Advances in Consumer Research
https://acr-journal.com/
Volume-2 | Issue-3 | Sep 2025
Original Researcher Article

Women And Western Medicine In Colonial India

Anshu Sharma[1], Dr. Rahul Tripathi[2]
[1]Research Scholar, Amity University Rajasthan.
[2]Director, Amity School of Liberal Arts, Amity University Rajasthan.

Received: 20/06/2025
Revised: 26/07/2025
Accepted: 12/08/2025
Published: 27/09/2025

ABSTRACT
The paper focuses on the intricate relationship between Western medicine and women in India during colonial times. It tries to explore the impact that Western medicine has had on the health and overall socioeconomic condition of Indian women. There were previous studies that analysed the impact of the introduction of Western medicine in colonial India, but the present study addresses the theme in a more extensive manner. Western medicine was brought to India primarily for the economic self-interest of the colonial rulers and for their survival. Due primarily to Purdah and societal stigma, imperial authority encountered significant obstacles while attempting to provide medical care to women. Therefore, laws were formulated to deal with the medical requirements of Indian women. The paper focuses on the analysis of Western medicine's somewhat convincing results, such as a decrease in pregnant women's death rates, the adoption of modern childbirth practices, an increase in the number of female physicians, and the opening of doors for women to pursue medical education. The arrival of Western medicine also paved the way for social reforms for women. However, there are concerns that this paper tries to address, such as whether offering Western medicine to women served colonial objectives or was a gesture of goodwill towards them. And it was also a process that culminated in the commoditization of medicine, treating the native populace as mere consumers with wide-ranging consequences. Indian women currently rely significantly on modern forms of medicine, so this paper makes an effort to examine how Western medicine has impacted Indian women in the past. By doing so, it hopes to contribute to the development of future policies that will ensure that current and future generations of Indians have access to effective medical care
Keywords: Western medicine, colonial rule, women, medical education, health....

1. INTRODUCTION:

Western Science and Western Medicine were previously seen as unquestionable books of colonial control in India and elsewhere. Scholars have recently begun to reassess the merits of western medicine in the erstwhile colonies of Western nations. Most historians now point out that Western medicine helped consolidate and expand colonial control, reducing the mortality and morbidity of Europeans in tropical places.[1]Present research in the field of gender and medicine has also shown how the concerns of gender and health care were intertwined in colonial ideology and politics and helped the "civilising" agenda of imperial control by disseminating its patronising and beneficent elements.[2] Several decades after Indian independence in 1947, experts reassess the merits of Western medicine, which apologists credit to the British Empire as one of the incontrovertible blessings of colonial rule. Similarly, historians have begun to doubt colonialism's purported favourable impacts on Indian women[3], as well as the role women played in advancing colonial power.[4] These two areas of concern, medicine and women's rights, were essential in colonial politics: colonial administrators regularly disparaged the condition of health care and the low status of women in colonial-ruled territories to bolster their own legitimacy. Gender and health were closely intertwined in colonial ideology and politics.

Obstacles to provide western healthcare to women

The colonial state's emphasis on epidemic management and male health neglected women's needs, with minimal infrastructure, such as lying-in hospitals, seeing low attendance due to societal aversions. Cultural restrictions, such as purdah and hostility towards male physicians, hampered women's admission to Western medical facilities, particularly in rural areas. Traditional female healers, such as dais, were marginalised because colonial biomedicine deemed them unscientific,[5] and hostility to women's medical education, as shown at Calcutta Medical College, slowed development. Class and caste inequities hampered rural and lower-caste women's access to healthcare, while colonial reforms benefited mostly urban elites.[6]

British govt healthcare policies and steps

In a medical system that was mostly male-oriented and male-operated in the first half of the 19th century, David Arnold has proposed that the army, prisons, and hospitals—all of which were mainly male domains—were the main areas of concern.[7] In the 1860s, the Contagious Diseases Act (1868) marked the first direct official intervention in the health of Indian women. It was created to safeguard troops' health and to lessen the threat of venereal diseases by controlling how prostitutes and soldiers were treated and kept in lock hospitals.[8] Over time, the status of Indian women was critically examined in the changing discourses surrounding colonial medicine. Critical attention was drawn to the zenana, or women's

quarters, in affluent Muslim and Hindu homes. Breaking the isolation of this zenana, or "uncolonized space," and fighting against ignorance about health and cleanliness were key components of western medicine's civilizing goal.

