

From God To Doctor: Paediatric Medicine in Colonial and Post- Colonial Uttar Pradesh (1880-1980)

SUMMARY of THESIS

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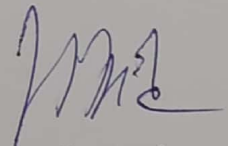
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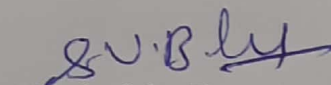
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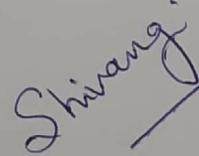
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DECLARATION

I hereby declare that the thesis titled “**From God To Doctor: Paediatric Medicine in Colonial and Post- Colonial Uttar Pradesh (1880-1980)**” submitted for the award of degree of Doctor of Philosophy is an authentic record of original research work carried out by me under the guidance and supervision of Dr. V.M. Ravi Kumar, Assistant Professor, Department of History, School of Ambedkar Studies, Babasaheb Bhimrao Ambedkar University, Vidya Vihar, Raebareli Road, Lucknow-226025 (U.P.). This is also declared that the thesis is essentially free from all kinds of plagiarism. I further declare that this research work has not been submitted before for the award of any other degree or diploma to any University or Institution. In keeping with the ethical practice in reporting research information, due acknowledgments have been made whenever the findings of others have been cited.



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SHIVANGI

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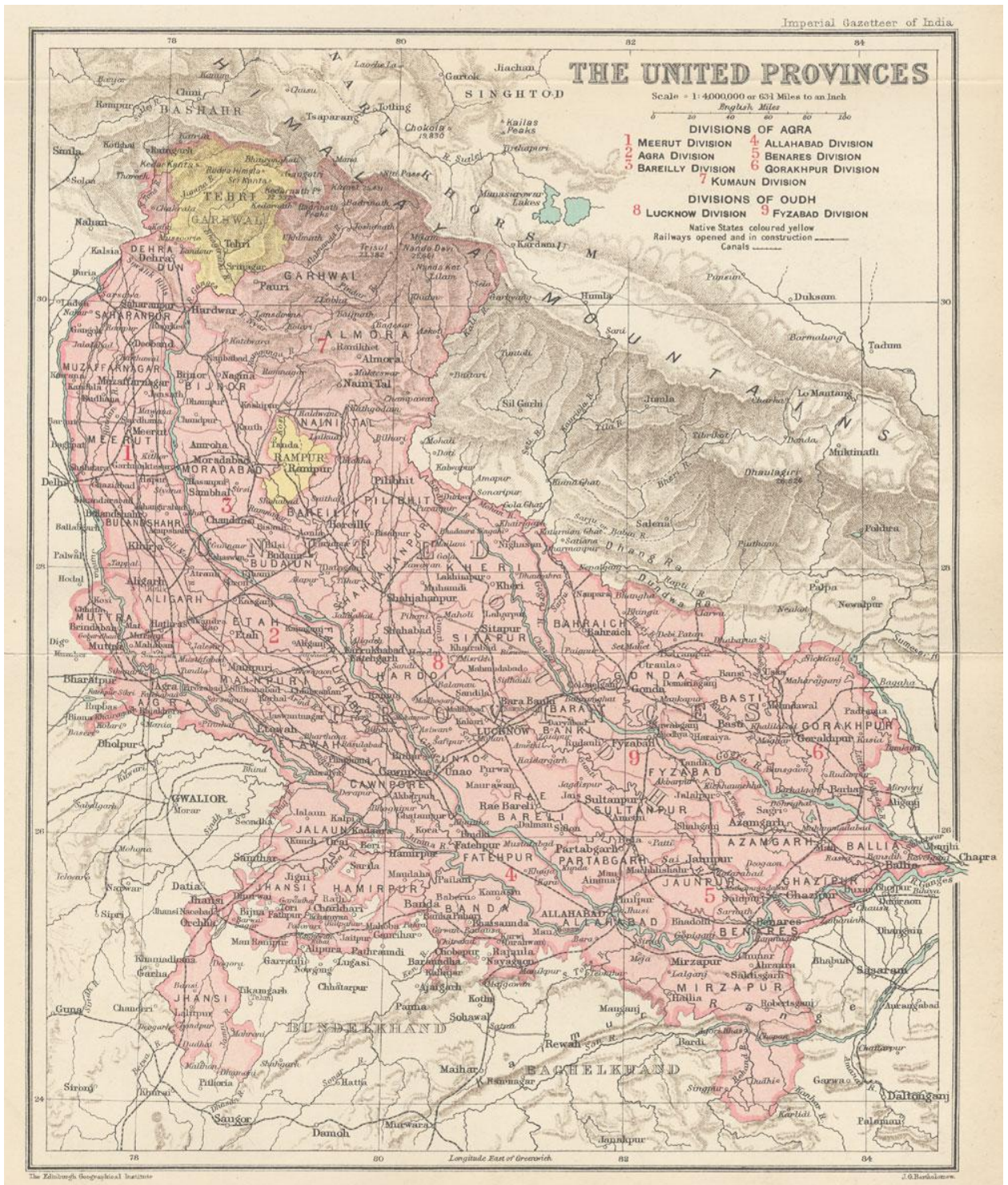
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ABBREVIATIONS

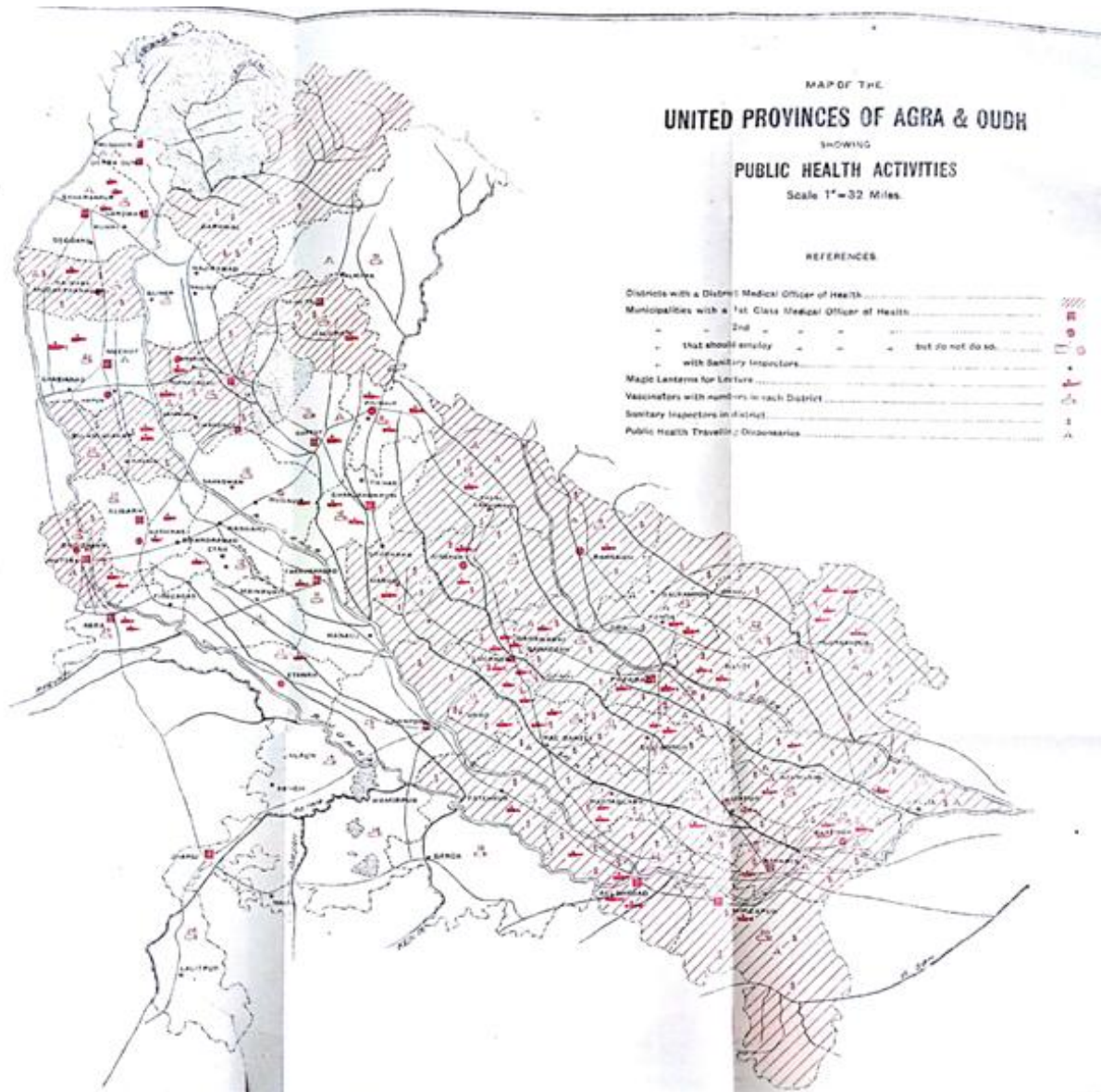
AIHPH	All India Institute of Hygiene and Public Health
AIWC	All India Women's Conference
AMWI	Association of Medical Women in India
ANM	Auxillary Nurses Midwives
ANP	Applied Nutrition Programme
AWW	Anganwadi Workers
BIM	Board of Indian Medicine
CABE	Central Advisory Board of Education
CABH	Central Advisory Board of Health
CARE	Cooperative for Assistance and Relief Everywhere
CS	Civil Surgeon
CWC	Child Welfare Centre
DB	District Boards
DF	Dufferin Fund
DGHS	Directorate General of Health Services
DMHS	Directorate of Medical and Health Services
DMOH	District Medical Officer of Health
DPH	Director of Public Health
DPI	Director of Public Instruction
EHL	Education, Health and Lands
EIC	East India Company
EPI	Expanded Programme of Immunisation
FHA	Female Hospital Assistant
GOI	Government of India
HA	Hospital Assistant
IAP	Indian Academy of Paediatrics
ICDS	Integrated Child Development Services
ICMR	Indian Council of Medical Research
ICCW	Indian Council of Child Welfare
IGCH	Inspector General of Civil Hospitals
IMA	Indian Medical Association
IMS	Indian Medical Services
IMR	Infant Mortality Rate
INC	Indian National Congress
IRCS	Indian Red Cross Society
IRFA	Indian Research Fund Association
LMS	Licentiate in Medicine and Surgery

LSG	Local Self Government
MCWC	Maternity and Child Welfare Centre
MCHC	Maternity and Child Health Centres
MDM	Mid Day Meal
MNP	Minimum Needs Programme
MO	Medical Officer
MoH	Medical Officer of Health
MPF	Multipurpose Food
NAI	National Archives of India
NASFMAWI	National Association for Supplying Female Medical Aid to the Women of India
NFHS	National Family and Health Survey
NWP	North Western Provinces
NWP and Oudh	North Western Provinces of Agra and Oudh
PHD	Public Health Department
PHC	Primary Health Centers
PSMS	Provincial Subordinate Medical Services
RAAUP	Regional Archives of Agra, Uttar Pradesh
RCS	Red Cross Society
SAS	Sub-Assistant Surgeon
SHO	School Health Officer
SNP	Supplementary Nutrition Programme
SOS	Secretary of State
SVN	Selections from Vernacular Newspapers
TD	Travelling Dispensaries
UIP	Universal Immunisation Programme
UNICEF	United Nations Children's Emergency Fund
UP	Uttar Pradesh
UPSA	Uttar Pradesh State Archives
WHO	World Health Organisation
WMS	Women Medical Service

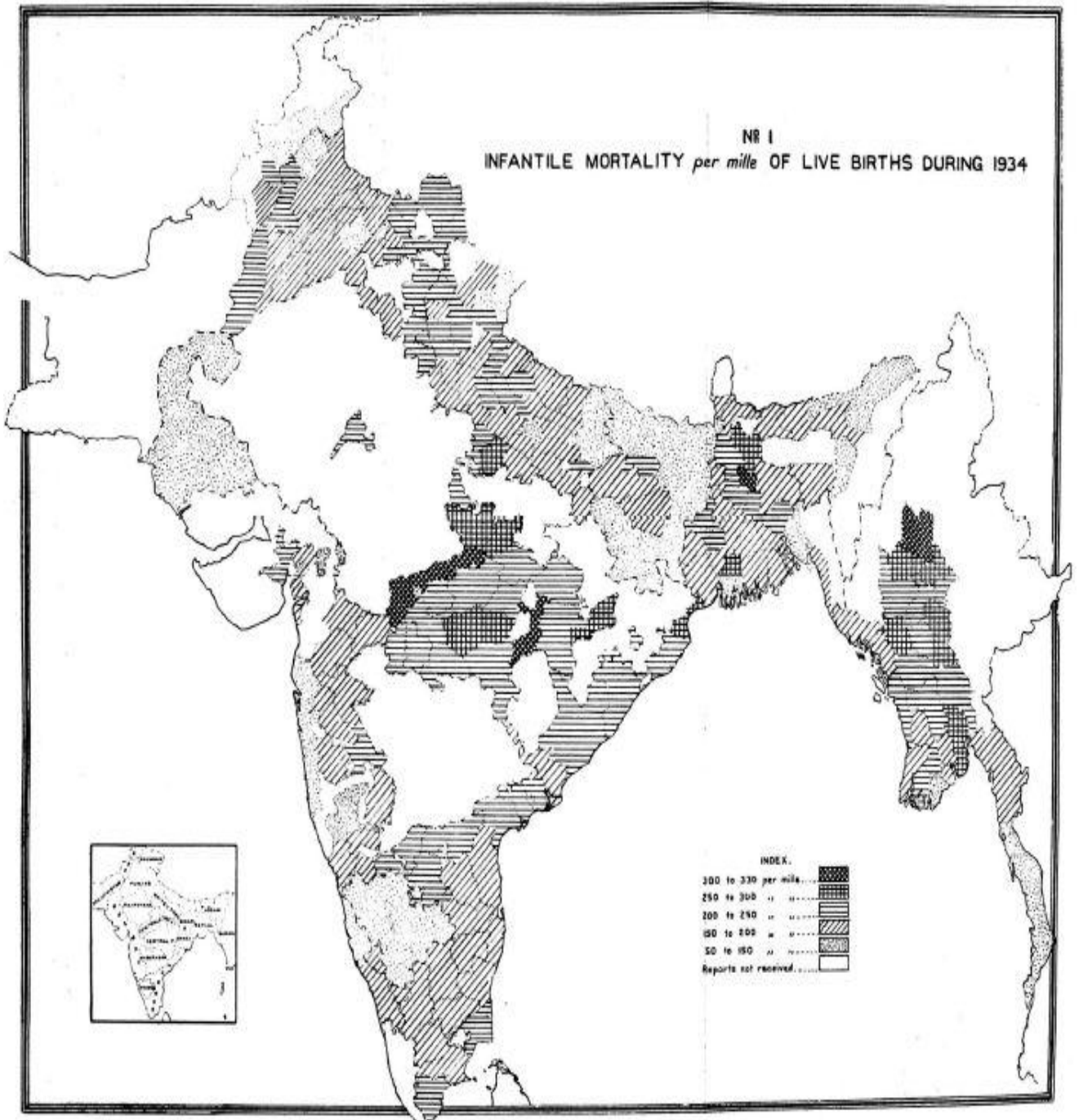
MAPS



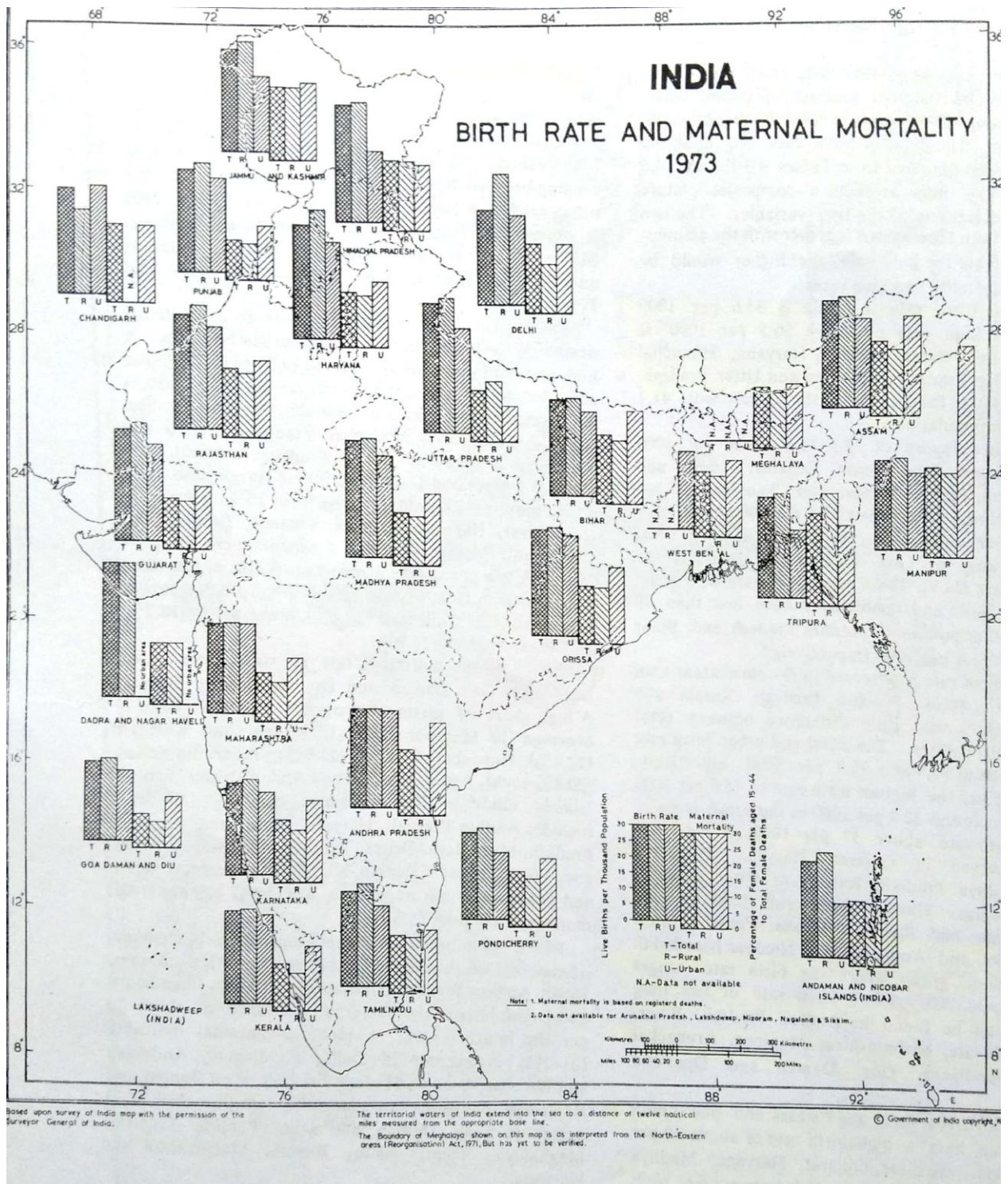
1. Physical and Administrative division of United Provinces during colonial India.



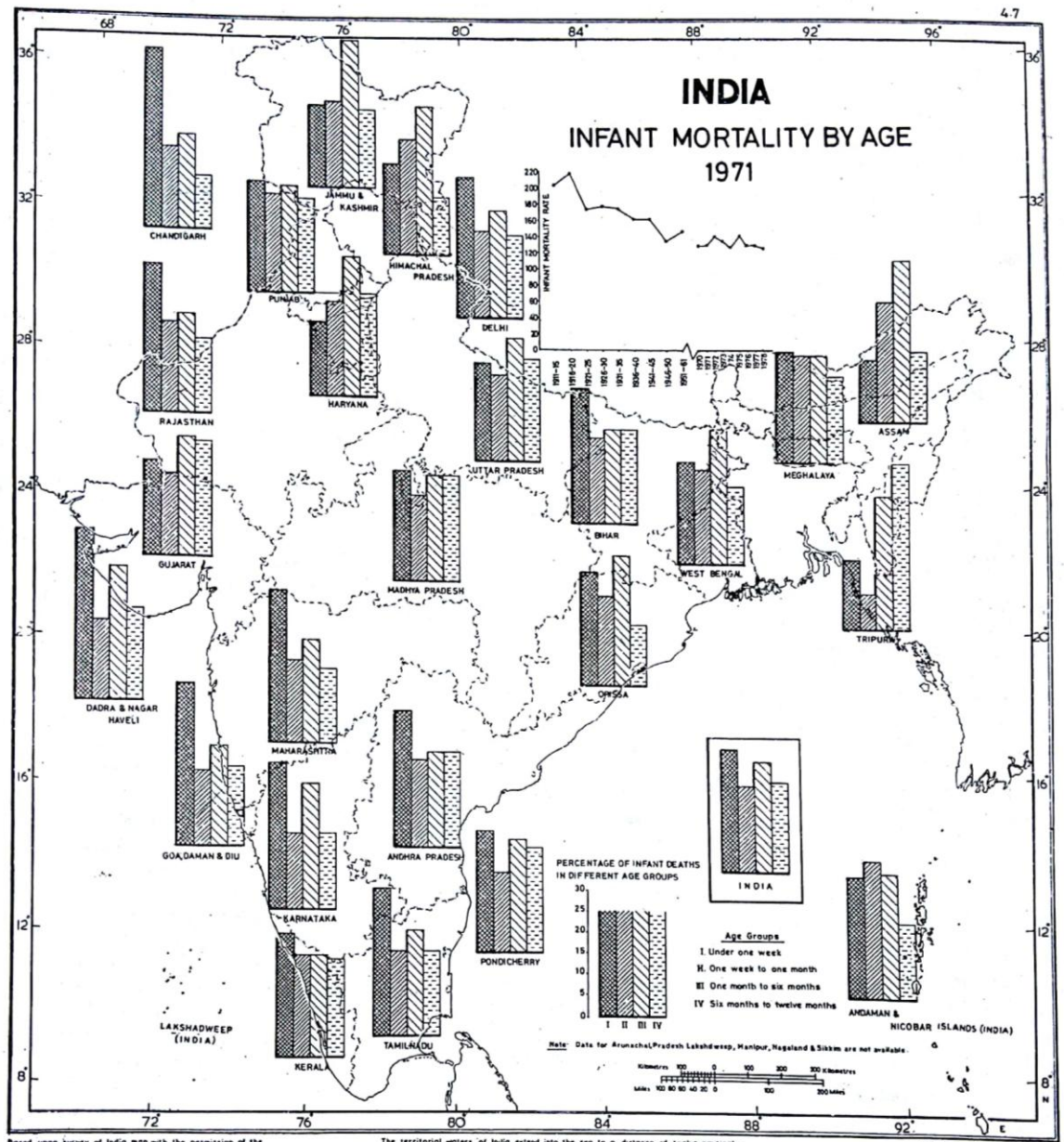
2. Map showing public health activities in United Provinces



3. Map showing variations in Infant mortality rate in British India



4. Birth and Maternal mortality in India after independence



Based upon survey of India map with the permission of the Surveyor General of India.

The territorial waters of India extend into the sea to a distance of twelve nautical miles measured from the appropriate base line.
The boundary of Meghalaya shown on this map is its interpreted from the North-Eastern areas (Provisional) Act, 1971, but has yet to be verified.

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5. Infant Mortality Rate in India by age group in various States of India after Independence

Preface

Social history of medicine is a recent and a well-established branch of the history of science. The medical historians have documented various aspects of this branch such as epidemic control policy, conflict between western and indigenous medicine, the emergence of women as medical professionals, etc. Within this larger domain, this study is a humble attempt to explore the sensibilities of the colonial state towards child medicine. Paediatric medicine is an unturned stone within the broader context of the colonial medical policy. Thus, in the absence of systematic documentation on paediatric medicine, this study explores the policy-making process and official sensibilities towards child healthcare. The chief objective of the work is to trace the history of paediatric medicine in India in general and United Provinces in particular. This thesis thus documents the process of emergence, development, progress and reforms in paediatric medical policy in Uttar Pradesh explicitly under both colonial and post-colonial India.

The thesis asserts that the hegemony of colonial medical policy for the paediatric care rendered through their institutions. These institutions not only attempted to discipline and colonize the child's body but also to extend the superiority of colonial medicine. Exploring paediatrics through the policy-making process by the colonial government opens new doors of historical inquiry in the history of colonial medicine. The work argues that the emergence and expansion of paediatric medicine in colonial India was an outcome of the proliferation of child welfare works by the voluntary organizations, medicalisation of childbirth, international sensibilities, growing bureaucratization and rationalization in the administrative structure of the colonial government. The limited measures and expenditure by the colonial state had a deep impact on the status of

health of children. In comparison to the colonial state, the post-colonial government had envisaged serious efforts towards paedia care through programmes yet the problem was more at the level of implementation than policy structure. The thesis thus attempts to fill the historiographical gap in the social history of medicine by exploring the official attitude towards child medicine.

Chapter I
Introduction

CHAPTER- I

INTRODUCTION

This thesis focuses on the colonial attitude and practices of colonial and post-colonial state in United Provinces towards paediatrics. Setting up in the time frame of 1880-1980, where the nationalist freedom movement accelerated by the formation of Indian National Congress (1885) to the independence, the study explores the sensibilities of the colonial state towards the child medical care. Paediatric medicine and its history is apparently a less explored domain in the history of colonial medicine in India. This study proposes that the paediatric medicine was an important agency with which the ideologies of the British Raj have been expressed in ruling strategies in India. An attempt has thus been made to construct the history of paediatric medicine from colonial to independent India.

While some historical analysis has been made with regard to understanding the ‘civilizing mission’ as a programme, concept, and ideology in British India, its continuities in post-colonial India are rarely the subject of academic analysis. The present topic is thus a less unexplored area in the field of history of medicine and has not been taken up by the scholars extensively. United Provinces in the medical history of colonial India has been studied by scholars as a part of Northern India. There is thus handful literature explicitly exploring the colonial medical policy in North-Western Provinces and Oudh (later renamed as United Provinces). This exploratory study attempts to capture the colonial and post-colonial state’s attitude towards child healthcare with special reference to the United Provinces. Thus, an insight to unfold the history of paediatric medicine in United Provinces is inevitable and will add up to the new horizons of knowledge in the social history of medicine.

The study on child and childhoods is not of recent origin and systematic efforts accordingly were made to understand the child in the Indian context.¹In the western academic and philosophical tradition various scholars such as Rousseau, Locke and Montessori, viewed ‘children’ as the prime population for better understanding of any society. In Indian culture too, children attracted the interest of scholars and nationalist

¹ Ankur Madan, Rajashree Srinivasan, and Kinnari Pandya, Parent-child relations: changing contours and emerging trends, pp-109-129, in T. S. Saraswati, Sailaja Menon and Ankur Madan, *Childhoods in India: Traditions, Trends and Transformations*, (London: Routledge, 2018).

leaders such as Gandhi, Nehru and Tagore.²In this interest of understanding children, the academic analysis on the study of ‘childhood’ relatively originated with the introduction of developmental psychology. This area paved the way in developing knowledge about children and in shaping how we view and understand children in modern society and the impact of policies and practices on children. Scholars have raised doubts questioning the narrative within the new sociology of childhood.³With Philip Aries book emerged a fresh line of scholarship called childhood studies during the second half of 20th century. He framed childhood as socially constructed and historically contingent.⁴His work provided the impetus for studying the childhoods with recent scholarships.⁵ This emergent paradigm postulates three characteristics- childhood as an inseparable part of- social construction, social variables such as caste, class and gender and thirdly, children as an active subject of structural determination. This methodology for studying childhoods thus shifted from positivistic traditions to the interpretative framework. Balagopalan stressed that these changes have caused an ‘epistemic shift’ because it released the ‘concept of childhood’ from its “traditional thereby making it available as an object of historical, sociological and ethnographic study.”⁶

The notion of childhood studied by scholars initially emerged with the exploration of the biological stage of development. Insightful and critical studies offer solution to the problem of gender, labour, education, and marriage.⁷ These studies are largely contributed by the sociologists along with practitioners of other domains who attempted to demarcate conditions of childhoods universally. The other set of scholarship emphasized on shifting the ideas and discourses that developed in India on the understanding of childhoods. The earliest discourse on cultural variability of child’s development was forwarded by Sudhir Kakar who analyzed the development

² S. Sen, Tagore’s Loksahitya: The oral tradition in Bengali children’s rhymes, *Asian Folklore Studies*, 55(1), pp-1-47. Retrieved from <https://nirc.nanzan-u.ac.jp/nfile/198>.

³ G. S. Cannella, *Deconstructing Early Childhood education: Social Justice and Revoultion*, (New York: Peter Lang Press, 1997).

⁴ Philip Aries, *The Centuries of Childhood: A Social history of Family Life*, trns. by Robert Baldick, (Pilmico: University of Virginia, 1996).

⁵ S. Balagopalan, Introduction: Children’s Lives and the Indian context, *Childhood: A Global Journal of Child Research*, 18 (3), 2011, pp-291-297. Retrieved from- <https://journals.sagepub.com/doi/pdf/10.1177/0907568211413369>.

⁶ Ibid.

⁷ O. Sirkar and D. Dutta, Beyond Compassion: Children of sex workers in Kolkata’s Sonagachi, *Childhood: A Global Journal of Child Research*, 18 (3), 2011, pp-333-349; S. Balagopalan, Inhabiting ‘childhood’: Children, labour and schooling in post-colonial India, (London: Palgrave Macmillan, 2014).

of high caste Hindus in the presence of complex cultural structure.⁸ Ashish Nandy⁹ reconstructed childhoods in light of colonial and post-colonial experiences. Few scholars have directed their energies towards elaborating the social and cultural relativism in expanding the narratives on 'childhood'. Post-colonial intellectuals contested the dominant discourses by building the counter-narrative that gave a voice to the 'unheard'. Gayatri Spivak¹⁰ and Ranjit Guha¹¹ were pioneers in giving voices to the silenced ones. The discipline of 'childhood studies' derived its interrogations around prevailing understandings of children as a passive set of population.

Despite the psychological, sociological and biological aspects of the recognition of childhood studies on 'the child as patient' or 'welfare object' hardly obtained a toe-hold in historical studies,¹² especially in the Indian context. Different studies published so far focusing on the 'child' by historians documents- history and politics of childhoods; deconstructing childhoods by analyzing their representations in culture; discourses on education and schooling of the child; the emergence of legal aid for children and gender discrimination in society. Hendrick stated that women have been 'hidden from history', so children have been 'kept from history'.¹³ The concept of childhood as an academic category thus evolved gradually.

The emergence of studies on the history of medicine and public health as far as the health of the child is concerned one can say that ancient civilizations had the grave concern about their birth and rearing. Most studies revolve around the historical analysis of paediatrics in the medical texts, archaeological accounts, ancient and medieval civilizations, and infant mortality. Historian's enquiry into the paediatric medicine in terms of the social and political policy is largely an unexplored domain. It was in the nineteenth century that paediatrics was separated from the branch of medicine and accepted that children require different care than the adults. It is thus

⁸ Sudhir Kakar, *The Inner World, A Psychoanalytic Study of Childhood and Society in India*, (New Delhi: Oxford University Press, 2012).

⁹ Ashish Nandy, *Traditions, Tyranny, and Utopias, Essays in the Politics of Awareness*, (New Delhi: Oxford University Press, 1992).

¹⁰ Gayatri Spivak, Can the subaltern speak? pp-271-313, in C. Nelson and L. Grossberg (eds.), *Marxism and the interpretation of culture*, (Urbana: University of Illinois Press, 1988).

¹¹ Ranajit Guha, *Subaltern Studies, Writings on South Asian History and Society*, (Delhi: Oxford University Press, 1987).

¹² Roger Cooter, *In the Name of Child' Health and Welfare, 1880-1940*, (London: Routledge, 1992), pp-1-2.

¹³ Harry Hendrick, Children and Childhood, *Recent Findings of Research in Economic and Social History*, Vol. 15 (Autumn, 1992), p-1.

significant to develop a critical historical account to include their (children) presence and their voices. Thus the thesis attempts to explore the emergence of the child under the state's policy in terms of their healthcare.

The term '*paediatrics*' derived from the Greek word 'pedie-pais'. 'Paidos' meaning 'a child' or denoting a relationship to a child (pedo), 'iatrike' meaning 'surgery' or 'medicine', i.e. treatment, and 'ics', the suffix of a subject of science. It has been understood as the science of childcare in the present day and includes planned preventive and curative care of children. In developing countries, this care extended to children up to 10-12 years of age. In the developed countries paediatric care and child health programs cater to adolescents as well.¹⁴ Paediatric as a specialized branch of medicine had no real existence until the middle of the 19th century. Hence the works of literature of the subject are deficient. Its earlier history is only a part of the primary current of internal medicine. Here we have used the term '*paediatrics*' intentionally in the chapters even though the origin of the term goes back to the twentieth century.

To understand the ancient Indian understanding of child health, medical tracts and texts are significant such as *Kasyapa Samhita*, *Charak Samhita* and *Susruta Samhita* provide a classic example of our medical knowledge. The *Kasyapa Samhita* is a comprehensive account which provides considerable information on infantile disorders and care of new-born babies and children.¹⁵ The *Uttaratantra* of Nagarjuna's version of the *Susruta Samhita* devotes no less than twelve chapters to this branch of medicine. Invocation of divine blessings, chanting of holy words and propitiation of supernatural forces formed a major part of such treatment, along with treatment by therapeutic drugs. The chapters in the *Susruta Samhita* convey the clear impression that an extremely high value was laid on the health, welfare and mental happiness of children at this time. This started even from the period of conception, and psychological well-being of expectant mothers. In such diversified accounts, midwifery and gynaecological knowledge was not, however, included in the branch of *Kumarbhartyas* i.e. paediatrician.¹⁶

Within the colonial context, it has been contended that women and children health measures were emphasized because the focus of the imperial government 'shifted

¹⁴ J. Vishwanathan and Avalokita B. Desai (ed.), *Textbook of Pediatrics*, Third Edition, (Delhi: Orient Longman, 2005), pp-1-3.

¹⁵ P.V. Tewari (ed., trns.), *Kashyap Samhita or Vrddhajivakiya Tantra*, (Varanasi: Chaukhamba Vishwabharti Oriental Publishers, 2008).

¹⁶ Ibid.

from production to reproduction'.¹⁷ The thesis thus proposes that the idea of introduction of paediatric medical care policies by the colonial government was directed to improve the conditions of childbirth and by bringing children into the sphere of western medicine, create the hegemony and to establish the paternalistic benevolence. Infant welfare thus constitutes a distinct discourse from its progenitor in the centre and forms a part of 'imperial medicine'.¹⁸ After independence, the medical services were added in the concurrent list of the Constitution. The new government formed in the United Provinces, now, Uttar Pradesh of independent India revised and reconstructed the health planning that was both curative and preventive in nature. Together with this, the competition arousing among the political parties to portray themselves as the most legitimate government and prove that they are good government developed strategically planned health care programs for children.

The present research is a pioneering attempt in an untried field. The research is a pioneer and systematic study in an area to identify the policy-making process for the childcare in colonial times and its continuity and development in post-colonial Uttar Pradesh. The prime objective of the work is to trace the history of paediatric medicine in India in general and United Provinces in particular. The study explores the sensibilities of colonial state in child healthcare and its impact on the policy formulations in Indian contexts. The thesis thus documents the process of emergence, development, progress and reforms in paediatric medical policy in independent India and especially in Uttar Pradesh. In the work, an attempt is made to understand the way the colonial state attempted to derive legitimacy for its rule in India with the introduction of paediatric welfare policies.

CONTEXT OF STUDY

History of Medicine is now a well-established branch of the study of the history of science. The nuanced study of the subject by the historians brought new interpretations in colonial history. Epidemic control policy, institutional history of medicine, emergence of women medical professionals and reproductive health are the significant areas of colonial medical policy substantially explored by the historians. As far as paediatrics is concerned, the issue of colonial sensibilities is an unexplored

¹⁷ L. Manderson, *Sickness and State: Health and Illness in Colonial Malaya 1870-1940*, Cambridge, 1996, pp-201-207.

¹⁸ Margaret Jones, *Health Policy in Britain's Model Colony Ceylon (1900-1948)*, (New Delhi: Orient Longman, 2004).

area in the social history of medicine. Thus, the thesis exclusively deals with colonial sensibilities towards child health. The study is an attempt to document the medical history of British in United Provinces with special reference to paediatrics. The research thus opens new doors of historical inquiry to understand colonial ideologies through the medical care of the children in Uttar Pradesh. Maximum studies on medical history assess only the colonial period, the study becomes significant as it explores the expansion and progress made by the post-colonial government of Uttar Pradesh in expanding health services for paediatrics in the State.

ANALYTICAL FRAMEWORK OF STUDY

The history of paediatric medicine is an unturned stone in the discipline of history. The current work will explore the evolution of paediatric medicine in colonial United Provinces and its progress and development in independent India. The study on the evolution of paediatric medicine in government policies is a historiographical gap in the history of medicine and public health in India. The present study proposes that the colonial government in India had introduced paediatric medicine in an attempt to reduce the mortality rate among the children and publicise themselves as a welfare state. Thus, this project will throw light on the impact of colonial medical policy on independent India's paediatric medicine policy and how the paediatric medicine underwent a change in free India and the success and failure of the government in combating the challenges posed by the change in the political and economic environment. The study basically revolves around the 'governmentality' approach proposed by Michael Foucault¹⁹ and Gyan Prakash.²⁰ The work is influenced by Foucauldian notion of knowledge and power and governmentality, according to this approach, knowledge produced in the colonial period used as a tool of dominance, therefore in independent India, we need to inverse the colonial knowledge to that project in to reinforce decolonization. Foucault²¹ traces the evolution of governmentalization of the modern state in western history which revolves around the economy and welfare of the state. In short, the focus will be to trace the evolution and

¹⁹ Michel Foucault, *The Foucault Effect, Studies in Governmentality*, (USA: University of Chicago Press, 1991).

²⁰ Gyan Prakash, *Another Reason: Science and Imagination of Modern India*, (New Jersey: Princeton University Press, 1999).

²¹ Michel Foucault, *The Foucault Effect, Studies in Governmentality*, pp-87-104.

development of paediatric medicine in the policy of state from 1880-1980 in the United Provinces.

AREA OF STUDY

The area selected for the research is the most populous and politically significant state of India. North-Western Provinces lied between 23⁰52' (Mirzapur) and 31⁰18' (Tehri-Garhwal State) North and 77⁰3' (Muzzafarnagar) and 84⁰39' (Ballia) in the East.²² The province was bound up by Tibet in North and on North-East by Nepal; and by Champaran, Saran and Palamau districts of Bengal in South- East and South by districts of Central Provinces. The Province, based on physical division, divided into four divisions- the Himalayas, the sub-Himalayas, the Gangetic plains and trans-Jamuna tract (Central India and East Satpuras). The region has rich alluvial soil and natural resources. It is also blessed with the rich Gangetic valley, which makes a region fertile and prosperous so much so that William Crooke designated as the 'veritable garden of India.'²³ The NWP/United Provinces had the area of about 112,191 square miles²⁴ and a large population which was 52,691,782 in following the census of 1901 to 49,614,833 in 1931.²⁵

The earlier history of the Province goes back to post-Vedic period where the kingdom of Hastinapur in Meerut district and Ajodhya in Faizabad district flourished. Over time, new towns and centers came to prominence either due to religious orientation or because of their economic significance or due to political change. For instance, Benaras and Mathura maintained their significance as a religious centers all times, while Agra, Jaunpur, Allahabad, Lucknow etc. emerged as a seat of power in different time frames. The State due to its diversified significance conquered by various rulers one after the other such as Ghaznavids, Mughals, Marathas, and British. Agra was the capital during the Lodi and Mughal times, which shifted to Allahabad when EIC took over the Province. Among all the foreign invasions to India Uttar Pradesh had suffered a loss whether it was Arabs or Britishers. Weakening of Mughal power during the early 18th century extended an opportunity for the Marathas who lost the

²² Imperial Gazetteer of India- Provincial Series, United Provinces of Agra and Oudh, Vol. I, Calcutta, 1898,p-1.

²³ William Crooke, *North Western Provinces of India- History, Ethnology and Administration*, London, 1897, p- 2.

²⁴ Census of India- United Provinces of Agra and Oudh, 1931, Vol. I, Allahabad, 1933, p-1.

²⁵ Census of India- NWP and Oudh, 1901, Vol. XVI-A, Part II, Allahabad, 1902; Census of India- United Provinces of Agra and Oudh, 1931, I, Allahabad, 1933, p-23.

Third battle of Panipat thereby losing stronghold in Northern India. The Maratha rule over Agra lasted for about eighteen years and the territory north of Chambal ceded by the Sindhia's was called the 'Conquered districts' while the other ceded by Nawab of Awadh designated as 'Ceded districts'. The Ceded districts were provisionally placed under the charge of Henry Wellesley with his designation as Lieutenant-Governor of the Ceded and Conquered districts under EIC.

Under British East India Company the northern territory was named as 'North-Western Provinces' including Agra. Allahabad was declared as the seat of the government of the State of NWP in 1834 but the capital was shifted to Agra in 1836. Before 1834, Agra was included in the presidency of Bengal, was then converted into a presidency in the same year. In 1836, it was renamed as Lieutenant Governorship of the North-Western Provinces. During mutiny in 1856 when Oudh was annexed, it was formed under a separate administration. It was retransferred to Allahabad in February 1858. When Oudh was amalgamated with the province in 1877, the seat of the chief executive authority in Awadh was also transferred from Lucknow to Allahabad²⁶ and thus was named as 'North Western Province of Agra and Oudh'. The Province had two native states Tehri and Rampur i.e. nine divisions (Agra, Meerut, Rohilkhand, Allahabad, Jhansi, Benares, Gorakhpur, Kumaun, Lucknow, Fyzabad) and 48 districts which were grouped into ten revenue divisions (Meerut, Agra, Rohilkhand, Allahabad, Benares, Gorakhpur, Kumaun, Lucknow, Fyzabad). In 1901, on the proposal forwarded by the government the name of the province was changed to United Provinces of Agra and Oudh. The name was again changed and shortened to United Provinces of British India, which came into existence on 3rd January 1921. The region had produced numerous political leaders and revolutionaries during the freedom struggle, such as Madan Mohan Malviya, Motilal Nehru, Purushottam Das Tandon, Jawaharlal Nehru, etc. During the Quit India Movement, the intensity of nationalist struggle was enormous so much so that in Ballia and Azamgarh the government ceased to exist in 1942 movement for a few days.

After independence on 25th January 1950, it was renamed as Uttar Pradesh. It continued to be central to Indian politics and was especially important in modern Indian history as the hotbed of the Indian national movement.

²⁶ Uttar Pradesh District Gazetteers- *Allahabad*, Government of Uttar Pradesh, 1965, p-192.

OBJECTIVES OF THE STUDY

The following are the chief objectives of the study of the topic-

1. To trace the history of paediatric medicine in India in general and United Provinces in particular.
2. To explore at intervention level, the sensibilities on child health and their impact on policy formulations in Indian contexts.
3. To identify the beginning of civil society's engagement with child medicine in United Provinces.
4. To reconstruct the state intervention and its anchoring of therapeutic interventions in the United Provinces.
5. To understand the way the colonial state attempted to derive legitimacy for its rule in India with the introduction of paediatric welfare policies.
6. To trace the emergence of women-centric medicine in United Provinces which had direct and an indirect bearing to paediatrics.
7. To explore the role of medical organisations and missionaries in the institutionalisation of paediatrics.
8. To explain the process of institutional development of paediatric medicine, like maternal hospitals, child health centres, clinics, etc.
9. To trace the policy level attempts from national to local levels centred on paediatrics.
10. To document the process of emergence, development and progress of paediatric medical policy in independent India and especially Uttar Pradesh.
11. To understand the means through which the government of Uttar Pradesh conceptualised the ideas of health, population and state responsibility in the period of political change.

SCOPE OF STUDY

The historiographical gap in the social history of colonial medical policy presents an opportunity to explore the official attitude and policies towards child medicine. The historians of medicine document the vaccination policy and infant mortality (within the sphere of maternal health) and birth control in the colonial period. Thus, in the light scanty systematic documentation on child medicine, this study takes a step further by exploring the policy-making process and official sensibilities towards child

healthcare. The chapters develop the methodological concept on child medicine during the colonial period and its impact and development in the post-colonial period. In doing so, the thesis captures the hegemony of western medicine through colonial institutions among children. The study of paediatric medicine in colonial United Provinces offers a new entry point into current debates on public health in colonial India.

HYPOTHESIS OF STUDY

The chief assumptions of the present work are as follows-

1. Colonial state did engage with the category of paediatrics not explicitly but implicitly.
2. At the policy and governance level, the government had sensibilities towards children and their welfare, even though it made a half-hearted approach for improving the deplorable conditions.
3. The medical intervention by the colonial state is a product of international sensibilities, nationalist articulations, moral conservations and imposing hegemony.
4. Penetration of western medicine in the *zenanas*, initiated the process of colonizing the child's body.
5. The emergence of women both native and Europeans in the social sphere had a deep and everlasting impact on the child health in colonial times.
6. After independence, paediatrics received utmost priority from the central and state government of Uttar Pradesh, yet impressions of colonial government gradually disappeared.
7. The post-colonial state-initiated various plans and programmes to combat morbidity and mortality among children however, the success rate of the efforts was undistinguished.

METHODOLOGY OF STUDY

It must have been evident from the foregoing discussion that the present thesis explores the ideologies of the colonial empire in the development of paediatric medicine in the United Provinces and the legacy of their policies after 1947. For achieving this aim, the study resorted to critical reading and deconstruction of various

sources. To situate the paediatric medicine, unpublished archival material from National, State and Regional archives, and various libraries enabled to develop an idea on the child medicine in the colonial and post-colonial period. The methodology adopted in this study would be characterized as critical, analytical, descriptive and interpretative using both primary and secondary sources, which helped to reconstruct the historical contexts of the policy of the colonial state towards paediatric medicine. Official attitude largely reflected in the reports, files and proceedings of Health department, Sanitary department, Education department, etc. rigorously used to study the topic for better understanding of the reflection of motivations of state policy for childcare. Secondary sources have been of particular help in getting a deeper insight into the history of science medicine in colonial India and outlining the argument of the work into the broader generalisations of history of social medicine.

The thesis also aims to explore the reactions and responses of the indigenous population towards the official policy of vaccination, school health or institutionalization of medicine. As the section of the population which is dealt here could not raise their voices, thus the study explicitly undertakes the arguments forwarded by the grown-up population to childcare. For the purpose, apart from colonial sources mentioned above, sources such as journals, magazines, periodicals, native newspapers, novels and pamphlets few in vernacular language also (Hindi) helped to get a better engagement with the topic. The present thesis thus uses a wide range of the sources to analyse the inclusion of the child in the medical care policy of the colonial and its transformations in the post-colonial state.

The research design planned for the work is exploratory and comparative, to study the history of paediatric medicine in Uttar Pradesh and the ideologies and motivation of the government in developing policies for its future subjects and understand how the post-colonial state at the policy level worked for promoting the paediatrics. With the availability of figures and a large amount of data tables, the study attempts to use the data interpretation and data analysis methods to interpret the colonial ideologies in delivering the childcare in United Provinces and impact of the programmes at policy level towards paediatrics.

REVIEW OF LITERATURE

The British had colonised India not only economically, socially, politically but also medically. The introduction of the western medicine by the colonial state to its Indian subjects was a part of their policy to portray themselves as modern-day ‘welfare state’. With the expanding literature on the field, it becomes inevitable to study the major arguments, interpretive shifts, and new emerging ideas. With this objective, the section analyses the major arguments and their role in shaping the historiography of medicine under the colonial state in India.

Before indulging into the exhaustive study of the history of medicine, it’s necessary to discuss the term ‘colonial science’ which has a close conceptual link with the history of medicine in India. As medicine is a part of a broader project of science so firstly understand the arguments of scholars on colonial science. For Aparna Basu, colonial science ‘was derivative and dependent, introduced by the British in India as a fully-developed system without roots and traditions. It borrowed ideas, models and even the language medium from the West.’²⁷ Mark Harrison concludes it as “little more than a label of convenience, lacking precise definition and of questionable utility”.²⁸ While Deepak Kumar, considers colonial science to be a replica of colonialism.²⁹ He emphasized that it involves an exploratory activities (e.g. flora, fauna, topography, minerals, etc.) and the introduction of new techniques in order to make economic gain.³⁰ Moreover, colonial science often seen as essentially different from science practised in non-colonial contexts. It portrayed as derivative, instrumentalist, and exploitative, with colonial scientists seen as just fact gatherers, making few theoretical contributions in their own right. The British idea of introducing modern science or science-based-technology in India, as argued, not aimed at the intellectual or material progress of this country but a political necessity. They brought some new technologies to India not to lead India to the way of industrialism or modernisation but to accelerate the process of its politico- commercial colonisation. But still, Indians

²⁷ Aparna Basu, *The Indian Response to Scientific and Technical Education in the Colonial Era, 1820-1920*, in Deepak Kumar (ed.), *Science and Empire, Essays in Indian Context (1700-1947)*, (Delhi: Anamika Prakashan, 1991), p-126.

²⁸ Mark Harrison, *Science and the British Empire*, University of Chicago Press, *History of Science Society*, Isis, Vol. 96, No. 1 (March 2005), p-63.

²⁹ Deepak Kumar, *Science and Raj, A Study of British India*, Second Edition, (New Delhi: Oxford University Press, 2006), p-15.

³⁰ Deepak Kumar(ed.), *Science and Empire*, op.cit., p-vii.

could not remain unaffected from the scientific activities being pursued by the colonial scientist in India.³¹

The widely accepted fact is that the chief reason that led to the introduction of colonial science in India was to serve the Europeans and the army.³² Further, the economic reasons hold a significant position in this argument as described in detail by Deepak Kumar in his work *Science and The Raj*. He delineates that colonial attempt to hegemonise the science of India was to make the economic profit. Thus, according to him, imperialistic economic motivation led to the institutionalisation of geological and botanical works.³³ Ian Inkster³⁴ establishes the relationship between the British commercial gain and India's economic decline. He emphasises that British science policy directed by commercial gain retarded the technological development or advancement in India. These arguments of economic profit have been contended by other scholars also. As Russell Dionne and Roy MacLeod³⁵ throws light on the purpose and role of government on science and technology in India during the period between the mutiny and First World War. They delineate the science-policy of East India Company motivated by economic gains and shows the legacy of EIC's science policies to the Crown especially 1858 afterwards.

While we look into the policies and motivations of the colonial state, it becomes inevitable to study the reaction and responses of various sections of societies. The early history of modern science in India runs parallel with the endeavours and contributions of scientists, whose prime objective was to build a bridge between the modern science and the cultural life of the country under the colonial state. These endeavours produced various responses which were critical to colonial sciences. The responses have been studied by Dasgupta³⁶ in the light of the biography of J. C. Bose. The author argues about the success of J. C. Bose's modern science and his failure of Indian response. Dasgupta concludes, "Bose made pure science a credible occupation

³¹ Satpal Sangwan, *Indian Response to European Science and Technology (1757-1857)*, in G. Kuppuram and K. Kumudamani (ed.), *History of Science and Technology in India*, Vol. V. Science and Technology, (Delhi: Sundeep Publications, 1990), pp-196.

³² Ibid.

³³ Deepak kumar, *Science and Empire*, op.cit.

³⁴ Ian Inkster, *Science, Technology and Imperialism in India*, pp-196-228, in Irfan Habib and Dhruv Raina, *Social History of Science in Colonial India*, (New Delhi: OUP, 2007).

³⁵ Russel Dionne and Roy Macleod, *Science and Policy in British India 1858-1914*, pp-159-195, in Ibid.

³⁶ Subrata Dasgupta, *Response to Western Science- Failures and Success*, pp-326-351, in Raina and Habib, *Social History of Science in Colonial India*, (New Delhi: Oxford University Press, 2007).

for Indians in the eyes of the world. In this lay, his ultimate success and significance in the history of the western scientific tradition and the social and cultural history of modern India.”³⁷ Similarly, Satpal Sangwan³⁸ discussing various facets of Indian responses to European science and technology argues that Indians had the positive outlook towards the adoption of western scientific theories and there exist no bias among natives till it becomes unsuitable in an Indian environment. Thus, according to him, Indians whole-heartedly welcomed European technology and made their life easier by taking its advantage. Limitations of colonial welfare for the Europeans and military has also been criticised by the scholars widely. As V. R. Muraleedharan had criticised the limited preventive health care measures taken by the government in Madras especially in areas dominated by European population leaving rest and rural areas.³⁹ Similarly, Partho Datta focuses on the notion of the emergence of public health in Calcutta which was a part of British imperialistic policies.⁴⁰ While Aparna Basu⁴¹ contends that providing scientific education was not planned in British policy, but it was on the part of educated Indians that professional colleges were established and promoted by them. She shows how overcoming the lack of monetary assistance, state patronage and European domination; Indians were successful in making their presence felt in imperial settings and later due to these efforts the government realised the Indians need to become a self-reliant economy. Michael Worboys too considers that science never practised on the empire-wide basis. He asserts that there was no imperial science, further describes in detail the utility and universalism as factors involved in policies and projects of the colonial state.⁴² The latest argument is forwarded by Gyan Prakash, who argued in his work that cultural hegemony of colonial science legitimized by the colonial power.⁴³

³⁷ Ibid, p-347.

³⁸ Sangwan, op.cit., pp- 169-213.

³⁹ V. R. Muraleedharan, *Malady in Madras: The Colonial Government's Response to Malaria in the early 20th century*, pp-101-114. in Deepak Kumar (ed.), *Science and Empire, Essays in Indian Context (1700-1947)*, (Delhi: Anamika Prakashan, 1991)

⁴⁰ Partho Datta, *Ranald Martin's Medical Topography (1837): The emergence of Public Health in Calcutta*, pp-15-30 in Mark Harrison and Biswamoy Pati (ed.), *Social History of Health and Medicine*, (Delhi: Primus Books, 2011).

⁴¹ Aparna Basu, *The Indian Response to Scientific and Technical Education in the Colonial Era, 1820-1920*, pp-126-138, in Deepak Kumar (ed.), *Science and Empire, Essays in Indian Context*, op.cit.

⁴² Michael Worboys, *Science and Colonial Empire 1895-1940*, pp-13-27 in Deepak Kumar (ed.), *Science and Empire: Essays in Indian Context (1700-1947)*, (Delhi: Anamika Prakashan, 1991).

⁴³ Gyan Prakash, *Another Reason: Science and the Imagination of Modern India*, op.cit.

Recent studies on the history of colonial science extended to medicine thus covering up different aspects of public health, medical policy, disease profile, official attitude, reproductive health, professionalization, indigenous medical responses, etc. The subject of public health especially during the recent years has become prominent in the historiography of medicine in India. Various aspects of public health i.e. epidemics, therapeutic measures, vaccination, mortality, government policies and institutions, etc., are the areas mostly focused by the research scholars now a days. Public health though not a new concept in India yet the policy for ensuring it had arrived with Britisher's but evidence of the same could be found in ancient and medieval India, however, it didn't create hegemony to outcaste other practices. As A. L. Basham asserts that the government's interest in the health of the people was encouraged by the political ethic of Hinduism, according to which the main function of the king was the protection of his subjects.⁴⁴ Deepak Kumar criticises the low priority given to the public health in colonial India and raises the doubt on the policy of the post-colonial state, as "Colonial India had its limitations. Could independent India show this synergy?"⁴⁵ Though critical he has aptly visualised the condition of public health in the country under colonial rule.

To study the policies and motivations of colonial state in promoting public health, it becomes inevitable to look into the studies taking up disease profile in the colonial India. The significance of it lies in the fact that they help us to understand better the official attitude and policy principles of the profit-oriented state. Studying the British policies in the light of the economy, Sheldon Watts⁴⁶ severely criticizes the irrigation policies of the British government and its indifference which took over the millions of lives and their neglect of the issue that led to spread of malaria in different parts of India due to hostile attitude of the government. She emphasises on the less attention directed towards the healthcare of rural areas where instead of understanding the state responsibility, they left the burden of sanitation and preventive measures on the local bodies ultimately leading to a huge number of deaths from malaria. Similarly,

⁴⁴ A. L. Basham, *The Practice of Medicine in Ancient and Medieval India*, p-40, in Charles Leslie, *Asian Medical Systems*, Vol. III, (Delhi: Motilal Banarsidass Publishers Private Limited, 1998).

⁴⁵ Deepak Kumar, *Perceptions of Public Health, A Study in British India*, p-55, in Amiya Kumar Bagchi and Krishna Soman (ed.), *Maladies, Preventives and Curatives, Debates in Public Health in India*, (New Delhi: Tulika Books, 2005).

⁴⁶ Sheldon Watts, *British Development Policies and Malaria in India 1897 c-1929, Past & Present*, No. 165 (Nov. 1999), pp. 141-181.

Ihtesham Kazi⁴⁷ argues about the environmental factors in the spread of malaria caused by exploitative policies of the government in making profit by constructing railways, roads and embankment which led to environmental degradation and spread of diseases. Focussing on the Bombay Presidency, Rammana⁴⁸ argues that the initiatives of the government, municipal bodies, doctors, Rockefeller Foundation and individuals were successful in combating malaria but after the epidemic was over and the curative measures ceased, the disease returned to take its vengeance to which government had no control. Thus, the author claims that government medical policies failed as they were unable to introduce the preventive measures in the presidency instead of curative. Establishing relationship between Cholera, Famine and colonialism, David Arnold⁴⁹ shows the colonial attitude to check the advance of cholera without disturbing the religious sentiments of the natives, though not intended yet carried out to check the advance and spread of disease in to save its army cantonments and European population.

David Arnold⁵⁰ traces the history of the major epidemic diseases like smallpox, cholera and plague in the light of colonial state policies. His main argument revolves around the fact that the colonial state introduced the medical care policies and reforms whose character was limited to the army and its political needs, not for the welfare of its subjects. He also shows how the state medicine crossed the enclaves of army cantonments and prison, thus became a part of public health policy of the state. Though Arnold focuses on state policy and its implication yet no attempt has been made to study the responses and reactions of indigenous population. Finally, justifying his title 'colonizing the body' Arnold shows how the Dufferin Fund opened the new doors of colonization of the bodies of women and children, with the establishment of hospitals and dispensaries.

⁴⁷ Ihtesham Kazi, Environmental Factors contributing to Malaria in Colonial Bengal, pp-120-143, in Deepak Kumar (ed.), *Disease and Medicine in India- a Historical Overview*, IHC, (Delhi: Tulika Books, 2001).

⁴⁸ Mridula Ramanna, A Mixed Record: Malaria control in Bombay presidency 1800-1935, p- in Deepak Kumar and Raj Shekhar Basu, *Medical encounters in British India*, (New Delhi: OUP, 2013), pp-208-31.

⁴⁹ David Arnold, Cholera and Colonialism in British India, *Oxford University Press*, No. 113, Nov. 1986, pp-118-151.

⁵⁰ David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India*, (Berkley: University of California Press, 1993).

Sandeep Sinha⁵¹ had focused his work on the factors responsible for the progress of western medicine in India, particularly in Bengal. He argues that the racist health policy of the government was solely responsible for the worse health condition of the people in rural areas. He further criticizes the limited public health policy of the government and the discouragement of research work in medicine and medical institutions, by the British health policies, carried out by native or European scholars. The author is equally appreciable of the medical infrastructure in Bengal and India yet laments the low position of Indian doctors in European settings. Mridula Ramanna⁵² in her work has criticized the new health policy of Bombay government which instead of curative medicine inclined much to promote the preventive medicine through persuasion. The significance of this work lies in the fact that it highlights medical welfare and cares for the women and children in Bombay presidency and the ignorance of the government to reduce the latter's death rate. Ramanna argues the biased approach of government towards the indigenous medical practitioners and their responses which were left unheard. However, she appreciates the dedication of the voluntary societies in promoting the maternal and child welfare in the presidency and equally the contribution of the women physicians in improving the women's health and childbirth.

The expansion and emergence of western medical centers was a unique feature of colonialism. Institutions for teaching, practicing medicine and dispensaries, research centers were not entirely absent in India. Few references could be found in the texts, for instance, state dispensaries also known as *Shifa-khana* in medieval India was established by the state for providing medical care both to the natives and royal families.⁵³ The evolution of hospitals in its real sense of the modern world was non-existent. Jayanta Bhattacharya⁵⁴ shows the trajectory of hospital medicine by the introduction of new strategies in building the modern institution of medicine and the

⁵¹ Sinha, Sandeep, *Public Health Policy and the Indian Public, Bengal 1850-1920*, (Calcutta: Vision Publications (P) Ltd, 1998).

⁵² Mridula Ramanna, *Health Care in Bombay Presidency, 1896-1930*, (New Delhi: Primus Books, 2012).

⁵³ For details see Afif, Shams-i-Siraj, *Tarikh-i-Firuzshahi*, extracts in Elliot and Dowson's, *History of India as told by its own Historians*, Calcutta, 1953, p-104, Manucci, Niccolao, *Storia do Mongor*, Translated by William Irvine, Vol. II, New Delhi, 1981, p-329. Firuzshahi mentions that Firoz Shah Tughlaq had established hospitals for the sick people. Competent physicians and doctors were appointed to superintend it and all necessary provisions were made available in the *shifakhanah* all the time. The medicines, food and drinks, expenses were drawn from the royal treasury.

⁵⁴ Jayanta Bhattacharya, From Persons to Hospital Cases: The Rise of Hospital Medicine and the Calcutta Medical College in India, *Indian Journal of History of Science*, 2015, pp-95-124.

evolution of preserving case histories and records in modern British time. Similarly, Mark Harrison⁵⁵ also, implies the significance of modern medical institutions i.e. hospitals as a site of medical experimentation and innovation. He shows the transfer of medical practices like mercurial therapy via medical institutions to treat the diseases in India from the metropolis. While in his article Chakravarti⁵⁶ studies debates about the establishment of a medical research institution and how actors imposed the political identities of nationalism on British colonial practices of medical science.

Another contention among scholars is the competition received by the indigenous medicine on the introduction of western medicine. Mostly all the scholars who championed as the advocators for indigenous medicine and its struggle of existence with the western medicine in colonial society argue that the hostile attitude and policies of the State were solely responsible for the dark age of indigenous medicine and its practitioners. Further, it has also been argued by them that the medical philanthropy of the Europeans was a tool of oppression and colonisation by imperialists. The nationalist scholars also pointed out the difference between the rhetoric and the reality of medical progress in India. They also accept the fact that it was these circumstances that were taken advantage to revitalise the movement for the revival of indigenous medical traditions.⁵⁷ With a similar opinion, K. N. Pannikar⁵⁸ shows the revitalization movement of indigenous medicines in Kerelam by medical practitioners in their quest to attain the cultural hegemony in colonial India. Ayurvedic renaissance during the British rule in India dealt in detail by Brahmananda Gupta.⁵⁹ He discusses the survival and resistance of Ayurveda to the western medicine and indifference of colonial state to indigenous medicine. He describes the individual initiatives to promote and popularise Ayurveda in Bengal which lead to the modern institutionalisation of Ayurveda.

⁵⁵ Mark Harrison, *From Bazaar Medicine to Hospital Medicine, Calomel, India, and the British Empire, c.1750-1800*, pp-61-70, in Deepak Kumar and Raj Shekhar Basu (ed.), *Medical Encounters in British India*, op.cit.

⁵⁶ Pratik Chakrabarti, “*Signs of the Times*”: *Medicine and Nationhood in British India*”, University of Chicago Press, *History of Science Society, Osiris*, Vol. 24, No. 1, Science and National Identity, 2009, pp-188-211.

⁵⁷ Poonam Bala(ed.) *Contesting Colonial Authority*, (USA: Lexington Books, 2012).

⁵⁸ K.N.Pannikar, *Indigenous Medicine and Cultural Hegemony*, pp-145-175, in *Culture, Ideology, Hegemony, Intellectuals and Social Consciousness in Colonial India*, (London: Anthem Press, 2001).

⁵⁹ Brahmananda Gupta, *Indigenous Medicine in Nineteenth and Twentieth century Bengal*, pp-368-377 in Charles Leslie, *Asian Medical Systems*, Vol. III.

Scholars such as Charles Leslie, K.N.Pannikar, Sumit Sarkar, Brahmanna Gupta, Deepak Kumar, Poonam Bala, Neshat Qaiser, and other's criticism of western medicine revolves around an argument that India had rich tradition of medical practices and indigenous medicine was self-sufficient enough to treat its population in the Indian environment and hence the benevolence of the civilised state not required by the natives. As far as the struggle of indigenous medicine is concerned, revivalism is the universally acceptable idea among concerned scholars. Charles Leslie argues that since the protagonists of indigenous medicine 'believed literally in the authority of the classic texts, and at the same time were impressed by the accomplishments of modern science, they set out to demonstrate that the institutions and scientific theories of cosmopolitan medicine anticipated in the ancient texts.'⁶⁰ He implies in his analysis that the inquiry into the causes of decline was to formulate a theory which would justify the revival. He dismisses 'the revivalist theory of decline', as there is no evidence to support the assumption that the general level of Ayurvedic practice in the nineteenth century was less efficacious than that of antiquity.

Indian national movement sought the issue of indigenous medical traditions to legitimise and identify their struggle. Poonam Bala⁶¹ throws light on the process by which the spirit of nationalism associated with the Ayurveda, which led to the formation of medico- cultural identity through modernising and reform missions. She had focussed on the colonial attitude and indigenous responses towards the Ayurveda and its revival and quest of identity as a branch of medicine. According to her the medical encounters in British India produced the new form of structures which she implies as "paradigms of defence" within which trajectories of negotiation between Indian and Western knowledge could perceive. With the introduction of western medicine, new advancement was prelude in indigenous medicine. Probably it would be more convenient to say that this was the modernisation of 21st century indigenous medical traditions which encountered the bio-medicine that further directed the development of pharmaceuticals, medical market and commercialisation of indigenous drugs and made them more accessible to people. Madhulika Banerjee⁶² contends the implications of colonial encounter and the emergence of pharmaceuticals

⁶⁰ Leslie, 'Ambiguities of Medical Revivalism', in Leslie (ed.), *Asian Medical System, op.cit.*, p. 365

⁶¹ Poonam Bala(ed.) *Contesting Colonial Authority, op.cit.*

⁶² Madhulika Banerjee, *Ayurvedic Pharmaceuticals, Contesting Economic Hegemony*, p-29-50, in Poonam Bala, *ibid.*

in the country and their struggle for survival within the hegemonic domain of western medicine. At another place⁶³ she throws light on the crucial relationship that developed between Ayurveda and government, its impact on the policies framed by the government regarding the indigenous system of medicine. She argues about the state policy on Ayurveda along with the very vital processes of commercialisation that are shaping the current common-sense about Ayurveda through the fashioning of consumer preference in the post-colonial era.

With works on Ayurveda revivalism, some scholars explored the Unani medicine and colonial state such as Claudia Liebeskind, Neshat Qaiser, Seema Alavi, and Guy N.A. Attewell. Neshat Qaiser in his work throws light on the issues of ‘marginalisation’ under the western medical hegemony. He further argues the resistance of Unani identity to western despotism which found expression in reconstructing the past through memory which was found among the educated class in the anti-colonial atmosphere. Scholars like Seema Alavi, and Guy N.A. Attewell, took a step further and have undertaken the issues such as the modernisation, commercialisation, professionalization, institutionalisation and inherent differences and problems in the Unani medicine which, of course, was the outcome of the introduction of western medicine by the state. Instead of condemning colonial medicine and their preventive measures, Attewell⁶⁴ has delineated the Unani as a system of medicine, its professionalization, reactions to the exposition to western medicine and transformation within Unani medicine took place with the change in the course of time in the colonial period. He analyses the role of Unani medical practitioners in different parts of India during the plague epidemic that followed Bombay’s 1896 crisis and shows how the epidemic shaped their professional identity. Similarly, the study of the pre-colonial encounter of Unani is initiated by Seema Alavi. She disagrees with the scholars who emphasize on the resistance of Unani with western medicine. She shows the harmonious and balanced development/existence of Unani in the colonial sphere. She asserts that the Company considered the Unani as a medical system and the former used local rajas and the rulers to authorize and promote, patronize and propagate western medicine. She emphasizes that ‘both within the

⁶³ Madhulika Banerjee, *Power, Knowledge, Medicine, Ayurvedic Pharmaceuticals at Home and in the World*, (Hyderabad: Orient Blackswan, 2009).

⁶⁴ Guy Attewell, *Refiguring Unani Tibb, Plural Healing in Late Colonial India*, (New Delhi: Orient Longman, 2007).

dispensary and outside it, Unani healing reconfigured itself and was not overwhelmed by colonialism.’⁶⁵

In the due course of time, the area of the social history of medicine has been expanded widely and feminist historians brought new discourses in the medical intervention of the colonial state. Reproductive health in colonial India is thus a recent area of research not only among feminist historians but also social historians. From the 1980s, the scholars have discussed the social aspect of women medical professionals, the medicalisation of childbirth and motherhood in colonial India. Recent scholarship throws light on- birth control and female sexuality, politics of reproductive health, the contributions of Christian female missionaries who were devoted to the cause of women’s health unlike their male counterparts and the female professionals in British India. Indira Chowdhury⁶⁶ focuses on the medicalisation of birth control in India. Further, she traces the process of criminalization of social practices under the hegemony of the colonial state. She has weaved her argument on the Foucault’s ‘governmentality’ where she analyses the issue of abortion, infanticide, contraception and endeavors of enlightened individuals to initiate birth control in modern India together with the reluctance of the government in framing birth control policies. Further, the criticism of the colonial government’s failure in reducing the maternal and infantile mortality rate has also gained momentum in this broader area of studies of reproductive health. Continuing with this notion, Aparajita Dhar⁶⁷ criticises the colonial state policies and their approach towards this grave problem which according to her were ‘lackadaisical’. Her arguments stand in support of the established view that women and children came to the policies and programmes of the government because of political requirements.

The most discussed issue among medical historians is the encounter of midwifery or dhais on the advent of western medicine. Dhais, were considered by the Europeans, solely responsible for the high maternal and infant mortality rate in India. Thus her

⁶⁵ Seema Alavi, *Islam and Healing- Loss and Recovery of an Indo-Muslim Medical Tradition 1600-1900* (Ranikhet: Permanent Black, 2007), p-155.

⁶⁶ Indira Chowdhury, *Delivering the ‘Murdered Child’ Infanticide, Abortion, and Contraception in Colonial India*, pp-275-298. In Deepak Kumar and Raj Shekhar Basu (ed.), *Medical Encounters in British India*, op.cit..

⁶⁷ Aparajita Dhar, *Western Approach to Infantile Mortality and Delivery Deaths’* pp-255-264, in Chittabrata Palit and Achintya Dutta(ed.), *History of Medicine in India The Medical Encounter*, (Delhi: Kalpaz Publications, 2016).

position underwent substantial transformation by the introduction of western medical practices. As Geraldine Forbes puts it “hegemony operated, not to change the system of health care, but to describe the dhais as a social pathology.”⁶⁸ Using the census reports, David Arnold criticises the low priority given to the maternal health and infant welfare activities by the government officials who rely extensively on local bodies and private organisations.⁶⁹ Though these studies raise questions about the intentions of the colonial government Mousumi Bandhyopadhyay⁷⁰ comes up with a new approach and insight for the study of women’s health in Colonial Bengal. She enlightens us with the role of the indigenous population and vernacular literature in condemning the medical policies of State in Bengal for the reproductive health. She elaborates the role of illiterate Dhais and the unsympathetic family members towards the expectant mother leading to the loss of many precious lives. Together with this, she focuses on the struggle of indigenous women doctors in establishing themselves in the conservative society and against the prevalent indigenous midwifery. Similarly, Sean Lang⁷¹ in her article presents a colonial approach and thus contradicts with scholars who criticise British hegemonic medical policies in India. She appreciates the role of lying-in hospitals in Madras and government’s aid to the hospital’s endeavour to decrease maternal mortality by introducing western trained midwifery in colonial Madras. She shows how the Madras excelled in producing the trained midwives in different provinces.

When studying colonial state policies in promoting women’s health in colonial India, it is inevitable to have an overview of various organizations and funds imparted by the government to its veiled citizens. The introduction of Dufferin Fund by Queen Empress for improving and initiating the maternal health services in India has received appreciation by the scholars yet the Fund was not free from colonial influence. However, the benevolence had some inherited problems as pointed out by

⁶⁸ Geraldine Forbes, *Managing Midwifery in India*, in ‘Women in Colonial India: Essays on Politics, Medicine and Historiography’, (New Delhi: Chronicle Books, 2005), pp-100.

⁶⁹ David Arnold, *Official Attitudes to Population, Birth Control and Reproductive Health in India, 1921-46*, pp-22-49. in Sarah Hodges (ed.), *Reproductive Health in India, History, Politics, Controversies*, (New Delhi: Orient Longman, 2006)

⁷⁰ Mousumi Bandhyopadhyaya, *Indigenous approach to Delivery Deaths in Colonial Bengal*, pp-235-254, in Chittabrata Palit and Achintya Dutta(ed.), *op.cit.*

⁷¹ Sean Lang, *Drop the Demon Dai: Maternal Mortality and the State in Colonial Madras, 1840-1875*, *Journal of Social History of Medicine*, Vol. 18, No. 3, 2005, pp-357-378.

Engels⁷² who examined the reforms of state in the light of differences between European and Indian women doctors and the role of nationalists in Bengal. He argues that political pressure was much more dominant than welfare among children and women's health and it was the independent middle class women who brought reform in childbirth birth practices rather than the European women, the latter much interested in strengthening their professional position. Sean Lang⁷³ however, critically appreciates the Queen Empress fund for female medical aid and the role played by Countess of Dufferin in providing medical services which were appreciated not only by inhabitants but also by the most critical newspapers and missionaries. Her work, according to Lang, was a milestone and had established the image of the colonial state's benevolence and magnanimity among its inhabitants. The lacuna of all these studies especially feminist writings on medicine is that none of the work (excluding the studies on infantile mortality) takes into account the health of a girl child or adolescent girl. Child marriage was prevalent in India, thus, it was necessary to look into the way society conceptualised the idea of adequate health measures for a girl child or the awareness in society about the health of female adolescents.

Studies exploring the emergence and expansion of the western medical system in United Provinces are scanty and have not been explored comprehensively. Yet few scholars took up different aspects of western medical policy in the context of United Provinces. Discussing a new area i.e. medical economy, Samiksha Sehwat⁷⁴ throws light on the emergence and expansion of public hospitals and dispensaries in North India i.e. Punjab, Delhi and United Provinces. She has criticised the low expenditure on medical facilities/ public health care by the State, leaving it in the hands of the private sector and the increase of state interference in the medical care for women. This work enlightens us with the role of gender and ethnicity in shaping medical care in India. In another article by Shamshad Khan⁷⁵ shows the politicising of the medical system especially the communal politics over the issue medical practices in United

⁷² Dagmar Engels, *The Politics of Childbirth: British and Bengali Women in Contest, 1890-1930*, pp-222-246, in Peter Robb (ed.), *Society and Ideology: Essays in South Asian History*, (New Delhi: OUP, 1993).

⁷³ Sean Lang, *Colonial Compassion and the Political Calculation- The Countess of Dufferin and Her Fund*, pp-81-96, in Poonam Bala (ed.), *Contesting Colonial Authority*, op.cit..

⁷⁴ Sehwat, Samiksha, *Colonial Medical Care in North India, Gender, State, and Society, c.1840-1920*, (New Delhi: Oxford University Press, 2013).

⁷⁵ Shamshad Khan, *Colonial Medicine and Elite Nationalist Responses in India, Conformity and Contradictions*, pp-69-114, in Poonam Bala (ed.), *Contesting Colonial Authority*, op.cit.

Provinces, where extreme discussion broke out at the point of use of indigenous and western medicine. He further criticises the government's inclination towards the western medicine and opening of institutions thereby neglecting the indigenous system of medicine. He criticises power, domination and hegemony of the colonial State that showed delinquency to the medical traditions in United Provinces. Khan using Legislative Assembly Proceedings of United Provinces also discusses the efforts to revitalise the Indian systems of medicines which faced internal differences of class, communal, religious and political agendas.⁷⁶ Madhuri Sharma⁷⁷ in her work concentrating in Benares division of United Provinces explores the struggle of indigenous medicine to establish its identity in competition with the allopathic medicine. She contends that the supporters of indigenous medical practitioners were much more firm in their attempt to establish their system of medicine despite the unsupportive attitude of the government and labeling them as 'quacks' by supporters of western medicine. In her another article, she explores the implications of medical and sanitary interventions of the colonial state in the city of Benares.⁷⁸ Exploring the famine and dietics, Sanjay Sharma⁷⁹ delineates the colonial intervention in dietary habits of the natives of North-Western Provinces (NWP) and Oudh during famines and in the jails. Amna Khalid in her work explores the colonial medical intervention towards cholera in NWP through the appointment of public health/police staff⁸⁰ and reactions or response of the indigenous population.⁸¹ Sanjam Ahluwalia using the wide variety of resources analyses the history of birth control in India and western countries simultaneously. She shows how women's body became a contested site among Indian elites, especially western advocators of birth control and Gandhiji. She argues that though willing the government due to social and political constraints were not initiating the birth control policies in India, 'instead of rushing to manage the

⁷⁶ Shamshad Khan, Systems of medicine and nationalist discourse in India: Towards "new horizons" in medical anthropology and history, *Social Science and Medicine*, 62, 2006, pp-2786-2797.

⁷⁷ Madhuri Sharma, *Indigenous and Western Medicine in Colonial India*, (New Delhi: Foundation Books, 2012).

⁷⁸ Madhuri Sharma, Knowing Health and Medicine: A Case study of Benares 1900-1950, pp-161-170, in Deepak Kumar and Raj Shekhar Basu (ed.), *Medical Encounters in British India*, op.cit.

⁷⁹ Sanjay Sharma, Measuring Hunger: Debates on an 'Adequate' Diet in Colonial North India, pp-184-235, in Kiranmayi Bhushi (ed.), *Farm to Fingers: The Culture and Politics of Food in Contemporary India*, (New Delhi: Cambridge University Press, 2018).

⁸⁰ Amna Khalid, 'Subordinate' negotiations-Indigenous staff, the colonial state and public health, pp-45-73 in Bismoy Pati and Mark Harrison (ed.), *The Social History of Health and Medicine in Colonial India*, (New Delhi: Primus Books, 2011).

⁸¹ Amna Khalid, Of Cholera, Colonialism and Pilgrimage sites: Rethinking Popular Responses to State sanitation, 1867-1900, pp-74-97, in Bismoy Pati and Mark Harrison (ed.), *Society, Medicine and Politics in Colonial India*, (New York: Routledge, 2018).

colonial bodies, British officials in India advised caution and restraints.⁸² Her work focuses on the rural areas of United Provinces where the basic facilities of healthcare were absent. Thus, the United Provinces medical policy as explored by scholars focusses on indigenous medicine, medical expenditure, birth control, and diseases. In the line of these works, this thesis attempts to explore the medical policy of the colonial state in United Provinces specifically focusing on government policy for childcare.

A study exploring the evolution of paediatrics in the colonial medical policy is another lacuna in the social history of medicine. However, the rich data source is available on smallpox and vaccination policy of the colonial state. This makes the study significant which explores the way the policies of the State manifested the child health care. In the context of Bengal, Mukherjee traces the growth of women and child healthcare through the efforts of voluntary groups, British officials and women associations.⁸³ The remarkable work is carried out by Sanjoy Bhattacharya on the vaccination policy of the colonial and post-colonial state.⁸⁴ He along with Mark Harrison, Michael Worboys, in their work *Fractured States*, traces the history of vaccination policy in colonial India and analyse the fractured nature of the administrative structure of colonial India. The author also focuses on the reactions and responses of the Indian population to take the vaccination. By explaining the link between the government and Indian bureaucrats, the study highlights that the tensions and conflicts within administrative systems deeply impacted the success of vaccination technology. The study takes an in-depth analysis of vaccination technology and medical history of vaccine research in colonial India. In his another work, *Expunging Variola*, Bhattacharya using the WHO reports critical analyses the Indian government and administrative officials, efforts and challenges to eradicate smallpox in post-colonial India.

⁸² Sanjam Ahluwalia, *Reproductive Restraints- Birth Control in India, 1877-1947*, (Ranikhet: Permanent Black, 2008).

⁸³ Sujata Mukherjee, Disciplining the Body? Healthcare for women and Children in early Twentieth Century Bengal, pp-198-214, in Deepak Kumar (ed.), *Disease and Medicine*, op.cit.

⁸⁴ Sanjoy Bhattacharya, Mark Harrison, Michael Worboys (ed.) *Fractured States, Smallpox, Public Health and Vaccination Policy in British India, 1800-1947*, (New Delhi: Orient Longman), 2005; Sanjoy Bhattacharya, *Expunging Variola: The Control and Eradication of Smallpox in India, 1947-77*, (New Delhi: Orient Blackswan), 2006.

On the basis of above historiography of the history of science and medicine in colonial India, paediatrics is less explored domain and thus this study claims to be a pioneer attempt to glance colonial policy from the paediatric point of view.

CHAPTERISATION OF STUDY

For the detailed analysis of the topic, the present work is divided into six chapters. They are as follows-

1. Introduction

The first chapter gives a blueprint of the thesis work plan and core argument. The chapter enables a reader to understand the objective and motivation of the work and the significance of the study. The chapter describes in detail the major arguments of scholarships in the history of colonial science and medicine and how the present thesis fulfils the historiographical gap in the study of the social history of medicine. This section of the thesis gives an overview of the methodology and a wide variety of literatures used to make the work possible. The area chosen for this work is United Provinces/Uttar Pradesh, which is a politically significant state of the country since earlier times. The first chapter thus provides zest of the entire work.

2. Evolution of Colonial Medical Policy in United Provinces

The second chapter provides the background of the evolution and emergence of public health policy in United Provinces. The chapter intends to understand the reactions and responses of the people on the introduction of western medicine. As the recent scholarship on the study of medical intervention in colonial NWP/United Provinces is meager, so the chapter will explore the medical policy of the colonial state with special reference to United Provinces. The chapter also serves as a base for the next three chapters where paediatric policy is contextualized in the background of colonial medical policy. This section of the thesis continues with the generalisations of medical historians. Various means adopted by the colonial state to create hegemony of western medicine through education, institutionalization and sanitation is described in detail in this section. The perspective employed in this chapter is influenced by the critical reflections

of medical historians such as David Arnold and Gyan Prakash who argued about the cultural and political hegemony of western medicine.

3. Paediatric Medicine: Idea and Practices

The third chapter explores the colonial sensibilities towards paediatrics. It also attempts to get an insight into the way paediatric medicine manifested into the medical policy of the colonial state. Together with this, there will be an attempt to throw light on the evolution of child health care policies in United Provinces and how the latter visualised, created and implemented the policy for the paediatrics. As till independence, there was not a remarkable decline in infant mortality rate. The focus will be on the question to find whether the medical policy for paediatrics in United Provinces was a part of the broader project of the colonizing mission of the welfare state. Together with this, an attempt will be made to study the attitude and sensibilities of the western nation towards child medicine. Thus the chapter claims to be the first attempt to understand colonialism and paediatrics in the medical history of India. The chapter argues that voluntary agencies and women professionals were key factors in pushing the paediatrics into the government's medical policy. Few scholars discussed in detail the paediatric policy of the colonial government, however, literature on infant and maternal mortality, vaccination are wide. The work by David Arnold and Sanjoy Bhattacharya on vaccination and smallpox medicine in colonial and latter on both colonial and post-colonial India is commendable. The chapter is unique in the sense that it unveils the health services in schools, immunization schemes, child health-oriented policy and nutrition policy of the colonial state with special reference to United Provinces.

4. Institutional History of Paediatric Medicine

Chapter Four of this work holds significance, as it studies various means adopted by the government in colonizing child's body. As childbirth received prime concern from all spheres of life, the chapter discusses the impact of rising western medical centers on paediatrics. These centers or hospitals or dispensaries directly or indirectly influenced the child's health through Dufferin Fund, education of medical women, training of midwives and replacing the indigenous dais. The chapter also attempts to explore the role of missionaries in the initial institutional

development of western medicine in United Provinces. The facilities for paediatrics in United Provinces revolved around reproductive health, thus no attempt was made to establish specialized paediatric institution while few Maternity and Child Welfare centers were opened, and concentrating more on women's healthcare and little for a child. The chapter also discusses the emergence of women doctors and nurses in the Province and their role in the expansion of western medical system. Further, these women professionals too had to face a number of problems which implicitly impacted the improvement of paediatrics. Thus when the colonial state targeted the *pardah-nashin* women for infiltrating western medicine, the existence of *dhai* was a chief obstacle in their mission of colonizing the body of Indian women. In India, *dhais* were sole authority in childbirth practices, thus due to a broader project of the colonial state, dais became a chief target. They, on the other hand, initiated the plan to replace the dais with trained midwives. The programme was partially successful. The chapter thus stresses how indigenous women were demarcated as dangerous by the colonial state and were replaced with the trained dais.

5. Paediatric Medicine in Uttar Pradesh

For independent India, the Bhore Committee had drawn attention to the poor state of paediatrics in the country. The report proved as a vision document for free India; however, the areas highlighted by the report were not implemented wholeheartedly. The chapter explores how far the government was successful in developing and implementing the medical policies for the child health care and reducing the infant mortality rate and delineating itself from the colonial mindset. Further, the chapter compare and contrast the paediatric medical policy of colonial and independent Uttar Pradesh. The chapter further intends to examine the paradigm shift in the post-colonial policy for paediatrics. The chapter lays that the policies and programmes for paediatrics in post-colonial India were more comprehensive and coordinated in comparison to the colonial state while the problem was at the implementation level. It is also argued here that even though the health of the children in the State improved to a certain extent yet the pace of growth was slow to make the State delivering poorest healthcare facility in the country. For the policy assessment the chapter explores the motivations of the government in infrastructural development, outlining nutritional programmes,

legalizing child right to health and framing of child-centric policies for improving the conditions of paediatrics in Uttar Pradesh particularly and in India in general.

6. Conclusion

This chapter underlines the findings of the study and answers the questions raised at the beginning of the chapter. The chapter establishes the argument of the thesis with the help of various sources used to study the paediatric medicine in colonial and post-colonial United Provinces.

Chapter II

*Evolution of Colonial Medical
Policy in United Provinces*

CHAPTER- II

EVOLUTION OF COLONIAL MEDICAL POLICY IN UNITED PROVINCES

This chapter intends to examine the medical policy of the British in United Provinces and changing responses and attitude of the people towards the bio-medical system. Also, this chapter seeks to trace the historical background of the medical policy of colonial state and politics that shaped the same. This chapter is also designed as a prelude to the next three chapters where discussions are centered on the paediatrics in colonial United Provinces, to foreground the whole discussion on the complexity of the relationship of child healthcare and state's policy in the post-colonial Uttar Pradesh. The chapter thus addresses the question of the historical implications of medical administration on the conditions of healthcare of the state of Uttar Pradesh after independence with special reference to paediatrics.

Existing literature on colonial medicine focuses on its complexities with the relationship of medicine, culture, colonialism and social reforms in Indian society. Studies on analysis of colonial medicine in India mainly focus on the Bengal, Madras and Bombay presidencies. The remaining provinces, except a few, await the attention of scholars to unveil the state policy of health and medicine. The colonial medical policy as elucidated by scholars such as Anil Kumar, V. R. Muraleedharan, Radhika Ramasubban, Kabita Ray, as a tool of empire for the better health of Europeans and colonial subjects, facilitating social control, and creating knowledge that fed a discourse justifying imperialism. The two dominant discourses on western medicine are that it was an inseparable part of colonial science, its transference from metropolis to colonies lead to the technological dominance over the natives. Together, initial intervention in public health administration was to ensure better health care for the Europeans natives and the army.¹ Recent argument stressed that when Indians became part of colonial administration, they also were brought under the sphere of colonial medicine.² Further, it privileged the needs of Europeans and the military; and the IMS was initially a military service, formed the backbone of medical administration under the British while many sanitary and medical provisions aroused from the need to

¹ Radhika Ramasubban, *Imperial Health in British India, 1857-1900*, pp-38-60, in Roy Macleod and Milton Lewis, *Disease, Medicine and Empire, Perspectives on Western Medicine and the Experience of European Expansion*, (New York: Routledge, 1988).

² David Arnold, *Colonizing the Body*, op.cit.

preserve the health of the army. As far as this study is concerned, the perspective employed in this chapter is influenced by the critical reflections on colonial medicine by medical historians mentioned above.

