Understanding Subordinate Healthcare in Colonial Madras: Shift in Women and Rural Healthcare (1918-1932)

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My research at the Rockefeller Archive Center (RAC henceforth) in June 2017 was part of my doctoral research on the history of urban and rural healthcare services in colonial Madras. The collections at the RAC were important for me as I am examining health services ranging from 1880 to the 1930s, thus including a good part of the inter-war period. Once I finished my research at British and Indian archives, on the advice of my advisor, I wanted to follow with a research visit to the RAC. The goals of my RAC research agenda consisted of two components: first, understanding colonial rule from a different perspective and, second and more importantly, consulting the diaries and personal papers of the officers who visited India, along with their official Rockefeller Foundation (henceforth RF) documentation. While writing the initial drafts of my dissertation, I became interested in understanding the relationships forged between individuals (British, Indian and also American), institutions and exchange of ideas in the single presidency of Madras. The diaries of the RF officers in India, particularly of William S. Carter[1], along with the records on rural health and nursing, will shape my thesis significantly by playing perfectly the role of 'informed outsiders' in this context.[2] I have also been delighted to identify materials on women's health at the RAC, which has been an under-researched area in the context of colonial south India. All of these kinds of source materials are particularly valuable, given the scarcity of detailed reports and documents of the inter-war medical changes in colonial India.

My thesis, as currently conceptualized, will make extensive use of the RAC materials in the third and fourth chapters of my dissertation. I will examine the contribution of the subordinate medical service and also that of the women medical services in the districts and rural areas of the presidency of Madras. These records will be invaluable to understand the complexity of colonial health policies which varied greatly in all three presidencies of colonial India. Finally, I have also been able to access some significant sets of RF photographs which show the mobile medical services in the presidency.

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During the interwar period, the RF's International Health Board (IHB, which became the International Health Division, IHD, in 1927) ran a series of surveys and provided grants for the rural health sector and for developing women's health in colonial India. I have gone through the annual reports of hospitals, dispensaries

and the government orders concerning this period but there were a few questions that remained unclear, such as:

1) How involved was the Rockefeller Foundation in the rural health sector in colonial Madras?
2) Were those really rural areas or more like mufassil (subordinate divisions of a district) which were next to the main city of Madras?
3) What role did the caste/class issues of Madras have in the collaborative approach of the IHB/IHD?
4) Who were the targeted women and how they started becoming involved when the IHB/IHD began funding medical bodies in Madras?

My consultation of the RF's project records in India and the documents sent by officer W.S. Carter proved extremely important in answering all of these questions. Here, I will expand on the materials I have collected and try to explain how they contribute to enriching the historiography of colonial Madras.

The British and the RF alike were fascinated by the 'wealth of problems,' the term used in their reports to refer to the varied forms of illnesses presented for treatment by Indian patients.[3] There were talks of opening research institutes to understand the diseases that affected the people in colonial India. Professor E.H. Starling outlined a proposal in his report to open an All-India Research Institute which would help understand different diseases and continue the research in creating vaccines. This was, however, in the period when the colonial government in India was showing interest to change its approach from a curative form of treatment towards an overarching health care system, which reflected a preventive form of medical care. The report speaks at length about the teaching and training procedures which became more systematic during the interwar period in the Madras presidency.[4] It emphasized that Madras was an important centre for training and supplying sub-assistant surgeons for the military department all over India and for the civilian department. It also produced large numbers of licensed medical practitioners (hereafter LMPs) who were engaged in private practice in both the large towns of the presidency, as well as in the smaller towns and districts. Many LMPs were engaged in practice in the Indian Native States, in the Straits Settlements, and in Ceylon. A large number were also hired as medical officers to tea plantations and other estates, as well as to the various railways.[5] An observation made by Carter in one of his reports to the RF, states the importance of Madras as a healthcare and medical research centre in colonial India. From the report, the structure of fees levied on British and Indian students stands out; at the

Coimbatore Medical School, the cost was Rs.60 per annum for British born students, while Rs.100 per annum for Indians.[6] As of 1926, the school was still under construction. Once completed, it was expected to be a centre for expert medical research along with nursing facilities, providing relief to the districts of South Kanara, Malabar, Coimbatore, Salem, and Nilgiris. It is understandable that paying Rs.100 for an LMP degree was not a viable option for most of the Indian population at that period. So, this medical program was directed specifically to the elite classes who were in control of the regional administration, as shown in detail by David Washbrook.[7] There were, however, alternative options for Indians who couldn't afford to become LMPs. Compounders were considered one of the lowest levels in the medical hierarchy but not all medical school offered the required coursework. According to the reports, Madura Medical School, opened in 1918, trained compounders.[8] The course was for one year with separate training space for men and women. Students could enrol in this course after completing their fifth form in secondary school, which was one level lower than was allowed for the LMP training.