The health of Indian women received little systematic attention and funding from colonial authorities in India before 1885. As numerous academics have said, the army was the primary focus of British health policy, with the European community coming in second. The government established the Royal Commission to Enquire into the Sanitary State of the Army in India in 1859 after learning that during the 1857 Indian Mutiny, more troops had perished from illness than from wounds. Its 1863 study was the first significant official investigation on the health of any Indian people. During the presidencies of Bengal, Bombay, and Madras in 1864, as well as in other provinces in 1866–1867, sanitary commissioners were constituted; nevertheless, they were largely ineffectual due to their lack of funding, power, and prestige.[9]

In the late 1860s, a few individual civil surgeons and missionaries started making patchy and irregular attempts to teach native midwives, or dais. In actuality, the first people who took an active interest in giving Indian women access to Western medical care were female missionaries from the United States and Britain. Under the sponsorship of the American Methodist Episcopal Mission, Clara Swain, the first fully qualified female medical missionary and a graduate of the Woman's Medical College of Pennsylvania, travelled to Bareilly, India, in early 1869. Swain, English physician Fanny Butler, and other missionaries from the United States, Great Britain, and Canada established hospitals and dispensaries, trained nurses and midwives, and provided medical care to hundreds of women.[10]

In order to increase Indian participation at the district and municipal levels, Viceroy Ripon implemented local self-government reforms in the fields of education, public works, and health in 1882. However, British authorities actually undermined this liberal program.[11] By 1888, at least fifty missionary doctors from various denominations were employed in India; these doctors made up almost two-thirds of all "lady doctors" in the country.[12] A number of new developments in the mid-1870s and early 1880s indicated growing interest in offering Western medical care to Indian women. However, Queen Victoria's personal initiative was credited with creating the Dufferin Fund. By giving women health care workers, the Dufferin Fund specifically sought "to bring medical knowledge and medical relief to the women of India."[13] The Prospectus of the National Association pledged to assist three areas in order to achieve this goal: (1) medical tuition, which includes training women to become doctors, hospital assistants, nurses, and midwives; (2) medical relief, which includes creating dispensaries and cottage hospitals under female supervision for the treatment of women and children; (3) providing trained female nurses and midwives to care for women and children in hospitals and private homes; opening female wards under female supervision in existing hospitals and dispensaries; and (4) providing female medical officers and attendants for existing female wards and the establishment of hospitals for women where funds were forthcoming.[14] The nineteenth-century mortality statistics clearly show how diverse groups of colonial people were given access to resources like money, water, and sanitary facilities: Death rates were generally lowest among Europeans and upper-class Indians.[15]

Nonetheless, the underlying presumptions of Dufferin Fund appeals were that Western-trained women physicians and separate wards in hospitals would provide Indian women with medical aid, that women's health would improve as a result, and that purdah was the only reason why Indian women lacked access to medical care. The more basic and systemic issues of poverty, nutrition, sanitation, education, and gender discrimination may be conveniently overlooked by such a limited definition of the issue and its resolution.

2. IMPACT OF WESTERN MEDICINE:

a) Decline in mortality rate of mothers.

Improvements in maternity Health: The Dufferin Fund (1885) and the construction of lying-in hospitals brought Western-style maternity care, which decreased maternal mortality in cities. However, the wider influence was constrained by cultural resistance and the marginalization of traditional midwives.[19]

Public Health Measures: Women benefited indirectly from colonial interventions such as vaccination campaigns, sanitation improvements, and research laboratories (e.g., Kasauli, 1884), which decreased mortality from infectious diseases like cholera and plague. From 1891 to 1931, the average lifespan for women grew little from 27.2 to 30.1 years.[20]

Medical Education for Women: With the help of programs like the Dufferin Fund, female physicians and midwives were better equipped to provide gender-sensitive treatment, which helped to reduce female mortality locally, especially during childbirth.[21]Due to limited access and cultural hurdles, rural and lower-caste women continued to experience high death rates, while benefits were mostly restricted to urban, higher-caste women. Colonial policies frequently ignored the wider health requirements of women in favour of British troops and commercial objectives.[22]

(b) Women medical education

Women missionaries from the United States and England who arrived in India starting in the late 1860s were the first group of foreigners to try this. After graduating from Pennsylvania's Woman's Medical College, Clara Swain was sent to Bareilly in 1869 by the American Methodist Episcopal Mission. In order to give Indian women, access to western medical care, Miss Fanny Butler of England and others set up private clinics and worked to train nurses and midwives.[23] Private persons in India made sporadic and fragmented attempts to bring in foreign-trained female medical graduates and to give Indian midwives institutional training. The idea of establishing a medical department in India that would be run solely by and for women was supported by female doctors in England.

(c) Social reforms for women

As is widely known, the 19th-century Bengali male intelligentsia's goal for social change was initially focused on bettering the condition of women, but it also addressed the needs of reforming middle-class families. Brahmo reformers who were ardent proponents of women's medical education included Durga Mohan Das and Dwarakanath Ganguly[16]. The necessity of female physicians with training in western medicine for female patients was highlighted in a number of publications and periodicals. In 1883, Brahmo Public Opinion stated: "India is without a doubt the nation where the need for female physicians is felt the most acutely".