Recent studies on colonial medicine emphasised the instrumentality of state intervention in the field of medicine and public health. Thus, the health measures of the imperialists focused more on urban areas, industrial estates and plantations in comparison to the people in the rural areas. Scholars have stressed on the fact that various aspects of British health policy in India were a part of the ideological enterprise which was set up to justify the Raj.³ It was during the second half of the nineteenth century that the reluctant colonial state in changing circumstances and nationalists pressure became involved in the interventionist attempts to know and manage Indian society. It was more an impact of the First World War and international scenario rather than the sudden realization of responsibility by a paternalistic state. Impact of the aspects of the civilizing mission of the state was limited and small, both at political as well as ideological level, but it was also the contentious issue among the administrators, Indian reformers and later by the Indian nationalists.

In the last few decades, medical history of India had created a surge of interest among scholars such as Arnold, Anil Kumar, Jeffery, Harrison, Ramasubban,⁴ etc. focused on colonial medical interventions and their socio-political implications to protect the health of colonial enclaves. The scholars not only tried to understand the popular reactions and responses but also studied how these reactions re-shaped medical interventions. While most studies support the notion of 'limited Raj',⁵ the focus of most of them is on the epidemics control policy of the colonial state. The excellent work under this comes from Arnold and Catanach, and others who saw the disease as a means to explore the tensions between state and subalterns.⁶ It has also been argued

³ David Arnold (ed.), *Imperial Medicine and Indigenous Societies* (Manchester: Manchester University Press, 1988); Roger Jeffery, *The Politics of Health in India*, (Berkeley: University of California Press, 1988).

⁴ David Arnold, *Colonizing the Body*; Anil Kumar, *Medicine and Raj: British Medical Policy 1835-1911*, (New Delhi: Sage Publications, 1998); Mark Harrison, *Public Health in British India: Anglo-Indian Preventive medicine 1859-1914*, (Cambridge: Cambridge University Press, 1994); V. R. Muraleedharan, *Malady in Madras: The Colonial Government's Response to Malaria in the early 20th century*, pp-101-114, in Deepak Kumar (ed.), *Science and Empire*, op.cit.

⁵ Anil Kumar *Medicine and Raj: British Medical Policy 1835-1911*; Anand A. Yang, *The Limited Raj: Agrarian Relations in Colonial India, Saran District 1793-1920*, (Berkeley: University of California Press, 1989).

⁶ David Arnold, *Touching the Body: Perspectives on Indian Plague 1860-1900*, pp-55-90, in Ranjit Guha (ed.), *Subaltern Studies*, Vol. V, (New Delhi: Oxford University Press), 1987; Ian Catanach,

that medicine became a 'tool of empire' to consolidate and legitimize European imperialism.⁷ Further medicine was used as an 'instrument of social control' to dominate the colonial subjects, was unfortunately not a benevolent extension of modern science and technology. Recent studies have challenged the assumption that the modern or western medicine was effective, humane and a welfare scheme for the welfare of colonies.

Medical historiography if not exclusively but substantially relies on the Foucauldian notion of 'power' as a means of extending hegemony and control over the subjects.⁸ Thus aspects of health and medicine regarded as humane, transformed under 'power' as 'governmentality'⁹ which was same as the form of governing a household by a family, thereby safeguarding wealth, prosperity and health of its members and "it is this general form of management that is characteristic of government; by comparison, the question of landed property for the family, and the question of the acquisition of sovereignty...are only relatively secondary matters."¹⁰ Taking this paternalistic character of the government, the chapter explores the emergence and expansion of colonial medical care in the most populous state of colonial empire- North-Western Provinces (renamed as United Provinces) and implications of the state's policy on the general health conditions.

EPIDEMIC DISEASES, STATE'S INTERVENTIONS AND POPULAR RESPONSES

Wide range of literature exists, which explores the epidemiological phenomena of diseases; the relationship between indigenous elites, subaltern classes and the colonial state; interventionist state's policy; diseases as a site of conflict between the colonial power and indigenous politics. The following pages thus shed light on the official attitude towards diseases, the role of government bodies to combat dreadful diseases and reactions and responses of people to the same in NWP/United Provinces.

Plague and the Tensions of Empire: India, 1896-1918, pp-149-71 in David Arnold (ed.), *Imperial Medicine and Indigenous Societies*, op.cit.

⁷ Daniel R. Headrick, *Tools of Empire: Technology and European Imperialism in the Nineteenth Century*, (Oxford: Oxford University Press, 1981) cited in Mark Harrison and Biswamoy Pati (ed.), *Health, Medicine, and Empire, Perspectives on Colonial India*, (New Delhi: Orient Longman, 2005), pp.11-12.

⁸ Michel Foucault, 'Body/Power' pp-55-62; and 'The Politics of Health in the Eighteenth Century' pp-182, in Colin Gordon (ed.), *Michel Foucault- Power/Knowledge: Selected Interviews and Other Writings 1972-1977*, trns. by Colin Gordon, Leo Marshall, John Mepham and Kate Soper, (New York: Pantheon Books, 1980).

⁹ Michel Foucault, 'Governmentality', pp-87-104, in Michel Foucault, *The Foucault Effect, Studies in Governmentality*, (USA: University of Chicago Press, 1991).

¹⁰ Ibid, p-94.

As early as in 1787, when Jonathan Duncan was made the resident of the city of Benares, the former promulgated the regulation for keeping the city (Benares) clean in 1790. The resultant was that the public peace saw a disturbance when a mob collected to persuade the merchants and traders of the city to observe hartal against the regulation, however, situation was controlled 'without any untoward incident occurring.'¹¹ However, sanitary improvements were regularly carried out by the shopkeepers of the city, who voluntarily contributed for the expenditure on the cleanliness.¹² The former is the earliest example of the sanitary intervention of the colonial state in a specific place of the Province. At large extent, the sanitary measures introduced in the country and the Province was the direct outcome of the experiences of war and reforms in Europe and the mutiny of 1857.¹³ Specifically in Europe, the unprecedented growth of towns affected the sanitary arrangements and water supply leading to the outbreak of diseases and alarming death rates. The reports of various commissions led to the formation of the Public Health Act in 1848 and establishment of the General Board of Health in England. The first step of colonial intervention was their sanitation policy. Harrison argued 'what had been the late element in the evolution of sanitary policy in Britain- the spur of military needs- was in India the starting point of serious concerns.'¹⁴ There were numerous diseases which took the European lives, and knowledge about their causes and treatment were traditional. The Civil Surgeon (C.S.) of Lucknow believed that the causes of fever in the Province were the high temperature, lack of food, fatigue and ill-ventilation.¹⁵ This miasmatic theory of diseases gained a firm ground in India, was however replaced by the environmental or climatic theory where series of studies in Europe proposed for the need of better sanitation and health conditions for Europeans.¹⁶ Thus sanitation of towns and cantonments was the first medical intervention by colonialists.

The initial attempts of medical interventions of colonial state in NWP and Oudh first appeared with the establishment of European quarter far away from the natives, as

¹¹ U.P. District Gazetteers, *Varanasi*, 1965, p-67.

¹² Imperial Gazetteer of India- Provincial Series, United Provinces of Agra and Oudh, Vol. I, p-124.

¹³ The high mortality of Europeans during the mutiny refreshed the memories of Crimean War in Europe, where British soldiers died ten times more due to dysentery than from the Russian weapons. William H. McNeill, *Plagues and Peoples*, (New York: Doubleday & Company, 1976), p-251; Veena Talwar Oldenburg, *The Making of Colonial Lucknow 1856-1877*, (New Jersey: Princeton University Press, 1984).

¹⁴ J. B. Harrison, Allahabad: A Sanitary History, p-170, in K. Ballhatchet and John Harrison (ed.), *The City in South Asia: Pre Modern and Modern*, (London: Curzon Press, 1980).

¹⁵ Sanitary Report of Oudh for the year 1968-69, Lucknow, 1869, p-8.

¹⁶ For details see- David Arnold, *Colonizing the Body*, pp- 15-50.

according to them the ‘habits of natives were such that unless they were closely watched, they would cover the whole neighbouring surface with filth.’¹⁷ How the condition is exaggerated in the statement could be understood from the fact that in 1827, Fanny Parks described a city (Allahabad) in the Province as ‘pretty and well-ordered, the roads were the best in India.’¹⁸ The conservancy system was rigorously executed in the cantonments in comparison to the resident areas. Even a European contractor in Lucknow made provisions for cleaning only the main streets as he believed that the other lanes were the responsibility of natives, which means that around two-third of the city remained uncleaned. The discriminatory treatment brought oppositions from the natives who regretfully noted that the main markets and lanes were “kept clean and neat, but in more remote situations there is said to be a neglect apparent, and the stench and filth are not only disagreeable but unwholesome ... In Lucknow the money provided for the general good is devoted to the improvement of one or two favoured places.”¹⁹ Numerous attempts were made to transform the Nawab’s city into a westernized European town but no one paid heed to the people who were not only forced to live under poor conditions but the new sanitary arrangements created havoc in their life not only environmentally but socially also.²⁰

Table 2.1: Mortality from the diseases in NWP and Oudh

Year	Total Deaths	No. of Deaths from the diseases				
		Plague	Cholera	Smallpox	Fever	Other causes
1901-10	18,747,113	1,305,474	634,537	140,801	13,436,582	3,229,719
1911-20	18,819,255	1,112,380	582,819	56,775	13,901,959	3,165,322
1921-30	11,993,248	429,136	420,891	60,247	9,048,160	2,034,814
1931-40	11,333,226	211,413	222,669	105,353	8,732,993	2,060,798
1941-50	9,668,671	156,521	363,194	112,820	7,490,040	1,546,096

Source: Data compiled from- Annual Report of the Sanitary Commissioner of NWP and Oudh (1900-1919) and Annual Report of the Director of Public Health United Provinces (1921-50)

As can be seen from the table above the mortality in the Province was exceptionally high. The higher number of deaths was registered under two diseases- plague and fever throughout the colonial time. The poor environmental conditions and insanitary

¹⁷ Royal Commission on Health of the Army in India, p-82-94, cited in Harrison, *Allahabad: A Sanitary History*, p-173

¹⁸ Fanny Parks, *Wanderings of Pilgrim in Search of Picturesque*, Vol. I, pp- 72-3 and 206, cited in Ibid, p-172.

¹⁹ Oudh Akhbar, Selections from the Vernacular Newspapers (hereafter SVN), 5 December 1865.

²⁰ Detailed description of sanitary arrangement and opposition of people in Lucknow, see- Oldenburg, *The Making of Colonial Lucknow 1856-1877*, pp-107-143.

state of affairs, as discussed in the above section, led to proliferation in the number of deaths, especially among women and children. After 1920, plague incidence reduced in the state while the control of cholera was slow. Compulsory inoculation against cholera during the pilgrimages and fairs proved vital significance, however, it was only after 1950 when the state of Uttar Pradesh introduced anti-cholera vaccine the disease was checked yet remained unabated. Smallpox though declined yet remained persistent and after 1930 seen an upward trend. Major epidemics were always present in the State, usually in a mild form but frequently taking an explosive turn. The measures followed by the State and local government were more a preventive one than curative. For instance, for plague, measures like temporary camps, disinfection and evacuation were considered by the government rather than any fruitful policy while for fever/malaria, distribution of quinine was preferred over anti-malaria measures. All these efforts were limited in nature than extensive eradication of disease, in the case, however, smallpox was an exception which was dealt seriously by extending it through legislation (continued in the next chapter). Ramasubban²¹ delineates that colonial authorities found it a cheaper alternative to respond to the incidence of disease through ‘expansion of medical education and encouraging medical practitioners rather than spend on resources on sanitary reforms for the general population.’

Cholera played the key role in shaping the colonial health policy in the latter half of the nineteenth century and the plague epidemic of 1897 brought serious interventions in medical spheres. The International Congress at Constantinople in 1866 believed that cholera radiated with pilgrims to a larger area and was accelerated by the railway to Multan and thus the epidemic broke out in Europe. Thus pilgrims from India were made responsible for the outbreak of the disease at Hajj in Mecca in 1865.²² Even, John Murray reported that “there were two remarkable instances during the “Hurdwar (Haridwar) epidemic” of the inhabitants being attacked by cholera on the second day after the poison had been communicated to the village tanks: in one instance from a pilgrim suffering from cholera having bathed in it, and remained on the banks during

²¹ Radhika Ramasubban, *The Development of Health Policy in India*, p-110, in Tim Dyson and Nigel Crook (ed.), *India's Demography: Essays on the Contemporary Population*, South Asian Publishers Pvt. Ltd., New Delhi, 1984.

²² Saurabh Mishra, *Beyond the bounds of time? The Haj Pilgrimage from the Indian subcontinent, 1865-1920*, pp-31-44, in Biswamoy Pati and Mark Harrison (ed.), *Social History of Health and Medicine*, (Delhi: Primus Books, 2011).

the day; and in the other after the clothes of a man who had died from cholera were washed in it and spread even outside India.²³ Thus Ganges delta was now designated as 'home of cholera' and Indian pilgrims were the transmitters of disease. The two pilgrimage sites, i.e. Allahabad and Haridwar and religious fairs such as Magh mela and Kumbh fair, were the main area of contention between colonial state and people. The pilgrims were always blamed in official correspondences of not following the basic principles of sanitation and poor sanitary habits.²⁴ In 1892, the leading medical paper asserted that cholera reached in Europe during the year was disseminated from Haridwar.²⁵ As both these sites were in NWP, both central and provincial governments under the international pressure took many retaliatory measures. This not only increased the panic but sadness on the part of the people. People were unhappy from the sanitary measures of the government, as they were stopped on the roadways and railways and were checked and sometimes were ordered to return homes without pilgrimage. A newspaper cited the poor condition of the people as, "such a check was placed upon pilgrims and people returning from the fair, that they were not allowed to enter cities or villages, and could not make the necessary arrangements to provide for their daily food on the roadside...water was not procurable from them."²⁶ A similar incident reported during the 1879 Kumbh fair at Haridwar and 1882 at Allahabad, when the death toll increased more due to sanitary arrangements of the government than the epidemic itself.²⁷ The people travelled after the dispersal of the fair through forests where in absence of food and water they died. It was noted that the roads from Haridwar to Almora were covered with corpses for several days.²⁸ The sanitary defects were blamed for the outbreak of diseases and the officials were held responsible for the state of affairs. During 1890, 80,295 deaths were registered in the Province due to cholera. The solution lied in the removal of defects in local conditions, of which the most glaring was the unprotected state of water supply and its contamination. As Sanitary Commissioner remarked, "There is no safety against virulent epidemics where there is an unprotected water

²³ John Murray, Report on the treatment of Epidemic Cholera, Calcutta, 1st June 1869, p-5

²⁴ Ibid.

²⁵ Twenty-Fifth Annual Report of the Sanitary Commissioner of NWP, 1892, Allahabad, 1893, p-29.

²⁶ Rohilkund Ukhbar, SVN, 7 December 1867.

²⁷ It was reported that the severe cholera was noted among the people at Chandi. The administration dispersed the people from the camps and also broke the communication. The action definitely had a reaction too. People who were forced to return had to face a lot of hardships and in this course many died on the way due to scarcity of food and water. Almora Akhbar, SVN, 1 May 1879, p-362.

²⁸ Almora Akhbar, SVN, 1 May 1879, p-362; Berar Mitra, SVN, 27 May 1879, p-431.

supply.”²⁹ Similarly, *Hindustan* reported that during the cholera outbreak of 1890 that, “The municipal commissioners in charge of the management of the fair are really to blame, and are responsible for all the deaths that have occurred. They have made latrines near the fair, and the filth is buried close by: the filth rots in the underground water which is close to the surface at the place and poisons the air.”³⁰ The conservancy officials working too was limited in nature which was criticized during cholera in Lucknow in 1894. *Azad* commented that “the Deputy Sanitary Commissioner lately arrived in Lucknow to ascertain the causes of the disease (cholera), but his efforts in this direction could not be very successful. Before inspecting any quarter of the city he always gave the previous intimation to the conservancy officials who had that quarter cleaned well before his visit.”³¹

The general conclusion which could be drawn from the experience of preventive measures adopted in this Province for checking the advance of diseases were the evacuation of infected dwellings and inoculation for plague; distribution of cholera pills, leaflets, removal of a patient to the infectious disease hospital, disinfection of wells with potassium permanganate were the chief precautionary measure for cholera; and quininization or cinchonization scheme for malaria/fever. These measures failed to make a mark on the health of people as cases occurred frequently and the rate of occurrence was high.³² Inoculation was performed compulsory among the pilgrims. To popularize inoculation, Chaytor White delivered lectures in order to familiarize people with the method of filling bottles with the vaccine and the precautions to be taken to provide against the possibility of contamination in the process in 1907.³³ And for the purpose, it was decided to appoint two whole time supervising officers- Chief Plague officer and Assistant Plague officer in the Province.³⁴ Chaytor White noted “Inoculation was provided when asked for, but the natives in these provinces have never taken to inoculation and have not come forward in any larger numbers, and

²⁹ UPSA, Proceedings of Government of N.W. Provinces and Oudh, Medical and Sanitation department, Part II, July- Dec 1892, p-5.

³⁰ *Hindustan*, SVN, 8 February 1890.

³¹ *Azad*, 17 August 1894, SVN, p-354.

³² Sanitary Report of the Deputy Sanitary Commissioner, 1st circle, for the calendar year 1899, p-3A, in Thirty-Second Annual Report of the Sanitary Commissioner of NWP, 1899, Allahabad, 1900.

³³ UPSA, Resolution of Sanitation Department No. 265/XVI-963B of 1907, dated 26 August 1907, Naini Tal, in File No. 950 B, Box No. 22, ‘Scheme for providing Extended facilities for Inoculation against Plague in the United Provinces’, 1907.

³⁴ UPSA, Letter No. G1125 C.O., From R. D. Murray to Secretary to Government, dated 11 September 1907, Naini Tal, in File No. 950 B, Box No. 22, ‘Scheme for providing Extended facilities for Inoculation against Plague in the United Provinces’, 1907.

during 1904 operations were confined almost entirely to Fyzabad. There were only 964 inoculations performed in the Provinces, 634 of which were done at Fyzabad. There were 167 done at Cawnpore and 138 at Meerut. Only two persons are reported to have died of plague after inoculation, but it is quite impossible to follow up cases after the operation.”³⁵ He further said, “No ideal scheme can be propounded to eradicate plague from the country, but if anything can be done to reduce the present heavy mortality it should, I think, be attempted. At present sufferers in a plague, town leave their houses and go to the district, always carrying plague with them. If more accommodation in health camps could be obtained and the people induced to avail themselves of it, the diseases will be proportionately nor confined, and will have less chance of spreading both in the infected city itself and in the surrounding districts.”³⁶

In 1904, when a proposal came to the government to establish permanent health camps for evacuation during a plague epidemic, it was rejected on the grounds that ‘there was no need to change the policy.’³⁷ However, the disinfection in Allahabad plague proved a failure as Chaytor White observed that the municipal members instead of persuading people, moved from their residences on the outbreak of the plague.³⁸ Disinfection though relied by the government, was proved unfruitful as glanced from the official correspondences. As an official remarked that “our knowledge of the spread of plague has hardly advanced any further than in 1896 when plague started in Bombay. Everything has been tried, but nothing that a medical skill and human ingenuity can devise has so far proved successful. The Government of India cannot apparently advance a plague policy and leaves all and sundry to work out their own salvation.”³⁹ The policy of evacuation during the colonial rule was not new to the natives as during mahamari people followed the practice. As Pearson discerned that, ‘the people themselves are very observant of certain signs, and on rats dying invariably leave their houses voluntarily, and, no matter what the weather was like, lived in the jungles for a month or longer.’⁴⁰ He further noticed in 1860 that, ‘invariably on the appearance of dead or dying rats do these peasants vacate their

³⁵ UPSA, Major. Chaytor White ‘Plague Administration in the United Provinces for the year 1903’, 14 May 1904, Naini Tal, in File No. 775B, Box No. 6, ‘Plague Policy’, Sanitation Department, 1904.

³⁶ Ibid.

³⁷ UPSA, Letter from S.H. Butler to Secretary, dated 25-04-1904 in Ibid.

³⁸ UPSA, Notes by Chaytor White on letter no. 1115/XXVII-173, dated 1 March 1904 from Commissioner, Lucknow division, in Ibid.

³⁹ UPSA, File No. 775B, Box No. 6, ‘Plague Policy’, Sanitation department, 1904.

⁴⁰ UPSA, File No. 623B, Box No. 5, ‘Plague (Mahamari) in Garhwal’, Sanitation Department, 1902.

houses and go to the jungle, and on a case of mahamari occurring people in the surrounding villages will cut themselves off entirely from the infected villages and hold no intercourse with them.’⁴¹ It was suggested that “one of the best ways of helping poor people who evacuated their houses, is to give them fuel, blankets, especially to women and children. Financial help may also be given with advantage to those who desire to open up the roofs of houses in which plague cases have occurred.”⁴² It was unfortunate that the epidemic control policy was so much so depended upon these measures that many a times their absence created havoc in the Province. For instance, in 1917, when there was a shortage of bleaching powder in the market and thus were not supplied to the DBs and therefore Sanitary Commissioner urged that “it would not be therefore fair to draw conclusive inferences regarding the effect of the ‘cholera scheme’ on the incidence of the disease.”⁴³

The anti-malaria programme of the state depended on the distribution of quinine. The first instance of the sale of quinine was first introduced in 1895. It was mentioned that people had no faith in the efficacy of quinine and even if they don’t object to its use when it was supplied by the government free of cost, they generally did not purchase the drug.⁴⁴ Sanitary Commissioner remarked that ‘though efforts were made to improve the surface drainage, pits and excavations were filled up and a large amount of drains laid out, and also to bring quinine within the reach of the poorer classes, but no organized efforts were made to destroy mosquitoes and their larvae.’⁴⁵ He further says that, “it is not the intention of the government that quinine should be distributed free, except when such a step is absolutely necessary, and Lieutenant Governor desires that this principle should be followed as closely as possible, as any departure from it reduces the funds available for supplying quinine where it is really required.”⁴⁶ As far as the prevention of malaria concerned old regulations continued, DBs were asked to prepare bye laws in their respective districts, such as “all depressions holding water within half a mile limits of a town or village should be kept free of aquatic

⁴¹ Ibid.

⁴² UPSA, Letter No. 141/XVI-775 B OF 905, from S.H. Butler to I.G.C.H., dated 20 May 1905, Naini Tal, in File No. 775B, Box No. 6, ‘Plague Policy’, Sanitation Department, 1904.

⁴³ Annual Report of the Sanitary Commissioner of United Provinces 1918, Allahabad, 1919, pp-10-11.

⁴⁴ H. R. Nevill, District Gazetteer- Ballia, Vol. XXX, Allahabad, 1907, p-26.

⁴⁵ Letter no. 135/1910, from L. Stuart, Secretary to Government to IGCH, UP., Dated 12 April 1910, Allahabad, in Annual Report of the Sanitary Commissioner of United Provinces, 1904, Allahabad, 1905.

⁴⁶ Ibid

vegetation and if any person or persons charged with any of the duties imposed by these byelaws, failing to perform any of such duties, or to carry out the necessary measures to the satisfaction of the DMOH within the time stated in the notice of DMOH shall be deemed guilty of a breach of these byelaws.”⁴⁷

As per official stand, there was open hostility to evacuation, segregation and disinfection and other remedial measures. In 1917, the Sanitary Commissioner of United Provinces accepted that the scheme of using bleaching powder during the epidemic was a failure, both due to inefficiency in its distribution and as he stated, “we know that cholera epidemics are not always due to infected water-supply, but the disinfection of wells is the only practical method of doing anything to check the disease in rural areas, and the scheme for cholera prevention, which unfortunately can at present only be carried out with difficulty and under disadvantages owing to the want of permanganate of potash, should certainly be continued.”⁴⁸ In order to check the advance of cholera in the province, it was decided to ban the arrival of cases from Nepal a scheme i.e. the barrier scheme was initiated at Basti and Gorakhpur in 1933.⁴⁹ In 1944, the army anti-malaria campaign was running in the province however, was hampered due to the desire of cooperation by civil authorities. Thus, Public Works Department issued an instruction for the prevention of malaria (to create or maintain a half a mile dry belt around the cantonments or other military establishments) to protect military defense forces from malaria, in connection with engineering works.⁵⁰ Later in July 1947, these provisions were extended to the whole Province. Further, some other provisions related to prevention of malaria, were due to irrigation, i.e. maintenance of canal banks, provision of suitable crossing places and it was decided to observe the principles laid down by water logging board of Punjab in 1930 for the design and execution of new projects. Unfortunately, in the middle of the government and people, Municipal and District Boards had no suitable byelaws to direct the way for the prevention of malaria. When the boards were asked to work upon this issue, instead of taking steps in the direction they started framing new innovative cause of malaria for instance, District Board Nanital contended that dirt, lack of rich diet and

⁴⁷ UPSA, File No. 506/1944, Box- 373, ‘Prevention of Malarial Fever’, Local- Self Government (LSG) Department.

⁴⁸ Fiftieth Annual Report of the Sanitary Commissioner of the United Provinces of Agra and Oudh for the year 1917, Allahabad, 1918, p-11.

⁴⁹ Annual Report of the Public Health Commissioner with the GOI, 1934, Vol. I, New Delhi, 1936, pp-35-36.

⁵⁰ UPSA, File No. 506/1944, Box- 373, ‘Prevention of Malarial Fever’, LSG Department.

rubbish etc. were the main reasons of malaria thus there was no need of any regulations.⁵¹

The colonial attitude received severe criticism both from the intellectuals and native press. During the plague of 1917, Indra Narayan Dwivedi asked for the help of people who were dying of plague for want of medical aid and lamented that “neither the Government travelling dispensaries nor any *Ayurvedic Mahamandal* agency visits them to alleviate their sufferings. Will a member of the Council ask what steps Government takes for the protection of the lives of villagers? Will the Home Rule League also do something in this direction? The members of the Allahabad *Seva Samiti* should come to Sarai Akil to help the inhabitants in their distress.”⁵² Similar demand was raised by Madan Mohan Malviya’s newspaper *Leader* which urged the government to take vigorous measures to combat plague as their preventive measures “were ill-conceived and injudiciously executed. The root of the evil is the appalling poverty of the people. Widespread general and technical education and the development of industries and commerce are essential for averting recurring plague, pestilence and famine. The immediate needs are that Government should help the people to evacuate infected quarters and that inoculation should be pushed forward vigorously.”⁵³ The *Musawat* complained that the disease was proliferating in United Provinces yet “no preventive measures are taken by the government. Government should provide thatched houses outside the affected areas, for inoculation and for destruction of rats. Pamphlets on the subject of plague should be published and lectures delivered.”⁵⁴ An inhabitant of Mirzapur raised his demand that local municipality should make proper conservancy arrangements for combating the outbreak of plague.⁵⁵ When Pioneer pointed out that Indian enemy should be devoted to sanitation rather than to politics, as agitation increased due to prevalence of plague and indifference of the government, *Nai Roshni* highlighted how the political agitators

⁵¹ UPSA, Letter No. 948/IX-506-44, From N. P. Chatterji, Deputy Secretary to Government Uttar Pradesh to Deputy Commissioner, Incharge Kumaun Division, dated 2 June 1950. File No. 506/1944, Box- 373, Prevention of Malarial Fever, LSG Department.

⁵² *Abhyudaya*, 8 December 1917, SVN, p-877.

⁵³ *Leader*, 10 December 1917, SVN, p-877.

⁵⁴ *Musawat*, 13 December 1917, SVN, p-877.

⁵⁵ *Abhyudaya*, 22 December 1917, SVN, p-316. *Anand*, 17 December 1917, SVN, p-877.

were “reciting this tale of woe, but the reply vouchsafed to them acts like salt on a sore.”⁵⁶

Few attempts on the part of government made people outrageous, such as forceful removal of people from the religious fairs or post-mortem of plague victims, etc. During 1892, Mahavaruni fair, when the plague broke out even after widespread arrangements by the government, they instructed all the railway companies to suspend all the trains to Haridwar and forceful removal of people. There was considerable opposition on the part of people, who infuriated over the religious intolerance of the government. People who were earlier dispersed, reached the fair from another road and raised their voice ‘*nahayenge nahayenge*’ and took a dip in the water⁵⁷ and said ‘*ghar jaane se behtar hai marna yahin.*’⁵⁸ Police forcefully evacuated all the people from the site within two days, still, around 10,000 returned at night to everyone’s surprise, but they were also herded out. Widespread discontent during the plague epidemic 1897-98 was evidenced in the country where people themselves took steps which came as a surprise both to the State and elite classes. When the plague broke out in Haridwar in April and Kankhal in September 1897, the danger of its spreading to Jwalapur was fully recognized and measures were taken to protect the town, however, a riot broke out in 1898. The people of Jwalapur (largest town of the Haridwar union), under the editor of *Akhbar-i-Am* (Lahore), organized an opposition against the local officers in their measures to combat with plague in Haridwar and Kankhal⁵⁹ and at Haridwar, two officers Dr Elphick and Mr Kendall were attacked as they tried to forcefully evacuate a suspect to the hospital. People not only stood against the evacuation of the man but they also attacked officials with sticks as they tried to burn the chappars of a person (who according to officials was suffering from the plague). When A.P. MacDonnell, (Lieut. Governor of NWP and Chief Commissioner Of Oudh) reached Haridwar, who was sent to balance the situation, the excited mass of people bore lighted torches as a symbol of darkness of the administration of the local officers.⁶⁰ People felt hardships due to medical subordinates and absence of private segregation camps. For the seriousness of the situation, police

⁵⁶ Nai Roshni, 11 December 1917, SVN, p-877.

⁵⁷ UPSA, Proceedings of the NWP and Oudh, Sanitation Department, March 1893.

⁵⁸ Ibid.

⁵⁹ UPSA, A. P. Mac Donnell, Minute, Bareilly, 1st April 1898, in Proceedings of the NWP and Oudh, Sanitation department, August 1898, p-106.

⁶⁰ UPSA, Proceedings of the NWP and Oudh, Sanitation department, August 1898, p-107.

force enforced yet the inspection rules were not relaxed. A telegram was written by Brahmans of Jawalapur, “We, Brahmans of Jawalapur beg to state that on 30th Dr Elphick and Magistrate Kendall has routed us all. One man was sick here and was kept in chappars which are assigned for sick persons, and they gave him some medicines, which we refused to give him, upon which they ordered to carry him to plague hospital and dragged him by hand and foot, set fire to chappars, insulted our women. We beg to come here and relieve us from the trouble we are suffering.”⁶¹ Further, Sanitary Commissioner in his report in 1918 mentioned that systematic rat destruction produced unsatisfactory results in this Province as disliked by the great mass of people and was passively hostile to it and those who understood its benefit “having learnt the lesson of its importance by bitter experience.”⁶² When the plague broke out in 1928, the villagers of Mohibullapur refused inoculation and evacuation but agreed to expose their furniture’s and clothes to sun and cleaning of house and burning of neem leaves in the house.⁶³ J. Chaytor White noted, “Mirzapur is one of the most striking instances where the policy of “do nothing” has succeeded. In 1902, the city was badly attacked, and 1,903 deaths occurred. No disinfection at all was done as the people would not allow it.”⁶⁴ The incident was more an exception than the prevalent affairs.

The new western technological introduction in the country was at the gun-point of the nationalists such as railways. Over time, railways became a symbol of the not only the subordination but also as carrier of diseases. In his *Hind Swaraj*, Gandhiji stressed that the railways accelerated the spread of bubonic plague. According to him, railways were the carriers of the plague germs but it had “increased the frequency of famines, because, owing to facility of means of locomotion, people sell out their grain, and it is sent to the dearest markets.”⁶⁵ To an extent this proved true when during the cholera epidemic of 1892 in Haridwar far more than cholera germs, large gatherings or

⁶¹ UPSA, Telegram from Brahmans of Jawalpur to Lieut. Governor, NWP and Oudh, Lucknow, dated 30 March 1898, in *Ibid*, p-112.

⁶² Fifty-First Annual Report of the Sanitary Commissioner of United Provinces 1918, Allahabad, 1919, p-12.

⁶³ Annual report of the Hygiene Publicity Bureau, United provinces for the year ending 31 December 1928, Allahabad, 1929, p-4.

⁶⁴ UPSA, Major. Chaytor White ‘Plague Administration in the United Provinces for the year 1903’, 14 May 1904, Naini Tal, in File No. 775B, Box No. 6, ‘Plague Policy’, Sanitation Department, 1904.

⁶⁵ M. K. Gandhi, *Indian Home Rule or Hind Swaraj*, International Printing Press, Phoneix, Natal, 1910, p-38.

conservancy, railways were held responsible for the outbreak of disease.⁶⁶When the people were dispersed after the fair was broke in the mid, people took railways and travelled 'in dirty wagons which had no ventilation and people unable to obtain potable water. It was thus perceived that the outbreak of cholera at religious gatherings were chiefly due to hardships and privations which pilgrims endured during railway travelling.'⁶⁷

Some agencies were organized by the government to disseminate the medical policies of the colonial state. These agencies were vaccinators, health officers, sanitary inspectors, police, school teachers and voluntary agencies like Sewa Samiti, Mahabir dal,⁶⁸ etc., who carried out sanitary works. Free distribution of quinine carried out through various agencies such as a district officer on tour, tahsil and police officials, schoolmasters, taluqdars, zamindars, mukhias, were employed on famine relief, non-official distributors of gratuitous relief, and such other officials whose duty required them on the tour. However, this agency was not considered far-reaching and also insufficient in numbers. Lieutenant Governor in his address at the darbar held on the 13 February 1909 referred to the subject and observed that 'the suddenness of the attack, the extreme prostration of the people, the impossibility of maintaining permanent establishments large enough to cope with such a calamity, and the fact that the agents employed to distribute quinine themselves suffer, all combine to hamper the government in its efforts to afford relief in such a case.'⁶⁹In such a situation also, Europeans when suffered from fever, were given 12 to 15 grain, often as much as 30 grains of quinine daily and five grains as a prophylactic for some days after the attack. Contrarily, Indians who were more prone to malaria were given one or two, five or seven grains of powders and above all were expected to get better sooner. Further, with view to encourage influential landholders, merchants, village headmen and others to assist in forwarding plague preventive measures and to render help in the cause of sanitation and vaccination, in 1913 taking example from the Punjab province, government authorized I.G.C.H. and Sanitary Commissioner to grant sanads and

⁶⁶ Bharat Jiwan, SVN, 5 September 1892.

⁶⁷ Ibid.

⁶⁸ Fifty- First Annual Report of the Sanitary Commissioner of United Provinces 1918, Allahabad, 1919, p-23.

⁶⁹ UPSA, File No. 136/1908, Box No. 21, Report on the Outbreak of Malarial Fever in the United Provinces, Sanitation Department.

parwanas and monetary rewards (in few cases).⁷⁰ As a general rule it was decided that the maximum number should not ordinarily exceed two or three sanads and half a dozen parwanas annually per district. A new innovation was taken up by Bengal in 1917, took measures for the organization by private enterprise of agencies for the destruction of mosquitoes, but on the basis of provincial reports received by the Sanitary Commissioner of India, he remarked that “it appears very little was done, and that the people were very apathetic in the matter. They also started ‘a mosquito brigade’ consisting of ten men under the supervision of a Hospital assistant in Puri town. Such measures were far sighted in the United Provinces, where the mortality from malaria/fever was severe. No organized efforts on a large scale were initiated in the United Provinces, but they focused more on distributing quinine and improving surface drainage.”⁷¹ Restricted measures on the part of the provincial government posed a challenge for the better health conditions of the natives.

Sanitary Commissioner of NWP, C. Plank lamented on the functioning of sanitary measures in the provinces. He criticized that the local officials of supreme authority gave little thought to sanitary conditions and “often spoke of their occasional visits to the less public quarters of a town or city as dangerous to health, a duty most safely performed under the influence of a lighted cheroot, or with the aid of an occasional pinch of powder camphor, as a defence against the prevailing unwholesome atmosphere... Plainly, indeed, the view was expressed that, if the natives chose to live amidst such insanitary surroundings, it was their concern. And how they managed to do it without greater penalty of death, than seemed apparent, was a frequent cause of expressed surprise. As a fact, however, the local authorities of those days had a little knowledge, or thought, of the true death penalty of a city or town, as of their true position as their people’s defenders against insanitary conditions. Conditions not born of any desire or fault of the people, but inseparable- until the authorities shall interfere with decision for their remedy or prevention- from the life circumstances of many families closely associated. At the present day, I have good reason to believe that much of this spirit of apathy, or unwillingness to acquiesce in long-established malpractices or insanitary evils, has given place to the ardent desire for

⁷⁰ UPSA, File No. 18/1913, Box No. 6, ‘ Grant of Sanads and Parwanas in recognition of meritorious services in connection with Plague prevention, Vaccination and Sanitation’, Public Health Department.

⁷¹ Annual Report of the Sanitary commissioner with the GOI, 1903, Calcutta, 1904, p-98.

improvement....”⁷²This was the official view which remained intact during the entire colonial tenure where local officials were blamed frequently.

In 1914, the government decided that travelling dispensaries should form as a regular supplement of the medical work for districts and each DB should contribute thousand rupees or roughly half of the cost towards the maintenance of the dispensary to be permanently attached to the district. It was done with the purpose that the nominal distinction between malaria and plague dispensaries should be abolished, that the only distinction should be between the DB dispensaries attached to districts and the provincial dispensaries which are entirely financed by provincial revenues and thus could be transferred to any part of the province according to circumstances. Ninety-three travelling dispensaries were sanctioned by the government in 1914.⁷³ Travelling dispensaries were thus made permanent on 21 February 1924 numbering 24. However, this T.D.s was insufficient to cope up with the widespread epidemics in the Province.⁷⁴

The committee of Medical experts presided by Sir Sankaran Nair in a Conference in May 1919 proposed the reorganization of the sanitary department in United Provinces.⁷⁵ The Conference considered that it is impossible to frame any useful proposals for a sanitary organization and the policy proposed by the committee. Based on the recommendations of the committee, the government of United Provinces considered the necessity of making better arrangements for the public health. Lack of officers hampered the proper functioning of the vaccination, school health services. It was thus decided to appoint DMOH and number of C.S., Deputy sanitary commissioners and other divisional or district personnel’s for better coordination and arrangements.⁷⁶ But the lack of funding on the part of central and provincial government did not make remarkable changes in the sanitary arrangements and health conditions of the Province.

⁷² Eighteenth Annual Report of the Sanitary Commissioner of NWP, 1885, Allahabad, 1886, p-60-61.

⁷³ Forty- Seventh Annual Report of the Sanitary Commissioner of United Provinces, 1914, Allahabad, 1915, p-11.

⁷⁴ Fifty-Seventh Annual Report of DPH of United Provinces 1924, Allahabad, 1925, p-26.

⁷⁵ UPSA, File No. 3/1920, Box No. 5, ‘Reorganisation of Sanitary Department in United Provinces’, Sanitation Department, 1920.

⁷⁶ Ibid.

MEDICAL EXPENDITURE

The presence of colonial authority into medical field expressed with funding provisions to carry on treatment. In 1838, the government initiated the trial of medical funding with twelve dispensaries, of which five were in Bengal and seven in NWP. It was decided that in the case of success of this attempt, it will be expanded to twenty dispensaries in later years. On the success of this trial as evident from the 1840s reports, it was extended to other provinces. Consequently, in 1851, there were 171 dispensaries in NWP with a total expenditure of Rs. 42,890. In this contribution, a large part was made by the government (40,966) and rest was fulfilled by private subscriptions.⁷⁷ As early as in 1879, there were no European subscriptions in Agra, Aligarh, Budaun, or Muttra and there were no native subscriptions in Agra or Muttra.⁷⁸ As the institutions were charitable ones, were partially supported by the government. The condition changed 1870s onwards where local subscriptions increased tremendously though not surpassed the government contribution. The expenditure on dispensaries and hospitals were incurred by the state of the amount subscribed by the public charity and of the various other funds concerned.

Table 2.2: Medical Investment and Expenditure of Colonial state in NWP

Year	Receipts (exclusive of balances)		Expenditure (exclusive of investments)	
	Government	Local	Government	Local
1876	1,66,581	1,35,043	1,66,016	1,04,118
1877	1,68,410	1,26,852	1,60,900	1,30,970

Source- Report on the Administration of NWP and Oudh 1877-78, p- 240

With changing scenarios and expansion of medical institutions, the contribution from the local bodies became the main base of medical care expenditure on the hospitals and dispensaries. The contribution from the side of government was nominal as they always focus on limited policy and insisted on providing medical care through Indian agencies comprising of medical philanthropy by private practitioners or through local taxation by elected representatives of the local bodies. Mostly, the amount granted by the government remained unspent. In Oudh region, there were hardly any subscriptions and it was thus customary for the local rates committees to supply the deficiency after allowing for the government share of expenses. Expansion of colonial

⁷⁷ John Briggs, *India and Europe Compared, being a Popular View of the Present State and Future Prospects of Our Eastern Empire*, (London: W.H.Allren & Co., 1857), p-184.

⁷⁸ Orders of Government No. 12A of 1880, p-8, in A. Christison, Report on the Dispensaries and Charitable institutions of the NWP and Oudh, 1879, Allahabad, 1880.

medical care policy contributed to an increase in public expenditure and it further devolves through provincial administration in the 1870s and later to municipal bodies 1880 onwards. By linking medical expenditure to reduction of Indian mortality from sickness and characterizing this as a welfare function of the state, 'Indian nationalist leaders sought to establish themselves as speaking for the impoverished Indian masses. The government's response of reiterating its policy of leaving provision of medical facilities to Indian agency proved unconvincing not merely to its nationalist critics but also other interlocutors calling for reform'.⁷⁹

At the provincial level, the initial financial outlay in NWP on medical relief was at a very lowest level. The monthly expenditure for each dispensary was limited to Rs. 300 within the charge of C.S. assisted by native doctors and apprentices. This lower level of state's charity though not a burden on government purse yet the increasing number of medical institutions required new technology and facilities which this amount could hardly fulfill. The expenditure on dispensaries in 1885 was Rs. 3,87,152 which increased to Rs. 29,14,441 in 1923.⁸⁰ Grants from the government were based on the condition that a sum of not less than 840 per annum, guaranteed locally. Government permitted the sufficient provision to be made in board's budget, at the cost of provincial funds, to meet the following items such as the pay of assistant surgeon, compounder, dresser, and cost of a suitable supply of European medicine and instruments.⁸¹

Table 2.3: Detailed Income and Expenditure on Medical aid by various means

Year	Income							Expenditure
	From Government	Local and other funds	Municipal Funds	Subscriptions	Interest and securities	Income excluding cash balances	Total income including cash balances	
1880	2,08,669	35,829	39,661	14,258	27,587			
1884	11,987	2,34,001	38,442	59,713	44,055	8,88,200	4,08,257	3,87,924
1885	11,022	2,46,539	39,083	55,087	32,452	3,84,185	4,03,576	3,87,152
1886	10,659	2,52,653	43,328	54,913	37,898	3,99,455	415,878	4,05,089
1887	10,786	2,69,113	39,977	57,705	42,245	4,19,829	4,30,667	4,19,840
1888	2,36,305	97,214	38,761	65,258	38,054	4,75,594	6,04,105	4,77,198
1889	2,51,906	90,666	41,493	65,378	35,478	4,84,923	6,10,528	4,81,060

Source: Report on the Administration of NWP and Oudh, 1890, p- 194.

⁷⁹ Samiksha Sehrawat, *Colonial Medical Care in North India*, p-64.

⁸⁰ Fifty-Sixth Annual Report of the DPH of United Provinces, 1923, Allahabad, 1924, p-29.

⁸¹ Report on the Administration of NWP and Oudh, 1890, p-84.

Table 2.4: Medical Expenditure under various heads in NWP and Oudh

Year	Establishment	Bazaar medicines	European medicine	Diet	Miscellaneous
1880	2,20,477	13,697	34,039	27,621	42,639
1884	2,47,131	12,864	40,718	25,732	40,791
1885	2,52,236	13,879	42,173	26,131	43,167
1886	2,61,760	14,049	37,549	27,691	50,092
1887	2,65,325	14,065	38,144	30,531	43,490
1888	2,71,719	16,088	37,655	34,781	72,751
1889	2,86,933	17,551	62,420	34,387	55,319

Source: Report on the Administration of NWP and Oudh, 1890, p-195

Generally, the government's aid was restricted to supply the services of native doctor or Hospital Assistants and a moderate quantity of European medicines. Local subscriptions provided the subordinate establishment, country medicines, the dieting of in-door patients, and all other contingent charges. Contributions from municipalities and DBs formed a significant portion of hospital income, as providing medical relief was considered the sole responsibility of local governments. The limited income and lack of funding to municipal and district boards hampered the modernization of medical institutions. Thus, the provincial and local governments had to institute the grant-in-aid schemes that could encourage the elite class to contribute to the hospitals and dispensaries of the Province. However, this means of medical philanthropy on the part of elite sections of society was unsuccessful compared to the other provinces.⁸² Depending upon medical philanthropy of public subscriptions was the weakest link in the medical policy of the colonial state in the Province. For instance, for building the medical college in the Province (KGMC), the people either elite or professional class generously contributed more than 15 lakh rupees. For medical institutions, public subscriptions mainly came from local elite connected with the colonial government either through involvement in municipal politics or trade.⁸³

Municipal institutions, however, lacked sufficient funds to undertake the medical expenditure and thus many times they took recourse to rent the buildings to a house a hospital or dispensary. The rent system was again a burden on the boards. The municipalities out of their gross income of 20 lakh expended nearly 3.5 lakh on conservancy and over 7.5 lakh on works of public utility and this over and above the

⁸² Provinces like Bombay presidency showed higher engagement with medical philanthropy. Mridula Ramanna, *Health Care in Bombay Presidency 1896-1930*, (Delhi: Primus Books, 2012), pp-77-80; Arnold, *Colonizing the Body*, pp-271-3.

⁸³ Samiksha Sehrawat, *Colonial Medical Care in North India*, p-36-37.

charges for dispensaries, vaccination, and lightning and watering the streets.⁸⁴ When in Fatehpur, the sadr dispensary showed a debit balance amounting to Rs 1,111, the Chairman exclaimed that “this unsatisfactory state of things will not be remedied until more public spirit and appreciation of the medical aid is shown both by members of the boards and by the general public.”⁸⁵ The allotments for sanitary improvements were for the most part devoted to improve the water supply in the villages. The District Board undertook one lakh within 3 years towards the cost of Haridwar drainage scheme, but the scheme postponed due to the opposition of Hindu Mahasabha and the general public, on the sewage disposal scheme.⁸⁶ No effort was made to understand the people instead schemes were declined. This devolution of expenditure was criticized both by the nationalist leaders and native newspapers. As *The Leader* as it says, ‘the United Provinces budget 1917-18 is almost featureless and that under several heads there is an over-estimate of expenditure. The existence of the present large balance shows either that more money has been taken from the people than was necessary or that less has been devoted to beneficial services, such as education, sanitation, and medical relief, than should have been spent on these.’⁸⁷ On the other hand, government too criticized the low expenditure on the part of DBs, as in 1925, DPH lamented the expenditure of over 5.5 lakh by the DBs instead of their income of over Rs. 167 lakh i.e. 3.29 per cent of their total expenditure on public health while municipalities spend 42 per cent.⁸⁸ Keeping this point, the government ordered that DBs must spend about 3 lakh on vaccination.

Hospitals fee was another and important source of income of the hospitals in colonial India. However, their income differed from one province to other. For instance, patients with a monthly income of less than Rs. 50 in Madras, 30 in Bombay, 150 in Punjab, 100 in Delhi and with an annual income of less than Rs. 2000 in the United Provinces and Central Provinces were exempted from hospital fees. The fees for hospital services were charged from well-to-do patients in the Province, ranging from Rs. 3 to 10 from Europeans. The fees comprised of the cost of medicines, dressings,

⁸⁴ Report on the Administration of NWP and Oudh, 1877-78, Allahabad, 1878, p-250.

⁸⁵ UPSPA, Letter No. 8396/XXI-67, From H. C. Ferard to Secretary to Government, United Provinces, dated 10th September 1909, Report on the Working of District Board in the United Provinces of Agra and Oudh for the year 1908-9, p-77, in File No. 88/1909, Box no. 28, LSG Department.

⁸⁶ Annual Report of the Board of Public Health, United Provinces for the year March, 1931, Appendix A, p-9A in Sixty-Fourth Annual Report of DPH for United Provinces, 1931, Allahabad, 1932.

⁸⁷ *The Leader*, 16 March 1917, Allahabad, SVN, p-162.

⁸⁸ Fifty- Eighth Annual Report of DPH for United Provinces 1925, Allahabad, 1926, p-49.

nursing, etc., provided by the hospital, but if procured from outside, was to be paid by the patients. A frequent complaint was made against the administration of Indian hospitals that a large number of patients who could afford to pay were also treated free of charge.⁸⁹ In the dispensary administration it was an accepted axiom that patients, who could afford, should bear the cost of their diet and they, on the other hand, will get attendance, lodging and medicine free of charge. In NWP, the dieting charge was entirely depended on the local subscriptions and thus government's contribution was nil in this item of expenditure. District boards were advised by the approval of the government that as far as possible outlying dispensaries should restrict their operations to afford medical aid to out-patients. Geoffrey C. Hall in his report remarked "the poor peasant is just as appreciative of personal interest taken in his case as the rich zamindar, who pays a fee when he calls in a doctor, and the poor patient is after all the backbone of the dispensary and it is through him that the attendance rises and falls."⁹⁰ In 1917, it was criticized by a leading newspaper that "since the announcement that public hospitals are meant only for the poor, medical officers attached to the hospitals and dispensaries generally, and the Agra Medical School hospital, in particular, interpret the rules so strictly that the benefit which the public derive from these institution is incommensurable with the high cost of maintaining them. It would be better if hospitals and dispensaries were closed, so that people might revert to the vaidic and unani systems of treatment. If, on the other hand, government is anxious to make allopathic treatment popular, the hospital rules should be relaxed."⁹¹ It was emphasized that a sick person must be referred to the dispensaries instead of sending them to the poorhouses. Many times homeless vagrants and poverty-stricken travellers were sent to the dispensaries because there was no refuge elsewhere. Thus, in 1877-78, dispensaries were relieved of the share of the work undertaken by poorhouses.⁹²

⁸⁹ E.W.C. Bradfield, *An Indian Medical Review* (hereafter IMR), Government of India Press, New Delhi, 1938, p-12

⁹⁰ *Triennial Report on the Dispensaries and Charitable Institutions of the NWP and Oudh, 1896-1898*, Allahabad, 1899, p-27.

⁹¹ *The Agra Akhbar*, 14 March 1917, SVN, p-163.

⁹² *Report on the Administration of NWP and Oudh, 1877-78*, Allahabad, 1878, p-238.

Table 2.5: Proportion of medical expenditure to total revenue expenditure (1943-44 budget)

Area	Proportion of medical expenditure to total revenue expenditure (1943-44 budget) In Per cent	Per Capita medical expenditure per annum of various provinces (1943-44 budget)
Madras	5.1	3 Rs. 8 p
Orissa	4.7	1 Rs. 11 p
Assam	4.2	2 Rs. 5p
Bihar	4.1	1 Rs. 2 p
North West Frontier Province	4.1	4 Rs.8p
Bombay	3.8	5 Rs. 2 p
Punjab	3.0	3 Rs.
Central Provinces and Berar	3.7	1 Rs. 8p
United Provinces	2.2	1 Rs. 6p
Bengal	2.1	1 Rs. 5p
Sind	1.8	3 Rs. 9p

Source: Five-Year Plan of Post-War Reconstruction in the Medical Department, United Provinces, A first draft prepared by the IGCH, United Provinces, Allahabad, 1944, p-2.

The government's policy of limited funding and over reliance on private and voluntary sector led to uneven development of medical care infrastructure, especially in rural areas. This occasional 'special grants' on the part of provincial government funding proved of no benefit. It becomes more inadequate when the hospitals and dispensaries of the province were suffering from the lack of basic infrastructure, even sometimes hospital buildings, which were mostly established in rented house. Thus, when the Provincial government in 1902 provided one lakh rupees for 'improving the general equipment and condition of hospitals and dispensaries of the Province',⁹³ it however proved to be a piece-meal service rather than as a regular feature of funding for such a large Province.

The reduction in medical expenditure by the Inchcape Committee, even though it was a small part of the total government expenditure, had a significant impact on the local health care facilities. Arnold argued that the cuts in expenditures by the committee 'badly hit scientific and medical funding.'⁹⁴ Expenditure on the medical head was more depended on the central government than provincial or local government. With limited resources and helplessness in front of the government, municipal and local boards accepted whatever they were presented. Further, in 1923, the medical department of provincial government in its resolution, stressed that even though the

⁹³ Annual Report of Hospitals and Charitable Institutions for the year 1904, Allahabad, 1905, p-3.

⁹⁴ David Arnold, *Science Technology and Medicine in Colonial India*, Vol. III, (Cambridge: Cambridge University Press, 2000), p-187.

growth of medical care was slow in the Province, 'the system of medical relief must be based primarily on local effort.'⁹⁵This over-reliance on the local government and lack of subscriptions severely impacted the healthcare provisions in the Province.

CONFLICT BETWEEN INDIGENOUS MEDICINE AND STATE

David Arnold has asserted that the widespread promotion of western medicine and public health projects advanced the security of the colonial state in India. It thus required the displacement or subordination of indigenous medical systems and practitioners, which represented the rival systems of ideas and authority. In this sense 'imperial hegemony stood for a deliberate confrontation with indigenous values and political power.'⁹⁶The colonial stand on the superiority of western medicine could be glanced from the statement of S. P. O'Donnell who remarked, 'There is no reason to run away from a frank declaration of our conviction that western science includes all that is of any value in the Ayurvedic and Unani systems; that it is progressive where these are stationary; and that its unpopularity and prestige are continually on the increase.'⁹⁷The stand remained intact throughout the colonial regime where western medicine received patronage, while the indigenous medicine was tried to be suppressed. However, Madhuri Sharma in her work argued that the nationalist historians underestimated the power of the indigenous system of medicine in the spheres of promotion and propagation of the medicine they practised.⁹⁸

The encounter of Unani with Ayurveda in India was overall harmonious. As A.L. Basham concludes that 'we have no record of animosity between Hindu and Muslim in the field of medicine.'⁹⁹But the relation of Unani and western medicine in modern India was somewhat strained as has been argued. Mostly, if not all, scholars highlight the troubled encounter of indigenous and western medicine and an attempt by the former to maintain its identity in the colonial era. With the same viewpoint, Qaiser

⁹⁵ Annual Report of the Civil Hospitals and Dispensaries of United provinces, 1925, Allahabad, 1926, p-2.

⁹⁶ David Arnold, Public Health and Public Power: Medicine and Hegemony in Colonial India, pp-152-72, in Dagmar Engels and Shula Marks (ed.), *Contesting Colonial Hegemony: State and Society in Africa and India*, (London: German Historical Institute, London, British Academic Press, 1994).

⁹⁷ NAI, Letter No. 500C, From S. P. O'Donnell to Secretary to Government of India, Naini Tal, dated 19th September 1916, in Pros. No. 26-51, Home Department, GOI, Medical Branch 'A', July 1919.

⁹⁸ Madhuri Sharma, *Indigenous and Western Medicine in Colonial India*, (New Delhi: Foundation Books), 2012.

⁹⁹ A.L. Basham, The Practice of Medicine in Ancient and Medieval India, p-40, in Charles Leslie, *Asian Medical Systems*, Vol. III, (Delhi: Motilal Banarsidass Publishers Private Limited, 1998).

argues the resistance of Unani identity to western despotism found expression in reconstructing the past through memory which was found among the educated class in the anti-colonial atmosphere. Quoting a verse by a hakim in 1910-

*Kuch ilaj aya na kuch Charagiri aye,
Tibb-e-Unan ke Munh Doctory aye,
Band Sheeshe Mein Vilayat se pari Ayee,
Lal-Peeli Hui, Gusse mein Bhari aye,
Chaman-e-Tibb se Guldasta Uda kar Layee,
Nayi Tarkeeb se Bandish Saja Kar Layee.*

(knows no method of treatment, but the Doctors dared to challenge Unani. In a close bottle a fairy has come full of anger from foreign lands. The bouquet stolen from the garden of Unani Tibb has been rearranged in a new fashion.)¹⁰⁰

The medical practitioners of indigenous medicine and western medicine were competitors. In this tug of war, western medicine labelled the practitioner of indigenous medicine as 'quacks'. Thus, a demand for registration of medical practitioners came from all walks of life especially from the press which always criticized the policy of the state to deliberately allowing the quacks to practice in the absence of legislation for a medical practitioner. However, indigenous medical practitioners were designated as quacks both by the State and the western medical educated Indians. Indigenous medical practitioners were thus considered as a major threat to western medicine. The newspapers supported the stance by their regular columns in editorial, thereby influencing the common masses. The editor of *Kaiser Punch* complained that quacks in Ballia are killing people by prescribing wrong medicines to them.¹⁰¹ A loud demand was raised from various sections that registration of medical practitioner should be made compulsory by the government.¹⁰² However, other sections pointed out that if these native practitioners were disqualified, then it will appear as 'a hardship to the poorer classes who could not afford the fees and medicines prescribed by the qualified doctors.'¹⁰³ Thus the

¹⁰⁰ Quoted by Neshat Quaiser, Unani Medical Culture, Memory, Representation and the Literate Critical Anticolonial Public Sphere, pp-115-135, in Poonam Bala (ed.) *Contesting Colonial Authority*, op.cit.

¹⁰¹ *Kaiser Punch*, 2 May 1894, SVN.

¹⁰² *Leader*, 14 March 1911, SVN, p-227.

¹⁰³ *Oudh Akhbar*, 13 May 1909, SVN, p-365.

editor of a newspaper considered it more a selfish demand than a public concern. Medical Registration Act thus received opposition from the vaidyas and hakims, All India Vaidya-Unani Tibb Conference, and Ayurveda Mahamandal. In midst these oppositions, the government of United Provinces appointed a committee to consider the 'United Provinces Medical Bill' in 1916. On the recommendation of the report of the committee, a clause 36 was added in the bill, which stated that 'the law in any way should not affect Ayurvedic, Homeopathic or Unani practitioners' and that association with such practitioners would not be regarded as constituting 'infamous conduct'.¹⁰⁴ Thus with these amendments 'United Provinces Medical Bill' was passed on 2 April 1917. The amendment was, however, could not remain untouched from the opposition as it was considered that the bill would penalise the association of registered practitioners with a qualified but unregistered practitioner also. The general criticism of the bill came from the press which considered the bill as, "a retrograde move; it will entail hardship on medical practitioners and on people in general and probably a considerable number of practitioners will not think it worthwhile to apply for registration if this amendment is passed."¹⁰⁵

A 'Board of Indian Medicine' (BIM) was constituted under the ministership of Rajashwar Bali Rai for United Provinces in 1926. It was established to advise the Government on all matters concerned with the organisation and development of the Ayurvedic and Unani system of medicine, prescribed the courses of study for examinations conducted by it, grants certificates, degrees and diplomas to successful students in examinations, maintaining a list of registered vaidas and hakims and distributing the funds of Rs. 50,000 placed at its disposal by the government to such Ayurvedic and Unani dispensaries, established in both urban and rural areas, to make free distribution of medicines among the indigent patients and; establish educational institutions affiliated to it where the indigenous systems of medicine could be taught.

A regulation was also made by the B.I.M., according to which the students passed from the Tibbiya College (Aligarh), Unani Medical Schools (Lucknow and Allahabad), Rishikul Ayurvedic College, Haridwar, were to be given five years practical and theoretical course and those passed from the Ayurvedic and Unani Schools, a four years course was authorized which included instruction in western

¹⁰⁴ NAI, GOI, Pros. No. 33-34, Home, Medical 'B' branch, October 1917.

¹⁰⁵ The Leader, 14-15 March 1917, SVN, p-164.

allopathic methods by the professors. Thus, in 1933 there aroused a demand that these students should also be provided with high sounding degrees, such as Licentiate in Indian medicine. However, the state authorities were uncomfortable in providing the 'Licentiate' which they consider would cause a confusion in public mind. As it was pointed out that "...nothing could stop such Licentiate from using such letters as L.A.M. or L.U.M. after their names, thereby, increasing the confusion already caused by the innumerable bogus letters used by all sorts of practitioners and quacks."¹⁰⁶ Interestingly, the B.I.M. proposal was accepted by the Madras province. The same could not be applied in United Province because it had the both systems of medicine i.e. Ayurvedic and Unani, thus the degrees awarded were under the 'Certificate in Ayurvedic Medicine' or 'Diploma in Ayurvedic Medicine'.

Condemning the western rule, the nationalist agitation based on the swadeshi and swaraj brought the indigenous medicine into the mainstream Indian politics. Thus, Congress passed its first resolution in favour of indigenous medicine in December 1918, in its 33rd session. The following were the resolutions passed for the promotion of indigenous system of medicine-¹⁰⁷

- a. "That recognising the comparatively dominant prevalence of the Ayurvedic and Unani medical systems came prominently in India and their undeniable claims to usefulness, this Congress strongly recommends to the GOI, the eminent desirability of taking definite steps to secure to them the advantages vouchsafed to the western system under the present administrative policy of the Government.
- b. That the consideration of the opinion of local governments with respect to placing the indigenous systems of medicine on a scientific basis as revealed in the summary laid before the Imperial Legislative Council at Shimla in 1918, should be postponed pending a thorough inquiry by a mixed committee of representative vaid, hakims, their sympathiser's and experts such other medical practitioners as may be nominated by the government"

The above recommendations showed the approach of Congress Ministry which came to power in 1937 elections and worked for the revitalization of indigenous medicine

¹⁰⁶ UPSA, File No. 131/193, Box No. 59, 'Board of Indian Medicine', Medical Department.

¹⁰⁷ Memorandum of the Ayurvedic and Unani Tibbi Conference, in NAI, Pros. No. 26-51, Home, Medical A, July 1919.

in the Province by various means. The first step was taken in the form of 'United Provinces Indian Medicine Bill, 1938' (passed in 1939 as U.P. Act No. X of 1939) to boost the development of Indian systems of medicine and to regulate their practices in the Province and reconstitution of Board of Medicine.¹⁰⁸ The bill was however an unfortunate incident which clearly showed that even the leaders and elite class favored the western medicine over Indian medicine and considered it far superior than the latter.¹⁰⁹ The understanding of the superiority of western medicine among Indian leaders became clearly evident when the National Planning Committee of INC (1938) and modernized group of Indian leaders- Nehru and M. A. Ansari, all extended their faith in western medicine.¹¹⁰ But this approach was not widespread as few ministers in Punjab and Bombay with their limited funds attempted to spend small sums for research to indigenous system of medicine too. This lack of faith was more a part of the dominant colonial discourse, as Arnold points out that by late nineteenth century, western medical ideas 'crossed a cultural threshold and became an active ingredient in indigenous rhetoric and social practice.'¹¹¹

It was not that the new Congress Ministry or modern Indian leaders totally disassociated themselves from the revitalization of indigenous system of medicine. As the neglect of former would not only become a threat to the ideas of nationalist movement but also a question on the superiority of cultural background of Indian systems of medicine. Socially and economically, indigenous system of medicine was considered more preferable by the Ministry, as it was more affordable and accessible especially to the rural people. Thus, in 1938, under Rural development scheme (discussed in Rural Healthcare section of the chapter), 126 Ayurvedic and 46 Unani dawakhans were decided to be established in the province. On 12 December 1938, names of all Ayurvedic and Unani educational institutions, the diploma-holders of which were entitled to get registered by the Board immediately after taking their Diplomas from the Ayurvedic College BHU, Benares; Rishikul Ayurvedic College,

¹⁰⁸ V. Mishra, *Uttar Pradesh Medical Manual*, (Allahabad: Hind Publishing House), 2015, p-615-634.

¹⁰⁹ On the basis of Legislative Assembly proceedings Shamshad Khan had discussed in detail how the people in the assembly were more inclined towards the allopathic medicine and considered it as superior. As Atma Ram Govind Kher, Parliamentary Secretary to the minister of LSG and Health, Vijay Laxmi Pandit stated that the practitioners of Indian systems of medicine lacked the fundamental background and sufficient fundamental education. See- Shamshad Khan, *Colonial Medicine and Elite Nationalist Response in India: Conformity and Responses*, p-72-73; in Poonam Bala (ed.), ed.) *Contesting Colonial Authority*, op.cit.

¹¹⁰ Roger Jeffery, *Politics of Health in India*, (London: University of California Press, 1988), p-54.

¹¹¹ David Arnold, *Colonizing the Body*, p-241.

Haridwar; Tibbiya College AMU; State Aided Unani Medical School; Unani Medical School, Allahabad. The graduates from Benares and Aligarh, Ayurvedic College at Gurukul, Kangri; Ayurvedic and Unani Tibbi College Delhi, could apply for the post of Vaid and Hakims at rural dispensaries (whether they were registered or not). It was also decided that diploma-holders of the institutions at Haridwar, Lucknow or Allahabad, if registered, should be given preference.”¹¹²This was a measure to fulfill the demand of qualified medical practitioners in the Province especially in rural areas.

The ‘United Provinces Unemployed Committee’ in 1938, recommended that an investigation should be made into the efficacy of the indigenous drugs according to the modern methods and after the recognition of such medicines by the medical profession and their standardization industries, for the manufacture of such and other drugs should be started and, if necessary subsidized at the initial stages. The Government of United Provinces recommended that action on this recommendation should be taken on an all India or inter-provincial basis rather than on an exclusively provincial basis.¹¹³The demand however was declined by the GOI on account of financial constraints and as such several research schemes concerning efficacy of indigenous drugs and their standardization was already financed by Indian Council of Agricultural Research and IRFA.¹¹⁴

Apart from government and native rulers, local organizations extended their support towards popularization of Indian system of medicine. Among all the most popular was Kashi Nagar Pracharini Sabha, which was founded by Sri Gopal Prasad Khatri in 1893¹¹⁵ along with students of Queen’s College. Though the institution aimed to promote Hindi literature and language, but later it associated itself with popularization of Ayurveda. The ‘Hindustan Academy’ on the other hand, patronized both Ayurveda and Unani, to bridge the gulf of growing communal tensions.¹¹⁶ ‘Health Improving Association’ appeared with an objective of training the youth to achieve better health

¹¹² UPSA, File No. 337/38, Box No. 200, Scheme for Medical Relief in Rural areas, Medical Department, 1938.

¹¹³ NAI, GOI, File No. 54-2/38-H, Department of EHL, Health branch, 1938.

¹¹⁴ NAI, GOI, Letter No, F.54-2/38-H, From S. Dutt Under Secretary to the GOI to the Secretary to the Government of United Provinces, Medical department, dated 5 November 1938, Department of EHL, Health branch, 1938.

¹¹⁵ Christopher R. King, *Forging a New Linguistic Identity: The Hindi Movement in Banaras, 1868-1914*, p-183, in Sandria B. Freitag, *Culture and power in Banaras: Community, Performance, and Environment, 1800-1980*, (Berkeley: University of California Press), 1992.

¹¹⁶ Madhuri Sharma, *Indigenous and Western Medicine in Colonial India*, p-32.

so as to serve the country.¹¹⁷The practitioners of Ayurveda and Unani were never static or aloof and also were never strictly confined to the religion. Even people never hesitated to consult a vaid or a hakim, thus making the systems of medicine more accessible to the general population. However, the era after 1920s brought religious tensions in the politics which unfortunately, politicized the Indian medical systems,¹¹⁸ confining them to a particular religion. The revitalization of Ayurveda and Unani systems of medicine gave a boost to nationalism among its practitioners and its supporters. However, the movement failed to disassociate itself from class, caste, religious polarizations.¹¹⁹The pro-western medical approach of Congress Ministry continued even after independence also, where the western medicine gained the upper hand.

VACCINATION POLICY OF THE BRITISH

Smallpox was the most dreadful disease both in India and in the world. With the acquisition of India by colonialists arose the demand of measures to combat the disease among Europeans through the Jennerian vaccination. Consequently, vaccines were imported in India from Britain and the first vaccine reached India on June 1802 through the children vaccinated from arm to arm from Baghdad to Bombay.¹²⁰ Consequently, vaccination policy was 'partly an in-depth defence of European health.'¹²¹ In earlier days, Indians indirectly became part of the new technology of western medicine, i.e. those who were in any way in contact with the Europeans such as servants, children, soldiers, labours, etc. Historically the introduction of vaccination was at the crucial moment of history of British India and the Company. By 1800 EIC had acquired most of the regions in India through wars, acquisition or subsidiary alliances. It was through vaccination drive that Company used to legitimized their regime as 'humane and benoalent' and an 'additional mark

¹¹⁷ Ibid, p-33.

¹¹⁸ Neshat Qaiser, Unani Medical Culture, Memory, Representation and the Literate Critical Anti-colonial Public Sphere, pp-115-135, in Poonam Bala (ed.), *Contesting Colonial Authority*, op.cit.; Charles Leslie 'Ambiguities of Medical Revivalism', in Charles Leslie (ed.), *Asian Medical System*, op.cit.; K. N. Pannikar, Indigenous Medicine and Cultural Hegemony, pp-145-175, in Culture, Ideology, Hegemony, Intellectuals and Social Consciousness in Colonial India, (London: Anthem Press, 2001).

¹¹⁹ Shamshad Khan, Colonial Medicine and Elite Nationalist Response in India: Conformity and Responses, p-70-71 in Poonam Bala (ed.), *Contesting Colonial Authority*, op.cit.

¹²⁰ S. P. James, *Smallpox and Vaccination in British India*, 1909, p-17

¹²¹ David Arnold, *Colonizing the Body*, p-135.

of the fostering care of the British government in India.¹²² With the introduction of local self-government by Lord Ripon, municipalities and local boards worked along with administrative officials to expand vaccination services. Several municipal committees passed bye-laws, by which the practice of inoculation was made public nuisance within municipal limits in NWP.¹²³ The vaccination system was first sanctioned in NWP by Lieut. Governor Mr. Edmonstone, accordingly one vaccinator was appointed for each tahsil and a Native Superintendent for every two districts.¹²⁴

In 1878, the Sanitary Commissioner of NWP remarked that the limited impact of vaccination policy was due to apathy of people and their religious beliefs.¹²⁵ The strongest opposition to vaccination came from Benares division especially from Brahmins and Kshatriyas. Official correspondence sheds light on the fact that there was clear apathy of upper class towards the vaccination during the whole colonial rule. An attempt was thus made to induce Brahmin inoculators as vaccinators but was failed. The Secretary to Government announced Rs. 500 to enlist the services of native practitioners in practicing vaccination.¹²⁶ Benares also had a number of hereditary inoculators who were also targeted to bring into the sphere of western medicine. Further, almost all the official correspondences highlights the prejudices and apathy of people towards vaccination.

For spreading vaccination the princely houses and elites were convenient targets for provocation and spread of the vaccination policy by the colonial state. After Mutiny of 1857, the colonial government acknowledged the local rulers who held command over the indigenous population. Taluqdars, Landlords and District Officers were thus influenced upon to enhance popularity of vaccination among the natives.¹²⁷ As people are in a habit of imitating their masters, thus they were easy prey, i.e. if the king was persuaded the entire mass will accept the change, was thought Britisher's had in their mind. As Pringle asserts "...the illiterate portions of the population hold back for a

¹²² Ibid, p-136.

¹²³ G.O. No. 505A of 1878, From the Secretary to Government NWP to Superintendent General of Vaccination, NWP, dated 24 June 1878, p-3, in F. Pearson, Returns of Vaccination for NWP and Oudh, 1877-78, Allahabad, 1878.

¹²⁴ Annual Report upon Vaccination in the NWP for 1866-67, Allahabad, 1867, p-4.

¹²⁵ Annual Report of the Sanitary Commissioner of NWP and Oudh 1878, p-30.

¹²⁶ UPSA, Letter No. 1850 A, From Secretary to Government, NWP, to Superintendent General, Vaccination, dated Nainital, 5th June 1867, in Annual Report upon Vaccination in the NWP for 1866-67, Allahabad, 1867, p-7.

¹²⁷ Report on the Administration of NWP and Oudh, 1890, Allahabad, 1891, p-xix.

lead, either from one who has the credit of some knowledge, and is generally of good caste, like school master or personal or hereditary influence like a Rajah or the headman of the village or villages. When the putwaree's or lumberdar's child is vaccinated, the rest of the village soon follows..."¹²⁸ For instance, in Allahabad and Jhansi circle, the increase in the successful cases of vaccination in 1866-67, was credited to the Maharaja of Mandah (in Allahabad), Raja of Teekumgarh was appreciated for his support to vaccination in Bundelkhand division, Raja Sahib Singh of Landoura, etc. Few Nawabs and taluqdars of Oudh too sought the western vaccination methods and promoted the vaccination in their estates.¹²⁹ If the medical policy of colonial state had to be successful and face minimal resistance, especially post-mutiny events, it required the support and acceptance of higher or elite class of Indian society. Vaccination was thus a part of infiltration policy of colonial state where involvement of natives was preferred over government's involvement. By the end of 1890s, several wealthy zamindars willingly approached for vaccination, which they considered of no expense and thereby ensuring safety of children from smallpox, with an underlying motive of getting themselves registered in the list of faithful citizen under colonial government. Not only did the elites but few natives also promoted the vaccination. As a judge in Benares, Rae Bakhtawar Singh Bahadur, as reported by Dr. Watson, 'had done more for Vaccination department than any other native official of his rank in North-Western Provinces'¹³⁰ and Pandit Bishan Datt, a Kumaun Brahmin, wrote a treatise on vaccination which was 'well-received by all classes' and promoted the technique especially targeting upper classes of Indian society.¹³¹

In its resolution of Sanitation department, W.H.L. Impey lamented that 'the duties which imposed on CS's as superintendents of vaccination in municipalities and cantonments have not been efficiently performed: sufficient interest has not been taken in the work, which has been left to the officials of the vaccination department to

¹²⁸ Annual Report of the Vaccine operations in the Agra and Meerut Division during the season 1871-72, by Surgeon R. Pringle, Superintendent of Vaccine, Agra and Meerut Division, dated Camp Dehra, 6th April 1872, p-12.

¹²⁹ Thakur Bharat Singh permitted his heir to get vaccinated, Nawab Ahmed Khan Talukdar of Mullihabad requested for posting of 2 vaccinators; Hydar Ali Lamberdar not only asked for services but also firstly vaccinated his own children. See- Report on Vaccination for the Province of Oudh 1871-72, Lucknow, 1872, p-2.

¹³⁰ F. Pearson, Returns of Vaccination for NWP and Oudh, 1877-78, Allahabad, 1878, p-4.

¹³¹ Ibid, p-5.

perform without the local control that has been expressly presided by the Government.¹³² The report on the vaccination for 1892-93 showed that at some instances the Deputy Superintendents and Native Superintendents of the Vaccination department didn't cooperated with the district officials, who have been frequently directed to exercise all proper influence in the extension of vaccination, without whose assistance vaccination failed to succeed especially in backward tracts.¹³³ After consultation with the IGCH and Sanitary Commissioner, the Lieut. Governor and Chief Commissioner decided to appoint officers in civil medical charge of districts to be ex-officio Superintendents of Vaccination within their respective districts in subordination to the Superintendent-General of vaccination. Impey believed that decentralization may lead to satisfactory result in the vaccination department. Even Public Health Commissioner accepted in 1938 that 'serious deficiencies existed in vaccination campaign'¹³⁴ due to defective registration, absence of compulsion for local authorities to enforce vaccination, lack of legal provision for periodical revaccination, and inadequate staff.

As mentioned earlier, the first vaccine reached India on June 1802 through the children vaccinated from arm to arm from Baghdad to Bombay.¹³⁵ But by the time lymph reached here, it was unfit for the further use. Thus, these shortages of vaccines impacted both the vaccination policy and vaccine development in the country. In United Provinces, as James mentioned that vaccination with animal lymph made progress only in nine towns in 1891-92 and vaccination was carried out almost entirely from arm to arm.¹³⁶ The lymph was extracted from infants who were one year of age and were also healthy one. Later in the 19th century, humanised lymph was produced by the vaccinators and was transferred to the vaccine depots. But in the process, vaccine was often lost in the process of human transmission and many a times, parents refused to allow their children, to be used to supply vaccination lymph for others. On the other hand, European mothers were hesitant in using the lymph of native children. Consequently, in Kumaun hills, technological advancements were made when vaccine crusts and lymph were collected for use in neighbouring plains

¹³² UPSA, Resolution No. 412/V-267-B-12 of 1893, Sanitation Department, dated Naini Tal, 23rd September 1893, in File No. 267B, Box No. 2, 'Reorganisation of Vaccination Department, NWP', Sanitation Department, 1894.

¹³³ Ibid.

¹³⁴ Annual Report of the Public Health Commissioner with the GOI, 1938, New Delhi, 1940, p-36.

¹³⁵ S. P. James, *Smallpox and Vaccination in British India*, 1909, p-17

¹³⁶ Ibid, p-39.

and the higher parts of Garhwal had availability of superior vaccine crusts in comparison to those imported from England.¹³⁷ By 1900 in about 39 districts (partially in two districts) of United Provinces, the technique of arm-to-arm vaccination was replaced by the calf lymph.¹³⁸ However, the technique of transferring lymph from animal to human patient did not immediately replace vaccination by the arm-to-arm method in the Province. On the contrary, the new technology of animal vaccination was opposed by the officials of the state. The prominent reason for opposition was the financial stringency and the backwardness of vaccinators who needed training in the technique's implementation. Furthermore, the compulsory vaccination increased the demand for the establishment of suitable depots for the supply of lymph was raised in the Province¹³⁹ and thus it was decided to establish the depots for the production of animal lymph, i.e. one permanent center at Mussorie and a temporary depot at Dehra Dun, Lucknow, and Allahabad¹⁴⁰; in addition the Province also had a small bovine depot at Agra. Instead of implementing this decision, it was urged that "the larger municipalities prepare their own arrangements regarding the supply of animal lymph following the example set at present by the municipalities of Lucknow and Agra where animal lymph used in the vaccine season. It must be remembered that until the vaccination be made compulsory in India, the lymph material will have to be distributed as a special present to each individual child in its own home; and the Europe practice of having vaccination centers to which the children are brought cannot as yet be introduced in this country, and the possibility of systematically using store tubes which suffice for the vaccination of a large number of infants at one and the same time and place is for the present precluded."¹⁴¹ The opposition of human lymph raised the demand of replacing it with bovine lymph, but the government doubted 'the effectiveness of lymph as the calves were under-fed and success of the process of examination of the calves.'¹⁴² The demand of such establishments was declined by the NWP government and IGCH on the basis of above arguments, opposition of people, and on the grounds of people's faith. It was

¹³⁷ W. Watson, Returns of Vaccination for the season, 1869-70, Allahabad, 1870, pp-1-2.

¹³⁸ Triennial Report on Vaccination in the United Provinces of Agra and Oudh for the years 1911-12, 1912-13, and 1913-14, Allahabad, 1914, p- 7.

¹³⁹ UPSA, Letter No. 3/201, From A. P. MacDonnell to Secretary to Government, dated 29 June 1889, Shimla, in File No.65B, Box No. 1, 'Use of Animal Lymph for Vaccination, Sanitation Department.

¹⁴⁰ UPSA, Letter No. 514C, From- G. Hutcheson to I.G.C.H., dated 21 August 1889, Meerut, in Ibid.

¹⁴¹ Ibid.

¹⁴² UPSA, Letter No. 131, From- Secretary to Government, NWP and Oudh to Secretary to Government, Home Department, dated 18 June 1890, Naini Tal, in Ibid.

thus encouraged to obtain the stored lymph from the depots of other provinces.¹⁴³ By 1900, United Provinces resorted to both humanized and bovine lymph.

In England, lancet was used to make six punctures, three on each arm to get adequate supply of lymph to vaccinate other children. In India, however, Dr. Pearson adopted a new instrument for extracting lymph from the children named vaccine needle.¹⁴⁴ This was done due to the fear of parents (Hindu) who could not tolerate the loss of blood from their children. The basic limitation of the use of the technique was that it does not quantify the total requirement of lymph especially in plains. Another experimentation was made when capillary tubes were used to store lymph by Dr. Husband for supply in plains where there was lack of vaccine depots.¹⁴⁵ The technique was introduced in NWP long before it was known in England. Table 2.1 clears that the mortality from smallpox remained exceptionally high after fever and plague in the Province, as for 30 million people only one lakh rupees was devoted by the governments, i.e. for 3000 persons one rupee was allocated by the NWP government to check the advance of deaths by ten thousands.

The limitation to the development of vaccination policy in the Province were the few vaccine depots, untrained vaccinators and the lack of will of state to promote and establish animal lymph establishments in the province. Pandit Bishan Dat complained that the failures of vaccination policy lied in the professional supervision.¹⁴⁶ Shortages of vaccines impacted both the vaccination policy and vaccine development in the country. W. Rice and later Sanitary Commissioner of NWP considered it 'unwise' to advocate the indiscriminate use of animal lymph. He asserted "The knowledge of a healthy infant and of its percentage far exceeds any veterinary safeguard that the calves, kids or any other animals used for vaccination are from constitutional disease. Whereas it is more than probable that much of the constitutional disease which afflicts humanity is derived from animals."³⁰ Consequently, the central government advised the government of NWP to procure animal lymph from depots of other provinces. By 1900, in about 39 districts (partially in two districts) of United Provinces, arm-to-arm

¹⁴³ UPSA, Letter No. 300, From C. J. Lyall to the Secretary to Government, NWP and Oudh, dated 15 October 1890, Shimla, in Proceedings of the Government of the NWP and Oudh in the Sanitation Department for the month of November 1890, p-1.

¹⁴⁴ W. Watson, Returns of Vaccination for the season, 1869-70, Allahabad, 1870, pp-2-3.

¹⁴⁵ Ibid, p-3.

¹⁴⁶ UPSA, File No. 267B, Box No. 2, 'Reorganisation of Vaccination Department, NWP', Sanitation Department, 1894.

vaccination was replaced by the calf lymph.³¹ Thus children became both carrier and supplier of vaccine

The provincial bovine lymph depot was established at Patwa Dangar (Nanital) in 1904-05 for the supply of pure fortified calf lymph. After the vaccine depots gained significance, extracting animal lymph was a challenge as acquiring calves faced with religious prejudices, lanoline lymph was discouraged as it was expensive and less pure and thus it was suggested to use goat based vaccines. Patwa Dangar and Lucknow were successful in fulfilling the requirements of the Province as well fulfilling the needs of neighborhood areas. By 1907, glycerin lymph was also produced in the province. These new experiments targeted infants and children as it produced pustules, but this also had painful experiences which increased suspicion among parents. As a result, Vaccination report gives us an account of unsuccessful vaccination which is easily discernable. Sanitary Commissioner of Central Provinces accepted the fact that the work done is insufficient, imperfect and carried out very unsystematically.¹⁴⁷ In his report for the year 1892-93, the Superintendent-General of Vaccination complained that the animal lymph depots at some places were inefficiently supervised and controlled, to such an extent apparently as to force upon his consideration the advisability of the abolition of some minor depots. He remarked that 'the remedy lied in the enforcement of proper supervision: animal lymph depots must be maintained in an efficient condition by Civil Surgeons wherever the prejudice against arm to arm vaccination renders such as a course necessary, and His Honour expects the heads of the Medical and Sanitation Departments to take steps to secure this result. Compulsory vaccination of children exists at present only in name: it is intended by the Government that it should become a reality now that the vaccination act has been universally applied throughout the Provinces.'¹⁴⁸

EMERGENCE OF WESTERN MEDICAL INSTITUTIONS

The preservation of Europeans health was the utmost priority of the colonial medicine and the emergence of Indian Medical Service (IMS) in the mid eighteenth century gave a breakthrough to provide the medical assistance to the armies of EIC. After

¹⁴⁷ UPSA, Letter No. 3103-147, From S. C. Townsend to Sanitary Commissioner, Central Provinces to the Chief Commissioner, Central Commissioner, dated 25th August 1874, in File No. 267B, Box No. 2, 'Reorganisation of Vaccination Department', NWP, Sanitation Department, 1894.

¹⁴⁸ UPSA, Resolution No. 412/V-267-B-12 of 1893, Sanitation Department, dated Naini Tal, 23rd September 1893, in Ibid.

mutiny, IMS was entrusted with the responsibility of the health of British Indian army. The doctors in IMS performed wide range of duties, for instance, they ran hospitals and asylums; supervised dispensaries; directed sanitary services; staffed medical school and research institutes and advised government in matters of health and sanitation. It was to their activities and state's requirements that during the second half of the nineteenth century, medical institutions promoting western medicine proliferated in the country. The premier hospitals were for the European soldiers and dispensaries served the poor people while police hospitals served during drought and famines. This paved the way for emergence of medical institutions promoting bio-medicine in the country.

The earliest requirements of Indian assistants arose with the expansion of empire by the colonial state. Foremost among them was the need of doctors who could work at the lower rate of pay and assist the British doctors in various regiments, settlements and factories. This provoked the rise of medical schools and colleges which could produce doctors in India with less expenditure. These assistants were addressed as 'native dressers' in Madras, 'country doctors' or 'black doctors' in Bengal and 'black assistants' or 'apothecaries' in Bombay.¹⁴⁹ However, after the getting recognized by the government in 1767, they were popularized as 'native doctors'. When their utility was proved during the wars of the EIC, they were assimilated into the medical organizations by the constitution of 'Subordinate Military Medical Department' thus giving them status of 'third class servants'.¹⁵⁰ The proposal of medical teaching institution was made towards the government during the year 1822, which took shape with the establishment of Native medical institution at Calcutta.¹⁵¹ Unlike Calcutta, Bombay and Madras, the history of medical institution and college in NWP and Agra, goes back to the foundation of a medical school. The institution popularly known as Agra Medical School was opened without the sanction of the government on 1 April 1855 from the savings in the allotment made for the Thomason hospital.¹⁵² Earlier, the

¹⁴⁹ W. J. Buchanon, "The Introduction and Spread of Western Medical Science in India", *Calcutta Review*, Vol. 1, No. 278, 1914, p-436, cited in Anil Kumar, *Medicine and Raj 1835-1911*, (New Delhi: Sage Publications, 1998); p-18.

¹⁵⁰ Anil Kumar, *Medicine and Raj 1835-1911*, p-18.

¹⁵¹ W. J. Buchanon, "The Introduction and Spread of Western Medical Science in India", *Calcutta Review*, Vol. 1, No. 278, 1914, p-436, cited in Anil Kumar, *Medicine and Raj 1835-1911*, (New Delhi: Sage Publications, 1998); p-18.

¹⁵² UPSA, File No. 788B, Box No. 4, 'Establishment of a Medical College for the United Provinces', Medical Department.

school was attached to the Thomason hospital, Agra and it served the purpose of instructing the apprentices of government dispensaries in the vaccination work. The first principal of the institution Dr John Murray (C.S.) proposed a scheme for the education of native doctors. The scheme suggested a three year training course with the study of anatomy, chemistry, botany, medicine, material-medica, surgery and midwifery. The scheme received sanction of the government. Thus in 1855, 35 students got enrolled in the School and they also received a maintenance allowance of six rupees per month. The first batch of 12 native doctors passed out of the school in 1857. In 1865, it was decided that only those students who had served a year at a military hospital or a civil dispensary would be admitted to the School.¹⁵³ It was in 1878, that a separate civil hospital assistant class (from the military class), was instituted for the first time.¹⁵⁴

The Medical School at Agra thus became the first institution in the Province which laid the foundation of the western medical education. With the passage of time and continuous establishment of universities in the presidencies, a demand for the establishment of a college/ university for medical education were raised in NWP also. The first voice found in the letter of Secretary of State in the year 1860 as he wrote, "The true remedy is the constitution of a medical college in the North-Western Provinces, and though the design has been delayed by recent events, it has long been in contemplation to raise the medical school at Agra to the level of an institution."¹⁵⁵ On this local government also proposed to raise the Agra school, with no sanguine expectations, to the status of a college, or improve it as a school. The former proposal was rejected by the GOI on the advice of the head of the Medical department that "no vital change be made in the constitution of the existing school at Agra."¹⁵⁶

The question of raising the school to the status of a college came up again in 1868, when the Lieut. Governor of the NWP presented a proposal to the government for establishing a medical college in the Province either at Agra or Allahabad, pointing out the advantages of Agra for having the services of Thomason Hospital and those of

¹⁵³ IMR, p-111.

¹⁵⁴ NAI, GOI, Pros .No. 23-53 (A), Home, Medical branch, July 1880.

¹⁵⁵ UPSA, File No. 788B, Box No. 4, 'Establishment of a Medical College for the United Provinces', Medical Department.

¹⁵⁶ Ibid.