Carter's reports show a different side of the colonial administration in Madras when he speaks about the lack of coordination among the provincial government and the Government of India (hereafter GoI). The medical schools and medical colleges required Indian Medical Service (hereafter IMS) officers as the administrators but unfortunately, the Madras government could only assign lecturers with specific training who were made available by the GoI. This issue became a matter of contention between the GoI and the Madras government regarding availability of trained physicians. It is interesting to note that the number of stipendiary students decreased on a rapid scale from 1918 to 1927. With the number as high as 24 in 1918, it came down to just one by the end of 1927. Although this shows the amount of money invested in training the sub-assistant surgeons decreasing, it does point out the number of Indians who were interested in paying for training. Madura district saw a massive surge of establishing dispensaries across the presidency in 1925, as 183 of the total 235 dispensaries that existed in 1926 were opened during 1925. Thus, the scheme of the Government of Madras to open dispensaries in rural districts received a significant boost in this period, but with a very limited supply of money, it was becoming increasingly difficult to find more interest among private practitioners to work in the rural areas. Carter could see the process of "Indianization" in the district-level hospitals and medical schools. The medical schools in Vizagapatam, Tanjore and Mysore had been completely Indianized by 1926, as reported by Carter. The schools in Vizagapatam and Tanjore illustrated opposing traits in the reports, as the first one

was being poorly staffed and very poorly administered with a mediocre staff, while the Tanjore one displayed very high standards of efficiency in medical training and administration. In this narrative, Carter's stance presents the reader with conflicting impressions. For Vizagapatam, he blamed the Indianization process and the mediocrity of the 'natives' for the hospital being poorly conducted, but the Tanjore school, which was equally Indianized and administered by an Indian, received his accolade as one of the best in the presidency. This explanation leaves a lot of unanswered questions about the mindset of the westerners undermining those in India and blaming Indians overall as a race for being less organised and inefficient. The reports Carter sent to the RF also spoke at length about the role of the subordinate staff like the midwives and compounders and their mobility in the rural areas of Madras.[9]

The IHD channelled its funds for the development of rural health conditions in India, as the majority of the population in India was living there. Colonel Webb, the Director of Public Health in the Madras presidency, prepared a project for an all-encompassing program in the Tiruvallur district to control public health. To quote the IHD report,

> It should be typical of the Presidency, as a whole, and should therefore conform to the requirements of all branches of work. It should be sufficiently near to the capital of the Presidency (Madras city) so that those concerned can visit direct, and guide the work as it proceeds. Proximity to Madras City should facilitate frequent visits by all interested in this Rural Development for demonstration purposes. The area should not be so near to the City that it will receive City influence. In other words, it must be a true typical rural picture. The area should, if possible, contain work which has already been started and is progressing satisfactorily. And lastly, it should be an area where the villager himself is likely to accept, although possibly with difficulty, the teachings and preaching of those who are offering him modern twentieth century principles for his advancement. The area now selected, therefore, is approximately the central one third of the Tiruvallur Taluk of the Chingleput district and all have unofficially agreed upon the suitability of this area.[10]

This step, however, lacked merit in certain ways. Madras Presidency was almost an empire in itself and it had numerous districts, taluks and villages to administer. It was not ideal to have rural health improvement very close to Madras city. This framework failed to take into account the whole idea of having rural health care. To a critical eye, this can only be understood as an elaborate plan of the West to cater to the public sentiment and getting publicity about bettering 'rural healthcare' in colonial Madras. Arguably, the healthcare system was aimed at creating an excitement among the locals and internationally, more in the fashion

of propaganda. The areas in close proximity to the capital city of the presidency were not considered rural when there were plenty of other areas far from Madras without any proper health care. Unfortunately, both the Madras government and the IHD were invested in establishing health care for the area they could easily monitor. They didn't pay attention to investigate and identify the areas which really needed their help.

The RF reports were instrumental in providing a critique of the colonial understanding of the Indian context. The reports illustrated how Indians were in competition among themselves, particularly after the implementation of the Montague-Chelmsford Reform, also known as the Government of India Act 1919.[11] This reform led to higher local control in the regional and municipal fronts, with Indians administering their own municipalities, Taluks and villages. Displeased with the functioning of the Madura municipal council, the Madras Government appointed a 'special officer' who was eager to show his good work. V. Ponnusami Pillai did an excellent job, according to the RF reports, as he strove towards optimising resources.[12] Thus, with the right attitude and willingness to deliver for the residents of the region, a person could do much good work. Irrespective of this, those with positions of power were ready to prevent a candidate from winning, if they so chose, even if by taking unlawful acts like bribing. The reports go on to present a list of Indians seeking training in Britain to better their technical knowledge of medical education and diagnosis. The RF showed interest in training these people and even provided stipends to most of them. This support allowed them to undertake training in the US and then they returned to India looking to be employed in government medical centres.[13]

The Foundation reports show a direct relation between the collaboration plans and how dependent the RF funding was on the colonial government's enthusiasm for continuing support to develop rural health care centres.[14] The reports also focussed on the development of health training institutions like Madura to train health officers in western medicine. In addition, the reports emphasized the opening of rural health care centres in far-off villages.[15] The steps taken to control diseases like malaria, plague, hookworm and other infectious diseases were highlighted in the RF records.