By acting as experts on the health and living circumstances of Indian women, English women doctors may have also played significant political roles. As medical professionals speaking on behalf of Indian women, European and later Indian women physicians assumed major positions in discussions of social reform issues because they were perceived as having an impact on women's health. For example, medical women took part in the contentious Age of Consent Act of 1891 debate, wherein fifty-five female doctors urged the viceroy to forbid marriage consummation with females younger than fourteen.[17] An address Edith Pechey gave against child marriage was translated into a number of vernacular languages and published widely as a brochure.[18]

It should come as no surprise that the imperial authorities claimed credit for the achievements of the National Association and used it to demonstrate to Indians and to themselves the virtue of their rule

Colonial Self-interests or goodwill?

"The body was utilized—or attempted to be utilized—by colonialism as a site for the construction of its own legitimacy, control, and authority".[24] Managing illnesses, or more accurately, managing epidemics, evolved into a means of managing the body. The introduction of Western medicine in India has several ramifications because medicine in the colonies was not restricted to therapeutic borders but rather transcended discursive boundaries and became an important part of colonial politics. It was in charge of bringing ancient Indian medicinal customs back to life. Their rebirth was spurred by the fact that they occasionally imitated Western medications and at other times competed with them.

However, new research has found that the British colonial government was more focused on preserving its own political and economic dominance than on promoting and enacting changes to gender relations in India.[25]

The perceived need of Indian women for Western medical aid provided by women became a key argument and a potent symbol for those interested in increasing British women's opportunities to obtain medical education and employment, both in the colonies and at home. The Dufferin Fund played a central role in this development, for it grew out of and focused increased attention on such arguments while also serving as the vehicle through which imperial opportunities were realized. For medical women's opponents and competitors, the proposal that medical women be sent off to India seemed a welcome opportunity to reduce competition at home.

Strong suspicions were expressed by certain Indian elites that the Dufferin Fund was just another instance of colonial self-interest disguising itself as goodwill. The well-known nationalist Bal Gangadhar Tilak attacked the government for forcing the maintenance of the Dufferin Fund onto the shoulders of the general populace, while the satirical Praja Bandhu remarked, "Behold, how very artfully Her Ladyship has drained out the wealth of many Maharajas, Rajas, and other noblemen of India."[26] Several newspapers expressed dissatisfaction over the district government officials alleged harsh and indirect tax-like pressure on the people to donate money to the group. Indian males were sent to lesser positions as "hospital assistants," while Europeans and Eurasians were granted "licentiate of medicine and surgery" or "assistant surgeon" degrees, as a result of British racism, which made sure that medical education in colonial India evolved in a tiered manner. Additionally, Indian women were grouped together under the "hospital assistant" or "certificate" categories. [27]

"The British used the particular form which gender divisions took in India as a vehicle for proving their liberality, as a demonstration of their superiority, and as a legitimation of their rule." In order to demonstrate that India was not yet prepared to rule itself, the administration was interested in both preserving women's subordination and liberalizing it in order to uphold Britain's superior gender relations.[28]

3. CONCLUSION

Indeed, the history of Western medicine in colonial India demonstrates that, with the exception of dire circumstances like starvation or epidemics, Western medicine only affected a very small percentage of Indian males and much fewer Indian women.[29].

REFERENCES

1. Lai, "Politics of Gender and Medicine"; Kearlekar, "Kadambini and the Bhadralok"; Whitehead, "Modernizing the Motherhood Archetype"; Ramusack, "Embattled Advocates"; Forbes, "Medical Careers"; Forbes, New Cambridge History of India, IV
2. Women in Modern India (Cambridge: Cambridge University Press, 1998), First South Asian Paperback ed.; Meredith Borthwick, The Changing Role of Women in Bengal, 1849–1951 (Princeton: Princeton University Press, 1984); Dagmar Engels, Beyond Purdah? Women in Bengal, 1890–1930 (Delhi: Oxford University Press, 1999).
3. Kumkum Sangari and Sudesh Vaid, eds., Recasting Women: Essays in Colonial History (Delhi: Kali for Women, 1989); and J. Krishnamurty, Women in Colonial India: Essays on Survival, Work, and the State (Delhi: Oxford University Press, 1989).
4. Nair, "Uncovering the Zenana," Women's History Review 2 (1990): 8–34; Burton, "Feminist Quest for Identity," Women's History Review 3 (1991): 46–81;