Allahabad in having the privilege of well maintained Colvin Hospital. It was pointed out that people from this Province disliked going to Calcutta to study, both due to uncongenial climate and the strange language and habits and that at the end of their service, Bengalis retired to Bengal, and so prevented the growth of class of retired private practitioners in this Province and were ever anxious to return to Bengal at earliest and even some threw up the service to get away from there. S. H. Butler thus requested for the urgent need, as the most prosperous regions of India was practically cut off from any advance education in medicine and surgery as a profession, and lack of home practice. He further accepted that no other quarter of India is so far behind in this respect as the NWP and Oudh.¹⁵⁷ The colonial government however considered it premature because the NWP lacked a market for medical graduates and considered that the students were not fit for such education due to their unfamiliarity with English language. The government lamented the dismal social conditions and argued hypothetically that if it were to turn adrift 20 Sub Assistant Surgeons to make their livelihood as general practitioners in the NWP, 15 of them would probably starve to death.¹⁵⁸ Finally it thwarted the proposal by maintaining that the annual supply, which the colleges at Calcutta and Lahore could turn out, would suffice to give the required number of MOs to the relatively less developed NWP.¹⁵⁹ In 1886, the question was raised in connection with technical education. A note on the technical education was prepared by the Home department and forwarded to the local governments. Accordingly, the Medical school at Agra was not ranked as a college. It considered the institution as a school of third rate rank, both as regards to the teaching power and the character of the Diplomas conferred.¹⁶⁰

The establishment of medical college in the Province aroused when Raja of Vizianagaram proposed to donate Rs. 2,00,000 for the establishment of such institution at Allahabad. But the proposal was turned down and the government insisted on the total funding of the outlay and maintenance of the institution by the natives, either through subscription or through provincial revenues. The GOI thus scuttled the proposal mainly due to financial involvement.¹⁶¹ The *Advocate* truly

¹⁵⁷ UPSA, S.H. Butler, 'A Medical College for the United Provinces', See- Ibid.

¹⁵⁸ NAI, GOI, Pros. Nos. 25-29, Home, Public branch, 21 May 1870.

¹⁵⁹ NAI, GOI, Pros. No. 17 (A), Home, Public branch, 17 December 1870.

¹⁶⁰ UPSA, File No. 788B, Box No. 4, 'Establishment of a Medical College for the United Provinces', Medical Department.

¹⁶¹ NAI, GOI, Pros. No. 17 (A), Home, Public branch, 17 December 1870.

remarked ‘the policy of liberal help on one condition viz that the people should help themselves.’ Again in 1905, the Lieut.-Governor of United Provinces, encouraged by the publication of the University Commission’s recommendation for a medical college in United Provinces and enthusiastic support given by the taluqdars of Oudh, professional middle classes, revived the proposal of 1870 and petitioned for a medical college at Lucknow, as a memorial to the visit of the Prince of Wales.¹⁶² The proposal was again turned down on the above mentioned argument.

However, in 1905 the demand and subscriptions were so loud that even government could not turn it down. But one thing was made clear that the finances of the scheme would be bore by the people. Thus, the second proposal of medical college at Lucknow forwarded by Raja Tassaduq Rassul Khan of Jehangirabad was fulfilled when it was decided to lay the foundation stone of the school on the visit of Prince of Wales in 1906. A huge amount of subscriptions, more than 15 lakh arranged by the people from all walks of life. As, *Pioneer* described the whole course of event as a spontaneous movement and an outcome of the people’s wishes and also ‘a movement in which all classes, high, low, rich, poor, official, and non-official took part.’¹⁶³ The Medical College at Lucknow was thus named after the Prince of Wales as King George Medical College was initially affiliated to Allahabad University, later transferred to Lucknow University. The College was completed in 1911 and during the same year, the first session of the college was initiated. By 1929, there were 248 students enrolled against 246 in 1928. In addition to these, there were 29 students in the DPH classes.¹⁶⁴ The medical schools and colleges had M.B.B.S, Post-Graduate, L.P.H, D.P.H courses. A course of ‘Diploma in Public Health and Licence’ in Public Health classes was started on 4th September 1920 with six students, with the view to accommodate the lack of health officers.¹⁶⁵ At Lucknow, an undergraduate course on Hygiene and Vaccination was started in 1922.¹⁶⁶ Municipal centers also started a course on the theory and practice of vaccination at Lucknow. A scheme for the PSMS officers post-graduate studies sanctioned by the government in 1934, but for an

¹⁶² NAI, GOI , Pros. No. 24-28, Home, Medical branch, December 1905.

¹⁶³ *Pioneer*, ‘The Medical College Fund’, 28 December, 1905.

¹⁶⁴ Sixty-First Annual Report of the DPH of United Provinces, 1928, Allahabad, 1929, p-37.

¹⁶⁵ Fifty-Third Annual Report of the Sanitary Commissioner of United Provinces 1920, Allahabad, 1921, p-29.

¹⁶⁶ Fifty-Sixth Annual Report of the DPH of United Provinces 1923, Allahabad, 1924, p-20.

advanced course of studies at the Agra Medical School was postponed due to financial constraints.¹⁶⁷

Table 2.6: Students studying in the Provincial Medical Colleges and Schools of Medicine in United Provinces

Medical College/School	University course	Assistant Surgeon or Medical Practitioner	Sub-Assistant Surgeons	Midwifery/ Nursing or Compounding
Allahabad	-	-	-	11
Agra	-	-	55	11
Lucknow	4	1	-	11
Benares	-	-	-	2
Total	4	1	55	35

Source: Thirtieth Annual Report of the NASFMAWI for the year 1914, Delhi, 1915, p-43.

The Province with such a large population had few enrollments in medical institutions, which impacted directly or indirectly to the health conditions of the Province. Further, Agra and Lucknow had the responsibility of delivering the western medical education, in the whole Province. Only a few could afford to study outside the Province or country. Together, the doctors produced by these institutions under the influence colonial education served in urban areas in comparison to the rural areas.¹⁶⁸ The proportion of doctors to population ratio as mentioned by the report of Bhore Committee, astonishingly show that in England it was 1:750. If we compare this to India in the year 1942, the position of doctors with regard to the availability of medical attention was very low i.e. in Bombay-1: 2218, Punjab-1: 4494, Bengal- 1: 4913, and United Provinces as 1:13,586 and 1:14,582 in the Central Provinces. Apart from State, state-aided and unaided medical institutions, there were about 3000 registered private medical practitioners who carry on their profession mostly in cities and larger towns.¹⁶⁹ Thus the basic lack of infrastructure deeply impacted the public health conditions in the Province.

Hospital as a center of western medicine criticized by the nationalists such as Gandhi, as “there are now diseases of which people never dreamt before, and an army of doctors engaged in finding out their cures and so hospitals have increased.”¹⁷⁰ Gandhi

¹⁶⁷ Annual Report of the Public Health Commissioner with the GOI 1935, Vol. I, 1934, New Delhi, 1936, p-224.

¹⁶⁸ Joseph Bhore, *Report of the Health Survey and Development Committee*, GOI, Calcutta, 1946, pp-34-36. (here after Bhore Committee Report)

¹⁶⁹ Five-Year Plan of Post-War Reconstruction in the Medical Department, United Provinces, A first draft prepared by the IGCH, United Provinces, Allahabad, 1944. p-3.

¹⁷⁰ Hind Swaraj, p-28.

once remarked, "Hospitals are institutions for propagating sin. Men take less care of their bodies, and immorality increases. European doctors are the worst of all. For the sake of a mistaken care of the human body, they kill thousands of animals. They practice vivisection. No religion sanctions this. All say that it is not necessary to take so many lives for the sake of our bodies...To study European medicine is to deepen our slavery." Further Gandhi exclaimed that 'the English have certainly effectively used the medical profession for holding us. English physicians are known to have used the profession with several Asiatic potentates for political gain.'¹⁷¹

Hospitals and dispensaries in NWP were partly charitable and partly government institutions. The colonial policy was based on the principle that where the residents of any town willing to establish a suitable building and also guarantee a permanent local contribution sufficient to meet the cost of basic infrastructure, public funds to be provided and government on the other hand will supply a small amount of European medicines. It was distinctly laid down that "the government would not help to keep up a dispensary unless the people who were directly interested arranged for the requisite share in the cost thereof."¹⁷² As later, the Secretary to Government of United Provinces accepted the fact that none of the medical institution founded in this Province, which was of more benefit to the Europeans. He further proposed that the European portion of the hospital to be supported entirely by the payments made by the patients and by European liberality. As regards native patient he remarked that , 'the hospital owing to its situation was not a success, and the native wards will have to be moved nearer to the bazaar.'¹⁷³

In 1877, 201 hospitals and dispensaries were opened in the Province,¹⁷⁴ at the moment when there were no first class branch dispensaries in Oudh and no third class institution in North Western Province. These arrangements were thus insufficient to cater to the need of the growing population. However, the dispensaries increased to 279 in the year 1889. Of which the district board dispensaries were 233, State dispensaries 2, private dispensaries 26 and state-aided dispensaries were 18 in number.¹⁷⁵ The organizations and societies proliferated during the reformation

¹⁷¹Ibid, p-52-4.

¹⁷² Report on the Administration of NWP and Oudh, 1890, Allahabad, 1891, p-xxi.

¹⁷³ Orders of Government, No. 328/V-159B-3 of 1893, from The Secretary to Government, NWP and Oudh to I.G.C.H., N.W.P. and Oudh, dated Nanital, 7th August 1893, p-2. In Annual Report on the Dispensaries and Charitable Institutions of the NWP and Oudh, 1893, Allahabad, 1894, p-2.

¹⁷⁴ Report on the Administration of NWP and Oudh, 1877-78, Allahabad, 1878, p- 234.

¹⁷⁵ Report on the Administration of NWP and Oudh, 1890, Allahabad, 1891, p-191.

movement in 19th century also contributed to provide better healthcare for people through charitable hospitals, dispensaries etc. For instance Ramakrishna Mission established a hospital in Varanasi in 1900, with 123 beds of which 48 beds for women and 75 for men. This institution had honorary MOs and doctors of indigenous medicine, 12 nurses and 8 dhais.¹⁷⁶ Similarly, Arya Samaj at Allahabad established Vedic Homoeopathic hospital.¹⁷⁷ Initially, the policy of the government for the hospitals was not to multiply these institutions but to improve it, so that it can be supervised properly and regularly. This was done to resort to these institutions even when they were miles from the accessibility of the poor people. On the other hand, the smaller dispensaries merely acted as centers for dispensing general drugs and other aids during the epidemics. In 1890, it was decided that only out-door patients were to be treated at the branch dispensaries and in door patients being ordinarily sent for treatment to the headquarter dispensary.¹⁷⁸ There were only four Government hospitals in the Province i.e. Civil Hospital Roorkee, Thomason Hospital Agra, European Civil Hospital Allahabad, King George Hospital Lucknow.

In general the condition of hospital facilities were inappropriate and inadequate. There were paucity of beds and rooms for treating patients. When I.G.C.H. visited Prince of Wales Hospital Benares, he found two of the wards full of cataract cases, and the verandas were also full. He lamented that, "it is not safe in the cold weather to treat cases in verandahs where there can be danger of pneumonia and moreover the air of wards is not as pure as it should be when the verandas are occupied."¹⁷⁹ Once, T.H. Sweeny considering the poor health of a girl requested I.G.C.H. to give utmost priority to provide her quarters as she was living in the portion of eye ward of the hospital.¹⁸⁰ IGCH too in his inspection found the old instruments and equipments in the dispensaries.¹⁸¹ Thus the chief defect in hospital system was the lack of basic facilities. For instance, Commissioner of Rohilkhand Division Bareilly on his visit to Sadr Hospital Moradabad, complained that "the most pressing need is more blankets. The allotment at present is only one per patient.' The inadequacy and insufficiency of

¹⁷⁶ Varanasi District Gazetteer, p-355.

¹⁷⁷ Allahabad District, Gazetteer, p-78.

¹⁷⁸ Report on the Administration of NWP and Oudh, 1890, Allahabad, 1891, p-xxi.

¹⁷⁹ UPSA, File no. 145B, Box No. 2, Building- Ishwari Memorial Hospital at Benares, and Dufferin Hospital at Allahabad, Medical Department.

¹⁸⁰ UPSA, Copy of Letter No. D/F/101, dated the 8th September 1904, from Lieut. T.H.Sweeny, I.M.S., C.S., Benaras, to I.G.C.H., United Provinces, in Ibid.

¹⁸¹ UPSA, C. H. Joubert, Annual report of the Hospitals and Charitable Institutions of the United Provinces, 1902, Allahabad, 1903, p-3.

hospitals beds and facilities pointed out in almost all the official correspondences. As I.G.C.H. mentioned that the Ishwari Memorial Hospital, Benares had accommodation of 68 in-patients but atleast 85 patients were admitted on the increased demand.¹⁸² In 1904, for the extension of the hospital Rs. 3000 was given by Maharaja of Vizianagaram.¹⁸³ The Commissioner of Agra Division reported that the wards of the hospitals were badly constructed, ill-ventilated, and with no proper furniture.¹⁸⁴ For the KGMU, Buckley reported that “the Hospitals at Patna and Bombay are superior to King George Hospital, Lucknow. The method of administration by Government through their administrative officer is more positive, more efficient and less open to canvassing, lobbying and intrigue. Further it is difficult to expect any Government to hand over large sums of money to an institution over which they have only a remote control.”¹⁸⁵ It further reported that ‘King George’s Hospital was managed for twenty years by the University. It has gained an unfortunate reputation in Lucknow. It is remarkable that the poorest classes do not gain admission in any great numbers. The qualifications of its staff compared with other Provincial teaching Hospitals are on a lower level. Its output of original work is mediocre.’¹⁸⁶

Table 2.7: Hospital Accommodation and In-patients in United Provinces, 1880-1925

Year	Hospital Beds		Percentage Increase in Hospital Accommodation		Average daily attendance	
	Men	Women	Men	Women	Men	Women
1880	1,697	695			1,144.5	
1885	1,778	823	4.8	18.4	1397.5	394.1
1890	1,919	990	7.9	20.3	1,572.9	497.2
1895	2,636	1,110	23.1	12.1	1,716.2	618.6
1900	2,765	1,577	17.0	42.1	1,558.7	658.9
1905	2,539	1,364	-8.2	-13.5	1,514.3	560.2
1910	2,883	1,627	13.5	19.3	1,664.1	818.8
1915	3,316	1,840	15.0	13.1	1,875.9	1,052.8
1920	3,674	1,883	10.8	2.3	1,797.4	1,247.8
1925	3,657	2,005	-0.5	6.5	1,957.4	986.9

Source: Data compiled from Annual Report of the Dispensaries and Charitable Institutions of NWP and Oudh, continued as Annual Report of the Civil Hospitals and Dispensaries of United Provinces (1878-1930)

¹⁸² UPSA, File no. 145B, Box No. 2, Building- Ishwari Memorial Hospital at Benares, and Dufferin Hospital at Allahabad, Medical Department.

¹⁸³ UPSA, Copy of a Letter No. 752, dated 20 November 1905 from E. E. Radice, Collector of Benares to the Commissioner of the Benares Division, in Ibid.

¹⁸⁴ UPSA, File No. 8/4, Box No. 7, ‘Annual Report of the District Boards in U.P. of Agra and Oudh, 1901-02’, LSG Department, p-20.

¹⁸⁵ UPSA, File No. 443/1941, Box No. 165, ‘Major Buckley’s Report on K.G. and Allied Hospitals’, Medical Department.

¹⁸⁶ Ibid.

In NWP, the hospital beds for women and their daily average attendance in hospitals increased considerably with an annual increase of 11.7 per cent. Comparatively to male hospitals or accommodations, female in-patients experienced a four-fold increase than in male in-patients. When the health became a provincialised subject after 1919, there was a frequent decline in the female beds from 23.1 per cent in 1895 to -0.5 per cent in 1925. This was the result of provincialisation of hospital and dispensaries whereby municipal and local boards were bestowed with the responsibility of funding these institutions. The local bodies in their reports showed their inability to spend on expanding the hospital accommodation in the Province.

Table 2.8: Number of Grade and Classes of hospitals and dispensaries in India and United Provinces

Area	Classes I III IV		Classes II VI		Class V		Total		Average population served per institution 1934
	1933	1934	1933	1934	1933	1934	1933	1934	
British India	5,154	5,202	361	850	533	545	6,548	6,597	41,800
U.P.	481	493	103	110	77	83	661	686	73,702

Source: Report of the Public Health Commissioner with Government of India, 1934, p-214.

Due to unsatisfactory financial condition of the boards, grants were provided by the government for the maintenance of the hospitals. This system proved defective consequently, the government ordered the provincialization of all district hospitals under District Boards. In 1944, a scheme for the establishment of subsidized dispensaries and settlement of subsidized private medical practitioners in rural areas was thus financed by the government. Under the post-Second World war period some development schemes were outlined by the medical department of United Provinces comprised of reconstruction, extension and improvement of hospitals; initiating new building projects; establishment of new institutions, expansion of medical education facilities; development of medical facilities in rural areas, special measures to be taken for extension of medical relief to women.¹⁸⁷ As the hospital buildings in the province were in extremely unsatisfactory condition related to basic facilities, I.G.C.H. proposed to construct 15 men's and 19 women hospitals in the province.¹⁸⁸ Further, as there were no paediatric hospitals in the province, I.G.C.H. also proposed to establish 2 such hospitals at Agra and Lucknow. Unfortunately, the scheme could never see the light of the day both due to Second World War and political instability due to Quit India Movement and central government's decision to endow freedom to

¹⁸⁷ Ibid, p-5.

¹⁸⁸ Ibid, p-11.

India. In 1945, the 'U.P. Provincialization of Hospitals Act' was passed in order to enable the provincial government to enforce local authorities and Trusts to hand over to it the management, property and endowments of such hospitals. DBs were thus relieved of the cost of maintaining their male and women's district hospitals, and were asked to utilize the resultant savings in improving medical amenities in the rural areas. Thus, it was hoped that by provincializing hospitals, DBs will spend more money on the rural dispensaries, which was long forseen.

Of all the medical institutions, state-promoted research institute or researches evidenced slow growth. Whatever, the developments took place were the product of personal developments rather than systematic research policy of colonial state. In India, specifically the beginning of research work was first made in 1869 when Messers. Lewis and Cunningham were appointed to investigate the causes of cholera. Consequently, in 1891 the first bacteriological laboratory in India was established at Agra under Mr. Hankin.¹⁸⁹ To promote it further in 1899, Harvey and Hutcheson proposed to establish a Central Laboratory of Research and provincial laboratories for the health problems. There was also a demand for trained chemist and medico-legal experts, separate purely bacteriological work and investigation from strictly chemical and medico-legal duties.¹⁹⁰ W.G. Thorold opined that provincial laboratory should be concerned with ordinary bacteriological work 'in which existing knowledge applied to everyday problems, and not with original research.'¹⁹¹ The limited scope of these laboratories and lack of funds from government hampered the development of research, as they were pre-occupied with manufacture of biological products required in the Province, for the medical and public health purpose rather than conducting original research works. By the 1940s there were chemical and bacteriological municipal laboratories at Allahabad, Benares, Cawnpore, Bareilly, Meerut, Fyzabad, Muttra, Musoorie. In these laboratories, bacteriological examinations were carried out for the private practitioners and testing of municipal water and food supplies and there was no specialized kind of investigative work in these laboratories due to lack of resources.

¹⁸⁹ UPSA, File No. 393 B, Box No. 3, 'Proposal to establish a Central Laboratory of Research and Provincial Laboratories for study of health problems', Medical Department, 1899.

¹⁹⁰ UPSA, Letter No. G/8710, From- Col. G. Hutcheson to Under Secretary to Government, dated 30 October 1899, NWP in File No. 393 B, Box No. 3, 'Proposal to establish a Central Laboratory of Research and Provincial Laboratories for study of health problems', Medical Department, 1899.

¹⁹¹ UPSA, Letter No. 4677, From- W.C. Thorold to I.G.C.H., dated 19 September 1899, NWP in Ibid.

The chief factor that affected the development of research in the Province was the shortage of medical officers. However, certain attempts were carried out in hospitals by few concerned individuals such as Lieutenant Col. Sprawson, Major Lister, and J.W.D. Megaw. These three did certain amount of clinical and pathological research in this Province. As an alternative to the situation, Prince of Wales Fund Committee offered a research studentship to all the graduates in Medicine of the Allahabad University. How many students were interested or had aptitude or gained this scholarship is a subject of inquiry. Further the natives such as Raja Sir Harnam Singh also proposed a scholarship for medical research in the Province in the memory of his son Kunwar Indrajit Singh to promote research in the Province. Lieut. Col. Kamta Prasad also extended an endowment of a medical research scholarship in Allahabad University. Thus the responsibility of medical research was bestowed on the young natives, without acknowledging the condition of Province which expected plenty of research work. Private and official generosity was looked forward by the colonial state to encourage research in the Province. The greatest need above all was an organisation by which all medical officers and sanitary officers could work in the direction of laboratory research. However, both Col. Sprawson, Principal of Medical College and Colonel Cochrane, Principal of Agra Medical School reported that laboratory accommodation and equipment were though available in their institutions but they face lack of efficient staff which could carry out research. At the conference of medical experts held at Shimla in May 1919, resolved that a post of Director of Research should be created under the Government of India, the idea being that he should control and direct the lines of research in the Central Research Laboratory and also in Provincial Research Laboratories for the purpose of co-ordination. Maharaj Singh commented that the situation as “the present policy as such was to keep research in their own hands and to retain the Bacteriological department as an Imperial department, placing the Imperial Research Officers at the disposal of Local Government if necessity arise.”¹⁹²

Consequently, United Provinces Medical Council passed a resolution on 8th June 1920, recommending the establishment of medical research in the Province and an appointment of a committee to advise the government on all matters connected with

¹⁹² UPSA, File No. 84/1920, Box No. 116, ‘Medical Research in United Provinces’, 1921, Medical Department.

it. The Medical council further recommended the addition of two non-official medical practitioners and the Professor of Hygiene at the Medical College. Thus, Provincial Medical Research Committee's first meeting held at Lucknow on 29th March 1921. The committee repeated the same ideas as referred earlier and accepted the forgoing demands. Thus, Meagaw rightly assessed that "research has advanced with enormous strides in the country but the utilisation of the results of research has crawled and is deplorably far behind."¹⁹³ Consequently, a Provincial Hygiene Bureau was established in 1928 to the spread the knowledge about the expansion of diseases, among the people about health, sanitation, etc. H. Ross opined that the work of the Bureau was far advanced in comparison to the other provinces of the country.¹⁹⁴ However, the Institute carried out limited investigative work, comprised of bacteriological analysis of water samples, amount of slits in water after sedimentation, analysis of adulteration of food products, etc. and later started a course on Diploma in Public Health. It worked more as a training institute than as a research center for working on the issues that required much attention both of the government as well as medical administrators.

MEDICAL POLICY AT GRASS-ROOT LEVEL

The policy of decentralization of administration endowed the municipalities and local government with the responsibility of medical services in the country. The first attempt at municipal self government in the Province came into effect by the Act X of 1842, by which government could appoint representative committees in any town where around two-third of the people applied for its extension. The arrangement proved unsuccessful which led to the Act XXVI of 1850 which provided more powers to the government for the formation of municipal committees. The Act was extended to Oudh, but in 1864 a special Act was passed to regulate the municipality in Lucknow and amended Act VI of 1868 was passed for the Province of Agra. Similar, committees were formed in Allahabad.¹⁹⁵ In 1882, a scheme was developed in the Province which transformed into as Act XIV of 1883, which provided District Board (earlier the District Committees) with a power to supervise and control the administration of roads, dispensaries, schools etc. besides other local works, with few

¹⁹³ Note on 'Research in the Province' by J.W. Megaw in Ibid.

¹⁹⁴ Fifty-Fifth Annual report of the Director of the Public Health of United Provinces 1922, Allahabad, 1923, p-26.

¹⁹⁵ Imperial Gazetteer of India, United Provinces of Agra and Oudh, Vol. I, 1898, pp-124-26.

restrictions. Till 1897, the boards were consultative bodies whose major work was limited to schools and hospitals, in the absence of financial independence. Few steps were taken to ascertain the normal income and expenditure in each district through GOI grants of four lakh in 1897 and U.P. Act II of 1906 paved the way for further financial independence.¹⁹⁶ Sanitary board for this Province was constituted in 1890 and the board submitted a bill to make better provision for sanitation in NWP and Oudh.¹⁹⁷ Even the arrangement could not be proved beneficial as till independence the municipal income depended on the octroi tax which aggravated their financial dependence on the government and thus its impact was visible on the conditions of health, sanitation, hospitals and dispensaries, etc. It was lamented that the local governments not only lacked funds but also lacked direction, continuity, professionalism and also failed to involve even 'respectable natives' of the towns except by an occasional consultation or appeal for subscriptions.¹⁹⁸

The establishment of municipality served two purposes. Firstly, government and elite class came closer to cooperate with each other, where natives tried to assert their superiority over the people while government could extend its 'power' by intervening in the daily life especially in urban areas. Secondly, through the application of the sanitary measures in the municipalities the authorities became empowered to extend western ideals of sanitation in the province through appropriate land use, and formulate sanitary rules, for instance, imposition of drainage tax, penalization in absence of non-following of rules, etc.¹⁹⁹ Almost every municipality maintained a dispensary or contributed to the one established by the government.

The conflict between the government and local boards also interfered in the working and management of health conditions in the Province. This could be glanced from the official communications and reports where government considered the inefficient working of local bodies responsible for the poor state of things while the latter lamented the lack of funds and grants from the government. As Sanitary Commissioner reported, that 'it is often lamentable to see large sums of money wasting municipalities in well-meaning but useless efforts to improve their drainage

¹⁹⁶ Ibid, pp-122-23.

¹⁹⁷ Report on the Administration of NWP and Oudh, 1890, Allahabad, 1891, p- xix.

¹⁹⁸ Harrison, Allahabad: A Sanitary History, p-172.

¹⁹⁹ For erecting buildings without permission over sewers or if any interference was made with the damage done to sanitary works, a person could be fined of Rs. 50. NAI, GOI, Pros No. 1017-1019, Home, Municipality branch, September 1892.

where had the original scheme been scientifically drawn up by an expert, the money could have been well and advantageously laid out and the drainage added to year by year to the scheme was completed.²⁰⁰ Even on the expenditure the Boards had more balance than expenditure. As in the 1919, DBs had a balance of 77,762 out of 1,32,882 and thus spent 53,302.²⁰¹ DPH lamented, “little definite efforts on the part of the majority of the boards to improve the working conditions of their water supplies; generally speaking the Boards have been not only dilatory in dealing with important matters, but in some instances even obstructive.”²⁰² Some DBs during the year 1924 evinced the desire to have their work carried out by agencies other than Public Health Department. However, those who favoured the ideology failed to arrange these kind of agencies.²⁰³ The question of employment of a qualified staff remained a great stumbling block to the local authorities in the management of their public works. On the other hand, Municipal Commissioner in 1924 reported that, ‘in Allahabad, Benares and Cawnpore, the pumping plant stands in urgent need of replacement and the Boards hope shortly to put the work in hand, but except in Cawnpore there is a little hope of the boards finding money for the remodeling of the distribution systems, a step which is needed only less urgently than the renewal of the machinery. At Dehra Dun the supply is distressingly inadequate, has decided to tap a new source of supply. The Allahabad board made real efforts to remove such defects in its water supply organization as were not due to the mechanical insufficiency of its plant. The same cannot be said of Benares of which it was reported that leaky taps and hydrants were noticed everywhere, that indents for repairs were ignored and no genuine attempts was made to check the waste for which the city is notorious.’²⁰⁴

As back as in 1890s GOI stressed on the fact that the promotion of sanitation regarded as one of the most important duties of all district and local boards and where such power didn’t existed, legislation should be enforced. Further, GOI also emphasized

²⁰⁰ Thirty-Seventh Annual Report of the Sanitary Commissioner of Sanitary, 1904, Allahabad, 1905, p-16.

²⁰¹ Fifty-Third Annual Report of the Sanitary Commissioner of United Provinces, 1920, Allahabad, 1921, p-31.

²⁰² Thirty-Second Annual Report of the of the Superintendent Engineer, PHD, United Provinces for the year ended March 31, 1927 in Public Health, 1926, p-iii.

²⁰³ Thirtieth Annual Report of the Superintending Engineer, PHD, United Provinces for the year ended 31 March 1925, pp-x-xi, in Fifty-Seventh Annual Report of the DPH of United Provinces 1924, Allahabad, 1925.

²⁰⁴ Report on Municipal Administration and Finances in the United Provinces of Agra and Oudh for the year ending 1924, Allahabad, 1925, p-6.

that for achieving this aim, the local boards should not be conferred the power of taxation by the local legislation, for fulfilling their duties and need of money. W. C. Bennett wrote “the greatest difficulties connected with the subjects- our ignorance. Hasty action, such as will certainly be forced upon us, is much more likely to do harm than good.”²⁰⁵ After 1870, it was expected from the DBs that they should take care of sanitation and related issues. However, latter always showed its inability to act because of the lack of financial resources. Due to the absence of power to levy taxation, DBs relied on the provincial revenue funds and local subscriptions. Even after so many negative views on the introduction of the scheme of rural sanitation, the U.P. Village Sanitation Act 1892 was passed and stressed for sufficiency and purity of the water supply in villages with a population not less than 2000. As an experimentative measure it was applied firstly at eight districts in 1894 and was later extended to whole province in 1896.²⁰⁶ The Act, however, was a unique step in the direction of ensuring the better health measures for the people especially in rural areas, but it failed to make a definite mark for various reasons i.e. apathy of officials, lack of funds on the part of Boards and reliance on villagers to keep their environment clean. Unfortunately, the amendment brought in the Act in 1929, sanitation of the rural areas which was previously ensured was cancelled.²⁰⁷ District Boards were thus made responsible for regulating rural sanitation through bye-laws framed by the former. A gap was thus created where there was lack of any sanitary legislation on which health staff worked.

At ground level, medical and sanitary interventions of the colonial state were implemented by the water supply and drainage schemes. Not only did the government and municipal bodies, but few organizations took serious efforts in the direction. For instance, in order to prevent the pollution of the water between Assi Ghat and river Varuna, *Kashi Ganga Prasadini Sabha*²⁰⁸ was formed in 1886.²⁰⁹ Large amount of money was collected and a project of 24 lakh for the construction of water-works and a complete drainage system was carried out with an assistance from the government.

²⁰⁵ UPSA, File No. 10B, Box- 10, ‘Sanitation in the towns and villages of the North-Western Provinces and Oudh’, Sanitation Department.

²⁰⁶ Provincial Gazetteer, I, p-139-40.

²⁰⁷ Sixty-Fifth Annual Report of DPH of United Provinces of Agra and Oudh, 1932, Allahabad, 1933, p-35.

²⁰⁸ It was an association established at the initiative of Raja of Benares in 1886 to construct a separate sewer lane to keep bathing ghats clean.

²⁰⁹ U. P., District Gazetteers, *Varanasi*, 1965, p- 283.

The scheme was approved by the municipal board at the end of 1889 and the works were completed in 1892 thereby Varanasi received pure, filtered and potable water. It was also employed for flushing sewers and drains, for watering roads and extinguishing fires. Another comprehensive organization for the improvement of rural sanitation emerged in the Province named as *Taraqqi Sabha* in Pilibhit district, with the purpose to provide simple medical aid to the villagers and improvement in rural sanitation.²¹⁰

The progress towards water supply scheme in the Province accelerated 1890s onwards by the reconstitution of the Sanitary board.²¹¹ The municipalities which first proposed to introduce water-works were of Agra, Allahabad, Lucknow and Benares. However the initial experiments which were made in boring for an artisan well, failed. On 21 March 1891, an Act was passed to confer power and impose duties on municipalities in NWP for the construction and maintenance of water works and the supply of water.²¹² In order to meet the charges for water supply and drainage work, a water rate was imposed at 12 annas per head per annum. The municipalities on the other hand spent on an average 28 per cent of their income on the water supplies, drainage and conservancy.²¹³ The metered consumers were charged for the use of water at the rate of 4.9 anna while most consumers were unmetered one. The Municipal Commissioner asked for low rate of pay to areas which receive an irregular and insufficient supply.²¹⁴ However it was reported that 'nowhere were wells properly protected from possible impurity.'²¹⁵ No arrangement was provided in the design for gauging the rate of flow from the proposed filter, and the chief engineer and sanitary engineer opined that the design was unnecessarily expensive and thus was asked to prepare a new scheme.²¹⁶ Criticising the outbreak of severe cholera even after the supply of filtered water in the city of Allahabad, *Prayag Samachar* noted that 'the insanitary condition

²¹⁰ Thirty -Sixth Annual Report of DPH of United Provinces of Agra and Oudh, 1930, Allahabad, 1931, p-20-21.

²¹¹ Its constitutions and duties were explained in the official report of 1888-1889. Report on the Administration of NWP and Oudh, 1890, Allahabad, 1891, p-xix.

²¹² Twenty-Fifth Annual Report of Sanitary Commissioner of the NWP and Oudh, 1892, Allahabad, p-47A.

²¹³ Report on the Administration of NWP and Oudh, 1890, Allahabad, 1891, p-pp- xxii-xxiii.

²¹⁴ Report on Municipal Administration and Finances in the United Provinces of Agra and Oudh for the year ending 1925, Allahabad, 1926, p-6.

²¹⁵ Annual Report of the Deputy sanitary Commissioner, First circle, 1892, in Annual report of the Sanitary Commissioner of NWP, 1892, p-37-38A.

²¹⁶ Report on the work of Sanitary Board , NWP and Oudh, p- 8A, in Annual report of the Sanitary Commissioner of NWP and Oudh, 1899, Allahabad, 1900.

of the town has much to say to the outbreak of the epidemic. Hundreds of bye-lanes are to be found in a most dirty side. The sweepings are allowed to accumulate at the bins for one to two weeks, the urinals in the streets are not washed and cleaned everyday and the sewage farms is situated close to the city. Adulterated articles of food are sold, and the butchers kill sickly animals and sell rotten and unwholesome meat.²¹⁷ The editor of *Karnamah* stated that owing to the outbreak of cholera at Lucknow, the Municipal board had alum and camphor thrown into the wells and asked people to take water from water works however the stand-posts from where people received water were time-bound, impure as well as unsatisfactory. Continuing with this, *Azad* noted the streets and roads are generally in a neglected state, on the other hand the two-third of the roads which were frequently used by the Europeans were kept clean as well as in a good condition. It further lamented on the open drains, conservancy costs and the attitude of Board towards the sanitation of the city during cholera epidemic. The editor lamented that 'poor carriage drivers arrested and fined; but government does not even rebuke the Board which levies taxes from people, but endangers their lives by its culpable neglect of sanitary arrangements.'²¹⁸ By 1908-09, municipalities spent on an average 43 per cent of their income on plague, conservancy, water supply and drainage.²¹⁹ Government later decided during 1934-35, that water supply scheme consequently undertaken by the private companies.²²⁰

The press had discussed in details about the sewage schemes and their application in this Province. For instance, an editor of a newspaper requested the elite and educated people of the Province to form an association which could spread sanitary knowledge among people so that they could improve sanitation in their houses.²²¹ Further, native newspapers tried to educate people of their duties and awareness on the selection of the municipal officers. As *Azad* blamed the citizens of Lucknow that they at the time of elections return the men 'who have little independence and whose only care is to gain the goodwill of the chairman with a view to promote their own interest.'²²² Similar voice was raised when a trader in his letter showed consensus of opinion that municipal board took little interest in sanitary measures and let people

²¹⁷ Vernacular Advertiser, SVN, 16 June 1894.

²¹⁸ *Azad*, 17 August 1894, SVN, p-354-55.

²¹⁹ Forty-Third Annual Report of the Sanitary Commissioner of United Provinces, 1910, Allahabad, 1911, p-20.

²²⁰ Sixty-Seventh Annual Report of the DPH of United Provinces, 1934, Allahabad, 1935, p-14A.

²²¹ *Hindi Hindosthan* (Kalakankar), 4 March 1906, SVN, p-129.

²²² *Azad*, 17 August 1894, SVN, p-355.

die during cholera epidemic. The writer further calls on the voters to elect better members, and not give their votes 'blindly'.²²³

Unfortunately, drainage works were under developed. The report of the municipal committee reported, 'that many towns had passable systems of water supply but in larger cities the demand is tending to outgrow the supply, the reserve of power is seldom adequate, and the problems of distribution and of avoiding waste are of ever growing difficulty. Drainage systems are still more backward than systems of water supply though municipal boards are becoming more and more alive to the benefits of general drainage systems.'²²⁴ DPH exclaimed that the maintenance of drainage works were generally defective and this is due to the employment of inexperienced staff. He further lamented that "no intelligent use is made of the existing drainage works, nor are they even maintained with care."²²⁵ The State instead failed of improving the natural drainage in the Province, focused on developing new ones. The average annual death-rates in certain localities before and after the introduction of a drainage scheme remained unsatisfactory. In 1920, Sanitary Commissioner lamented that signs of steady progress in sanitary matters all round are visible but in a few places no endeavour made to carry out recommendations made by the sanitary experts and thus the situation remained intact instead of introduction of the modern and reformed methods.'²²⁶ From the official correspondences it can be glanced that the practically no steps were taken by the local bodies to prevent waste, which was a heavy loss of the tax payers money annually.

New developments in the medical and sanitation policy of the colonial state increased after non-cooperation movement because of the introduction of dyarchy, international inclinations on healthcare developments and growing national movement. Consequently, the District Health scheme was launched in United Provinces in June 1922. The expenditure was divided between government and D.Bs. It was the first systematic attempt to grapple with the problem of preservation of the public health

²²³ Hindustani, 5 August 1894, SVN, p-389.

²²⁴ Report on Municipal Administration and Finances in the United Provinces of Agra and Oudh for the year 1915-16, Allahabad, 1917, p-7.

²²⁵ Thirty-Second Annual Report of the Superintending Engineer, PHD, United Provinces for the year ended 31 March 1927, pp- xi, in Fifty-Ninth Annual Report of the DPH of United Provinces 1926, Allahabad, 1927.

²²⁶ Fifty-Third Annual Report of the Sanitary Commissioner of United Provinces, 1920, Allahabad, 1921, p-30.

especially in rural areas, with an objective to improve wells and the cleanliness beyond the larger villages. Later when the scheme was implemented, the M.O. reported on the condition that, “a village of those districts in which District Health Scheme has been extended, knows much more about the epidemics and how to protect himself from them than a villager elsewhere. He actually sees the wonderful result of the anti-epidemic measures adopted by us in his village. He no longer believes the epidemics as uncontrollable or being due to the visitations of Devi-Bhawani to devour human beings, without regard to the fact whether they observe elementary principles of hygiene or not. Though we have been able to wholly remove the subscriptions and inertia that have their hold over the rural population for centuries, yet as a result of our patient propaganda, we find that their conservatism and apathy are gradually disappearing and their suspicion and distrusts are giving place to confidence.”²²⁷ As the small municipalities could not afford the whole time MoH thus the condition of vaccination and sanitation was more or less poor in those areas. Further steps were taken by Hygiene Publicity Bureau, which started Village Adult Night Schools in 1928, where lectures on elementary hygiene were given by DMOH.²²⁸ Yet these were time-bound and piece-meal services which could hardly deliver any fruitful results.

The colonial urban-centric policy and training of medicine to students impacted the availability of higher number of medical professionals and doctors in urban areas than in rural areas. To accommodate this, a scheme was launched in the Province whereby DBs encouraged qualified medical practitioners to settle themselves in such rural areas, which were remote from existing dispensaries. The scheme was subsidized by the government with DBs to let more practitioners settled down in rural areas to render medical aid to poor patients. As a matter of fact, 30 medical practitioners in 1926, 33 in 1927 and 19 in 1928 and 15 in 1929 settled in rural areas.²²⁹ However, remarkable decline in the numbers after 1927 was evident due to the failure of DBs to appoint doctors and consequently the grants made to them were withdrawn later. The scheme hereby after 1930 received a death blow and again villagers were left at their own fate. The scheme also failed as with the passage of time the medical practitioners lost their interest in working in rural areas. They lacked the both the facilities and

²²⁷ Atma Ram, Suggestions for Village Sanitation, *Indian Medical Gazette*, July 1934, pp-379-84.

²²⁸ Annual report of the Hygiene Publicity Bureau, United provinces for the year ending 31 December 1928, Allahabad, 1929, p-4.

²²⁹ Triennial Report of Civil Hospitals and Dispensaries of the United Provinces for the year 1926, 1927, 1928, Allahabad, 1929, p-2.

monetary assistance which they received in urban areas. As already mentioned the local governments showed their incapacity to provide grants to these doctors and provincial government unlike earlier cried for the financial constraints in the State. However, despite prevailing financial stringency of the colonial state, the DB of Gorakhpur continued the scheme of employing resident public health officials for public health circles which was discarded in this province by the government.²³⁰ The duties of these officials were to tour for the circle and performed the public health duties for e.g.- disinfection of wells, distribution of anti-cholera medicines and quinine, vaccination, registration of vital statistics, hygiene publicity, village aid work, health publicity and enforcement of district board bye laws.

For promoting the healthcare, voluntary and international agencies played a significant role. References of their work regarding healthcare is made in further chapters. As regards rural healthcare, the Rockefeller Foundation stressed on the need of a Health Unit scheme and also considered the same as the ‘only means yet devised for bringing adequate health protection in rural communities.’²³¹ Thus on the lines of Ceylon health scheme, a health unit was established with an aid from Rockefeller Foundation and United Provinces branch of IRCS at Pratabgarh in 1931, for serving in rural areas and improve MCW work. Other health units in the country were established at Poonamallee (Madras), Najafgarh (Delhi), and Neyyattinkara (Travancore). The unit at Pratabgarh was a training ground of health visitors and provided amenities for the health protection in rural areas in the same manner as enjoyed by the municipalities for undertaking sanitary measures, maternity and child welfare work, health education, vaccination, preventive inoculation, school health etc.²³² The work of the unit received appreciation across the Province and few demands were also forwarded for the extension of such scheme in other parts of the Province to endow better facilities for the people. Due to the lack of funding on the part of government and total reliance on the part of Foundation and IRCS, the scheme never received the benevolence of the State and till independence the private agencies worked for the better healthcare provision in the Partabgarh and in this Province too.

²³⁰ Sixty-Fourth Annual report of the DPH of United Provinces 1931, Allahabad, 1932, p-24.

²³¹ UPSA, File No. 125/1931, Box No. 125/1931, ‘Establishment of Health Unit U.P. (Pratabgarh)’, PHD, 1931.

²³² Ibid.

The activities of these units discussed in detail by Public Health Commissioner, yet in short the work of the unit was preventive in nature.

With the formation of the Congress government in 1937 in United Provinces, attempts were made to strengthen the district health scheme. It was proposed to ensure better medical aid widely distributed among the population. The objective was that no villagers have to travel five miles to get the medical aid. It was further decided to appoint in every district, four vaid and hakims and two allopathic doctors along with 100 allopathic and 200 Ayurvedic and Unani dispensaries in the Province. For the purpose, Rs. 50,000 was allocated to DBs on contributory basis to enable them to stock necessary medical facilities rural dispensaries. The allotment was made according to the detailed study conducted in 1929 by Sir Ivo Elliot. Under the scheme, each vaid and hakim were assigned a definite area within which they were required to tour occasionally in order to provide medical relief as well as undertake educational propaganda for sanitation and hygiene, together with this, they were not allowed to do private practice. To ensure the fulfillment of scheme a success, travelling dispensaries were used for medical relief in rural areas for common ailments among the villagers on the spot and travelling dispensaries with M.O. were also required to carry out disinfection of wells and village huts in case of epidemic diseases. However, only 146 Ayurvedic and 46 Unani dispensaries; 46 fixed and 16 travelling allopathic dispensaries were established.²³³ Under the scheme, it was further proposed to appoint supervisory staff at Ayurvedic and Unani dispensaries as the M.O. appointed lacked knowledge and thus paid scant attention on the dispensaries²³⁴ and thus Rs. 4,00,000 was provided in the budget of the year 1938 under Rural Development programme for medical and public health and Dr. Kher prepared the budget accordingly. The plan exceeded the amount allocated thus it was revised by Rural Development Officer.²³⁵ Consequently, 49 M.O.s were recruited by the United Provinces government.²³⁶ In the State assembly, Raja Jagganath Baksh Singh raised the question that ‘what is the main function of the scheme? Whether to provide medical relief or to carry on Public Health propaganda?’ In the budget speech, it was announced that ‘100 allopathic and 200 Unani and Ayurvedic dispensaries’ be established, if fully

²³³ UPSA, Letter No. 1538 to D.P.H., U.P., dated 12-10-1938, in File No. 337/38, Box No. 85, ‘Schemes for the Medical relief in rural areas’, Medical department, 1938.

²³⁴ UPSA, File No. 337/38, Box No. 85, ‘Schemes for the Medical relief in rural areas’, Medical department, 1938.

²³⁵ UPSA, Letter from Bhagwan Dubey to H.M. L.S.G., dated 22-09-1938, in Ibid.

²³⁶ UPSA, Note from I.G.C.H., p-76, dated 10-02-1939, in Ibid.

qualified personnel's were made available. It was made clear that the cooperation of DBs will be continued, along with subsidizing doctors, hakims and vaidis. In this manner, it was considered that it will be possible to provide 500 centers with medical relief."²³⁷ For the medical staff, IGCH regarded the replacement of sanitary inspectors by appointing doctors. In reality it was not possible owing to the paucity of doctors in the Province as mentioned earlier. Government encouraged local bodies to undertake the responsibility of some of the allopathic dispensaries on a subsidized basis and thus government "will be relieved of 1/4th of the recurring expenditure of each dispensary so established or put in charge of a local body."²³⁸ The scheme unfortunately could not make a mark in the history of medical relief of the Province as the Ministry resigned in 1939 due to the outbreak of World War and India's forceful involvement. The scheme thus came to standstill and people had to wait for freedom from foreign yoke. Yet by 1940, all the travelling dispensaries appointed functioned regularly in the Province.

Conclusion

The condition of medical and sanitary state of affairs in United Provinces was a mixed one. On one hand, the urban areas became a ground of medical innovations and applicability of new scientific developments towards rising challenges, rural areas on the other hand became a center of power tussle between government and local bodies. Focusing on United Provinces, this regional study contributes in developing an understanding of healthcare scenario in colonial India 1880 onwards. The health condition of the people of the politically active state of this country remained poor in both colonial and post-colonial India. For the condition, both the people and the governing bodies were more or less equally responsible. Furthermore, insanitary environmental conditions, low expenditure, inadequate infrastructure accelerated the deterioration of state of health of its subjects. The weak foundation of modern system of medical facilities in the Province during the nineteenth century had a deep and everlasting impact on the healthcare policy of this State. Even after independence, the state remained on the last number in the list of basic facilities of healthcare and nutrition in the country.

²³⁷ UPSA, File No. 337/28, Box No. 85, 'Scheme for Medical Relief in Rural Areas', Medical Department, 1938.

²³⁸ UPSA, Letter from A. Guha to H.M., dated 16 June 1936, in Ibid.

Chapter III

*Paediatric Medicine: Ideas and
Practices*

CHAPTER- III

PAEDIATRIC MEDICINE: IDEA AND PRACTICES

This chapter explores the evolution and development of paediatric care in United Provinces with the combined efforts of provincial government, voluntary societies and the natives. The chapter intends to study the attitude and sensibilities of the colonial government towards the 'child' with special reference to their healthcare and how the former visualized, created and implemented the policy for the paediatrics. Thus an attempt would be made to get an insight into the way paediatric medicine manifested in the medical policy of the British. The chapter establishes that the bio-medicine was not only used to propagate the superiority of western medicine but its extension on the children served two purposes. Firstly, to legitimise its claims of paternalistic benevolence and secondly, making children, both as a carrier and propagator of western medical system.

As far as the health of the child is concerned, it is more a scientific aspect than the social. With the emergence of the historical enquiry in the colonial medicine especially in India, the scholars have focused on exploring issues of prime significance i.e. its complexity of relationship with the diseases, public health, conflicts with indigenous medicine, gender and healthcare, attitude and responses of the population. Studies on 'pediatrics' in colonial medical policy is scanty yet touches various significant areas, i.e. reproductive health, midwifery, birth control, infant mortality, maternal mortality, and vaccination policy. This chapter attempts to capture multiple axes through which child was brought under the influence of colonial medicine. This chapter do attempts to contextualize multiple features of broad changes that took place in the medical policy in the colonial United Provinces, in relation with the emergence and role of voluntary associations, evolution of public health administration, establishment of maternity centers and women's hospitals, reforms in midwifery, discourses on marriage and birth control, dissemination of western medicine through educational institutions- all of these played significant role in varying degrees in the colonization of child healthcare during the colonial period.

There are several discourses on the critical study of children and childhood as discussed in the first chapter. In context of colonial discourse on childhood, there are

studies which enable us to understand the anti-colonial nationalism and Indian child.¹ Another point of argument was that childhood ‘functioned as a point of obstruction, negotiation, and facilitation in the (domesticity and femininity) colonizing manoeuvres.’² The colonial attitude towards children traced through the jails and reformatory schools established by colonial state, according to Sen, was a part of extension of ‘boundaries of increasingly scientific constructions of race that undergirded contemporary imperialism.’³ Development of multiple childhood in interaction with colonialism and anxiety of the colonial state through the lens of labour, schools, jails, traced by Balgopalan.⁴ In recent literature, much attention directed to the history of the medicalization of birth and infant nurturing, there have been few such undertakings in the area of the health and welfare of children in colonial times.

Understanding paediatric medicine as a branch of science and public policy owed its origination to colonial state in India. During the period of our study, wide spectrum of policy interventions were involved which targeted the child. So this chapter attempts to capture these interventions by the way of putting them in context of paediatrics in United Provinces. As existing literature lacks the colonial state’s engagement with child medicine with reference to government’s policy, this section traces the colonial attempt to bring children under the sphere of western medicine to legitimize their regime. This chapter thus focus on the question to find- Whether the medical policy for paediatrics in United Provinces was a part of the broader project of colonizing mission of the welfare state or not? What were the sensibilities of colonial state which shaped their policy towards paediatric medicine? What factors influenced policy of colonial medicine towards paediatrics? How medical politics worked in the domain of paediatrics? The chapter proposes that the growth of paediatrics in United Provinces was an outcome of colonial sensibilities and imperatives. The policies and programmes initiated for the betterment of the child health in the Provinces was to

¹ Partha Chatterjee, *The Nation and its Fragments: Colonial and Post-Colonial Histories*, (New Jersey: Princeton University Press), 1994.

² Satadru Sen, *Colonial Childhoods: the Juvenile Periphery of India, 1850-1945*, (London: Anthem Press, 2005), p-4.

³ Satadru Sen, *Disciplined Natives, Race Freedom and Confinement in Colonial India*, (New Delhi: Primus Books, 2012).

⁴ Sarada Balgopalan, Colonial modernity and the ‘child figure’: reconfiguring the multiplicity in ‘multiple childhoods’, pp-23-43, in in T. S. Saraswati, Sailaja Menon and Ankur Madan, *Childhoods in India: Traditions, Trends and Transformations*, (London: Routledge, 2018).

address the rising of nationalism in the country and portray to the people in general the benevolence of the welfare state.

CHILD WELFARE MOVEMENT IN INDIA

The earlier western medical intervention for child care in colonial India came with the advent of missionaries. Their first attempt was the establishment of the infant schools and the first school was established at Calcutta in 1830 by John Mathias Turner.⁵The emphasis of this school was not only to train the young minds of children ‘in fear of the Lord’ but also to develop the ‘habits of cleanliness’ among them.⁶These were thus the primary attempts of the missionary intervention in education and medical relief in the country impacting the health of children which later was taken over by the Montague’s claim of responsible government. After schools, missionaries focused their attention towards establishment of women hospitals which undertook pre-natal and post-natal care. Apart from hospital and dispensary work and training of nurses, the Mission hospitals were also pioneers of the medical inspection of school children. In the boarding schools of United Provinces, which were attached to Mission hospitals, children who were from subordinate mission workers or Christian families were provided with better medical facilities, especially for girls as their health was poor who often suffered from tuberculosis. But in a few cases, this inspection work was performed in Mission day schools were also for non- Christian pupils and thus these children were frequently monitored by the MOs.

Together with missionaries, reform for child medical care was initiated by the British women mostly the Vicerines who took a keen interest in establishment of hospitals or funds for maternal and infant health and welfare. One of the most important Victorian responses to the conditions of female health and childbirth in India was the foundation of the *National Association for Supplying Female Medical Aid to the Women of India* or *Dufferin Fund* in 1885. The objective of the Fund was to train Indian women in medicine so that they could provide western medical care to Indian women. Unfortunately, the Fund or policies were not designed to medical care to entire gamut of women but specifically to *pardahnashin* women. It encouraged the establishment

⁵ Helen May, Baljit Kaur, Larry Prochner, *Empire, Education, and Indigenous Childhoods: Nineteenth Century Missionary Infant Schools in Three British Colonies*, (London: Routledge, 2014), Chapter 3.

⁶ Ibid.

of maternity hospitals as well as baby clinics.⁷ The fund was a lucid example of British paternalism in India. 'In Europe the struggle against midwifery won by the male dominated medical sciences, in India however, there was no takeover of birth by men in institutions and hospitals. State interference in childbirth, as the Dufferin Fund was perceived, was rejected because of the strong ritual injunctions surrounding giving birth'.⁸ Dufferin Fund was also the representation of the colonial medical philanthropy. The chief feature of the colonial medical policy was to sought private subscriptions to ensure medical supply to the people. Secondly, the local governments were encouraged to take steps for ensuring the popularity of western medical aid to Indian society. Viceroy Lansdowne at Agra in November 1890 described the work of the Fund as one of the most important 'experiments' to have been attempted by British India.⁹ Further, there were many institutions and associations that were closely linked with the development of female care in the country and thus the foundation for the child medicine in India was laid implicitly. On the other hand, the Fund operated through voluntary agencies, government though offered its good will, yet never took the task whole-heartedly and when the private subscriptions began to dry up, the burden was laid on the local governments. And without the communication the activities of the Dufferin Fund became difficult to sustain and unable to command public support.¹⁰

Around 1900, infant welfare centers were established in England followed by starting of ante-natal clinics. During the same time span, till the introduction of the National Health Services, there had been developments in the field of Maternity and Child Health and general health conditions. Consequently, both the infant mortality rates and child mortality fell consistently and considerably.¹¹ Child Welfare movement in India corresponds to the period when the services for mothers and children were intensified in England and the Maternity and Child Welfare (MCW) Act was passed

⁷ Dagmar Engels, 'The Politics of Childbirth: British and Bengali Women in Contest 1890-1930', p-138, in Peter Robb (ed.), *Society and Ideology: Essays in South Asian History*, (Delhi: Oxford University Press, 1993).

⁸ Balfour and Young, *Work of Medical Women in India*.

⁹ David Arnold, *Colonizing the Body*, pp-263-264. In his speech, the Viceroy said "we have to overcome the dislike of going to hospitals, the old aversion to Western medical and surgical methods and all the prejudices which, till now, have caused this particular branch of the medical profession to be degrading and to be relegated to persons of the lowest caste."

¹⁰ Ibid.

¹¹ Cicely D. Williams and Derrick B. Jelliffe, *Mother and Child Health : Delivering the Services*, (Oxford: Oxford Medical Publications, 1972), p-67.

in 1918. In India unlike in England, the child welfare activities owed its origin mainly to the efforts of enthusiastic voluntary workers. However, in England, the work was carried out by the MCW Department of the Ministry of Health. In India, English women and later Women Medical Association of India, Indian Council of Social Welfare, Indian Red Cross Society (IRCS), AIWC, Balkanji Bari and Children's Aid Society, Bombay Mofussil Maternity, Child Welfare and Health Council, Bombay Presidency Infant Welfare Society, The Bombay Baby and Health Week Association, Dacca MCW Trusts, were anxious to work for the infant and child welfare. The sympathetic and enthusiastic Vicerines and wives of officials too showed interest in child welfare policies to present benevolent face of the imperial power among the masses. Consequently, child welfare schemes were started in a few places in India. The first MCW work on large scale to be organized in India was started by Lady Willingdon in Bombay in 1912.¹² She was the president of Bombay Presidency branch of the DF. However, it was only from 1918 onwards the MCW work was started in India at initial level. Madras was one of the few provinces where government especially local bodies dedicated itself in maternal and infant welfare work. For instance, as early as in 1875, the Madras government had bestowed the responsibility to employ western style midwives and in 1917, a far-reaching MCW scheme was launched in Madras city with the appointment of women doctors and medical centers.¹³ Few private doctors worked more enthusiastically towards the women and child care, as Dr. A. Lakshmanaswami Mudaliar who was a non-official and highly effective advocate for the provision of women and children's health in Madras from late 1920s onwards.¹⁴ His report went a long way in stimulating the official thinking for organizing the MCW in the districts which were at the stage of infancy.

In 1920s the discourses on childbirth and health established itself against a changed political scenario. Motherhood and fertility was no longer regarded as predominantly moral issues, but as social problems linked with women's health and living conditions.¹⁵ It was the First World War that brought to light the fact that health

¹² Balfour and Young, *Work of Medical Women in India*, p- 42.

¹³ David Arnold, *Official Attitudes to Population, Birth Control and Reproductive Health in India, 1921-46*, p-38, in Sarah Hodges (ed.), *Reproductive Health in India- History, Politics, Controversies*, (New Delhi: Orient Longman, 2006).

¹⁴ *Ibid.*

¹⁵ NAI, GOI, Pros. No. B 53, Education Department, Sanitary Branch, August 1919.

standard of population must be kept a priority especially among children. The same ideas flourished in India could be glanced from the fact that in India where considerable attention was paid to the problems of childbirth during the scenario for example, in Bombay, small maternity homes were established. At other places such as in Madras, an attempt was made to distribute milk free, or below cost price, home visiting of infants, or the establishment of regular clinics for infants.¹⁶ Moreover, the changed political scenario as well as pressure from League of Nations, ILO and England directed serious attention towards the public health especially towards maternal and child health services. According to Anna Davin, in post-war Britain the activities culminated in the 1918 Maternity and Child Welfare Act 'which envisaged the provision of a network of infant welfare centers'.¹⁷ However in India, the League of Nations and ILO were influential in condemning the issues related to children's health and raising questions at international level to the condition of public health in India and inquire the efforts of the government to the same. This international pressure and the urge to maintain the image of the state on civilizing mission alarmed the reforms in paediatric care. As the nationalist movement had an internationally renowned leader in Gandhi, the British authorities were sensitive to their image in the outside world. Nevertheless, few reforms were outlined and initiated to some extent. They either coincided with the interest of the Indian nationalist movement or had a clear bias towards the Western middle- class gender stereotypes which were emulated by Indian women's organizations. Unfortunately, the number of women and children benefitted by this paternalistic benevolence were few and rural areas were still far from the concerns of welfare state.

The year of 1920 was a milestone in the paediatric policy in the country politically. The announcement of Montague Chelmsford on 20 August 1917 in the House of Commons to introduce representative and responsible government accelerated the works of child care in country. Introduction of dyarchy transferred the Department of Health to the Provincial governments. In 1920, the GOI gave a grant of Rs. 5000 to the MCW Exhibition and holding baby week in Delhi promoted by Lady Chelmsford and over 2,000,000 pounds on the promotion of these activities.¹⁸ However the same grant was not provided in 1923 due to financial constraints and it was considered that

¹⁶ IMR, p-30.

¹⁷ Anna Davin, Imperialism and Motherhood, *History Workshop Journal*, No. 5, Spring 1978, p-43.

¹⁸ NAI, GOI, Pros. No. 9, Health Branch, Department of Education, Health and Lands, 1923.

health was a provincial subject and thus local government must bear the responsibility of such activities. The latter too showed its inability to promote such activity at provincial level. Following the declaration, Lady Chelmsford participated in the child care by establishing Lady Chelmsford League for Maternity and Child Welfare in 1920. The 1920s thus gave stimulus to child welfare movement by two events. Firstly, the Maternity and Child Welfare Exhibition and Child welfare Exhibition organized in Delhi by Lady Chelmsford League. The League oriented towards the government for funding child welfare which received little appreciation from the later. There was marginal cooperation or coordination existed between official and non-official bodies in MCW work in India. The Lady Chelmsford League collected funds and with income from the funds it assisted different local committees in various Provinces to establish nuclei of services for children. In 1931, the entire work of MCW was coordinated by establishment of MCW Bureau under the Indian Red Cross Society (IRCS). The IRCS was thus an important voluntary organization to promote MCW services and administered all funds of the two Committees- the Victoria Memorial Scholarship Fund (1903) and Lady Chelmsford League (1920). The Bureau was entrusted with the administration of all the activities of Victoria Memorial Scholarships Fund, Lady Chelmsford League Fund with the Association for the Provision of Health Visitors and Maternity Supervisors.¹⁹ Later, Army Child Welfare Committee also amalgamated with Maternity and Child Welfare Bureau, thus civil and army welfare were brought under one single office. In 1924, Lady Reading started the 'Baby Week' Movement in India.²⁰ The first Baby Week was organized by the Lady Chelmsford League and IRCS and later a National Baby Week Council was formed. For the purpose, Health Schools were established by the League at Delhi, Lahore, Calcutta, Madras, Poona, and Nagpur. These Health visitors work comprised of visit to people, holding of child welfare clinics, and training of dais. These schools unfortunately failed to receive financial support from all the provincial governments except Lahore.

The event of Baby shows thus became a part of the schedule of Dufferin hospitals. Some of the Vicerines particularly Lady Reading took active interest in maternal and child care activities. It was due to her efforts that Lady Reading Hospital for Indian

¹⁹ Central Advisory Board of Health (CABH), Report of on Maternity and Child Welfare Work in India by Special Committee, 1938, GOI, Shimla, 1939, p-3.

²⁰ Balfour and Young, *Work of Medical Women in India*, p-148.

Women and Children was established at Shimla. In February 1924, when she visited a baby welfare centre in the Delhi slums, she expressed her ‘perverse affection for Indian slums and a particular attraction to brown babies’.²¹ The purpose of these ‘Child Welfare Exhibition’ was to encourage better child care by offering material prizes and moral rewards. It was during this period that the nationalist movement was at its peak with Gandhi’s non-cooperation movement and the rise of Swarajists that claim of Indian *Swaraj* was thrashed on the pretext that Indians were not able to look after themselves and thus Lady Reading commented on the nationalists demand that “we declare them unfit for Self- government.”²² The nationalist press, on the other hand, considered it as an insult on Indian motherhood, while the real need was for combating malnutrition and providing pure and healthy milk.²³ Moreover, the reform in the conditions of childbirth failed because they were as unconnected with the lives of Indian women as Lady Reading’s baby shows. It has been argued that even like baby shows indicated the motive of both British officials and Indian leader to divert from private to public relationships. The idea behind the baby shows was to promote health education, create clients for maternal and child centers and to appoint lady health visitors.²⁴

Both central and provincial government left major portion of the organization of child welfare work to voluntary societies. Although they professed sympathy with the proposals of voluntary organizations yet declined financial aid. Whatever was of little economic or political significance was brushed aside. Outside the central organizations, there were few philanthropic efforts made to develop the work in rural areas where need was greatest. The state’s initiative in MCW work thus remained peripheral. Major A.J.H. Russell in his speech said “if the movement is to become a real national one- there must first of all be an enlightenment of the public mind and the formation of the public opinion. But this can only be achieved by spreading knowledge of the principles and practice of hygiene among great mass of the people.”²⁵ The voluntary organizations thus started collecting funds and the idea was

²¹ Cited in Dagmar Engels, p-241-42.

²² Ibid, p-242.

²³ Ibid.

²⁴ Sujata Mukherjee, *Disciplining the Body? Healthcare for women and Children in early Twentieth Century Bengal*, pp-209-210, in Deepak Kumar (ed.), *Disease and Medicine*, op.cit.

²⁵ Major A.J.H. Russell, “The Organization of Maternity and Child Welfare Work in India”, in Report of the Maternity and Child Welfare Conference held at Delhi, 4-8th February 1927, The Lady Chelmsford All-India League for Maternity and Child Welfare, Delhi, p-11.

to give grants to the places already undertaking child welfare work. The initial efforts received a setback as the local bodies and municipalities suffered the low funding. Voluntary organizations, however, were under the obligation of the government to get approval of its expansion of health measures from the government and were not allowed to initiate any programme independently. It was suggested by A.J.H. Russell, that voluntary organizations should form the link with the child's home, midwives and health visitors and work for building public opinion and the dissemination of knowledge regarding 'the advantages to be derived birth by mothers and children from regular attendance derived by MCW centers'. He does not favoured legislation for procuring better health for children, as according to him if local bodies opened CWC aiding poor mothers and investing in the development of healthy child.

Both Red Cross Society and Lady Chelmsford League worked together to be more productive and both divided their area of work. Thus Lady Chelmsford League continued to give grants to places outside Governor's Provinces i.e. NWFP and Rajputana and Indian States while the Red Cross Society confined its operations to Governor's provinces. In addition, the Lady Chelmsford League aided Health schools in Governor's provinces. League carried out its propagation through books, pamphlets, vernacular films, lantern slides, posters, for increasing the awareness about inevitability of child health care into the provinces.

Provincial governments assumed little responsibility in case of paediatrics. Few exceptions too existed such as the government of Madras, appointed an Assistant DPH in the office of DPH in 1931 for MCW with an assistance from IRCS. Some of the Corporations maintained a few MCWC and maternity homes, but were far too few in comparison to the size of the cities and the number of births. In 1936, the ICMR appointed the MCW Advisory Committee to deal with various aspects of MCW. Investigations were carried out to study the causes of maternal deaths in Calcutta, Bombay, and Calcutta. Another Committee was appointed in 1937 by Central Advisory Board of Health for recommendations on MCW, the first all India attempt to review the conditions and coordinate the future action. This Board served an all India forum for health ministers and officials from princely states and British India. The committee made detailed recommendations on the administration, provision of

technical guidance and on the training of health personnel.²⁶It revealed the general neglect of specific provisions for the MCW works. From 1938 to 1947, Bengal, Orissa and Punjab established post of Superintendent, MCW in the State Public Health Directorates, while others focused on establishment and proliferation of MCWC.²⁷Health visitors became an important single unit in the MCW services and for their training health schools were opened. There were five health schools at Punjab, Central Provinces, Delhi, Madras and Poona. The first two were maintained by provincial governments while the rest were financed by the IRCS with the grants from government sources and Poona was sponsored by the Seva Sadan Society and received the grant from MCW Bureau of IRCS.²⁸There were no medical women employed by the GOI to advise on MCW work, whereas at provincial level only Madras had a medical women assistant to the DPH.²⁹A shift in official policy was evident in 1932 when the AIIHPH was established at Calcutta which posed as an opportunity for those who were 'intimately concerned with maternity and child welfare had long been looking'³⁰ But its MCW section was opened due to the rigorous attempts of DF and Red Cross Association of India.³¹ It was not until 1937 that the government took over the funding of the section. The way the section was established, funded, worked and expanded, clearly indicates the priority of the colonial state.

For the welfare of women and children in the country, Skippo Fund Committee presented a Mobile Health Centre.³²It was suggested to name the scheme as Ashoka Akbar Van. The purpose of this mobile health center was to provide the basic aid in health care of children and women in remote areas and villages. The van scheme was started from Bombay and it was decided that the service will be transferred to other states once it has served the former state. Further, Indian National Congress in 1938 established a commission i.e. National Planning Commission and a National Health Sub-committee under the chairmanship of S. S. Sokhey and leadership of Jawaharlal

²⁶ Ibid.

²⁷ Ibid, p-4.

²⁸ Annual Report of the Public Health Commissioner with the GOI for 1934, Vol. I, GOI, New Delhi, 1936, p-117.

²⁹ Ibid, p-118.

³⁰ CABH, Report on Maternity and Child Welfare, p-3.

³¹ Annual Report of the AIIHPH, Calcutta, 1934, p-12-13, 25; 1935, p-42.

³² Roshni, Vol I, No. 2, March 1946, Lucknow.

Nehru. The report of the committee was not as extensive³³ as Bhore Committee report but significant to glance into the minds of future planners of this country. Its interim report presented in August 1940 suggested for maintaining the health of public, arranging the trained medical personnel's and arrangement of modern medical techniques and instruments.³⁴

These initial measures continued to be practiced in various provinces of the country. The branches of the voluntary organizations worked along with the provincial and local governments. The MCW works received appreciation from all spheres however at grass root level the condition remained stagnant. The monolithic policy of government and voluntary organizations focused to reduce infant mortality and thus other issues related to paediatrics failed to see the light of the day. At provincial level, few provinces like Bombay, Madras, Delhi, progressed in terms of child care while others had to wait for the independence. On the eve of independence paediatric services existed in only big cities of the country. For instance, J.J. Hospital, Bombay; the Children's Units at the Presidency General and the Chiitranjan Seva Sadan Hospital, Calcutta; Ghosha Hospital, Madras.³⁵ Voluntary efforts increased after independence with Kasturba Gandhi Memorial Trust and Indian Council of Child Welfare (ICCW), both promoted medical, midwifery services and care of mother and children in the rural areas. In 1943, Bhore Committee made useful recommendations on the areas of priorities for improvement in healthcare of women and children, unfortunately, those recommendations had shallow beginning.

MORTALITY AND MORBIDITY OF CHILDREN IN UNITED PROVINCES

The condition of paediatrics in the Province in the light of child welfare movement could be best understood from their morbidity and mortality status, especially among the lowest strata of society where medicine though desirable yet was unreachable. This could be glanced from the narrative set up in villages of Avadh by Premchand, the famous Hindi poet, in two scenarios. Here, a peasant Hori due to his sheer poverty lost three children out of six in infancy. His wife Dhanian regretted that her three sons could have been saved if she could have been able to arrange medical care or

³³ Roger Jeffery, *Politics of Health*, pp-112-113.

³⁴ National Planning Committee, Report of the Subcommittee on Public Health, 1940, Bombay, National Planning Committee of the Congress Party.

³⁵ Central Health Education Bureau, *M.C.W. Services in India*, DGHS, GOI, New Delhi, 1960, p-3.

purchase medicine worth anna at least.³⁶ The situation of the family was worse due to the zamindars and money lenders who exploited them to the extent that they could not meet their basic necessities. In another scenario, one of their child Gobar along with his wife migrated to city in search of job and better income. His wife Jhunia had a two year old son and was pregnant. It's a gut wrenching moment when the author described Jhunia as so weak due to illness and lack of food that her "breast were dry; but Lallu (her son) howl to be fed. Both her heart and body weakened. When Lallu did not get milk, he bit the nipples; but she did not had strength to push him. She could only see death coming in front of her...Lallu had diarrhea and stopped drinking milk from her, then Jhunia felt a great sense of relief; but when he died after a week, she was filled with remorse"³⁷ In third scenario, when Jhunia was to give birth to the other child, she could not get any assistance from midwives or dais. After delivery too, she had no milk and was so weak as if she had no blood in her body and the newly born child cried for milk, if given milk otherwise, child could not digest it and the condition of the child worsened with every passing day. Later a retired physician, when examined her exclaimed, "How can she expect milk when she is so anaemic? She would have to take a long course of tonics before she can hope to have milk in her breast. How can this little bundle of flesh live without breast feeding till then."³⁸ This novel is one of the literatures which created awareness about the inevitability of healthy child and mother. Thus, poverty, starvation and contagious diseases accelerated the child mortality in the Province which never became a serious point of discussion among colonial administrators and officials. Even the official reports had a clear stand that the apathy of people towards western medicine degenerates the health condition of the people in the Province.

The attitude of colonial state towards the infant mortality could be gauged from the statement that 'India is over- populated as it is; why save more babies when the land cannot support them?' and once a member of IMS remarked, 'What India wants is not Child Welfare, but Marie Stopes.'³⁹ India population was large yet leaving the process of regulation to nature when the country had significantly higher rate of infant mortality rate was unsympathetic on the part of colonial state. The higher infant

³⁶ Munshi Premchand, *Godan 1935-36*, (New Delhi: Publication Division, Hindi Edition, 2016), p-7.

³⁷ *Godan*, p-250-251.

³⁸ *Godan*, p-254-55.

³⁹ Balfour and Young, *The Work of Medical Women in India*, p-141.

mortality in British India was 189, of which 89 occurred in first month of the child born. Comparatively, mortality figures of the towns in India were terribly high especially in industrial areas of Cawnpore 484, Bombay 255, Ahmedabad 438 and Dacca 234, Poona 733, Benares 314, and Lahore 241.⁴⁰

J. M. Kumarappa, who reviewed the position of mortality among infants in 1941, observed that nearly 30 per cent of the new born babies died during the first year of their life. In 1930, IMR in big cities of Bombay, Calcutta, Madras, Delhi were 298, 268, 246, and 199 respectively.⁴¹ Of the total deaths during 1935-39, nearly 48 per cent were of children below the age of 10 as against 10 per cent in England. In 1941, Kumarappa further laid stress on the importance of setting up a large number of pre-natal and child health centers in rural and urban areas because according to him, 'the most important economic and social causes which contribute to infant and maternal mortality are poverty, ignorance, bad housing, venereal diseases, early marriage and immaturity of the mother, untrained dais or midwives, employment of mothers during pregnancy, and the neglect of children.'⁴²

The focus of colonial state was so much on cheking the advance of epidemics that the high mortality among children failed to catch their attention and took a back seat. The colonial attitude summarized by Mrs. Balfour as, "... it absorbs thought and energy of the officers concerned, and so, unless there is unusual vision to what it can accomplish, it is naturally undone.....child welfare work in India, is not yet either powerful or widespread, nor has it wealthy patrons except in a very few instances. In addition, the general mass of the public is as yet uninformed as to the true purpose of the work."⁴³ The official reports does not have sufficient and reliable and detailed vital statistics to enable one to make a comprehensive study on the mortality status of the children in India. However, a broad conclusion of a qualitative nature could be drawn from the registered data. Even though it is difficult to rely on the mortality figures, overall it can be ascertained that the child mortality was extremely high. Available data suggests that the infant death rate was considerably higher in NWP and Oudh than in England. During the decade ending in 1885 the infant mortality rate in

⁴⁰ Annual report of the Public Health Commissioner with the GOI for 1926, Vol. I, New Delhi, p-18-22.

⁴¹ J. M. Kumarappa, The Family in Child Welfare, *The Indian Journal of Social Work*, 1, 4, (March 1941), p-480.

⁴² Ibid, p-497-98.

⁴³ Balfour and Young, *Work of Medical Women in India*, p-125.

England was 142 per 1000 while in United Provinces it was 211.⁴⁴ In England, the first attempt was made by voluntary workers who enquired into conditions and remedies, organised experimental measures, and continually drew more recruits into the field of work.

Table 3.1: Comparison of Infant deaths in England and United Provinces

Gender	English Rate of 1874	North Western Provinces			
		1874-75	1875-76	1876-77	1877-78
Boys	17.24	52.09	52.04	51.01	51.22
Girls	24.92	47.91	47.96	48.99	48.73

Source- Report on the Administration of NWP and Oudh for 1877-78, Allahabad, 1879, p-54

The actual situation of child care was pathetic in United Provinces. Corroborating the fact, Municipal Commissioner reported that in Lucknow, Rae Bareli and Shahabad, out of every three children born one die. He further added that ‘though vaccination undoubtedly did not reach a reasonable standard, the failure is not the only perhaps the main cause of the mortality.’⁴⁵ Child mortality and specifically the death of infants was higher in United Provinces owing to the frequent outbreak of epidemic diseases, recurrent famines, poor sanitary state of affairs and under-developed maternal health conditions. Not only this, the lack of trained midwives and professional gynecologists led to poor maternal health which on the other hand produced weak children who often failed to see their first year of birth. There were other reasons also which are discussed in the further sections. However, disregarding these inherent issues, Sanitary Commissioner of United Provinces remarked “the infantile death-rate in a European population is usually considered to form a delicate index to the sanitary conditions under which such a community is living, but in a country where children are hurried into the world with a very little consideration as to how they are to be maintained, it loses a good deal of such significance.”⁴⁶ This unsympathetic attitude of colonial officials towards the grave situation was responsible for the under-developed policy for child welfare. Further, A.F. White mentioned in the Memorandum of the Executive Committee, “His Excellency hopes that such a scheme (National Baby week) will gradually awaken the people to the great problem of infant mortality, the

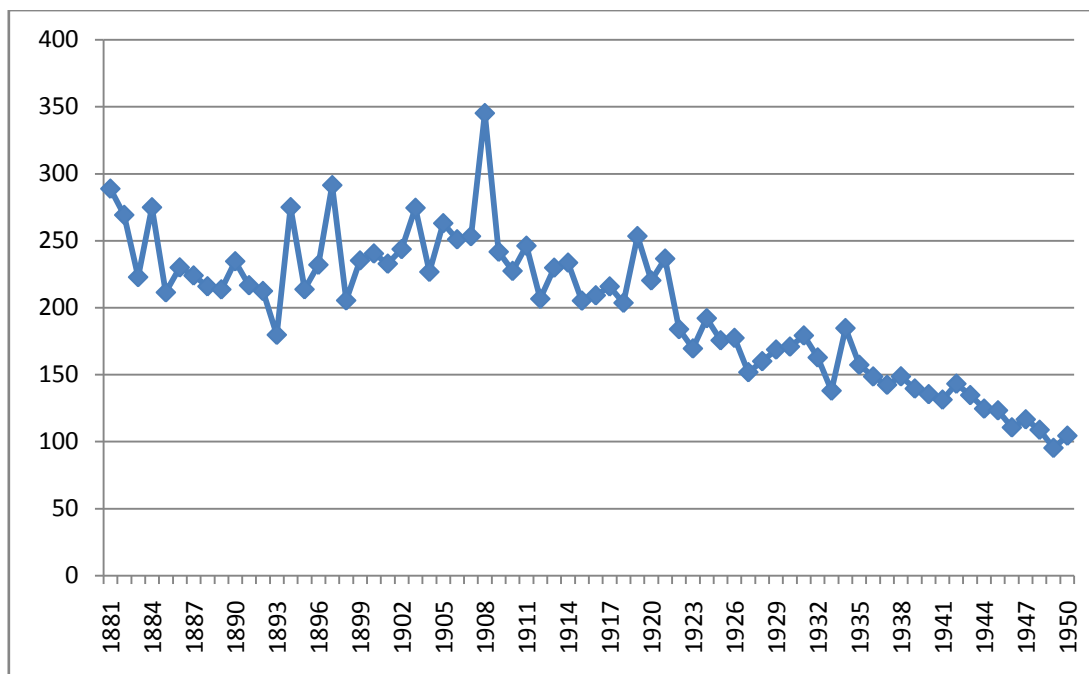
⁴⁴ Census of India, 1921, V. 1, p-209.

⁴⁵ Report on Municipal Administration and Finances in the United Provinces of Agra and Oudh for the year 1915-16, Allahabad, 1916, p-9.

⁴⁶ Thirty Fourth Annual Report of the Sanitary Commissioner of United Provinces of Agra and Oudh, 1901, Allahabad, 1902, p-4

solution of which can only come from within by the efforts and by the will of the parents of India.”⁴⁷

Chart 3.1: Infantile mortality rates in United Provinces (1881-1950)



Source: Infantile Mortality in United Provinces compiled from Annual Report of the Sanitary Commissioner of NWP and Oudh (1881-1919) and Annual Report of the Director of Public Health United Provinces (1921-40)

The highest mortality among children was from fever such as enteric, intermittent, remittent, and simple continued fever, and diseases as smallpox, cholera, plague, malaria etc. at different age periods. The census report mentioned that malaria as the indirect cause of the considerable infantile mortality in the province from inanition, premature birth, and infantile convulsions.⁴⁸ The mother suffering from malaria preceded premature births or starving of children. The epidemic outbreaks were fatal especially among children as around 90 per cent perished in the scourges. In case of plague and cholera, the people living in hill areas of Kumaun and Gharwal, buried their unmarried and male children who were not invested with the sacred thread, their remains were never exhumed.⁴⁹ In 1898, 4,103 deaths among children under 16 years of age, 964 deaths were caused by malarial fevers, 641 by unclassified fevers, and 641 from ‘all other causes’. There were only two deaths from cholera and eleven from

⁴⁷ NAI, GOI, Pros. No. 9, EHL Department, Health Branch, 1923.

⁴⁸ Census of India, 1911, Vol. XV, United Provinces of Agra and Oudh, Part I, Allahabad, 1912, p-45.

⁴⁹ UPSA, File No. 623B, Box No. 5, ‘Plague (Mahamari) in Garhwal’, Sanitation Department, 1902.

smallpox, measles caused 327 deaths, dysentery 344, and diarrhea 111, and lung diseases 654 deaths.⁵⁰ In the malarial survey of 1923, 933 children were examined and the survey found 88 per cent with enlarged spleen and the percentage of children in villages was 100.⁵¹ Manufacturing towns specifically suffered from infant mortality owing to the employment of female labour. Cawnpore and Benares tops the list of industrial towns where mortality rates among children remained higher throughout the colonial period. Chart 3.1 shows the fluctuating and remarkably high infant mortality in this Province. It was only after the 1940s that mortality among children evidences a continuous decline; unfortunately the figures were unsatisfactory even after independence. In the year 1909, the infantile mortality was highest in the history of the United Provinces i.e. 345.1 death rate among children. It was due to severe malaria epidemic in northern India and the high peak in 1918 was caused by the pandemic of influenza.

On the proposals of sanitary conference of 1908, an inquiry into causes of mortality was commenced in Cawnpore by a lady doctor and two midwives.⁵² In the report on the results of this experiment, C.S. assessed the diseases or factors which contributed highest infantile mortality among all the causes of deaths in children and reported that tetanus caused 30.22%, pneumonia- 17.03%, teething- 14.40%, malnutrition- 12.17%, and premature birth- 9.33% of deaths. The high evidence of plague, malaria and smallpox which was not highlighted in the report also caused increase in infantile mortality for instance in the same year, one evidences 16,974 increase in smallpox deaths. Thus, these were the non- communicable diseases which accelerated the high rate of child mortality but there were no attempt to ascertain the real facts to the causes of infant death in the province or to eradicate these ailments in the children. Another reason high mortality was the large number of still births in the Province, which in 1917 was 31,954 and in 1918 was 30,299. Eastern districts evidenced high still births could be assessed from the fact that till independence Gorakhpur heads the list with mortality around 5000 still births. During the year 1918, the still-births in Gorakhpur was 4,299, Sitapur 2,404 followed by Basti 2,229, Azamgarh 1,992, Gonda 1,936, Bahraich, 1535, Barabanki, 1441, Kheri 1321. Increase in still births

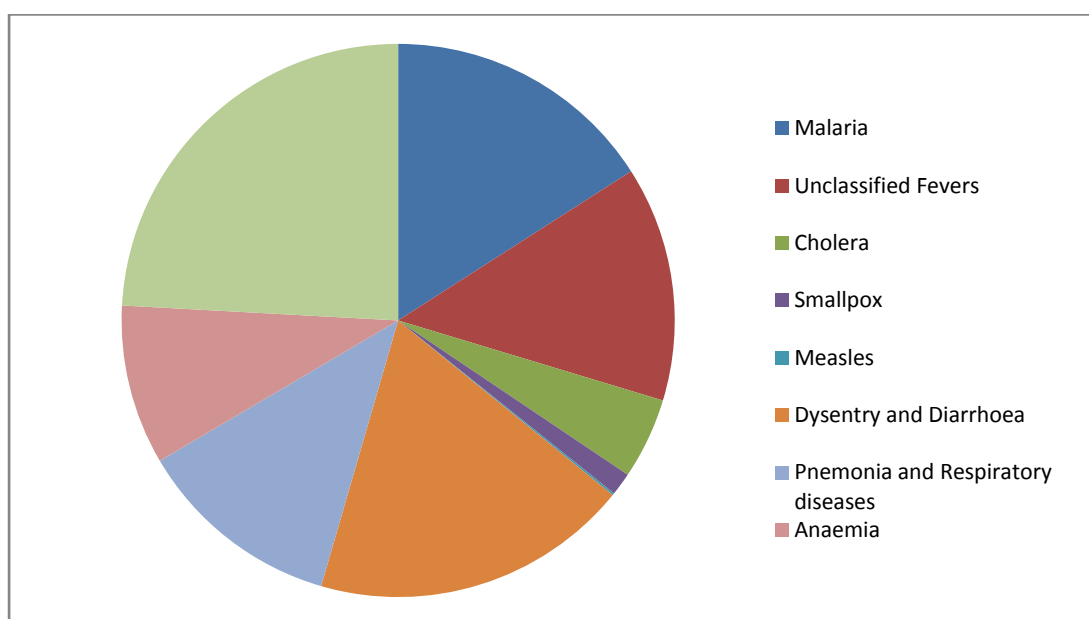
⁵⁰ Thirty- First Annual Sanitary Report of the Sanitary Commissioner of NWP and Oudh, 1898, Allahabad, 1899, p-26.

⁵¹ Fifty- Sixth Annual Report of DPH for United Provinces, 1923, Allahabad, 1924, p-22.

⁵² Orders of Government No. 476/XVI-104 of 1909 Resolution, Sanitation Department, Dated Naini Tal, 16 July 1909, p-2. Forty First Annual Report of the Sanitary Commissioner of United Provinces of Agra and Oudh, 1908, Allahabad, 1909.

was due to deficiency in maternal health such as malaria, poor nutrition, poverty and epidemic diseases. MoH appointed in municipalities in 1925-26 noted that the causes of still-births comprised of prolonged labour, less care of women, malaria, syphilis, plague, fever, poverty, untrained dais, etc.⁵³ Variations in mortality from the causes differed from region to region and mostly by the availability and accessibility of medical facilities. As for instance, the deaths occurring in young children was not uniform as in 1916, Lucknow reported no deaths from tetanus while 1,387 deaths were recorded from wasting diseases whereas Cawnpore evidenced 539 deaths, Allahabad 666 from tetanus and none from wasting diseases in Cawnpore and 29 at Allahabad.⁵⁴ The measures adopted by the government, on the other hand, for the reduction of infantile mortality were- distribution of pamphlets comprised of instructions for mothers and midwives, employment of health visitors, training of dais and employment of trained midwives, delivery of lectures by maternity supervisors and resident midwives, introduction of byelaws for the regulation and control of milk shops, free distribution of quinine in tarai and bhabar.

Chart 3.2: Causes of Deaths among Children in United Provinces



Source: Infantile Mortality in United Provinces compiled from Annual Report of the Sanitary Commissioner of NWP and Oudh (1881-1919) and Annual Report of the Director of Public Health United Provinces (1921-40)

⁵³ Fifty-Ninth Annual Report of the DPH of United Provinces 1926, pp-6-7; Sixtieth Annual Report of the DPH of United Provinces 1927, pp-6-7.

⁵⁴ Forty-Ninth Annual Report of the Sanitary Commissioner of United Provinces of Agra and Oudh, 1916, Allahabad, 1917, p-5.

Sanitary Commissioner showed his concern towards the increasing the infant mortality in the Province. Instead of suggesting measures or policy or schemes to reduce infant mortality as highlighted in the report, L. M. Thorton advised that “it will be well to compare the infant death rate of this Province with that of other provinces of India.”⁵⁵The colonial attitude thus was to cover up the loss of child or infants by comparing it with other states and not focusing on the issue of large number of deaths of children. It was not merely a statement made by any officer but coincidentally the reports of Public health, 1902 onwards gave data at all India level where it was shown that though the mortality was high in the Province the highest mortality was there in Central Provinces.

