, Dr. Scott, Dr. Hayes, and others at different points. Indigenous nurses, dispensers, and assistants, trained internally and via other missions, also contributed to the hospital's operations, but as subordinates. Religious teachings interestingly combined with medical relief to care for patients of various faiths and ages, including elderly women and young infants (Delhi State Archive (DSA), 1902, File.106). Though, Hindu and Mohammedan *purdah-nashins* (women observing *purdah*) received outdoor treatment, they hesitated and preferred medical care at home over hospitalization. The Times of India documented, 'the low-castes are always anxious to be admitted as in-patients but it is not easy to get a high-caste woman to take up her abode (The Times Of India, 1895, p. 5).' For the very few that stayed, a privacy screen was thoughtfully arranged to facilitate visits by husbands. During these occasions, fellow patients also discreetly covered themselves, ensuring separation (Hayes, 1909). Similar considerations were extended when male missionaries visited.

EXPANDING FEMALE MEDICAL CARE: WOMEN'S HOSPITALS AND THEIR REDEFINITION

During the late nineteenth and early twentieth centuries, women's healthcare became a significant concern for the state**.** As an exotic sphere of upper caste/ class female Indian household, 'in need' of rescue, the zenana emerged as the epicentre of colonial medical discourse (Metcalf, 1994). A detailed discussion might be redundant given the extensive coverage this topic has received. However, it is safe to underscore Nair's argument, that the mysterious and impenetrable nature of the zenana was a seat of sedition and intrigues, whose increased visibility was made possible through a variety of Englishwomen's writings (Nair, 1990). Foreign missionaries, bureaucrats, and doctors working within the colony played a pivotal role in this (Stanton, 1908; Scharlieb, 1925; Balfour & Young, 1929). Next to the missionaries were the Vicereines who quickly joined the medical bandwagon.

Against this backdrop, the establishment of the Dufferin's Fund (DF) in 1885 was a critical step in institutionalizing Western medical care for 'Indian women from the better classes (Countess of Dufferin's Fund, 1892, p. 17). This initiative not only funded and deployed foreign-trained female doctors to manage women-exclusive hospitals in India, but also engaged in instructing and equipping local women to qualify as proficient doctors, nurses, and midwives,

preparing them for service in similar institutions or private residences. By the turn of the century, subsequent developments on these lines heightened people's trust in incorporating female/maternity services into general hospitals, like the Hindu Rao and Civil hospital (National Archive of India, 1920, File. 51-52; DSA, 1920, File. 27 Pt. B). Moreover, alongside the St. Stephen's, healthcare facilities dedicated to women, such as the Victoria Zenana Hospital and Lady Hardinge Medical College and Hospital ensued shortly.

Established in 1906, the Victoria Zenana Hospital was founded to honor late Queen Victoria's commitment to women's health (DSA, 1901, File. 104 Vol. 1 Pt. 1). It was initially aimed at providing medical and surgical care to women of all backgrounds, regardless of caste or class. However, its focus gradually shifted, evolving into an institution catering exclusively to purdahnashin/purdahdar women of Delhi, thereby deviating from its original goal of inclusivity. This transformation resulted in several consequences.

Creating such medical facilities required careful consideration, including aspects of location, layout and structure of institutions, interior spaces, staffing, patient preferences, and more. For instance, the hospital drew inspiration from zenana hospitals in Cawnpore and Lucknow, such as St. Catherin's, Lady Dufferin, and Lady Kinnaird, renowned for their elevated enclosing walls. The construction work, initiated following extensive discussions and site inspections, involving various stakeholders, had to stop midway, because 'respectable women had great objection in going into that part, i.e., the south-western side of Jama Masjid (DSA, 1901, File. 104 Pt. II).' Similarly, having an all-female staff, especially doctors with London degree, were preferred. However, this required substantial financial resources at their disposal, making it a rather costly endeavour. On the other hand, nurses and compounders of Brahmin background, possessing some education, were regarded as effective and capable assistants. 'They were apparently very much acceptable to the high caste Hindu patients who came to the hospital for treatment (Ibid, 1908).

To ensure privacy within the hospital, enclosure walls similar to those seen in St. Stephen's, were incorporated, preserving women's seclusion. Simple curtains were used to create separate cubicles around each bed, allowing free movement (DSA, 1901, File. 104 Vol. V). Separate wards and kitchens for Hindu and Muslim patients were also present. To prevent any contact with men, stringent rules were enforced. Staff members were strictly prohibited from introducing or allowing males into the hospital, except under specific conditions set by the lady doctor. For male relatives visiting family wards, different entrance was provided to ensure minimal disruption to other patients. Violation of these rules meant immediate discharge without compensation.

The arrangements in the Lady Hardinge Medical College and Hospital were no different. Conceived by Lady Hardinge in 1912 and opened in 1916, it functioned as both a medical college and a hospital, uniquely staffed by women, and dedicated to women's care (DSA, 1913, File. 92). Back then, societal taboo associated with pursuing medicine in co-educational settings, with male teachers, deterred women from the 'right class' to take up a career in the same field (DSA, 1924, File. 3-54). To address these concerns, lady doctors from the Women's Medical Service (DF), predominantly consisting of white physicians, taught and administered the college. Students from diverse religious backgrounds were allocated separate hostel accommodation, with boarding facilities according to caste and other considerations (DSA, 1916, File. 43). Moreover, like St. Stephen's and Victoria Zenana, the wards were also designed to enable patients to 'retain their *purdah* and caste customs,' as depicted in fig. 4 (The British Medical Journal, 1919, p. 614).

Therefore, a deliberate attempt was carefully made to facilitate the access of upper-class *purdahnashins* to medical facilities. In other words, the *zenana* environment transitioned from its traditional home-bound confinement to being situated within hospital premises. But, offering free treatment to the wealthy went against established relief norms, risking misuse of public funds. Col. Cunningham, Delhi's Chief surgeon, instead proposed redirecting the same funds to improve the female section of the Delhi Civil hospital, with the option to isolate it for strict *purdah* if needed (Salam, 2019). As anticipated, his concerns materialized in practice. These healthcare facilities, despite their charitable and private-aided nature, encountered financial difficulties, even with public subscriptions and contributions from the state, local governments, and DF. Surprisingly, 'private-aided' hospitals and dispensaries amassed the largest share of private income in the entire Delhi region (In 1935, subscriptions from European and Natives in the 'Local Fund,' 'Private Fund' and 'State Public' medical institutions were Rs. 130, Rs. 66,925 and 0 respectively). Clearly, even this was insufficient.

CONCLUSION

In retrospect, women's healthcare in colonial Delhi flourished with the support of missionary activities, bolstered by the Vicereine's efforts to expand trained female staff and medical institutions. Over time, the need for elite *purdah* women overshadowed those from lower social classes and castes who did not observe seclusion. While numerous scholars have explored the "why," this paper stresses on the costs incurred. Hence, in the quest to emancipate secluded women and offer medical access, the zenanas paradoxically shifted to colonial medical settings,

resembling elite urban residences, as seen in St. Stephen's, Victoria Zenana, and Lady Hardinge Medical College and Hospital. Moreover, financial challenges also pushed them to the brink of dysfunction at different junctures.

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