Chaudhuri and Strobel, Western Women and Imperialism; MacMillan, Women of the Raj.
5. Mukherjee, Sujata. Gender, Medicine, and Society in Colonial India: Women's Health Care in Nineteenth- and Early Twentieth-Century Bengal. New Delhi: Oxford University Press, 2017.
6. Pati, Biswamoy, and Mark Harrison, eds. Society, Medicine and Politics in Colonial India. London/New York: Routledge, 2018.
7. Arnold, David. Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India. Delhi: Oxford University Press, 1993.
8. Kenneth Ballhatchet, Race, Sex, and Class under the Raj: Imperial Attitudes and Policies and Their Critics, 1893–1905 (New York: St. Martin's Press, 1980); see also Mridula Ramanna, "Control and Resistance: The Working of the Contagious Diseases Acts in Bombay City," Economic and Political Weekly 35 (2000): 1476–1483.
9. David Arnold, "Medical Priorities and Practice in Nineteenth-Century British India," South Asia Research 5, no. 2 (1985): 167–83; J. B. Harrison, "Allahabad: A Sanitary History," in The City in South Asia: Premodern and Modern, ed. J. B. Harrison and Kenneth Ballhatchet (London: Curzon Press, 1980), 170–71; Radhika Ramasubban, "Imperial Health in British India, 1857–1900," in Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion, ed. Roy MacLeod and Milton Lewis (London: Routledge, 1988), 38–60.
10. Margaret Balfour and Ruth Young, The Work of Medical Women in India (London: Oxford University Press, 1929), 13, 16–18, 29.
11. S. Gopal, British Policy in India, 1858–1905 (Cambridge: Cambridge University Press, 1965), 146; John R. McLane, Indian Nationalism and the Early Congress (Princeton: Princeton University Press, 1977), 10.
12. Countess of Dufferin's Fund, Fourth Annual Report of the Association for Supplying Female Medical Aid to the Women of India (Calcutta: Superintendent of Government Printing, 1889), 3.
13. Dufferin, "National Association" (n. 19), 259.
14. Ibid., 260–61; Countess of Dufferin's Fund, First Annual Report (n. 19), 13.
15. Ira Klein, "Urban Development and Death: Bombay, 1870–1914," Modern Asian Studies 20, no. 4 (1986): 725–54.
16. Accounts of Anandibai Joshee are based on:
(a) Caroline Healey Dall, The Life of Dr. Anandibai Joshee (Boston: Roberts Brothers, 1888);
(b) S. S. Joshee, Anandi (Bombay: Majestic Book Stall, 2nd ed., 1970);
(c) Meera Kosambi, "Women and Equality: Pandita Ramabai's Contribution to the Women's Cause," Economic and Political Weekly 23, no. 44 (October 29, 1988): WS 38–49;
(d) Rosemarie Tong, Feminist Thought: A Comprehensive Introduction (Boulder, CO: Westview Press, 1989).
17. Charles Heimsath, Indian Nationalism and Hindu Social Reform (Princeton: Princeton University Press, 1964).
18. Louisa Garrett Anderson, Elizabeth Garrett Anderson, 1836–1917 (London: Faber and Faber, 1939), 236.
19. Sujata Mukherjee, Gender, Medicine, and Society in Colonial India: Women's Health Care in Nineteenth- and Early Twentieth-Century Bengal (New Delhi: Oxford University Press, 2017).
20. James Fenske, "Missing Women in Colonial India," The Economic History Review 68, no. 4 (2015): 1303–30.
21. Sujata Mukherjee, Gender, Medicine, and Society in Colonial India: Women's Health Care in Nineteenth- and Early Twentieth-Century Bengal (New Delhi: Oxford University Press, 2017). Ibid.
23. Geraldine Forbes, "Managing Midwifery in India," in Contesting Colonial Hegemony: State and Society in Africa and India, ed. Dagmar Engels and Shula Marks (London: The German Historical Institute, 1994), 152–53. See also Forbes's article in this journal.
24. David Arnold, Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India (Berkeley: University of California Press, 1993).
25. Carroll, "Hindu Widows' Remarriage Act of 1856," in Women in Colonial India, 1–26; Gilmartin, "Kinship, Women, and Politics," in The Extended Family, 151–73; Mani, "Contentious Traditions," in Recasting Women, 88–126.
26. Prajabandhu, 23 March 1888, in RNP (Bengal), 31 March 1888, 355; Mahratta, 4 April 1886, in RNP (Bombay), 10 April 1886, 13.
27. J. H., "The Countess of Dufferin, C.I.," Leisure Hour 37 (1888): 802.
28. Joanna Liddle and Rama Joshi, "Gender and Imperialism in British India," Economic and Political Weekly 20, no. 43 (26 October 1985): WS73–WS77.
29. David Arnold, "Medical Priorities and Practice in Nineteenth-Century British India," South Asia Research 5, no. 2 (1985): 178–79; Patricia Jeffery, The Politics of Health in India (Berkeley: University of California Press, 1988), 92

.