Table 3.2: Provincial Infant Mortality Rates in Colonial India

Year	Punjab	Bengal	Madras	United Provinces	Bombay	Bihar (Orrisa)	Assam	Central Provinces	Delhi	NWFP	Burma
1901	237.4	200.4	168.0	243.6	196.3	-	-	-	-	-	-
1903	265.0	194.6	177.6	274.4	213.4	-	-	-	-	-	-
1904	226.0	186.6	183.2	226.6	194.5	-	203.4	220.2	-	-	-
1905	235.0	208.7	172.5	262.9	224.5	-	-	293.2	-	198.6	196.6
1906	235.0	206.3	190.9	250.9	220.3	-	197.1	287.7	-	224.6	213.3
1907	246.0	198.9	177.0	253.2	199.0	-	175.6	271.7	-	228.1	198.5
1916	200.2	195.4	182.7	209.7	199.6	190.7	202.0	265.3	223.1	185.4	206.3
1917	247.9	184.6	193.9	215.7	216.7	180.4	189.28	226.8	224.8	194.3	213.2
1920	182.7	207.4	161.5	220.2	183.2	169.5	187.6	255.8	212.1	161.9	186.6
1927	167.5	-	175.4	151.7	161.5	133.4	171.4	221.6	191.7	150.7	197.7
1930	185.7	187.3	185.7	170.8	187.1	137.8	174.4	211.8	190.8	146.5	202.3
1931	178.3	174.0	186.4	179.0	161.6	143.6	152.8	261.2	185.4	128.3	190.8
1932	178.5	178.9	-	162.7	156.4	128.8	156.6	201.1	236.0	129.3	184.5
1933	192.5	200.1	184.8	137.8	160.6	135.0	163.5	200.0	226.2	137.4	192.3
1934	187.4	189.2	192.7	184.6	174.8	149.5	165.4	253.5	212.4	134.3	219.5
1935	155.2	158.5	178.5	157.2	163.9	129.2	163.2	223.5	177	132.1	186
1936	158.4	170.9	164	148.6	166	117.9	150.8	234.9	162.8	121.7	-
1937	163.0	175.5	169.7	142.3	160.7	115.9	160.0	218.6	166.6	148.6	-

Source: Annual Report of the Sanitary Commissioner of NWP and Oudh

The lower mortality in Madras and Bombay in comparison to United Provinces was never taken into account. If mortality compared at all India level, it can be seen that mortality rates among children was comparatively higher in North Indian provinces i.e. in Punjab, United Provinces and Central Provinces during the colonial era in comparison to the rest of the country. Public Health Commissioner with GOI, also

⁵⁵ Orders of the Government, No. 1130/XVI-282B-107 of 1902, From L. M. Thorton, Secretary to Government to Sanitary Commissioner of United Provinces, dated 24 June 1902, p-2, in Thirty Fifth Annual report of the Sanitary Commissioner, 1902, Allahabad, 1903; Twenty- Fifth Annual Sanitary Report of the Sanitary Commissioner of NWP and Oudh, 1902, Allahabad, 1903.

stressed that the reduction in number of maternal and infant deaths could be expected 'until every town and district properly equipped and properly staffed with center and a number of maternity beds at least for difficult or abnormal obstetric cases.'⁵⁶

An elaborate scheme for the care of mothers and prevention of infantile mortality in Lucknow was prepared by Dr. Said-uz-Zafar Khan in 1917 and Lucknow municipality was hopeful that with the help from the Board of Public health the scheme could be introduced as an experiment in one division of the city of Lucknow. But Sanitary Commissioner raised his doubt on the success of the scheme because according to him the scheme would be "far too expensive to permit of its general adoption in our cities"⁵⁷ and thus once again a measure to combat infantile mortality was declined in lieu of financial constraints. On the other hand, measures adopted by the government were occasional and restricted. For instance, dhais were admitted for training in essentials of midwifery and care of young children, leaflets and posters on feeding of young children and the prophylaxis and treatment of malaria were distributed.⁵⁸ It was various voluntary organizations and educated elite people who took serious efforts for improving the conditions of child mortality and morbidity.

PAEDIATRIC CARE IN UNITED PROVINCES

The history of child welfare in colonial United Provinces goes back to 1870s when missionaries established and laid the foundation of medical work for women. As mentioned earlier, child welfare movement in India corresponded with the voluntary organizations in India. Consequently, United Provinces branch of the All India Lady Chelmsford League for Maternity and Child Welfare work was inaugurated by Harcourt Butler in 1922 December at Lucknow, which laid the foundation stone of the paediatric care in the Province.⁵⁹ First center was opened at Bareilly and second at Allahabad, which were also the training centers for midwives. Thereby the scheme of MCW work was launched in other districts of this Province. With this midwives were appointed to visit homes of expectant mothers and to supervise their work, sub-assistant surgeons were appointed. At Bareilly, Mrs. Stubbs Maternity and Child

⁵⁶ Annual Report of the Public Health Commissioner with GOI, Vol. I, 1935, New Delhi, 1937, p-11.

⁵⁷ Fifty-Second Annual report of the Sanitary Commissioner of United Provinces, 1918, Allahabad, 1919, p-7.

⁵⁸ Fourty-Seventh Annual report of the Sanitary Commissioner of United Provinces, 1914, Allahabad, 1915, p-4.

⁵⁹ Fifty- Sixth Annual Report of DPH for United Provinces, 1923, Allahabad, 1924, p-29.

Welfare Society affiliated to the Lady Chelmsford League and Mothercraft Training school, worked for the infant and child welfare. Agra municipal board on the other hand, started a baby clinic in 1922 at their own expense.⁶⁰ Training centers for the indigenous dais was established at Lucknow, Agra, Allahabad, Meerut, and Gonda by Victoria Memorial Scholarship fund in 1919. These centers worked under the Fund but from 1924 onwards the management and control of the scheme was taken up by the Provincial branch of the League. At the instance of Lady Reading, the League approved the organization of Baby weeks in all districts of the Province in 1923. For these programmes, municipal, local boards and Victoria Memorial Scholarship Fund contributed annually,⁶¹ but the pressure of these expenses on Boards was too much for them to bear thus this indirectly impacted the success of these initiatives. Cawnpore municipal board decided to maintain one health visitor and two *dais* at the maternity centers. In addition to the scheme, another scheme was approved for the training of superior class of midwives at the Dufferin hospitals at Aligarh, Bareilly, Moradabad, Benares, Lucknow, Cawnpore, Allahabad, Fyzabad, Meerut, and Gorakhpur.⁶² Together with this, probationer midwives were given scholarships of Rs. 12. Later, the training center was transferred to Lucknow in 1928, where a health school was established for the training of health visitors. However, due to lack of funds and the health visitors, the school was abolished in 1932. IRCS and the League of the Province were amalgamated in 1931. By 1935, there were 293 maternity centers while only 18 child welfare centers. This shows the low priority given to the child health in the medical policy of the United Provinces. Furthermore, for the purpose, the government granted Rs. 50,000 in 1926 which increased to 1,22,600 in 1936 and the expenditure in 1937 was Rs. 2,54,718 including the grant from the IRCS.⁶³ In 1935, one lakh rupees was granted by Silver Jubilee Fund for the construction of health school at Lucknow for the training of health visitors, midwives and dais.

The branch of the League in 1926 instead of holding a baby week arranged for the All India Lady Chelmsford Travelling Exhibition, where they undertook 660 cases with the help of indigenous dais and paid 16,214 visits in the patient's homes.⁶⁴ Baby

⁶⁰ Ibid.

⁶¹ In 1922, municipal and local boards contributed Rs. 10,000 and Fund gave Rs. 6430. Fifty- fifth Annual Report of DPH for United Provinces, 1922, Allahabad, 1923, p-5.

⁶² Fifty- fifth Annual Report of DPH for United Provinces, 1922, Allahabad, 1923, p-5.

⁶³ Report of the Maternity and Child welfare Work in India, 1938, p-10.

⁶⁴ Forty-Ninth Annual Report of DPH for United Provinces, 1926, Allahabad, 1927, p-70

weeks and child health exhibitions were organized at different districts in the Province. How far they were successful in disseminating the cause of paediatrics, is a subject of inquiry. Few remarks help us to understand the scenario. As Dr. Tilak lamented that exhibition without proper demonstration just work more as a formality than as educational propaganda for paediatrics.⁶⁵ Secondly, such baby weeks were organized in urban areas and towns in comparison to rural areas, so the impact of the programme was more visible in the areas possessing several facilities rather than those whose hands were empty. Thirdly, the basic limitation of the work was the lack of follow-up. No effort was made to find the impact of these exhibitions and programmes and whether parents followed these efforts, the initiative tried to disseminate among masses. Further, there was no separate municipal organization for MCW work or any Red Cross maternity hospital in the United Provinces unlike at other provinces. Municipal commissioner noted, 'Government desired to use the provincial branch of the League for the direction of the movement and place at its disposal for distribution to local centers such funds as they are able to provide; but yet intended position of the branch has not been fully appreciated either by the branch committee or by the general public. Better coordination and more energy needed if the branch is to fulfill the functions allotted to it.'⁶⁶ With a view to organize a Maternity and Child Welfare League in Lucknow, Mrs. Cassels convened a meeting on March 2, 1925, at which a central committee with power to co-opt was appointed. The proposal for the reorganization of the Lucknow Maternity Welfare League drafted according to which the town was divided into eight centers and the control of the work was proposed to be handed over to the local branch of Lady Chelmsford League and be affiliated to the central body of the League. For the scheme municipal board, IRCS and government contributed together for the proposal to be effective.⁶⁷ To boost such activities, municipal board of Lucknow asked for special grant for child welfare work. Following the demand a question aroused whether the Board of Public Health undertake to assist such schemes. The government, however, decided that all MCW schemes fall in the sphere of the United Provinces branch of the Lady Chelmsford League and that grants to the local centers provided through the League.⁶⁸ Thus by

⁶⁵ Dr. H. V. Tilak, *Propaganda Work*, p- 181, in Report of the Maternity and Child Welfare Conference held at Delhi, 4-8th February 1927, Lady Chelmsford All India League for Maternity and Child Welfare, Delhi, 1927.

⁶⁶ Report on Municipal Administration and Finances in the United Provinces of Agra and Oudh for the year ending 1925, Allahabad, 1926, pp-8-9.

⁶⁷ Fifty-Eight Annual Report of the DPH of United Provinces of Agra and Oudh, 1925, Allahabad, 1926, p-53.

⁶⁸ Annual Report of the Board of Public Health, United Provinces for the year ending December 31, 1925, p-9A, in Ibid.

1936, Dufferin and Mission hospitals were made members of the local committees in few places to supervise MCW work. A children's nursery was also started at Silver Jubilee Health School, Lucknow for the care of babies. It was also decided to open Rural Development Maternity Centers for training of local dais, but was not opened for the want of suitable workers.⁶⁹ To give a further boost to MCW work, a Ladies Special sub-committee was formed in the Province in 1944 to stimulate the interest in MCW.⁷⁰ Further an Assistant Director of Maternity too was appointed by the government. These were the primary efforts of the government to ensure child care in United Provinces.

Iss mehngai se nit ekadashi manate,

*Ladke bale sab ghar gahr mein chilllate*⁷¹

Famines were more fatal to the young population than any other age group. The above poem shows the condition of children especially during famine. Recurrent famine not only increased mortality rates among children but also produced higher number of malnourished children in the Province. The poem above indicates that due to famine the rates of commodities reached its apex and that the poor is helpless to purchase food and thus their children die from hunger. Occurrence of famine in NWP and Oudh could be found in colonial records during the years 1803-04, 1817, 1833, 1837-38, 1860-61, 1868-69, 1878, 1890 and 1908. The famine of 1837-38 turned out to be the severest in the colonial time. Government during 1837 decided to provide relief to the well-to-do population by engaging them in doing physical work such as the construction of buildings and roads, repair or digging wells, etc. Children too were employed in these works, got 3 pice as rate of allowance. The relief society formed at Agra during the famine failed to cope up with the growing patients.⁷² Children suffered from diarrhoea and dysentery due to bad food and thus the condition of women and children was described as of 'walking skeletons'.⁷³

⁶⁹ Seventy-Third Annual Report of DPH of United Provinces, 1940, Allahabad, 1941, p-22.

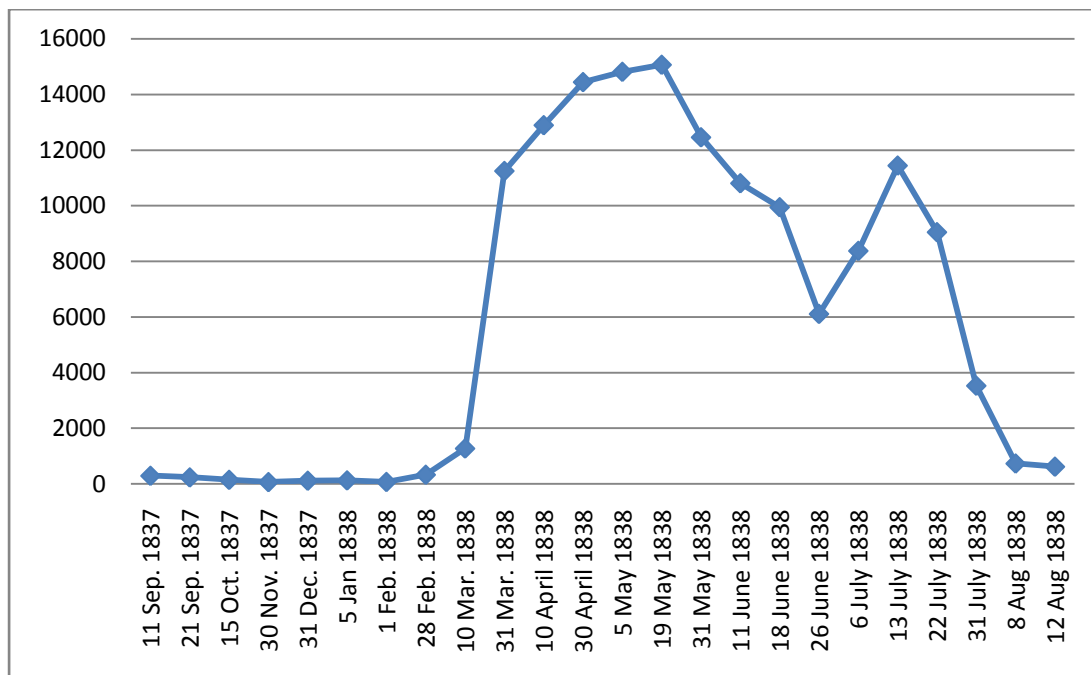
⁷⁰ Annual Report of the Public Health Commissioner with GOI, 1943-44, New Delhi, 1946, p-28.

⁷¹ Badrinarayana Chaudhury 'Premghan', 'Ab Kaal pada hai bhari', Deshbhakti ki Kavitayen, Prakashan Sansthan, New Delhi, 2005, p-4.

⁷² H. R. Nevill, Agra District Gazetteer, p-44.

⁷³ Cited in Sanjay Sharma, Measuring Hunger: Debates on an 'Adequate' Diet in Colonial North India, p-191, in Kiranmayi Bhushi (ed.), *Farm to Fingers: The Culture and Politics of Food in Contemporary India*, (New Delhi: Cambridge University Press, 2018).

Chart 3.3: Number of children as labour employed by the government at Agra during famine



Source: Sanjay Sharma, *Measuring Hunger: Debates on an 'Adequate' Diet in Colonial North India*, pp-188-89, in Kiranmayi Bhushi (ed.), *Farm to Fingers: The Culture and Politics of Food in Contemporary India*, (New delhi: Cambridge University Press, 2018).

Missionary women like Miss. Wahl and various societies played significant role in providing the women and children with food and medicines.⁷⁴ Cavalier on her visit to Lucknow mentioned her experience during famine where she elucidated how Miss Wahl's tent in Sissndi (village near Lucknow) distributed grains, food and medicines to women and children and opened a center for providing relief during famine year of 1897.⁷⁵ Government gave nominal grants to these societies and asked orphanages to take care of such children who lost their parents and were weak as well as malnourished. For the medical aid to the children in NWP, a proposal was recommended by the Lieut.-Governor, that free supply of medicines from public stores granted to the Secundra Orphanage at Agra⁷⁶ on the lines of Roman Catholic Orphanage at Agra from 1848 and at Meerut, which had facility of supply of good medicines. However, the charity was not extended to other institutions as it was

⁷⁴ A. R. Cavalier, *In Northern India*, London: Zenana Medical Mission, 1899, p-31.

⁷⁵ *Ibid*, pp-38-41.

⁷⁶ NAI, GOI, Letter No. 1688A, dated 23 April 1870, Allahabad, in Nos. 7-8, Home Department, Public branch 'A', 28 May 1870.

considered that if granted other institutions too would demand the same and thus be a financial burden.⁷⁷ Few privately owned orphanages also supported children through the Famine Relief Fund of the Provincial Government, such as Qaisari Orphanage (Hamdard Islam) established at Agra on the 16 May 1894, sent many famine orphan children to this orphanage. Children were sent to private orphanages until the famine relief operations closed. Orphans sent from State to private orphanages during famine (1896-97) and for them the Famine Orphan Funds paid Rs. 2 per head.⁷⁸ C.S. Rae Bareli and Unnao reported that “the condition of children alone is said to be bad and children under 10 years of age is much below par.”⁷⁹ Further, the situation was described as, “children are very weakly as a rule, and diarrhea is prevalent among them. They eat various indigestible fruits which are to be bad at this time of the year, and this in their weak state produces severe diarrhea. This is also applies to the weakly women and men, but it is most marked in the case of children.”⁸⁰ C.S. of Kheri gave a heartbreaking account of his tour as, “There are large numbers of men and woman and children without the means of obtaining food, and the emancipated condition of many I have seen on the roads, points to their not having had sufficient food for some days. There are a number of men and women seeking employment who are physically unfit to do full day’s work: these people in many instances are encumbered with one or more children, and it is not possible for them to earn sufficient to nourish themselves and children.”⁸¹ The Deputy Commissioner of Kheri thus said that he wanted to start a large system of village relief, and he was then told to open relief works and attach children’s kitchen to them. But the work never commenced owing to the lack of funds. Even an I.M.S. officer wrote to the Commissioner of Lucknow division that ‘the women themselves were in fair and even good condition, while the young children were very thin and starved looking. When I passed through the Hardoi district there was a good deal of smallpox prevailing.’⁸² Famine funds though provided could never actually delivered the relief it was meant

⁷⁷ NAI, GOI, Nos. 7-8, Home Department, Public branch ‘A’, 28 May 1870.

⁷⁸ UPSA, File No. 157/1907, Box No. 44, Care of Orphans during Famine, Scarcity Department, 1908.

⁷⁹ UPSA, File No. 118, Box No. 30, Report on the condition and health of the People on famine relief works in NWP and Oudh, Scarcity Department, 1897.

⁸⁰ UPSA, Fortnightly report on the Health and conditions of the population in the NWP and Oudh during the second fortnight of June 1897, p-111, in Ibid.

⁸¹ UPSA, Letter No. 441, From C.S. of Kheri to Sanitary Commissioner of NWP, dated 16 July 1897, in Ibid.

⁸² UPSA, Letter from H. R. Brown to Commissioner, Lucknow Division, dated 3 June 1897, in Fortnightly report on the health and conditions of the population in the NWP and Oudh during the second fortnight of June 1897, p-2A, in Ibid.

to, as many perished from hunger and those who survived suffered from various diseases. The fund received an opposition in 1894 in Aligarh when a 'special tax' was levied for ensuring its application in famine affected areas.⁸³ Such acts instead of providing relief to the people, emancipated their sufferings.

Tifle mein buu aaye kya maa baap ke avatar ki,

*Doodh to dabe ka hai taleem sarkar kee.*⁸⁴

In the above couplet the writer is disheartened to see the commercialization of education and food by the government policy where family traditions and cultures were colonized by the western systems. The criticism of paediatric policy not only appears in vernacular literatures but also from the pen of contemporary poets. Attention for the health of children raised from the newspapers and articles in the journals. *Bharat Jiwan* drew attention to the necessity on the prohibition of the sale of intoxicants such as cigarettes, biris and liquors to persons below fourteen years of age in all provinces by the government.⁸⁵ In 1906, a sadhu was given life imprisonment on account of willfully murdering a child by giving him some intoxicating drug at Allahabad during Kumbh fair. Another newspaper raised the question of the lack of legislation for its prohibition by the government.⁸⁶ Demand for the better child health raised from all walks of life as will be seen in the chapter later and the step-motherly attitude towards native children only worsened the grave situation.

To the Rural Development programme, the Governor sanctioned the starting of 24 maternity centres in rural areas for training of village dais in prophylactics of child birth under the supervision of the United Provinces branch of I.R.C.S. The establishment too suffered from some problems such as lack of indoor facilities for treatment of patients, lack of personnels such as nurse and compounders and inadequacy of grants for medicines, instruments and 'country medicine'.⁸⁷ Public Health Commissioner commented that the proportion of the provincial resources allocated for MCW varied from zero in Assam and Bombay to 9.3% of the public health budget in the Central Provinces, while the largest sum of money allotted by a

⁸³ Tohfa-i-Hind, 25 September 1894, SVN, p-422.

⁸⁴ Akbar Allahabadi, "Sarkari Taleem", *Saraswati*, 26, 1925.

⁸⁵ Bharat Jiwan, SVN, 18 June 1906.

⁸⁶ Arya Mitra, SVN, 24 May 1906, p-318.

⁸⁷ UPSA, Progress Report of the rural allopathic fixed and travelling dispensaries established under Rural Development Programme by I.G.C.H., U.P., in File No. 337/38, Box No. 85, 'Schemes for the Medical relief in rural areas', Medical department, 1938

local government Rs. 1,20,000 in United Provinces and greatest proportional allotment from a PHD's budget was of Central Provinces. Thus, it was in the Central Provinces and United Provinces, where large sum from the provincial budget was given to the voluntary societies for expenditure.⁸⁸

Children were many times used by the colonial authorities to spread the western science and medicine among the masses. For instance, school children were encouraged to participate in the health weeks and anti-malarial scheme of the government by distributing cinchona and quinine tablets to the sick during epidemics of malaria and kerosining of tanks and filling of hollows, permanganating wells, assisted public health authorities in anti-cholera and plague inoculations as also in vaccination and first aid.⁸⁹ This was carried out through the agency of *Boys Scouts and Junior Red Cross groups* and children were also trained in such tasks. During the year 1934, 8,355 boys were trained to implement minor anti-mosquito measures in the respective areas.⁹⁰

The chief difficulties experienced in child welfare services in the Province were- inadequate local supervision, growing yet inadequate sense of cooperation and discipline among the workers and paucity of funds for the expansion and improvement of the work. Dagmar Cujrel argued that the real solution of the problem lies in educating the Indian women in case of her own health, and that of her offspring, and in the elements of domestic hygiene, by every possible means.⁹¹ For them, it was unlike *home rule* for the women and children of this country.

VACCINATION OF CHILDREN IN UNITED PROVINCES

The vaccination reports divides the introduction of vaccination in United Provinces into three stages- first that of terror, where mothers hide their children in the fields on the approach of vaccinators; second is that of apathy towards vaccination and third and final stage leading to the faith in the vaccination in NWP and Oudh. As per Sanitary Commissioner, by 1875, all the districts of the Province passed the stage one

⁸⁸ Annual Report of the Report of Public Health Commissioner with the Government of India for 1934, Vol. I, New Delhi, 1936, p-116-117.

⁸⁹ Seventieth Annual Report DPH of United Provinces of Agra and Oudh 1937, Allahabad, 1938, p-52.

⁹⁰ Sixty-Seventh Annual Report DPH of United Provinces of Agra and Oudh 1934, Allahabad, 1935, p-34.

⁹¹ Dagmar Florence Cujrel, Papers by Medical Women on the Improvements of the Conditions of Childbirth in India, p-40, in DMSF, *Improvement in Conditions of Childbirth in India*, 1918, Calcutta, 1918.

and few second also.⁹² For instance, at Pilibhit, much assistance was given by Mr Gordon by asking the village chaukidars to collect children for vaccination and inspection, but the authorities doubted the applicability of employment of the village police.⁹³ Earlier, the government was not willing to take the responsibility of vaccinating children due to the parent's opposition but post-1857 government themselves endowed the local and municipal boards to ensure vaccination of children.

Vaccination Act of 1880 made it compulsory for the parents to vaccinate their children. The chief cause of parent's opposition, apart from the official view of religious contention especially among Hindu's, were the inefficient vaccinators, the taxes that were levied and faith of the people in indigenous methods of prevention of smallpox. The fact could be glanced from the letter of Parmeshari Das and some other petitioners who opposed the extension of Vaccination Act in their municipality (Cawnpore) in 1888, as "this proposed measure will only create discontent and mortification among the ignorant people, and their number is not small in this town; a feeling which our just and benevolent government will never like to foster among its illiterate subjects. When the provisions of the Act are to be carried out by the uneducated and unsympathising vaccinators, there is sure to be miscarriage of the provision of laws, and the residents of the town will have to endure great hardship and oppression. Even now when the Act has not been formerly introduced, the vaccinators have been performing their work by force, which has created dread in the minds of the people. But when they are armed with the 'Act', there will be no safety to age or position....the major portion of our community believes that smallpox is the direct expression of the wrath of Goddess Bhawani or Sitala. It is not malady that can be cured by medicine and any attempt to check its progress will only enrage Goddess, who is otherwise pacified by the prayers and simple diet. The belief is founded on sacred texts.....we believe that our just Government will not offend the religious feelings of its loyal subjects.....so when the people come to understand the value of vaccination there will be no necessity to force them to accept it."⁹⁴ This objection was corroborated by 1144 people in the Cawnpore by their petition against vaccination.

⁹² Report of the Administration of the N-W Provinces, 1875-76, p- 200.

⁹³ UPSA, File No. 8/4, Box No. 7, Annual Report of the District Boards in United Provinces of Agra and Oudh, 1901-02, LSG Department, p-34.

⁹⁴ UPSA, Petition from Parmeshwari Dass and others, Cawnpore Municipality, dated 24 March, 1888 in File No. 14B, Box No. 1, Extension of Vaccination Act (XIII of 1880) to the Cawnpore municipality, Sanitation Department, December 1888.

Similar criticisms were also forwarded by the public of Unnao municipality in the following year.⁹⁵ A protest was launched by the people of Unnao municipality where more than hundred people signed against the extension of vaccination in their area.⁹⁶ The chief concern of the people thus was the increased taxation levied on them on account of extension of Vaccination Act which accordingly ‘squeezed them freely’. Further people were unhappy with the vaccination work especially in the province where vaccinators were inexperienced.⁹⁷ As J. M. Chisholm contended that the vaccination was not against any religious scruples but the main opposition was from the employment of bad agents, whose proceedings ‘irritate the people, and create a feeling that the operation is useless and affords no protection.’⁹⁸ Even editors of few newspapers complained about the forceful vaccination of children by vaccinators, harassment of people and the deaths of children due imperfect method of vaccination⁹⁹ and use average vaccine matter leading to the death of many children. T.W. Holderness mentioned that the people of Oudh object to the lymph being taken from their children’s arms, and the supply of the good animal lymph or good human lymph being defective.¹⁰⁰

To ensure the success of vaccination, government decided to follow a policy of persuasion i.e. children to be vaccinated by visiting the houses. Apart from persuasion, it was stressed that native practitioners i.e. vaidas and hakims, be taught and altogether recruit the Brahmans for vaccination.¹⁰¹ The President of the Sultanpur Board emphasized that there was a consensus of opinion that vaccination should be

⁹⁵ UPSA, Translation of a petition from Kashi Din, Din Dayal, Girja Dayal, and 105 other residents within the limits of the municipality of Unnao, dated the 21st September 1889. File No. 62B, Box No. 1, Extension of Vaccination Act (XIII of 1880) to the Nawabganj and Unnao municipality (Barabanki), Sanitation Department, March 1890.

⁹⁶ UPSA, Letter from S.P. Sanyal to Sanitary Commissioner dated 5 October 1889, in File No. 62B, Extension of Vaccination Act (XIII of 1880) to the Nawabganj and Unnao municipality (Barabanki), Sanitation Department, March 1890.

⁹⁷ *Shola Tur*, SVN, 4 March 1879, p-185.

⁹⁸ UPSA, Letter No. 3103-147, From J. W. Chisholm, Secretary to the Chief Commissioner, Central Provinces to the Sanitary Commissioner, Central Commissioner, dated 2nd September 1874, in File No. 267B, Box No. 2, ‘Reorganization of Vaccination Department’, NWP, Sanitation Department, 1894. Same view could be glanced from the Chairman of District Board who stated that the work of some of the vaccinators was unsatisfactory. See File No. 8/4, Box No. 7, ‘Annual Report of the District Boards in United Provinces of Agra and Oudh, 1901-02’, LSG Department, p-12.

⁹⁹ Sajjan Vinod, SVN, March 1894; Tohfa-i-Qadiri, SVN, 15 April 1894; Ram Patrika, SVN, 23 April 1894.

¹⁰⁰ UPSA, File No. 267B, Box No. 2, ‘Reorganization of Vaccination Department, NWP, Sanitation Department, 1894.

¹⁰¹ Annual Report of the Vaccination in the NWP for the season, 1866-67, Allahabad, 1867, p-3.

performed by one who belonged to either Mali or Brahmin.¹⁰² On the other hand, Strachey stressed that, “this should be our constant aim, for it is impossible to suppose that Government can, at its own expense, undertake to keep vaccinated 200 millions of people. The people must be taught to do it for themselves, and the first step is to make them want it.”¹⁰³ But the method too had to face few challenges, for instance, once the people of Kurakut promised to the officials that they will vaccinate their children, on the condition that vaccinator will not come in the months of Poos and Magh.¹⁰⁴ These months coincided with the vaccination season declared by the NWP government leading to lower number of children vaccinated. Another method adopted to promote the technique, was to offer rewards such as rice to poorer classes who brought their children to be vaccinated, and small presents to those who allowed arm to arm vaccination from their children or the collection of the vaccine crusts from their arms.¹⁰⁵ Sultanpur municipality in 1885 added some new rules in the Vaccination Act XIII of 1880, accordingly, a vaccination station to be established in Sultanpur circle, by which children were to be vaccinated either at the station or at home on the request made by parents or guardians. It was also declared that for vaccination people should not be charged.¹⁰⁶ However, for vaccination by animal lymph, public vaccinator could demand a fee of 8 anna. For the purpose, a public vaccinator was appointed by the Municipal committee. It is to be noticed that, the reforms in the Vaccination Act of Sultanpur municipality was not shared by the other municipalities of the Province. Bhattacharya argues that “it is possible to argue that while colonial European officials might have represented the unwillingness of the people to accept vaccines as being the result of superstition and illiteracy, and accused Indian bureaucrats of being corrupt and lazy, it seems by far more likely that the lack of working vaccine combined with use of painful operating techniques might have stocked civilian and official resistance to the forcible introduction of schemes of smallpox immunisation.”¹⁰⁷

¹⁰² UPSA, File No. 22, Box No. 209, Extension of the Vaccination Act XIII, of 1880 to the Sultanpur Municipality, Medical Department, October, 1885,

¹⁰³ NAI, Pros. No. 32-38, Home, Public, 12 November 1864, p-4.

¹⁰⁴ Letter no. 51, from W. Watson to F. Pearson, Almorah, 20th April 1873 in F. Pearson, North Western Provinces- Returns of Vaccination for the season 1871-72, Allahabad, 1872, p-23.

¹⁰⁵ S. P. James, *Smallpox and Vaccination in British India*, p-20.

¹⁰⁶ UPSA, Notification no. 286M/V-22-4 of 1885, Medical Department, 30th September 1885, in Proceedings of the NWP and Oudh in the Medical Department, October 1885.

¹⁰⁷ Sanjoy Bhattacharya, Mark Harrison, Michael Worboys (ed.) *Fractured States, Smallpox, Public Health and Vaccination Policy in British India, 1800-1947*, (New Delhi: Orient Longman), p-72.

Dr. Moir, C.S. of Meerut submitted a proposal for the improvement of imperfect vaccination of children in the municipalities of United Provinces. He favored the removal of special vaccinators who were appointed to strengthen the work of vaccination to the establishment of civil dispensaries and bestowing the responsibility on C.S.¹⁰⁸ His proposal was discussed by Sanitary Commissioner and Surgeon-General, unfortunately both declined it on account that it was not feasible and the point of working on keeping accuracy of record remained unnoticed. This proposal was a little short of compulsory vaccination as the Province had the voluntary vaccination. The chief obstacle was considered to be the attitude of parents rather than acknowledging the failure of vaccinators by the colonial administrators. As the mortality from small pox was high that's why to prohibit inoculation and make vaccination compulsory for children the GOI passed Act XIII in 1880 for compulsory vaccination of children.¹⁰⁹ This was the first legislation of colonial state for preserving the health of children but its success was impacted by the factors mentioned in the above paragraphs. It was however lamented that, in 1883 due to orders of Commander-in-Chief in Meerut division in military cantonments, vaccination could not be legally carried out in a compulsory manner. Thus, people in the cantonments refused to vaccinate themselves and their children.¹¹⁰ Finally, on the extension of Vaccination Act in the Meerut, it was made compulsory to vaccinate both adults and children.

Another unique feature of vaccination and its introduction in the Province was its gender bias aspect, which was particularly have been unique in United Provinces or northern India. Parents themselves kept their children, especially girl child away from the vaccinators. When the Vaccination Act of 1880 was to be extended in Kanpur municipality, a petition opposed this move of the government that people especially upper classes would not welcome this as they keep their women in purdah. Parmeshari Dass wrote "the Superintendent is to make enquiry and to have all unprotected children vaccinated. A girl of eight years comes within the scope.

¹⁰⁸ UPSA, File No. 3, Box No. 209, Supervision of Vaccination operations in Municipalities by C.S., Medical Department.

¹⁰⁹ File No. 182B, Box No. 28, 'Application of the Vaccination Act 1880 (XIII of 1880) to notified areas', 1907, Sanitation Department, United Provinces, Proceedings for May 1907 NOS. 18-38, Amendment of the Vaccination Act, 1880 (XIII of 1880) in its relation to this province.

¹¹⁰ UPSA, Letter No. 13, dated 20 January 1883, From Deputy Sanitary Commissioner to Cantonment Magistrate, Meerut, in File No. 10, Box No. 209, 'Medical rules for the enforcement of the vaccination Act (XIII of 1880) within the limits of the Meerut Cantonment', 1884.

Among the higher classes of Hindus and among Muhammadans generally, girls of that age keep purdah. What difficulties and heart burnings will take place on the enforcement of this provision...”¹¹¹ The act for prohibition of the female infanticide already placed restrictions in the society, so keeping a girl child away from the vaccination and inoculation was another weapon in the hands of people. As R. Pringle mentions that by rejecting vaccination for the girls, people have gained a safe way of murdering them in infancy at the rate of 60 per cent and more. The worst part was that as the disease was considered the wrath of the Goddess Sitala, no queries were made how the child died and thus the shame of their houses disappeared.¹¹² These conclusions were not always applicable as in several districts where infanticide was severe such as Mainpuri and Etawah, the number of girls vaccinated exceeded that of the number of boys. In some villages of Aligarh, all girls were brought for the vaccination or inspection. May be that’s why the vaccination reports considers Muslims more supportive than Hindus in advocating the spread of vaccination. Contrarily the policies were very much influenced by the Hindu population beliefs and superstitions. John Richardson describes the situation as “the idea suggested by the refusal of these people to have their infant females vaccinated was, I presume, that they were so impressed with the life saving properties of vaccination, as to make it an object with them to decline it for those they did not wish to live. The predominance of the females vaccinated might, and I believe does, indicate an explanation less complimentary to the vaccine department. It may be that the parents are still so suspicious of vaccination that they will not trust it for their boys; whilst they are satisfied to let their girls serve as the *corporavilia* upon which its effects can be tried.”¹¹³ He also throws light on the fact that both the higher caste Hindus as well as Muslims in NWP were more averse to bring their girls for vaccination in comparison to elsewhere in the country. In the rural population, except Dehradun and Tehri state,

¹¹¹ See above -Petition from Parmeshwari Dass and others, Cawnpore Municipality, Dated 24 March, 1888.

¹¹² Annual Report of the Vaccine operations in the Agra and Meerut Division during the season 1871-72, by Surgeon R. Pringle, Superintendent of Vaccine, Agra and Meerut Division, dated Camp Dehra, 6th April 1872, p-14; in F. Pearson, North-Western Provinces- Returns of Vaccination for the season 1871-72, Allahabad, 1872.

¹¹³ UPSA, Letter No. 224, From John Richardson to F. Pearson, dated Camp, Dehra Doon, the 5th April 1873, pp-38-39, in Ibid.

the number of girls was considerably in excess of the boys vaccinated.¹¹⁴ In 1873, 2,361 more male children were vaccinated than the females while the following year difference increased to 6,067. In Saharanpur when rabies spread in 1920s at the fast pace and took many lives. Angle Allen recalled that for saving themselves they had to search for a place where they could get better treatment as ‘there was no vaccination and everyone was supposed to destroy their dogs.’¹¹⁵ One can imagine if the European family and children had to move to ‘some place’ in India, what would have been the condition of the poor children in the country.

Apart from the households, educational institutions become a centre where children, without severe resistance and aid from teachers, brought into the sphere of vaccination policy. Compulsory vaccination in schools checked the advance of smallpox in the Province at an early stage. Such example was evident in 1871, when a school teacher at Landora (in Roorkee tahsil) vaccinated himself to set an example and the impact of this incident was such that parents willingly agreed to get their children vaccinated.¹¹⁶ The case was an exception rather than the widespread practice. As in another two cases, chief opposition came from school teachers who cautioned the parents not to vaccinate their children.¹¹⁷ During 1926, 256 students in seven schools were examined and the Assistant director of DPH showed in his report a non-protection rate of more than 50 per cent.¹¹⁸ As late as in 1934, the Public Health Commissioner also noted that ‘nearly 30 per cent of the total smallpox mortality occurred among infants and 40 per cent among children, aged 1-10 years, points to poor vaccination.’¹¹⁹ A similar view could be glanced from the vaccination reports¹²⁰ which revealed that nearly 33% of the children attending the municipal schools in Allahabad were unprotected by the vaccination. Thus, in September 1925,

¹¹⁴ Letter No. 208, From John Richardson to F. Pearson, dated Camp, Dehra Doon, the 10th April 1874, p-25. F. Pearson, Returns of Vaccination for the North-Western Provinces and Native states of Bundelkhand, 1873-74, Allahabad, 1874.

¹¹⁵ Lawrence Fleming, *Last Children of the Raj, British Childhood in India, 1919-1939*, (London: Radcliff Press, 2004), p-194.

¹¹⁶ Annual Report of the Vaccine operations in the Agra and Meerut Division during the season 1871-72, by Surgeon R. Pringle, Superintendent of Vaccine, Agra and Meerut Division, dated Camp Dehra, 6th April 1872, p-12; in F. Pearson, North-Western Provinces- Returns of Vaccination for the season 1871-72, Allahabad, 1872.

¹¹⁷ Letter from John Macgregor, Superintendent of Vaccination, Benares division to F. Pearson Superintendent-General of Vaccination, dated 11th April 1873, Benares, in J. Richardson, *Returns of Vaccination for the season 1872-73*, Allahabad, 1873, p-36.

¹¹⁸ Fifty-Ninth Annual Report of the DPH of United Provinces 1926, Allahabad, 1927, p-21.

¹¹⁹ Annual Report of the Public Health Commissioner with the GOI, 1934, Vol. I, New Delhi, 1936, p-51.

¹²⁰ Triennial Report on Vaccination in United Provinces of Agra and Oudh- 1923-24, 1924-5, 1925-26.

the Government asked all the Assistant directors of Public Health, District Superintendents of Vaccination and Municipal MoH to inspect all the school children, in municipalities, notified areas, town areas, and rural areas. They were also instructed to vaccinate those children who do not possess the vaccination marks and to ensure that the students above seven years of age, must be revaccinated under their personal supervision. Unfortunately, again rural areas remained unaffected, as the rule of compulsory vaccination was not applicable on them inspite of regular demands from the DPH in their reports. The report submitted by these appointed officers shows the low profile of vaccination in United Provinces, leading to the high rate of mortality of children. Instead of this poor structure, the report advocated that “the necessity of vaccination and revaccination of all unprotected or poorly protected school children cannot be too strongly urged.”¹²¹ It was also highlighted in the report that some of the school authorities were averse to take action in this direction for the fear of fall in the attendance of students especially in rural areas. But they further suggested that admission to any school aided by public funds should be forbidden till a certificate of protection against smallpox rendered by the students and for the purpose the headmaster responsible for ensuring that the enrolled child vaccinated.

In the official correspondences, it is evident that the vaccination was compulsory in municipalities, cantonments and in hostels attached to a government, Anglo-Vernacular School, intermediate colleges and hostels attached to normal schools and training colleges. Thus, the Indian intellectuals and bureaucrats like Jagdish Prasad suggested to the government for getting the public opinion in favour especially the parents to the advantages of vaccination. Surprisingly Jagdish Prasad was not alone there were other District Boards and Commissioners who were against the decision of introduction of compulsory vaccination in rural areas.¹²² Out of all these opposition

¹²¹ Ibid.

¹²² Three District Magistrates, Sixteen DBs and Two Commissioners expressed their opposition to the proposal. As per collector of Etah there was a prejudice of upper caste to the vaccination, so he opposed the same. With the same opinion of opposition, the Commissioner of Agra was not in favour of changing the present state of vaccination administration. However the Collector of Allahabad comes with a different view that “the country is not ready for the measure. Among the lower classes there still prevails the belief that smallpox is the visitation of a goddess and that vaccination is an impious proceeding.” The superstition of the people was the chief argument of refusal on the part of administrative section.

and support, United Provinces enforced the compulsory vaccination in the rural areas in 1930.¹²³

At the conference of health officers, MOs and heads of English institutions held at Cawnpore and Jhansi in August and September 1932 it was recommended that some regulations must be issued to ensure compulsory vaccination of school children. Thus, a new clause was added at in the U.P. Educational Code 1932, accordingly “before admitting any boy into the recognised English Institutions the head of the Institution should satisfy himself that the boy has either been vaccinated or bears clear marks of vaccination or of having had smallpox on his body. If neither of these conditions exists, admissions should be made on the clear condition that the boy will get vaccinated in the next vaccination season.”¹²⁴ As far as vernacular schools were concerned, the government ordered on 6 April 1927 that children especially in rural areas who were often protected from smallpox, be compulsorily vaccinated and all the headmasters of vernacular primary and middle schools were directed to co-operate with the officers of the PHD in getting boys vaccinated.¹²⁵ Consequently, when the smallpox epidemic broke out in Firozabad in 1939, 342 scholars were revaccinated, which resulted to check the spread of the disease in school children.¹²⁶ The serious epidemic of 1926 compelled the Secretary I. D. Elliot to write about the deplorable state of vaccination in the Province. He unveils that, as in primary schools, where it was possible to examine a large number of children, the total number of children remained unvaccinated were around 40%. Unfortunately, the percentage of failure of vaccination was higher in municipalities but it was even higher in the rural areas. He also pointed out that “...in all probability large percentage of unprotected children does not exist among the menial classes who do not as a rule send their children to school. I and my Assistant Directors have repeatedly noticed during our inspections that well over 90 per cent of the children produced for inspection belong to the menial classes and we have always attributed this to the fact that the menial classes are not aware that vaccination is voluntary and only require the order of the vaccinator to get

¹²³ UPSA, File No. 243/1926, Box No. 233, ‘The United Provinces Vaccination Bill’, Public Health Department, 1930).

¹²⁴ UPSA, File No. 324/1933, Box No. 220, ‘Vaccination to be compulsory for all Boys attending all the recognised English institutions’, Education Department.

¹²⁵ UPSA, File no.1087/1927, Box No. 144, ‘Vaccination of Day scholars’, Education Department.

¹²⁶ Regional Archives of Uttar Pradesh (RAAUP)- Agra, Annual Report on the Health of School Child of Agra District for the year ending December 31, 1941, Agra Collectorate Records, Department XXVIII, 1941.

their children vaccinated. The better classes are quiet aware that vaccination is voluntary and, therefore, refuse to have their children vaccinated.”¹²⁷In his report, Colonel Dunn drew attention ‘that there is a ground for thinking that proportionately more children of the lower classes are vaccinated than of the upper classes, because the former have some idea that vaccination is compulsory, whereas the educated people know that it is not.’¹²⁸The point is not a sole example but in all the vaccination reports from 1860-1940, it was found that vaccination was more popular among lower classes than the higher one.

The motive of vaccination policy was not only to save lives of children but was also to justify the foreign rule as a paternalistic one, endowed with kindness and humanity. The resistance of parents in lieu of their love and affection for children, to the ideals of benevolent imperialism, was considered to be a proof that the colonial subjects were incapable to protect and care for the children of the empire. The chief limitation to the development of vaccination policy in the Province were- few vaccine depots, untrained vaccinators and the lack of will of the state to promote and establish vaccine experimentation in the Province. However, it is to be considered that parent’s attitude in United Provinces towards vaccination underwent a significant change though not overall from 1866 to 1935. The success of the vaccination policy was limited as number of children under one year of age successfully vaccinated to total births was 59.98 in 1940.¹²⁹

MEDICAL INSPECTION OF SCHOOL CHILDREN

The educational institutions were ‘relatively modest institutions for modest relatives, experiments in guardianship and tutoring- highlighted childhood itself as a live border in colonial India.’¹³⁰Schools were specifically intended to produce a section of society that could participate as loyal allies reared through to Macaulayan system of education in British administration. School thus served as the space where the soft targets i.e. child’s body was colonized, could thus be turned into the agents of good governance. They also facilitated the wider surveillance by the British officials to track its future population. School medical system was one of the significant site with

¹²⁷ UPSA, File No. 243/1926, Box No. 233 , The United Provinces Vaccination Bill, Public Health Department.

¹²⁸ *ibid*

¹²⁹ Seventy-Third Annual Report of DPH of United Provinces, 1940, Allahabad, 1941, p-28

¹³⁰ Satadru Sen, *Colonial Childhoods*, p-143.

which the colonial state pushed interventions on child health and medicine. As mentioned in the first section of the chapter that the beginning of school medical inspection was made by the missionaries in their educational institutions.

In England, an Education Act was passed in 1870 where for the first time officers were appointed to control epidemics by excluding sick children from school or closing down schools. Elementary education thus became compulsory in 1880 and was free in 1891. It was then that the poor health of children, in general, became apparent, and young recruits to the Boer War were noted to be in poor physical shape.¹³¹ Together with this, the Education (Administrative Provision) Act 1907 placed a duty on the local education authorities to provide for the medical inspection of children on their admission to public elementary schools, which was made a statutory obligation on every local education authority. The inspection was compulsory but the treatment was made permissible only in 1918 Education Act. The Education Act of 1921 went a step further and made it compulsory for all authorities to make adequate arrangements for the treatment of children attending public elementary schools. These developments had a significant impact on Indian medical and educational policy. Specifically in India, as early as in 1909, the princely state of Baroda laid the foundation of medical inspection followed by the other provinces.

Prior to 1919, medical inspection of school children in the United Provinces was at its infancy stage except in missionaries schools and some European, aided, normal and training schools, but not regular periodic inspection was carried out.¹³² Annual Sanitary inspection was prescribed by the government,¹³³ instead of a comprehensive medical inspection. Historically it was in 1919 that the foundation of medical inspection was laid by a scheme in United Provinces for the compulsory medical inspection of boys in all recognised English schools, whether aided or unaided by the government. Significantly, the government remained unfavourable towards the universal medical inspection of scholars, which was considered by latter as impracticable.

¹³¹ P.A. Gardener, 'A Brief History of Rise and Fall of the School Medical Service in England', *Journal of the Royal Institute of Public Health*, 12, II, 2008, 261-67.

¹³² UPSA, File No. 19/1918, Box No. 68, 'Medical Inspection of School children', Education Department.

¹³³ UPSA, Extract from the Note on locally conducted quininization schemes in the United Provinces in 1912 by Major J. D. Graham, Special Malaria Officer (Appendix B), in File No. 334/1919, 'Report of the Committee on Educational Hygiene', Education Department, 1914.

As the mortality from malaria especially fever among children was high in the Province, schoolmasters were employed to ensure the responsibility of providing quinine drug to the children. Later the sanitary conference of 1908 in its report suggested that DBs should distribute quinine through village school masters who knew when a child is absent on account of fever. In 1912, quininization scheme was implemented to prophylax 100 schools with 5,392 scholars and 217 teachers in Meerut. For making the scheme success, 217 teachers and 606 poor students were given medicine free of cost while 4,756 students paid two annas.¹³⁴ Further, in 1915, Government ordered that except in Municipal areas possessing a health officer, they should similarly inspect all aided colleges and their hostels, as well as all aided high and middle schools.¹³⁵ However, the government was doubtful whether the quinine reached to the people or not at the time of requirement.¹³⁶ Another factor which hampered this scheme of quininization was the compulsory charge levied by DBs which was disapproved by parents in many cases.¹³⁷ Unfortunately government gave space to the local governments where they could implement the schemes as per their will, thus affecting the development of medical services. Scheme was thus dropped in 1917 owing to the high prices of the drug whereas Harris suggested for the use of 'residual alkaloid' as a substitute for quinine, but he failed to get the nod from the government.¹³⁸ Similarly, in 1931, a scheme was forwarded by the Education department, according to which a nominal fee of Rs.1-4 per month or Rs. 1 per scholar per annum was to be charged for the treatment of malaria and other commoner ailments among children. It aimed at providing an efficient whole-time school health service in all 48 districts for health examination and education of the child in matters of public health. The scheme was also accepted by the DPI but was not introduced as it was not considered feasible to increase school fees in order to finance it.¹³⁹ Unlike other valuable schemes this scheme was also dropped which could have been of enormous value to the growing generations.

¹³⁴ UPSA, Letter from H. Spencer, Deputy Commissioner Bahraich to the Commissioner Fyzabad Division dated 1st March 1909, in File No. 168/1908, Box No. 210, 'Free Distribution of Quinine', Medical Department, 1908.

¹³⁵ Sixty-Third Annual Report of the DPH of United Provinces, 1931, Allahabad, 1932, p-38.

¹³⁶ Notes on Annual Returns relating to Civil Hospitals and dispensaries in e United Provinces, in Annual Report of Hospitals and Dispensaries of United Provinces for the year 1908, Allahabad, 1909, p-2.

¹³⁷ UPSA, Report on the working of District Boards in the United Provinces of Agra and Oudh for the year 1916-17, p-114 in File No. 7A, Box No. 2, Local-Self Government department , 1918.

¹³⁸ Fiftieth Annual Report of the Sanitary Commissioner of the United Provinces of Agra and Oudh for the year 1917, Allahabad, 1918, p-14.

¹³⁹ Sixty-Fourth Annual report of the DPH of United provinces 1931, Allahabad, 1932, p-39.

As Teachers and Head Masters were prominent figures in the schools, it was expected from them that they should keep a strict vigilance on the students and on their well-being too. Together with this, teachers were considered individually responsible for seeing to the sanitary condition of the premises, washrooms, classes etc. It was lamented by De LA Fosse that “Headmasters do not realize their responsibility in the matter of their pupils and do not use their influence to support medical inspectors. From more than one division it is reported that medical history cards were looked up, on the departure of the medical inspector and not referred to again to again until his next visit.”¹⁴⁰ The Hygiene committee recommended that much more care and attention should be paid to the sanitation. The inspecting officers were also instructed to pay special attention to recommendation of committee at the time of inspection. On the basis of the report of this committee, the Lieut. Governor instructed DPI¹⁴¹ to make sure that no efforts spared in remedying the defects. However, it was reported that due attention was not paid to the medical examination of students by the local governments and municipalities in accordance with the order of GOI, along with the demand for food and clothes for poor students.¹⁴² Even DPH also considered the paucity of dispensaries and qualified men in the rural areas, responsible for not implementing the advice of district health staffs for the treatment of students.¹⁴³

In the absence of a proper scheme for the school health children, I.G.C.H. in 1922 proposed a scheme for the MOs. He exclaimed that the school teachers should recognize that the main success lies with them and not with their medical conferences. However, DPI S. Philip refused this scheme on the grounds of financial stringency.¹⁴⁴ From the official correspondence between I.G.C.H. and Education

¹⁴⁰UPSA, Letter No. G-1316/XVII-81, From C. F. De LA Fosse, DPI, United Provinces to Secretary to Government, Allahabad, dated 18th July 1918, in File No. 19/1918, Box No. 125, ‘Medical Inspection of School Children’, Education Department, 1918.

¹⁴¹ UPSA, Letter No. 176/XV-334/1915-1914, From S. P. O’Donnell, Secretary to Government to Secretary to Government of India, Department of Education, Allahabad, dated 8th February 1915, in File No. 161/1915, Box No. 53, ‘Sanitary Inspection of all Colleges and Secondary, Middle, Primary schools either state or aided as Medical and Sanitary departments’, Education Department, 1915.

¹⁴² Tofah-i-Hind, 4 Dec ember 1917, SVN, p-365.

¹⁴³ Fifty-Ninth Annual Report of DPH of United Provinces for the year 1926, Allahabad, 1927, p-73.

¹⁴⁴ UPSA, Copy of A.D.O. No. 200/c dated 17 June 1922. DPI expressed that “.....I consider that the school medical work should centre round the medical offices of Health of these municipalities who are well-qualified officers with English degrees and public health qualifications and who can also be given L.P.Hs as assistants. We can supply these also. I also agree that two specialists in eye work one for the eastern portion and other for western part of the province should be especially entertained by the Education department who will be touring officers. These should be specially recruited and should have knowledge of ear, nose, and throat work in addition to eye work.” See- File No. 409/1924, 40/1921, Box No. 94, ‘Medical Inspection of Schools and the Intermediate Colleges’, Education Department.

Secretary, Jagdish Prasad, it is evident that though they were willing to enforce such a comprehensive scheme for medical inspection of students, yet lack of financial resources was the biggest hurdle in its initiation. It was only in 1922 that Sahibzada Dr. Said-uz Zafar Khan was appointed to draw up a scheme for the medical inspection of schools. Again as the scheme involved huge expenditure, it was dropped. Though Sahibzada Dr. Said uz Zafar Khan was ready to publish his report on the medical inspection of school children at his own expense, due to the fear of public clamour government did not gave him permission to do so, because if people understood the situation then the government will have to face public criticism. The DPI introduced a less significant measure and in selected towns appointed certain special SMOs for treating students within the school premises. However, the DPH didn't shared the same opinion and did not favour the arrangement for he considered whole-time SMOs, which were far sighted.¹⁴⁵

When medical inspection of school children was carried out in 1931, it reported a remarkable uniformity existed in the Province in respect of the defects in the children. Defects in teeth and gums, granular eyelids and scabies were the most frequent ones. In the Agra Municipality in 1940, it was found that maximum children were suffering from the malnutrition and eye problems. It was found that the children who were given the spectacles usually do not bring or use them in school. This increased the eye defects in the scholars and thus the school authorities were instructed to direct children to use spectacles when they study. For the purpose, government sanctioned in 1933 a sum of five thousand rupees for free supply of medicines and spectacles in thirteen European schools of the United Provinces,¹⁴⁶ while no such sanction was made for poor and rural areas students. Unfortunately, the SMOs were unable to treat eye defects and thus there was an urgent requirement of an ophthalmologist in the Province. Consequently, a provision was made that a MO should be an eye-specialist appointed throughout the province in order to treat the eye defects among children. An investigation into the prevalence of flourosis among the school children was carried out in 1940, consequently, it was found that the water of the wells in the districts of Allahabad, Agra, Benares, Meerut, Cawnpore, Etawah and Partabgarh and in a school at Brindaban were found to contain excessive fluorine. As a result many

¹⁴⁵ Fifty-Ninth Annual Report of DPH of United Provinces for the year 1926, Allahabad, 1927, p-73.

¹⁴⁶ UPSA, File No. 936/1933, Redistribution of Rs. 5000/- to European schools for the free supply of medicines and spectacles, Education 'A' Department.

children found to have dental flourosis.¹⁴⁷ The district MO of Agra confirmed that there were no arrangements for eye testing or for teeth extraction except in few dispensaries. Thus after 1940 treatment provided by the traveling MO, were made absolutely free by the government and spectacles were provided free of cost to the poor students. In other places, the students were advised to go to the nearest dispensary for treatment. From 30 to 50 percent, of the students examined were found to suffer from defective eyesight. At Gorakhpur, the Students Medical Service Association provided free glasses and dental treatment to 80 poor students out of its funds.¹⁴⁸ A similar association (School Medical Association) was formed at Fyzabad in 1937 which collected Rs. 550 and spent the amount on purchasing glasses for poor boys, employing the services of an ophthalmic surgeon and dentist and cost of medicines.¹⁴⁹ Most of the reports testify that the general cleanliness improved and students started appreciating the sanitary measures in the surroundings. However, the sanitation of the primary girl's school in the municipalities as reported by the SHO was unsatisfactory unlike the boy's schools, if not worse.¹⁵⁰ Even the MO of Agra records that "general standard of cleanliness is much below, what may be regarded as normal and health is poor".¹⁵¹

Table 3.3: General health conditions of students in educational institutions of Agra

S. No.	Defects Detected	Percentage of children
1.	Malnutrition	10.8
2.	Tonsilitis	37.8
3.	Carious teeth	5.04
4.	Tarter Coated Teeth	5.7
5.	Enlarged Glands	5.04
6.	Gross defect in Vision	10.8
7.	Dirty Ear	1.8

Source- RAAUP, Annual Report on the Health of School Child of Agra District for the year ending December 31, 1941, Agra Collectorate Records, Department XXVIII, 1941.

However, a comprehensive inspection and removal of ailments in children were limited and underscored unlike other provinces of British India. The inspections of

¹⁴⁷ Seventy-Third Annual Report of DPH of United Provinces, 1940, Allahabad, 1941, p-31.

¹⁴⁸ Seventeith Annual Report of DPH of the United Provinces, 1937, Allahabad, 1938, p-49.

¹⁴⁹ Ibid.

¹⁵⁰ Sixty Fourth Annual Report of DPH of the United Provinces, 1931, Allahabad, 1932, p-60.

¹⁵¹ RAAUP, Annual Report on the Health of School Child of Agra District for the year ending December 31, 1941, Agra Collectorate Records, Department XXVIII, 1941.

English schools were preferred more than the vernacular schools by the government. All these arrangements show the indifferent attitude of the authorities towards the natives. Efforts of natives and princely state's filled gap by their participation to ensure the good environment for the children and relieved the government from the burden of expenditure. For the inspection of schools in Benaras state, it was generally preferred that the inspector should visit only English school in the state twice a year, and thus the Maharaja of Benaras offered Rs. 300 per annum for such services to the government which was later accepted.¹⁵²

It was unfortunate that the recommendation made by the Hygiene committee (on buildings, class rooms, playgrounds, health measures and hygiene) were not executed in the province till 1945 as the same demand was made again in Vernacular schools and rural areas.¹⁵³ The condition of poor sanitation was evident in the educational institutions and with so loud demands but no change in policy was evident in the state leading to increased rates of child mortality in the Province. Various accounts reported the satisfactory state of general cleanliness in English institutions but this was usually not the case with primary and middle schools. Even the SHO of Cawnpore summarized in his report on the sanitation of schools, hostels and attached premises as "the general cleanliness in the high schools was more and in the middle schools less satisfactory while in the primary schools it was most unsatisfactory."¹⁵⁴ Enough attention was thus not paid to the environments and surroundings of primary school children. It was because the schools were located in hired buildings which were never meant to be schools.

The concept of physical drill was taught in the schools of the Province, yet there was the lack of apparatus for making it better. The physical training is mentioned in almost all the reports and highlights the popularity of '*desi kasrat*' especially in rural areas.¹⁵⁵ However, the provision of gymnasia was not considered necessary by the government but the emphasis was laid on the increased participation in physical

¹⁵² UPSA, File No. 255/1911, Box No. 79, Inspections of schools in the Benares State by the Inspector of Schools, Benaras Division, Education department.

¹⁵³ RAAUP, Annual Report on the Health of School Child of Agra District for the year ending December 31, 1941, Agra Collectorate Records, Department XXVIII, 1941.

¹⁵⁴ Sixty-Fourth Annual Report of the DPH of United Provinces of Agra and Oudh, 1931, Allahabad, 1932, p-61.

¹⁵⁵ UPSA, Report on the Working of District Boards in the United Provinces of Agra and Oudh, 1909-10 in Annual Administrative Report on the Working of District Boards in the United Provinces, 1946.

exercises. The committees established from time to time criticized the unsatisfactory physical training activities in the vernacular and Anglo-vernacular schools. Thus, in order to promote the education and hygiene among pupils in the country the Government of India in 1913 granted three lakh rupees for expenditure on educational hygiene, gymnasia, playground, swimming- baths, gardens, reading-rooms, common-rooms, etc.¹⁵⁶ The DPI also approved Rs. 7521 for allotment of funds out of the imperial grant to ensure resources for the physical strength and stamina in the pupils. Unfortunately, these grants and sanctions had limited impact on improving the physical activities of the children as these were bestowed mostly in European schools and were occasional. This is evident from the fact that as late as in 1923, the Legislative Council carried out the resolution proclaiming “that this Council recommends to the Government to take steps to an early date to make physical training including Indian Games and sports and drills compulsory for all male students who are physically fit and are receiving instructions in the vernacular and Anglo-vernacular schools and in the intermediate colleges of the United Provinces and arrange for such training in consultation with experts.”¹⁵⁷ Subsequently, on the recommendation of a committee appointed by the Government in 1928, a post of Provincial Superintendent of Physical Training in Government training college at Allahabad, Agra, and Lucknow was created¹⁵⁸ and decided to award two state scholarships for training in methods of physical education in London. Further, the scholars on their return were to be appointed in the Training Colleges of Lucknow and Agra under the United Provinces Educational Service to train the teachers in the methods of physical education.

The concept of Hygiene was one of the important themes of colonial policy towards child care. The teaching of hygiene was exclusively preferred in the schools. Teachers were trained in hygiene, personal cleanliness and epidemic diseases and they used to take one period every week in classes. In the English schools, teachers use to take classes in Hygiene up to eight standard. On the other hand, in Government Training Colleges, the SHO delivered a special lecture on infectious and general diseases.

¹⁵⁶ UPSA, File no. 114/1913, Box No. 35, ‘Government of India’s Non-recurring grant of three lakhs for Educational Hygiene, gymnasia &c., Education Department.

¹⁵⁷ UPSA, File No. 258/1925, Box No. 66, Physical Training in Anglo- Vernacular and Vernacular Schools U.P., Education Department.

¹⁵⁸ UPSA, Resolution for March 3, 1925 regarding making physical training and drill compulsory in A.V, Vernacular Schools and Inter Colleges, Education Department, in Ibid.

Consequently, a Junior Red Cross groups were instituted in municipalities and districts to teach health and hygiene habits to students by the teachers under the guidance of MoH.¹⁵⁹ Even the training and practical demonstrations were also provided to the teachers for mosquito catching, oiling of pools and prevention of malaria, smallpox, and cholera. Lectures were organised in epidemic diseases, rural sanitation and knowledge about first aid were given to the scholars, for the prevention of diseases. These lectures were given by the DMOH and sanitary inspectors when they visited any school. Attracting the serious attention of the students was a challenge to the teachers as well as SMOs. That is why in annual reports it was emphasized, firstly, to make hygiene classes more practical and compulsory allotment of a period to the subject. Secondly, serious concern was highlighted on the half-hearted teaching of lessons in First Aid or the Mackenzie School Course (elementary course of instruction for school children including physiology and hygiene). Even then there was no fixed curriculum for the teaching of hygiene to the boys in primary schools, but Junior Red Cross groups initiated few activities which attempted to instill health habits through various means.¹⁶⁰ SHOs on the other hand were provided materials to guide them in giving lectures on nutrition and cleanliness.

In 1932, Government approved that all recognized English institutions should cooperate with the SHO in maintaining the health of scholars through regular medical inspections.¹⁶¹ Whole-time SHOs were appointed in 13 large towns (Lucknow, Benaras, Cawnpore, Allahabad, Agra, Jhansi, Fyzabad, Gorakhpur, Saharanpur, Moradabad, Bareilly, Shahjahanpur and Meerut) for arranging regular medical inspections of scholars in English institutions and in other 20 municipalities the MoH acted as SHOs and conducted examinations on health conditions of children. Further a medical history sheet was also required to be maintained for each scholar (which was to be given to the scholars on the time of their transfer to other institutions). As regards vernacular schools, the cost of the medical inspection of middle vernacular schools was calculated about Rs. 24,000, and it was proposed that the DBs should be asked to arrange finances. However, DB also rejected the scheme on account of the poor financial condition and the low grants by the government. Thus, for the

¹⁵⁹ Sixty- Third Annual Report of the DPH of United Provinces, 1931, Allahabad, 1932.

¹⁶⁰ Seventieth Annual Report of DPH of the United Provinces, 1937, Allahabad , 1938, p-51

¹⁶¹ UPSA, File No. 316/1932, Box No. 197, Addition of a new rule in the Educational Code on Medical Inspection of Scholars, Education Department.

vernacular school's government and local governments were less inclined to support and cooperate, on whom the state had left the responsibility of child welfare. In the meeting of 17 December 1918, the Finance Committee decided that it was optional for DBs either to adopt the system or not.¹⁶² The Education Committee of 1919¹⁶³ recommended that the system of medical inspection of the students in vernacular Schools, which should be as same as that of European schools. The Municipal Boards of Gorakhpur,¹⁶⁴ Sikandar Rao, and Lucknow, also expressed their willingness in the matter of providing for the regular medical inspection of scholars. Finally, in October 1919, the system for compulsory medical inspection of all the recognised English schools for boys was extended to the middle vernacular schools.

In 1925, government of United Provinces sanctioned the purchase of 641 weighing machines for the government educational institutions in United Provinces with a grant of Rs. 2240/-.¹⁶⁵ Later only 41 weighing machines were purchased for academic institutions. These machines were found defective and then the DPI ordered the purchase to be made only for the European schools.¹⁶⁶ Once again it is evident that European schools gained priority over the vernacular school children. In 1931, it was reported that "in few schools records of weight are not kept regularly and the machines have either not been provided or are out of order. Test cards too have not been provided in many schools, hence the low estimate of defects in vision. One school in a municipal has been provided with a spittoon in each class."¹⁶⁷

Some legal interventions were also proposed for pushing the concept of child health in United Provinces. Such intervention apart from Vaccination Act of 1880, became evident when on 4th March 1925 in the Legislative Council a resolution was moved by Dr. Ganesh Prasad, according to which the Council recommended to the government to make effective arrangements in every high school either under the direct control of the government or received aid from the government for the medical inspection of all students and treatment of those children who were suffering from any disease or

¹⁶² UPSA, Extract from the Proceedings of a meeting of the Finance Committee, held at Lucknow on the 17th December 1918, in File No. 19/1918, Box No. 125, Medical Inspection of school Children, Education Department, 1918.

¹⁶³ UPSA, Extract from the Proceedings of a meeting of the Municipal Board of Lucknow, held at Lucknow on the 29th November 1919 in Ibid.

¹⁶⁴ The Municipal Board agreed to pay Rs. 15 as a monthly fee for the medical inspection of schools.

¹⁶⁵ UPSA, File no. 409/1924, Box No. 160, Purchase of Weighing machines for 56 institutions, Education Department.

¹⁶⁶ Ibid.

¹⁶⁷ Sixty-Third Annual Report of the DPH of United Provinces, 1931, Allahabad, 1932, p-56.

defects. Thus, from July 1926 onwards, government as an experimentative measure appointed ten-whole time MOs of schools at Allahabad, Lucknow, and Agra. In these centers, three MOs were appointed at Rs. 200/- p.m. The primary aim was to treat free of charge all boarders residing in the hostels attached to the government training colleges, Normal schools, Intermediate schools and High schools.¹⁶⁸ In the scheme mentioned above under which ten SMOs were appointed, provision was made for the appointment of a supervising medical officer who would be an eye specialist. This appointment, however, was not acted upon at ground level because of the want of funds. A significant thing to note in these reports is that all the SMOs emphasized that the scheme cannot be a success unless diagnosis and medical advice on their part are followed by free treatment also, at least in the case of the poorer pupils. From October 1929, the medical inspection of school children in recognised schools i.e. in 44 municipalities in other than 10 centers where there were whole time SMOs appointed and the rest of the 85 municipalities in United Provinces were transferred to the Public Health Department. For the medical inspection, a scheme of school clinics was initiated in the Province in 1934 among all the government and non-government secondary schools and for the scheme they levied Rs. 1 per scholar as medical fees. The fee was deposited to the government.¹⁶⁹ In 1941, Ewing Christian college and Jumna Mission Dispensary were exempted from this fee on account of better medical facilities for students in the institution.

School system as a space to address the healthcare of child received the attention of colonial state. To check the advance of epidemics and diseases, schools were considered significant center, that's why when a query aroused in front of the state how to prevent the scholars suffering from infectious diseases to attend the school, a clause was added in the United Provinces Educational Code 1927.¹⁷⁰ Accordingly it was laid that, any scholar discovered by the school authorities to be suffering from any infectious diseases, as a preventive measure, debarred from attending a recognised school until they were certified free of such diseases by the Medical and Health Officer in charge of the school. Finally, in 1930 there were three separate agencies for school health work, namely-(a) local school committees (b) the Education Department and (c) the Public Health Department.

¹⁶⁸ UPSA, File no. 409/1924, Box No. 160, Medical Inspection of Schools and Intermediate Colleges, Education Department.

¹⁶⁹ UPSA, File No. 558/1944, Box No. 320, Scheme of school clinics, Education 'A' Department.

¹⁷⁰ UPSA, Letter No. G/303G/XV-271-1929, from A.H. Mackenzie to DPI, dated 24 March 1930, File no. 777/1929, Box No. 165, Education Department.

In 1937, a separate scheme was introduced for the medical inspection of school girls. It was recommended that medical inspection of school girls should be introduced in the six towns of United Provinces where over 2000 girls were enrolled. These towns were Lucknow, Benares, Kanpur, Allahabad, Agra, and Bareilly. The Women School Health Officers were under the administrative control of the DPH. For better arrangement, it was proposed that two to three days in the week be reserved at dispensaries for girls, and that the women SHO should hold these clinics. In 1940 the SHO of Agra municipality suggested that “unless we educate the future motherhood of the country and raise their health conscience and give them an idea of the scheme of school medical inspection and bring home to them the advantage of the scheme by actual practice, the desirable cannot be attained....medical inspection of girls are very necessary.”¹⁷¹ Same demand was raised by AIWC in 1941 and regretted that the serious issue failed to attract the attention on the grounds of lack of funds.¹⁷² However, evidence of remarkable reform in the medical inspection of girls was far from satisfactory. From the year 1941,¹⁷³ the government endowed the Assistant inspectress of girl’s school authority to close the institution for any period (not exceeding one month) when the epidemic occurred.

Almost all MOs complained the apathy of parents in the matter of the health of their children. The MOs lamented that the voucher sheets they sent to the parents, with a statement of condition and diagnosis of the pupil and advising medical treatment were either disregarded or returned with apathetic reply “cured” or “improved”. The cause of this indifference was considered to be ignorance, an insufficient realization of the importance of good physique and lack of appreciation of the new system by the people. The Medical Officers and inspectors endorsed the same charges even against teachers and headmasters. Imtiaz Ahmed Khan, the SMO of Meerut exclaimed that, “the scheme has proved very useful. Many cases of infectious diseases which are always a source of danger were detected. All headmasters appreciate the scheme but unfortunately, some took little interest and without the cooperation of schoolmasters, the scheme cannot be made a success. Parents and guardians also show little interest. There is no provision for the proper treatment of students (especially the poorer ones) with defective vision.” But the majority of MOs testified to the helpful attitude of the

¹⁷¹ RAAUP, Annual Report on the Health of School Child of Agra District for the year ending December 31, 1941, Agra Collectorate Records, 1941.

¹⁷² Roshni, Vol. II, No. 8, AIWC, Lucknow, December 1941.

¹⁷³ RAAUP, Annual Report on the Health of School Child of Agra District, 1941, Agra Collectorate Records, Department XXVIII, 1941.

staff and heads of schools and attributed to those measures of success they have achieved by such cooperation. Some reports showed that health of boarders received treatment as well as medical advice better than those of day scholars. All the SMOs confirmed that as a result of their inspections there was a marked improvement in the general health of the scholars. Another benefit of which prominent mention was made by authorities is that lectures on hygiene to parents, teachers, and students have succeeded in breaking down appreciably the apathy and ignorance of the public and had tended to create a hygienic conscience among the parents. A. H. Mackenzie noted that “on the whole the scheme has been a success.” The success and failure of the scheme depends on the overall improvement in the health scenario of the children, which was far from evident in colonial India.

The AIWC of 1940 in Allahabad in its resolution emphatically opined that the health of the children and specially of school children and college students, is of vital importance to the well-being of the country. It therefore appointed a sub-committee to study the matter related to- school hygiene and sanitation, medical inspection of school children, school clinics and care-committees, health education, physical culture, adult classes for the study of child welfare and child hygiene and dietetics for children.¹⁷⁴ Similarly, AIWC time to time raised the demand of legislation for the compulsory medical inspection and treatment in all educational institutions and to combat the malnutrition among the children.

Table 3.4: Percentage of children found suffering from specific defects during medical examination, 1904

Name of the Province		Defective vision	External eye conditions	Enlarged tonsils and adenoids	Dental caries and Pyorrhoea	Ear diseases and defects of hearing	Enlarged spleen	Skin disease	Malnutrition
Bengal		25.9	-	10.7	8.7	1.0	0.6	1.6	6.9
Punjab		10.0	-	26.6	-	-	2.4	-	18.8
United Provinces	Urban	7.5	6.6	16.4	16.1	-	0.5	2.7	14.0
	Rural	0.9	4.8	4.5	10.8	-	1.5	2.3	6.0
Orissa		7.3	5.4	10.7	11.2	-	12.0	6.6	19.5

Source: CABE, Report on the Medical Inspection of School Children and Teaching of Hygiene in Schools 1941, GOI, 1942, p-12.

The ‘central school dispensary scheme’ drawn by Hygiene Publicity Bureau in 1933, started at Benares, Agra, Lucknow, Cawnpore, and Allahabad in 1934. In its first year

¹⁷⁴ Fourteenth Session of All India Women’s Conference, Allahabad, 27-31 January 1940, p-132.

6,886 children attended these dispensaries. Out of this 54% appeared for treatment in Lucknow, 95% in Agra and 57% in Benares. In other areas, the *School Boys Medical Associations* provided treatment to school children by opening dispensaries, whilst no less than 4000 such dispensaries worked in the Province. Anti-meningococcal inoculations were given to 3,721 children in Agra city and Anti-cholera inoculations were given in Benares, Agra, Lucknow, Bareilly, Gorakhpur, and Allahabad.¹⁷⁵ Schools were thus the center of dissemination of western medicine by the colonial state where treatment was given to children within the school premises by the administrators.

CHILD NUTRITION: INITIATIVES AND INTERVENTIONS

A Province which had a large number of malnourished children, having a nutrition policy becomes inevitable. Such scheme not widespread in the Province but was restricted to educational institutions in prominent towns. It was only in 1947 that the Indian government recognized that the educational institutions should focus towards the child as the scheme of school feeding was educational in character and not primarily a nature of relief. The Sargent Report stated that the provision of a mid-day meal in school is recognized to be a good thing both for combating mal-nutrition and for enabling children to benefit from the lessons imparted at the end of the school day. The Bhore Committee endorsed that “it is essential both from the point of view of education and of health, that all the children should be given a mid-day meal, whether it is brought by the children from their homes or provided at the school by the authorities. The growing child is particularly susceptible to the adverse effects of malnutrition and under-nutrition and no school health scheme can be considered satisfactory unless the provision of a balanced mid-day meal forms part of the scheme.”¹⁷⁶ Since Swadeshi movement, the nationalist press drew attention to the inequities of the colonial economy. Foremost among the conditions which were, they argued, the cause of high infant and mortality was the supply of low- quality milk. The poor milk was blamed on the lack of official care and control as well as on bribery.

In 1936, League of Nations asked information about the problem of human nutrition and possibilities of its improvement. GOI appointed a committee which emphasized

¹⁷⁵ Annual Report of the Public Health Commissioner with GOI, 1934, New Delhi, 1936, p-128.

¹⁷⁶ GOI, *Report of the Health Survey and Development Committee*, Vol. I, (Delhi: Manager of Publications, 1946).

on nutritional surveys amongst school children and surveys of their dietary habits due to absence of accounts on state of nutrition in children. An enquiry on chief balanced diets was initiated by the Baby and Health Week Association, Bombay. The Association conducted the impact of cheap vegetarian and non- vegetarian diets in schools and other institutions.¹⁷⁷ On the point of conducting nutritional surveys in various provinces of the country, the United Provinces declined this activity on account of financial provision but requested to send an officer to Coonor for training purpose, which was granted by the GOI.¹⁷⁸

For combating malnutrition among children, which was highest in this Province usual methods and strategies were followed by the government. Prime focus was on milk-feeding schemes and for the purpose three cooperative dairies were maintained at Benaras, Allahabad, and Lucknow. As far as the average supply was concerned, Vishweshwar cooperative dairy at Benares distributed a maund and a half of milk; Katra cooperative dairy Allahabad produced 700 maunds, and another Barf Khana cooperative dairy at Lucknow was closed (not formally) in the year 1920, because this institution was at a loss and was under heavy debt.¹⁷⁹ Similarly, for the Reformatory Schools in Chunar, DPI in consultation with the Director of Nutrition Research, Coonoor, South India, proposed certain changes in the menu of diet prescribed in the rules for the management and control of the Reformatory School and asked that additional provision may be made in the budget to give effect to the changes proposed. The changes proposed were approved and the necessary additional provisions were sanctioned and also included in the budget.¹⁸⁰

¹⁷⁷ NAI, GOI, Nutrition work now in progress under I.R.F.A., in File No. 37-25/36-H, 1936, Department of EHL, Health branch, 1936.

¹⁷⁸ NAI, GOI, Telegram from the Government of the United Provinces, Medical department, No. 1590, dated 24th December 1936, in Ibid.

¹⁷⁹ Fifty-Fourth Annual Report of the DPH of United Provinces of Agra and Oudh 1921, Allahabad, 1922, pp-5-6.

¹⁸⁰ UPSA, File No. 708/1940, Box No. 246, Provision- Addition- of Rs 1600/- in the Schedule 41-42 to make certain changes in the Diet of the Boys of Reformatory Schools Chunar, Education 'A' Department.

Table 3.5: Revised rule 38 of the Chunar Reformatory School rules

Days	Morning Meal	Days	Mid Day Meal		Evening meal	
	I and II classes		I class	II class	I class	II class
Monday Wednesday Friday	2 ch. Parched gram, 1 ch. gur	Monday Wednesday Friday Sunday	6 ch. Pure wheatflour made in to chapattis, 1ch. Dal, 2ch. vegetables	5 ch. Pure wheatflour made in to chapattis, 1ch. Dal, 2ch. vegetables	6 ch. Pure wheatflour made in to chapattis, 1ch. Dal, 2ch. Vegetables, 3l. milk	5 ch. Pure wheatflour made in to chapattis, 1ch. Dal, 2ch. Vegetables, 3 ch. milk
Tuesday Thursday Saturday Sunday	2 ch. Warm wheat dalya, ½ ch. Gur, 1/8 ch. Ghee	Tuesday Thursday Saturday	6 ch. Flour (mixture of gram and wheat) made in to chapattis, 1ch. Dal, 2ch. vegetables	5 ch. Flour (mixture of gram and wheat) made in to chapattis, 1ch. Dal, 2ch. vegetables	-do-	-do-

Source: UPSA, File No. 708/1940, Box No. 246, Revision in the diet changes of the boys detained in Reformatory School Chunar, Education department

The most prominent scheme to fight the malnourishment in children of the Province, a milk-feeding scheme was initiated. The scheme was started at Agra, Lucknow, Cawnpore, Allahabad and Benares where the central school dispensaries were established. The SHO of Cawnpore reported that each boy was given a quarter seer of milk in ten schools.¹⁸¹ In 1937, eight schools of Lucknow started “Milk Clubs” as an experiment with the supply of pasteurized milk from the military dairy. A fee was charged from each boy varying from Rs. 12 to Rs. 1 p.m. At Allahabad, intermediate college, Rs. 3 was charged. SHO of Benares observed that where pasteurized milk was supplied free to 275 students in nine different institutions with a total of 120,201 meals of ¼ seer to each students daily for an average of 20 to 60 days, as a result, 73.8 per cent of the boys gained in weight. The average gain in weight varied from 1.4 lb. to 5.9 lb.¹⁸² Municipal Board of Benares gave a grant of Rs. 300 for free supply of milk to 145 poor students who were suffering from the after-effects of epidemic dropsy. At Agra and Cawnpore, pasteurized milk was supplied free to 175 and 206 respectively for short periods. By 1944, out of 15,33,000 students, only 83,600 children¹⁸³ were brought in the sphere of the scheme. Milk Supply Scheme was started in Lucknow and was later extended to Kanpur in March 1946 for the children in

¹⁸¹ Sixty-Ninth Annual Report of the DPH in United Provinces, 1936, Allahabad, 1937, p-43.

¹⁸² Seventieth Annual Report of the DPH in United Provinces, 1937, Allahabad, 1938, p-48.

¹⁸³ UPSA, File No. 922/1947, Box No. 361, School Feeding Schemes, Education –A1 Department.

Municipal primary schools up to the age of 7-12 years.¹⁸⁴ The milk was served with toffee or fruits, on the basis of availability. The provincial government advanced a subsidy of Rs. 86,730 for the scheme in Lucknow which supplied sixty maunds of milk per day to 10,000 school children on alternate days at a price of half anna. For the scheme, schools were grouped into two, one group getting milk on one day and the other group on the second day. The task of distribution of milk was endowed on the Cooperative Milk Supply Union and municipal boards were endowed with the responsibility of financing the scheme. The chief defect of the scheme was that the poor scholars who could not afford to pay were untouched by its benefits and the need of such poor children was even greater, which authorities failed to realise. Secondly, rural areas, girl's institutions and schools other than in municipalities, were not within the purview of this scheme. At Agra, the scheme for the distribution of milk was started in 1930 implemented in middle schools of Achnera, Midhakur, Fatehabad, and Etmadpur. Under this scheme, 400 boys received milk daily. The scheme proved to be beneficial, as the boys who consumed milk gained weight than those who escaped it. Few philanthropist also contributed towards the milk feeding scheme at Chilibila (Pratabgarh) by the donation of Rs. 500 in order to provide half a seer of milk to young ill-nourished babies and mothers.¹⁸⁵

The SHOs of United Provinces found 14 per cent children ill-nourished in larger towns and 20 per cent in rural areas.¹⁸⁶ They also reported that the incidence of largest proportion of ill-nourished children were in the age group of 7 to 10 years.¹⁸⁷ Thus a scheme for providing food in educational institutions was started in United Provinces where on a payment of fees, children were provided with sprouted grams. This was an initiation of MDM in the Province in 1932. The SHO of Mirzapur, Bahraich and Gorakhpur investigated the effects of gram-feeding for various ages and assessed district-wise anomaly in increase in height and weight of children. In 1945, the municipal board of Allahabad decided to provide sprouted gram as a MDM to the students of its primary and middle schools on payment of one anna per month and

¹⁸⁴ UPSA, File No. 28/46, Scheme for Distribution of Milk on a subsidised basis to School Children, Lucknow, Cooperative Department.

¹⁸⁵ Annual Report of the Public Health Commissioner with GOI, 1943-44, New Delhi, 1946, pp-19-20.

¹⁸⁶ Sixty-Fifth Annual Report of the DPH in United Provinces 1932, Allahabad, 1933, p-46.

¹⁸⁷ Ibid.

received the sanction of the Governor.¹⁸⁸ The finance committee was however reluctant to favor such an expensive scheme. However, as the meal provided was not proper and was followed half-heartedly and thus later discontinued. This could be glanced from the fact that when SMO inspected the scholars in educational institutions found 14.1 poorly nourished in urban areas and highly poorly nourished scholars i.e. 29 per cent were found at Lucknow, Cawnpore and Saharanpur whereas in the remaining towns it was between 10-20 per cent.¹⁸⁹

In Lucknow, the Education department and municipal board worked for the milk scheme while in Rampur state Junior Red Cross carried out the scheme.¹⁹⁰ There was thus no uniformity in system of school feeding in the Province. Few schemes were undertaken by the government while others were implemented through voluntary agencies. It was due to lack of specialized Nutrition staff or Nutrition research and the difficulties in organization of the programme, nutrition policy could never see the light of the day.

MARRIAGE REFORMS, NATIONALIST IDEOLOGY AND CHILD CARE

Outside India the changing political scenario and rising nationalist movement had significant impact on the international opinion. The British government attempted to give best possible image of India. Both World Wars had increased the American influence in international arena. The new political environment had a definite impact on the public health policies in the country. Katherine Mayo, who visited India in 1925 had significant impact on the international public opinion and also on Indian politics.¹⁹¹ Her book argued that Indians were unfit for self-rule on the grounds of their traditions related to marriage and early maternity, thus focused on urgency of reforms in health sector yet these revelations did not had a major impact on the conditions of women. The publication of 'Mother India' put the British record in India on the line and the Viceroy called for action.¹⁹² As the proof of their concern, the Indian government decided to set up a commission to investigate the state of affairs in the country, and in June 1928 the Age of Consent Committee or the Joshi Committee was

¹⁸⁸ UPSA, File No. 915/1945, Box no. 332, Supply of sprouted gram and milk as a Mid- Day Meal to the students of Primary and Middle schools at Allahabad, Education Department.

¹⁸⁹ Seventy-Third Annual Report of DPH of United Provinces for the year 1940, Allahabad, 1941, p-23.

¹⁹⁰ Roshni, Vo. III, No. 2, March 1948, Lucknow.

¹⁹¹ Katherine Mayo, *Mother India*, Blue Ribbon Books, New York, Cornwall Press, 1931.

¹⁹² NAI, GOI, Home Department, Judicial Branch, No. 382/1927, Notes, p-8.

established under the chairmanship of M. V. Joshi.¹⁹³ The committee concluded that not only early maternity, but also the frequency of births at short intervals coupled with the conditions under which birth took place had a remarkable impact on maternal and child health.

Marriage reform campaigns relied heavily on the official maternal and infant mortality figures and doctors spoke out publicly in favour of rising the age of consent and against the practice of child marriage, calling it 'barbarous'.¹⁹⁴ While Crooke noted, 'the evils of the custom of infant marriage have probably been exaggerated. When the people speak of physical degeneration it is sufficient to point to races like the Sikhs and Rajputs, among whom it prevails, and who certainly show no signs of decadence. Here the so-called infant marriage is really a betrothal, and married life does not begin until the girl has come of age. It prevails as widely, perhaps more widely, among the lower than among the higher castes in the plains.'¹⁹⁵ With the rising political agitation in the country, the demands of women as right bearing subject articulated with the movement, thereby breaking the patriarchal nationalist paradigm and thus political, social and economic spheres saw the emergence of stronger women. They knew the challenges a women faced both inside and outside the four walls of house. Thus the chief reform undertaken by them was to reform in the institution of marriage. The formation of All India Women Conference, All India Association for Medical Women of India strengthened their voices.

The two significant legislations for marriage reform were Age of Consent Bill 1891 and the Sarda Act of 1929. These campaigns led to confluence of medical opinion, official attitude and nationalist agitation with the demand of raising the age of marriage from 12 to 14 years. Social reformers asserted that the high rate of maternal and child mortality was due to child marriage which led to mothers producing weak babies. Thus, they claimed that child marriage accelerated the moral and physical decay in the Indian society. For the reformers, the practice of child marriage both provided the historical background to India's state of backwardness as well as prophesied that India was unlikely to emerge or progress in the future. But the condemnation of tradition of child marriage was double-edged sword- it was equally

¹⁹³ Ibid.

¹⁹⁴ David Arnold, *Colonizing the Body*, p-265.

¹⁹⁵ William Crooke, *The Native Races of the British Empire: Natives of Northern India*, (London: Archibald Constable and Company, 1907), p-184.

open to appropriation by the nationalists and to appropriation by apologists for the colonial regime. While nationalists argued that colonial rule weakened India morally, physically and economically, colonial apologists countered that the high rates of maternal and infant mortality were due to the widespread practice of child marriage and that this was evidence of the continued inability of Indians to govern themselves.¹⁹⁶

Medical personnel's raised the issue of child marriage because that was considered the chief cause of maternal mortality. Babu Gauri Shankar Prasad of Benares mentioned that in one of his relatives house a girl of 14 years gave birth to a child and consequently died in hospital as a result of labour.¹⁹⁷ Dr. Douglas stated that labour was a terrible for young mothers and mostly their first or second baby died or did not survive. Miss Adderley who worked at Hazaribagh, Cawnpore and Lucknow lamented that girl-mothers of 13 years delivers pre-mature and weak child, whose death becomes inevitable. She mentioned a case of Cawnpore where difficulty occurred in birth because of 'girl's immaturity.'¹⁹⁸ Dr. Ernst of Jhansi described that she came through the cases where 'the health of very young women was ruined through pelvic inflammations, and had come across traumatic cases requiring prolonged treatment.' Hafiz Hidayet Hussain of Cawnpore refers to few cases of Hindu and Muslim girls who were married at the age of 12 and cohabitation of those girls started between 12 and 14, and when a child was born next year, there was a rapid deterioration in the health of girls leading to death of girls either immediately or not long after childbirth. The girl mother between the age of 12-14 suffered which led to her death, osteomalacia, they had no milk making both mother and child weak. Some of the Kunbis at Benaras stated that in their caste , girls were at times sent to their husbands before puberty, that many girls had become very weak and their children were very weak and unfit to do any sort of agricultural work that they had tried their best that no marriage should take place before 10 years of age for boys and 7 for girls but nobody would agree to it"¹⁹⁹Mr. Mata Pershad, the Secretary of the Koeri Sabha, continued propaganda work and fixed the 12 as the minimum age of marriage for girls. A member of the municipal board of Allahabad representing the depressed Ccasses acknowledged the evils of early consummation and maternity

¹⁹⁶ Sarah Hodges, *Reproductive Health in India: History, Politics, Controversies*, (Delhi: Orient longman, 2006), p-13.