The RF reports also covered women medical education, which attracted much interest in the Madras government during the inter-war period. This approach to include women in medical education started with a co-educational model, although women candidates were not treated equally; they always used to stay in the background during practical demonstrations. However, the eagerness of the government to find women sub-assistant surgeons was evident from the

number of stipends which were made available during the 1920s. For the women candidates, there were no fees and twenty stipends were offered, each contributing Rs 20 per month for female students. The RF also worked towards bringing more women into healthcare, so that female medical education became an integral part of the colonial policy in India. The IHD conducted surveys to understand this shift.[16] The Government of Madras showed great enthusiasm in welcoming the surveyor. The local governments also were eager to be seen as welcoming to the IHD, as they knew about the funding they might receive, and also to show their hospitals and places in a positive way. Women education in colonial Madras was bolstered in the early twentieth century and the RF grants helped to open up more opportunities for women. The Madras government during this period was also looking to increase the number of women in medical services which helped the effort of the RF in establishing women health centres in Madras.

The year 1932 saw drastic steps being taken on part of the government to curtail the annual public health budget, which witnessed a total reduction of 8%. The RF wanted the government of Madras to commit to providing financial support, after the initial investment made by the RF.[17] But following a reduced budget allocation and other financial trouble looming in Europe, it was only becoming more difficult for the GoI to continue a similar budget for healthcare in India. In this environment, it is significant that in the 1930s, more health care centres were established in Madras, specifically in the districts of the presidency. This led to a further rise in collaboration among the RF and the colonial Madras government. However, the Government of India also played a significant role in this. From the reports of the RF, it becomes quite evident that Madras lacked the supply of qualified medical personnel and this led to ground level collaboration and control of the health services by the Indians. The RF records and diaries have been significant in establishing this connection among the urban and rural segment of Madras presidency. This sign of collaboration and further competition among the medical administrative sectors will be further examined with the help of the annual reports, dispensary reports and other colonial official documents from Madras.

Thus, in conclusion, it can be stated that IHB/IHD did significant work in colonial Madras. It contributed to a large extent to the Madras Presidency becoming an important place to study colonial medical intervention. The surveys and assistance helped in understanding the relationship between the Indians with the colonial health officers. The Madras government was also eager for the grants offered by the RF as it was, more often than not, short of money. The RF, on the other hand, was trying to explore the areas and provide grants to develop a

standing relationship with the Indians, as well as with the British government. Particularly, these grants have been very important during the interwar period as the development of India was one of the least concerns of the British government in London as it began dealing with a serious economic crisis. Thus, consultation of the records at the RAC has shed considerable light on these aspects, where other materials are largely silent.

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[1]W. S. Carter Report, 1926, Box 10, Series-464/464A India, Record Group (RG) 1.1, Records of the Rockefeller Foundation (RF), Rockefeller Archive Centre, Sleepy Hollow, New York (henceforth RAC).
[2] Sunil Amrith, *Decolonizing International Health: India and Southeast Asia, 1930-65*, (Basingstoke; New York: Palgrave Macmillan 2006).
[3] Report by EH Starling, 1926-27, Folder 66, Box 8, Series-464/464A India, RG-1.1, RF, RAC.
[4] Ibid.
[5] Govt. Medical School of Madras, W.S. Carter, October 1926, Folder 58, Box 8, Series-464 India, RG-1.1, RF, RAC.
[6] Ibid, 4.
[7] D.A.Washbrook, *The Emergence of Provincial Politics: The Madras Presidency, 1870-1920*, (Cambridge; New York, Cambridge University Press 1976)
[8] Govt. Medical School of Madras, W.S. Carter, October 1926, Folder 58, Box 8, Series-464 India, RG-1.1, RF, RAC.
[9] Government Medical Schools of the Presidency, Folder 58, Box 8, Series-464A, RG 1.1, RF, RAC.
[10] Ibid.
[11] It was also called the Government of India Act 1919. This Act established the dual government system in the provinces and also led to the formation of local councils in rural areas.
[12] Report by JF Kendrick, September 6, 1932, Folder 596, Box 74, Series-464/464C, RG 2, General Correspondence (henceforth GC) - 1932, RF, RAC.
[13] Recommendation of fellowship, August 1932, Folder 360, Box 44, Series-464, RG 2, GC - 1932, RF, RAC.
[14] Letter from Sweet to Heiser, July 29, 1929, Folder 223, Box 27, Series-464/464C, RG 2, GC – 1929, RF, RAC.
[15] Ibid.
[16] Report by JF Kendrick, September 6, 1932, Folder 596, Box 74, Series-464/464C, RG 2, GC - 1932 RF, RAC.
[17] Notes by Sweet, January 1934, Folder 824, Box 105, Series-464/464C, RG 2, GC – 1934, RF, RAC.