¹⁹⁷ Report of the Age of Consent Committee, 1928-29, p-83. Available from-
https://archive.org/stream/in.ernet.dli.2015.52906/2015.52906.Report-Of-The-Age-Of-Consent-Committee-1928-29_djvu.txt

¹⁹⁸ Ibid, p-84.

¹⁹⁹ Ibid, p-85.

supporting legislation in favour of a minimum age of marriage at 14 years.²⁰⁰ The issue of marriage below 14 years was criticized on account of ensuring a healthy and beautiful child.²⁰¹ These prejudices had another repercussions, that one could not be able to find match for the girls as she would be considered a grown up. These are the arguments of that section of society which favoured the legislation; however, there was a lot of hue and cry against the Act.

In United Provinces, especially there was a tradition of 'guana' (sending the girl with groom after attaining desired age or maturity). Under this, even the parents had their children married, the girl was not send with groom, which was only done when the boy attained the age of 16 or 17 and the girl of 12 or 13. The tradition was more or less followed everywhere in this province. But yet the age for child bearing was much less, cannot be denied. Census report of 1951 mentioned that 'a slight post-ponement in marriage age since 1931 is also visible...these factors must have helped in the decline of infant and maternal mortality. The fall in birth rate itself must lead to a fall in infant mortality.'²⁰² It must be taken into account that it was more due to omissions in vital statistics rather than the measure of marriage age.

Sarah Hodges argued that the marriage reforms were central to the eugenics discourse in India. Meagre attention paid to the eugenics research and investigations into the specific mechanisms of heredity. In India, however, the eugenicists focus was caste based as 'arranged marriages' deep rooted in Indian culture. Arranged marriages were perceived as the Indian way of uniting couples capable of producing healthy offspring. As a part of eugenics discourse, reform of child marriage was connected to reproductive health as well as contribution in national progress.²⁰³ The eugenic argument was visible in the writings of vernacular literature where maintenance of purity was considered essential for a happy marriage and healthy child. *Brahmacharya* was thus flooded in the vernacular literatures during colonial rule. Charu Gupta showed that the endless instructions were made for the males.²⁰⁴

Post- Swadeshi and Non-cooperation movement, a large number of pedagogical texts emerged which brought Indian women in to the political and social life. Family thus

²⁰⁰ Ibid.

²⁰¹ Stri Subhodhini, III part, Lucknow, Munshi Naval Kishor Press, p-3.

²⁰² Census 1951, Uttar Pradesh, pp-88-89.

²⁰³ Sarah Hodges, Indian Eugenics in an Age of Reform, in Sarah Hodges (ed.), *Reproductive Health in India: History, Politics, Controversies*, (Delhi: Orient longman), 2006.

²⁰⁴ Charu Gupta, *Sexuality, Obscenity, community: Women, Muslims and the Hindu Public in Colonial India*, Delhi: Permanent Black, 2001, p-70.

emerged as a site where national reconstruction programmes could be initiated. It was pointed out that women who were ignorant of their healthcare not only harmed them but also produced weak babies, thus destroying the nation.²⁰⁵ As early as in 1875, the vernacular literatures flooded with the theme on child healthcare in manuals like *Shisupalan* by Shib Chunder Deb, who claimed that the ‘ignorance on the part of Hindu families regarding careful management of infants and the great mortality that arises from the cause’ led him to write a book.²⁰⁶ Advising women to take care of their body, child birth and child rearing, Dr. C. C. Sarkar in his book ‘*Stree Va Bal Rog Chikitsa*’, explained the various types of illness related to women and children and also suggested the means of its treatment.²⁰⁷ Journals focusing especially on women healthcare like *Madhuri*, *Stri Darpan*, *Stri Subodhini*, had articles on domestic hygiene, pre-natal and post-natal childcare, childbirth, pregnancy and infertility. Few local women organizations such as *Prayag Mahila Samiti* helped in establishing and supporting the magazines such as *Saraswati*, etc. Women in all these journals were advised on child bearing and their nurture. *Santan Shastra* addressed the issues related to the motherhood, childbirth, and significance of adequate diet and food, diseases and the health of a child.²⁰⁸ The nationalist journal *Abhyudaya* of Madan Mohan Malviya had a regular column (*matramandir*) talking specifically on women’s health. These articles showed the concern towards the better women’s healthcare for the healthy babies but also influenced gender, class, caste, religious and national identities. These articles and magazines made the women and mothers realize their duties towards the nation, which would need healthy children after independence, for a successful economy. Few tracts focusing especially on child health was written during the period to disseminate the ideas of good health. For instance, a pamphlet ‘*Balako Ke Poshanarth Avashyak shikshayen*’ drew attention to the fact that one-third of the new-born in Benares died every year and for that the author blamed the unsanitary conditions and ignorance of parents which made children vulnerable to epidemic diseases.²⁰⁹ For overcoming this, author suggested proper nutrition such as

²⁰⁵ Pradip Kumar Bose, Sons of the Nation: Child rearing in the New Family, p-123, in Partha Chatterjee (ed.), *Texts of Powers: Emerging Disciplines in Colonial Bengal*, Calcutta, 1996.

²⁰⁶ Meredith Borthwick, *Changing Role of Women in Bengal 1849-1905*, 1984, p-159, Cited in Mousumi Bandyopadhyaya, Indigenous approach to Delivery Deaths in Colonial Bengal, p-237, in Chittabrata Palit and Achintya Dutta(ed.), *History of Medicine in India The Medical Encounter*, (Delhi: Kalpaz Publications, 2016).

²⁰⁷ Dr. C. C. Sarkar, *Stree Va Baal Rog Chikitsa*, Newal Kishore Press, Lucknow, 1937.

²⁰⁸ Ganesh Dutt Sharma Gaur, *Santan Shastra*, IInd edition, Allahabad, 1928.

²⁰⁹ Pandit Kali Charan Dubey, *Balakon ke Poshanarth Avashyak Sikshayen*, Benares, PHD, Municipal Board, 1913.

mother's milk, barley water and broth for the infants. Unfortunately in all the literatures, all the suggestions were for the male child only.

Booming print culture opened new discursive spaces for literate women. Educated literate women undertook the task of disseminating ideas of health care among the women. But most of these works focused on a particular section of women i.e. the literate ones. The uneducated one was again forced to remain on the mercy of the educated class. These articles and magazines made the women and mothers realize their duties towards the nation, which will need healthy children after independence, for a successful economy. Thus the nationalist sentiments were invoked through vernacular literature among the women of the Province.

CONCLUSION

The child welfare work was under developed not only in the Province but in the whole country. Though there were some regional differences in the implementation of the policy but at the grass root level situation was same everywhere, for instance, Madras province was much more advanced in maternal and child health services in comparison to other provinces of the country. The Government, however, was not absolutely indifferent towards the child care as from time to time policies were framed to cope up with the increased rate of child mortality and morbidity even though their approach was half-hearted. At policy level, the Medical, Public health and Education departments together dealt with issues of vaccination, medical inspection of school children or appointment of trained midwives. Keeping record of health condition of children in schools, compulsory vaccination, establishment of child welfare centers, were few innovations of the colonial state. These efforts played significant role in the decline of infant mortality after 1920s though it was not substantial. There is no denying the fact that the voluntary, non-official charitable agencies were prime initiators of the paediatric subject in the Province and the central, provincial and local governments supported their effort either by financial support or providing medical staff, etc. Unfortunately, comprehensive policy could not develop in absence of general awareness of child welfare especially paediatrics both at world and India level. The Statement that 'our future depends on these little mites of humanity; we must have strong healthy mothers and strong healthy babies'²¹⁰ though recognized never came to foreground.

²¹⁰DMSF, Improvement of Childbirth in India, 1918, p-134.

Chapter IV

*Institutional History of
Paediatric Medicine in United
Provinces*

CHAPTER- IV

INSTITUTIONAL HISTORY OF PAEDIATRIC MEDICINE

This chapter traces the historical development of medical centers, institutions and organizations in the United Provinces, further their role and significance in improving the conditions of paediatrics. Colonial state was reluctant to actively participate in women and child care movement but was also not ready to disassociate itself from maintaining medical institutions for the purpose as it will question the paternalistic benevolence. The Dufferin Fund and unlike financial aids were encouraged but when grants solicited, private philanthropy was much regarded than the state's involvement. Thus this chapter argues in the light of colonial medical policy, the trend of limited imperialism of the state for paediatrics in United Provinces could be observed.

While taking a child to a paediatrician is common today, the concept and reality of physicians especially trained to treat sick children and to prevent sickness in well children are very modern phenomena. In the world that can trace its historical roots back several millennia, the notion of doctors for children did not begin to be formulated until the nineteenth century.¹ It was in the twentieth century that the child care attracted the attention of the government. This chapter traces the existence of institutional set up in United Provinces for child healthcare.

It was with regard to childbirth that women's and child's health was explicitly and officially dealt with in United Provinces. Dagmar Engels emphasized that 'imperial interest in childbirth cannot be explained by straightforward references to economic or military engagements'.² Geraldine Forbes rightly assesses that the British rulers were not 'particularly interested in the health of their subjects and neither British nor Indian men were concerned with the process of birthing. It was women missionaries and the wives of the Indian officials who brought these issues into the public arena.'³ Women organization enthusiastically raised the issues of high maternal and IMR in the country as we have seen in earlier chapter. On the other hand, the colonial

¹A.R. Colon and P.A. Colon, *Nurturing Children: A History of Paediatrics*, (USA: Greenwood Publishing Group), 1999, pp-xiii-xiv

² Dagmar Engels, *Politics of Childbirth*, p-222.

³ Geraldine Forbes, *Women in Colonial India: Essays on Politics, Medicine and Historiography*, (New Delhi: Chronicle Books, D. C. Publishers, 2005), p-80.

government adopted a restricted policy of rewarding those wealthy and influential Indians who sponsored medical institutions.

In existing accounts, the colonial context of institutionalization of western medical care for children, training of female medical students and the process of colonizing the body of children through centers of dissemination of western medical care, are the least focused area. These unexplored issues are studied here in the context of United Provinces. The chapter emphasizes that- How the changing contexts of imperial administration shaped the chief features of colonial policies for the institutional care of paediatrics? What was the condition of education and training of the female doctors and complexities in the relationship of medicine, colonialism and feminism in United Provinces? How institutions and independent organizations influenced child medicine in colonial State? How medical institutions pioneered in the United Provinces for disseminating modern medical practices for paediatric medicine? How successful were the administrative arrangements in delivering health services in rural areas for the women and children?

This chapter thus evaluates the role of western medical ideas and institutions in driving the policy for children in United Provinces. This chapter argues that the imperial government was quick to acknowledge the necessity of medical care centers for women and children in United Provinces; however, it failed to initiate the comprehensive policy for the relief of most vulnerable sections of society as they donated sums from time to time as can be seen in the chapter. The organizations and associations such as Dufferin Fund established in the early twentieth century and sometimes the princely states were also sympathetic towards the care of children. Further the government in the United Provinces limited itself in providing grants and funds to the institutions rather than to take an active interest in child care. This limited care was relinquished after 1919 reforms; thereby Provincial Government and local bodies were bestowed with the responsibility of paediatric care. Unfortunately, these administrative bodies always showed their incapacity of performing the welfare of children for the lack of financial aids. This chapter, therefore, explores the policy-making process of the colonial state for initiating the institutionalization of western medical care for paediatrics with special reference to United Provinces.

In the context of colonial United Provinces, the issues of female medical education, the medical profession for women as well as aspects of reproductive health and institutional care of paediatrics have so far received scanty attention in the existing literature. In the following pages, it has been argued that for the paediatrics, as far as the colonial state was concerned it looked after women's health it was with regard to childbirth. We argue here that for the paediatrics, as far as the colonial state was concerned it looked after the women's health it was with regard to childbirth.

MEDICAL MISSIONARIES: INITIAL EFFORTS OF WESTERN MEDICINE

When Charles Grant was elected as the member of Court of Directors, the Benthamite reformists and Evangelicals gained decisive voice and influence in policy and politics of the colonialists. The introduction of the Charter Act of 1813 allowed Christian missionaries to enter India subject to obtaining license either from Court of Directors or Board of Control. Western medical care too arrived in India with the arrival of missionaries. This was welcomed by the colonial state on account of their welfare activities; however, the religious apprehensions of these reforms were too dominant among masses. Fitzgerald⁴ delineates the initial lack of interest of missionaries in health and medicine and the diversities of the overseas protestant missionary movement in India. Her work delineates the acceptability of medical missions by patients who rejected the 'religious component' of missionary medicine which blended religion, medicine, science and spirituality transformed in to 'heal the body and soul'. Basu argued that medical missionaries by the end of 19th century realized the implications of their 'care to cure' policy as a complex process of Christianization.⁵

By and large women missionaries were wives whose job was to help their husbands by teaching the wives and children of male converts.⁶ After mutiny when the Indian empire was officially taken over by the colonial state and according to Charter Act of 1858, the number of single women missionaries increased significantly in India. Consequently, by the 1860s a number of missionary societies sponsored separate

⁴ Rosemary Fitzgerald, 'Clinical Christianity': The Emergence of Medical Work as a Missionary Strategy in Colonial India, 1800-1914, p-88-136, in B. Pati and M. Harrison, *Health, Medicine and Empire: Perspectives on Colonial India*, (New Delhi: Orient Longman, 2006).

⁵ Raj Shekhar Basu, *The Canadian Baptist Missionaries in the Telgu Country (1870-1952)*, p-181, in Deepak Kumar (ed.), *Disease and Medicine in India- a historical Overview*, (New Delhi: Tulika Books, 2001).

⁶ Geraldine Forbes, *Women in India*, p-85.

women associations, proliferated in British Empire during the administrative reorganization of the colonial state where the policy of legislative and financial decentralization inaugurated to ensure the development of state affairs under local government.

In the United Provinces, the chief societies undertaking medical work were American Episcopal Church, the Women Union Missionary Society, and Zenana Bible and Medical Mission. In 1889, American Episcopal Church started working in Bareilly and Bridaban. The other American Societies were at Jhansi, Fatehpur Lucknow, and Jaunpur. In addition, the 'Society for the Propagation of the Gospel' started its medical mission work at Cawnpore, and by the Methodist Mission of South of Australia at Azamgarh. A sanitarium was also established which was financed by many missionary societies and carried out their activities at Almora.⁷ When medical care was added to the missionary repertoire, the Indian custom of *purdah* aroused a demand for women doctors.⁸ This eagerness towards penetrating into *zenanas*, later became chief area focused by the colonial state to colonize reproductive health.

The first qualified medical women came to India from USA. Miss. Clara Swain graduated from the Women's Medical College of Pennsylvania was sent to India by the American Episcopal Church and she reached Bareilly on January 1870.⁹ This laid the foundation of activities of medical women not only in the Province but in India also. Thus, United Provinces received first qualified women medical professionals in the country. Dr Swain started working with the Women's Foreign Missionary Society of the Methodist Episcopal Church. She was accompanied by Miss. Isabella Thoburn who participated with her in medical relief works, although she worked for the education of females and opened first school for women in the Province at Lucknow.¹⁰ D. W. Thomas who was in charge of the girl's orphanage attached to the mission at Bareilly was keen to provide efficient medical treatment for Indian women and thus started training the elder orphans in physiology and hygiene. Later Dr Swain came in contact with Dr Thomas and they both bestowed training to three married women and fourteen girls of the orphanage in medicine, nursing and compounding. In

⁷ Balfour and Young, *Work of Medical Women in India*, pp-80-81.

⁸ Geraldine Forbes, *Women in Colonial India*, p-104.

⁹ Balfour and Young, *Work of Medical Women in India*, p-107.

¹⁰ Isabella Thoburn opened a school in 1870 in Aminabad (Lucknow) with six girls and her institution became the first missionary and prominent institution providing English education in the province. In 1901, the institution was named after her founder.

1873, these girls were examined by the board of three doctors and were declared as competent by the board. Dr Johnson granted them certificates of practice in all ordinary diseases. As Swain's work attracted people from far places, she felt the need for a regular hospital and dispensary. Realizing this Nawab of Rampur gifted her land on which a dispensary was opened in 1873 followed by the hospital in 1874. Both institutions expenditure was about thirty- five thousand rupees. Dr Swain remained in charge of these two institutions till 1885, when Raja of Khetri requested her to take up the post of physician to the Queen and her ladies. This she did only on the understanding that she was allowed to carry on her 'christian work'.

Consequently, the American Presbyterian Society and Foreign Missionary Society sent Sara C. Seward to Allahabad in 1871.¹¹ In March 1872, she opened a small dispensary and later with an increased demand she opened a large dispensary for women. She died in 1891 of cholera and it was in her memory, a hospital was established in Allahabad named Sara Seward hospital.¹² Another effort was made by an Indian doctor Babu Ganga Prasad in Bareilly. He and his promoters were keen to spread relief for women but here again, the education was incomplete and unsatisfactory, and thus class was closed in 1875.¹³

In 1883, Brigade- Surgeon Hilson proposed to the government to start the class for Hospital Assistants at Agra. His idea was to carry on the class along with that of the men, but along with provision for privacy and protection of the women students. He estimated the modest sum of rupees one thousand for the first year and subsequently two thousand for the next five years. The Lieut.-Governor at the time was Sir Alfred Lyall sanctioned the scheme. Thus, a new class was formed in 1884 through the efforts of Dr Hilson and twenty one candidates were secured for this class. Out of these twenty one candidates, a Brahmin girl of 14 years took part in this class.

At Lucknow, the medical relief work was initiated by the Zenana Bible and Medical Mission at their hospitals by Dr Bielby. Miss Elizabeth Bielby reached Lucknow on 26 January 1875 with an aim of providing the medical services to the women of this Province. She describes the condition of female healthcare in the Province as, "very difficult to describe the real state of things that I found in Lucknow- and how hopeless

¹¹ Balfour and Young *Work of Medical Women in India*, p-18.

¹² District Gazetteer Allahabad, p-79.

¹³ Balfour and Young, *Work of Medical Women in India*, p-107.

everything seemed to be... I am writing of more than fifty years ago- the people were far more ignorant, superstitious and prejudiced than they are now. Female education was then nil; except for what the zenana missionaries gave. It ought never to be forgotten that it was these ladies who first brought education to the purdah women of India.”¹⁴ Miss Bielby opened a dispensary and also a small hospital. Her sister, who was a trained nurse, too accompanied her, but unfortunately died in a few months from enteric fever. In the same year, Miss Hewlett joined her for six months, in order to learn the language before commencing work in Amritsar. Miss Bielby left Lucknow in 1881, for completing her medical training in England.

While Bieibly was practising in Lucknow, the Maharaja of Punna (native state of Bundelkhand) asked her to attend his wife. Balfour describes in her work that the Queen recovered soon and told Miss. Bieibly, “I want you to tell the Queen and the Prince and Princess of Wales and the men and women of England, what the women of India suffer when they are sick.” On her return to England, Bieibly met Queen Victoria and delivered the message of Maharani of Punna. Queen Victoria reportedly assured the better facilities for women in near future. Consequently, when Lady Dufferin was leaving for India in 1883, the Queen instructed her to initiate some plan for providing medical aid to the women of India. After analyzing the condition of women health care in the country, correspondence with the wives of Governors to elicit their support, and enlisting the sympathy of the Raja of Rutlam, the Countess of Dufferin Fund, begun in 1885. This effort considered as the starting point for a history of western medical care for the children and the year 1885 marked the first intervention by the official support to focus on the medical care and education of Indian women. The year coincidentally clashed with the formation of Indian National Congress, which created a platform for raising nationalist voices towards colonial medical policy. This was certainly not the first training scheme for medical women in India but was definitely the first coordinated program with official support. Thus, the Maharani of Punna was the prominent figure behind the realization of the colonial state’s responsibility towards the teeming millions of India.¹⁵

In 1886, at the inaugural meeting of National Association for Supplying Female Medical Aid to the Women of India, the Viceroy explained that “Queen Victoria had issued a special injunction to provide Western medical aid to women trapped in

¹⁴ Ibid.

¹⁵ Ibid.

zenanas. Bound to their homes by religion and custom, these women could not see male doctors and were at the mercy of grossly and dangerously ignorant dhais.”¹⁶ It was thus a policy to penetrate into the elite class women or the *pardanashins* of the society. Thus, it was deemed necessary to set up hospitals especially for women and staffed by female doctors and midwives exclusively Indian women. However, it was the British women doctors who practised in these hospitals. But this professional monopoly was challenged by the Indian women doctors in the early nineteenth century. Together with Indian women, who aimed at reforming midwifery and conditions of birth in India, they argued that British women were more interested in their careers as doctors or official wives and ignorant of the needs of Indian mothers. Consequently, Indian women and nationalists depicted colonial health policy for women and children as proof of imperial ignorance and incompetence.

Medical care provided by missionaries to the women and children continued even when the State lacked the empathy to the subject.¹⁷ This was thus the historical account of the initial and missionary work for women and children in this Province. It was missionaries who attracted the attention of the State towards the alarming rate of maternal and child mortality. The next sections will thus explore the policy formation of the colonial United Provinces for the women and children.

WESTERNIZATION, MOTHERHOOD AND DUFFERIN FUND

In the 18th century Britain, the childbirth was ‘a social rather than a medical event.’¹⁸ The medicalisation of childbirth in India however, was a part of the broader project of imperialists to modify the *zenanas* on western level of sanitation and medical practices by integrating the hospitals and dispensaries into ‘a hierarchy resort for birthing women.’¹⁹ For institutionalizing the healthcare for women, providing western medical aid to the secluded *zenanas* was prioritized by the State. This was a means of infiltration of colonial medical policy to the elite class women, so as to create hegemony of western medicine. The discourse of zenana medical care projected ‘Indian women as an undifferentiated mass, all affected by the prejudices and customs

¹⁶ First Annual Report of the National Association for Supplying Female Medical Aid to the Women of India (NASFMAWI), January, 1886, Calcutta, pp- 79-80.

¹⁷ Roger Jeffery, *Politics of Health in India*, p-90. Balfour and Young, *Work of Medical women*, p-182. By the 1927, out of 183 hospitals in India were staffed by the women and 93 were mission hospitals.

¹⁸ Irvine S. L. Loudon, Childbirth, p-1046 in W. F. Bynum and Roy Porter (ed.), *Companion Encyclopedia of the History of Medicine*, (London and New York: Routledge, 1993).

¹⁹ Sarah Hodges, Towards a History of Reproduction in Modern India, p-5, in Sarah Hodges (ed.), *Reproductive Health in India*, op.cit.

of female seclusion'.²⁰ The concept of *zenana* medical care was to provide western medical aid to women of elite class without disturbing the *purdah* or any Indian tradition. The *zenana* was regarded as a dangerous place to its inhabitants considering it as a center of dirt, disease and dominance.

Providing medical care to women and maintain their seclusion was challenging for the state. However, the government of NWP and Oudh was the steadfast supporter of the 'female hospital movement' acknowledging the necessity of special arrangements to accommodate practices of female seclusion even before the initiation of Dufferin Fund.²¹ In 1884, NWP and Oudh made arrangements to provide separate arrangements for females and children in the hospitals and dispensaries. What the administration failed to acknowledge was that women were always accompanied by the male members of their family to the hospitals. Sometimes female patients themselves preferred waiting room of the male ward than females due to the better arrangement in the latter.²² Further, in rural areas where there were few arrangements of female hospitals or wards, the dispensaries only catered the medical requirement of the women. Even of the fact, the I.G.C.H. concluded that the attendance in the dispensaries would increase when separate hospitals for females constructed in the Province along with the female staff and doctors.²³

A similar concern was also showed in 1891, when the Committee of Dufferin Fund in its report highlighted that, "in order to induce *purdah* women to enter wards in hospitals, private accommodation is must be provided for them, and that otherwise they can only be reached by visiting midwives, or by the employees of the Association attend them in their homes when at leisure. The Central Committees would, therefore, once more impress on provincial and local branches in Provinces where such prejudices are deeply rooted, the necessity of providing special accommodation of women of this class. It is glad to notice that Provincial and Local reports contain not a few indications that the ignorance and superstition which are rife in the minds of the great mass of Indian women are in many quarters being quietly but

²⁰ Samiksha Sehrawat, *Colonial Medical Care in North India: Gender, State and Society c. 1840-1920*, (New Delhi: Oxford University Press, 2013), p-105.

²¹ J. Richardson, Notes on the Annual Returns of the Dispensaries and Charitable Institutions of the NWP and Oudh, December 1891, Allahabad, 1892, p-42.

²² W.R. Rice, Notes on the Annual Returns of the Dispensaries and Charitable Institutions of the NWP and Oudh, December 1887, Allahabad, 1888, p-5.

²³ W. Walker, Report on the Dispensaries and Charitable Institutions of the NWP and Oudh, December 1886, Allahabad, 1887, p-5.

surely overcome and that purdah women are being induced to enter hospitals specially provided for them and to accept in their homes assistance from Lady doctors.”²⁴ Later, Lady Dufferin wrote to the Central Committee about the reluctance of *purdah* women to attend Dufferin hospitals and apprehended that it will continue till these hospitals were visited by male doctors even it was for inspection only.²⁵ In Fyzabad, Dr Cadge reported “it may be safely presumed that a class of women is attending Dufferin hospitals who did not come to Sadr Dispensary, viz, the *pardah-nashin* women, and this I know to be the case amongst the out-patients. The Hospital-Assistant at this station is reported as having attended 200 *pardah-nashins* in their own houses.”²⁶ Yet this remained illusion rather than a reality because as late as in 1917, Miss Kathleen Vaghan wrote an article in *Hindustan Review*, in which she appealed for women’s hospital to be kept entirely separate from men’s hospitals and staffed by only qualified women doctors. She lamented that “the Dufferin scheme is unsatisfactory as the salaries offered are insufficient to attract well-qualified women doctors. The women Hospital Assistance (HA) in charge of women’s wards, who work under the C.S., are of little use, as Indian women prefer not to go to the hospital rather than risk being seen by a man. A properly organised WMS for Indian women and children is required, and Indians themselves should take up this question.”²⁷

Table 4.1:- Beds for Maternity cases and Number of Labour cases attended to in Provinces of India, 1938.

Province	General hospitals			Women’s Hospitals			Maternity Homes		
	Number of Beds available for Maternity cases	Number of delivery cases attended to		Number of Beds available for Maternity cases	Number of delivery cases attended to		Number of Beds available for Maternity cases	Number of delivery cases attended to	
		Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
United Provinces	40	881	251	388	3,806	2,937	45	194	19
Madras	609	10,626	3,012	838	15,117	7,178	93	1,389	205
Bombay	413	11,471	1,579	836	4,416	1,434	1,386	17,482	1,982
Bengal	333	7,525	1,194	369	8,179	2,875	119	6,132	1,810

Source: IMR, p- 18.

²⁴ Seventh Annual Report of the NASFMAWI The Countess of Dufferin Fund, 1891, Calcutta, 1892, p-14

²⁵ Twenty-Fifth Annual Report of the NASFMAWI The Countess of Dufferin Fund, 1909, Calcutta, 1910, p-22.

²⁶ Seventh Annual Report of the NASFMAWI The Countess of Dufferin Fund, 1891, Calcutta, 1892, p-14

²⁷ Hindustan Review, April 1917, SVN, p-296.

The expansion in female hospitals, for providing greater care in observing female seclusion, took place sporadically but was not a dominant trend. This strategy worked as observed in the average increase in hospital beds for women. In United Provinces, DF maintained hospitals which provided maternity beds while in other provinces, majority of beds were provided by the government, municipal boards or local bodies. However, the distribution of available beds was not uniform i.e. 74 in urban and 11 rural in hospitals which provided 284 and 8 maternity beds respectively. Official reports shows that the opening of separate enclosures for women in hospitals and dispensaries led to increase in number of female and children cases in hospitals. Understanding the problem of Indian women of purdah, an initiative was taken up by the Thomason dispensary at Agra. Miss. Yerbury, Mrs. Moomta and Miss. Cray's opened a separate reception room for women and children at Agra in 1886.²⁸ This increased both in-door and out-door daily average attendance of women and children in this dispensary. When separate accommodation was provided for females, in 22 districts with separate hospitals, men had 45.5, women 26.7 and children as 27.8 per cent of attendance in hospitals and dispensaries while in 26 districts with no separate arrangement available, the hospitals and dispensary accommodation was 64.2 men, 15.9 women and 19.9 per cent for children.

The increased number of hospitals and dispensaries forced the provincial government to acknowledge the requirements of the Indian women apart from the zenana patient. United Provinces thus provided female branch dispensaries where female hospital assistants (FHA) were appointed to provide medical care to women of all classes. This catered the requirements of those women especially of lower strata of society, who earned for their family abandoning the secluded life.²⁹ The hospital reports evidenced that the women of the lower castes, treated to a considerable extent at the ordinary hospitals and dispensaries, even in those places where separate Dufferin hospitals were available. The ladies of the upper class or *pardah nashin* women rarely visited these centers and were not much inclined towards the westernization of medical care. The reason was more of *pardah* seclusion rather than indifference towards modern scientific methods or prejudices of society. For instance, Mildred Staley claimed that,

²⁸ W. Walker, Report on the Dispensaries and Charitable Institutions of the NWP and Oudh, December 1886, Allahabad, 1887, p-9.

²⁹ S. Bandyopadhyay, Caste, Widow Remarriage and the Reform of Popular Culture in Colonial Bengal, pp-8-36 in Bharati Ray (ed.), *From the Seams of History: Essays on Indian Women*, (New Delhi: Oxford University Press, 1997).

“...the more obscure *pardah nashin* ladies and the respectable women of the upper and lower middle classes have not the slightest objection to finding themselves when ill under the same roof together or even sharing the same wards, always provided that no men are ever admitted either as visitors or officials, and that the reasonable tact is exercised in all the internal arrangements.”³⁰ The condition was no different in NWP where Geoffry C. Hall, reported that “.....inspecting officers often condemn a female hospital as useless for the purpose for which it was intended, to give medical aid to *pardah nashin* women, unnecessarily, because although the *pardah nashin* class may not make much use of the hospital itself, yet they very often make use of the female medical aid which is presiding over the female hospital, this is where the value of the Dufferin schemes comes in – it is in placing the female medical aid at the disposal of the people....I found in some of my inspections that although the *pardah-nashin* wards were not made use of, yet the female medical attendants has been called to see *pardah-nashins* in the city near the hospital, and it was here good work was done. I hope a careful record of all cases will be kept in future so that we really can see the extent to which the people are making use of the female medical aid brought to their doors by the Dufferin Hospital scheme.”³¹ Further it was accepted that in some places the failure to attract female patients is undoubtedly due to the incompetence of the staff, in others to structural defects in the buildings (which do not provide for strict privacy), and in others again to the novelty of system, which was hoped to ‘be remedied in time’³² and overcrowding.³³ Even though *purdah nashin*’s accommodation in hospitals does not evidence the slightest increase, yet hospital reports highlight that these women sought the assistance of these hospitals. As in 1901, 4,202 *purdah nashin* ladies were treated at their homes by lady doctors and FHAs, as compared with 4,009 and 3,222 were treated and visited during 1899 and 1900 respectively.³⁴ Of these private patients, in 1901 there were 271 midwifery cases

³⁰ British Medical Journal (BMJ), “*The Countess of Dufferin Fund*”, 8 September, 1900, p-695.

³¹ Triennial Report on the Dispensaries and Charitable Institutions of the NWP and Oudh, 1896-1898, Allahabad, 1899, p-42.

³² See Orders of the Government of NWP and Oudh, p-6. In J. Richardson, Notes on the Annual Returns of the Dispensaries and Charitable Institutions of the NWP and Oudh, December 1891, Allahabad, 1892.

³³ A. R. Cavalier, *In Northern India: A Story of Mission Work in Zenana, Schools, Hospitals and Villages*, (London: S. W. Partridge & Co., 1899), p-30.

³⁴ Colonel G. Hutcheson, Triennial Report on the Hospital and Charitable Institutions of United Provinces of Agra and Oudh, 1899-1901, Allahabad, 1902, p-7.

treated in the hospitals and dispensaries.³⁵ This was a continuous trend in United Provinces, where in twentieth-century also the female doctors attended thousands of women at home than treating them within the four walls of hospitals and dispensaries.

However, the secretary of DF in Bareilly praised medical care for women and children and Dufferin Hospitals as “hardly...any empty bed during the whole year, many (patients)...coming from long distances.”³⁶ Yet hospital accommodation was still not satisfactory as highlighted, “the remarkable increase in the number of women and children treated as patients since 1887, and the large and growing extent to which they have availed themselves for better accommodation of late years wherever it has been provided for them, make it clear that the hospital accommodation hitherto available for women of the country is far from meeting their requirements....”³⁷

The establishment of Dufferin Fund was described as a lucid example of British paternalism in India. However, the fund had a significant impact on medical education and women’s health which cannot be ignored considering the fact that India was under foreign rule. Scholars have argued that leaving Indian women’s healthcare to the wives of viceroys and governors was indicative of “secondary importance” given by the state and was not taken up as official business. The government offered its goodwill but would not take up the work itself. It believed that if it did so, private subscriptions would dry up.³⁸ While the other scholars raise the quasi-governmental nature of the Fund.³⁹ Even then, the provincial government of NWP and Oudh supported the Fund by opening hospitals and dispensaries. In 1885, five dispensaries were opened and 20 dispensaries were established for the treatment of females in 1891 which increased to 56 in 1901.⁴⁰ The administration made this clear to civil servants that they should not spare any effort in improving female medical aid and training. The districts which associated themselves with Dufferin Association were able to provide proper hospital accommodation for women in comparison to State-owned institutions. The condition and sanitation in the hospitals were less

³⁵ Ibid.

³⁶ Cited in Samiksha Sehrawat, *Colonial Medical Care*, p-136.

³⁷ UPSA, File No. 117B/1, Box No. 1, ‘Accommodation for Women and Children in Hospitals and Dispensaries of these Provinces’, Medical Department.

³⁸ David Arnold, *Colonizing the Body*, p-264.

³⁹ Maneesha Lal, The Politics of Gender and Medicine in Colonial India: The Countess of Dufferin’s Fund, *Bulletin of the History of Medicine*, Vol. 68, 1994, p-31.

⁴⁰ Annual Report on the Dispensaries and Charitable Institutions of NWP and Oudh, 1889, Allahabad, 1890, p-2.

appreciative. As in the first meeting of Central Committee attended by the representatives of Bombay, Burma, United Provinces, Assam, Central Provinces, Bengal, Bihar, Orissa, and Punjab participated in 1918, Lady Chelmsford lamented about the acute demand for the extension of buildings of women's hospitals, need of adequate number of staff, poor sanitation, lack of operating rooms and appliances for maternity cases, and huge requirement of nurses.⁴¹ Nevertheless, the Fund reflected the attitude of colonialists towards women and child care, as Viceroy Curzon proudly proclaimed in 1899 that the fund promoted the cause of bringing western civilization to Indian women by 'lifting the veil of purdah without irreverence.'⁴² Similar comments were made by earlier viceroys who considered the work as most important experiments attempted in British India.⁴³

Whether it was government or associations, both considered that the movement in due course of time will be taken over by the local bodies with the financial support from natives. This could be glanced from the report by the DF that "With regard to the valuable support which has been recently given to the Dufferin Fund movement by Local bodies, it may be explained that the promoters of the Association always hoped that each year the management of female hospitals would pass more and more into the hands of the people for whose benefit the movement was organised."⁴⁴ As late as 1909, it was lamented that the majority of the Dufferin hospitals had no effective arrangement for the purdah system and thus these hospitals had failed to attract genuine *purdahnashins*. Further, pay and positions of medical women possessing high professional qualifications called for some improvement and that Dufferin hospitals needed more efficient nursing services.⁴⁵ Finally a resolution was passed in the Council which recommended to the Government that in public hospitals and dispensaries separate wards for Indian females be constructed, where they do not exist, in these provinces, was thus passed in 1927.⁴⁶ Consequently, 50 midwives (demand for 65) and 30 sub-assistant surgeons (demand 52) were sanctioned to be

⁴¹ Thirty-Fourth Annual Report of the NASFMAWI, 1918, Calcutta, p-25.

⁴² David Arnold, *Colonizing the Body*, p-265.

⁴³ *Ibid.*

⁴⁴ Twenty-Fifth Annual Report of the NASFMAWI-The Countess of Dufferin Fund, 1909, Calcutta, 1910, p-9.

⁴⁵ *Ibid.*, NASFMAWI 1909, p-19.

⁴⁶ UPSA, Resolution No. 87/XVII-131, Legislative Department, 9 February, 1927, Allahabad, in the Proceedings of the Government of United Provinces, Medical Department, October 1927.

appointed from 1928.⁴⁷ However, only 10 women sub-assistant surgeons and 13 midwives were recruited in this province in the year 1929.⁴⁸ Thus Colonel Illius asked the C.S. to make direct recruitment and distributed the balance of the grant throughout the province in order to hasten the scheme. However, the recruitment was slow as the pay of Rs. 75 without private practice (as scope was less in rural areas) was not attractive to draw desirable sub-assistant surgeons, and most sub-assistant surgeons were not prepared to work in villages at such low pay. Many times the skilled doctors and surgeons attracted the people from far places and when they left or were transferred, people visit to those hospitals and institutions. For instance, Assistant Surgeon Karar Haider and Sheoraj Misra were famous Surgeons of this province from Ballia.⁴⁹ When Miss Thomas working at Bahraich posted at Benares in 1890, the hospitals popularity was declined. These small yet significant points remained away from the colonial policy framers to bestow good health facilities in the Province.

Most newspapers praised the DF and official contribution to this fund promoting the women's health in United Provinces.⁵⁰ Some of the newspapers reported the role of civil surgeons and collectors in raising the funds.⁵¹ Further, United Provinces government took over the expenditure of institutions supported by the Fund, for instance, Dufferin hospitals at Agra were undertaken in 1917.⁵² However, this support was never formalized and the DF was not considered a part of colonial administration.⁵³ This was also evidenced from the statements made by the officials, for instance, Lord Wenlock, Governor of Madras, told in a branch meeting in December 1895, 'the Government of India had always made clear that while providing "general medical aid", it would keep itself "studiously....aloof" from schemes designed to give "special benefit for particular class...because the DF was not an official body, it could not always count on the support of officials, and "unless we have officials supporting us as we ought to be supported, it is almost impossible to

⁴⁷ UPSA, Proceedings of the Government of United Provinces, Medical Department, February 1929, p-1-3.

⁴⁸ UPSA, File No. 25/1927, Box No. 5, Scheme for Extending Medical Relief to Women in Smaller towns in the United Provinces, Medical Department, UPSA, p-22.

⁴⁹ Annual Report on the Dispensaries and Charitable Institutions of NWP and Oudh, 1892, Allahabad, 1893, p-8.

⁵⁰ Almora Akhbar, 21 September 1885, SVN, p-660.

⁵¹ Mufid-i- Agra, 1 April 1889, SVN, p-215.

⁵² Annual Report on the Civil Hospitals and Dispensaries of United Provinces of 1918, Allahabad, 1919, p-10

⁵³ Samiksha Sehrawat, *Colonial Medical Care*, p-122.

do any good work.”⁵⁴ Thus, official stance was that DF was a non-state private voluntary organization relied more on private philanthropy rather than state’s benevolence. Ironically the DF and private organizations strengthened the claim of colonial rulers to be the savior of Indian women and children. It was lamented that the lack of funds hampered the working of Dufferin hospitals, the main reason was the reduction in their grant by municipal board significantly and in many cases to 15%.⁵⁵ Even DBs of Sitapur, Kotra, Bijnor, Kheri, Fyzabad, Benares and Allahabad in 1933 stopped their contributions for the maintenance of the Dufferin hospitals because of considerable difficulty in managing their finances.⁵⁶ On the other hand, DF ensured that it would withdraw its aid unless all bodies contribute equally into the cause. This tussle continued for a long time where the responsibility of investment became a conflict in hierarchical levels of administration of medical policy in United Provinces.

The British believed that the native aristocracy or princely states ought to participate in medical philanthropy of the colonial state in contribution towards the DF or female dispensaries. On the other hand, various associations and local subscriptions wholeheartedly supported the cause of good health for women and children. For instance, the Central Committee of DF gave 10,000 as a contribution with an additional 10,000 and the Committee of NWP and Oudh gave 20,000 in 1887 and the medical philanthropy of the government increased the grant from 2000 to 4000.⁵⁷ Notwithstanding these amounts were in abundance, however, were not enough to cater to the demand of such a large Province. The native rulers enthusiastically gave grants or land gifts, also willingly took an active interest in providing medical care to women and children. The Maharajas of estates such as Balrampur, Benares, Rampur, Tehri- Garhwal showed their keen interest in the establishment of hospitals and dispensaries. Some of the noted medical philanthropists were Rai Pratap Chand Bahadur who not only opened a dispensary in Phulpur but also donated Rs. 25,000 to DF at Allahabad; Raja of Nanpara donated 20,000 to Bahraich female dispensary in

⁵⁴ David Arnold, *Colonizing the Body*, p-264.

⁵⁵ Report of the Dufferin Hospital, Cawnpore during the year 1923, in NASFMAWI, 1923, Calcutta, p-18

⁵⁶ UPSA, Letter No. 253/IX-408, From Under Secretary to Commissioners of Sitapur, Kotra, Bijnor, Kheri, Fyzabad, Benares and Allahabad, dated 22 November 1933, in File No. 408/1932, Resolution-Countess of Dufferin Fund regarding contribution by District Boards, LSG Department.

⁵⁷ UPSA, Proceedings of the NWP and Oudh of the Medical Department, 1887, p-17.

1892.⁵⁸ When the demand aroused for the construction of a female hospital at Muzzafarnagar it was suggested that rich men should be asked to contribute ‘on a condition that F.H.A should attend their families free of cost.’⁵⁹ Chaudhuri Ghasi Ram, Lala Keshav Das and Syed Menhdi Ali Khan thus agreed to donate the specific amount for the establishment of the institution. In NWP and Oudh, as reported by association of DF, ‘not only the Princes and Noblemen but also the middle class, have cordially supported the objects of the Association.’⁶⁰ However, the newspapers did in fact report the dependence of princely rulers on the colonial state had induced them to contribute magnanimously to the DF. It was reported that the donations made by native chiefs had been given under the official pressure also claimed that “the fact is that they are entirely at the mercy of the Foreign Office, and must do what they are bidden to do. They are given to understand that if they contribute to funds like the one in question, they will receive titles and honors and that in case of default they will incur the displeasure of the Foreign Office.”⁶¹ Other newspapers reported that a government resolution was passed to forbid government officials from collecting subscriptions for works of public utility from princely rulers without special permission, but officer’s wives were asked to collect to get around it.⁶² Azad claimed that the success of the Fund was due entirely to the fact that it was a cause espoused by the Viceroy’s wife, as people who had never before supported the charitable cause, contributed to it.⁶³ Despite the claims of the press about the coerced contribution by the native rulers and their desire of gaining privileges by flattery,⁶⁴ native rulers openly declared that the donations were more a part of charity rather than official pressure.⁶⁵ Reliance on voluntarism and medical philanthropy of indigenous population served two purposes of the colonial state. Firstly, British paternalism for

⁵⁸Orders of the Government No. 328/V-159B, p-9 in J. Richardson, Annual Report of the Dispensaries and Charitable Institutions of NWP and Oudh 1892, Allahabad, 1893.

⁵⁹ UPSA, Extract of Proceedings of District Boards on 25 March 1893, in File No. 117B/9/1893, Box No. 2, ‘Accommodation for female patients and provision for the training of a female staff in the districts of Muzzafarnagar and Bulanshahr’, Medical Department, 1893.

⁶⁰ Seventh Annual Report of the NASFMAWI The Countess of Dufferin Fund, 1891, Calcutta, 1892, p-74

⁶¹ Hindustani, 6 September 1885, SVN, 1885, p-639.

⁶² Najm-ul-Akhbar, 6 April 1885, SVN, 1885, p-544.

⁶³ Azad, 24 November 1885, SVN, 1885, p-846-7.

⁶⁴ Raja Shiva Prasad was criticized when he decried the Hindu treatment of women in public meeting and praised the DF in order to gain seat in Viceroy’s Legislative Council. See Hindi Pratap, Allahabad, February 1886, SVN, 1886, p-132-33 and Bharat Bandhu, Aligarh, 25 September 1885, SVN, 1885, p-679.

⁶⁵ The Maharaja of Benares and Nawab of Oudh made a donation to the DF declared that it had been made under no official pressure. (Hindustani, 20 September 1885, SVN, 1885, p-661-2).

the well-being and good health of its subjects was established without rigorous involvement and secondly, incurring heavy expenditure on healthcare. Another side of this picture could be glance from the local press which reported the harassment by the government officials while collecting the subscriptions for DF. In 1886, when the NWP was suffering from scarcity many tehsildars were busy in collecting subscriptions of DF.⁶⁶ Added to this, an official in Kanpur issued summons through tehsildars for the recovery of subscriptions, and the subscribers were asked to pay subscriptions at once in advance for 16 years. Thus the collection of subscriptions was more like income tax⁶⁷ rather than a public charity.

The international lobby for women's health was most active with regard to women and children in an organized economic sector. The debate on maternity benefit and maternity leave was initiated by the Convention of International Labour Conference which met in October 1919 in Washington.⁶⁸ Throughout the 1930s the convention remained unrecognised in Indian presidencies. In 1930, Royal Commission on Labour in India recommended in the interest of mothers and children that in order to encourage delivery of women by the trained dais, a small bonus should be given to the women concerned, if her delivery was effected by a trained woman instead of the ordinary untrained dhai. Even the Whitley Commission pointed out the great need for an inspectress in the factories. It was argued that, medically qualified inspectresses would be the best as they could supervise trained midwives and gain the confidence of dhais thereby improving the standard of work. This report insisted that the work of the traditional birth attendant had to be restricted or maternity schemes would never succeed.⁶⁹ As an effect of these recommendations, Bombay, Madras and Bengal presidency passed maternity benefit laws. For instance in Bengal, a laissez-faire policy was adopted with respect to maternity benefit and leave. Women in tea plantations who needed and deserved support, received benefits from the planters on a voluntary basis; mining women, being part-time workers and backed by agricultural families, were not regarded as being in need, and jute women workers thus received

⁶⁶ Prayag Samachar, Allahabad, SVN, 1889, p-423.

⁶⁷ Hindustani, Lucknow, 8 December 1889, SVN, 1889, p-779; Hindustan, Kalankankar, 15-17 February 1888, SVN, 1888, p-129; Najmu-i-Akhbar, Etawah, 24 September 1886, SVN, 1886, p-685.

⁶⁸ The Draft convention suggested a six week leave before and after childbirth, accompanied by sufficient benefits, for women in commercial and industrial undertakings. On resuming work work women should be entitled to two extra breaks of thirty minutes each during their working hours while they were breastfeeding their babies.

⁶⁹ Geraldine Forbes, *Women in India*, p-92.

nothing.⁷⁰ All these conditions in women healthcare especially of poor class explicitly impacted the paediatrics.

Consequently, in the Legislative Assembly of United Provinces Pandit Raja Ram Shastri criticized the working of the government where the bill was pending for last two years in comparison to the provinces of Bombay, Madras and Bengal, where the act was already implemented. He also lamented that even when all other provinces of the country fulfill the requirements of welfare works, United Provinces still under the process to introduce such works. However, a bill was introduced and passed by the Congress government of the United Provinces in 1938.⁷¹ This was named as '*United Provinces Maternity Benefit Bill*' which provided to every woman working in factories a maternity benefit at the rate of 8 annas a day for the four weeks. Further, maternity benefit was decided to be provided for 8 weeks to those women workers who availed the service of a qualified midwife or a trained woman health visitor. Additionally, she was to be provided with a bonus of five rupees. Further, every factory employer was to establish a crèche with a female attendant, qualified midwives and a trained women health visitor to take care of the children of the factory women. The Act passed by the government under the Congress not only laid the vision of foundation of maternal and paediatric policy in post-colonial government but also proved that child health and welfare too was part of nationalist movement in the country.

Even though the Act was beneficial for both the women and children, this act benefitted the women in the factories and mills only but this act was not extended to the working women in municipalities, local bodies or at agricultural farms etc. Although malnutrition and hard factory labour placed the heaviest burdens on mothers and babies, the schemes which were introduced largely ignored these problems. Further, outside the economic sector, state initiatives to reform childbirth marginalized after 1920. However, the implementation of this Act was not full-fledged. Many times employer refused or did not give the amount to the women. On the other hand, a question arises, why plantation owners were so solicitous of pregnant women when they generally treated their workforce so callously? Geraldine Forbes answers, "probably they viewed reproduction as a less expensive method of labour recruitment than any other. Consequently, they did not like dhais who

⁷⁰ Dagmar Engels, *The Politics of Childbirth*, pp- 238-39.

⁷¹ UPSA, File No. 120/1930, Box no. 98, Bill- Maternity Benefit, Legislative Department, 1930.

according to Dr Whitell, Civil Surgeon of Lakhimpur, operated as an abortionist in towns outside the jurisdiction of planters.”⁷² It is not known whether women used these services or not but they did not want to give birth so that their children would not face the misery as they were experiencing. Reforms and debates were thus politically significant with regard to the British effort to contain the nationalist movement and to prove the wholesome effect of British rule in India to the international community. This section thus focused on the pre-natal care in the western medical institutions in United Provinces. The post-natal and child care, which is focal point of the thesis, is discussed in the next section.

DEVELOPMENT OF INSTITUTIONAL CARE FOR PAEDIATRICS

As discussed earlier, DF’s impact on the medical care of women and children was considerable, taking into account the colonial state and the provincial administration of healthcare. The fund had not only opened many hospitals but also trained female medical practitioners. The success of DF or hospitals could be assessed by the accommodation and number of women and children patients in the medical institutions. The variations in the number of patients in the hospitals and dispensaries are not cited in hospital reports except blaming the distrust of people, their orthodox nature and general apprehensions towards western medicine. In female hospitals also there were no separate arrangement for children i.e. lack of paediatric beds or wards in the Province. On that place there were separate Dufferin hospitals and that too specifically in urban areas and the significant towns such as Agra, Aligarh, Lucknow, Benares, etc. Few antenatal care clinics existed in the Province.⁷³ It was women’s hospitals, female dispensaries, and child welfare centers which catered the health care requirements for children. These centers and institutions must have carried out treatment of children and provided them with medicine or general ailments during epidemics. Government more relied on DF and local subscriptions rather than state expenditure. This is evident from the statement of I. D. Elliot who remarked that “...in such an important movement government might be prepared to take the initiative and make grants.”⁷⁴ The post-mutiny empathetic administration and the ‘responsible government’ failed to recognize the alarming conditions of child health

⁷² Geraldine Forbes, *Women in India*, p-93.

⁷³ Three Ante-natal and Infant Welfare Centres at Agra provided midwifery cases for the training of the students of the Medical College.

⁷⁴ UPSA, File No. 25/1927, Box No. 5, Scheme for Extending Medical Relief to Women in Smaller towns in the United Provinces, Medical Department, p-3.

but also thwarted India's demand of independence on the grounds that they could not take care of the children. Provincial and local governments had their own limitations which only made the conditions worst.

As Hospital reports are silent on the issue of the measures used to provide medical care provided in these institutions, a general overview can be speculated about the working in these institutions. The advancement in the scientific technology which were available in the hospitals were utilised by the parents for the better health of their children. For instance, the surgical operation of lithotomy was performed by the doctors in hospitals and dispensaries for children also. In the operation for stone in the bladder, litholopaxy was considered suitable for the adults and for children this technique was not followed because the number of children treated by the technique was nominal and hence there was no proved success for its suitability for a child.⁷⁵ It was reported by I.G.C.H. that due to the advances in surgical operations of children; "small boys now have their stone crushed quite comfortably, as the smaller sized lithotriti have been provided at most dispensaries."⁷⁶ The surgical operations of children were more popular among people as mentioned in the hospital reports. This may be due to the western technique of surgery and x-ray machines, which not existed in indigenous medicine.⁷⁷

Table 4.2: Number of Surgical operation of lithotomy on children

Age	1862-65			1886			1887		
	Total Number of Operations	Total deaths	Percentage of deaths to total number of operations	Total Number of Operations	Total deaths	Percentage of deaths to total number of operations	Total Number of Operations	Total deaths	Percentage of deaths to total number of operations
0-5 years	3622	208	5.74	226	9	3.98	216	10	4.62
6-10 years	4084	166	4.06	224	7	3.12	199	7	3.51
11-20 years	2852	184	6.45	119	7	5.88	136	9	6.61

Source: W. Walker, Report on the Dispensaries and Charitable Institutions of NWP and Oudh 1886, Allahabad, 1897, p-27

⁷⁵ W. Walker, Report on the Dispensaries and Charitable Dispensaries 1886, Allahabad, 1887, p-26.

⁷⁶ Col. Geoffrey C. Hall, Triennial Report of the Dispensaries and Charitable Institutions of the NWP and Oudh, 1898, Allahabad, 1899, p-42.

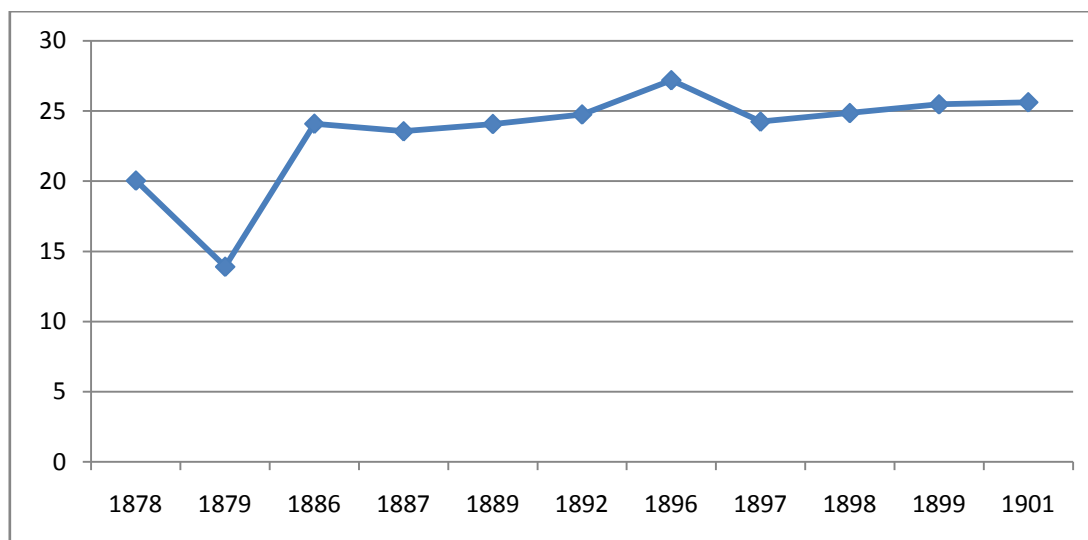
⁷⁷ The reference of surgical operations could be found in Charak Samhita, Susrut Samhita. Further *Jarrahs* were the group of barber-surgeons who practiced surgical operations under Unani system of medicine at Agra in the Province. For details see- Gazetteer of India, Uttar Pradesh, District Agra, 1960, p-311.

As far as children were concerned, modern science though attracted parents to the hospitals and dispensaries, their average daily attendance instead of increasing remained stagnant. After the 1900s, the attendance of women evidenced a remarkable increase but the same was not applicable on the number of admissions of children. No particular explanation could be cited from the reports of I.G.C.H. of United Provinces. Further there were many areas and region-wise anomaly in the attendance of children in this Province. Such as in 1886, the Aligarh and Hathras districts in Agra regions had dispensary attendance of women and children combined was respectively 9.18 and 11.54 per cent, while at dispensaries at Sikandra Rao and Atrauli was 19.8 and 22.4.⁷⁸ When the separate female hospitals and dispensaries were opened by the Provincial government and DF, it is interesting to note that the average number of child patient attendance or the number of children treated was higher in general hospitals and dispensaries (5540.20) rather than in hospitals and dispensaries for females (1,046.23) in 1901, but steadily the number of children increased in the latter institution to five-fold (6527.06) in two years (in 1903).⁷⁹ Furthermore, the attendance of children many times depended on the existence of medical professionals who gained popularity due to their commendable works. Yet it can be ascertained that the children were only brought to hospitals in the case where indigenous medicine could not deliver the demand of the individual. In addition, in the Indian family, the elders especially women were considered a knowledgeable fellow who could suggest home remedies for quick relief, if not cured then they approach for the assistance of baids and hakims for the child care. In this much significant role was played by vernacular literature like *Stri Subhodhini*, *Stri Darpan*, *Madhuri*, which educated literate women about the care of children from ante-natal to the stage of neonatal. Unfortunately, the issue of low attendance failed to attract the government's attention and no effort was made to bring children under the western medical influence through institutions. In I.G.C.H. reports, focus was more on the female attendance in dispensaries rather than on children.

⁷⁸ W. Walker, Report on the Dispensaries and Charitable Dispensaries 1886, Allahabad, 1887, p-10.

⁷⁹ R. D. Murray, Annual Report of the Hospitals and Charitable Dispensaries of United Provinces 1903, Allahabad, 1904, p-138A.

Chart 4.1: Ratio per cent of average daily attendance of children in the hospitals of NWP and Oudh



Source: - Annual Report of the Dispensaries and Charitable Institutions of NWP and Oudh, continued as Annual Report of the Hospitals and Charitable Institutions of United Provinces (1878-1902)

Many hospitals were closed on account of lack of private philanthropy and funds. In this part, Dufferin Hospitals did more work than government aid. Later, the government also instead of participating in opening hospital and dispensaries for women, bestowed grants to Dufferin Funds, to deliver care to children. Thus, pediatrics in UP was much depended on the Dufferin hospitals and private philanthropy rather than on government's will and conviction.

Table 4.3: Indoor and Outdoor Children patients treated in Hospitals and Dispensaries by Local Funds, Private Funds, and Subsidized Dispensaries of United Provinces in 1926-1928

Dispensaries	Indoor patients		Outdoor patients			
	Daily average number		Total treated		Average daily attendance	
	Male	Female	Male	Female	Male	Female
General	164.82	57.777	8,49,278	554,394	5,604.90	3,817.16
Female	48.47	85.29	87,799	90,928	502.64	517.98
Subsidised	0.40	0.02	18,378	11,534	113.45	63.85
Total of Province	213.69	123.087	9,55,455	656,856	6,220.99	4,398.99

Source: Col. C. A. Sprawson, Triennial Report of Civil hospitals and Dispensaries of the United Provinces for the years 1926,127 28, Allahabad, 1929, p-40-41A.

It was an accepted fact that social conditions were too dominant in the status of health of women and children. Yet the general poverty was a dominant reason, never cited in any official correspondences and reports. A similar attitude was evident towards the consciousness towards the male and female child. As male child was prioritised by parents over girls in the country; and the United Provinces was no exception to this fact. Unfortunately, the same could be assessed from the Hospital reports of IGCH, where the remarkable difference was evident in the treatment of children in the medical institutions. As discussed in the earlier chapter, the gender bias was evident in the vaccination, school health services, and nutritional status; together with social prejudices, were equally responsible for restricting the medical aid for a girl child. There were many social prejudices in the country but that were removed by the British through legislation. However, apart from Vaccination Act 1880, no legislation was passed by the colonial government of United Provinces for compulsory medical aid for a girl child, where there attendance and treatment was almost half (table 4.4) in comparison to a male child, whether that was differentiation on the basis of religion or gender. Religious prejudices were more dominant in Hindu community, which reduced over the years on account of acceptability of western medicine by the parents, even though the gap between the attendance of boy and girl child as patients in hospitals remained same yet the attendance of girl child in hospitals steadily increased over the years in both Hindu and Muslim community but the percentage of Hindu girl was higher than Muslim girl child. Unlike the other issues related to child healthcare, this never concerned the government, local bodies or medical professionals.

Table 4.4: Number of in-door and out-door children patients according to class and gender treated in State -Public Fund and Private-aided dispensaries of United Provinces

Year	Europeans and Eurasians		Hindus		Muhammadans		Others	
	Male	Female	Male	Female	Male	Female	Male	Female
1905	1,447	1,405	3,25,207	1,96,010	2,04,517	1,38,829	32,053	
1906	1,334	1,847	3,67,788	217,791	2,29,554	1,57,218	36,889	26,190
1908	1,595	1,635	4,01,641	2,38,849	2,57,534	1,77,525	39,003	28,366
1923	975	790	5,06,840	3,23,887	3,09,090	2,25,148	23,797	18,528

Source: Annual Report of the Civil Hospitals and Dispensaries, 1908, p-40-43A; 1923, p-74A-79A.

Apart from hospitals and dispensaries, MWCs and Baby clinics were another unit worked for the child care in the United Provinces. The total number of MCWCs in the

United Provinces was 45 till 1927.⁸⁰ Twelve new centers were opened during 1928 at Allahabad, Bareilly, and Lucknow cantonment, Basti, Jalaun, Lansdowne, Mussorie, Mirzapur, Mainpuri, Rae Bareli, Sitapur and Shahjahanpur.⁸¹ Dr T. S. Iyer, Director of the MCW of the Provincial branch of the IRCS of United Provinces ran 147 rural and 146 urban maternity centers.⁸² As in the Province evidenced the shortage of trained midwives thus the government discouraged the opening of more MCWs from 1928 onwards. In 1927, in Bareilly MCW center treated 608 infants and 342 mothers and out of the total number of infants 63 died within first ten days of delivery.⁸³ On the contrary in Pilibhit, 4,322 deaths were registered under one year of age out of which 544 occurred in the area in charge of the midwives, and 3,788 in the other rural towns and municipal areas. The infant welfare workers in these centers focused on the infants under one year of age among whom the mortality was highest in this province. The expenses of these centers were undertaken by municipal board. In Dehradun also a centre named Ross Maternity and Child Welfare Centre started in 1924 and soon three probationer *dais* passed from here in 1928. In Meerut, too, 151 cases were conducted by the maternity staff in 1927, amongst whom eight deaths occurred and 412 infants and 304 mothers were treated at the centre and 473 home visits were made by the staff of the centre and 25 classes were taken by the 171 indigenous *dais* appointed at the centre. During the same year, in the municipality 2,843 births with 497 deaths of children (under one year) were registered at the rate of 174.81. At Lucknow, there were six centers of MCW. Thus the concentration of such centers was in the prominent towns of the Province in comparison to the rural areas, which widely relied on the dispensaries where the centers were ill-equipped and also inaccessible. A children's clinic was opened at the Kashi Anathalaya in which children up to the age of five years were treated and nurtured. Agra too had two baby clinics i.e. Balka Basti Red Cross Clinic and Nai Basti Clinic. At both these centers, child welfare programmes were conducted in which bathing and washing of children, treatment of minor ailments, and discussion on infant feeding and domestic hygiene were conducted.

⁸⁰ Sixty-First Annual Report of the Director of Public Health of United Provinces of Agra and Oudh, 1928, Allahabad, 1929, p- 109.

⁸¹ Ibid.

⁸² UPSA, File No. 337/38, Box-85, Scheme for the Medical relief in Rural areas (I), Medical Department, 1938.

⁸³ Sixty-First Annual Report of the Director of Public Health of United Provinces of Agra and Oudh, 1928, Allahabad, 1929, p- 109.

Table 4.5: Maternity and Child Welfare Centers maintained in United Provinces

Years	Centers maintained by					Medical Women		Trained Health Visitors		Trained Midwives		Trained Dais	
	Government	Local and Municipal Bodies		Others Agencies		Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
		Rural	Urban	Rural	Urban								
1933	-	-	118	56	3	-	-	-	14	-	-	121	113
1934	-	109	60	7	3	-	-	-	15	106	120	44	189
1936	-	61	56	60	80	-	20	-	22	124	179	174	399

Source: Annual Report of the DPH of United Provinces of Agra and Oudh, 1936, Allahabad, 1937, p-34-35A.

Leper, poor and blind asylums were maintained in the districts were charitable institutions which worked for the welfare of destitute children and also maintained their healthcare through charities. Not only did the government but the native rulers contributed a large amount of money in these asylums. In 1891, there were 27 districts which had these type of asylums in NWP and Oudh. The charities given to these asylums were sufficient to take care of the weak sections of society. In 1889, they had a cash balance of Rs. 27,369 and they invested around 5,14,400, while in 1892, it increased to 32,789 and invested funds of 5,50,767.⁸⁴ In the year 1889, in Bahraich (4), Raja Kali Shankar Asylum (5), Rae Bareli (1), children were benefitted. Further, there were two blind children in Bahraich and Raja Kali Shankar Asylum; 5 children were taken care in Allahabad Stranger's Home, one in Bahraich, 8 in Dehra dun, thus total 14 children, remained from the benefit of help from these institutions. From the reports, it is evident that the poor children were more benefitted by these institutions in comparison to children suffering from other ailments. Thus, no comprehensive works were undertaken for promoting better facilities of healthcare for the children.

Table 4.6: Number of children benefitted by the charities in NWP and Oudh

Year	Number of children benefitted		
	Blind	Leper	Poor
1879	21	16	560
1886	10	16	194
1892	1	17	102
1898	8	8	177

Source-Data compiled from Annual Report on the Administration of NWP and Oudh (1878-1892) and J. Richardson, Annual Report of the Dispensaries and Charitable Institutions of NWP and Oudh 1892, Allahabad, 1893, p-37A.

⁸⁴ J. Richardson, Annual Report of the Dispensaries and Charitable Institutions of NWP and Oudh 1892, Allahabad, 1893, p-26.

With provincialization of colonial administrative system, new centers of dissemination of colonial medical power emerged. In the United Provinces, five central school clinics were established at Lucknow, Agra, Allahabad, Cawnpore and Benares, thus overall thirteen school clinics were established. At places where the clinic does not exist, treatment to children were provided by the private associations. For instance at Gorakhpur, the School Boys Medical Service Association was formed to serve the needs of the scholars in educational institutions.⁸⁵ The Association provided the funds to establish dispensaries in seven schools in Gorakhpur. Though, school health services discussed in the earlier chapter, here attempt is made to understand the schools serving as a medical institution for the welfare of children under colonial rule. The children studied above were mostly infants and here we focus on young and adolescent children of urban areas under direct colonial administration. In rural areas many schools use to keep village aid boxes. In Agra, schools at Dayalbagh, Sikandara, and Firozabad had clinics at their own institutions. These clinics created a platform on which students, parents, teachers and SHO could meet the parents and explained about the ailments of the children. During the medical inspection, the scholars who were found to be suffering from any ailments were treated in these clinics. At the clinics, operations of the children were also carried out at the instance of SHO. In 1932, ten operations including those for hernia and hydrocele were performed at Gorakhpur.⁸⁶ Another advantage of this system was that the students with eye defects were tested in clinics and were prescribed spectacles here. Dental cases so common in children were also handled here by the dentists appointed by the government in the clinics. In short, the central school dispensaries were the main source of providing treatment to the children. For instance in Allahabad, one college maintains that, in hostels, every student was required to take prophylactic treatment, namely anti-typhoid, anti-cholera injections and smallpox vaccination,⁸⁷ and the wardens ensure that students provided with all the safety measures like the mosquito net so that they do not fall prey to dreadful diseases. In rural areas, village aid dispensaries delivered the medical facilities for the

⁸⁵ Sixty-Seventh Annual Report of the DPH of the United Provinces for the year 1934, Allahabad, 1935, p-43

⁸⁶ Sixty-Fifth Annual Report of the DPH of the United Provinces for the year 1932, Allahabad, 1933, p-47.

⁸⁷ UPSA, Letter No. P/372-44, dated June 2, 1944, from the Principal Ewing Christian College Allahabad. File No. 558/1944, 'Exemption of the Ewing Christian College Allahabad and Jumna Christian High School Allahabad, from the scheme of school clinics', Education Department, 1944.

treatment of school boys. Besides the central school dispensaries, there was also a provision of treating minor ailments in schools itself. For instance, four schools of Agra- D.A.V. High School, Shuaib Muhammadia High school, Mufiq-i-Am High School were provided medicines in stock from the Central School Dispensary. Thus, minor ailments like throat infection, providing eye drops, ear problems, were taken care successfully in the schools. Whenever any case which cannot be treated in the schools was at utmost priority transferred from schools to the central school dispensaries (Table 4.7). In the Municipal Schools also some arrangements made to take care of the minor ailments of the students. In Agra, for keeping medicines, a medicine chest was provided within the school. After attaining medicines, the teacher-in-charge distributed those medicines to scholars. If any scholar due to any reason cannot attend the school, they were encouraged to move to school dispensary for treatment.⁸⁸ This arrangement proved successful in disseminating timely aid to the children. But this aid was not so fruitful at other places due to lack of resources and finances. As mentioned above the arrangement was restricted to four places and others were in the want of these facilities for their scholars.

Table 4.7: Total number of scholars treated through the School Medical Service during the year 1940-41 in Agra district

Centre	Number of Scholars
Central School Dispensary	6591
4 School Dispensary	5228
At the Municipal Schools	19730
At one Hostel	51
At one of the schools not contributing towards the scheme	304

Source- RAAUP, Annual Report on the Health of School Child of Agra District 1941, Agra Collectorate Records.

The clinic exercised a social and educational influence as a centre of interest for guardians, doctors, teachers and patients. School clinics served as a link between hospital and home treatment provided regular treatment. The average attendance of children in these central school clinics was about four. The total attendance of the all the clinics in the Province was 25,000 in 1933-34; 37,000 in 1934-35; 43,000 in 1936-37. It is thus obvious that the school clinics touched only small fringe of work in educational institutions. Thus, the chief medical institutions which colonized the child's body through western medical system were the female hospitals and

⁸⁸ RAAUP, Annual Report on the Health of School Child of Agra District, 1941.

dispensaries, Dufferin hospitals, school clinics, CWCs, and charitable institutions in United Provinces. Specifically taking care of children was at their infancy stage and it was after independence that the real begin of paediatrics under medical institutions could be traced.

AGRA MEDICAL SCHOOL AND FEMALE MEDICAL EDUCATION

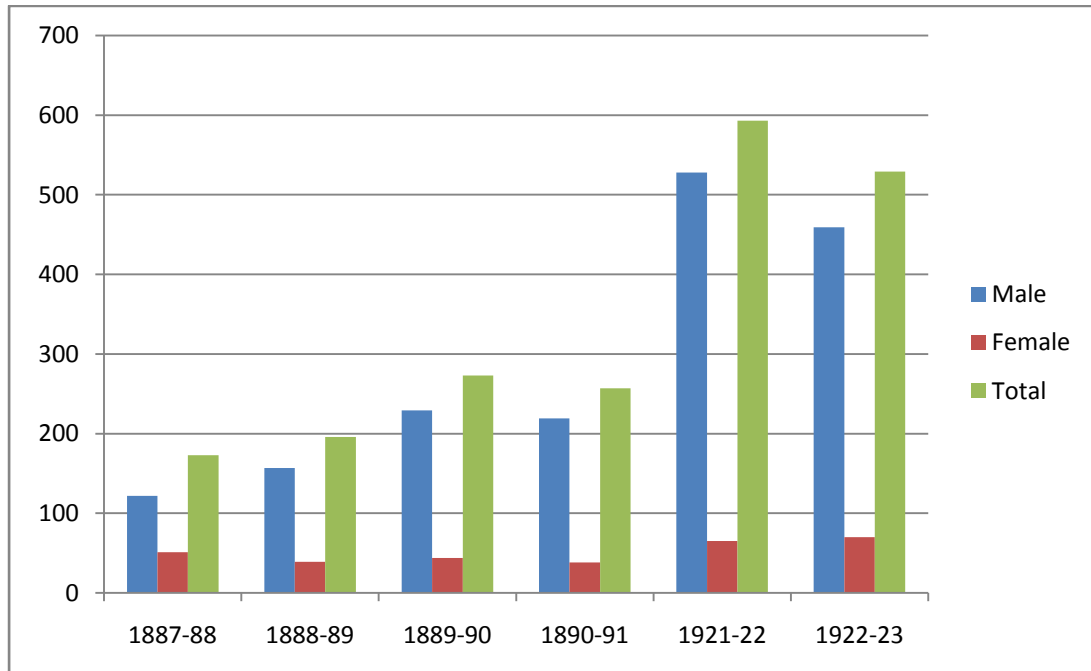
Training and treatment of women were part of broader projects of institutionalizing medical care for women. The priority of zenana care in policy formation for women healthcare and DF emphasized on producing doctors, nurses, training of indigenous dhais and H.A.s in the Province. This was followed so as to attract women to hospitals having female staff with, minimal expenditure. The paediatric care thus raised the demand of women medical professionals in the Province. The sections of the chapter thus trace the emergence of women in medicine which implicitly impacted the healthcare of children in the Province.

As early as in 1883, a small class was started with 8 female students in the Male School for Sub-Assistant Surgeons (earlier known as Hospital Assistants) in Agra Medical School. All these eight students successfully completed their Diploma of Hospital Assistants class in 1887. A remarkable rise was evident in the female students when in 1890 there were 44 female students appeared in the examination. However, only 10 female students acquired their Diploma. Many authorities doubted the success of these students in the medical field due to their background knowledge which was considered inferior. But the skill of these students received praise and recognition from all authorities, even I.G.C.H. admired female students quest for medical training “as a proof that Indian women can be taught to become good doctors, it is satisfactory to learn that at the final examination the successful female students, passed better than the male students of the military section.”⁸⁹ All the Principals and authorities of the school appreciated the aptitude of the female students towards medical practice. But in all the reports, their lack of knowledge of the English language was considered major drawback in their medical education. There was always a demand for providing education to those who had good knowledge of the English language. In case of admission in the Medical school concerned, it was found

⁸⁹ UPSA, Proceedings of the Government of NWP and Oudh, Medical Department, December, 1887, p- 18.

that the number of female students was less than their male counterparts. Further, their number in the School evidences a major downfall 1888 onwards where in 1887-1888 there were 29.7 per cent of female candidates in Agra Medical School which drastically decreased to 10.96 per cent in the year 1922. This was not a fall in decades but a continuous decline was evident in every year especially in comparison to male candidates (Chart 4.2). In between 1888-1922, three-fold rise was evident from 1890-91 where 38 female students studied in the School which increased to 65 in 1921-22 and hereafter the percentage increase was 2-3 per cent every year. The low percentage of female medical students impacted deeply the child welfare movement in the Province. The hospitals, dispensaries, and MCWC had a huge demand for qualified women doctors, F.H.A. and nurses. Agra Medical School was thus a single institution of its kind catering to the demands of the large population of United Provinces. DF played a significant role in encouraging and acknowledging the problems of female students but social conditions, lack of finances and apathy of local bodies were chief obstacles in the welfare of paediatrics.

Chart 4.2: The number of students in the Agra Medical School, 1889-90.



Source: Report on the Administration of North- Western Provinces of Agra and Oudh, 1890, p- 197, Annual Report of the Civil Hospitals and Dispensaries of United Provinces, 1923, Allahabad, 1924, p- 3.

The majority of female pupils in the Agra Medical School were Native Christians, and other communities such as Hindus and Muslims were few in number.⁹⁰ From 1884-85, the increase in the number of female pupils was nominal however in 1886, the number of female students of Hindu community declined significantly. On the other hand, in case of the Muslim female students, the number who joined the school was more in comparison to those who continued their training in the institutions. The government considered the caste prejudices of Indians responsible for the apathy of women and their families in United Provinces for studying medicine, yet there was no serious attempt from the administration to attract the young females to join the women health welfare movement in the Province. Furthermore, the government lacked the arrangement of scholarship to encourage and attract the female students. The policy of the State was not to get directly involved with the movement. Their welfare was limited to granting of aids to DF or Victoria Memorial Scholarships. These grants increased year by year by the government on account of their welfare works scheme. It was a limited policy of Raj that refrain them to be entitled as the welfare state for women and children. That's why the task was taken over by the natives who whole-heartedly supported the movement and extended their help. Raja Tasadduk Rasul Khan of Jahangirabad found a permanent endowment for awarding annually a bronze medal and a small case of instruments to the pupil of Agra Medical School who stood first in the final exam of Surgery.⁹¹ Similarly, Maharaja of Benares offered a Gold Medal in the name of Lady Chelmsford to the best student of the academic year⁹².

The Provincial committee of DF, provided scholarship to the students of Agra Medical School to obtain the degree of L.M.S from Lahore Medical College and also the Bareilly Municipal Committee took the same initiative by providing scholarship to the female candidates.⁹³ As the principal of Agra Medical School writes, ".....all this liberality much more money is required before the scheme of female education at Agra can be placed and maintained on a satisfactory footing, and it is much to be regretted that the limit of expenditure to which have been restricted has not enabled

⁹⁰ Source: UPSA, Proceedings of NWP and Oudh, Medical Department, 1882, p-15

⁹¹ Government Notification No. 142/V-359B of 1899, Medical Department, dated 28th February 1899, in Proceedings of the Government of the N.W. Provinces and Oudh, Medical Department, March 1899, pp-2-3.

⁹² Thirty –Fourth Annual Report of the NASFMA, 1918, Calcutta, 1919, p-19.

⁹³ Report on the Administration of the NWP and Oudh, 1891, Allahabad, 1892, p- I.

me to lay out the new female hospital and other buildings on a scale commensurate with the importance of the objects they are intended to fulfill.”⁹⁴ Consequently, in its resolution of May 1891, the Provincial Committee of the DF decided to bestow annually five scholarships to girls whose parents were desirous of their child studying at Agra Female Medical School, after upper primary examination.

Table 4.8: The number of students who joined and trained in the institution, 1884-1886

Year	Number who joined the school					Number who were under Training till 1887				
	Eurasians	Native Christians	Hindu	Muhammadden	Total	Eurasians	Native Christians	Hindu	Muhammadden	Total
1884	-	8	4	-	12	-	2	1	-	3
1885	1	10	7	1	19	1	7	4	1	13
1886	1	21	3	17	42	1	16	7	1	25
Total	2	39	14	18	73	2	25	12	2	41

Source: UPSA, Proceedings of NWP and Oudh, Medical Department, 1882, p-15

The students of the female medical class received extra academic instruction at the dispensaries to polish their skills. However, 1888 onwards, the system was done away with the education of female pupils. It was also decided that arrangements would be made at Thomason Hospital, Agra to teach pupils the practical pharmacy. This was done to the effect that dispensary officials paid little or no attention to the progress of pupils placed under their care. Further, they were under a great disadvantage in not having a separate female hospital and dispensary with a medical and surgical ward for the poorer class of patients and a range of small separate wards or cottages for the use of better class patients, some of which was used for practical instruction in midwifery. But their overall performances hampered their subject- wise performances. The performance of the maximum students was low in the Materia Medica and practice of medicine. The average marks gained by the students was also unfavourable as the students of the military class scored 920.0, Civil 926.60 and in their comparison, the Female class attained 714.20.⁹⁵

As the faculty was dominated by male teachers, which was highlighted as a prominent cause of low admission of female candidate's later two female doctors, Miss Fairweather and Miss Yerbury were appointed by the committee of DF to work for

⁹⁴ UPSA, Proceedings of the Government of NWP and Oudh, Medical Department, December, 1887, p- 17.

⁹⁵ UPSA, Proceedings of NWP and Oudh, Medical Department, 1887, p-11.

the progress of the female class.⁹⁶ By their exertions a new extempore out-door dispensary was established and it witnessed the increase in the in-patients attendance. However, the medical training of female students in Agra Medical School was in a poor state. Thomason Hospital where there was an opportunity for these students to learn, failed to cater to their demands. The hospital 'main wards were too narrow and dark where female students could hardly see and study a patient'. These limitations were aggravated with the miserable condition of the operation theatre in the Thomason Hospital, where the basic facility of lightning was so poor that the operator was not able to perform', thus it can be speculated that how students could have studied and performed. By 1890, there were women medical students were trained in Madras, Calcutta, Bombay, Agra and Lahore. However, the conditions of women candidates in Agra and Lahore were far from ideal.⁹⁷

Table 4.9: Result of Women Medical School, Agra

Year	Number of students enrolled	Number of Students passed
1925-26	64	8
1926-27	63	7
1927-28	75	8

Source: Triennial Report of the Civil Hospitals and Dispensaries of United Provinces during the year 1926,1927, 1928, Allahabad, 1929, p-6

As regards the teaching arrangements concerned for the female section under which the lectures on most subjects were given in mixed classes. The female section was placed behind the curtain and under the charge of the matron.⁹⁸ However, the appointment of two lady doctors, mentioned above, enabled these female pupils to receive special clinical instruction. By the year 1914, the women students had separate hostel and hospitals, yet they attended classes with male students. The senior medical women delivered a lecture on Obstetrics and gynaecology, but she was not permitted to do gynaecological operations, which were in the hands of the Superintendent of the School, an IMS person, nor does she had an independent position. As the Agra Medical School was a provincial institution under the government of United Provinces, it was difficult to set up the standard which the Women Medical Service had set up for its women employees. Consequently, due to

⁹⁶ UPSA, Proceedings of NWP and Oudh, Medical Department, 1882, p-17.

⁹⁷ Balfour and Young, *Work of Medical Women in India*, p-111.

⁹⁸ UPSA, Letter No. 235M/V-85, from T. W. Holderness, Secretary to Government, NWP and Oudh to I.G.C.H., NWP and Oudh, dated Nanital, 26th August 1887, in Proceedings of NWP and Oudh, Medical Department, 1887.

efforts of James Meston, (Lieut.-Governor) and Lady Chelmsford in 1918, the Women Medical School, Agra was (except for theoretical lectures) separated from the Male Medical School, and Mary O' Brien was appointed as the Principal with full administrative and professional control over the hospitals and hostel.⁹⁹In 1923, the school was reorganized thereby making it as an institution with entire women staff. This process thus made Agra Medical School a self-contained and an important institution for training female medical students not only in United Provinces but in India also. Nearly one-third of the women trained in India pass through Lady Harding Medical College and Agra Medical School.¹⁰⁰Highlighting the requirements of the institution, Balfour exclaimed that "with some further buildings and reconstruction of the older parts of the Hospital (Agra Medical School) it would be a first class institution. The work, medical, surgical, and obstetrical, done in the Hospital is of a very high order, and the students have ample clinical experience and excellent teaching."¹⁰¹

Within the curriculum, an alternation was suggested by Dr Wilcocks that the last six months should be devoted to practical work and the students should be permitted and encouraged to take up the written examination in the medicine, surgery and midwifery at the end of the fourth semester. Thus, a systematic instruction was desired in the medical jurisprudence, morbid anatomy and pathology in the School. Consequently, in 1888, a class of medical jurisprudence was initiated in Agra Medical School. This was a significant decision in the case, if the government withdrew the decision that the H.As. were not permitted to conduct post mortem examination in United Provinces. In 1891, eight Hospital Assistants earned their diploma from the School. A rule was further proposed by the I.G.C.H. that a special lecturer should be appointed to teach these subjects. From 1888 onwards, prominence was given to the teaching of midwifery in the institution still Agra Medical School lacked practical instruction in midwifery. Because of less number of in-patients in the hospitals, the instruction to female students was supplemented by the instructions on the out-door patients.¹⁰²In the same year, the curriculum of the school was extended from three to four years.¹⁰³

⁹⁹ Balfour and Young, *Work of Medical Women in India*, p-58.

¹⁰⁰ Ibid, pp-68-69

¹⁰¹ Ibid, p-120-21.

¹⁰² Annual Report of the Agra Medical school for the year ending May 1890, p-12.

¹⁰³ UPSA, Proceedings of the Government of NWP and Oudh, Medical Department, 1888, July- Dec 1888, p-21.

Further, rules were revised of the institution in 1888, made civil students enrolled only when they had passed the middle class Anglo-vernacular examination.¹⁰⁴ This was done to raise the standard of education and intelligence in the school. The Council of NASMAWI in 1887 decided that women who have obtained the diploma should spend a year at a hospital for the purpose of acquiring a practical knowledge of their profession.¹⁰⁵ Consequently, Provincial DF committee started training F.H.A so that they could be appointed in female dispensaries and hospitals.

Table 4.10: Students studying in the Medical Colleges and Schools of Medicine in United Province

Medical Colleges, School or Hospital Class	Assistant Surgeon or Medical Practitioner Class	Hospital Assistant Class	Nursing or Compounding classes
Agra	-	72	11
Lucknow	-	-	12
Benares	-	-	4
Total	-	72	27

Source: Report of NASFMA, 1909, p-23

Women, traditionally, were healers and they commonly prepared medicine with products available at home, but ‘their professional entry into medicine was viewed as unnatural and unnecessary.’¹⁰⁶ Female medical students faced not only the pressure of the society but also a biased attitude of the State, who most of the time underrated their skills and gender bias towards native pupils of this Province was loud.¹⁰⁷ These viewpoints received a big blow by the success of students of Agra Medical College such as Miss Quin, Miss Alice Arif Masih and Miss Elmore who surpassed their male counterparts in their academic performances. Unfortunately maximum students were European women and the percentage of Indian women in United Provinces was much less than that of the Europeans. This was another set back to the movement as many of these European and Eurasian students were not interested in working in the rural areas after training and they moved to their native countries. Further these women

¹⁰⁴ Ibid.

¹⁰⁵ UPSA, Proceedings of the Government of NWP and Oudh, Medical Department, December, 1887, p- 20.

¹⁰⁶ Narain Hassan, *Diagnosing Empire: Women, Medical Knowledge and Colonial Mobility*, (England: Ashgate Publishing Limited, 2011), p-65.

¹⁰⁷ Dr. Hilson, Principal of the Agra Medical College, was not satisfied with the progress made by the female students and he concluded that their preliminary education and general mental training was not equivalent to those of the male students. Furthermore, W.R. Rice laid allegations against the Principal of the Agra Medical College that he is unable to maintain the standard of the institution as he gave admission to girls who were interested to study the medicine. According to the former, ‘the girls should not be given admission in the college, as they are inferior to the male students. This will make others estimate this profession as casual and easy to work on.’

also monopolized the posts supported by DF. Consequently, the women and children conditions of health deteriorated slowly. The government was, on the other hand, was indifferent to the grave situation.

In 1923-24, the Women Medical School at Agra was reorganized and separated from medical school, thus making it a self-contained institution.¹⁰⁸ Eight students qualified from this institution and four among them worked as House Surgeons and others joined at different hospitals and dispensaries. In this institution, 80 students studied L.M.P. and L.C.P. course in the whole Province, however, L.M.S. and Apothecary or Certificated Practitioner, courses remained aloof and thus was again a drawback of the movement. In 1926, State Medical Faculty took control of the work formerly performed by the State Board of Medical examinations and also examinations of Agra Medical School as well as of midwives and Assistant midwives.¹⁰⁹ From August 1927, United Provinces State medical faculty approved a post-graduate course of 12 months duration at Agra Medical School. This was done so as to enable L.M.P.s to appear at the final membership examination of the faculty. Since 1928, the government sanctioned the grants for an allowance of Rs. 100 to women medical graduates and Rs. 50 to women of the certified class to compensate them from low pay.¹¹⁰ The State Medical Faculty granted licentiateship, membership and fellowship of its faculty as well as to the LPH.

As this colonizing mission of the State to colonise the bodies of native women, the task was in the hands of noble associations or sympathetic vicereines such as Lady Dufferin and Lady Reading. The chief failure of the medical training school in the United Provinces was that they neglected research on conditions of pregnancy and infancy. The college had young minds which could have been diverted to research and innovative work but were only considered useful of completing their degree and left them for searching opportunities of replacing dhais by western methods of childbirth.

‘NEW WOMEN’ OF COLONIAL STATE

In England, during the early years of the nineteenth century, attention was drawn towards by means of the declining birthrate, to the high rate of infant mortality. In

¹⁰⁸ Annual report of NASFMA, 1923, Calcutta, p-22

¹⁰⁹ Triennial Report of the Civil Hospitals and Dispensaries of United Provinces during the year 1926,1927, 1928, Allahabad, 1929, p-6

¹¹⁰ Ibid, p-3.

1902, England evidenced introduction of the *Midwives Act* and the *Education Act* in 1911 (or more specifically medical inspection of school children act), *Insurance Act* of 1917, and in 1918 a *Notification of Births Acts and the Maternity and Child Welfare Act* introduced simultaneously. These long term goals in India did not see the light of the day and also was never considered that the work similar to that springing up so widely in England could be organized in India, nor whether any reconsideration of the conditions of service of its employees was required. Imperial efforts to improve the conditions of childbirth and of female health, in general, were closely connected with the training and employment of the British and Indian women doctors.

As *zenana* was regarded by the imperialists as a dangerous place which was a centre of dirt and disease thereby the imperial government first focused on these centers. Consequently, the *pardah* institutions were established which demanded medical women professionals trained in western medicine. As mentioned earlier, DF played a significant role in training and teaching of Indian women and Victoria Memorial Scholarships promoted the medical education among Indian women. Thus, the government plan to hegemonies *zenana* failed and thus they created a class of women doctors and Hospital Assistants who paid a visit to the home for treatment of elite women rather than their attendance in hospitals and dispensaries. Women doctors and F.H.A. provided in-house assistance and resolved many health-related problems. As in 1906, during the personal visit to homes, the female medical professionals treated 5,049 medical cases, 415 surgical and 521 midwifery cases. Among lady doctors, Miss Harman performed 101 operations and Miss Pierce, 85 operations in 1898.¹¹¹ How popular was personal attendance among the elite class could be understood from the fact that in 1906 the women doctors paid a visit to 274 Europeans, 249 Eurasians, 2116 Muslims and 2,845 Hindus in United Provinces.¹¹² In accordance with the suggestions made by the triennial report of hospitals in for United Provinces in 1908, a record was maintained to assess the work done by female medical practitioners in affording relief to *pardahnashin* women outside dispensaries under their charge. It was thus reported that 3,222 female patients homes were visited by the lady doctors

¹¹¹ Triennial Report on the Dispensaries and Charitable Institutions of the NWP and Oudh, 1896-1898, Allahabad, 1899, p-13.

¹¹² Col. R. D. Murray, Annual Report of the Civil Hospitals and Dispensaries of the United Provinces, 1906, Allahabad, 1907, p-2.

and F.H.As, of the number 200 ordinary midwifery cases, 231 were surgical and the remaining 2,695 were the medical cases.¹¹³

In the absence of women doctors in this Province, the problems of women aggravated as the male doctors were not allowed to check their patients or enter the secluded zenana. The table 4.11 below shows the prominent feature of this Province was the paucity of lady doctors, practitioners and H.A.s. In United Provinces, Agra Medical School provided training up to the standard of Hospital Assistant but in 1890s demand increased for the female practitioners who could perform the duties of assistant surgeon. Apart from this, the DF committee realized the significance of knowledge of local language by the English women doctors so as to understand their patients. Further, during the plague epidemics in 1890s and 1900s led Indians raising the demand of female doctors for inspecting zenana quarters, examining female rail passengers as English women could not understand and respect Indian traditions.

Instead of meeting the demands of the women doctor, the medical educational institutes produced FHAs. It was suggested that as per government order, United Provinces should obtain the services of a qualified FHA from the Dufferin Association. The chief obstacle in the movement was difficulty in obtaining qualified medical practitioners, as mentioned earlier that female medical students though complete their education did not join the hospitals and dispensaries instead practised from their residence. Excluding the staff of Balrampur Female Dispensary and of the Ramsay Hospital, the latter appointed a lady doctor, a trained lady superintendent and a staff of nurses. As early as in 1892, female hospitals and dispensaries in NWP and Oudh consisted of, one lady doctor, one L.M.S, four certified practitioners, one assistant surgeon, one apothecary and 15 HAs. To deal with this lack of staff, Agra Medical School started training of students as the HA, compounders and midwives, however, the scheme failed as few appeared as an applicant. Apart from the lack of medical women, another issue was that they were ill-equipped as well as poor in qualifications. The success of the movement required the well trained women H.A, though the association doubted the success of this scheme and considered to take small step in the direction as “ this failure will put the most powerful weapon of attack in the hands of those who, from prejudice or other motives do not sympathise with the

¹¹³ Colonel G. Hutcheson, Triennial Report on the Hospital and Charitable Institutions of United Provinces of Agra and Oudh, 1899-1901, Allahabad, 1902, p-21.

movement.”¹¹⁴ The women hospitals and dispensaries lacked FHA which hindered child welfare activities in the Province. Till January 1906, there were 373 H.A, contrarily to the Province requirement of 426.¹¹⁵ This was another lacuna in the poor healthcare of women and children of the Province. Many times the decline in average attendance in hospitals and dispensaries of women was due to the lack of qualified FHAs. The reason for the same was the lack of students, funds and subscriptions, together with the lack of comprehensive policy on the part of the government. As Commissioner of Meerut division lamented, “it would be very difficult to raise more funds at present. The appointment of a female hospital assistant is still in a rather remote future and people cannot be enthusiastic about an arrangement which cannot be made for 2 or 3 years to come. Moreover, subscriptions for the proposed college are now being called ...for the want of funds.”¹¹⁶

Table 4.11: Women employed in female dispensaries in NWP and Oudh

Year	Number of dispensary and hospitals	Lady doctor		FHA		Nurse		Midwives	
		Number	Rate of pay	Number	Rate of pay	Number	Rate of pay	Number	Rate of pay
1895	35	13		24		16		12	
1897	46	14	1,955	31	819	21	166	8	246
1898	47	16	2,380	33	845	18	144	12	197

Source: W. P. Warburton, Notes on the Annual Returns of the Dispensaries and Charitable Institutions of NWP and Oudh, 1897, Allahabad, p-14; for 1898, p-40-41.

Women doctors of European origin employed easily in Indian hospitals in comparison to Europe. Their admission was also legitimized by the government. DF was lamented as exploitative and discriminatory as in 1891, Kadmbini Ganguly was overlooked for a permanent position.¹¹⁷ The increasing number of Dufferin hospitals enhanced the employment possibilities of women trained in the medical colleges except they were willing to accept a low salary. More than European and Eurasian women, Indian women accepted this offer of Rs. 250-400 and Rs 30 to 50 per month by the municipalities. This kept the Indian women at the position of disadvantage and United Provinces with dearth of skilled women medical doctor. Though DF provided

¹¹⁴ UPSA, Proceedings of the Government of NWP and Oudh of Medical Department, December, 1887, p- 21.

¹¹⁵ R. D. Murray, Annual Report of the Civil Hospitals and Dispensaries, 1906, Allahabad, 1907, p-2.

¹¹⁶ UPSA, Letter from A. H. Harrington, Commissioner Meerut Division to the Secretary to Government, NWP and Oudh, Medical Department in File No. 117/9/1893, Box No. 2, ‘Accommodation for female patients and provision for the training of a female staff in the districts of Muzzafarnagar and Bulandshahr’, Medical Department, 1893.

¹¹⁷ Geraldine Forbes, *Women in India*, p-112.

handsome salaries to the 'new women', increased demand and low funds was a hurdle in improving the condition of women doctors. Further, the Indian women graduates had many obstacles in getting an appointment in various women's hospitals. Their professional life was not easy, as they practised privately or within the four walls of the house. In addition, the capability of the Indian female doctors was always doubted and considered inferior to their European and Eurasian colleagues. Margaret Balfour, for instance, described the moral and intellectual standard of Indian women students as 'second class.'¹¹⁸ All the official correspondences raised the question on the intellectual capacity of Indians, which clearly reflected the bias of the European community towards the women students and professionals.

In 1914, the Women's Medical Service (WMS) was established which was administered through the DF and was subsidized by the government grant. In AMWI, only a few Indian women were members and proposed a two-tier system with inferior and superior grades.¹¹⁹ The demand for WMS centered on the demand for treatment of *pardanashins*. These developments gave an impression that it favoured Indian women doctors, they were in fact marginalized since the plan rewarded medical credentials and knowledge of English above local knowledge. Even some trained Indian women doctors from Bombay sent a petition to show less partiality in favour of English trained doctors in case of their appointment.¹²⁰ Government officials made it clear that they would prefer more efficiency through privatization regardless of the insecurity for women doctors.¹²¹ Moreover, at the time of greatest expansion of female medicine, after the foundation of the WMS, western medicine became a target of criticism from the nationalist movement.¹²²

¹¹⁸ Balfour and Young, p-111.

¹¹⁹ J. Lewis, *Women in England 1870-1959: Sexual Divisions and Social Change* (Brighton. 1984), p-195.

¹²⁰ NAI, GOI, Home Department, Medical 'B' Branch, June 1912, No. 22, July, Nos. 61, 79; NAI, GOI, Home Department, Medical 'B' Branch, February 1914, No. 32, NAI, GOI, Home Department, Medical 'A' Branch, 1914, No. 28-33.

¹²¹ NAI, GOI, Pros. Nos. 107-08, Home Department, Medical 'A' Branch, June 1911.

¹²² It was after 1920s that instead of organizing services such as increasing funds or establishing hospitals, attempts were made to reach directly to Indian women. In 1920 the first Maternity and Child Welfare Exhibition was organized in Delhi; First All India Baby Week was celebrated in 1924, and All India Conference on Maternity and Child Welfare held at Delhi in 1927. The organizing secretaries of these movements were members of Women Medical Services in India.

Table 4.12:- Arrangement and facilities in hospitals and dispensaries for females in NWP and Oudh (out of 27 institutions)

Hospitals and dispensaries	Number of patients (out-door and in – door)	Number of bed	Expenditure in 1892	Sum invested	Special staff of Lady Doctors and others
Lady Lyall Hospital, Agra Maternity Hospital, Agra Two Female Dispensaries in Agra	33,109	52	Rs. 25,653	-	1. One Lady Doctor 2. One Licentiate in Medicine and Surgery 3. Two Hospital Assistants
Lady Lyall Hospital, Lucknow King's Female Dispensary, Lucknow.	28,235	43	10,415	33,000	One Apothecary and Two Hospital Assistants
Ishwari Hospital, Benaras Bhelupur Female Dispensary, Benaras	25,856	38	69,631	40,000	One Apothecary and One Hospital Assistant
Dufferin Hospital, Allahabad	12,116	24	35,306	32,500	One Certified Practitioner
Dufferin Hospital, Bareilly	28,786	41	2,969	-	One Hospital Assistants
Dufferin Hospital, Cawnpore	4,740	7	22,781	20,000	One medical practitioner

Source: J. Richardson, Notes on the Annual Returns of the Dispensaries and Charitable Institutions of the NWP and Oudh, December 1892, Allahabad, 1893, p-4.

For training medical women in MCW schemes, a course was started at AIIHPPH, Calcutta in 1933. It was unfortunate that few women availed for the course on all India basis and this further hampered the development of paediatrics in this Province due to lack of training institutions and health schools. There were few medical women in the province, if any that was in urban areas of big cities as Agra, Bareilly, Allahabad, Lucknow etc.¹²³ and most unfortunate was that not a single rural area of this Province had a medical women or health visitors. Rural areas were solely depended on the indigenous dhais or assistant midwives.

EMERGENCE OF PARA-MEDICAL PROFESSION

The history of colonial nursing is shaped by the wide literature on social history of medicine. Fitzgerald's work focuses on the role of missionaries in establishment of nursing as a profession and their work as a cultural mission of imperialism.¹²⁴

¹²³ Seventy- Third Annual Report of the DPH of United Provinces, December 1940, Allahabad, 1941, pp-2A-3A.

¹²⁴ Rosemary Fitzgerald, ' Making and Moulding the Nursing of the Indian Empire: Re-casting Nurses in Colonial India' in Avril Powell and Siobhan Lambert-Hurley (ed.), *Rhetoric and Reality: Gender*

Medelaine Healey in her book has traced the history of nursing profession in colonial and post- colonial India in light of their professional engagement with government's policy and neglect.¹²⁵ She argues that the post-colonial government's ignorance and unsympathetic attitude towards nursing profession gave a serious blow to their position in society as a professional and thus they were never included in post-colonial state's medical policy. Her work also examines their participation in the international and feminist's movements and sought legitimacy to their profession.

Proliferation of women hospitals and dispensaries in nineteenth century aroused the need of women medical staff too. The chief purpose of these hospitals was to enable women to seek medical care provided solely by the women. Above section had shown that due to the dearth of women doctors, FHAs took up the cause of medical care of women and children. In this line was the emergence of nurses with the advent of western medicine with missionaries and established DF and Victoria Memorial Scholarships. These developments impacted the emergence of nurses in NWP and Oudh. Though they faced many obstacles in their duties such as society, family, neglect of state and lack of adequate pay, here focus is on colonial state's measure for promoting the para-medical staff.

The head centre of training for nurses in the NWP was at Agra. There were 49 students in the school, and were trained to become H.As. Out of the ten students who were examined in May 1890, eight secured diplomas as H.As and other two obtained appointments as compounders. For the trainees, the report of NASFMA was impressed with their hard work and dedication and considered them "exceptionally bright, those of the second and third year, though not so intelligent, are attentive and making fair progress and the first year class consists of 25 girls are reported to have a better preliminary education than is generally found in students entering the school."¹²⁶ There are striking instances in the NWP and Oudh that the system of employing midwives for working at district level was highly appreciated especially by the poorer classes, and more especially by *purdah* women. DF branch made efforts to bring more

and the Colonial Experience in South Asia, (New Delhi: Oxford University Press, 2006); Rosemary Fitzgerald, 'Rescue and Redemption: The Rise of Female Medical Missions in Colonial India during the late Nineteenth and early Twentieth Century' in Anne Marie Rafferty, Jane Robinson and Ruth Elkan (ed.), *Nursing History and Politics of Welfare*, (London: Routledge, 1997), pp-64-79.

¹²⁵ Madelaine Healey, *Indian Sisters: A History of Nursing and the State, 1907-2007*, (New Delhi: Routledge), 2013.

¹²⁶ Annual Report of NASFMA, 1891, Calcutta, 1892, p-13

purdah-nasins within the scope of that aid and was also urged to support a certain number of qualified midwives and nurses in the Province.

During her visit to Lady Lyall hospital at Agra, the Health Minister found that the nursing arrangements were inadequate in the hospital. She lamented about the deplorable conditions as- the wards were at some distance, it was thus difficult for the nurses to work with promptitude. It was also reported that there was mostly one nurse at night to attend for so many patients. Apart from the inadequacy of the nursing staff, their shortage too was responsible for the poor state of maternity hospitals. For instance, Dr Dalai complained that “in case anything goes wrong with the patients eg if a child died in the ward and if the mother wanted to send a message to her relations, there is no body in the hospital who would convey a message to the relatives of the patients.”¹²⁷

Mostly, the medical institutions had one sister and three staff nurses. Even I.G.C.H. recommended that in order to provide adequate nursing arrangements, two sisters and eight staff nurses should be provided in the hospitals and dispensaries as he reported “There are ten wards requiring one trained staff nurses each; a staff nurse is also required for the operation theater and two staff nurses are needed for night duty at Maternity hospital and Lady Lyall hospital. Against the 13 staff nurses required as above, only five have been provided. The eight more nurses were recommended on a pay of Rs. 95-3-110 p.m. plus board and uniform allowances aggregating to Rs. 32 p.m. for each.”¹²⁸ In Agra, it was Thomason hospital and Lady Lyall hospital where facilities for the training of nurses existed. In female hospitals of Lucknow, Allahabad, Benaras, there were arrangements for training and classes of nurses, midwives and compounder and was later appointed in dispensaries and hospitals.¹²⁹ Consequently, a Nurses training scheme was inaugurated at Agra on a temporary basis. The following are thus the arrangements which existed for training of nurses in United Provinces-

- a. King George Hospital, Lucknow- Nurses received practical training in the wards under the supervision of the ward sisters. The theoretical study was

¹²⁷ UPSA, Letter No. N/23, dated 10.3.1939, from Colonel Philips, I.G.C.H., File No. 232/1934, Box No.- 76, ‘Nursing Arrangements at Lady Lyall Hospital’, Medical Department, 1934, p- 2.

¹²⁸ Ibid , p- 5.

¹²⁹ Report on the Administration of NWP and Oudh for the year 1891, Allahabad, 1892, p-1.

based on the syllabus of General Nursing Council. There was no grant by the government for the training of nurses in this institution.

- b. Dufferin hospital, Allahabad- There were facilities for the training of nurses for midwives and Assistant midwives, diploma in General Nursing training was also given, but an additional six months in the male hospital was arranged in each case. No expenditure was incurred on the training of nurses, except in form of grants for stipend to the nurses who were in training received from different bodies.
- c. Thomason Hospital, Agra- Here, practical training was given by the staff nurses or the wards. There was shortage of nursing staff and absence of ward sisters in the institution even though the demands being numerous. There were no paid lecturers. Private lectures were provided by the Assistant demonstrators of the Agra Medical School. Nursing lectures was delivered by the matron. There was no equipment in any preliminary training school, the apparatus used in the wards was utilized for demonstrations during the lecture periods. There was lack of class rooms for nurses. In short, there were no facilities for training of nurses, dining, restrooms or laboratories within Thomason Hospital. Further, in order to attract women to take up this profession, no provision was made for the Provident Fund, further, posts were not pensionable and few leaves were given to them.
- d. Lady Lyall Hospital, Agra- This preliminary training school of nurses in this province was given equipment by the DF. Lectures were given by the medical staff, matron and sister to the probationer nurses. Practical training given in the medical and surgical wards and in the theatre of the Lady Lyall Hospital. The Dufferin and Maternity hospital provided training in gynaecology, nursing and midwifery.

Nursing as a profession was not looked as favourable by the women.¹³⁰ This increased the dearth of nurses in the Province. As, Platt in his inspection report stated that most of the girls who took up the nursing as a profession were, Indian Christians or Anglo Indians and missionaries were reluctant to allow their girls to be trained in Dufferin

¹³⁰ Presidential Address before 18th session of AIWC at Hyderabad (Sind), by Mrs. Hansa Mehta, Roshni, Vol I, No. 1, Lucknow, February 1946.

hospitals on the ground that in these hospitals, the girls were not well-cared.¹³¹ To encourage the participation of girls into the profession time to time scholarships were provided by the voluntary agencies such as DF and Victoria Memorial Fund. In 1939-40 four stipends of Rs. 12 each for two probationers midwife compounders and two for probationer nurses for general training was provided by the provincial committee, DF, United Provinces and local committee of DF provided two stipends for general nursing probationers and four for midwife compounders. A non-recurring grant Rs. 200 was provided by the central DF in March 1939 for teaching material for probationer nurses in training. In United Provinces, there was no provision for educational qualification for the Assistant midwives before taking up the midwifery training and they were mostly illiterate.

As mentioned earlier, the lack of female medical practitioners and staff was the chief cause of high maternal and child mortality. Both official and social conditions were too dominant in the medical personnel arrangement in United Provinces. Same view could be glanced from the views of I.G.C.H. who lamented that if government was interested to attract educated Indian girls of good family to the nursing profession, 'they must be conferred with the condition under which they could be prepared to be trained'. He further elaborated that "it is considered by us to be utterly useless at the present time to try and recruit them for a full training in a men's hospital with a men medical students. They would be, I think, unwilling to work under Indian male doctors."¹³² He further said that the, "posts have been freely advertised in the vernacular papers but there have been extremely few applications, and the reason is that facilities offered are unsuitable for attracting good family Indian girls. The training or such girls could gradually be encouraged in the medical and surgical wards or the Lady Lyall Hospital but with the New Scheme this is being amalgamated with the Thomason hospital." Another reasons cited in various reports was the early marriage of girls in United Provinces and after marriage girls were not allowed to work outside the four walls of their houses. Many who entered the profession lived the life of celibacy a profession was considered a menial job.

¹³¹ Thirtieth Annual Report of the NASFMAWI for the year 1914, Delhi, 1915, p-18.

¹³²UPSA, Copy of letter no. N/1, dated March 30 1940, from Superintendent Thomason Hospital, Agra to I.G.C.H., U.P. in File No. 232/1934, Box No.76, Nursing Arrangements at Lady Lyall Hospital, Medical Department, 1934.

As a part of a welfare scheme, government sanctioned in July 1928, 30 women sub-Assistant surgeons and 50 midwives for medical aid to women especially in small towns and rural areas.¹³³ Continuing this in 1929, extra posts for 30 women of L.M.P. grade and 50 midwives for rural work was also sanctioned by the government.¹³⁴ It was unfortunate that always the seats and sanctions were approved by the government without analyzing the existing condition of availability of efficient and qualified staff. For official stand, the statement of H. R. Nutt is significant, where he expressed that “it would be more profitable to proceed slowly and gradually to fill vacancies, than to fill at once with applicants whose qualifications and attributes are doubtful.”¹³⁵

In this situation, nursing problems in United Provinces was considered in 1943 by the special committee convened by the President of the Trained Nurses Association of India. The committee made the following recommendations-

- a. To improve the status and condition of service of the nursing profession;
- b. To secure for them wider representation than they enjoy in the Nurses and midwives council; and
- c. To transfer the powers relating to the training and examinations of nurses which was vested in the State Medical faculty to the Nurses and Midwives council.

On the question of implementation of these recommendations and amendments in the ‘*United Provinces Nurses, Midwives, Assistant Midwives and Health visitors Registration Act 1934*’, a member opposed the plan on the pretext that “time has not come yet when we should make any change in the existing policy of the government. This may be done when we have more experience of the new system at other places and I would strongly stress that if any change has to be made at all it should be deferred till after the war is over as the government should not undertake any greater financial responsibility, which can be avoided during the war time.”¹³⁶ The Act was amended in 1944 so as to-

¹³³ Triennial Report of Civil hospitals and Dispensaries of United Provinces during the year 1926, 1927, 1928, Allahabad, 1929, p-3.

¹³⁴ H. R. Nutt, Annual Report of the Civil Hospitals and Dispensaries of United Provinces for the year ending 1929, Allahabad, 1930, p-6.

¹³⁵ Ibid.

¹³⁶ UPSA, Letter from Rai Bahadur Kunwar Raghuraj Singh to the Secretary to Government, United Provinces, Medical Department, dated 11 November 1943, Agra, in File No. 301/43, Box- 1, ‘Bill to amend the U.P. Nurses and Midwives and Assistant Midwives and Health Visitors Registration Act, 1934’, Medical ‘B’ department.

- a. provide increased representation to nurses, midwives and health visitors on the United Provinces Nurses and Midwives Council from the State Medical Faculty, and
- b. transfer the function of conducting the nurses examination to the United Provinces Nurses and Midwives Council from the State Medical faculty, and
- c. permit the registration in the United Provinces of nurses trained in other provinces and outside countries, in addition those already registered i.e. the nurses trained in the countries and provinces which allow reciprocity of registration.
- d. The condition of nurses was lamentable as reported by Major Buckley as ‘nurses in the wards were harassed and insulted by young house surgeons or physicians. No action is taken either by the head of the section or by Superintendent.’¹³⁷

The chief defect of the ‘*Nurses, Midwives and Health Visitors Registration Act*’ passed in the 1934 was that there was no provision of prohibition related to indigenous dais. The above Act was further amended in 1945 to include the Superintendent of Nursing Services in the constitution of the United Provinces Nurses and Midwives Council as an ex-officio member, whose appointment was necessitated by the establishment of the provincial and subordinate nursing services in the Province.

THE ‘DANGEROUS’ DHAI AND STATE

In the Indian context, *dhai* was considered as the appropriate person to assist in childbirth. The faith people had in her could be understood by the fact that even after independence she was a dominant figure in natal, antenatal and neonatal care. Miss. K. M. Bose exemplified in 1927 that “the majority of births are usually and happily normal and the *dai* is a cheerful soul, hard- working and respectful to her clients.”¹³⁸

With the advent of colonial rule, she was gradually transformed into an evil witch, ignorant, illiterate, and thus it was her ignorance that was held responsible for the high

¹³⁷ UPSA, File No. 443/1941, Box No. 165, ‘Major Buckley’s Report on K.G. and Allied Hospitals’, Medical Department.

¹³⁸ A paper read by K. M Munshi, ‘*Is indigenous dhai worth training?*’, At Maternity and Child Welfare Conference, Delhi, 1927 in Report of the Maternity and Child Welfare Conference held at Delhi, February 4-8th 1927, Lady Chelmsford All India League for Maternity and Child Welfare, 1927, Delhi.

maternal and infant mortality. David Arnold writes that “ideologically, medicine was a conspicuous part of self- vindication of colonial rule and of its subordination of Indian society.”¹³⁹ In this case, the middle class women willingly accepted this subordination yet they asserted their autonomy in front of vindicating hegemony.¹⁴⁰ In the case of *dhais*, the hegemony operated not to change the system of health care but to describe *dhai* as a ‘social pathology’. Thus, century’s old institution of *dhai*, who were considered the care giver of Indian women and children were systematically replaced from the scenario by targeting elite and middle class women, in order to legitimize the colonial rule. For colonials, *dhai* became the symbol of superstition and resistance to change. Indigenous *dhais* were the first target in maternal and child health policy of the colonial state. In other words, the colonial medical policy for children revolved around the training of indigenous *dhais* and midwives. They were not only criticized by officials in all their correspondences but were attacked by missionaries, state officials and voluntary organizations too. The policy of the State was to replace *dhais* by trained women doctors in western medicine.

According to Balfour and Young, it was from the efforts of missionary women that first *dhai* training schemes were initiated by the teaching in zenanas and the need which aroused after watching their pupils dying in childbirth.¹⁴¹ Differences of opinion aroused when missionaries came in contact with the zenanas. On one hand, some workers tried to deliver the need by themselves and urged the government to send women doctors in India while others felt that the only feasible scheme was to give training to Indian women themselves. Among the latter were some American missionaries, members of the Methodist Episcopal Church. One of its members, Dr Humphrey started a class for training women at Nainital in 1869. Unfortunately, due to the lack of adequate staff and complacent teaching, this institution was closed in 1872. The same mission, however, wrote to America for the services of medical women to instruct a class of native Christian girls and enable them to take advantage of opportunities to practice in the city of Nainital.¹⁴²

¹³⁹ David Arnold, ‘Medical Priorities and practice in the 19th century British India’, *South Asia Research*, 5 (1985), pp-167-83, 179.

¹⁴⁰ Geraldine Forbes, *Women in India*, p-99.

¹⁴¹ Balfour and Young, *Work of Medical Women in India*, pp- 13-14.

¹⁴² Balfour and Young, *Work of Medical Women in India*, pp-106-107.

Until about the 1920s, the official line blamed cultural and religious customs that is incompetent *dais*, poor hygiene and early marriage responsible for high maternal and child health.¹⁴³ Due to the political circumstances, the government and official view ignored Census findings which uncovered the fact that women who were malnourished and overworked could not deliver or nurture healthy and strong children. As early as 1911, a census official wrote, “Among the labouring classes many of the mothers are poorly- fed women, who continue to work to the very end of their pregnancy, with the result that they give birth to weakly, and not infrequently premature infants, who succumb during the first few hours, days or weeks of external life... owing to poverty and malaria, the failure of nursing powers is not uncommon. In such cases, unsuitable substitutes for proper artificial food help to undermine the health of infants.”¹⁴⁴

In the United Provinces, the government for reducing the infant mortality focused on strengthening the scheme for the training of indigenous *dais*. The Maternity Supervisor and Resident Midwives for the same purpose delivered lectures by visiting the mothers of newborn child. Some instructional classes were also conducted for the indigenous *dais*, to bring them under the colonial scheme of benevolence. The scheme was implemented prominently in the large municipalities and like always the rural areas left at their own fate. The impact of this scheme could be assessed rightly by an official statement that by and large “efforts to replace them (*dais*) by better-educated midwives have to a large extent failed because of the affection with which the women of the country cling to the hereditary and family *dai*.”¹⁴⁵ Dr Agnes Henderson, a medical missionary in Nagpur opened a school for the children of these indigenous *dai*'s which was popular and successful. Scholarships provided to the children of the indigenous *dais*, was a significant part of this scheme. It was hoped that if this scheme extended in United Provinces, the children attended this school would be better ‘fitted than their mothers and grandmothers for training in midwifery.’¹⁴⁶ There were other scholarships provided to the candidates for *dais* certificate training from Provincial

¹⁴³ Census of India, 1911, VI, 1, p-30.

¹⁴⁴ Census of India, 1911, V, 1, p-269.

¹⁴⁵ UPSA, File No. 195/1917, Box No. 124, Education of the Children of indigenous *dais* by Scholarship, Education Department, January 1918.

¹⁴⁶ UPSA, Letter No. 51 From Honorary Secretary, Countess of Dufferin's Fund, Central Committee to Secretary to the Government of India, Department of Education, dated 11th July 1917, in File no. 19/1917, Box No. 124, Education of the Children of indigenous *dais* by Scholarship, Education Department, January 1918.

League Funds. The attempt to educate the children especially girls of indigenous dais by providing scholarships was to penetrate colonial medicine to a child's body from their birth and hegemonies the future generation of dais.

The foundation of the training of indigenous dais in United Provinces was laid by the Central Committee of the Victoria Memorial Fund, under the supervision of Dr Gertrude Campbell in 1917. Six centers at Lucknow, Allahabad, Cawnpore, Benaras, Fyzabad and Bareilly were chosen for the activity. A qualified supervising maternity matron was appointed, whose work was to visit the centers and to supervise the work of indigenous dais and providing lectures to them. Further at each centre, it was decided to appoint a qualified maternity nurse who would be in local charge, and the indigenous dhais were to be paid for bringing the cases to her and for working under her instructions. The scheme was decided to be financed partly by the Victoria Memorial Fund and partly by the local government. With this scheme, the Committee of Victoria Memorial Fund decided to stop the grant it was bestowing as scholarships for the training of better class non-indigenous dais, but the local government agreed to grant a large number of such scholarships so that the education of midwives of the class referred to could not be abandoned.¹⁴⁷ Whenever any schemes failed, there was no attempt by the government for self-assessment or interrogation and the scapegoat was always the people who were blamed to be ignorant and superstitious. Additionally, all the schemes which could have improved the health in the state were turned down both by Government and local bodies on account of financial stringency. In Lucknow, there were two schemes which focussed on the improvement of indigenous dhais within the Lucknow municipality were under the Victoria Memorial Scholarship Fund and the child welfare scheme of the boards. The subscriptions for Victoria Fund came mostly from the natives of the province. Local government also granted Rs.6000 to spend on the training of indigenous dais.

In 1903, Lady Curzon organized the Victoria Memorial Scholarship Fund for training midwives in western medical education. The fund was an effort to improve the conditions of childbirth which the DF and other organizations had revealed to be in such a bad state. However, the purpose failed to achieve its objectives as the midwives after some classes returned to their traditional methods along with their

¹⁴⁷ Fifty- First Annual Report of Sanitary Commissioner of United Provinces of Agra and Oudh, 1918, Allahabad, 1919, p-6-7.

demand for high fees, especially in rural areas. Officials and the training centers lamented that the dhais were hostile and refused to attend the classes. Dhais, on the other hand, believed that there was some trap in the scheme and that they would be ousted from their means of livelihood. No doubt, also some of the doctors who undertook the instruction adopted the wrong attitude and instead of being tactful and willing to placate, were superior and somewhat overbearing. The villages were left practically untouched. This was natural because women doctors were hard to find in villages, and *dhais* could not travel to the nearest town for a lesson when that involved time and money. But it was a tragic irony too, for the village women, who were left at their own fate without skilled help and therefore were dependent on the *dhai's*. Contrarily, Amritsar, Hyderabad, and Bombay were far ahead of the United Provinces, in village administration of maternity health. For instance, the scheme for training village dais i.e. Lady Wilson Village Dai Scheme started in Bombay, where dais were brought into towns for a short intensive training of two weeks in a hospital. One important thing to notice here is that the government had no role to play in the healthcare of women and children. These were all individual or voluntary organization efforts. The schemes for the improvement of the indigenous dais and the training of dhais taken over by the All India Lady Chelmsford League for Maternity and Child Welfare, United Provinces branch from January 1924. The DB of Sultanpur formulated a scheme for supplying simple midwifery boxes to certain village *dhais* and panchayats were asked to purchase such boxes from their funds and kept under sarpanch¹⁴⁸ Apart from Victoria Memorial Scholarships, the local government in United Provinces gave grant of Rs. 6000 for the training of indigenous dais and the amount was distributed by I.G.C.H to CS and Medical women (first class) to meet expenses in connection with their training. But on the outcome of the scheme, I.G.C.H lamented that the 'result has been anything but most disappointing'¹⁴⁹ and he asked the local government to drop the grant. In 1926, the MCW league at Lucknow prepared a scheme which had a cost of Rs. 29,000 for the training of dais at 51 hospitals in the Province. For the purpose, municipal board agreed to subscribe Rs. 10,000 for a scheme, provided IRCS and government also subscribed Rs. 10,000. RCS granted 7,500 in 1925-26 and promised a grant Rs. 50,000 made by the government to the

¹⁴⁸ Fifty- Ninth Annual Report of the DPH of United Provinces of Agra and Oudh 1926, Allahabad, 1927, p-58.

¹⁴⁹ DMSF, *Improvement in Conditions of Childbirth in India*, 1918, Calcutta, 1918, p-15.

disposal of the League.¹⁵⁰ A proposal was also forwarded by the medical women of this Province for the compulsory registration of dais as well as compulsory supervision of their work, which IGCH considered ‘impracticable and utopian’ and denied legislation on the grounds that no local government would undertake such legislation and no other Province in their Acts for registration of medical practitioners made any such provision. Thus United Provinces could also not undertake the scheme of compulsory registration of indigenous dhais.¹⁵¹

Later, the few institutions in United Provinces were recognized for the diploma in midwifery at Lucknow, Cawnpore, Allahabad, Benares, Agra and Aligarh. The centres at Moradabad, Gorakhpur, Meerut, Bareilly and Fyzabad were also formerly recognized for the dais certificate only.¹⁵² A scheme of MCW launched at Allahabad in a more concentrated form.¹⁵³ It was lamented that in Allahabad, people “are rather backward to take advantage of this scheme and indigenous dais do not call the resident midwives on their cases.”¹⁵⁴ In Fyzabad, however, when the maternity supervisor visited to supervise the work of indigenous dais, didn’t summoned the supervisor in the delivery cases.¹⁵⁵ Similarly, in Cawnpore, it was reported that “a good many dhais attended the lectures when the maternity supervisor was present. The fact that midwife failed to befriend the dhais.”¹⁵⁶ In Pilibhit, Mrs Hallowes, the wife of the Collector started a scheme in which a trained midwife delivered lectures to the midwives. Not only this, a *dhai* was rewarded with an amount of 93 rupees during the year 1921. However, a concern was raised that the success of the scheme was hampered owing to the ignorance of *dhais* and the apathy of the people.”¹⁵⁷

In Hospitals and Public Health reports, it was emphasized that the traditional dhais resisted the training, Balfour also concluded that dhais would not attend lectures because they were “afraid of losing their work and reputation for doing so, they are

¹⁵⁰ Report on Municipal Administration and Finances in the United Provinces of Agra and Oudh for the year ending 1926, Allahabad, 1927, p-7.

¹⁵¹ DMSF, Improvement in Conditions of Childbirth in India, 1918, pp-15-16.

¹⁵² Fifty- Ninth Annual Report of the DPH of United Provinces of Agra and Oudh 1926, Allahabad, 1927, p-71.

¹⁵³ Col Baird, Annual Report of the Civil Hospitals and Dispensaries of United Provinces 1923, Allahabad, 1924, p-4.

¹⁵⁴ Fifty- Fourth Annual Report of the DPH of United Provinces of Agra and Oudh 1921, Allahabad, 1922, p-6.

¹⁵⁵ Ibid.

¹⁵⁶ Ibid.

¹⁵⁷ Ibid.

trying, out of jealousy to create distrust of, and prejudice against, the European mode of confinement in the minds of ignorant women.”¹⁵⁸ Even when they accepted training and kits containing soaps, scissors etc, it was difficult to provide further supervision. Dr Leach, MO of district hospital Cawnpore opined that “there is no improvement in the work of the dais in the city or district since the Fund operations were started. On the contrary ‘a little knowledge is dangerous.’ The bazaar dais who have been coaxed and paid to attend a few classes have become bold and daring and are deceiving the public by giving them to understand that they have had a hospital training, whereas they have not, and have only attended a few lectures and then remained away... I am of opinion that it is hopeless to undertaking to get any good out of the bazaar indigenous *dai*, who is steeped in superstition and wedded to her old system of practice, and it is a waste of time, good money, and trouble to make ourselves believe that any good can be got out of them.”¹⁵⁹ There were significant reasons that dhais associated with DF did not attend lectures. Firstly, they regarded their time as money and wanted to be paid to attend the cases. Secondly, they found the training schemes interfered with their ability to practice their craft. Third, they did not recognize the superiority of the western way of childbirth. And finally, clients were satisfied with their services.¹⁶⁰ However, though the kits were given to these trained dhais, “but not forceps, speculums, or chloroform.”¹⁶¹ For training, classes were organized where even though theoretical knowledge was given but had no practical experience in obstetrical work. The demand for trained midwives came from urban and district hospital and dispensaries, factories and plantations but not from the individual families. In rural areas, training of *dhais* and child welfare work in the villages was organized by the PHD working through Lady Chelmsford League and later by the provincial branch of RCS. Training of superior class of midwives was introduced at Gorakhpur, Fyzabad, Meerut, Aligarh, Moradabad, Allahabad, Bareilly, Benares, Cawnpore, and Agra with Lady Chelmsford League in 1923.¹⁶² Even after so many training centers around 73 per cent of births conducted by the untrained attendants in United Provinces and 50 per cent in Madras.¹⁶³ However, the training in obstetrics was not uniformly organized and there were no arrangement of teaching of

¹⁵⁸ Balfour and Young, p-20.

¹⁵⁹ Ibid, pp-16-17.

¹⁶⁰ Sixth Annual Report of the NASMAWI, 1890, p-222.

¹⁶¹ Quoted in Geraldine Forbes, p-107.

¹⁶² Annual Report of the DPH of United Provinces of Agra and Oudh, 1924, p-38.

¹⁶³ Annual Report of the Public Health Commissioner with GOI, 1935, Vol. I, New Delhi, 1937, p-70.

midwifery under domiciliary conditions. However, there was a single institution for the training of domiciliary midwifery in the Women Medical School, Ludhiana and specialists courses in obstetrics were taught at Calcutta, Bombay, and Madras.

The training of probationer midwives was started at the Provincial Training Center in Lucknow but the training of candidates in the women's hospital and MCW centers were discontinued from 1932.¹⁶⁴ By 1930s, AIWC were determined to abolish *dhais* and replace them with midwives trained in western techniques. In All India Women's Conference passed a resolution at its annual meeting calling for legislation requiring the "compulsory registration of dhais and midwives".¹⁶⁵ They also passed resolutions supporting maternity and child welfare acts, the appointment of medical women to the position where they could advise the government on health policies and birth control. Despite demands that all midwives be trained and licensed, remarkably little seems to have been done to make this a reality. Missionary schemes began in the nineteenth century, always small and limited in scope, gradually disappeared. The newer hospital programs turned out that the trained midwives were in less than adequate numbers. And also envisaged a time when it would be illegal for Indian midwives to practice without a license.

Child's body was indirectly colonized by the state through encouragement to midwifery and disregarding the existence of indigenous dais in the society. Especially it was the elite class women who were the chief target of the colonial policy of westernizing the childbirth and infant care. There is no data to show what improvement occurred in the life of trained dais. It is lamented that they turn back to their old ways and further they charged more due to their training and were thus more popular in middle or lower income group. Thus, the wealthy family, government hospitals and dispensaries employed trained midwives by replacing the *dhai* to trained midwives.

CONCLUSION

The colonial administration for delivering healthcare for paediatrics was a monolithic structure. Sensibilities of high mortality rates especially among infants were evident

¹⁶⁴ Sixty-Sixth Annual Report of the DPH of United Provinces of Agra and Oudh 1933, Allahabad, 1934, p-43

¹⁶⁵ Eighth- Annual Report of All India Women's Conference, 1934, Calcutta, p-150.

from official correspondences yet initiation a full-fledged comprehensive policy for paediatrics failed to see the light of the day. To achieve the mission, they targeted indigenous dais, women, and social prejudices of the population. However, on their part, the State failed to undertake the responsibility by outlining the measures to combat infantile mortality, promoting research into the causes of high death-rates among children, propagating the significance of the life of children. They, on the other hand, focused singularly on the issue of childbirth. For the purpose, a new class of women was created to attract the children into the institutional arena of colonial benevolence as the access of children to western medical care institutions remained stagnant. This policy too failed due to the indifferent attitude of the colonial government. The infant/child welfare centers established were milestones in the paediatric care. Yet the centers too had serious drawbacks such their work was unorganized and uncoordinated and records were not kept properly so that future policy provisions could be outlined. No sincere effort was made on the part of the government, not only to attract the medical women of United Provinces in medical arena but also to encourage them to continue the profession in the preposterous environment. DF initiated to reduce this gap but with no promising results in the absence of handsome funding from the government and local bodies except false promises. The failure to develop institutions directing the study of problems and solutions of paediatrics in Indian environment further made the situation averse. Agra Medical School, the pioneer medical institution, had no separate department for the course and research on paediatrics. The limited policy of the government focussed only on opening women hospitals, targeting school children, replacing indigenous dais, cry of financial stringency and blaming people for their prejudices. Thus urban-centric and restricted approach of the government became a major setback in the paediatric policy of colonial medical care. The fact, however, is that the structural foundation for emergence of paediatric medicine was laid down during the British colonialism.

Chapter V
Paediatric Medicine in Uttar
Pradesh

CHAPTER- V**PAEDIATRIC MEDICINE IN UTTAR PRADESH**

“But somehow the fact that ultimately everything depends on the human factor gets rather lost.....
in our thinking of plans and schemes of National Development in terms of factories and machinery
and general schemes. It is all very important and we must have them, but ultimately, of course, it is the
human being that counts, and if the human counts well, he counts much more as a Child than as a
grownup.”

-Pt. Jawahar Lal Nehru

The above statement is significant to understand the attitude of the GOI to the healthcare of children. The reality was contrary to the statement where ‘New India’ was more inclined towards economic-oriented development rather than healthcare. This becomes inevitable due to the scenario where India’s GDP was in negative, industrial development was none and the tragedy of partition. For Healthcare, India received aid from various international agencies to cope up with the immediate challenges, i.e. reducing the toll of infectious diseases like National Malaria Control Programme, tackle vaccine-preventable diseases with BCG vaccination programme, and eradication of smallpox and checking the advance of epidemics. The post-colonial state was thus unable to go beyond the foundation laid by the colonial state in the domain of medicine. The policy for healthcare of children received challenges from economic instability, food scarcity, series of wars country faced and underdeveloped healthcare infrastructure.

The Report of the Health Survey and Development Committee (Bhore Committee) drew attention to the fact that the existing health organization of maternal and child health services was altogether inadequate, and asserted that ‘any plan for improving the health of the community must pay special attention to the development of measures for adequate health protection to mothers and children.’¹The Committee, therefore, recommended that in the development programmes of health, maternal and child health services should be given the utmost priority. However, it can be seen that these recommendations were never fully adopted by the Central government. Policy-

¹ GOI, *Report of the Health Survey and Development Committee*, Vol. I, (Delhi: Manager of Publications, 1946), p-9.

making reflected the desire of the government to expand and improve health services for mothers and children. From the earlier chapters, it can be concluded that the growth of MCW work was mainly due to the efforts of voluntary non-governmental agencies. After independence, however, both the Union and State Governments assumed the responsibility for the paediatrics, but voluntary agencies were never out of the picture. Guha lamented that “children in this country are perhaps the most neglected section as far as the State is concerned. Whatever, has been done so for them is hardly a drop in the ocean and compared to other advanced countries is not even worth mentioning.”²

Most works on medical policy in India specifically only the colonial period. What about after independence, it was certainly not a happy ending. It is necessary to explore the condition of health of people and paediatrics in a newly born country. On the eve of independence, the nationalist policies focused on gaining power and removal of alien rule. Due to the prime concern of ‘free India’, there was few full-fledged policy outlines for social and economic changes. On the stumbling foundation of public health, the newly independent government took over the regime. The vision for ‘New India’ by the Congress, Socialists and Gandhians was to create a healthy society and healthy children. However, the basic structure of the administration of the system was much similar to the colonial state. It was on the remnants of the colonial state that post-colonial government built the structure of paediatrics. The chapter argues that more or less, the health policy of the post-colonial state did not totally differed itself from colonial phase but was more welfare-oriented. The measures taken by the government for paediatrics in the early 60s and 70s were like old potions in a new bottle, however it was more comprehensive and coordinated effort. Thus, this section of this work explores the paradigm shift in the health policies under the new government. The earlier part of this work brought to light the medical and child care policy of the colonial state in United Provinces, the following pages, assess the impact of the former policy on the Uttar Pradesh (25 Jan. 1950). To understand the challenges, vision and policy structure of the new government in the independent scenario. The work further explores the development of policies and programmes by the post-colonial state.

² Phulneru Guha, ‘Feeding of School Children’, *Roshni*, Vol. 2, No. 4, May 1947.

Rammasubban correctly argues, “the independent Indian state, although it recognized public health as one of its main concerns, lacked the commitment to carry through public revolution.”³ Chaudhuri⁴ and Baran⁵ argued that capitalist path of development launched in India remained distorted and slow. Thus it could neither impart dynamism to the public health system, as it had very little demands to make, nor could the productive forces develop to the extent which would improve the health status of the population by meeting their nutritional and other ‘basic needs’. For paediatrics, O.P. Ghai considered the failure of government in outlining the goal-oriented health planning especially focusing on children and the need of strengthening the efficient training facilities for the paediatric health workers especially ANMs.⁶ UNICEF in its report on women and children lamented “a significant feature of health in India is its mal-distribution, biased in a favour of the urban, upper and middle classes, and biased against the rural poor and in particular children and women among them, in the populous states of the north. While the health policy rightly focuses on providing the “goods” to maintain health and “services” to reduce or prevent illness in the case of who have neither, the level of health facilities for the higher income groups (in terms of well-equipped hospitals and sophisticated medicine) is being maintained in the face of increasing demand. While the existing infrastructure reaches down to the village, the interface between health services and clients remains as weak as the vertical link between barefoot cadres and the medical professionals,...the implementation of primary health centers (PHC) is thus dependent on the linkages between health delivery system, social organization and technologies.”⁷ Further, Banerji assesses that the services were poorly planned and still more poorly managed and therefore, exceedingly wasteful.⁸ In the light of these studies, this chapter explores the following questions- Does new government evolved new policies to ensure better health facilities for paediatrics in the post-colonial environment? What measures were undertaken in the implementation methodology of the framed policy? To what extent

³ Radhika Ramasubban, The Development of Health Policy in India, p-108, in Tim Dyson and Nigel Crook (ed.), *India's Demography: Essays on the Contemporary Population*, South Asian Publishers Pvt. Ltd., New Delhi, 1984.

⁴ P.K. Chaudhuri, *The Indian Economy: Poverty and Development*, (London: Crossby Lockwood Staples), 1979

⁵ P. Baran, *The Political Economy of Growth*, (Delhi: People's Publishing House), 1958.

⁶ O.P. Ghai, Editorial- 'Health Planning for Children', *Indian Pediatrics*, Vol. X, No. 1, January 1973, pp-1-4.

⁷ UNICEF, *Children and Women in India: A Situation Analysis*, New Delhi, 1990, p-168.

⁸ Banerji, *An Analysis of Health Policies and Programmes in India in the Eighties*, Lok Paksh, 1990, P-134.

does the high mortality of children in this State was checked by the U.P. government? Was there any development of specialized paediatric treatment facilities in the State through institutionalisation?

In the context of Uttar Pradesh, the following pages argue that the State worked according to the nature of the welfare state. However, the growth and development of paediatric facilities in the State was slow and unsatisfactory. Many substantial factors simultaneously affected the growth of paediatrics, such as the legacy of the weak structure of paediatrics, the dearth of specialized doctors and institutions for paediatrics, the unreliable registration system of births and deaths, and insanitary condition of the state.

POLICY AND PLANNING FOR PAEDIATRICS

Pt. Jawaharlal Nehru, who was hailed as an architect of modern India and was also well-known for his love for children and their welfare. As first 15 years after independence Nehru was the Prime Minister, the decade could be designated as 'Nehruvian era' (1947-64), the health policies were thus a reflection of his ideology and sensibilities. These years were those of high hopes, aspirations, and optimism. Consequently, one can evidence many child welfare programmes of the government focusing towards children. In October 1951, the State Committee for Children, Uttar Pradesh along with Indian National Committee for Children decided to celebrate the birthday of the Prime Minister and to collect funds for organizing activities related to the welfare of children. DMHS was asked to prepare literature (related to health issues of children) to be sold along with other things during this celebration.⁹The welfare and healthy children were thus the chief focus of both Central and State governments. Various means were adopted for attaining this goal. Foremost among them was outlining Five-year Plans adopted by the welfare state based on the lines of Soviet Union. The earlier visit and communications of Nehru to the two world powers- America and Russia had a long lasting impact on the initial policy formulations. His earlier inclination towards socialism was even before independence. All these led to setting up of a Planning Commission and formulation of the Five-year Plans. But the implementation of these Plans suffered from various hindrances such as political will,

⁹ UPSA, File No. 1381, Box No. 50, 'Celebration of Children's Day on 14-10-1951 on birthday of Pt. Nehru', Medical 'B' Department, 1951.

financial constraints, limited goal, lack of machinery and underdeveloped medical institutions.

In the First-Five Year Plan (1951-56), maternal and child health services were kept at the forefront of planning for health programmes. It was fully realized that the lack of trained personnel-women doctors, health visitors, midwives, and dais and institutional facilities for training they had, till then, been a great handicap and responsible for the meagre efficient services. A sum of Rs. 15 lakh was provided for expanding the training schemes for health visitors and midwives to staff the proposed PHCs and MCWC in states. During 1951-56, two major developments-one in the field of rural welfare and the other in the field of voluntary social work- laid the foundation for improving these services. Community Development blocks were established in rural areas and the Central Social Welfare Board established in 1953. It was the principal agency for the promotion and implementation of social welfare schemes for specific groups of persons- women, children and handicapped.¹⁰ During 1952-58, 13 states formulated and implemented programmes of maternal and child health services.

With regard to healthcare, the first three of the Five-year Plans of the Central government concentrated on creating the basic infrastructure for rendering more effective health services. The highest priority in its First Plan was accorded to agricultural production in order to make the country self-sufficient in food production. On the other hand, in the Second Plan, the top priority was accorded to industrialization. It is not that child welfare was totally neglected. But its full significance had not been realized and no coordinated attempts at the development were initiated till 1960s. On the lines of Central government, UP government framed its policies and plans for paediatrics. In the First Five-year Plan of UP government it was emphasized that women's health was a stepping stone to national progress and proclaimed that "immediately on assumption of office this government accordingly took up an extension of both these activities and the present rate of expenditure under these heads has increased from 169 lakh to just over three crore in 1950-51 and about 3.5 crore in 1952-53".¹¹ Consequently, in its First Plan, Public Health Department (PHD) of UP formulated many comprehensive schemes. As child mortality from fever

¹⁰ C. H. Rao, *Social Welfare in India*, The Central Social Welfare Board 1960, p-12.

¹¹ UPSA, File No. 107/1952, Box No. 86, 'Five Year Plan of PHD 1951-56', Public Health Department.

was significantly high especially in eastern districts of UP the first step of the government was the anti-malarial measures. The scheme thus comprised of survey work, D.D.T. spraying, and training the local population in the hygienic mode of living. The cost of the scheme was shared by both State, various departments of UP government and W.H.O. to eradicate the scourge of malaria from the State. A new scheme received the nod from the government in 1953 for MCW and two children's hospital under First Plan, sponsored by Mrs Lilawati Munshi in collaboration with WHO and UNICEF. The government decided to open 200 new MCWCs with a health visitor and a midwife as in charge. The scheme was divided into three phases- in the first and second year, 66 centers and in the third year 67 centers were decided to be established.¹² Further, training for health visitor and midwives were also promoted by the government. Under this scheme, it was decided that two hospitals for children were to be opened at Agra and Lucknow. The total provision of this scheme under First Plan was of 29.87 lakh with 10.76 lakh recurring expenditure. By the end of the First Plan, with the help of WHO and UNICEF, 559 MCWCs were established in UP.¹³

There was no policy that each State must have at least full-fledged independent paediatric centers. In order to meet the demand, both the governments of federal-state decided to work together. In Second Plan (1956-61), UP government, in the health sector, focused on opening hospitals, dispensaries and health units especially for extending women and child medical relief. Further emphasis was on medical education and training with a view to producing more doctors and trained personnel for the hospitals and dispensaries in the State. It was decided to establish 40 (earlier 65) dispensaries with 4 beds (2 general and 2 septic), in contrast to the demand of 131 and that to in the form of women's wing into the existing general dispensaries with the women doctor and staff i.e. compounders, midwives, nurses etc. Further, it was outlined that there should be an arrangement for specialist treatment for children's diseases in medical institutions and Child Guidance Clinics in the State. Government thereupon decided to open a centre of specialist treatment of children diseases at Gorakhpur and Bareilly. However, Atikrit Sachiv of UP suggested for dropping the

¹² Ibid.

¹³ Uttar Pradesh, *Annual 1963*, Information Department, 1964, Lucknow, p-158.

idea of establishment of Child Guidance Clinic and Bareilly to be established as a centre.¹⁴

Up to 1959, there was no single organization at the Central or State level which was responsible for building up the total welfare of children. Commenting on it in its 'Memorandum on Child Welfare and Priorities' in the Third-Five year Plan (1961-66), the Indian Council of Child Welfare exclaimed that "whereas there is a wide recognition of the importance of the child, the fact that planning for children has been considered so late is an indication that this is still a world of adults. Child welfare as distinct from other aspects of social welfare is an integral part of the economic plan. There is thus a difference in the concept of social welfare as applied to the adult on one hand and as applied to the child on the other. Social welfare for an adult is a part of expenditure, social welfare for a child is a part of investment."¹⁵ A clear policy was enunciated at the beginning of the Third Plan, that the child should be a part under the economic plan. Planned and organized efforts for paediatrics to extend medical and health services were started from Third Plan. It was proposed to spend over Rs. 28.14 crore on the expansion of the medical and health facilities in the State. Of this amount Rs. 662.50 lakh was allocated for opening PHCs, hospitals and dispensaries; Rs. 1358.50 lakh on the controlling of communicable diseases; Rs. 533 lakh for medical education and training, Rs. 74.40 lakh on the development of indigenous systems of medicine, Rs. 102 lakh for family planning. Out of the total outlay of Rs. 28.14 crore, a sum of seven crore allocated for construction of new buildings.¹⁶ By the end of this plan, there were 2,362 hospitals and dispensaries in the State. The total number of doctors was only 9,738 while that of nurses was comparatively low in number i.e. 3,143. Thus, there was one doctor for every 8,320 persons and a total seven medical colleges.¹⁷ Further, in order to give boost to paediatric services the government decided in this Plan, to start some additional specialized branches, i.e., a Polio Clinic and Rehabilitation centre, children's clinic at four places and consequently, a children's hospital was established at Kanpur in 1963, and Child Guidance Clinic and

¹⁴ UPISA, Memo of a Meeting Held at the office of Chikitsa Sachiv on 12-2-1958 in File No. 725(4)/1955, Box-174, 'Establishment of Women's Dispensaries', Medical 'B' Department.

¹⁵ Ika Paul Pont, *Child Welfare in India: an Integrated Approach*, Ministry of Education, GOI, 1963, Delhi, p-8-9.

¹⁶ Uttar Pradesh, *Annual 1962*, Information Department, 1963, p-104.

¹⁷ J. P. Chaturvedi, *States of our Union: Uttar Pradesh*, Publications Division, Ministry of Information and Broadcasting, December 1970, p-43.

Neuro-Surgery unit at Lucknow.¹⁸ Thus, it was hoped that by the end of the Third Plan it will be possible to provide facilities for all types of specialist treatment, besides the essential preventive services.

Table 5.1: Medical services for paediatrics in Uttar Pradesh in the Fourth-Five Year Plan

Items	Fourth Plan Target (1966-71)	Already achieved in two years of the Fourth Plan	Total number anticipated at the end of the Fourth Plan	End of Fourth Plan
Children's Clinics	10	6	22	33
Nursing Scheme	17	6	75	77
Upgrading of Paediatric Department	5	Nil	11	NA

Source: Uttar Pradesh, 1972, Information Department, Lucknow, March 1973, p-185.

Direct government efforts were started during sixties through the formation of committees such as Child Care Committee (1960), Committee on the Programmes for Child Welfare (1968), etc. These Committees focused on studying the problems related to child welfare and development and also suggested measures to improve the condition of children in the country. Later the voluntary agencies were assisted by the Central Social Welfare Board and for the cause, Board received an assistance from the central government, for instance Rs. 40 million under the First Plan.¹⁹ It was during these years that economic situation in the country was intractable and was in recession thus deteriorating. Not only this, the rains failed for second successive year in 1966 with a severe draught in comparison to the earlier year.²⁰ Famine was most severe in Uttar Pradesh and Bihar. Together with this, war of 1962 and 1965 led to sharp rise in military expenditure and diversion of resources from planning and economic development. Government was however successful in dealing with the draught and famine situation which Chandra described as 'major achievement for Indian democracy.'²¹

¹⁸ Uttar Pradesh, *Annual 1962*, p-105.

¹⁹ C. N. Ray, *Child Development Project in India: Field Experience in Eastern Uttar Pradesh*, Working Paper No. 80, Giri Institute For Development Studies, Lucknow, p-2.

²⁰ Bipan Chandra, Mridula Mukherjee and Aditya Mukherjee, *India since Independence*, (New Delhi: Penguin Books, 2008), p-281.

²¹ Ibid.

Table 5.2: Financial Outlays under MNP in the Sixth Plan 1980-85 (in lakh) in U.P.

State	Sixth Plan 1980-85				Revised Outlay 1981-82			
	Rural Health	Rural Water Supply	Environmental improvement	Nutrition	Rural Health	Rural Water Supply	Environmental improvement	Nutrition
U.P.	7,489	22,000	1,000	883	1450	4000	150	168
India (all States including U.P.)	40,846	1,40,711	15,145	21,874	7827.47	24100.25	2553	3867.15

Source: GOI, *Health Statistics of India*, Ministry of Health and Family Welfare, New Delhi, 1982.

From the above paras, it is clear that in the five year plans, the subject of child welfare could be apportioned as 'start-halt-shift-restart'. As in the first year plan, it was decided to start MCWCs, while in the Second Plan they focused on dispensary system and Third and Fourth Plan on specialized services for paediatrics and increasing medical personnel's. Fifth plan prioritises family planning and packaged programmes. The lack of continuous and comprehensive planning, according to the changing scenarios in the country, severely impacted the development of paedia care in the State. For instance, during the period of the Third Plan, another important measure was taken by the Central government by setting up of the Ganga Saran Sinha Committee to examine in depth the needs of India's children. This was the first comprehensive survey and the findings of the Committee were that it was not Rs. 3 crores (the allocation of the Third Plan) that were needed for minimum child welfare services in the country, but 1200 crores. While Ganga Saran Sinha Committee rendered a service to the cause of better coverage for the child, it did not apparently influence subsequent plans.²²

The role of international organizations such as UNICEF and WHO was invaluable in developing paediatric services and teaching programmes. UNICEF provided equipment and scholarships, whereas WHO provided paediatricians and nurses to assist the staff. To provide experience in paediatrics to medical students and nurses and enable them to observe the growth and development of children, peripheral

²² Tara Ali Beg, Policy Provisions, p-72, in Sharad D. Gokhale and Neera K. Sohoni, *Child in India*, (New Delhi: Somaiya Publications), 1979.

paediatric clinics established in association with the MCWCs by UNICEF and WHO. International scenarios too impacted health policy in India such as the Alma Ata Declaration of 1978 stressed on 'Health for All' through PHC approach. This Declaration emphasizes access to all levels of care to all people. United Nations declared 1979 as the 'International Year of the Child' (IYC) to focus the attention of planners, policy makers, administrators, and social scientist on the various problems encountered by the children, particularly in developing countries and to call for a concerted effort to tackle these problems. Then in 1982, came the Rome Declaration which aimed to end World Hunger by 2000A.D. as well as to see that 'no child shall go to bed with Hunger.'²³ So instead of focusing on what we are planning, policy makers jump towards the international ideology without understanding whether it was feasible to local conditions or not. Understanding of government for the urgent requirements of paediatrics could be glanced from the planning process and the targets achieved during the Plan years. However, the speed with which the task could have been taken up was slow yet was a continuous agenda. As rightly assessed the problem as 'to assess the quantity and quality of population and to plan action in such a way that a great democracy like India and its future bearers survive decently.....there is at present enormous gap between India's aspirations and accomplishments...'²⁴ Further, child welfare was too low in relation to the total Plan outlay and expenditure. It demonstrates that child welfare as the nation's highest priority mentioned in official publications was not realized. As the draft of Seventh Plan of UP admitted, 'on the healthcare side, considerable intra-regional and rural-urban disparities exist in the relative distribution of medical services...The comparative picture of the health status of the people of this State as compared to the National average and other states continues to be unfavourable as judged from infant mortality and death rates...The availability of indoor beds in hospitals, doctor-population ratio and nurses population ratio in the State also compares unfavourably.'²⁵

²³ B.N. Saxena and Kalyan Bagchi (ed.), *Towards the Implementation of A National Nutrition Policy in India*: Report of National Seminar, Srinagar, 28-30 October 1985, p-viii.

²⁴ Kumudini Dandekar, Demographic Portrait 1950-1975-2000, pp-3-4 in Sharad D. Gokhale and Neera K. Sohoni (ed.), *Child in India*, (New Delhi: Somaiya Publications), 1979.

²⁵ M. S. Ashraf, *Infant Mortality in Rural India- A Diagnostic Study*, (Lucknow: Giri Institute of Development Studies, Print House), 1990, p-14.

HEALTHCARE CARE THROUGH LEGISLATIONS

The needs of children and our duties towards them are enshrined in our Constitution. Article 39 of the Constitution proclaims that the state shall, in particular, direct its policy towards securing that the health and strength of workers, men and women and the tender age of children are not abused and that children are not forced by economic necessity to enter a vocation unsuited to their age or strength. Keeping in view the constitutional provisions and the United Nations Declaration of the Rights of the Child, GOI adopted a National Policy for Children in 1974. The Policy recognized children as the “nation’s supremely important asset” and declared that the nation is responsible for their “nurture and solitude”. The policy also provided for setting up of a high-level National Children’s Board to focus attention on child welfare and child development and to ensure, at different levels, continuous planning, review and coordination of all essential services directed towards the children.²⁶

With independence, more definite legal initiatives were taken aimed at the protection and the preparation of the child. The Directive Principle of State Policy (Part IV of Constitution), had few provision for ensuring better health for children, but it was not a legal or constitutional obligation on the state. Article 47 states that the ‘State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties.’²⁷ Further, Article 243 G read with Schedule 11 of the Constitution, focused on the role of Panchayats in development policies, provides for the institutionalization of child care and to raise levels of nutrition and standards of living, as well as to improve public health and monitor the development and well-being of children.²⁸

After independence, the Central Government prepared a ‘*Children’s Act*’ and directed the state’s government to prepare the same based on the local requirements and conditions. Bombay, Madras, Madhya Pradesh prepared the Bill for the protection and nurture of children especially juveniles. In UP, when the bill was sent to the select committee, Shri Raja Ram Shastri in the meeting of select committee stressed on the problem of an increasing population which could hinder the purpose for which it was

²⁶ GOI, *National Plan of Action for International Year of the Child 1979*, Ministry of Education and Social Welfare, Department of Social Welfare, New Delhi, September 1978, p-2.

²⁷ R. N. Chaudhury, *Law Relating to Juvenile Justice in India*, (Allahabad: Orient Publishing Company, 2006), p-9.

²⁸ P. M. Bakshi, *The Constitution of India*, (New Delhi: Universal Law Publishing), 2011, pp-416-7

done. Shri. Shivdayalu Upadhyaya stressed that if the government could nurture children then the criminal activities could be avoided.²⁹ Both these members were asked to prepare a separate bill to endorse these two prominent ideas. The bill was presented in the assembly of UP by the Education Minister Shri. Sampurnanad on 12 September 1950 and was passed on February 1952³⁰ (this was based on the bill passed by Legislative Council in 1939 incorporated with some amendments). As per this Act, “the children under the age of 16 years who were orphan, destitute, beggar, juvenile or devoid of medical aid by anyone shall be punished and the State government was to open schools for their nurture.” The provision related to the maintenance of the health of the children were-

- a. If a child was given intoxicating drug or liquor, without the order of a qualified medical practitioner, shall be punishable with fine, which may be extended to 50 rupees.
- b. If a person found drunk and in charge of child under seven years of age may be arrested and shall be punishable with fine, which may be extended to 50 rupees.
- c. If a person sells a child under twelve years, any cigarette, cigarette paper, bidis, tobacco or smoking mixture, he shall be liable to a fine not exceeding 100 rupees. The Police Officer authorised to seize these articles and forfeited to State Government. Every police officer could search any child except a girl, if found smoking.
- d. If a child found to be suffering from leper, the government was empowered to send them to leper asylum and was kept in that institution till declared by MO of his relief.
- e. If it appears to government that a child is of unsound mind, that Government should send the child to mental asylum and that they should be treated as per the directions of the government and was kept in that institution till declared by MO of his relief.
- f. Any registered medical practitioner empowered on his behalf by the State government could visit any approved school at any time with or without notice to its manager in order to report to the Chief Inspector on the health of the

²⁹ UPSA, File No. 2107/50, Box No. 451, ‘U.P. Children’s Bill’, Education ‘A’ Department; File No. 383/50, Box-155, ‘Bill-U.P. Children’s 1950’, Legislative Department.

³⁰ Government Gazette of Uttar Pradesh, Lucknow, February 19, 1952.

inmates and the sanitary condition of the school, provided that where any such school is for the reception exclusively of girls, a male registered medical practitioner shall not visit such school without giving previous notice to the manager there of.

- g. The State government may cause any institution for the reception of poor children supported wholly or partly by voluntary contributions, and not liable to be inspected by or under the authority of State government to be visited and inspected from time to time at all reasonable hours, by persons appointed by them for the purpose of securing the health and welfare of the children and the sanitation of the premises. Any person so appointed shall have power to enter the institution at the reasonable hours and if he was obstructed then that person shall be liable of conviction to a fine not exceeding 50 rupees. For girl's women inspectress was to be appointed.

Interpreted in another way, it means that child growth should be a planned process and that the state has a role in protecting the child. These two points emerge as dominant elements which in the post-independence era, had significantly shaped the techniques and responsibilities for child upbringing in India.

MAPPING PAEDIATRICS IN UTTAR PRADESH

In UP, the infant mortality rate throughout the period 1900-47 was substantially high. It thus becomes inevitable to understand how the UP government visualized the problem and the steps taken by the government to deal with the situation. As seen in the earlier chapter, the maternity and child health movements were placed on firm ground when in November 1922, Articles of Association were drawn up in Lucknow to get the United Provinces branch of the Lady Chelmsford All- India League registered. Its activities were confined to firstly in urban areas and gradually extended to cover the rural population. In 1930, the Lady Chelmsford Maternity and Child Welfare League was amalgamated with the UP branch of the IRCS and continued until 1948, when this important public health activity was taken over by the government.

Over 40 per cent of the total population in UP comprised of children below 15 years.³¹ The rural-urban differentials in the population below the age of 15 were more evident

³¹ Moonis Raza & Sudesh Nangia, *Atlas of the Child in India*, (New Delhi: Concept Publishing Company, 1986), p-691.

in the rural areas than in the urban areas for both males and females. To some extent, this reflects the fertility differentials in the rural and urban areas from 1971 indicating a decline in fertility both in the rural and urban areas. This was more due to the population control measures by the Central and State government. The per cent distribution of children below 15 years age groups, 38 per cent belonged to the age group of 0-4 years, 32 and 30 per cent of the total children in the age group of 5-9 and 10-14 years respectively.³² The age-specific death rate in the age group 0-4 years is a key indicator of general mortality. Of the total deaths in UP, it was reported that nearly half of the deaths (42-45 per cent) occurred in the first four weeks. The National Sample Survey of 14th round indicated that the all India IMR was 146 per 1000 births. The infant mortality rate varied from 109 in Madras to 186 in Uttar Pradesh in 1960.³³ The survey report of GOI shows the same case in rural areas where IMR varied substantially from 42 deaths per thousand births in Kerala to 172 in Uttar Pradesh.³⁴ Not only this but the overall rate, IMR was highest in UP as 35 per cent and with 17 per cent lowest in Kerala. The infant mortality in the rural areas of UP was around 221 of which 107 comprised of neonatal mortality while 114 was post-neo-natal mortality.³⁵ The IMR in UP reflected fluctuating tendency from 198 in 1975 to 168 in 1977 declined to 130 in 1981 and 155 in 1983. The age-specific death rates as obtained from SRS and the survey in table 5.3, it is observed that child mortality among female child was more than male. Child mortality in the rural areas of UP was higher in urban areas at all India level,³⁶ indicated the urgent need for increased facilities by way of additional hospitals, trained nurses and doctors through an integrated health, maternal and child welfare programmes.

Anrudh Jain in his study focused on the relative importance of the medical over non-medical care factors in explaining regional variations in IMR in rural areas. He concludes three determinants of infant mortality as poverty, birth attendant and triple vaccination.³⁷ Further, focusing on three districts of UP, M. E. Khan analysed the role

³² GOI, *Survey on Infant and Child Mortality, 1979*, Office of the Registrar General, India, Ministry of Home Affairs, New Delhi, 1980, p- 695.

³³ M.B. Kagal, Scope of Maternity and Child Welfare, p-117 in *National Policy for Children*, Indian Council of Child Welfare, New Delhi, 1964.

³⁴ *Survey on Infant and Child Mortality, 1979*, New Delhi, 1980.

³⁵ *Ibid.*

³⁶ M.S. Ashraf, *Infant Mortality in Rural India- A Diagnostic Study*, (Lucknow: Giri Institute of Development Studies, Print House, 1990), p-3-5.

³⁷ Anrudh K. Jain, Determinants of Regional Variations in Infant Mortality in Rural India, pp-128-164 in Anrudh K. Jain, Pravin Visaria, *Infant Mortality in India: Differentials and Determinants*, (New Delhi: Sage Publications, 1988).

of medical and social factors on the IMR in UP and emphasized the need of education of women and better environmental conditions for reducing IMR.³⁸ R. B. Gupta argues that the high rates of infant and child mortality was due to the low socio-economic status of the population and the limited exposure of the rural people to advanced medical technologies.³⁹ A study conducted to assess IMR considered the level of education of women, water supply facilities, age of marriage of women, etc. as the factors which explicitly influenced the child mortality in the State. It showed that in rural areas of UP, among illiterates, the IMR was 188 while among women with the educational level of primary and above, the level of infant mortality was 115.⁴⁰ A similar pattern observed in the urban areas.⁴¹ Another study conducted by NFHS found that in Rajasthan, Bihar and UP more than 80 per cent of children had illiterate mothers. By contrast, only 17 per cent of children had illiterate mothers in Kerala.⁴² It also reveals that neonatal mortality (73), post-natal mortality (46), infant mortality (120) and child mortality (52) and under-five mortality (166) highest in the State in comparison to the whole country. In UP, the survival ratio dropped steeply throughout the five-year period, but in Kerala, the survival ratio changed very little after the neonatal period.⁴³

Table 5.3: Neo-natal and post-neonatal mortality in Uttar Pradesh

Year	Rural			Urban		
	Neo -natal	Post- natal	Infant mortality	Neo -natal	Post- natal	Infant mortality
1970	92	73	165	58	52	110
1971	103	70	173	63	56	119
1972	100	113	213	55	65	120
1973	97	85	182	67	65	132
1974	99	80	179	58	52	110
1975	106	99	205	64	64	128
1976	107	77	184	63	58	121
1977	95	79	174	58	61	119
1978	93	79	172	59	51	110

Source: Moonis Raza & Sudesh Nangia, *Atlas of the Child in India*, 1986, p-701.

³⁸ M. E. Khan, Infant Mortality in Uttar Pradesh: A Micro- Level Study, pp-227-246, in *Ibid*.

³⁹ R. B. Gupta, Causes of Death among Children in Rural India, p-150, in K. Srinivasan, P. C. Saxena, Tara Kanitkar (ed.), *Demographic and Socio-Economic Aspects of The Child in India*, (Bombay: Himalaya Publishing House), 1980.

⁴⁰ Moonis Raza & Sudesh Nangia, *Atlas of the Child in India*, 1986, p-703.

⁴¹ *Survey on Infant and Child Mortality, 1979*, New Delhi, 1980, p- 703-4.

⁴² Arvind Pandey, Minja Kim Choe, Normany Luther, Damodar Sahu, and Jagdish Chand, *Infant and Child Mortality in India*, National Family Health Survey (hereafter NFHS), Subject Reports, No. 11, December 1998, Indian Institute of Population Sciences, Mumbai, p-21.

⁴³ *NFHS*, Subject Reports, No. 11, 1998, p-32.

As far as the question of causes of deaths among children in UP is concerned, the major cause of the death was tetanus, accounted for 30.6 per cent of the total infant deaths.⁴⁴ It was highest among children in both rural (39.5) and urban (26.7) areas. The second major cause of infant deaths was pneumonia. A respiratory infection accounted 30 per cent of out-patient hospital visits and 40 per cent of pediatric admissions.⁴⁵ The report further clarified that 20-30 per cent of all children suffered from pneumonia every year. Another major killer of children aged one year was typhoid, followed by jaundice. In 1954, several towns of UP i.e. Agra, Allahabad, Bareilly, Hardoi, Kanpur, Lucknow, and Sitapur experienced a 'mystery disease' i.e. encephalitis chiefly targeting infants and children. The mortality rate was about 20 per cent and in 1945, 106 cases were recorded at Agra Medical College hospital, 19 cases from Balrampur Hospital Lucknow, and in 1958, over 300 cases were admitted to Lucknow hospitals and 191 at Agra.⁴⁶ The disease even today takes more lives of children in eastern districts of UP. Infantile cirrhosis became apparent in the State later years and 233 cases were admitted in the children's hospital in Lucknow i.e. 3.6 per cent of all admitted cases in 1960.⁴⁷ NFHS data in its report on the health of children stated that children under five years of age suffered three episodes of diarrhea in a year on an average, 10 per cent experienced dehydration and one per cent required hospital assistance. As diarrhoea was a major killer of children due to poor feeding and nutrition,⁴⁸ the government thus made extensive availability of free ORS (Oral Rehydration Salt) in an effort to address the major cause of acute death by dehydration. It further showed that from 1985-89, the proportion of dehydration in paediatric hospitals decreased from 35-40 per cent to a much lower levels as a result of effective management of diarrhoea at home and in the out-patient department.⁴⁹

⁴⁴ Moonis Raza & Sudesh Nangia, *Atlas of the Child in India*, 1986, p-722.

⁴⁵ Report on the State of Health of Uttar Pradesh-With particular reference to Certain Diseases, 1961, Lucknow.

⁴⁶ N.P. Gupta, Encephalitis in Uttar Pradesh, p-132-33 in Report on the State of health of Uttar Pradesh- With particular reference to Certain Diseases, Lucknow, 1961.

⁴⁷ Report on the State of health of Uttar Pradesh- With particular reference to Certain Diseases, Lucknow, 1961, p-10-11.

⁴⁸ N. L. Sharma, Infant Feeding, Diarrhoea and Malnutrition, *The Journal of Tropical Pediatrics*, Vol. 1, No.2, September, 1955.

⁴⁹ UNICEF, *Children and Women*, p-156.

Table 5.4: Percentage distribution of infant deaths by major cause-groups and percentage due to important cause within each major cause-group in 1979-81

Year	Pre –maturity	Respiratory infection	Diarrhoea	Malnutrition	Convulsions
1979	11.3	3.6	11.8	22.6	1.0
1980	23.1	12.1	14.4	12.1	0.8
1981	21.3	14.8	12.1	15.1	2.3

Source: GOI, *Child in India: A Statistical Survey*, Ministry of Welfare, New Delhi, 1985, p-204.

Since colonial time, schools became a centre where the recognition of ailments and their treatment carried out regularly. Medical Inspection of school children was continued in UP by whole-time SHOs in 14 larger towns and by municipal MoH in others. Examinations were of two types-detailed for higher secondary schools and less detailed for the primary institutions. In 1960, 14 school clinics treated total 31,105 cases. The cases requiring prolonged treatment were referred to district hospitals. Spectacles and medicines were provided free of cost and special stress was laid on nutrition, the prevention of blindness, tuberculosis and B.C.G. vaccination.⁵⁰ The Health Education Bureau of Lucknow medically examined the students of junior high schools and higher secondary schools and treatment was provided to children at the central dispensaries in the districts of Lucknow, Jhansi, Allahabad, Moradabad, Varanasi, Kanpur, Faizabad, Dehra Dun, Shahjahanpur, Saharanpur, Meerut, Agra, Bareilly and Gorakhpur where whole-time SHOs were appointed.⁵¹ Statistical data of these medical inspections reported that around 50 per cent of children were suffering from different ailments.⁵² Chief defect among children was severe malnutrition was found among 50 per cent children in comparison to other defects as bad teeth, tonsils, eye disease, anaemia, etc.⁵³ Yet another survey was carried out in Deoria district, found 30 per cent of the children suffering from goiter. Similar surveys showed that districts such as in Dehra Dun, Tehri, Pauri, Bijnor, Budaun, Gonda, Basti, and Gorakhpur were also affected from this deficiency.⁵⁴ GOI in 1960 appointed a School Health Committee to assess the standard of health and nutrition of school children and the status of school health programme. The committee rightly commented that the

⁵⁰ Report on the State of health of Uttar Pradesh- With particular reference to Certain Diseases, Lucknow, 1961, p-12.

⁵¹ Annual Report of the State of Uttar Pradesh, 1964-65, Vol. I, Production, Development and Welfare Activities, Information Department, U.P., Lucknow, p-145.

⁵² Health Statistics, 1964. This year reported that out of 61,436 children examined during inspection 32,186 found suffering from various defects.

⁵³ Health Statistics, 1964.

⁵⁴ GOI, Report of the School Health Committee 1960-61, Part I, Ministry of Health, New Delhi, p-9.

advance was made in the urban areas towards medical inspection of school children and treatment, however, that progress is slow.⁵⁵

Table 5.5: Main defects noticed in urban and rural areas of scholars

Nature of defect	Percentage of cases found defective			
	Urban		Rural	
	1951	1950	1951	1950
Poor nutrition	16.78	21.1	20.45	11.0
Teeth and gums	9.25	9.1	7.7	8.6
Pyorrhoea	2.1	2.6	2.6	2.2
Tonsils and adenoids	8.6	10.8	5.5	4.2
Mouth breathing	1.5	2.0	0.7	1.11
Other glandular enlargements	0.9	1.6	2.2	0.9
Diseases of eyelids	4.5	5.1	2.2	1.8
Defective vision	8.3	7.0	3.7	2.7
Enlarged spleen	0.2	0.3	1.9	1.6
Skin diseases	1.7	2.2	4.2	4.3
Boys with One defect only	22.5	39.8	18.8	16.7
Boys with more than One defect	11.0	14.3	4.1	6.1

Source: Annual Report on Public Health Department in Uttar Pradesh 1951, Lucknow, 1957, p-12.

For overcoming these ailments, the government initiated a programme i.e. protection of children against diseases which benefitted around 95.8 per cent of children in 1988-89 and government decided to extend the benefit to 33 lakh children in the State.⁵⁶ However, the mortality among children in U.P. evidences a decline after independence but unfortunately was highest in the country even in the 90s. Even after so many policies and programmes, the failure of the government was on implementation and continuation level. Sanitary defects, food adulteration, poor supply of milk, and water supply problems aggravated the problems of paediatrics, which unfortunately continued even today.

DEVELOPMENT OF HEALTH INFRASTRUCTURE FOR PAEDIATRICS

On the lines of the Bhole Committee report, which dedicated a whole chapter on the inevitability of paediatric services in the country, health services were outlined for women and children and a shift was made from primarily voluntary services to a government-owned public sector. Secondly, on the eve of independence, the country experienced serious dearth of both medical personnel's and centers. In order to equip

⁵⁵ Ibid.

⁵⁶ Uttar Pradesh, 1988-89, p-186.

medical men in childcare, provision was made under the Second Plan to improve paediatric services at the hospitals attached to medical college and to provide improved facilities for the teaching of paediatrics. GOI contemplated starting six paediatric centers with at least three attached to M.C.H. peripheral centers.⁵⁷

The MCW organization in the State which was administered by the UP branch of the IRCS was provincialised from 1 April 1948. Under the scheme of provincialization, two hundred MCWCs were established in the rural areas of various districts in UP. However, in rural areas demand for both maternity hospitals and centers was raised from all walks of life. Consequently, in 1949, the DMHS proposed that 100 additional centers be opened, but the proposal was rejected on grounds of financial stringency. The demand was reported by him in 1950, with the modification that “only 50 additional centers might be opened, keeping in view the need for the economy”, but it was again deterred. The proposal involved an expenditure of Rs. 1,13,400 (recurring) and Rs. 25,000 (non-recurring) in the budget year.⁵⁸ A proposal came in 1949 for the establishment of a MCWC at Agra as the municipality had only four midwives in Raja Mandi, Hari Parbat, Shahganj, Tajganj. These centers were not sufficient to meet the growing need and constant demand for some maternity homes and centers. The municipal committee of Agra decided that there should be one central organization and that all maternity centers should be placed under the control and guidance of this center.⁵⁹ In 1949, a Bal Mahila Chikitsalaya was established at Kanauj for treatment of women and children. This institution was provided with a lady doctor and a nurse. The popularity of the institution could be assessed from the fact that from December 1949 to June 1950, the daily average attendance of children was 256.⁶⁰ The CS of Fatehgarh opined that the hospital could not run efficiently without a suitable recurring grant from the government as the financial position of the hospital was very poor.⁶¹ Understanding the critical situation, the government in 1951, initiated Women Welfare Scheme in 140 villages of 12 districts i.e. Azamgarh, Bahraich, Basti, Deoria,

⁵⁷ Dr. Harish Chandra, Paediatric services, p-130, in *National Policy for Children*, Indian Council for Child Welfare, New Delhi.

⁵⁸ UPSA, File No. 431/1951, Box no. 82, ‘Opening of fifty additional Maternity and Child Welfare Centers in the rural areas of the State’, Public Health Department.

⁵⁹ RAAUP, File No. 4(A), List No. 5, Box No. 32, Department- XXIII-49-50.

⁶⁰ UPSA, File No. 1098/50, Box No. 124, ‘Grant-in-Aid to Bal Chikitsalaya Kanauj’, Medical ‘B’ Department.

⁶¹ UPSA, Letter No. G-4/50/17, From Dr. Kartar Singh, CS Fatehgarh to DMHS, UP, dated 24 August 1950, in File No. 1098/50, Box No. 124, ‘Grant-in-Aid to Bal Chikitsalaya Kanauj’, Medical ‘B’ Department.

Dehradun, Etawah, Faizabad, Gorakhpur, Hamirpur, Lucknow, Mathura and Rae Bareilly for maternity and infant care education and health education for mothers and school children.

With independence, in the medical colleges of UP, maternity and paediatric sections were established in the State. In 1948-49 the government of U.P. decided to postpone all building projects to divert its resources towards the 'Grow More Food Schemes'. Reduction in financial commitment from the Central government exacerbated the difficulties of the U.P. government as it impacted the scheme of MCWC in rural areas.⁶² The issue desired utmost priority due to the sorry state of affairs in hospitals and dispensaries. For instance, when G. B. Kabaraji inspected the Rishikesh branch dispensary in July 1954, she felt the urgent need of lady doctor and women hospitals. A women hospital was promised in the district by Mr Shanti Prappan (M.L.A.) and Mr Bhargava, Secretary municipal board. In inspection it was found that in one room all kinds of operations (septic and aseptic) were carried out, there was no private ward, and basic necessities of dispensaries i.e. keeping of linen, examination table of the doctor, obstetric bed, sterilizer etc were far from satisfactory.⁶³ The condition of hospitals and dispensaries remained the same at every place with few exceptions; however, the condition of rural areas remained impecunious. Taking this into consideration, the government of UP sanctioned the construction of buildings for rural women's dispensaries with six beds during the year 1960-61 with the total cost of Rs. 12.75 lakh. Thus in 1960, 15 places in rural areas received nod for this scheme- Rishikesh, Goshainganj, Sirsaganj, Achnera, Bhonbahadurnagar, Bangarmau, Nanpara, Mohamdi, Bah, Navanagar, Powayan, Bewar, Masauli, Rath and Shahbad.⁶⁴

To provide an efficient ante-natal as well as post-natal domiciliary service, the State government launched a new maternity and childcare scheme in the State with the aid from WHO and UNICEF in 1953, by which 39 new MCWC were opened in the State.

⁶² UPSA, File No. 233/1951, Box No. 161, 'Proposal for opening additional rural allopathic dispensary under Medical Post War Reconstruction scheme and their inclusion in the SND for 1952-53', Medical 'B' Department.

⁶³ UPSA, Inspection remarks recorded by Dr. G.B. Kabaraji, Deputy Director, DMHS (Women) UP on occasion of her visit to Women's Hospital, Rishikesh, district Dehra Dun, on 2 July 1954 in File No. 350/1949, Box No. 21, 'Construction of Women Hospital at Rishikesh district Dehra Dun', Medical 'B' Department.

⁶⁴ UPSA, Letter No. 1750B/V-230/1960, From Sri. K.C.Joshi UP Sachiv Uttar Pradesh Sashan to Swasthya Sewa Nideshak, UP, Lucknow, dated 18 August 1960, in File No. 350/1949, Box No. 21, 'Construction of Women Hospital at Rishikesh district Dehra Dun', Medical 'B' Department.

A provision of Rs. 11,300 and 5000 was approved in the budget estimates in the year 1952-53 for the establishment of ten additional MCWC in the rural areas of U.P.⁶⁵ The DHMS insisted to increase the number of MCWCs to 100 in the rural areas. The proposal was rejected on account of financial constraints. Subsequently, the DMHS moved in 1950 the question of the establishment of fifty additional rural MCWCs in 1951-52, but the proposal was again deterred.⁶⁶ Due to continuous insistence, scheme for expansion of maternity and child care services in UP was started during 1953-54, provided for the opening of 50 rural centers and 65 maternity centers were sanctioned for the rural areas.⁶⁷ The urgent need for such centers in rural areas aroused again as the State had only 213 rural MCWC, which were too scanty. In order to boost the facilities for women and children in 1964-65, 133 MCHCs were taken over from the planning department.⁶⁸

For ante-natal care in hospitals of towns, services were provided on fixed days but the dearth of medical personnel supervising and conducting the work affected the success of the programme. As for instance, in the Dufferin hospital, Lucknow, the clinics held once a week and attendance per clinic was 200.⁶⁹ However, in smaller hospitals and in the rural areas, there were usually no separate days for ante-natal clinics. Further, hospital services lacked home follow up service, as reported that, '40 per cent of the ante-natal cases do not seeked hospital confinement with the result that authorities had no way of knowing whether the woman was dead or alive'⁷⁰ As regards the opening of a women's hospital at Jaspur in pursuance of resolution adopted by the Congress Workers Conference, DMHS opined that 'it would be difficult to find a suitable building since a maternity centre already exist at Jaspur, the question of opening a women's hospital there may not be considered for present.'⁷¹ I.G.C.H. recommended to the government that no request for the establishment of women's hospital in rural areas of the province should be entertained owing to the shortage of lady doctors.

⁶⁵ UPSA, Letter from Deputy Secretary to DMHS (H), in File No. 551/1951, Box No. 84, 'Opening of Maternity and Child Welfare Centers- Rampur district', PHD.

⁶⁶ UPSA, Letter No. IX-F-5675-W/12582, dated 28-2-1951, From DHMS to Deputy Secretary, in Ibid.

⁶⁷ Report on the General Administration of Uttar Pradesh, 1954, Lucknow, 1956, p-54.

⁶⁸ Annual Report of the State of Uttar Pradesh, 1964-65, Vol. I, p-143.

⁶⁹ Report on the State of health of Uttar Pradesh with particular reference to certain diseases, 1961, Lucknow, p-155.

⁷⁰ Ibid, p-156.

⁷¹ UPSA, Letter No. W 3303/ 19-W/45/B, From DMHS, U.P. Sri A.N. Das, dated 29 May 1951, in File No. 272/46, Box No. 56, 'Establishment of a Women's Hospital at Ramnagar, District Naini Tal', Medical 'B' department.

Owing to the shortage of lady doctors it was not possible to establish a large number of women hospitals and dispensaries in the rural areas of the State. It thus required the training of women in medical services so as to provide sufficient number of women doctors for hospitals.⁷²

Thereafter a scheme of PHCs each with four maternity centers came into existence under the First Five Year Plan. The medical facilities to expectant mothers during the ante-natal period and immediately after childbirth were scarcely available in rural areas. In the absence of maternity homes and trained medical personnel, expectant mothers usually have their delivery at home where they were attended by unskilled personnel. The percentage of infants attending the well-baby clinics too was low. Ika Paul stressed that although a good percentage of women took advantage of ante-natal services, very few of them return with their babies.⁷³ As the Report of the Ministry of Health states “hardly five per cent of the children are covered in the rural areas by health services indicating that the needs of children have not been sufficiently emphasized in the basic development programmes of the country. The existing services required to be reorganized and strengthened, for only very limited direct health programmes for children can be expected with the present staffing pattern of primary health centers.”⁷⁴

Table 5.6: Medical Centers established under the Special Component Programme

Medical care Centers	Number till 1-4-83	Achievements expected till 1984	Target for the year 1984-85
Allopathic hospitals/dispensaries	32	27	15
Ayurvedic hospitals/dispensaries	28	54	13
Homeopathic dispensaries	41	32	10
Primary Health Centers	11	6	5
Subsidiary health centers and buildings for women and children	81	54	25
Sub-health centers	772	80	360

Source: Uttar Pradesh, 1984, p-308

The issue of the lack of women hospitals especially in rural areas continued after independence as it was reported that in absence of women hospitals or female wards,

⁷² UPSA, Extract from the Letter dated March 14, 1947, From Deputy Commissioner Kumaun Division, in Ibid.

⁷³ Ika Paul Pont, *Child Welfare in India: an Integrated Approach*, Ministry of Education, GOI, 1963, Delhi, p-45.

⁷⁴ Cited in Ika Paul Pont, *Child Welfare in India*, p-52-53.

the lady doctor treated women in the corner of the male hospital and thus few women visited the hospitals due to lack of accommodation, purdah etc⁷⁵ and many infants and mother died during labour in the lack of proper medical help.⁷⁶ In the rural areas, the absence of women hospitals was also one of the chief reasons for high maternal mortality and morbidity.⁷⁷ The lack of hospitals forced people to cover the long distances. For instance, it was also reported that "...the means of conveyance is so slow and troublesome that a female patient cannot be taken to it easily. We have to go by deteriorated pukka road for about 10 miles to catch a train for either to Kasganj or to Farrukhabad. This is not an easy journey for a patient."⁷⁸ Ghokhale and Sohoni lamented that the healthcare in the country concentrated on 'non-perambulatory and institutional approaches with the onus of healthcare lying on the medical centre and the doctor. In the existing system, the health service programme is pivoted around metropolitan and capital cities serving as centers, with the coverage of rural areas being attempted through intermediate institutions such as regional and district hospitals and PHCs and sub-centers. The coverage and quality of health thus rendered is at its best in the centers, gradually diminishing in intensity at the intermediate levels and substantially failing at the lower or peripheral levels.'⁷⁹

Table 5.7: Facilities for Maternal and Child Health in 1978 in Uttar Pradesh

Rural					Urban									
C. D. Blocks	No. of PHCs functioning	No. of Sub-Centers functioning			Other Medical Institutions	F.P. centers	MC HC	Maternity centers	Maternity Hospitals	Maternity wards in General hospitals	Children's hospital	Children's wards in General hospitals	No. of Maternity beds	No. of Children's beds
		Health sector	F.W. programme	Total										
875	875	2,625	4,375	7,000	N.A.	214	133	34	199	146	1	13	7,818	609

Source: E.V. Sebastian, Maternal and Child Health Programmes in India, p-338-339 in K. Srinivasan, P.C. Saxena, Tara Kanitkar, (ed.), *Demographic and Socio- Economic Aspects of the Child in India*, (Bombay: Himalaya Publishing House, 1980).

⁷⁵ UPSA, File No. 193/53, Box No. 178, 'Opening of Women's Hospital at Rasra District Ballia', Medical 'B' Department.

⁷⁶ UPSA, File No. 236/1955, Box-173, 'Establishment of Women's Hospital at Raya District Mathura', Medical B Department.

⁷⁷ Danik Bharat, Varanasi, 22 December 1958.

⁷⁸ UPSA, Letter from Raj Bahadur Chairman, Town Area Committee Aliganj to Secretary, Health department, U.P Government, Uttar Pradesh, dated 7 Feb 1955, in File No. 34/55, Box No. 171, 'Establishment (and construction) of Women Dispensary (Building) at Aliganj, district Etah', Medical 'B' Department.

⁷⁹ Sharad D. Gokhale and Neera K. Sohoni, Overview, p-280, in Sharad D. Gokhale and Neera K. Sohoni (ed.), *Child in India*, Somaiya Publications, New Delhi, 1979.

For paediatrics, the independent government apart from the establishment of MCWC was keen to develop institutions specifically dealing with children. Accordingly, Sarojini Naidu Memorial Children's Hospital at Allahabad was sanctioned on 20 November 1954 with a sum of Rs.2,75,000 provided by the government.⁸⁰ The opening of the children's hospital in Lucknow at a cost of approximately Rs. 3,00,000 which was a part of the comprehensive scheme was undertaken in 1953.⁸¹ Under construction buildings programmes in connection with the provision of specialist treatment for children's diseases at Meerut and Varanasi was initiated in 1956.⁸² Further, a proposal for dental clinics and clinics for specialist treatment of children's diseases were also approved by the government for these hospitals.⁸³ In 1962-63, a children's clinic was established at the Doon hospital, Dehra Dun⁸⁴ and a paediatric unit with 50 beds were started at Agra Medical College and a 60 bedded children's hospital was established in the Lucknow Medical College in 1962.⁸⁵ In 1964-65, children's clinics were opened at Moradabad, Aligarh, Basti⁸⁶ and child guidance clinics at Agra and Varanasi were established for looking after cases of children referred by the Reformation Officers, to Directors who were considered authorities in the field of child psychology.⁸⁷ The government of UP to facilitate leper children in 1952 decided to open a sanatorium building for leper children at Faizabad.⁸⁸ Not only government but some voluntary organizations played a significant role in the development of paediatric services. For instance, 'Missions to Lepers' raised an amount to construct a sanatorium for looking after the general health and taking care of children of lepers at Faizabad.⁸⁹ Apart from the establishment of institutions, many other facilities such as x-ray and pathology department for the benefit of children was endowed to Chacha Nehru Children's

⁸⁰ UPSA, File No. 769/50, Box No. 6, 'Acquisition of land for the Construction of Sarojini Naidu's Children Hospital, Allahabad, Medical 'A' Department, 1954.

⁸¹ Annual Report of the Activities of Medical and Public Health Department, 1953-54, Uttar Pradesh, Lucknow, 1954, p-5.

⁸² Report on the General Administration of Uttar Pradesh, 1956, Lucknow, 1959, p-263.

⁸³ Report on the General Administration of Uttar Pradesh, 1957, Lucknow, 1960, p-284.

⁸⁴ Annual Report of the State of Uttar Pradesh, 1962-63, Lucknow, 1965, p-124.

⁸⁵ *Uttar Pradesh Annual 1962*, Information Department, 1963, p-103.

⁸⁶ Annual Report of the State of Uttar Pradesh, 1964-65, Vol. I, Lucknow, p-148.

⁸⁷ Annual Report of the State of Uttar Pradesh, 1962-63, Lucknow, 1965, p-185.

⁸⁸ UPSA, File No. 341/51, Box No. 123, 'Acquisition of Land for Construction of Sanatorium Buildings for Children at Faizabad', Medical 'B' Department.

⁸⁹ *Ibid.*

Hospitals, Cooperganj, as the hospital had 100 beds and about 41,500 children were treated for various diseases and ailments.⁹⁰

During the Fifth Plan, a Minimum Needs Programme (MNP) was launched by the GOI. Under this programme, the UP government decided that some selected PHCs to be upgraded to serve as a referral rural 30-bed hospitals by providing surgical, gynaecological and physicians services.⁹¹ The training programme was started during the Sixth Plan period. However, due to half-hearted approach, these planning had limited application on grounds. Specialist services were promoted by the government that by the end of 1985 there were 171 paediatric centres in the hospitals of the State.⁹² Together with these improvements effected in the Agra Medical College, a paediatric unit with 50 beds also started. By the end of the year 1987-88, there were 222 children's clinics functioned in the State and some 42 more such clinics were proposed to be set up in the year 1987-88 and another 31 in 1989-90.⁹³

Table 5.8: Statistics relating to Maternity and Child Health Services

Years	Maternity Hospitals		Maternity Wards in General Hospitals		Paediatric Hospitals		Paediatric Wards in Hospitals		Maternity Homes		M.C.H centers		
	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds	Rural	Urban	Total
1961	91	881		2,428	1	184	13	425	10	98	1,453	127	1,580
1962	91	2,206		2,428	1	184	13	425	10	98	1,843	127	1,970
1963	199	2,416	183	2,708	1	184	13	425	39	138	1,843	127	70

Source: Data compiled from GOI, Health Statistics, 1961-62; 63.

The above development reflects that development in paediatrics was progressing well yet if we compare the ratio with other states of the country, these reforms appear to be piece-meal services. Out of the total number of paediatric hospitals in the country, around 43 per cent in Rajasthan and 33 per cent were established in Maharashtra i.e. around 76 per cent of the total number of paediatric hospitals were existed in these two states of the country (Appendices).⁹⁴ The same condition goes with the beds for paediatrics also. States of the country except the above mentioned were more inclined arranging beds in the paediatric ward in hospitals rather than working on building paediatric hospitals. As the other alternative i.e. MCHC were established in all states

⁹⁰ Uttar Pradesh, 1985, p-243.

⁹¹ Uttar Pradesh, 1977, p-232.

⁹² Uttar Pradesh, 1985, p-295.

⁹³ Uttar Pradesh, 1988-89, p-151.

⁹⁴ Health Statistics, 1961-63.

of the country except Bihar, J&K and Tripura. UP had established the highest number of MCHC in the country both in rural (1843) and urban (127) areas.⁹⁵ Although the building of hospitals and dispensaries continued in the rural areas, yet the State failed to deliver the actual requirements of the people. All these hospitals and dispensaries lacked new born departments and thus paediatric supervision of the new born was unavailable such as lack of incubators etc. in the hospitals.⁹⁶

Even though PHCs were catering to the need of people, the system failed to develop a hierarchy and communication from PHC to the district hospital to the big hospitals in urban areas. The urban bias of the government continued after independence too where more beds in hospitals and specialized services were available for women and children than in rural area. Even research and training institutions of medical and para-medical staff too carried out in urban areas and the personnel's produced by them were also urban oriented. When Bierman toured the country, she found that services for infants and children were inferior in both quantity and quality because of 'general policy and partly because few at the personnel in the centers had training in paediatrics and child care.'⁹⁷

BUILDING THE STRUCTURE FOR PAEDIATRICS

Bierman observed that "A 'well-baby' is seldom if ever seen in an MCH centre in India"⁹⁸ Consequently, for strengthening the medical structure of paediatrics, efficient paediatricians, nurses, midwives and development of teaching and training courses was the urgent requirement after independence. The Second Plan of the Medical and Health Department, U.P. considered enhancing the strength of doctors, nurses, and other medical and health personnel in the State. As the doctor-population ratio in U.P. by the end of the Second Plan was 7900 i.e. about 1:7640,⁹⁹ on the other hand, the lack of paediatrician in the country could be glanced from the fact that there were 121 paediatricians in the country instead the requirement of 9,000.¹⁰⁰ To cope with this

⁹⁵ Health Statistics 1961-63.

⁹⁶ P. Robinson, Maternal and Child Health Services in South East Asia (I) India, *Journal of Tropical Paediatrics*, Vol. 1, No. 4, March 1956, p-223.

⁹⁷ Jessie M. Bierman, Report on Observations of Maternal and Child Health Problems and Activities in India, *Journal of Tropical Paediatrics*, Vol. 2, No. 2, September 1956, p-129.

⁹⁸ *Ibid*, p-130.

⁹⁹ Uttar Pradesh, 1971, p-178.

¹⁰⁰ M. B. Kagal, Scope of Maternity and Child Welfare, p-117, in Indian Council for Child Welfare, *A National Policy for Children*, New Delhi, February 1964.

shortage of doctors in the U.P., government sanctioned a new medical college at Kanpur in 1957 with an annual intake of 100 students per year, which was further raised to 150 in 1960-61. Even the Central government too made a provision of 45 lakh to improve paediatric services at hospitals attached to medical colleges, provide better facilities for teaching of paediatrics and paediatric training schemes at medical colleges in Madras, Bombay, Hyderabad, Trivandrum, Agra, Darbhanga and Dibrugarh.¹⁰¹

Table 5.9: Distribution of Health services in Rural and Urban areas in UP

Medical Graduates holding Public Health Qualifications				Medical Licentiates holding Public Health Qualifications				Epidemic Staff	Sanitary Health Inspectors		School Medical Officers		Other Health Staff	
Wh ole time		Par t tim e		Wh ole time		Par t tim e			Rur al	Urb an	Rur al	Urb an	Rur al	Urb an
89	39			30	17			180	502	371		14		

Source: Health Statistics, 1959-60.

Medical institutions and trained medical practitioners both were higher in urban areas than in rural areas. The situation was more or less the same as in every state with few exceptions. For instance, Kerala balanced the rural-urban disparity in the institutions and medical personnel.¹⁰² Unfortunately, the situation in UP was no different in comparison to other states. Its position remained unsatisfactory as it lacked medical institutions especially in rural areas. The lowest number of doctors and para-medical staff of 0.14 and 0.30 per 1000 population respectively were available in UP.¹⁰³ The high number of untrained medical practitioners affected not only the health of people but children's survival also. The rural areas outnumbered urban areas in untrained medical practitioners not only area-wise but within the whole country. A survey conducted showed that among infants about 66 per cent of the deaths were not attended by trained medical practitioners in the rural while in the urban areas, the percentage is 33.¹⁰⁴ Among child deaths in the age group of 1-5 years, the percentages of the child deaths not attended by trained medical practitioners in the rural and urban

¹⁰¹ Central Health Education Bureau, *M.C.W. Services in India*, DGHS, GOI, New Delhi, 1960, p-12

¹⁰² GOI, *Survey on Infant and Child Mortality, 1979*, Office of the Registrar General, India, Ministry of Home Affairs, New Delhi, 1980, p- 703.

¹⁰³ Moonis Raza & Sudesh Nangia, *Atlas of the Child in India*, 1986, p-234.

¹⁰⁴ GOI, *Survey on Infant and Child Mortality, 1979*, p- 700-10.

areas was 41 and 16 respectively.¹⁰⁵ Thus, the proportion of infant deaths not attended by trained medical practitioners was more as compared to child deaths both in the rural and urban areas. Further, around 40 per cent of the morbidity among children was attended by medical institutions and 30 per cent by untrained practitioners in the rural areas. It can also be seen from the table below that more attention was given to children below one year of age who are sick than the grown-up population. In the case of urban areas, 66 per cent of children attended by the medical institutions. Thus in the urban areas most of the sick children were attended by medical institutions or trained medical practitioners irrespective of the age of the children in comparison to the rural areas. The percentage of births attended by medically trained personnel in 1978 (including in medical institutions) varied from a low of 6 per cent in U.P. to 62 per cent in Kerala. Around 79.8 per cent of the births in U.P. were undertaken by untrained medical practitioners.¹⁰⁶ The reduction in infant and child mortality and morbidity to a great extent required the availability and accessibility of infrastructure facilities especially in the rural areas, which the State evidences slow growth rate.

Table 5.10: Per cent distribution of live births by type of medical attention at birth in 1971 and 1978

India/ State	Year	Type of Medical attention at birth					
		Rural			Urban		
		Medical Institutions	Trained Medical Practitioners	Untrained Medical Practitioners	Medical Institutions	Trained Medical Practitioners	Untrained Medical Practitioners
India	1971- 73	7.6	11.2	81.2	32.1	25.0	42.9
	1976- 78	7.1	9.4	83.5	43.1	23.1	33.8
U.P.	1971	0.4	4.2	95.4	11.7	34.8	53.5
	1978	0.3	5.7	94.0	13.8	49.4	36.8

Source: Sample Registration System, 1970-75, pp-71, 79-191; Sample Registration System, 1976-78, pp-18-19; GOI, *Survey on Infant and Child Mortality, 1979*, Office of the Registrar General, India, Ministry of Home Affairs, New Delhi, 1980, p- 703.

Ashok Kumar argues, “The Maternal and Child Health (MCH) programme has been accorded high priority at the official level but the MCH coverage is substantially lagging behind the all-India levels. Targets for the six programme forming part of MCH i.e. tetanus oxide for pregnant mother, DPT for children 0-2 years, DT for children 2-11, Iron and Folic for pregnant women and children, Vitamin A for children up to 6 years are set at 20-25 per cent of the target population. On an

¹⁰⁵ Ibid.

¹⁰⁶ Moonis Raza & Sudesh Nangia, *Atlas of the Child in India*, 1986, p-238.

average, nearly 70 per cent accomplished.”¹⁰⁷ The same study enlightens us with the fact that 65 per cent of deliveries were assisted by family members and the mortality risk among them is extremely high. The institutional deliveries in rural areas were less than 5 per cent, trained dais assist in 13 per cent, untrained in 10 per cent and ANMs in 7 per cent of deliveries. Only 18 per cent of the deliveries were handled by trained personnel. Of these large proportions i.e. 48 per cent conducted by the trained dais. About 90 per cent deliveries were non-institutional and the proportion of such deliveries was the highest among minority and weaker section. The urban-rural dichotomy was the most significant of all the inequalities in India’s health services systems although a subject of discussion. Although the resources were concentrated in urban areas, even then urban population did not get the benefits of the series of hospitals. Even the government accepted in 1970 that not more than 11 per cent of the home deliveries in rural areas attended by any kind of trained personnel, even though 93 per cent deliveries conducted at home.¹⁰⁸ The inaccessibility of PHCs and the inability to pay fees of medical personnel’s left poor people especially in rural areas at their own fate.

Table 5.11: Per cent distribution of children by type of medical attention received when sick, 1978.

Area	Type of Medical attention	Age					
		Below 1 year	1 year	2 years	3 years	4-6 years	All classes
Rural	Medical Institutions	50.35	41.24	36.51	38.67	38.54	39.76
	Trained medical practitioners	30.50	35.57	30.21	28.89	29.43	30.44
	Untrained medical practitioners	19.15	23.19	33.20	32.44	32.03	29.80
Urban	Medical Institutions	79.36	73.91	60.84	58.14	62.57	65.99
	Trained medical practitioners	19.35	21.74	31.33	37.21	31.74	29.05
	Untrained medical practitioners	1.29	4.35	7.83	4.65	5.69	4.96
Total of State	Medical Institutions	65.54	56.05	46.44	47.10	47.00	50.54
	Trained medical practitioners	24.66	29.30	30.71	32.50	30.74	29.87
	Untrained medical practitioners	9.80	14.65	22.85	20.40	22.26	19.59

Source: Moonis Raza & Sudesh Nangia, *Atlas of the Child in India*, 1986, p-709-710.

During the earlier days in the country, regarding the complementary training in maternity and child welfare, only 123 general practitioners registered for Diploma in Medical and Child Welfare course organized by AIIHPH, Calcutta. This one year

¹⁰⁷ Ashok Kumar, Health and Family Welfare Programme in Uttar Pradesh: An Over-view, pp-128-129, in M. E. Khan, R. B. Gupta, C. V. S. Prasad, S. Ghosh (ed.), *Performance of Health and Family Welfare Programme in India*, (Delhi: Himalaya Publishing House, 1988).

¹⁰⁸ GOI, Fifth-Five Year Plan 1974-79, Ministry of Health and Family Planning, Department of Family Planning, New Delhi, 1974.

course was designed to prepare doctors in general public health and in maternal and child health with special reference to prevention of disease and promotion of healthcare for the children.¹⁰⁹The unpopularity of the course had a long term impact on the paediatric care due to inadequate availability of specialized doctors for children, especially in rural and tribal areas. For instance, in 1987, total of 457 students were trained in the course.¹¹⁰Out of these students, there was not a single student from Uttar Pradesh registered in the course while West Bengal had the highest enrollment in the country with 17 students.¹¹¹The reason of ignorance by the students of this course was uncertainty of their carrier as paediatrician as on one hand they cannot get teaching posts in paediatrics on the other hand they would not 'accept or be accepted service in peripheral MCH centers, especially males.'¹¹²

Table 5.12: Percentage distribution of state of undergraduate paediatric education in India, 1970

Status of Paediatric departments		Teaching staff			Teaching of Peri-natal Pediatrics			No. of Doctors				
Autonomous	Part of Department of Medicine	Professor	Associate Professor	Lecturer	Pediatrician	Obstetrician	Pediatrician jointly with Obstetrician	> 25	10	5-10	3-5	< 3
75	25	57	12	31	55	11	30	3	11	43	33	10

Source: M. Nagaraj Rao and Harish Chandra, Present Status of Pediatric Undergraduate Education in India, *Indian Pediatrics*, Vol. X, No. 2, 1973, p-124.

As the State lacked the teaching facilities in paediatrics, the Principal of S. N. Medical College Agra requested to start a course for Diploma in Child Health and Diploma in Maternity Services.¹¹³ For building the structure for paediatrics, U.P. government during the First and Second-Five year plan, at S. N. Medical College Agra (Former Agra Medical College) gave nod to the degrees of Doctor of Medicine and Diploma in Child health was recognized by both the Medical Council of India and General

¹⁰⁹ Ika Paul Pont, *Child Welfare in India: an Integrated Approach*, 1963, p-106.

¹¹⁰ Annual Report of All India Institute of Hygiene and Public Health, 1st July 1986 and 30 June 1987, Calcutta, p-X.

¹¹¹ Ibid, p-23-24.

¹¹² P. Robinson, Maternal and Child Health Services in South- East Asia (VII) Critical Discussion, *Journal of Tropical Paediatrics*, December 1957, Vol. 3, No. 1, p-117.

¹¹³ UPSA, Letter from DMHS. Lucknow to Secretary to Government UP, dated 25 August 1951, in File No. 37/1951, Box No. 50, 'Starting of Diploma course for Diploma in Child Health at the Sarojini Naidu Medical College, Agra', Medical 'A' Department.

Council of Great Britain.¹¹⁴ Though the S.N. hospital had 20 in-door children's bed, which was considered insufficient for the six post-graduate students to study child health, it was thus decided to expand these arrangements. The proposal of teaching paediatrics got an approval of the Governor of UP in 1951.¹¹⁵ Students were required to complete one month of clinical experience in paediatrics. On the other hand, in the M.B.B.S examination of the State, there was no separate paper on the paediatrics subject. It thus became inevitable to develop a course for training of paediatricians in the State. The Committee on Medical Education later recommended that instructions in paediatrics should be of three months duration and clinical experience should be arranged in the wards and outpatients departments and also at MCWCs. These decisions laid the foundation of teaching and training of paediatrics in UP. Yet the lack of qualified teachers to train these future paediatricians failed to attract the attention of the State. Robinson stated that only three paediatric teachers in the whole India had the title of professor, one in Madras and two in Calcutta.¹¹⁶ It was AIIHPH Calcutta which offered ten months course in MCW and all MCH officers were graduates of the Institute.¹¹⁷ Measures were taken to improve the quality of teaching and services with the help of the WHO by giving a refresher course. Under this, in 1962-63, one sister tutor was deputed for two months refresher course in paediatric nursing.¹¹⁸ Training in the nursing of the child was an essential requirement of the general nursing course and a hospital not recognized for training unless there were at least eight beds for children. To improve both the training and practice of paediatric nursing, a number of short courses in the subject started in U.P. from 1951. In 1956, the Indian Nursing Council recommended that 'the student should get six to eight weeks experience in the domiciliary field including work in MCH centre during the second or third year of training and that midwifery students should get the experience of ante-natal and post-natal home visiting domiciliary midwifery and work in the MCH clinic.'¹¹⁹ In 1958, it was reported that 120 schools gave training in domiciliary

¹¹⁴ Gazetteer of India, Uttar Pradesh, District Agra, 1960, p-291.

¹¹⁵ UPISA, Extract from the letter of K.P. Srivastava, Officer on Special duty to Government U.P. to DMHS, Lucknow, dated April 1953, in File No. 37/1951, Box No. 50, 'Starting of Diploma course for Diploma in Child Health at the Sarojini Naidu Medical College, Agra', Medical 'A' Department.

¹¹⁶ P. Robinson, Maternal and Child Health Services in South East Asia (I) India, *Journal of Tropical Paediatrics*, Vol. 1, No. 4, March 1956, p-225.

¹¹⁷ P. Robinson, Maternal and Child Health Services in South East Asia (I) India, *Journal of Tropical Paediatrics*, Vol. 1, No. 4, March 1956, p-223.

¹¹⁸ Annual Report of the State of Uttar Pradesh, 1962-63, Lucknow, 1965, p-125.

¹¹⁹ Ika Paul, p-109.

midwifery and about 60 schools in the country had arranged for their students to get the experience of home visiting.¹²⁰ DHMS at the inaugural address of Indian Academy of Pediatrics (IAP) mentioned that in the field of paediatric education, not only nine independent paediatric departments were established in the medical colleges of the State, but services facilities like neonatology at Lucknow and paediatric surgery at Allahabad were also started.¹²¹

Public health nurses had no significant role in MCH services instead lady health visitors were the key personnel in all MCH work. In order, to meet the demand for trained personnel, schools for the training of midwives and health visitors were promoted by the government. Under the Second Plan, six schools for the training of ANM were also opened¹²² and six centres for training nurses were established at S. N. Hospital Agra, Lady Lyall Hospital Agra, Lala Lajpat Rai hospital Kanpur, Ursula Horsman Memorial Hospital Kanpur. Even then, the country suffered from the scarcity of the most needed grassroots workers, as only about 5000 came out of training schools. Due to this lopsided growth till 1982, there were only 162,875 nurses, 156,870 midwives, 80,012 ANMs and 10,912 health visitors¹²³ in the country, which proved insufficient for such a large population.

Table 5.13: Distribution of health workers for pediatrics in UP, 1964

	Registered during 1964	Progressive registered up to December 31, 1964	total Registered till 1981
Nurses	293	3,436	7516
Midwives	233	2,695	10124
Health Visitors	62	597	2724
Auxiliary Midwives	110	360	8576
Assistant Midwives	6	1,330	

Source: Annual Report on the Administration of UP, 1964-65, p-153.

Since the beginning of the Fourth Plan, a Health Visitors Training School established at Agra¹²⁴ and forty-two ANM training centers were also started in the State. In rural areas, a scheme was introduced in 1952 for granting subsidies to women vaidyas and tabibas. For the purpose, in 1969-70 grants amounting to Rs. 1,17,985 sanctioned to

¹²⁰ Ibid.

¹²¹ D. N. Sharma, Inaugural Address for the Scientific session of the IX National Conference of Indian Academy of Pediatrics, Lucknow, in *Indian Pediatrics*, Vol. 9, No. 9, 1972, p-493.

¹²² Report on the General administration of U.P., 1956, Lucknow, 1959, p-257-58.

¹²³ GOI, *Health Statistics of India*, 1983, CBHI, p-104.

¹²⁴ Uttar Pradesh, 1971, p-179.

109 vaidyas and hakims.¹²⁵ Under this scheme, a centre was opened at Alambagh, Lucknow in October 1951 to provide training to *gram sevikas*. At the end of 1951, a batch of 20 *gram sevikas* was given a four months training with a comprehensive syllabus. In 1952, there were 60 women's welfare centers; each centre comprising three to four villages and having three *gram sevikas*- one trained in adult and preschool education and physical culture, another in midwifery and the third in crafts. The centers were also provided with maternity boxes to enable them to handle maternity cases. 33 *gram sevikas* were trained in midwifery and 48 in other subjects.¹²⁶ Under the scheme, the *gram sevikas* move from door to door advising the mothers and collecting the *balbari* children. Creation and training of *balsevikas* undertook by the Central Social Welfare Board and entrusted to the Indian Council for Child Welfare.¹²⁷ During the year, 1964, 1,55,887 children took advantage of the various facilities offered by 5,585 *balbari*'s.¹²⁸ In all 5,548 Mahila Mandals with a memberships of 1,23,823 women and 5,209 Yuwati Mangal Dals with a membership of 1,02,209 Yuvatis dals were formed. 11 camps for associate women workers were organized at different Gram Sevika Training Centres and 350 *gram sevikas* were imparted training in fruit preservation, applied nutrition programme, agriculture, animal husbandry, first aid etc.

There were large nursing homes in U.P. as in Bombay except in few KAVAL towns which had a few beds attached to the MCWCs meant purely for normal cases but without any ancillary services. The most that was done in the institutions was to apply forceps for a delayed labour case.¹²⁹ Thus in order to introduce aseptic midwifery services in the rural areas, the UP government started from 1948 the training of village dais who received nine months training under the midwife of the centre. However, for untrained dais, there was no legislation. In the urban areas, the municipal bye-laws dealt with the registration and licensing of dais, but they were not well enforced, consequently many cases of toxemia of pregnancy were admitted to hospitals.¹³⁰ Women in rural areas did not travel long distance for common ailments

¹²⁵ Uttar Pradesh, 1972, p-192.

¹²⁶ Report on the General Administration of U.P. 1952, Lucknow, 1954, p-41.

¹²⁷ Ika Paul, p-121.

¹²⁸ Annual Report of the State of Uttar Pradesh, 1964-65, Lucknow, Vol. I, p-16.

¹²⁹ Ashok Kumar, Health and Family Welfare Programme in Uttar Pradesh: An Over-view, p-157, in M. E. Khan, R. B. Gupta, C. V. S. Prasad, S. Ghosh (ed.), *Performance of Health and Family Welfare Programme in India*, (Delhi: Himalaya Publishing House, 1988).

¹³⁰ Ibid, p-158.

and they consult in MCWC or dispensaries only for serious obstetric and gynaecological ailments. To meet this problem, at each MCWC, five indigenous *dhais* were given training in midwifery under the scheme in 1949. These five *dhais* were given a scholarship of Rs. 14-20 to each candidate.¹³¹ Further at each women hospitals and women wings in the hospitals, trained midwives were appointed by the government. For the maintenance of non-government women hospitals and dispensaries, government sanctioned a grant of Rs. 1,18,513 in 1959. There were some arrangements at each rural centre for the training of village *dhais* and scholarships were allowed to the trainees. It was also decided by the government to make a free supply to each successfully trained *dhai* of medicines and other necessary medical aids. As *dhai* was popular and trusted in the rural areas, government instead of replacing them provided training and kits.

The dearth of women doctors also continued. With a view, moreover, to encourage girl students to join the MBBS course in larger numbers at the KGMC, Lucknow, three more scholarship of Rs. 30 per for a period of five years was sanctioned, making a total of 6 such scholarships.¹³² Besides three stipends of Rs. 25 each for two years compounders training course and three stipends for combined training in midwifery and compounding were sanctioned for the girl students, in addition to the 25 stipends of Rs. 20 each for the training of certificated midwives in the women's and Dufferin hospitals, for appointment in rural dispensaries.

Lack of coordination at the government and voluntary level effected pediatric care policy implementation. Firstly, government had weak administrative structure and secondly the dependence of voluntary agencies on the government grants and international aid, consequently, independent existence of an agency to deliver the needs of paediatrics was hampered. Some agencies worked in isolation or treated any individual programmes. As teaching and training in paediatrics was underdeveloped, the State (and country) faced the dearth of specialized doctors and field level workers for implementing the programmes of the State. Family planning, school health programmes and MCH programmes worked independently which not only created an acute shortage of trained personnel, thus their working together could had economize men, means, material and services.

¹³¹ Sanyukt Prant ki Samanya Prashashan ki Report, 1949, Allahabad, 1951, p-162

¹³² Report on the General Administration of the United Provinces 1946, Allahabad, 1949, p-117.

GOVERNMENT NUTRITIONAL PROGRAMMES FOR THE PAEDIATRICS

Independence arrived with a huge challenge of lackadaisical economic condition where agricultural productivity was low and underdeveloped industries, which explicitly impacted the health and nutritional status of the people in the country. When the death rate declined after the expansion of medical services, the population increased thereby increasing the demand of nutritional food. The Nutrition seminar of ICMR in 1985 noted that the nutrition situation in India 'has remained more or less static without showing any sign of further deterioration nor any overall improvement of significant nature.'¹³³ The seminar suggested for orientation courses for the supervisors of AWW organized on a continuing basis and adequately strengthening of the training centers of the AWW and maximum emphasis laid on the training of mid-level nutrition managers in supervision, support and nutrition management.¹³⁴

Malnutrition accelerated the health problems of the children and was undermined by the policy makers and thus one of the chief reasons that child mortality in UP was highest in the country. As Gopalan in his study reported that 'the preschool child mortality rate has been more or less stationary, amounting to 40 per cent of the total deaths in the country'¹³⁵ and in 90 per cent children the height and weights were below the tenth percentile values of American children of corresponding ages. 18 per cent children suffered from grade III malnutrition (weight deficits of 40 per cent or more), 65 per cent from grade II, and 14 per cent from grade I malnutrition (weight deficits of 25-40 per cent and 10-25 per cent respectively).¹³⁶ Another study conducted by the ICMR reflected nutritional morbidity pattern in terms of the prevalence of nutritional deficiency in the two age groups i.e. 1-5 and 5-12 years, as this age group constituted about 40% of the total population and were thus nutritionally vulnerable. The data suggests that the 5-12 year group suffered more from the vitamin deficiency signs as

¹³³ Dr. B. N. Saxena and Dr. Kalyan Bagchi, Towards Nutrition Implementation of a National Nutrition Policy in India, Report of a National Seminar, Srinagar, 28-30 October 1985, ICMR, 1986, p-5.

¹³⁴ Ibid, p-10.

¹³⁵ C. Gopalan, Special Problems and Preventive Programmes- India, *Journal of Tropical Paediatrics*, 14, 1968, p-228.

¹³⁶ C. Gopalan, 'Some Aspects of Nutrition in India', p-103 in Ashish Bose, P.B. Desai, Ashok Mitra and J.N. Sharma (ed.), *Population in India's Development 1947-2000*, (New Delhi: IASP Publication, 1974).

compared to 1-5 years age group.¹³⁷ Protein-calories malnutrition and vitamin A deficiency was thus a major public health problem among children.¹³⁸ As a large number of malnourished children came from the low-income group, that's why nutrition programmes were included in the First Plan of the Indian government. The chief nutritional programmes of the government were the mid-day meal scheme, milk feeding scheme, Applied Nutrition Programme, etc. There were several nutritional interventions of the Central and State governments formulated time to time as per requirements. As the Ministry of Health initiated many health programmes such as National Prophylaxis Programme, prophylaxis programme against blindness due to vitamin A deficiency, Goitre Control programme- iodised salt,¹³⁹ nutritional programme for pre-school children through *balwadis*.

One of the earliest supplementary feeding programmes of UP was initiated in 1951. The Nutrition Advisory Committee recommended on the suggestion of Dr R. K. Mukherjee that milk distribution scheme subsidised by the State government in Lucknow, to be made permanent and extended to all schools in Lucknow and Kanpur, the beneficiaries being the children below the age of 12 years of age. This scheme was approved by the government for the supply of milk to primary school children as also to MCWCs at Lucknow and Kanpur.¹⁴⁰ Under the subsidized scheme at Lucknow, every boy and girl of primary schools got 8 oz. of milk, every alternate day, while under the private scheme which was started at girl's school only every scholar got 8 oz. of milk daily. In Kanpur, the scheme was a combined one, for the primary school children unlike the Lucknow and also for the MCWCs.¹⁴¹ Multi-vitamin tablets also distributed at maternity centers and to SHOs provided to expectant or nursing mothers and to school children. Similarly, the UP branch of IRCS, Lucknow supplied skimmed milk to primary school children at Agra.¹⁴²

¹³⁷ N. Prahlad Rao and J. Gowrinath Sastry, Nutrition Profile in India Over a Decade, p-26 in Dr. B. N. Saxena and Dr. Kalyan Bagchi, Towards Nutrition Implementation of a National Nutrition Policy in India, Report of a National Seminar, Srinagar, 28-30 October 1985, ICMR, 1986.

¹³⁸ Kamala S. Jaya Rao, Protein Calorie Malnutrition, *Indian Journal of Medical Research*, 68 (Suppl.), October 1978, p-17.

¹³⁹ P. C. Sen, Nutritional Interventions of the Health sector, pp-58-59 in Dr. B. N. Saxena and Dr. Kalyan Bagchi, *Towards Nutrition Implementation of a National Nutrition Policy in India*, Report of a National Seminar, Srinagar, 28-30 October 1985, ICMR, 1986.

¹⁴⁰ Report on the General Administration of the United Provinces 1946, Allahabad, 1949, p-19.

¹⁴¹ *Ibid*, p-116.

¹⁴² District Gazetteer of Uttar Pradesh, Agra, p-330.

In 1954, General feeding programme was launched by the UP government. In this scheme, distribution was made through hospitals, MCHCs, orphanages, educational and other institutions dealing with the children up to the 14 years of age, managed both by State or voluntary organizations. Under this scheme, milk was allotted to municipal MoH of Agra, Benaras, Lucknow, Bareilly, Jhansi, Saharanpur, Shahajahanpur and Allahabad. They were made responsible for supplying milk separately to educational institutions under the school-feeding scheme. Even some schools and colleges in Benaras introduced milk feeding schemes in their educational institution, for instance at Kanpur the scheme was executed by Lal Imli and Elgin Mills for their primary schools.¹⁴³

A provision of Rs. 450 lakh was made in the milk-supply scheme during the Third Plan. There were 16 cooperative milk supply unions in the State till 1963. Out of these 16, six such unions were organized in Meerut under the Delhi Milk Supply Scheme. Other unions were operated at Lucknow, Allahabad, Varanasi, Kanpur, Meerut, Haldwani, Almora, Dehra Dun, Bareilly and Aligarh. The Supply of these unions in 1962-63 was 3.63 lakh maunds as against 3.05 lakh maunds in 1961-62. Another supply union was established at Agra in 1963. A programme of milk supply to children aided by UNICEF was started at Kanpur. During 1962-63, a scheme to start a new milk dairy in Bareilly was initiated and foreign exchange was also promised to implement a scheme of opening a new milk dairy at Dehra Dun.¹⁴⁴ In 1963-64, the children of goldsmiths and 30 expectant and nursing mothers of Allahabad were provided with milk powder daily when the goldsmiths were disturbed by the Gold Control Order of 1962.¹⁴⁵

Along with U.P. government, UNICEF played a significant role in improving the nutritional status of children. During the year 1950, the children below 12 years of age who were malnourished and pregnant mothers were distributed milk powder by UNICEF¹⁴⁶ and in 1952, 4,00,000 lb. of skim milk powder and 2,00,000 lb. for feeding expectant and nursing mothers and children of 14 years was provided by UNICEF. Some of the milk was also distributed through general relief centers in scarcity

¹⁴³ Annual Report on Public Health Department in Uttar Pradesh for the year 1951, Lucknow, 1957, p-12.

¹⁴⁴ Annual Report of the State of Uttar Pradesh for the year 1962-63, Lucknow, 1964, pp-107-108.

¹⁴⁵ District Gazetteer, Allahabad, p-315.

¹⁴⁶ Uttar Pradesh ke Samanya Prashasan ki Report, 1951, Allahabad, 1952, p-44.

areas,¹⁴⁷ and by UNICEF through the Directorates of Health Services, and institutions, like schools and other dealing with groups of children, Allopathic, Homeopathic or Ayurvedic hospitals and dispensaries maintained by the State, District or Municipal Board, Missions and Charitable bodies; MCHC, including orphanages, thus about five lakh beneficiaries were daily distributed milk through the health centers¹⁴⁸ and in rural areas, distributing centers were under the supervision of presidents of gram panchayats under panchayat ghars and rural schools maintained by government or a local or charitable body. It was decided by the government that only 10 per cent of the total supply for a district be utilized for school children.¹⁴⁹ Whereas in urban areas, apart from above-mentioned distribution centers, labour and sweeper colonies, railway settlement and family planning centers were also included in the scheme. MCHC was the chief distributing centre of UNICEF's separate schemes for MCH services. It was proposed that though the milk or supplements were for expectant and nursing mothers and children visiting the centers as ante-natal and post-natal cases, a midwife could also start a distribution centre not attached with the MCHC.¹⁵⁰ UNICEF's programmes of the supply of milk powder to primary school children from 2 October 1963 was extended to ten eastern and seven hill districts, covering one and a half lakh of children.¹⁵¹ However, these milk feeding programmes were discontinued owing to the UNICEF's withdrawal from all feeding programmers as a direct donor. However, some States like Kerala, Tamil Nadu, and West Bengal had restarted the programme with corn-soya-milk donated by the CARE.

In a conference of U.P. Medical Conference of IMA held at Kanpur in August 1948, Dr Navin Chandra proposed for urgent steps in the nutritional care of school going children through compulsory school lunch.¹⁵² There were around 269 institutions which provided sprouted or parched grams to students, the cost of which was beared by the students only. However, the scheme was more prevalent in higher secondary

¹⁴⁷ Report on the General Administration of Uttar Pradesh of 1951, Lucknow, 1953, p-200.

¹⁴⁸ Malini Karkal, Nutritional Programmes for the Child- A Review, p-589 in K. Srinivasan, P.C. Saxena, Tara Kanitkar, (ed.), *Demographic and Socio- Economic Aspects of the Child in India*, (Bombay: Himalaya Publishing House), 1980.

¹⁴⁹ RAAUP, File No. 16, Box No. 26, Dept. XXVIII, 'Distribution of Milk Powder'.

¹⁵⁰ Ibid.

¹⁵¹ Annual Report of the State of Uttar Pradesh for the year 1963, Lucknow, 1965, p-152.

¹⁵² UPSPA, Copy of Resolution No. 15 of the XIII U.P. Medical Conference of IMA held at Kanpur on August 29 & 30 1948, in File No. 922/1947, Box no. 361, 'School Feeding Programme', Education 'A' department.

schools than in primary institutions.¹⁵³ The scheme's chief defect was the cost which was again a burden on the population as the government was not ready to subsidise it. A similar demand was raised in the same year by U.P. Ayurvedic and Unani system of Reorganisation committee 'to consider the question of building positive health through an organization for hygienic improvement and physical culture on Indian lives.'¹⁵⁴ Nutrition Advisory Committee of U.P. also supported the move to introduce MDM in urban areas. However, the scheme to provide sprouts or grams as nutritious food to children could not see the light of the day. In 1952, Rs. 1,87,000 granted for providing nutritious food in schools of UP was also cancelled and if an institution wanted to provide food in schools at the rate of 8 anna, the expenditure was on those institutions. To boost this scheme, the scientist of Vivekananda Laboratories, Almora, Dr Bosi Sen, requested the government to allow him to prepare a cheap but nutritive Multi-Purpose Food (MPF). Considering the advantage of the experiment which was financially apt and could allow the government to maintain its welfare state, he was granted Rs 15,000/- in the year 1949-50 to eradicate classroom hunger. Finally, 2000lbs of MPF containing rich nutritive ingredients was prepared by Bosi Sen¹⁵⁵ and as an experiment was distributed to the school children in Lucknow. When the food was provided in schools to assess its advantage, the outcome was impressive as students (except in few institutions) showed an increased weight from one to three pounds (Appendices). However, the food failed to relish children as they denied consuming it. Except for Lucknow, other D.B.s showed their helplessness in introducing school feeding programme on account of financial constraints. Apart from this, there were from time to time suggestions to provide nutritious food in school with an adequate menu, but those were recommendations which remained in the correspondence files. This MPF remained limited to the children of poor and middle-class students in schools, colleges and their hostels and it was also accepted that it increased the weight of children but Nutrition Survey Officer of the State did not favoured its distribution on account of the nutritional value not mentioned in the

¹⁵³ UPSA, Letter No. G17/7005/XVII-2, From Deputy Director, U.P., to Secretary to Government, dated 22 Feb. 1949, Education A department, Ibid.

¹⁵⁴ UPSA, File No. 922/1947, Box No. 361, 'School Feeding Programme', Education 'A' Department

¹⁵⁵ Bosi Sen visited America to get the samples of multipurpose food and he also discussed with the manufacturers in America about the possibilities of trying it in India. UPSA, File No. 2183/49, Box No. 409, 'Grant- Vivekananda laboratory Almora of sum of Rs. 5000/- out of discretionary allotment during current financial year to- for experiment- Mid day Meal', Education 'A' Department.

MPF.¹⁵⁶ Later, Education Secretary gave the responsibility to educational institutions to charge 8 anna every month for MDM from each student to provide mid-day meal comprising sprouted or boiled gram and fruits in higher secondary schools.¹⁵⁷

The State government established a Nutrition section in the Provincial Hygiene Institute, Lucknow under a qualified and especially trained Nutrition Survey Officer. The main function was to undertake nutritional, diet and clinical surveys, field programmes, laboratory investigations and nutrition training and education. In 1950, dietary and nutritional surveys were carried out in the rural areas of six districts were undertaken with the object of determining the extent of malnutrition among school children. Medical examination of children continued with the treatment of children in school clinics of fourteen larger towns.¹⁵⁸ Similarly, a survey was carried out on 6,371 school children in 1951, showed the deficiency of animal proteins, calcium, vitamin A, riboflavin and vitamin C among children. Protein deficiency diseases conditions occurred in infants and children.¹⁵⁹ To find out the incidence of endemic goiter, a survey was carried out in Jaunsar-Bawar area of the Dehra Dun district where the Iodized Salt scheme was enforced in 1949, thus potassium iodide tablets were distributed among school children in certain districts was continued to control endemic goiter.¹⁶⁰ It was found that in the case of the lower-age groups the incidence of goiter was reduced and in few other places in UP where goiter was prevalent, potassium iodine (0.2 gm each) was distributed to school children between the ages of 5 and 12.¹⁶¹

On children's day, 14 November 1961, UP government launched a scheme to provide mid-day meals to children of primary schools with local cooperation and the responsibility to run the scheme was laid on the Prathamik Pathshala Prabhandhak Samitis. The scheme was introduced in five thousand primary schools for benefitting nearly four lakh children.¹⁶² In 1967-68, 132 lakh children were fed by the government

¹⁵⁶ UPSA, Letter No. CD-925, from Shiksha Sanchalak I.R.Khan, to Shiksha Sachiv, dated 14 June 1952 in Ibid.

¹⁵⁷ Report on the General Administration of Uttar Pradesh, 1954, Lucknow, 1956, p-239; Uttar Pradesh Samanya Prashashan Report 1955, Lucknow, 1957, p-266.

¹⁵⁸ Report on the General Administration of Uttar Pradesh, 1950, Lucknow, 1952, p-173.

¹⁵⁹ Report on the State of health of Uttar Pradesh- With particular reference to Certain Diseases, Lucknow, 1961, p-11.

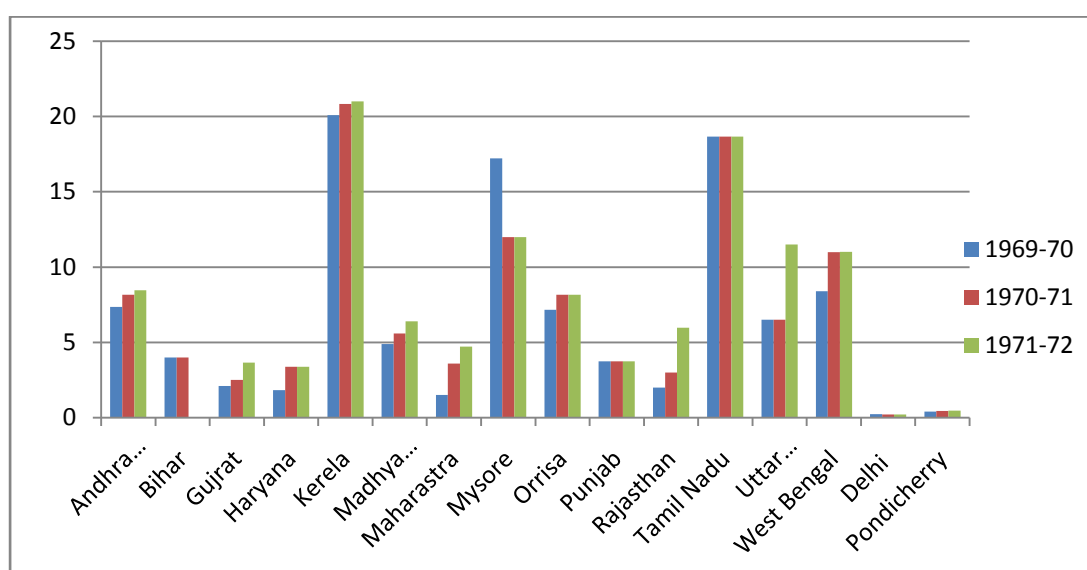
¹⁶⁰ Report on the General Administration of Uttar Pradesh, 1956, Lucknow, 1959, p-257.

¹⁶¹ Report on the General Administration of Uttar Pradesh, 1954, Lucknow, 1956, p-240.

¹⁶² Uttar Pradesh Annual 1962, Information Department, Uttar Pradesh, p-97.

under scarcity relief programme. 6.50 lakh children were benefitted by the MDM programmes in schools of UP from 1969-71 which increased to 11.50 lakh children. However, UP was far behind Kerala (21 lakh), Mysore (12 lakh), Tamil Nadu (18.67 lakh) which covered more children under the programme. It is also an accepted fact that the population of UP was highest in the country so the low coverage was inevitable. The number of children benefitted by the MDM scheme in Tamil Nadu remained stagnant in comparison to other states where at least one per cent rise was noted.

Chart 5.1: Coverage of MDM in Schools during 1969-72 (figures in lakh)



Source: Planning Commission, Report on School Feeding Programmes, 1980.

A new scheme was launched in various states on large scale by GOI where preschool children were fed as a part of the MDM programme in the year 1971-72. By this scheme, 1,395,000 children were benefitted in Andhra Pradesh, Gujarat, Haryana, M.P., Mysore, Maharashtra, Orissa, Punjab, West Bengal, Delhi and Dadar and Nagar Haveli. Unfortunately, the government of UP did not initiate this scheme on account of financial constraints. The GOI's Third Plan had no provision for the school meal programme. However, realizing the value of the scheme the Central government provided the States with one-third of their expenditure to boost the scheme. Food supplies were also provided by international agencies; all that the State Governments did was to bear the expenses of transportation of the food to school and the cooking of meals. By the end of the Fourth Plan, 12 million and by the end of the Fifth Plan, 16.5 million children received meals in schools. The GOI allotted Rs. 326.80 crores for the

purpose at the rate of 20 paise per child per day for a period of two hundred days. The State government bore the expenses on transportation and the preparation and distribution of meals.

Under the MNP, the GOI started a Special Nutrition Programme (SNP) in 1970-71 for providing supplementary food to children of 0-3 years. This was launched as a crash programme with hundred per cent central assistance in UP on November 17, 1970. Later, this scheme was extended to children of six years age, pregnant mothers and nursing mothers living in slum areas in cities and in tribal areas of the State belonging to tribal and backward classes. Under this programme, it was decided that the children would get nutritive food containing 300 calories and 14 grams of protein.¹⁶³ The chief areas of focus were those which were untouched till then i.e. tribal areas and slums in Khatima (Naini Tal), Chakrata (Dehra Dun), Kalsi (Dehra Dun), and Palia (Lakhimpur Kheri). The number of centers in the urban slum areas in Lucknow was 4000, 144 at Kanpur, 80 at Allahabad and 50 at Varanasi, while in the tribal areas there were 60 centres at Khatima (Naini Tal), 24 at Chakrata (Dehra Dun), 36 at Kalsi (Dehra Dun) and 36 at Palia Kalan (Lakhimpur Kheri).¹⁶⁴ During the year 1972, a provision of Rs. 29.45 lakh for SNS was made in the U.P. budget. By the end of 1980, there were 1.68 lakh beneficiaries in the State which increased to 2.46 lakh in 1985.¹⁶⁵

To evaluate the programme, in 1977-78, the National Institute of Public Cooperation and Child Development took a study at 23 centers of the country between 1971-76 to make an in-depth study. Accordingly, it was found that around 48.6 per cent of the community leaders complained about faulty distribution of food, about 68.6 per cent of the community leaders were unhappy about an unfair selection of beneficiaries and only 20 per cent mentioned the irregular supply of bread and malpractices in implementation of the programme.¹⁶⁶ The 1973 Annual Report of the National Institute of Nutrition indicated that the feeding under SNP failed to make definite impact on the health and nutritional status of the enrolled urban slum children. A report on Project *Poshak* by Tara Gopaldas indicated that health and nutrition education was ignored in the SNP. The supplement provided did not make up for

¹⁶³ Uttar Pradesh 1977, Information Department, 1978, p-147.

¹⁶⁴ Uttar Pradesh 1972, Information Department, 1973, p-205.

¹⁶⁵ GOI, *Child in India: A Statistical Profile*, Ministry of Family Welfare, New Delhi, 1985, p-712.

¹⁶⁶ K.G. Krishnamurthy, Formulation and Implementation of Nutrition Policies and Programmes, p-88, in B.N. Saxena and Kalyan Bagchi (ed.), *Towards the Implementation of A National Nutrition Policy in India: Report of National Seminar*, Srinagar, 28-30 October 1985.

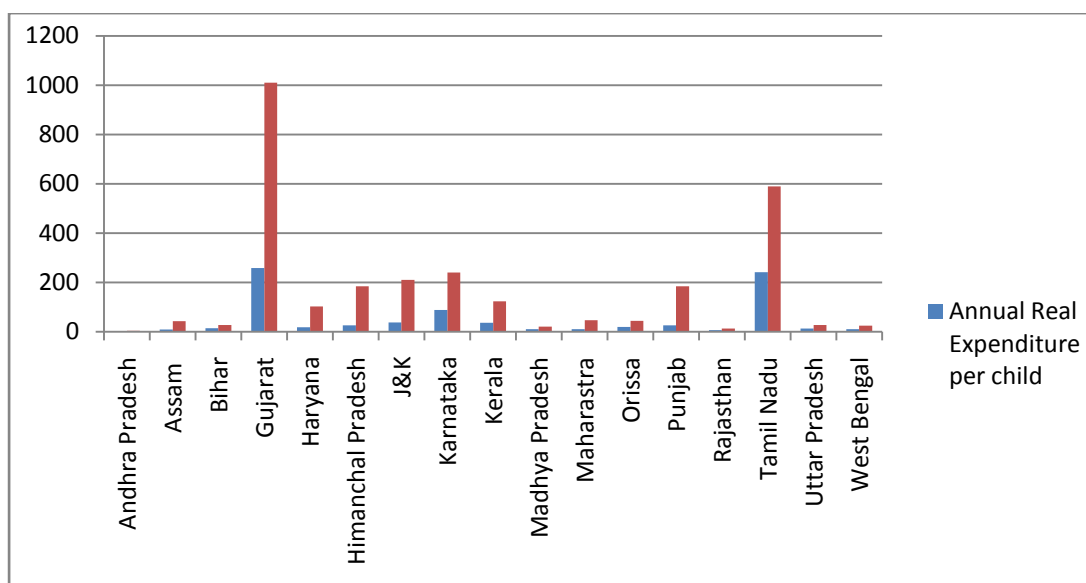
deficiencies in the diet of the 1-3 years old children. The supplement for pregnant women remained short of calories iron, vitamin A and calcium.¹⁶⁷ The data on the distribution of children under feeding programmes by State (Appendices) quantifies that direct nutrition expenditure per child in all the States were negligible. In contrast, the spending on supplementary feeding was substantial in Tamil Nadu, Kerala, Gujarat and Karnataka.

Another celebrated scheme of the Central government was the Applied Nutrition Programme (ANP) was started in 1959 for pre-school children and pregnant women in collaboration with WHO, UNICEF, FAO from 1962, to increase at the village level, the production of nutritive foods such as poultry, fish, milk, fruit, and vegetables and to provide facilities for training and education in the production, preparation and consumption of these foods. The programme started in UP in 1963-64 with an assistance of UNICEF in the rural areas of the State for improving the health of the children. In this scheme, UP had (during the Third Plan) allotted total of 197 blocks from 1966-1976.¹⁶⁸ In 1970-71, the Social Welfare Department of GOI provided supplementary foods to 680,000 children in the 0-3 age group, later, children in the 3-6 age group and pregnant women were also included in the programme. Thus till 1978-79, it was a fully centrally sponsored scheme but after 1979 it was transferred to the State government. The chief target of the programme during the Fourth Plan period was to train to 20,000 officials and non-officials in nutrition and assistance to associate-organisations, i.e. 1240 Mahila Mandals and 629 Yuvak Mandals Dals. Under the Sixth Plan, U.P. government sanctioned Rs. 12 lakh to aid 96,720 children in plain areas and 11,472 children in hill areas.¹⁶⁹ To increase the effectiveness of the programme, training of Mahila Mandals, Yuvati Mangal Dals, Mukhya Sevikas and Gram Sevikas was organised under the ANP which helped hundred different categories of service officers receive training in the science of nutrition. Serving health inspectors, students of the Jubilee Health School and students of K.G. Medical, were also taught about the nutrition programme with the help of lectures on the subject, so as to develop consciousness about the scheme among general population to increase its popularity.

¹⁶⁷ Ibid.

¹⁶⁸ GOI, *Report of Ministry of Agriculture and Irrigation 1974-75*, Department of Rural Development, 1975.

¹⁶⁹ Uttar Pradesh 1982, Information Department, 1983, p-210.

Chart 5.2: Distribution of Nutrition Expenditures by State (1985-86) in Rupees

Source: UNICEF, *Children and Women*, 1990, p-153.

From the above paras, it is obvious that significant programmes undertook to reduce the incidence of nutritional disorders. As welfare measures, a number of nutritional programmes were initiated, with emphasis mainly on supplementary feeding to bridge the gaps in the dietary conditions of the needy children. But, these programmes not produced the desired results of raising the levels of the nutritional status of low socio-economic sections of the society. This was corroborated by the evaluation study carried out in Jhansi region which established that poor socio-economic status of parents and environment effected the growth of the child.¹⁷⁰ Even after so extensive monetary assistance and schemes whether aided or un-aided could not develop comprehensive MDM in schools of UP, where at least half of the children remained undernourished. In Tamil Nadu and Gujarat, school feeding was the principal intervention, to the relative neglect of children under three years who were extremely vulnerable from malnutrition.

Under the Fifth Plan (1971-76), the highest priority was accorded to child welfare programmes. The most important programme was the ICDS. Under the scheme a package of services consisting of supplementary nutrition feeding, immunization, health check-up, referral services provided to children of 0-6 years and nursing and

¹⁷⁰ B. L Verma and R.N. Srivastava, Nutritional Anthropometry of the Pre- School Children in a Rural community, pp-389-406, in K. Srinivasan, P. C. Saxena, Tara Kanitkar (ed.), *Demographic and Socio-Economic Aspects of the Child in India*, (Bombay: Himalaya Publishing House, 1980).

expectant mothers. As seen above, time to time various vertical health programmes were initiated by the government which unfortunately didn't reach out to the targeted groups. In pursuance of National Policy for Children, GOI focused on delivering the holistic multi-centric programme with a package of services consisting of supplementary nutrition, immunization, health check-up, referral services, health and nutrition education and non-formal pre-school education in an integrated manner to pre-school children and pregnant and nursing mothers.¹⁷¹ With these objectives, ICDS was launched on 2 October 1975 targeting children up to the age of six years, pregnant and lactating mothers and women.¹⁷² For the funding of such a diversified programme, the National Children's Board on 22 July 1978, passed a resolution approving the proposal to set up a National Children Fund at the Centre and the similar Fund at the State level. It was decided that the fund was to be utilized by the voluntary organizations for extending child welfare services especially weaker sections of society. The scheme of ICDS was again a centrally sponsored programme implemented through State government except for supplementary nutrition under the MNP in the State. In pursuance of the National Policy for Children, eight ICDS projects were initiated in UP, at Dalmau (Rae Bareli), Jawa (Aligarh), Shankargarh (Allahabad), Moradabad, Gorakhpur, and Reotipur (Ghazipur), Nagal (Saharanpur). NORAD (Norwegian Agency for Development) provided cash assistance for training and administrative expenses in three districts in the state of UP for ICDS.¹⁷³ By the year 1985-86, there were 176 such schemes initiated for children of the State.¹⁷⁴

The report of ICDS (1987-88) data on nutritional status of children (0-6 years) showed that low prevalence of severe malnutrition existed in Andhra Pradesh, Haryana, Karnataka, Kerala, Maharashtra, Orissa, Punjab, Tamil Nadu, Uttar Pradesh and West Bengal.¹⁷⁵ A study conducted in 1989 by National Nutrition Monitoring Bureau showed the negligible change in the pattern of the average intake of calories and proteins. It was estimated that the percentage of children deficient in calories is far higher than that of children deficient in protein.¹⁷⁶ In rural areas of UP, another study revealed that even ICDS focused on rural and tribal areas, a high share of

¹⁷¹ GOI, *Scheme of Integrated Child Development Services*, Ministry of Human Resource Development, Department of Women and Child Development, New Delhi, p-4.

¹⁷² Uttar Pradesh, 1978, p-275

¹⁷³ UNICEF, *ICDS- Integrated Child Development Services*, New Delhi, 1984, p-35.

¹⁷⁴ Uttar Pradesh, 1985, p-342.

¹⁷⁵ UNICEF, *Children and Women in India- A Situation Analysis*, p-35.

¹⁷⁶ *Ibid*, p-40.

children still eligible for the nutritional supplements i.e. 70.9 per cent in Jawan and Shankergarh was between 60-70 per cent children in the country.¹⁷⁷ The impact of the efforts of UP government glanced from Nangia and Raza's study which found that Kerela had the highest percentage of normal pre-school children (28) followed by UP (18.8) and Andhra Pradesh (15.3).¹⁷⁸ Mild signs of malnutrition i.e. around 40-50 per cent were found among the children of both sexes in U.P. and 23.8 per cent children under moderate and severe malnutrition category.¹⁷⁹

Table 5.14: ICDS programme in Uttar Pradesh

Health functionaries						SNP in ICDS project			
No. of Medical Officers		No. of LHVs		No. of ANMs		No. of Anganwadis		Children on SNP in age group 0-6 yrs.	
Sanctioned	In position	Sanctioned	In position	Sanctioned	In position	Reporting	Providing service	No. (in '000s)	Average No. per a.w.
39	24	29	28	134	117	660	609	45.95	75.45

Source: GOI, ICDS- Annual Report 1983-84, Health and Nutrition sector, Central Technical Committee on Health and Nutrition, AIIMS, New Delhi.

The chief weakness of ICDS was the training of AWW which was carried out through the institutions organized by voluntary organizations and the organizational pattern where instead of supervising the programme under a separate department the scheme was undertaken by existing departments of the States such as in UP. Already burdened government departments considered the scheme more as a burden than welfare. For Anganwadi, a study documented the incident where when the officers went to survey the working of the scheme, met with the protest of villagers who complained about the irregularity in the schemes i.e. the supplementary food, were not supplied regularly, poor quality and quantity of the food, lack of care provided by the workers, lack of health check up or immunization etc.¹⁸⁰ Occasional visit of officials and no fruitful communication with villagers impacted the proper functioning of the programme. The failure of supply of nutritious food due to lack of resources and funding was compensated by the CARE from 1984 onwards. Malnutrition is

¹⁷⁷ Moonis Raza & Sudesh Nangia, *Atlas of the Child in India*, 1986, p-254.

¹⁷⁸ Ibid, p-248

¹⁷⁹ Ibid.

¹⁸⁰ C. N. Ray, *Child Development Project in India: Field Experience in Eastern Uttar Pradesh*, Working Paper No. 80, Giri Institute For Development Studies, Lucknow, pp-6-7.

related to abject poverty and the programmes simply overlooked the problem by the policy makers.

The chief criticism of nutrition policy were leakages in the delivery system, insufficiency of supportive services, difficulties in reaching the target groups and doubtful utility of the scheme in bringing about improvement in nutritional status.¹⁸¹ In an extensive, multi-centric evaluation of the massive ICDS conducted by Nutrition Foundation of India in 1988, pointed out that the ICDS has degenerated into a concern of the 'provider and the bureaucrat'.¹⁸² Gopalan commented that 'it is doomed' and warned that 'unless the community takes the front seat in the implementation of the programmes'.¹⁸³

IMMUNIZATION STATUS OF CHILDREN IN UP

Due to financial constraints, the general vaccination services remained weak in Uttar Pradesh. The health administrator's strategy to prepare new strata of funding into health system was beyond a success. In the report of the government, DMHS declared in 1950 that "at present, the vaccination against smallpox is compulsory in the urban area up to a certain age. The Director of Medical and Health Services is of the opinion that compulsory vaccination should be introduced in the rural areas and revaccination should be made compulsory everywhere. Unfortunately, the District Boards are at present financially crippled and cannot be expected to share the extra cost involved. State Government will, therefore, have to foot the entire bill in the present state of financial stringency it would be prudent on our part to spread over the expenditure to a period of five years."¹⁸⁴ Consequently, UP DMHS prepared a moderately ambitious five-year plan for combating smallpox, which aimed to make vaccination and re-vaccination compulsory in rural areas. The motive behind this scheme was to base existing vaccination structure on a gradual improvement extending over the period of five years from one region to another so as to work within the constraints set up by the lack of personnel and financial resources of state authorities. The project was based on the expectation that local authorities would share the costs and other means

¹⁸¹ M. M. Rajendran, National Policy for Children, p-25, in A.P. Barnabas, *Profile of Child in India: Policies and Programmes*, Ministry of Social Welfare, GOI, New Delhi, 1980.

¹⁸² Nutrition Foundation of India, *Integrated Child Development Services: A Study of Some Aspects of the System*, Nutrition Foundation of India, Scientific Report 7, New Delhi, 1988.

¹⁸³ C. Gopalan, *ICDS: An Overview in Nutrition Foundation of India*, New Delhi, Nutrition Foundation of India, 1988.

¹⁸⁴ UPSA, File No. 308/1950, Development Programme of the PHD, Public Health Department, 1950.

of extending vaccinal coverage at the cheap rates were assessed. An official communication declared that- “it might be possible in the due course to train panchayats inspectors in the technique of vaccination to supplement efforts of regular vaccination staff. Indeed, this should be done regardless of whether vaccination is or is not made compulsory. This will not entail extra expenditure and will provide an ancillary agency for vaccination in villages.¹⁸⁵ Thus, authorities and administrators, after independence, were under the colonial shadow. Vaccinations and re-vaccinations were thus continued on usual lines to combat smallpox. Training in the technique of vaccination was arranged for Panchayat Secretaries to enable them to supplement the work of vaccinators within their respective areas. It was felt that a large number of persons in the villages could be vaccinated even without making vaccination compulsory in rural areas if a permanent agency could be available to approach the people more often than it was possible for the vaccinators to do.¹⁸⁶

Table 5.15: Outline for Five year plan in Uttar Pradesh for the extension of Vaccination services

Period	Regional details	Cost of installing New scheme	Cost of scheme implemented in Previous Years	Total
First year	Gorakhpur-Banaras Divisions (Nine districts)	75,810	-	75,810
Second year	Fyzabad-Lucknow Divisions	77,720	153,530	231,250
Third year	Allahabad-Jhansi Divisions (Nine Districts)	51,060	204,590	255,650
Fourth year	Rohilkhand- Kumaun Divisions (11 Districts)	60,950	265,540	326,490
Fifth year	Meerut –Agra Divisions (10 Districts)	58,195	323,735	381,930
Total Expenses		323,735	947,395	1,271,130

Source: UPSA, File No. 308/1950, Development Programme of the PHD, Public Health Department, 1950.

On the eve of independence, out of 443 towns, 264 had compulsory vaccination in United Provinces, the remaining towns and rural areas were offered vaccination on the basis of persuasion. Greater emphasis was consequently offered on the basis of persuasion.¹⁸⁷ At the instance of the GOI, the UP government appointed in May 1958, a committee to suggest ways and means both on a short and long term basis, for the control and ultimate eradication of the vaccine-preventable diseases. The Committee

¹⁸⁵ Ibid.

¹⁸⁶ Report on the General Administration of Uttar Pradesh 1953, Lucknow, 1955, p-237.

¹⁸⁷ Report on the General Administration of the United Provinces 1946, Allahabad, 1949, p-116.

recommended to make vaccination more effective in the State through uniform legislation making primary vaccination of infants compulsory; reorganisation and reorientation of the existing administrative set-up for vaccination work; adequate facilities for proper storage of vaccine; at district and vaccinators level and for transport of vaccine, improvement in the efficiency of working of the birth and death registration systems.¹⁸⁸ A short term programme the Committee recommended that a mass vaccination campaign immediately be launched throughout UP with a view to immunizing the whole population of the State against smallpox.

In September 1949, a mass scale B.C.G. vaccination was organized in Lucknow and later in Kanpur, Agra, Allahabad, and Bareilly, under the auspices of WHO.¹⁸⁹ In Agra, Dr Kvissalgaard of Danish Red Cross Society trained the local team of vaccinators for the programme in educational institutions. For making the scheme successful, publicity was carried out in the cities via posters, loudspeakers, and press, cinema shows etc. This propagation was considered necessary to increase the awareness about the tuberculosis disease in children and the significance of B.C.G vaccination to the parents and teachers. In a survey on immunization of children in Agra district, revealed that immunization status in both urban and rural infants was far from being even satisfactory. In the study on 4410 cases, the study found that 86.3 per cent urban and 97.5 per cent rural infants were immunized with BCG or Polio vaccines and only 14.2 per cent infants were immunized at six months of age with one, a combination of all three vaccines.¹⁹⁰ Raza and Nangia reveal that BCG vaccination had low coverage among children in both rural and urban areas among children from infancy to six years, though higher in urban areas than in rural areas.¹⁹¹ The percentage of total immunized children increased with age and urban-rural differential diminished with age.¹⁹² There appears to be greater awareness and utilization of immunization programme in the urban areas as compared to the rural areas especially with regard to BCG, triple vaccine and polio vaccine (Appendices).

¹⁸⁸ Report on the State of health of Uttar Pradesh- With particular reference to Certain Diseases, Lucknow, 1961, pp-60-61.

¹⁸⁹ RAAUP, Letter No. IX-F- GO-3/1000, dated- 14 January 1950, from A. C. Banerjee, D.M.H.S. U.P. to R. N. Tandon, Chairman, Municipal Board, in File no. 11/49, XXVIII Department, B.C.G. Vaccination, 1950.

¹⁹⁰ Ramesh Kumar, K. Kalra and R.S. Dayal, A Survey on the Immunization Status and Breast Feeding Practices of Infants of Agra, *Indian Paediatrics*, XV (2), Feb. 1978, pp-107-115.

¹⁹¹ Moonis Raza & Sudesh Nangia, *Atlas of the Child in India*, 1986, p-707.

¹⁹² Ibid.

Table 5.16: Percentage of children immunized by age and sex in U.P. 1978

Area	Sex	Age of Children						
		Below 1 year	1 year	2 years	3 years	4 years	5 years	6 years
Rural	Male	29.70	62.75	78.89	88.66	91.15	92.96	95.10
	Female	31.66	61.12	79.12	88.25	91.23	92.03	95.20
Urban	Male	56.33	82.39	92.72	95.03	94.12	94.78	95.80
	Female	53.14	85.57	92.49	93.98	94.68	94.94	95.24

Source: GOI, *Survey on Infant mortality*, p-706

The National Smallpox Eradication Programme was started in 1962 in the form of mass vaccination of the population. Though the result of these efforts was that the intensity of the diseases was checked to a certain extent yet eradication was farsighted. Intensive Smallpox Eradication Programme was, therefore launched from October 1973 with the help of WHO so as to achieve complete eradication. Thus, the last smallpox in UP was registered on 8 March 1975 in Aligarh and thus the State was declared Smallpox free on 20 April 1975.¹⁹³ This was made possible by the government's announcement of a reward of Rs. 1000 per case for correct reporting of any smallpox case in the State. Expanded Programme of Immunization (EPI) launched in 1977 with an objective to reduce the incidence of diseases which were preventable, thus integrated and unified, so that all the immunization services available under one management through the PHCs and sub-centers in rural areas and hospitals and dispensaries in urban areas. Unfortunately, started in 1978, the EPI protected barely a third of the children by 1985. Thus, the programme was restructured in 1985 as the Universal Immunization Programme (UIP) and by the year 1989-90, immunization among children in U.P. against deadly diseases covered 36.22 lakh children and the achievement was 86.8 per cent.¹⁹⁴

For smallpox and polio eradication programme, the chief weakness was the unsympathetic attitude of the government machinery as it was a 'leaky bucket punctured with holes at every level'¹⁹⁵ especially in UP and Bihar. WHO and UNICEF wanted both Central and State governments to initiate rigorous efforts to improve the condition of vaccine coverage while the government blamed the transfer of resources in routine immunization instead on urgent measures to be taken in public health. International deadlines and voluntary agencies kept the movement of immunizing

¹⁹³ Uttar Pradesh, 1977, pp-233-34.

¹⁹⁴ Uttar Pradesh, 1989-90, p-98.

¹⁹⁵ Thomas Abraham, *Polio: The Odyssey of Eradication*, (Chennai: Context Publications, 2018), p-156-57.

children vigorously. Both door to door and booth vaccination played a significant role in increasing immunization coverage among children in the State.

RESTRICTING BIRTHS

Even before independence, India's growing population was the debatable among the intellectuals, economists and media. The prime concern was that the growing population would reduce its pace of economic development and other achievements. After independence, the GNP of India which stagnated till independence grew by 3 per cent. But the increasing population was the chief obstacle in its development. Consequently, social workers had set up a Family Planning Association of India in 1949. Similar concern too was shown by the Planning Commission since its inception in the 1950s. However, India's Five-year plan endorsed to family planning by linking the health of mothers, to the rearing of children and the economic future of the nation.¹⁹⁶ Despite this consciousness in independent India for the implementation of the national family planning campaign in 1951 and earlier; it was not until around 1960 that family planning received any actual promotion by the State.¹⁹⁷

The U.P. government insistence on measures of family planning work was carried out by IRCS, while research on the most acceptable methods of family control in the rural areas was carried out by J.K. Institute of Sociology and Human Relations under Lucknow University. The activities of both these institutions were subsidized by the State government. The J.K. Institute thus carried out research work for exploring ways and means to popularise family planning among the rural masses. They also established an Action Research Centers at Almora, Meerut, Etawah, Lucknow, Pratabgarh and Gorakhpur.¹⁹⁸

For securing better maternal health and healthy babies, a 'Planned Parenthood Scheme' was started in Lucknow in 1951.¹⁹⁹ Under this scheme, parents were advised

¹⁹⁶ In the draft of First Five Year plan it was made clear that, "the rapid increase in population and the pressure on the limited resources available have brought to the forefront the urgency of problems of family planning. The main appeal for family planning was, however, based on considerations of health and welfare of the family. Family limitation or the saving of children is necessary and desirable in order to secure better health for the mother and better care and upbringing of the children." GOI, Planning Commission, *The First Five Year Plan: A Draft Outline*, Delhi, 1951, p-107.

¹⁹⁷ GOI, Circulars Letters and Orders issued by the Government of India on Family Planning, Vol. 1, May 1953- December 1965, Delhi, 1966.

¹⁹⁸ Annual Report of the Activities of Medical and Public Health Department, 1953-54, Uttar Pradesh, Lucknow, 1954, p-6.

¹⁹⁹ Uttar Pradesh ke Samanya Prashashan ki Report 1951, Lucknow, 1952, p-196.

free of cost on the measures to adopt family planning. Early in 1952, Governor of UP called a conference of persons interested in family planning and to take stock of the efforts already made and to plan for the future. Further, the State Government sanctioned Rs. 15,000 to UP branch of the IRCS which supplied materials to the local centers.²⁰⁰ A circular was issued authorizing all hospitals and maternity centers to offer advice on family planning. The hospitals were also advised to perform surgical operations in certain circumstances.

After independence in most States, the child population recorded an increase especially during 1961-71. However, few states and Union Territories such as Kerala, Manipur, Nagaland, Punjab, Sikkim, Delhi, Goa, Daman and Diu, and Lakshadweep, registered a marginal decline during the same period. In most states, the proportion of child population evidenced greater than its percentage for the whole country (42.02 per cent) in 1971. Only in Andhra Pradesh, Himachal Pradesh, Kerala, Maharashtra, Nagaland, Punjab, Sikkim, Tamil Nadu, Uttar Pradesh, Arunachal Pradesh, Delhi, this percentage was lower than the national level.²⁰¹ The decadal change in the population of the child in UP during 1961-71 was 23.78 and the population increased from 29,864 in 1961 to 36,965 in 1971. UP had high birth-rate (38.6 in comparison to India as 33.8) and this was due to the preference of more number of children. The desire of more children in the State depended on three factors. Firstly the low rate of survival of children, secondly due to the preference of boy child over girls and thirdly to increase the means of livelihood among people. A study conducted by M. E. Khan and R. B. Gupta²⁰² in rural areas of UP, assessed that desire of additional children was to have a son (20 per cent) and at least one daughter (10 per cent). The study also corroborates the third factor mentioned above where the poor parent's conscience was that if they have more sons then they could work as wage earners.

The family Planning organization of the Red Cross and Provincial branch of the Indian Medical Association and its district branches lacked proper coordination and cooperation on the issue of the family planning. Thus, for initiating family planning in

²⁰⁰ Report on the General Administration of Uttar Pradesh, 1952, Lucknow, 1954, p-178.

²⁰¹ Census of India, 1961, Social and Cultural Tables, Vol. I, Part II, New Delhi, p-476; Census of India, 1971, Social and Cultural Tables, Series- I, Part II-C, New Delhi, p-199-211.

²⁰² M. E. Khan and R. B. Gupta, Familial Values, Contraception and Utilization of MCH services in Rural Uttar Pradesh, pp-94-121, in M. E. Khan, R. B. Gupta, C. V. S. Prasad, S. Ghosh (ed.), *Performance of Health and Family Welfare Programme in India*, (Delhi: Himalaya Publishing House, 1988).

the State, DMHS suggested that a fee for operation of sterilization of Rs. 150/- charged from a person with an annual income of Rs. 3000, should be made free.²⁰³ As sterilization allowed free of charge in Hyderabad and Rajasthan, and sterilization fees of charge to indigent and other person having an income up to Rs. 1200-1500 was allowed at Punjab, Madras, Madhya Pradesh whereas in Bihar those admitted to paying wards were required to pay sterilization fees, in Assam and Mysore this concession was not allowed, so the same was suggested to be applied in UP. Further DMHS reported that a sum of Rs. 34,600 was charged as sterilization fees from patients in government hospitals during 1952-55. It was estimated that the government, surgeon and their staff would get a loss of 12,000 if this was made free of charge. Out of the total amount 30 per cent was deposited with the government while the balance was distributed.²⁰⁴ In 1954, a similar resolution was passed in the conference on Family Planning held at Lucknow on 7 September to effect that surgical intervention in the government hospitals for family planning should be free of charge.²⁰⁵

The family planning programme was started in the State during the Second Plan period. By 1960-61 only 25 urban and 150 rural family planning clinics were opened. It was proposed to establish 1500 rural and 50 urban family planning centers during the Third Plan. All districts and women's hospitals and all maternity centers in the State were also authorized to give advice, but owing to the various factors, including paucity of staff, the results were not very encouraging. Health visitors and midwives also undertook family planning work in addition to their routine work, distributed contraceptives during their visit and referred cases to family planning centers. The programme was intensified with emphasis on sterilization operations on males. A sum of ten rupees was paid to each person operated upon and two rupees to the motivator who accompanied the person, Rs. 4 to the surgeon who performed the operation in the urban area and Rs. 5 to the surgeon performing the operation in rural areas. A sum of

²⁰³ UPSA, Letter No. IX-f/37119 dated 24 November 1954 from DHMS UP to Deputy Secretary, File No. 1541/54, Box-61, Surgical Operations in Government Hospitals for limitation of Births free of charge, Medical 'A' Department.

²⁰⁴ UPSA, Letter No. IX-F-/42220, From DHMS UP to Secretary to Government dated 30 November 1955, Lucknow, Ibid.

²⁰⁵ Ibid.

Rs. 1.50 was paid to the attendant to the surgeon.²⁰⁶ These measures were though extensive yet its impact was.

The 1970s evidence the transformations of the Malthusian programme for population control programme into a broad based family welfare programme. However, the shift was more due to post-emergency debacle rather than political foresight. Highlighting the over-emphasis on the family planning programme in comparison to other public health works, it is argued by various scholars that “While the family planning programme donned the mantle of integration, it retained its position of priority and its essentially vertical character. Nominally integrated at the district level, it called the shots at the State and Central levels. Poised thus, it had access to all the resources invested into the infrastructure, while other programmes were gradually eroded.”²⁰⁷

In the early 1970s, the then P.M. Indira Gandhi prepared a twenty-point programme related to areas to be focused immediately. However, the plan was amended by Sanjay Gandhi, who formulated a five-point programme to complement the earlier plan. These five plans were- family planning, afforestation, the abolition of dowry, the removal of illiteracy and slum clearance. ‘Young people of 20 years, old, invalid people were dragged off to the sterilization camps forcefully without asking basic questions of their age, etc. The government gave a target which was carried out by gatecrashing the houses of people. People faced too many hardships during the conditions of emergency. Police vans would come to take people to the nearest health centre. Many times a person who was not married was sterilized. Those who had undergone vasectomy were too embarrassed to talk about. It’s because those officials who would carry out more sterilization to be rewarded more, consequently the situation became worse.’²⁰⁸ This led to widespread coercion among the people. Lower government officials had to submit people to the surgeon’s to get clearance of their arrears of pay and the truck drivers would not get their licenses renewed if they could not produce a sterilization certificate. In September 1976, an underground paper reported the protest made by the people in UP and Delhi. Sultanpur, Kanpur and Bareilly witnessed great protest among people. Great resentment was among school

²⁰⁶ Annual Report of the State of Uttar Pradesh, 1964-65, Vol. I, Production, Development and Welfare Activities, Information Department, U.P., Lucknow, p-144

²⁰⁷ Imrana Qadeer, *Public Health in India, Critical Reflections*, (Delhi: Daanish Books, 2011), p-316.

²⁰⁸ Ramachandra Guha, *India after Gandhi: A History of India’s largest Democracy*, (London: Pan Macmillan), 2007, pp-515-17.

teachers who were asked to conduct the survey in pursuance of the sterilization campaign. The worst incident took place in the town of Muzzafarnagar in UP, where on 18 October 1976 a tussle broke out between officials and people who were forced to get sterilized. People torched the health clinics and threw bottles and stones on officials. Consequently, police was called for the rescue of officials, fired on people and around 50 people died. A large number of deaths especially among infants was the chief reason for resistance against the sterilisation. A case study conducted by M. E. Khan and R. B. Gupta in rural areas of UP showed that the fear of a child's death was always dominant among the parents. In the interview by the author respondents, only 3% accepted the premature death of children.²⁰⁹ It may be noted that sterilization was the predominant method of family planning in UP. But the acceptance was among 22 per thousand population compared to the national average of 49 per thousand population.²¹⁰

In view of the high birth rate and the high mother and child mortality rate in the State the first India Population Project was implemented with the cooperation of the World Bank, the GOI and UP government between March 1973 and 1980 in the six districts of Lucknow, Rae Bareilly, Sultanpur, Pratapgarh, Muzaffarnagar, and Saharanpur. Special emphasis was laid under this project on the construction of hospital and dispensary buildings, provision of healthcare facilities and training, and integrating all these activities with the programme of providing nutritive food to the children.²¹¹ The Second India Population Project was implemented in UP in the districts of Azamgarh, Basti, Deoria, Ghazipur, Mirzapur and Varanasi with financial assistance from the World Bank. The project was estimated to be of Rs. 58.24 crore and to be completed by 1985. The main objective of the project was to step up efforts for bringing down the infant and child mortality rate, improve the health of mothers and children and

²⁰⁹ One respondent of the interview Bhagwati (four children), told "I have delivered six children but now I have only four children; two sons and two daughters. My first child died after one week of birth, while the third- a son died at the age of three. Government wants us to accept sterilization after two or three children, if two or all of them die, what will happen". Another women mentioned the case that "though in these days children are dying less often but who knows when death strikes. See Rupali, who had only two children and both died. What would have happened to her, if she had undergone sterilization after two children?" This interview is available in M. E. Khan and R. B. Gupta, *Familial Values, Contraception and Utilization of MCH services in Rural Uttar Pradesh*, pp-94-121, in M. E. Khan, R. B. Gupta, C. V. S. Prasad, S. Ghosh (ed.), *Performance of Health and Family Welfare Programme in India*, (Delhi: Himalaya Publishing House, 1988).

²¹⁰ Ashok Kumar, *Health and Family Welfare Programme in Uttar Pradesh: An Over-view*, pp-128-129, in M. E. Khan, R. B. Gupta, C. V. S. Prasad, S. Ghosh (ed.), *Performance of Health and Family Welfare Programme in India*, (Delhi: Himalaya Publishing House, 1988).

²¹¹ Uttar Pradesh, 1988-89, p-153.

popularize family welfare steps among the people through health education and publicity; as many as 1175 primary health sub-centers were proposed for the above-mentioned districts. In the year 1985-86, U.P. secured the first place in its group in the implementation of the family welfare programme and received a prize of Rs. 2.50 crore from GOI. In 1987-88, UP not only ranked first in its group but also got the first place in the whole country in this respect and received once again the prize of Rs. 2.50 crore from Central government. The same award repeated in 1987-88.²¹²

However, all these efforts though progressed yet with slow speed as the birth rate in the State remained high. The family planning programme gained much priority over other paediatric programmes in the medical policy of UP, but was not integrated into the paediatric welfare work. It could be glanced that the emphasis on family planning measures gave a setback to the paediatric programmes in the State, which had a long term impact on the paediatric in UP.

CONCLUSION

The healthcare delivery system in general and paediatrics in particular in UP was, unfortunately, a poor copy of the British system. Most unfortunate is we did not move away from the colonial shadow and took a definite stand on which a new beginning could be made. The independent State could have directed a radical departure from the colonial pattern by improving environmental conditions for health through a public health revolution. It settled instead for the softer option of essentially continuing the colonial tradition of centrally-administered crash programmes, initially for epidemic disease control, and subsequently for population control and for the complementary MCH programme, aided by massive international assistance. Apart from these central programmes, the health services run by the State remained weak in planning, finances and administration, thus health occupied a secondary status. The State government of U.P. followed the directions of the Central government with regard to paediatrics. Every area had its own problems, needs and challenges and State government failed to develop paediatric policy on that lines. Among Indian planners and demographers, there was a tendency to treat the population as a constraint or pressure, in other words, a liability. Unfortunately, poverty and undernourishment, illiteracy, and sad sanitary conditions made almost impossible to

²¹² Ibid.

develop healthy environment for children. Utilization of government health services including MCH and immunization facilities was low and most families preferred private doctors to state services mainly because the distance of PHC or government hospitals restrained people to utilize the services, the PHC functionaries were also not fully trained to perform. The situation reflects a woeful inadequacy of achievements and leaves out the immense ground to be covered. All the programmes and schemes originated in the 1960s and 70s thus its impacting was to be visible after 1980 and 1990s. Further, the requirement of manpower was the chief bottleneck in progressing child welfare programmes in the State. With the enhancement of policies and programmes, manpower supply remained substantially underdeveloped.

Chapter VI

Conclusion

CHAPTER- VI

CONCLUSION

For the colonial government, India served as a revenue and resource gathering colony, not a charitable land. This was evident as the imperialists invested a little amount in the healthcare of the natives. This does not mean that there were no sensibilities towards children even though policy existence was of limited nature. The development of paediatrics in colonial India was a part of the process of emergence of voluntary organizations, growing bureaucratization, increasing international pressure for reform, and rationalization of administration that rendered the realization of state's responsibility of being a welfare state as Montague declared it as 'responsible government'. It was also a means of 'disciplining the child's body' through the medical facilities at schools, training of midwives, the establishment of child welfare centers, technological developments such as surgery, vaccination etc. This was a part of colonial governmentality which generated a 'peculiar colonial discursive formation' which was a complex reproduction of the western medicine in the context of the colonial rule in India.¹ As after the 1880s, the healthcare was made the provincial subject, it was voluntary agencies, municipal and DBs who were held responsible for this initiative. The municipalities in Province do not organize separate schemes for maternity and child welfare work. Unfortunately, both of these administrative bodies failed to take up the paedia care due to financial stringency. This further aggravated the poor condition of children leading to the high mortality in this Province. There was an absence of paediatric hospitals or some places even lacked paediatric wards, where special care for the children could have been delivered. Thus, a child was treated as a part and parcel of general medical out-patient or in-patient departments in the colonial state.

In a nutshell, the policy of the State was rendered through those centers which were within the aura of colonial empire i.e. schools, hospitals and dispensaries, MCWC and in urban areas. Schools especially European and aided schools had medical officers and facilities. Vernacular and rural schools not only had a poor structure but even lacked facilities of medical aid, sanitation and water facilities, within the premises. The Province had more than forty per cent, malnourished children. This issue was

¹ Gyan Prakash, *Another Reason*, 2000, op.cit.

raised in all reports and official communications. However, nutrition policy failed to see the light of the day in the United Provinces. Furthermore, for childcare, the official line was too restricted to train the non-indigenous dais in the western medical system thereby replacing the indigenous one.

Legislation through Vaccination Act of 1880 and the introduction of Dufferin Fund in 1885 laid the foundation of the paediatric care in colonial India. The former was the State's effort to regulate paedia care through the state's intervention while later was an outcome of women's health movement in the country through voluntary efforts. The Fund received meagre assistance from the GOI except in two particulars- it received the services of a clerk, and it had permission for the MO of the government to supervise the work of the employees of the Associations. The government was unsympathetic towards the children, though not absolutely, who were not only geographically but also on paper were away from any welfare measures of the colonial state. Thus, there were as no full-fledged policy of the colonial empire for the children in the United Provinces. It was different institutions and associations that carried out child welfare work such as Lady Chelmsford League, All India Institute of Hygiene and Public Health, and National Association for supplying Medical Aid to Women of India, All India Women Association and other such institution.

These associations went ahead with the programmes to ensure a reduction in infant mortality and basic health care facilities for the children. The failures of the colonial government came both as a challenge and an opportunity for the independent government in UP. Separate services, programmes were organized to bring down the very high infant mortality rate in the State. The mortality rates remained substantially high in this State. National Policy of Children, 1975 and National Health Policy 1983, cleared the vision of the independent state where overall development of the child along with health was prioritised by the government. However, the problem in the independent State was not at a policy level but there were several loop-holes in the implementation of these policies.

Here we agree with Margaret Jones who contended that Ceylon had developed better child health services in comparison to the whole South-East Asia under the colonial government. Margaret Jones asserts that the welfare of child health in Ceylon was a part of imperialistic measures of the colonial state. She emphasises that the increasing

control of the reproduction by the midwifery laws, aim of controlling the infant mortality rate and the insanitary conditions in schools was a part of the broader project of colonizing the child's body.² As Jones concludes "in none of these colonies (India, Hong Kong, Malaya) does there appear to have been a programme of free school meals." In this, as in other preventive health work, the Ceylon government advanced far along the road to an interventionist state. It accepted, just in Britain, that the health of school children was a responsibility of the state.³ With a similar argument, Kabita Ray concludes that the school health service in Bengal was "one of the least developed of the public health services."⁴ Specifically in terms of paediatrics, the colonial state did engage with the category in United Provinces, even though it made a half-hearted approach. Institutions such as schools and central school dispensaries were unique steps in the Province yet its impact on the child and adolescent's health was unsubstantial. These services could not make a mark on the health of children due to the lack of financial resources and weak administrative structure. For infants, the comprehensive measures remained inexistent taking into consideration the level of mortality in the Province. Further, gender-specific health policy in the Province was far from evident except in case of marriage acts. Whenever any policy or programme was outlined, unfortunately, it explicitly left the girl child on the pretext of social and religious prejudices of the people. Consequently, the weak and undernourished girl produced weak babies, which not only led to high neo-natal mortality but also severely impacted the health of girl's. Colonial state to a large extent remained reluctant to develop any measure to promote healthcare for girls which demanded utmost priority.

The prevalent conditions of paediatrics in the United Provinces were an outcome of the general health conditions. The sorry state of affairs in terms of health conditions had either directly or indirectly influenced the child health specifically in rural areas. The Province had an existence of dreadful diseases which due to preventive measures of colonial state were never abated. Insanitary conditions in the Province increased the probability of an outbreak of epidemic diseases. In them, Smallpox mostly

²Margaret Jones, *Infant and Maternal Health Services in Ceylon 1900-1948: Imperialism or Welfare?*, *Journal of Social History of Medicine*, Vol. 15, No.2 (2002), pp-263-289.

³ Margaret Jones, *Health Policy in Britain's Model Colony Ceylon (1900-1948)*, (New Delhi: Orient Longman Private Limited, 2004), p-257

⁴ Kabita Ray, *History of Public Health: Colonial Bengal, 1921-27*, (Calcutta: K. P. Bagchio, 1998), p-312-13.

affected the children which could not be eradicated by the colonial state, instead, the deaths of children from the disease had a chequered carrier in this Province. Further, the tussle between local bodies and the colonial state gave a serious blow to the child health movement. Ill-equipped hospitals and dispensaries had no child-specific health centers which could boost their healthcare or improve the conditions.

There were no research institutions in this Province or in the country which could have developed sensitivity and search for causes, towards the deplorable conditions of paediatrics in all spheres. Provinces such as Bombay, Madras, Calcutta had Bacteriological Laboratory, Kings Institute for Preventive medicine and All India Institute of Hygiene and Public Health established respectively and Pasture Institute, Kasauli, none of them contributed in reducing the loss of children or their declining health. Lack of funds and limited expenditure on the part of the government always created a hindrance in the policy implementation. Even Indian Research Fund Association never took advantage of its position to investigate on the relationship between slow growth of children and malnutrition, high mortality from malaria and other diseases, and role of famine and poverty concerning the health of children to specify measures to improve paediatrics in the Province. The Province thus had no policy, scheme, propaganda work to decrease infant morbidity and mortality and promoting paediatrics. The work of the government is not only to prepare policies but also to take into account the correct implementation of the same policy. Colonial government at that level failed to achieve anything remarkable. As the registration details of births and deaths were imperfect, inefficient work of vaccinators and the lack of financial aid were the key factors of the poor medical policy of the colonial state for the paediatrics. Furthermore, the increasing rate of vaccination, attendance in hospitals and dispensaries and decrease in infant mortality after the 1920s, indicates the inclination of parents towards western medicine to save the lives of their children. Yet considering that the people left their old traditions and faith is unjustified. Religious rites and rituals continued along with adoption of the western bio-medical system. Thus, the success of colonial medicine for paediatrics was partially successful both due to government's restrictive involvement, failure of local governments and parent's suspicion of western medicine.

The present work is significant from the historiographical point of view. The historical study on children presently limited to education, mortality, childbirth and

reproductive health in the colonial settings. The present study establishes that paediatrics under the medical policy of the colonial state was underdeveloped to the extent that mortality in the United Provinces though declined after the 1920s remained extremely high. The paediatric policy was limited to medical inspection of school children especially to Europeans and colonial institutions in urban areas; and compulsory vaccination of children in urban areas. For vaccination, persuasion was the means adopted by the government instead of enforcement of Vaccination Act of 1880. Further, the work opens new doors to explore the paediatrics after independence. Though a small attempt was made to assess the policy of Uttar Pradesh and its implications, yet as the period of study is restricted till 1980 (even though an overview was made till 1990) and many efforts on the part of government was made in the era liberalization, exploring the paradigm shift in the health policy during the economic liberalization of India and its relation to current problems of paediatrics enable us to find the way how our government ensured the better facilities for our future generations.

In the well-established field of medical history in India, paediatric medicine is unexplored. Medical historians, who contributed for the study of India, unanimously accepted that colonial medical policy in India was for the privilege of Europeans and military.⁵ Other scholars argument revolve around the claim that the limitations of the policy were due to resistance, apathy and superstitions of the indigenous population.⁶ The present work, however, delineates that nationalist concern towards high mortality in the State, international pressures and voluntary organizations made government intervened in the conditions of paediatrics. However, the colonial policy for paediatrics proved to be limited as it was fruitful to elite class residing in urban areas and focusing only on the conditions of childbirth, vaccination and underdeveloped medical inspection of school children. Colonial state in United Provinces missed the opportunity to provide efficient healthcare facilities for paediatrics to exclaim their 'civilising mission' which accelerated the deplorable condition of child health in the Province by levying the responsibility on the local

⁵ Anil Kumar, *Medicine and Raj: British Medical Policy 1835-1911*, (New Delhi: Sage Publications, 1998); Kabita Ray, *History of Public Health: Colonial Bengal 1921-47*, (Calcutta: K. P. Bagchi & Sons, 1998), V. R. Muraleedharan, *Malady in Madras: The Colonial Government's Response to Malaria in the early 20th century*, pp-101-114, in Deepak Kumar (ed.), *Science and Empire, Essays in Indian Context (1700-1947)*, (Delhi: Anamika Prakashan, 1991).

⁶ Mark Harrison, *Public Health in British India: Anglo-Indian Preventive medicine 1859-1914*, (Cambridge: Cambridge University Press, 1994).

governments. The latter on the other hand too proved to be inefficient in framing the policy for paediatrics both due to lack of funds and will. After independence, Uttar Pradesh government from its First Plan showed its concern towards the development of paediatrics through the establishment of hospitals, MCWCs, MDM, ICDS, ANM, etc. But the state, though, improved the condition of its children was at the last position among all States in providing healthcare to its vulnerable groups as both rural and urban mortality among children in UP though declined remained highest in the country, unfortunately, even today.

Exploring colonial medical policy through their sensibilities towards child healthcare enables to better understand the nature of the colonial administrative structure. The policy formation for children in colonial India was influenced by international policy formulations, developments in western countries and the rise of women in political as well as social life. The colonial interventions were for their future subjects whose better health ensured the stability of the empire. In the process, children became both the beneficiary as well as endorser of western medical care. Child's body thus acted as a site of colonial government's claim of a welfare state and proof of their role of paternalistic benevolence.

Even after so many policies and programmes of the Central and state governments, Uttar Pradesh remained the poorest state in case of healthcare. Poverty, insanitary conditions, failure of the medical administrative system, recognition of the significance of paediatrics in policy-making and lack of affordability and accessibility in healthcare remains a serious challenge for the policy-makers. The organization of paediatric is of paramount importance for the proper care and development of children. Unfortunately, this is the weakest link in our programme of childcare and its imperative that due importance has to be given in formulating national health policy for paediatrics.

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GLOSSARY

Anganwadi	centers providing care for mother and young children
Ayurveda	traditional system of ancient Indian medicine
Balwadis	pre-school child care centres
Balsevikas	women who guide to mother's on child care methods
Brahmacharya	celibacy
Chawkidars	lowest rung of the police organisation
Dawakhanas	hospitals
Gauna	sending bride with groom after marriage
Gram Sevikas	group of women providing healthcare aid in villages
Hakim	practitioner of Unani medicine
Jarrah	barber-surgeon
Kaviraj	traditional Ayurvedic practitioner
Kumarbhartyas	paediatricians
Mahila Mandals	Network of Womens's Associations/women's rural club
Mandals	associations
Magh	month in hindu calender
Poos	month in hindu calender
Purdah	segregation of women
Purdah-nashins	women in separate quarters
Shifakhana	hospital
Vaid	practitioner of the Ayurvedic tradition of medicine
Tibbi	medical
Tikadar	variolator
Unani	a system of Indian medicine believed to have Graeco- Arabic origins
Zenana	women's quarter

ILLUSTRATIONS



Image 1: Lady Lyall and Dufferin Hospital for Women, Agra

Source: www.chomi.org

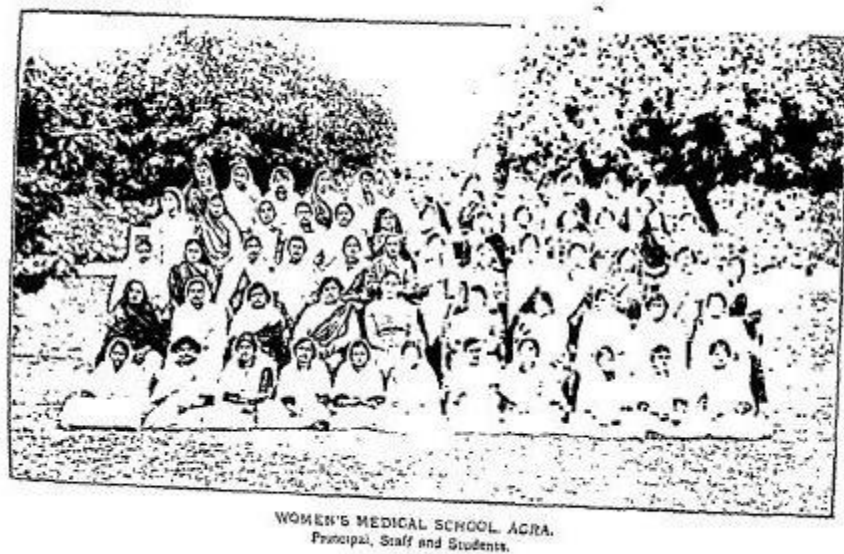
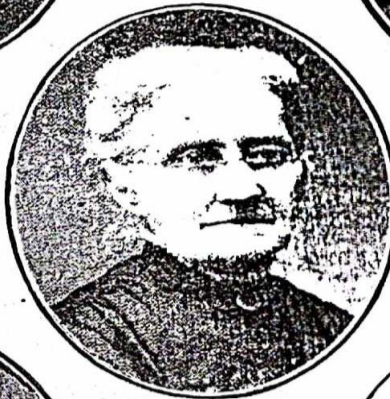


Image 2: Women's Medical School Agra, Principal, Nurses and Staff

Mrs. Pechey Phipson, M.D.
Qualified, 1877
Died, 1908



Miss E. Bielby, M.D.
Qualified, 1885

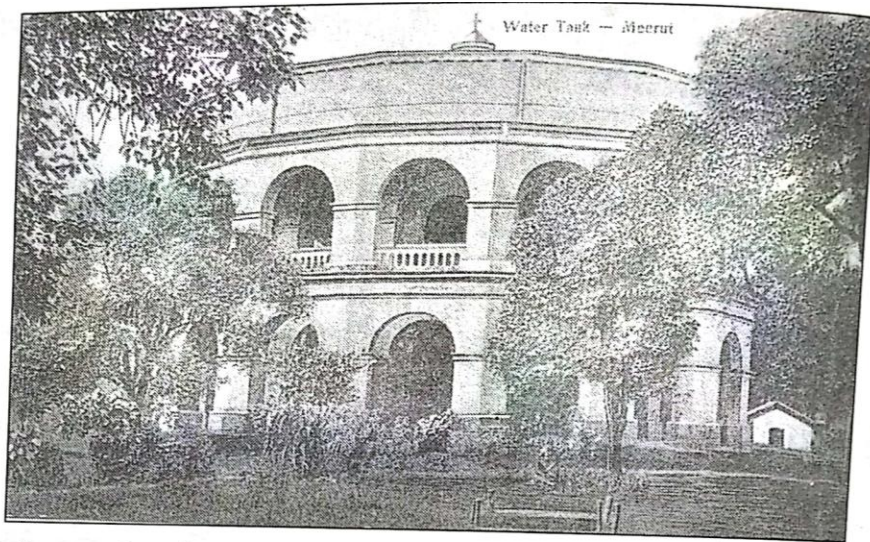


Miss Clara Swain, M.D.
Qualified, 1869
Died, 1910

Miss A. Jaganadhan, L.R.C.P. & S.E.
Qualified, 1890
Died, 1894

Miss Rukhmabai, L.R.C.P. & S.E.
Qualified, 1895

Image 3: Leading ladies of Women and Children movement in India



*Water Tank for supply of water to Meerut cantonment in Old Postcard (about 1910),
Collection of Dr. Amit Pathak*

Image 4 : Water supply in Meerut cantonment.

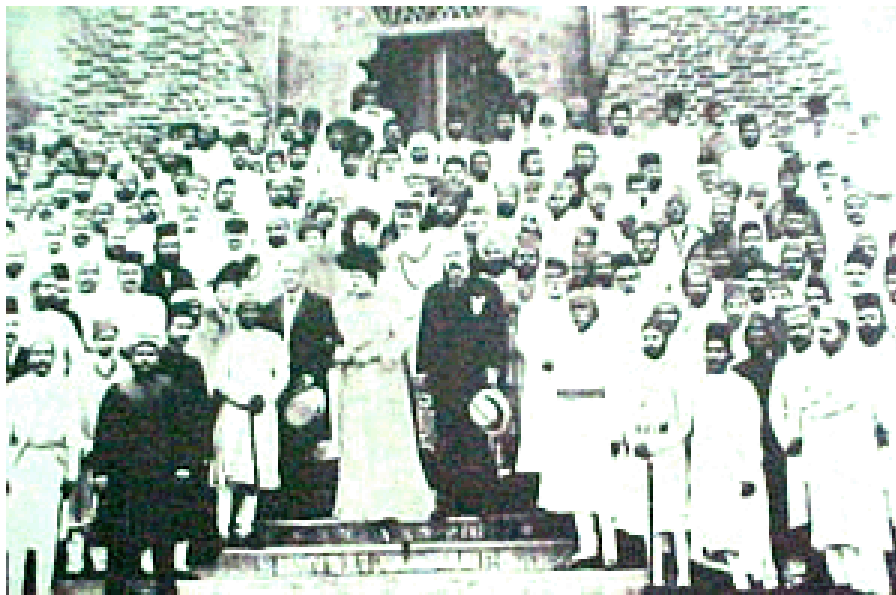


Image 5: Prince & Princess of Wales with eminent citizens of Oudh at the Foundation Ceremony of the college- KGMC

Source: <http://www.kgmu.org/history.php>



Image 6 : Keneddy ward Benares hospital.

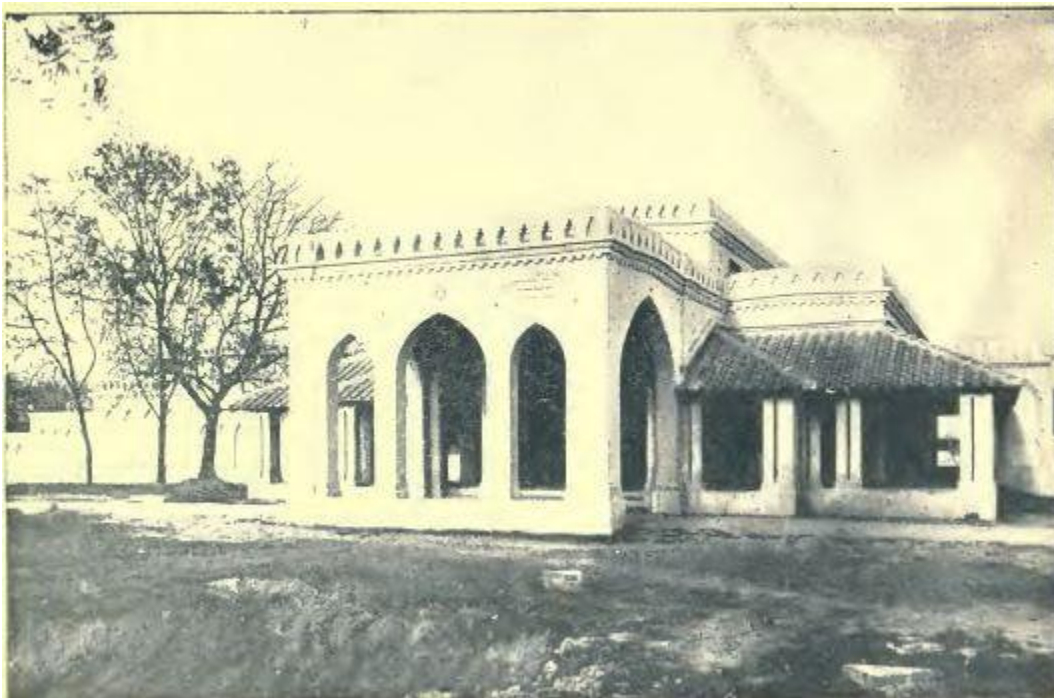


Image 7: Lady Kinnidard Hospital Lucknow.



Image 8: Child Patients in Victoria Hospital, Benares.



Image 9: Victoria Hospital, Benares.

MEDICAL DEPARTMENT.

NORTH-WESTERN PROVINCES AND OUDH, OCTOBER, 1885.

(b) Sultanpur Municipality Vaccination Circle.

No. _____ No. _____

Certificate of unfitness for vaccination.—Issued on the _____
Date _____ of _____ 188 .

Name of child.	Child.			Parent or guardian.			Instruction.
	Name.	Sex.	Age.	Name.	Caste.	Place of abode.	
_____	_____	_____	_____	_____	_____	_____	Child to be presented for re-inspection on _____ _____
_____	_____	_____	_____	_____	_____	_____	

Name of parent and place of abode. _____

Cause of unfitness. _____

I hereby certify that the abovenamed child was presented to me for vaccination this day, and found unfit for vaccination for a period of _____

by reason of _____

(Countersigned)

Public Vaccinator. Superintendent of Vaccination. Public Vaccinator.

Image 10: Vaccination form in NWP and Oudh



Image 11: Infant Food Factory, Moradabad, Uttar Pradesh



Image 12: Child care in hospital



Image 13: Child vaccination services in rural areas.



Image 14: Travelling dispensary Lucknow, 1974.



Image 15: DDT spraying in the houses under Malaria Eradication Programme.



Image 16: Family Planning advice to women in Clinics



Image 17: Post-natal care at home



Image 18: Preparation of delivery at home



Image 19: Family Planning center, Lucknow.



Image 22: Sarojini Naidu Medical College, Agra (former Thomason school/Hospital- oldest medical school of India)

APPENDICES

Table 1: Average area and population served by each hospitals and dispensary

Provinces	Total Number of hospitals and dispensaries in the province	Average area served by each hospital or dispensary (sq. miles)	Average population served by each hospital or dispensary
Madras	1,134	126	530
Bombay	429	180	360
Bengal	1,449	540	287
United Provinces	597	178	345
Punjab	896	111	551
Bihar	528	131	83
Assam	343	160	194
Central Provinces	343	291	310
Sind	108	429	96
Orrisa	164	145	95
North- West Frontier Provinces	114	118	106
Delhi	24	24	31
Ajmer Merwara	10	271	13
Baluchistan	41	1,327	40
Coorg	11	145	145

Source: IMR, p- 7

Table 2: Vaccination coverage in NWP and Oudh (1881-1900)

Year	Successful primary vaccination		Deaths from smallpox		Successful vaccination under one year		Percentage of infant population protected	
	NWP	Oudh	NWP	Oudh	NWP	Oudh	NWP	Oudh
1880-81	572,670	67,554	5,613	2,637				
1881-82	596,765	87,261	12,528	4,635				
1882-83	564,064	34,842	18,110	8,518	249,221	8,979	20.0	2.0
1883-84	530,216	26,135	59,372	79,269	256,367	8,129	19.0	1.7
1884-85	537,288	26,576	100,962	101,559	283,101	11,482	20.0	2.1
1885-86	557,216	31,805	6,828	7,765	2,69,242	13,185	20.0	2.5
1886-87	575,574	37,444	3,390	6,556	2,75,050	12,769	23.0	2.7
1887-88	610,688	41,880	6,441	2,051	298,534	12,324	24.0	2.4
1888-89	609,259	49,932	8,520	16,480	302,699	13,415	25.0	2.7
1889-1900	623,935	76,494	12,764	35,479	303,560	20,362	26.0	4.2

Source: Report on the Administration of NWP and Oudh 1890, p-208

Table 3- Number of Deaths Registered according to the Age in the Districts of NWP and Oudh

Year	Under 1 year		1 and under 5 year		5 and under 10 years		10 and under 15 years	
	Male	Female	Male	Female	Male	Female	Male	Female
1880	2,448	2,363	21,682	17,068	39,198	16,628		
1892	131,239	108,819	133,951	130,868	48,851	37,195	27,599	18,941
1899	279,012	251,343	132,072	133,942	40,646	32,442	23,591	16,525
1900	2,38,197	216,414	112,608	114,616	38,924	30,607	24,565	17,436
1901	2,42,730	216,293	123,080	125,358	34,743	28,169	22,914	16,986
1902	280,554	252,126	134,197	136,846	41,468	36,122	26,370	21,765
1903	318,416	285,224	204,013	203,545	59,163	50,638	33,732	28,556
1904	262,538	24,908	126,033	132,347	44,913	43,957	33,757	32,559
1906	2,49,574	231,810	177,736	180,341	3,195,199	2,914,632	3,091,210	2,475,28
1909	201,242	182,726	132,728	135,809	53,843	47,774	30,522	24,355
1924	82,024	67,359	128,733	2,098,014	38,331	32,734	26,630	22,317

Source: Annual report of Sanitary Commissioner, 1892, p- viii-ix. Report on the Administration of NWP and Oudh, 1879-80.

Table 4: Percentage of School Children medically examined and Diseases and Defects Found in United Provinces

a. Municipal Areas (41 areas)

DEFECTS IN CHILDREN EXAMINED	NO. OF CHILDREN FOUND DEFECTIVE	PERCENTAGE OF SUCH DEFECTIVE CHILDREN TO THE TOTAL EXAMINED
1. Nutrition		
a. Good	18617	38.70
b. Fair	19055	39.61%
c. Poor	10573	21.98%
2. Defect in Teeth	5375	11.17%
3. Enlargement of Tonsils and Adenoids	2877	5.98%
4. Defects in Hearing	617	1.28%
5. Defects in Eye		
a. Diseases of the Lids	3502	7.28%
b. Vision	2600	5.40%
6. Defect in Speech	150	0.31%
7. Tuberculosis		
a. Pulmonary	50	0.10%
b. All other forms	483	1.00%
8. Lung Diseases Other than Tuberculosis	374	0.78%
9. Heart Diseases	188	0.39%
10. Alimentary Disease	621	1.29%
11. Anaemia		
a. Evidence of parasites or other diseases	288	0.60%
b. Enlargement of Spleen	2244	4.66%
12. Deformity		
a. Congenital	109	0.23%

b. Acquired	80	0.17%
13. Skin Diseases	1474	3.06%
14. Infectious Diseases	430	0.89%
15. Unprotected from Smallpox	3960	8.23%
16. Protected by vaccination and re-vaccination	41346	85.94%

b. Rural Areas

DEFECTS IN CHILDREN EXAMINED	NO. OF CHILDREN FOUND DEFECTIVE	PERCENTAGE OF SUCH DEFECTIVE CHILDREN TO THE TOTAL EXAMINED
17. Nutrition		
d. Good	30291	33.20%
e. Fair	44192	48.44%
f. Poor	16440	18.02%
18. Defect in Teeth	9753	10.69%
19. Enlargement of Tonsils and Adenoids	1858	2.04%
20. Defects in Hearing	428	0.47%
21. Defects in Eye		
c. Diseases of the Lids	5047	5.53%
d. Vision	583	0.64%
22. Defect in Speech	120	0.13%
23. Tuberculosis		
c. Pulmonary	90	0.10%
d. All other forms	175	0.19%
24. Lung Diseases Other than Tuberculosis	993	1.09%
25. Heart Diseases	156	0.17%
26. Alimentary Disease	930	1.02%
27. Anaemia		
c. Evidence of parasites or other diseases	755	4.34%
d. Enlargement of Spleen	3680	0.80%
28. Deformity		
c. Congenital	76	0.08%
d. Acquired	319	0.35%
29. Skin Diseases	2428	2.60%
30. Infectious Diseases	788	0.86%
31. Unprotected from Smallpox	11,681	12.80%
32. Protected by vaccination and re-vaccination	69265	75.93%

Source: Sixty-Third Annual Report of the Director of Public Health of United Provinces, December 31, 1931, p-54-55.

Table 5: Result of the MPF used by the students of Lucknow schools by the School Authorities.

Name of school	No. Of children on whom experiment was conducted and Age Group	Experimentation method	Time Period	Result	Financial Position	Expenditure	Remarks made by institution
Government Jubilee Inter College	128 8-12 yrs.	As instructed by Bosi Sen	30 days	About 50% showed increase by 2 to 3 lbs and height by ½" to 1" and about 10% remained stationary. The rest have declined in weight and no efficiency in other spheres was discernable	Mostly of Middle and Lower class families	nothing	MPF containing vitamin may be served as a nourishing diet to school children.
Kali Charan Inter College	120 11-13 yrs.	Served as Dry powder	From Nov. 1951-31 st Jan 1952	General tendency towards increase in weight. No noticeable change in efficiency	Mostly from poor families	Nothing	-
Lucknow Christian College	53	The food was taken along with other food	One month	No improvement in weight	-	-	The food was rather coarse, it could have been finer and more palatable.
K. K. College	120 10-13 yrs.	The food was taken along with other food	3 months	Slight increase in weight of children	Ordinary	The work was done in honorary capacity, along with other Physical work	No increase in weight and efficiency.
D.A.V. College	75 10-12 yrs.	Dry powder	2 months	Weight of 6 boys increased by about 2 lbs and that of 10 boys 1 lb. And all the students found energetic	Unsatisfactory	Per student per chatak	The boys liked the food very much
Lalbagh Higher Secondary School	180 6-12 and 12-18 yrs.	Used with chapatti flour	-	Better physical condition when students have this extra food. Student didnot make any complaint the feeling of hunger as they did when only rationed food was available.	Didnot account financial position	-	Favoured the MPF.
Primary Alambagh	8 9-10 and 11-12 yrs.	Half chatak was given to each student	3 months	No increase in height. Weight of boys increased and the weight of 3 boys decreased . height of 6 students increased. One remained stationary.	Lower Middle class	-	Result should be considered disappointing
Mahila Vidyalaya College	100 6-10 yrs.	Served s Dry powder	15-30 days	General increase in weight up to 5 lbs	Middle class students	-	Children did not like the taste but were benefitted by the use of MPF.

Table 6: MCWC in Urban and Rural areas of United Provinces

Year	Centres maintained by								Trained Personnels					
	Government		Local and Municipal bodies		Other agencies		Total		Trained Visitors		Trained midwives		Trained dais	
	Rural	Urban	Rural	Urban	Rural	Urban	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
1934	-	-	109	60	7	3	116	63	-	15	106	120	44	189
1935	-	-	120	109	-	-	109	120	14	6	151	142	350	524

Source: Annual Report of Public Health Commissioner with GOI, 1934, p-318; 1935, p-237.

Table 7: Status of Pediatric centers in the country.

State	Paediatric Hospitals		Paediatric Wards in Hospitals		M.C.H. centres	
	No.	Beds	No.	Beds	Rural	Urban
Andhra Pradesh		50		37	993	385
Assam		50		37	238	6
Bihar						
Gujarat			8	268	555	126
J&K						
Kerala	1	140	13	500	773	52
Madhya Pradesh	1	10	18	246	295	42
Madras	2	232		573	194	123
Maharashtra	18	672	41	671	594	155
Mysore	1	65	10	356	41	7
Orissa	1	100	3	76	561	21
Punjab		64		234	577	81
Rajasthan	23	422			8	59
Uttar Pradesh	1	184	13	425	1843	127
West Bengal	5	285	12	241	419	312
Andaman and Nicobar Islands			1	36	2	1
Delhi					30	57
Himachal Pradesh			6	79	63	8
Manipur						
Laccadive Minicoy and Amindivi Islands					2	
Pondicherry	1	52			3	
Tripura			1	24	15	
India	54	2276	182	3674	7347	1570

Source: Health Statistics 1961-63.

Table 8: Maternity and Child Welfare Centres in Rural and Urban Areas during 1960

State	Rural	Urban	Total
Andhra Pradesh	+	+	+
Assam	238	11	249
Bihar	+	+	+
Gujarat	148	173	321
J&K	+	+	+
Kerala	558	+	558
Madhya Pradesh	146	83	229
Madras	1659	286	1,945
Maharashtra	366	304	229
Mysore	+	+	+
Orissa	+	+	+
Punjab	192	81	273
Rajasthan	5	63	68
Uttar Pradesh	1248	103	1,351
West Bengal	216	123	339
Andaman and Nicobar Islands	2	1	3
Delhi	+	+	+
Himachal Pradesh	21	9	30
Manipur	-	1	1
Laccadive Minicoy and Amindivi Islands	1	-	1
Pondicherry	3	-	3
Tripura	+	+	+
India	4,803	1,238	6,041

Source: Health Statistics 1959-1960

+Figures not available; - No information

Table 9: Vaccination performance of School children in India 1979-82 (Figures in Lakh)

Immunization category	Period	I dose	II dose	III dose	Booster
D.P.T. (to prevent diphtheria)	1979-80	92.33	72.89	59.43	8.62
	1980-81	90.62	72.27	60.27	10.96
	1981-82	104.09	84.03	71.22	13.33
T.T.	1979-80	60.08	46.05	30.78	1.40
	1980-81	69.04	50.38	37.02	1.97
	1981-82	70.46	54.10	-	9.29
Polio	1979-80	10.78	7.39	5.40	1.28
	1980-81	22.93	17.12	13.76	3.01
	1981-82	37.50	27.20	22.64	4.70
D.T. (to prevent whooping cough)	1979-80	114.58	98.63		8.69
	1980-81	111.08	91.76		9.12
	1981-82	111.48	92.49		8.28
Typhoid	1979-80	9.84	3.97		
	1980-81	28.91	17.39		
	1981-82	36.33	22.13		
T.T. school children	1979-80	-	Not started		
	1980-81	3.70	2.50		
	1981-82	21.50	17.41		

Source: Health Statistics of India, 1982.

Table 10: Distribution of Children under Feeding Programmes by State

State	SNP Including ICDS	School Meals scheme	Others	Total	Number of		Malnourished Children	
					All Children	Poor Children	All Children	Poor Children
Andhra Pradesh	908	0	11	919	12600	4590	5594	743
Assam	512	95	12	619	7000	1650	0	0
Bihar	690	0	7	697	18600	9210	0	0
Gujarat	1151	3000	43	4194	8800	2140	5245	1338
Haryana	284	0	6	290	3500	550	0	0
Himanchal Pradesh	75	0	2	77	1000	140	0	0
J&K	102	0	1	103	1600	260	0	0
Karnataka	884	0	11	895	9300	3260	3980	520
Kerala	552	950	8	1510	6000	1610	1134	90
Madhya Pradesh	1048	1200	11	2259	15400	7120	7962	1771
Maharashtra	954	2000	40	2994	14600	5080	6950	1007
Orissa	1314	184	11	1509	7100	3040	3635	632
Punjab	159	0	6	165	3800	520	0	0
Rajasthan	563	0	5	568	10200	3500	0	0
Tamil Nadu	300	6400	6	6706	10000	3960	3980	520
Uttar Pradesh	682	0	27	709	29000	13140	9541	1769
West Bengal	1250	3200	11	4461	15500	6080	3565	

Source: Children and Women in India- A Situation Analysis 1990, UNICEF, New Delhi, 1991, p-154.

Table 11: Nutritional status of pre-school children (0-6 years) in ICDS project areas

State	Total No. of		Nutritional Status (2-<6 years children)					
	Projects	Children	Normal	Grade I	Grade II	Grade III	Grade IV	Not Recorded
Andhra Pradesh	5	2626	22.4	32.2	25.6	6.5	1.4	11.8
Haryana	5	1517	52.4	19.4	11.4	2.9	0.2	13.9
Karnataka	4	1985	32.7	35.1	18.7	4.1	0.4	9.0
Kerala	3	1816	47.9	28.0	12.1	1.7	0.2	10.1
Maharashtra	4	1647	23.6	32.4	23.3	7.4	0.6	12.6
Orissa	4	2112	25.9	42.9	24.6	2.1	0.5	4.0
Punjab	2	1044	54.1	26.3	10.0	2.9	0.0	5.5
Rajasthan	2	1328	30.2	26.1	23.6	10.9	7.5	1.6
Tamil Nadu	4	2610	36.8	37.7	16.4	3.2	0.8	5.1
Uttar Pradesh	7	4055	39.2	18.8	14.7	5.1	1.5	20.6
West Bengal	4	2322	30.9	36.0	222.0	6.3	1.5	3.3

Source: UNICEF, Children and Women in India: A situation Analysis, p-38.

Table 12: Per cent distribution of Immunised children by Age and Type of Immunisation, 1978

Area	Age (year)	Sex	Type of Immunization			
			Smallpox	BCG	Triple Vaccine	Polio Vaccine
Rural	Below 1	Male	27.28	3.71	0.87	0.07
		Female	29.59	3.32	0.25	0.08
	One	Male	61.27	10.29	0.36	0.04
		Female	59.33	11.08	1.36	-
	Two	Male	78.12	15.10	1.68	0.23
		Female	77.78	17.15	2.42	0.11
	Three	Male	87.55	15.27	1.50	0.15
		Female	86.89	18.66	2.27	0.09
	Four	Male	88.82	16.48	2.81	0.29
		Female	89.41	15.52	3.35	-
	Five	Male	91.70	15.78	2.53	0.08
		Female	90.13	16.15	2.52	-
Six	Male	90.52	18.98	2.97	0.11	
	Female	91.26	19.86	2.17	-	
Urban	Below 1	Male	51.98	28.43	14.30	2.22
		Female	49.82	26.53	11.31	1.82
	One	Male	79.58	37.15	17.44	4.47
		Female	84.07	38.20	16.84	4.80
	Two	Male	89.89	44.25	21.84	6.46
		Female	89.97	42.76	19.62	6.07
	Three	Male	92.85	45.46	21.57	5.74
		Female	91.84	42.50	19.85	5.49
	Four	Male	91.79	42.57	20.88	5.75
		Female	91.88	44.92	22.09	5.43
	Five	Male	91.56	42.29	19.64	6.24
		Female	92.58	44.70	22.46	6.80
Six	Male	90.64	46.26	20.84	5.65	
	Female	88.79	41.87	17.11	4.60	

Source: Moonis Raza & Sudesh Nangia, *Atlas of the Child in India*, (New Delhi: Concept Publishing Company), 1986, p-707.

PAEDIATRIC MEDICINE IN INDIA AND BOTTLENECKS OF DEVELOPMENT IN NURTURING DEMOGRAPHIC ASSETS

Shivangi

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ABSTRACT This article argues that the poor state of paediatric medicine in India still restrains and often prevents the healthy development of far too many young Indians. Infants as junior-most citizens deserve diligent care, as they have legal entitlements to specialised medical services, ensuring their survival and healthy growth, ultimately for the benefit of the entire nation. The article first traces the somewhat stunted colonial institutional development of paediatric medicine in India. It then proceeds to perform a critical analysis of the continuing harm of negligence concerning the health and upbringing of India's vulnerable infants, challenging the state to become more committed to integrated child development.

KEYWORDS: *children, development, health, India, infant mortality, nutrition, paediatrics, smallpox, state*

Introduction

On 11 December 2016, the President of India showed his concern for the current state of childhood not only in the country but across the world when he launched, together with Nobel laureate Kailash Satyarthi, a televised campaign on Zee News called '100 Million for 100 Million', with the aim to mobilise 100 million youth and children for 100 million underprivileged children of the world. This activity highlighted the menaces of child labour, slavery and violence against children and promoted demands for the right of every child to be safe, free and educated, to be implemented over the next five years. However, surprisingly, the next day, this initiative failed to find any mention in India's leading newspapers. This limp response within India indicates continuing lack of attention in implementing comprehensive child rights and proper healthcare for all children in India.

It is widely proclaimed worldwide that children are precious assets for any nation, while the education, health and well-being of many children remain major challenges for many countries today. Declaring 1979 as the International Year of the Child is reflected in some Indian social science literature (Gokhale & Sohoni, 1979; Srinivasan et al., 1979). Yet, also among historians, only the last few decades have witnessed a growing inclination to study childhood and the ‘child in history’, notably often still in colonial contexts (Pomfret, 2015; Saha, 2017; Sen, 2010). While earlier studies on children and child health in India exist, they focus on female infanticide (Pakrasi, 1970), violence in the family (Kapur, 1993), very often child labour (Weiner, 1991) and also the problematic distinction with child work (George, 1990) and impacts on education (Srinivasan et al., 1979). Earlier focussed on colonial agenda, few analyses of the deficient institutional setup of paediatric medicine in postcolonial India exist, particularly in relation to broader developmental goals. Concerns for the health of children, and their mothers, became first a matter of growing concern in British India (Saha, 2017; Sen, 2010), largely focussed on colonial personnel.

High infant mortality, undernutrition, malnutrition and low immunisation, coupled with inadequate medical facilities in many underdeveloped nations, cause shockingly high early death rates. India, with 472 million children (Government of India, 2016b: 20), has one of the youngest populations in the world, but India also contributes about 21 per cent to global infant mortality. One of the reasons for this is the poor state of paediatrics and of paediatric medicine in India. This is confirmed by insufficient numbers of paediatricians, resulting, to some extent, from lack of specialised paediatric medical institutions of education and related associations. Inadequate access to life-saving childcare provisions still restrains and often prevents the healthy development of far too many young Indians, especially in India’s tribal and rural areas (Dhanalakshmi, 1993).

This historically focussed article uses qualitative documentary evidence to highlight the contemporary deficiencies of paediatric medicine in India and their pernicious consequences, linking the medical field to developmental issues. The research first traces the institutional development of paediatric medicine in India after seven decades of independence. It seeks to map statistics of professional bodies and institutions engaged in paediatric medicine and draws attention to the urgent need for restructuring paediatric medicine and improving the status of paediatricians and paediatric medical institutions in India. The ambit of the article is then widened to include broader child-centred developmental agenda, which are found to ignore even most basic aspects of the right to life for Indian children.

The article first briefly traces the colonial history of paediatric medicine and then documents India’s post-Independence institutionalisation of paediatric medicine. Various government policies and programmes to ameliorate paediatrics in India are assessed, and the need for integrated legislation and more focussed child health financing is explored. The final major part examines the impact of the current status of paediatric medicine on the cognitive growth of children in India in a wider

developmental context. This brings out the urgent need to promote more effective child healthcare facilities in India, to give this domain a higher profile, more resources and also more attention as a matter of basic entitlement theorising (Choudhary, 2015).

History of Paediatric Medicine in Colonial India

The history of paediatric medicine remains largely unexplored, although it received some attention under the Raj (Arnold, 1993a; Saha, 2017; Sen, 2010). While the male-centric nature of the colonial enterprise is strongly reflected in its focus on men's health (Sen, 2010: 253, 255), some attention was given to women's health in hot climates (Sen, 2010: 259–60). Comments about children's health within family medical handbooks at the time reflect 'prevailing fears about child mortality' (Sen, 2010: 257). While the colonisers' children as a particularly vulnerable section of British India's population attracted growing concern (Saha, 2017; Sen, 2010), responsibility for the health of all children remained largely below the radar, although British children were thought to be at risk from Indian servants who might transmit diseases, especially smallpox, from their obscure homes in the bazaar (Arnold, 1993a, 1993b; Sen, 2010).

Some recent studies emphasise the 'child in history' (Aries, 1996), often still in colonial contexts (Pomfret, 2015; Robinson & Sleight, 2016). The framing of various policies by the colonial state reflects different attempts to colonise the body of its future slaves and servants. Studies on diseases targeting children and the responses of indigenous medicine and certain religious superstitions (Arnold, 1993b: 224) largely indicate the precarious state of knowledge about child health in India (Sen, 2010). Moreover, while the imperial context suggests that India was colonised for economic exploitation, the colonisers were certainly not unaware of the significance of their subjects' health and education, though they were generally unwilling to commit sufficient resources, as Basu (2018: 277–8) shows with reference to sports education for children.

In colonial times, smallpox was a dreaded disease of children, so common in northern India that Sir John Pringle, a prominent early British physician in India, whose famous work *Observations on the Diseases of the Army* was first published in 1753, maintained that 'it has become quite a saying among the agricultural and even wealthier classes never to count children as permanent members of the family until they have been attacked with and recovered from smallpox' (cited in James, 1909: 49). In the opinion of the Smallpox Commissioners in Calcutta in 1850, the small, overcrowded and ill-ventilated homes of the poor were 'permanent storehouses of every pestilence disease', including smallpox (Arnold, 1993a: 135). Similarly, when Sir Syed Ahmed Khan introduced a bill for compulsory vaccination in the Viceroy's Legislative Council in 1879, he said that smallpox was 'the inevitable bridge which every child has to cross before entering into life' (Mohammad, 1972: 142), so that recovery from the disease was considered a second birth. While other diseases were looked upon as accidental, smallpox was regarded as almost universal, 'the scourge of India' (Arnold, 1993b: 224). Vaccination policies were initiated by the colonial state to combat increasing smallpox

mortality among Europeans. However, Arnold (1993a: 135) asserts that vaccination, introduced at a critical moment in the history of colonialism in India,

... was never intended exclusively for the white population of India. Indeed, the speed with which it was taken up as a cardinal feature of state medicine in India demonstrates the extent to which Western medicine was not governed by a purely enclavist mentality, though it soon became clear that the enthusiasm of the medical profession was not well supported by financial constraints and political pragmatism of the government itself.

The first smallpox vaccine reached India in June 1802 through a relay of children vaccinated from arm to arm from Bagdad to Bombay. Unfortunately, the vaccine was often 'lost' in this process of human transmission, or parents refused to allow their children to be used to supply lymph for the vaccination of others (Arnold, 1993a: 140). It was estimated that between 1867 and 1876 less than a third of children in the north-western provinces were vaccinated (Pearson, 1877: 29). By 1908, nearly 50 per cent of infants in the United Provinces had been vaccinated (Vaccination Report, UP, 1909: 3). In Bombay, the advance was more impressive, with some 80 per cent of children vaccinated by the end of the nineteenth century, yet this still left at least 20 per cent unprotected, and this failure to vaccinate about one in five children prevented substantial progress in reducing smallpox mortality in India until independence (Arnold, 1993a: 141).

Colonial policies were not limited to vaccination. Though other measures were not comprehensive, they help to understand various colonial attitudes towards children (see Basu, 2018). The Education Department of the United Provinces introduced medical inspections of school children in High School and Intermediate Colleges. Medical and Health Officers were appointed to examine day pupils as well as students staying in hostels (UPSA, 1918). A proposal was also made to carry out regular weighing of school children, and the appointment with ophthalmologists for children showed signs of awareness about ear, nose and throat problems (UPSA, 1925). Yet, these measures were not effectively implemented, again mainly due to financial stringency. However, regular vaccination of school children showed effects in curbing the spread of communicable diseases. Health officer reports considered teachers and parents as the most prominent hurdle in the overall development of children. In 1931, the responsibility of medical inspection of school children was transferred to the Department of Public Health. Overall, a fruitful comprehensive policy could not evolve under British rule, but some foundation stones were laid for paediatric medicine in independent India.

Paediatric Medicine in Postcolonial India

Postcolonial India took a long time to wake up to children's healthcare needs, and paediatric medicine, it seems, suffered neglect as a subject. No serious attention has been given by historians to studies of childhood in India in different time periods (Baru, 2008; Chandrashekhar, 1959; Raza & Nangia, 1986). Globally, the history of

paediatrics and paediatric sub-specialties is seen as important for seeking to understand the health challenges that the children face in the twenty-first century (Colon & Colon, 1999: xv), but India lags behind. Only in the 1980s did the government for the first time introduced a National Health Policy, reflecting a changing government approach to medical facilities, institutions, infrastructure and human resources to improve citizens' health. Framing policies for better healthcare of citizens acquires much more urgency when one observes that India is globally ranked 143 among 188 nations in terms of health performance, reported, for example, by the *Times of India* (23 September 2016: 6). Continuing high infant mortality and especially high under-five mortality in India reflect multiple failures of healthcare delivery systems.

To assess the present number of paediatricians across India, data from various official sources, especially DLHS-3 (2010), are used here. Particularly in tribal areas, paediatricians are scarce and there are many vacant positions. States with large tribal populations, including Chhattisgarh, Gujarat, Madhya Pradesh and Rajasthan, are known to face acute shortages of paediatricians. Similarly, the data for rural areas disappoint, reflecting the well-known reluctance of doctors to work in remote, backward areas. Except Punjab, no state and union territory (UT) has satisfactory availability of paediatricians. The relevant data indicate that one of the fastest growing economies in the world lacks the most essential requirement for paediatric medicine, namely specialised doctors. According to the DLHS-3 (2010) report, community health centres in India have a total of just 805 skilled paediatricians. The worst conditions prevail in the eastern states, especially Mizoram and Tripura, with zero availability of paediatricians. The UTs of Lakshadweep and Dadra & Nagar Haveli suffer, too, and only Daman & Diu has full availability of required paediatricians. Arunachal Pradesh, Gujarat, Himachal Pradesh, Meghalaya, West Bengal and Tamil Nadu have less than 10 per cent of needed paediatricians, while no state in India can rely on more than 50 per cent availability of specialised paediatricians needed. In fact, the DLHS-3 (2010) report showed that only 25.2 per cent of community health centres had gynaecologists in position, while on average 19.3 per cent had paediatricians. Rural community health centres faced around 82.2 per cent shortage of paediatricians.

However, between 2005 and 2015, remarkable progress in fulfilling the requirements for paediatricians seems to have been achieved and the north-eastern states now report positive outcomes. The most representative association of paediatrics in the country, the Indian Academy of Paediatrics (IAP), established in 1963, is credited with making paediatrics recognised as a separate discipline in India. Bansal and Gupta (2013: 41) revealed that it has 20,473 members, 26 state branches, one UT branch in Chandigarh, 303 local branches and notably even an international branch in the United Arab Emirates. IAP provides categories for Ordinary Members, Life Members, Associate Members, Associate Life Members, Students Members and Associate Foreign Members (Bansal & Gupta, 2013: 41). Ghosh (2015) reported that IAP is now the world's second largest paediatric association after the American Academy of Paediatrics, with its own journal. This organisation is consulted both by state and central governments

in formulating health policy for paediatrics. Surprisingly, there are no consolidated registries of specialists available to the Medical Council of India (MCI). Under MCI regulations, it is mandatory for all practising doctors to re-register every five years, which is least followed practice. Ghosh (2015) reported that associations of specialists admit an obvious urban–rural divide, but overall, the country is woefully short of qualified medical practitioners, even in ‘bread and butter’ specialties.

If India had enough paediatricians, they could play crucial roles also in increasing awareness about child health and could improve policy formulation. But there are several obstacles, especially the low number of professional bodies, research institutes and specialised hospitals. There are around 18 professional organisations and associations for paediatric medicine in India, with both national and international recognition. The chief objective of the Millennium Development Goals-IV (MDG-4) was to reduce under-five mortality rates by two-thirds between 1990 and 2015. IAP works in close association with the government for reducing under-five mortality and achieving the MDG-4 objectives through implementing its Mission Uday project. This aims to reduce the mortality rates due to childhood pneumonia, diarrhoea, dengue and other common infections illnesses. Mission Uday aims to train paediatricians, general practitioners and Accredited Social Health Activists ASHA staff as community health workers appointed by the government to create awareness on health and its social determinants, in 150 high-risk districts of the country. The project also emphasises disease surveillance and reporting of adverse events following immunisation. In addition, management of severe acute malnutrition has become a major objective of IAP since 2013, with many IAP policies related to child health, reflecting a more holistic and integrated approach. The Policy on Age of Children for Paediatric Care mentions that the purview of paediatrics commences with the foetus and continues through the stages of newborn, infancy, preschool and school age, including adolescence, up to and including 18 years of age (Bansal & Gupta, 2013: 46).

The growth of paediatrics has also given rise to several other specialised fields with their own associations to promote particular sub-areas within this branch of medicine. This step makes the field of paediatrics more diversified to tackle critical problems, yet effective progress still has a long way to go. Among research institutions, the Indian Council of Medical Research is most prominent in developing Paediatric Research Institutions in India and enhancing their research contributions. There are seven major medical research institutions in India: the National Institute of Occupational Health (Ahmadabad), the National Institute for Research in Environmental Health (Bhopal), the National Institute of Nutrition (Hyderabad), Central India’s Child Hospital and Research Institute (Nagpur), the Regional Medical Research Centre in Bhubaneswar, St. John’s Research Institute in Bangalore and the Imperial Hospital and Research Centre (Apollo) in Bengaluru. These institutions, though often not directly, conduct research on child-related health problems in India. Furthermore, the National Health Portal of the government enumerates around 256 specialised hospitals, both private and public, dedicated to providing proper paediatric healthcare.

According to the MCI website, 320 teaching institutions and academic bodies throughout the country prepare future paediatricians. Yet specialist courses are limited in number, and some courses do not provide advanced specialisations like Paediatric Anaesthesia or Paediatric Cardio-Thorac Vascular Surgery. The MD in Paediatrics course is offered by altogether 257 colleges, both private and public, while the MCh Masters Degree in Paediatric Surgery is offered in 52 colleges. Such limited resources indicate that further improvements of the current structure of paediatric education must be prioritised by policymakers. The slow increase in the number of paediatric research institutions also hinders the progress of paediatric medicine.

Overall, the dearth of adequate numbers of paediatricians especially in rural and tribal areas and in eastern India remains a matter of immediate concern for the government (Ghosh, 2015). This lack of human resources in paediatrics is largely responsible for the poor state of child health in India. While the number of specialised hospitals for paediatrics is increasing, the development of hospital facilities and intensive care units is typically most visible in the private sector in urban areas, restricting the accessibility of healthcare services for children in poor and rural areas.

Integrated Legislation for Securing Children's Health

As indicated above, after more than 70 years of independence, India is still far behind in policymaking to include health for all, especially for children. In 2009, the Ministry of Health and Family Welfare presented a draft law, the National Health Bill, with the mandate to 'provide for protection and fulfilment of rights in relation to health and well-being, health equity and justice, including those related to all the underlying determinants of health as well as healthcare; and for achieving the goals of health for all; and for matters connected therewith or incidental thereto' (Government of India, 2009). In 2018, this initiative was launched as the 'Ayushman Bharat Scheme', also known as the Pradhan Mantri Jan Arogya Yojna or National Health Protection Scheme, to increase accessibility and affordability in healthcare, thereby achieving the proclaimed aim of 'Health for All'. This fits into recent government rhetoric of 'development', but it is too early to assess how effective it will be.

Except for Article 21, concerning the fundamental right to life, and Article 47 as Part IV of the Indian Constitution, the Directive Principles of State Policy, there is no constitutional obligation on the government to provide adequate health facilities for children. Article 47 makes it a duty of the State 'to raise the level of nutrition and the standard of living and to improve public health' (Chaudhury, 2006: 9). Article 243 G, read with Schedule 11 of the Constitution, focussed on the role of Panchayats in development policies, seeks to provide for institutionalising child care to raise levels of nutrition and standards of living, as well as to improve public health and monitor the development and well-being of children (Bakshi, 2011: 416–7). Efforts have been undertaken to strengthen legal education about child rights (Chakrabarti et al., 2004). To what extent such broad constitutional mandates and related activism

actually guide government policymaking remains debatable, however. Typical of the country's excessively bureaucratic legal order, India already has a large number of Acts and Rules to promote paediatric health and medicine. For example, the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act of 1992, amended in 2003, regulates the production, supply and distribution of infant milk substitutes, feeding bottles and infant foods for protection and promotion of breastfeeding and ensuring the proper use of infant foods. It may be doubted, however, whether this has any relevance for poor parents in remote parts of India who are struggling to raise a family.

More recently, though, the National Food Security Act, 2013, also known as the 'Right to Food Act', which aims to provide subsidised food grains to the country's needy people, appears to signal progress in terms of safeguarding nutrition (Sharma, 2019), also for children. The Act covers midday meal schemes, integrated child development services and the public distribution system and focusses on nutritional support to women and children, with many elaborate details. For example, the schemes provide nutrition support for pregnant women and lactating mothers until six months after the birth, and entitled women will also receive maternity benefits of not less than ₹6,000 (Sharma, 2019: 55). Children up to class VIII, or within the age group of 6 to 14 years, will be entitled to nutritious meals according to prescribed standards, and will receive one midday meal ensured free of charge, every day in all schools run by local bodies, government and government-aided schools. The obligations of the centre and state governments are categorically different under this Act. The centre allocates foodgrains to states based on the number of persons to be covered in each state. While there are numerous provisions now in India regarding food security, it is unfortunate that, legally, there is no directly enforceable right to ensure adequate provision of paediatrics.

More recently, the Indian government has launched a plethora of further new programmes and schemes as part of policies to promote child-centric welfare provisions, including specific healthcare measures. Notable among earlier programmes are the Integrated Child Development Scheme (ICDS) since 1975, the Total 'Clean India' Sanitation Campaign (Swachh Bharat Mission) of 1999, revised in 2014, the National Education Mission (Sarva Shiksha Abhiyan) of 2000, the National Health Mission of 2005 and the Integrated Child Protection Scheme of 2009. In addition, a National Plan of Action for Children (NPAC) was introduced in 2016 (Government of India, 2016b: 12–4), replacing the Plan of Action adopted in 2005, to enlarge the rights protection and welfare of all children. The previous plan had identified 12 key areas keeping in mind priorities and challenges that require sustained attention: (1) reducing infant mortality rates; (2) reducing maternal mortality rates; (3) reducing malnutrition among children; (4) achieving 100 per cent civil registration of births; (5) universalisation of early childhood care and development and quality education for all children, attaining 100 per cent access and retention in schools; (6) complete abolition of female foeticide, infanticide and child marriage and ensuring the survival,

development and protection of the girl child; (7) improving water and sanitation coverage in rural and urban areas; (8) addressing and upholding the rights of children in difficult circumstances; (9) securing for all children all legal and social protection from all kinds of abuse, exploitation and neglect; (10) complete abolition of child labour with the aim of progressively eliminating all forms of economic exploitation of children; (11) monitoring, reviewing and reforming of policies, programmes and laws to ensure the protection of children's interests and rights; and (12) ensuring child participation and choice in matters and decisions affecting their lives. It is obvious that this comprehensive list leaves little room for a specific focus on paediatric services. To promote the achievement of the above objectives, many other government programmes with big-sounding names are now also included in the NPAC of 2016. Sharma (2019: 55–6) lists some of them for Jharkhand.

Apart from the National Health Mission, for ensuring better health of all children, the National Nutrition Policy, adopted in 1993, also advocated a multi-sectoral strategy for eradicating malnutrition and combating hunger. This policy monitors nutrition levels across the country together with sensitising the government machinery on the need for adequate nutrition and prevention of malnutrition. The National Nutrition Policy also includes the Food and Nutrition Board, which develops posters, audio and video materials for disseminating correct facts about breastfeeding and complementary feeding. Further, the ICDS is one of the most comprehensive child development schemes in the country, perhaps in the world. It provides integrated services to pre-school children, particularly to ensure proper growth and development of children in rural, tribal and slum areas. This centrally sponsored scheme also monitors children's nutrition and is connected to the Midday Meal Scheme, launched in 1995 to boost the universalisation of primary education and simultaneously impacting on nutrition of students in primary classes. These midday meal schemes also eliminate 'classroom hunger' and are a significant challenge to caste, class and gender inequalities (Drèze & Goyal, 2003: 4674).

Despite such new schemes and policies launched every year, India still suffered 1.34 million under-five deaths in 2013, the highest in the world (UNICEF, 2014). Neonatal deaths are the highest contributors of under-five and infant deaths in the country (UNICEF, 2011: 4). According to NFHS-3 (2007) data, infant and child mortality rates in 2001–5 were 50 per cent higher in rural than in urban areas.

Health Financing of the State for Paediatric Medicine

India's health system overall has been ranked 112 among 190 countries of the world, which seems to reflect a disproportionately small health budget, but may raise issues about what actually counts as a health budget if one pursues integrated policies. According to an estimate by the WHO (2014: 98), India's total expenditure on health as a percentage of GDP is 4.7 per cent, which suggests that India's health investment in comparison to GDP is not a small figure in relative terms. India's per capita public

expenditure on health has increased from ₹621 in 2009–10 to ₹913 in 2013–4. The centre–state share in the total expenditure on health was 34:66 in 2013–4. The share of the centre in total public spending on health has decreased steadily over the years (Government of India, 2016a: xvi).

Taking into account the 2016–7 financial year budget, this section now briefly analyses the resource allocation to the development of child healthcare services. The 2016 Budget by the Finance Ministry allocated ₹39,533 crore (a crore being ten million), an increment of approximately 13 per cent over the previous year's revised estimate of ₹34,957 crore (Government of India, 2017: 5). This resonates with the government's underlying theme of the year's budget, built around nine major pillars, with healthcare as one of the social pillars. The allotment of ₹16,120 crores towards the ICDS was doubled from the previous year's budget of ₹8,000 crores, aiming to improve primary healthcare services for children under six and their mothers.

Constitutionally, healthcare falls under the concurrent list, with central and state governments being jointly responsible for formulating and implementing policies. However, at ground level, state governments are more accountable for healthcare service delivery, reflected in the 34:66 split of 2013–4 mentioned above. To obtain a more precise picture, state-wise data on budget allocations and expenditure on healthcare of children prove helpful. Development-oriented and wealthier states like Andhra Pradesh, Karnataka, Tamil Nadu, Gujarat and Haryana are inclined to increase healthcare facilities for paediatrics (Government of India, 2017: 16–36), but various factors are involved in decision-making about expenditure, with much discretion at state level. For example, no states except Kerala and Mizoram are allocating funds on the Reproductive and Child Health Programme of the Central Government (Government of India, 2017). Tamil Nadu and Uttar Pradesh surpass all states and UTs in their budget allocations and actual expenditure on medical services for maternal and child healthcare (Government of India, 2016c, 2016d, 2017). For Tamil Nadu, this reflects long-established projects of child-focussed healthcare and school-based nutrition (Drèze & Goyal, 2003), while Uttar Pradesh has of course a much larger population than all other states. Notably, the health of children in these two states differs remarkably, as exemplified by the report by Niti Ayog, India's Planning Commission (Government of India, 2017: 41). This shows that children in Tamil Nadu now have a much higher chance of survival than in Uttar Pradesh. The north-eastern states remain neglected in terms of funding as far as maternal and child healthcare are concerned. However, Assam, Meghalaya, Mizoram and Tripura are developing at a fast pace, while Arunachal Pradesh, Sikkim and Nagaland are still far from providing adequate finance for children's health.

Challenges to Child Survival and Paediatric Medicine in India

The statistics of actual expenditure of states do not fully match with the present unsatisfactory situation of paediatrics in India. The above discussions suggest it may

be pertinent to consider how policymakers are going to cope with future challenges to the health of children, posed by continuing scarcities of paediatricians and allied specialist institutions. Neonatal and infant mortality rates as well as nutrient-deficiency among children will remain looming threats in the coming years, as the data reveal. The following paragraphs further scrutinise the present condition of infant and child mortality rates, the increase of undernutrition and also the impact of poor health on the academic achievement of children.

Regarding infant mortality, it cannot be denied that India has come a long way since the first five-year plan in improving paediatrics, but there is still much scope for improvement. The NFHS-3 (2007) data show that the infant mortality in India declined from 77 deaths per 1,000 live births in 1991–5 to 57 deaths per 1,000 live births in 2001–5. The neonatal mortality rate further decreased by 12 deaths per 1,000 live births, the post-neonatal mortality rate also decreased by 7 deaths per 1,000 live births and the child mortality rate overall declined by 14 deaths per 1,000 children aged 5 and below during the same period.

Despite such reduced death rates, one out of every 14 children born in India during the five years before NFHS-3 (2007) had died before reaching the age of 5 years. Rural/urban differences in mortality, as noted, remain significant. In 2001–5, the child mortality rate was 50 per cent higher in rural areas (62/1,000) than in urban areas (42/1,000). NFHS-4 (2016) provides only key indicators, yet the overall picture seems to remain similar. According to the data from NFHS-4 (2016), among the 29 states of India, infant mortality is highest in Uttar Pradesh (73/1,000) and lowest in Kerala and Goa (15/1,000). Also, in under-five mortality, Uttar Pradesh has the highest rate (96/1,000), and Kerala has the lowest (16/1,000). High levels of infant and child mortality are found in Chhattisgarh and Madhya Pradesh in the central region, Assam and Arunachal Pradesh in the north-east; Jharkhand, Orissa and Bihar in the east and Rajasthan in the north. In contrast, all states in the southern and western regions have lower levels of infant and child mortality. Three north-eastern states, Arunachal Pradesh, Meghalaya and Nagaland, have lower than average reported levels of neonatal mortality, but higher than average post-neonatal and child mortality rates. Evidently, great challenges remain for India's health delivery services for young children.

India remains one of many countries with severe child malnutrition (Sharma, 2019), a major underlying cause of infant mortality. NFHS-4 (2016) data establish that 48 per cent of children under the age of 5 years are stunted and 43 per cent are underweight. Very few children under the age of 5 years are overweight, and both boys and girls are equally undernourished. Poverty, low purchasing power and female illiteracy, often connected to lack of parenting skills, are mainly held responsible for increasing rates of malnutrition among India's children. Again, undernutrition is higher in rural areas, but even among urban children, 40 per cent are stunted, and 33 per cent are underweight. The poorest nutritional status was found in tribal areas, with a high prevalence (about 28 per cent) of wasting, a matter

of grave concern. State-wise undernutrition is particularly high in Madhya Pradesh, Bihar and Jharkhand and is higher than average in Meghalaya and Uttar Pradesh. In Mizoram, Sikkim, Manipur, Kerala, Goa and Punjab, problems of malnutrition are not that grave.

Various studies have sought to understand the relationship between mortality rates and malnutrition. One such study, carried out to determine the effects of malnutrition on mortality in Paediatric Intensive Care Units and the paediatric risk of mortality (PRISM) found that 'malnutrition is solely associated with higher mortality even with similar PRISM score' (Nangalu et al., 2016). Both protein-energy malnutrition and micronutrient deficiencies are known to have long-lasting impacts on the physical and cognitive growth of children and increase susceptibilities to infectious diseases. Inadequate nutrient intake during the first two years of a child's life leads to deficient cognitive and social stimulation, with adverse impact on educational performance and the child's psycho-social functioning. ASER (2018), India's *Annual Status of Education Report*, shocks with its data on rural children in India aged 14–18 years. Its key findings are that about 25 per cent of this age group still cannot read basic texts in English fluently, and more than half struggle with division problems. While there are doubts whether ability to read in English can be directly connected to nutritional status, in the wider context and in the long run, this seems to indicate that malnutrition in childhood undermines labour outcomes in adulthood, since undernourished unhealthy children perform poorly in school and low schooling attainment compromises labour market performance (Deaton, 2008). NFHS-4 (2016) reveals that over 70 per cent of children have iron deficiency, while 1.5 million children suffer from vitamin A deficiency.

Other studies indicate that health problems due to deficient nutritional status in primary school-age children result in low school enrolment, high absenteeism, early dropouts and unsatisfactory classroom performance. Srivastava et al. (2012) found obvious relationships between growth status, school performance and intellectual achievement. Sankar and Pulger (1994) selected four villages and 90 children from Sikkim with high prevalence of severe iodine deficiency on a random basis. Various test results proved that children with iron deficiency showed impairment in language, meaningful and non-meaningful memory, conceptual thinking, nonverbal reasoning, numerical reasoning, motor skills and social intelligence. Similarly, Seshadri and Gopaldas (1989) assessed the impact of providing iron supplements for school and pre-school children's cognitive development. This study shows that nutrition therapy improved intelligence scores of both anaemic and non-anaemic children, and iron therapy improved cognitive performance among anaemic children. Other medical studies found deficiencies in social interactions and overall development of children due to malnutrition (Upadhyay et al., 1989). Overall, the present conditions of health and nutritional status for many young and school-age children in India remain, thus, worrying and are made worse by the absence of specialist paediatric health services.

Conclusions: Entitlement to Healthy Upbringing?

Despite a plethora of government rhetoric, schemes and provisions, bottlenecks of development in nurturing the future demographic assets of India have been identified in this article, not only regarding lack of fully developed paediatric healthcare. It appears that the lack of a consolidated public health law in India continues to impair full commitment to the complete well-being of the country's 'silent' young citizens, who are also future voters and right carriers in constitutional terms. The argument therefore becomes that adequate child healthcare should with some urgency be given the status of a fundamental right for all juniormost or infant citizens of India. This would confirm and increase the state's commitment to providing basic healthcare for children, a responsibility presently not effectively activated, despite the catch-all provision of the right to life in Article 21 of the Constitution. Notably, since 2002 this has also included in Article 21-A young children's right to free and compulsory primary education. However, first, a child in India has to survive the school-going age to be able to claim that important constitutional protection.

This article identified deeply worrying links between inadequate provisions for basic paediatric health services, especially in more remote parts of India, and still unsatisfactory health and educational statistics for far too many Indian infants. Immediate government action and, if necessary, further public interest intervention by the judiciary as the ultimate arbiter of justice, as has happened before (Drèze & Goyal, 2003: 4673), seems to be called for. Till today, health, sanitation and hospitals are merely included in the state list of the Constitution, which suggests that there should be a constitutional amendment transferring these domains, too, into the concurrent list. Paediatricians, as key professionals in the field discussed here, share a professional and ethical responsibility for raising ongoing concerns about the urgent necessity to promote all aspects of healthcare awareness and facilities for India's youngest children. India today produces engineers, scientists and doctors who are among the best in the world, but many of them are serving foreign countries, for all kinds of reasons. If insufficient attention continues to be given to the health and welfare of less privileged infants and young children in India itself, this will seriously damage India's ambition to become a respected developed nation, perhaps even the topmost economy of the world. What is being asked for here is not an unrealistic pipe dream. It is as much a matter of national pride as of determined alert action in strengthening a well-known entitlement framework, discussed in a different context by Choudhary (2015). Focussed in the present article on necessary infrastructure developments related to paediatrics, that is an issue which India can surely not afford to ignore.

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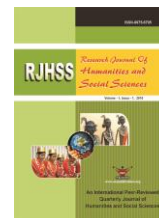
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RESEARCH ARTICLE

‘Restricting Birth’: Dr B. R. Ambedkar as Advocate of Population Control Policy

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ABSTRACT:

In colonial India, the maternal and child mortality rates were higher, this paper thus attempts to explore the ideas of Dr. Ambedkar on the birth-control movement in the nineteenth century India. As the number of studies on reproductive health in India is proliferating today, it becomes inevitable to study the views of Indian reformers on the family planning and problems of over-population. His speech in Bombay Provincial Assembly later published in the volume of his ‘writing and speeches’ used as a source to get an insight into Dr Ambedkar’s insistence on the necessity of birth-control measures in post-colonial India for better health and a sound economy.

KEYWORDS: Birth-control, Ambedkar, Health, Infant mortality, Poverty, Over-population.

INTRODUCTION:

Whenever any country faces difficult situations and, challenges, whether they are political or economic, the intellectuals and politicians at some point or other need to search their own country's history for the solutions. The historical events, people and their thoughts that have shaped the country prove to be the vital elements for solving the current challenges of the country.¹ Dr Babasaheb Ambedkar was one of our greatest jurists, economists, crusading champion of human rights, and social reformer. What is well known about Dr. Ambedkar's fights against social prejudices in India, but what is little known is how he had also impacted his impression on the economy through his views and thoughts.

Ambedkar's identity as an economist might have escaped mass notice it's because of his fame as the Chairman of the Drafting Committee of the Constitution and as a leader of the backward and downtrodden sections of Indian society. Prof. Amartya Sen, the first Asian winner of the Nobel for economics, claimed during delivering Sir Dorabji Tata Memorial Lecture Series in May 2007 that "Ambedkar is my father in Economics. He deserves more than what he had achieved today. However, he was a highly controversial figure in his home country, though it was not the reality. His contribution in the field of economics is marvellous, and will be remembered forever."²

As an economist, Dr Ambedkar propagated that the state is the owner of the land. To him, the basic industries should be state monopolies and rest should be controlled by the private owners. He thought that the "democratic state socialism" can be achieved by state control over land, some basic industries, religions, caste and through an elaborate scheme of the constitutional method. According to him, caste consciousness hampers all the economic systems.³ Surprisingly, enough Dr Ambedkar had also suggested free economy, globalization, liberalization and privatization as early as in 1923 side

by side with state-owned basic industries, land and insurance. He had stressed that the value of a rupee must be kept stable if the policy of the free economy is to be successful. Hence, one can say that Dr Ambedkar, a man educated in USA and UK, was "not an armchair economist" but he was "an economist in thought and action with a rare vision".⁴

How one can expect that the problems and challenges posed by poverty, population growth, agricultural decline and economic degradation had not caught his attention. Ambedkar realised very earlier that the increased population would be a burden on the growing economy of free India's future development. Therefore, to eradicate poverty, unemployment, and safeguard reproductive health, Ambedkar favoured proper birth control policies and measures to be implemented by the government for progressive and stabilised growth and development.

If we talk about India, it has the youngest population in the world with 472 million children⁵ still globally India contributes about 21% of the total global burden of child death. The current population of India as per the census of 2011 is 1210.2 million.⁶ This increased population is a burden on the economy and the future development of India. Dr Ambedkar was quick to acknowledge this problem when on behalf of Dr B. R. Ambedkar, the speech delivered by Shri P. J. Roham on 10th November, 1938 in Mumbai Provincial Assembly on a non-government resolution was to be considered, it is a fundamental base to understand the thoughts of Dr B. R. Ambedkar on family planning and population control. Of course, B. R. Ambedkar himself wanted to present the resolution, but due to some unavoidable circumstances, he could not attend. The resolution was comprised of the limited size of the family and also the urgent need for proactive measures among the masses regarding birth control. According to Ambedkar there were "few people have an adequate idea of the immense loss sustained by children born of persons who are handicapped either physically, mentally or financially. The prevention of the births of such children would reduce the death-rate among mothers who succumb to child-birth and its concomitant diseases, lower infantile mortality, improve public health by removing the many diseases due to want of even the prime necessities of life felt by many persons, check the offences perpetrated by persons suffering from intense poverty and would bring about an all-round uplift of society by affording full scope to its spiritual advancement."⁷

Dr B. R. Ambedkar emphasised that some measures to control the population such as the ban on child marriage system, increasing the age of marriage, economic empowerment of women are also limited, ineffective and impractical. Thus to avoid the unexpected births and to

maintain control of various diseases, he emphasised upon the use of scientific instruments of birth control. He advocated that family planning is the only one measure to control the population. He considered the problem of population in respect of family, child development, female health and food grain supply. The following pages will discuss Ambedkar's views, and thoughts on the necessity of population control policies by the government and the problems our country is subjected to due to increased rate of population.

OBJECTIVES:

The following are the chief objectives of this study-

- a. To explore the vision of Ambedkar with special reference to population-control policy.
- b. To document Ambedkar's ideas on birth-control in colonial settings and its impact on post-colonial India.

METHODOLOGY:

The methodology of the paper is, qualitative as well as exploratory. With the help of Dr. B.R. Ambedkar's speech which was delivered by P. J. Roham on 10th November, 1938 in Mumbai Provincial Assembly on a non-government resolution, which was later published in the form of collections of his thoughts and speeches, books and articles which studies the Dr. Ambedkar as reformer, are used to explore the Ambedkar's insistence on scientific measures in India with comprehensive economic development of the country.

REVIEW OF LITERATURE:

Extensive literature contributed towards Dr Ambedkar's as a social reformer and as an economist.⁸ By analysing various aspects of Ambedkar's thoughts on population control, Dr Rajendra (2014) studies the opinion of former on birth-control and highlights that Ambedkar emphasis on population-control was to bestow on people the equal standard of living and for that population control is inevitable. Similarly, taking his speech in the assembly, Bhadarge (2017) shows Ambedkar's insistence on the need for birth-control measures in the country. He studies the propagation of birth-control through his journal *Samajswathayay* to educated people on the problems of over-population. This work, however, in colonial setting attempts to explore the significance of Ambedkar's ideas of birth-control when the infant and maternal health was higher in India. The paper thus studies Ambedkar as a visionary who understood the complexities of over-population as an obstacle in economic growth of the country and thus suggested birth-control both for colonial and post-colonial India.

FREEDOM OF WOMEN ON CONCEPTION:

Dr Ambedkar was equally sympathetic with the women as with the downtrodden class of Indian society. He not

only recognised the freedom of women from the superstitions of religion and higher classes dogmas but also keen for her independence on childbirth. Together with the young lives, Ambedkar was concerned for the health and well-being of the females of society. As he writes, "The present keen struggle of life renders timely marriage impossible for many and thus exposes them to various diseases and habits. Many women become invalid for life and some even lose their lives by the birth of children in their diseased condition or in too great numbers or in too rapid succession."⁹ Availability of data on maternal mortality and morbidity in colonial India is not sufficient to assess the loss of lives during childbirth, assessment made by our great leader's open doors to understand the need reformation in healthcare. Ambedkar emphasised that "attempts at abortion, resorted to for the prevention of unwanted progeny, exact a heavy toll of female lives. Unwanted children are often neglected by their mothers and hence they become nothing but a burden to society which is further deteriorated by the addition of defective progeny from diseased persons. Birth-control is the only sovereign specific that can do away with all these calamities. Whenever a woman is disinclined to bear a child for any reason whatsoever, she must be in a position to prevent conception and bringing forth progeny which should be entirely dependent on the choice of women. Society would in no way profit by the addition of unwanted progeny. Only those children, who are welcomed by their parents, can be of social benefit and hence every woman must be enabled to resort to prevention of conception quite easily."¹⁰

Even today also the increased infant mortality is a serious concern to the government. Dr Ambedkar not only emphasised on the reduction of infant mortality rates in India but was also concerned with the percentage of survival of the children, as he suffered the loss of four out of five children which according to him he never regretted. He argued, "due to excessive child-mortality, the rate of growth of the population of countries like India is not equal to that of countries like England though the birth-rates in countries of the former type are higher than those in the latter type. The birth-rate of England is nearly half that of India. Yet we find that the population in England increased by nearly 23 per cent. Between 1901 and 1931, while the population in India rose by only 17 per cent in the same period. This will show that even for a rapid growth of numbers, the better way is to adopt the practice of birth-control and thus cut down infantile mortality."¹¹

In contrast to people who were condemning western medicine and considered it a threat to indigenous medical practices, Dr Ambedkar welcomed the new development wholeheartedly. He advocated the movement of reformers who raised voices for women's

freedom of contraception as "the experience of several scientists from different places has proved that the higher the birth-rate, the higher is the death-rate also and no sooner the birth goes down, the death-rate also declines. The result is that not only is the survival-rate not adversely affected but very often it even rises. Dr Maria Stopes has found from the experience gained in "*The Mothers' Clinic*" that the greater the number of conceptions the higher is the rate of maternal and infantile mortality."¹²

POVERTY AND BURDEN OF POPULATION:

Poverty is the cause of overpopulation in our country, unfortunately, today also. The poor people have a notion that the more children you have, the more hands to work and earn. But what they ignore is the fact that those earning hands have the mouth too. It's because of poverty that the poor parents fail to rear their children properly. As Ambedkar himself born in a low-income family, he understood the lack of facilities whether it is food or education, a child faces because of poverty. But this challenge, he considers was because of the parents who for the purpose of economic strengthening of the family gave birth to more children. Thus he emphasised that eradication of poverty is essentially more than the introduction of measures to control overpopulation. For he opined, "in our country, the same condition prevails in cities like Bombay. A few exceptions apart, it is observed that virtue is palsied where poverty prevails. Further on it will be shown how it is well-nigh impossible to uproot poverty without the aid of birth-control. The aphorism, बुभुक्षितः किम् न करोतीपापम्, is well known."¹³

He further by exemplifying countries like China explained that parents are forced to abandon their children on the streets because of utter poverty and distress. He criticised poverty as "it is bitter and terrible poverty that makes the parents expose their infants. In the light of such instances, it is futile to hope that ordinary persons will be able to avoid progeny merely through self-control."¹⁴ Furthermore, Dr. Ambedkar on the urgency of family planning gave the example of Western nations where "modern contraception is utilised by persons of all races, religions and strata. For instance, it is found that the notion that the Roman Catholics are against birth-control is unfounded. France is a Roman Catholic country and still it is notorious that the birth-rate in that country is quite low....."¹⁵

GANDHI AND AMBEDKAR ON BIRTH CONTROL:

The chief difference between the philosophy of Gandhi and Ambedkar was that the former inclined towards religious and spiritual approach while the latter emphasised upon the western or scientific approach.

The birth control activist Margaret Sanger and Marie Stopes visited India; they desired that Gandhi should extend his support to the birth control measures in India. While 'he strongly advocated brahmacharya, by which he meant control over all senses, including the sexual. Because he believed that women were sexually passive and apathetic, he primarily addressed men while speaking of the ideal of attaining control over one's senses, betraying an underlying masculinist premise that informed his understanding.'¹⁶ Gandhi in his interviews was against the use of contraceptives by the Indian women, which according to him "contraceptives are an insult to womanhood."

Though, Tagore, Nehru, Ambedkar and Bose, advocated the birth control measures in the country yet three of them failed to bring this movement at ground level. He said, "When we have realised that birth-control is the sine qua-non for every progress, we must consider the means to attain that end. To be satisfied with only that much of sexual enjoyment that is necessary for getting the desired number of children and to banish sexual thoughts from one's mind when progeny is not required is one of the ways. The use of modern contraceptives is the other way. As for the first way, it must be remembered that while continence in the unmarried state may be possible, it is nothing but displaying ignorance about human nature to expect that young and healthy married couples, living together and fond of each other, can observe continence for years together. The cases of strong-willed persons, whose minds are not affected in the presence of objects of enjoyment, apart, there is no doubt that ordinary human beings are bound to fall a prey to the influence of enticements. Is it not strange, therefore, that this fact, which is as clear as daylight, is denied by some."¹⁷

He further criticises the spiritual thoughts of Gandhi in the following words, "Self-control has been proved to be absolutely useless for birth-control from the experience of several countries and ages. Even the advocates of continence cannot claim that ordinary persons will be able to eschew sexual intercourse altogether throughout their lives. The laying aside of continence even for a single day every year may lead to an annual conception. Even, if we assume that self-control enables certain persons to bring about birth control, we cannot draw the conclusion that others will be able to follow them. It is necessary to remember that just as appetite for food differs in the case of different persons, so sexual appetite also varies from person to person." In his speech, he emphasised "strict observance of certain rules laid down in Hindu scriptures necessitates the neglect of the ideal of family-limitation. For instance, verse 8, Chapter 54, of "Vishnu Smriti" enjoins sexual intercourse on certain specified days. As a doctor has wisely remarked if men had to bear the pangs which women have to undergo

during child-birth none of them would ever consent to bear more than a single child in his life. It is wrong to hold that because the ideal of large families is before society up to this time nobody wishes to limit his family."¹⁸

As a champion of female health and birth control measures, Ambedkar enthusiastically asserted "...it is, therefore, established that there is no go without recourse to modern contraceptives. To deny the necessity of those remedies is to show one's preference for abortions, infanticides, etc."¹⁹ He was, thus, one of the chief advocates of western medicine in the country paving the way for the freedom of women on contraception and decline in the child mortality rates in the country.

SOCIETY AND POPULATION:

Dr B. R. Ambedkar further recognised that the common people even illiterate were sensible enough to understand the significance to modern medicine and if proper promotion of latest research executed properly and birth control measures were made available to them by the colonial government they would use them at a greater extent, than expected.

Ambedkar was against the politicisation of welfare measures for personal gains by political parties. He criticised about the people who in order to increase their mass base and the political base does not strengthen the institutions promoting contraceptive measures. For he said, "Some people think that they would be losers if the numbers in their particular race, religion, or region are lessened. They are afraid that their adversaries would thereby be enabled to gain ground over them. In the first place, it is necessary to remember in this connection that the rate of increase of a population does not necessarily dwindle down as soon as family limitation is resorted to. That rate is dependent not merely on the birth-rate but chiefly on the survival-rate with the exception of London, all the (above) towns are solidly Roman Catholic, yet they all have a lower birth-rate than London. Three of them are in Mussolini's Italy. It will be thus seen that the fear, that other communities will neglect birth-control and will thus become stronger in numbers, is altogether a baseless one."²⁰

He thus kept the country's progress above personal gains and appealed from masses for promoting birth-control for better women and child healthcare in colonial days. He feared that the birth-control propaganda will fail to filter down to the masses and outcome of this movement would be 'dysgenic instead of eugenics, is also groundless'. In his speech in Legislative Assembly of Bombay Presidency he considered that the "lower classes do take advantage of contraceptives as soon as they are made cognizant of them, the need being greater in their cases. The masses in our country, though

illiterate, are intelligent enough to know in what their own interest lies and hence there is no doubt that they will fully utilise this invention also as soon as they are made aware of its existence. Vasectomy would be found to be useful in the case of such persons and hence Government and municipalities must provide facilities in this respect in their hospitals, etc.”²¹

In his answer to the political contentions on birth control measures, Ambedkar refuted their arguments by his own logical argument that “the opponents of this movement try to show its futility by pointing out the examples of France, Germany and Italy but they forget that we cannot follow these countries unless it is proved that their attempts at the increase of their populations are justified. In the first place, it must be kept in mind that the birth-rates of these nations are much lower than the birth-rate of our country.”²²

MARRIAGE AND BIRTH-CONTROL:

Marriage reform campaigns relied heavily on official maternal and infant mortality rates and medical professionals spoke out publicly in favour of raising the age of consent and against the practice of child marriage, calling it ‘barbarous’.²³ Two significant legislations for marriage reform were ‘Age of Consent Bill 1891’ and the ‘Sarda Act of 1929’. These campaigns led to the confluence of medical opinion, official attitude and nationalist agitation with the demand of increasing the age of marriage from 12 to 14 years.

Social reformers asserted that the high rate of maternal and child mortality was due to child marriage which led to mothers producing weak babies. Thus they claimed that child marriage accelerated the moral and physical decay in Indian society. For reformers, the practice of child marriage though part of the historical background to India’s yet they considered it as backwardness developing in the country and would unlikely to hamper progress in the post-colonial India.

But the condemnation of child marriage was a double-edged sword- it was equally open to appropriation by nationalists and to appropriation by apologists for the colonial regime. While nationalists argued that colonial rule weakened India morally, physically and economically, colonial apologists countered that the high rates of maternal and infant mortality were due to the widespread practice of child marriage and that this was evidence of the continued inability of Indians to govern them.²⁴ Journals focusing especially for women healthcare like *Madhuri*, *StriDarpan*, *StriSubodhini*, had articles on domestic hygiene, negligent child care practices, childbirth, pregnancy and infertility. These articles addressed the issues of high maternal mortality and need for better women’s healthcare for healthy babies. This paved the way for hygiene promoting

different kinds of literatures which raised not only the health issues but also ‘influenced in elaborating gender, class, caste, religious and national identities.’²⁵ These articles and magazines made the women and mothers realize their duties towards the nation, which will need healthy children after independence, for a successful economy. Thus the nationalist sentiments were invoked through vernacular literature among the women of the province.

Critics of birth control measures thus considered lowering of child marriages in India as a means to reduce the infant mortality rate and keep a check on overpopulation. Ambedkar denied this remedy too as he apprehended that “... years must elapse before the ages at which girls are married would be sufficiently raised in our country...when we notice the difficulties in the enforcement of the Sharda Act, fixing the minimum age of marriage of a girl at 14, we can easily see that it is almost useless to hope that in the near future women in our country will postpone their marriages up to 22 and population will be checked thereby.”²⁶ Dr. Ambedkar quoted the conclusions drawn by Mr. P. K. Watal on the fertility-enquiry based on the 1931 census that “even when late marriages would come into vogue generally, there is no chance of population being appreciably checked thereby. More children would live up to mature ages and hence there is a chance of an increase and not a decrease in the rate of growth of our population.”²⁷ He emphasised on the birth-control even when the government increased the age of marriage for girls and for people being unable to marry at proper ages.

ECONOMY AND BIRTH-CONTROL MEASURES:

India’s economy primarily rests on agriculture. Even today agriculture is the mainstay of our economy as about 70% of our population depends on this industry. Thus, it increases the burden on land which forces the people to withdraw and look for other sources else thrown to the mouth of utter poverty. As an economist, our expectations increase on how Dr Ambedkar visualised the role of population control policy in the development of the country further maintaining the economic balance of the state. He considered that the economic independence of women has nothing to do with family planning as women working on fields still have many children.

It was believed that independence would change the then situation, but Ambedkar disagreed with them. By comparing the situations in America and other western countries asserted that due to overpopulation countries like Holland, America, Britain failed to feed its population with proper diet. Hence the rate of malnutrition is higher among the children and people of the state and thus failed to prepare for health policy for all. He considered that India could gain economic

development and maintain the standard of life of the masses only if there is a comprehensive policy for population control as “with every opportunity afforded for its expansion, population begins to grow rapidly and thus nullifies all the advantages secured through great efforts.”²⁸

He suggested that the post-colonial government must take into account the rising poverty which not only a cause of over-population but also a means of high rates of malnutrition in the country. As poor could not afford nutritious food, it will increase the prevalence of diseases and anaemia among women, who on the other hand will produce weak bodies. Emphasising the need and advantages of the implementation of birth control measures, he exemplified the western countries where such measures had brought not only prosperity but also economic advancement. Ambedkar explained that the main object of the movement for birth-control is to reduce birth-rate so that to maintain population decently with the aid of its self-sufficiency.

People were under the impression that modern scientific discoveries will solve the problems of food. According to Ambedkar, it is mal-distribution that is the root cause of the economic difficulties in the country. He highlighted that it is necessary to remember that equal distribution would never bring a permanent and material amelioration of the condition of the people unless the growth of population is controlled by means of family-limitation. For he said, “Land being the chief source of all wealth, there cannot be plenty for all unless plenty of fertile land falls to the share of each individual. In India, there is only three-quarters of an acre of cultivable land for each individual and, as has been already pointed out, according to the opinion of the Royal Commission on Agriculture, much of the uncultivated land in this country is practically useless.”²⁹

CONCLUSION:

Ambedkar asserted that “Birth control movement has afforded such an opportunity to our provincial government and it is hoped that they will not let it slip but will fully utilize it to the benefit of themselves and the people.”³⁰⁻³⁷ Unfortunately, his resolution was defeated, only eleven members voted in favour and fifty-two opposed it.

It is unfortunate that we have still not focussed towards the problem of overpopulation highlighted by Dr. Ambedkar. It is a high time when if we underestimate the suggestions and warnings of the great leaders and intellectuals of our country we would face utter disorder, poverty, unemployment and ill-health. Ambedkar advocated birth control measure to be a prominent and sole measure through which a country can beat the consequences of over-population. He propagated the

modern scientific investigations of twentieth century in the country for the welfare of women and children which failed to attract attention of leaders and masses. His vision for the new India was the path of continuous and comprehensive economic progress which could be achieved by checking the growth of population through birth-control measures.

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CONFLICT OF INTEREST:

The author declares no conflict of interest.

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