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The Indian Women Advisors to the Bhore Committee: The Early Indian Feminists

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ABSTRACT

This paper focusses on the life of three women members of the Health Survey and Planning Committee, also known as the Bhore Committee. The Bhore Committee was constituted in 1943 with the aim to take stock of he health of the nation and to recommend a blueprint for the development of health services in independent India. Amongst the twenty-five members there were only three women members. These women despite living in a time when women were largely confined to the home and the hearth were exceptional in their achievements and accomplishments. The paper situates them and their life trajectories in the larger context of early health care services- the *zenana* mission and the Dufferin fund, offered to women in a colonial era. The women discussed are Mrs. Khadija Shaffi Tyabji, Dr. (Mrs.) D.J.B. Dadabhoy and Lt. Col. (Miss) H.M. Lazarus. Their life journey offers an alternative view of colonialism and modernity. It gives us a perspective of social reform and feminism that goes beyond the conventional documenting of the role of upper caste men and some women.

Key Words : Khadija Shaffi Tyabji, D.J.B. Dadabhoy, H.M.Lazarus, Bhore Committee, zenana mission, Dufferin Fund, Feminism

INTRODUCTION

While writing about social reforms for women in British India one tends to focus on men or on women associated with these men. The role of women has been portrayed as an adjunct to men with men leading the charge of social reform. This is generally true but there have been a few women who have been exemplars. Three such women were a part of the Health Survey and Planning Committee under the Chairmanship of Sir Joseph Bhore, an Indian ICS officer from Maharashtra. The women members were exceptional and their accomplishments in a country at a time when women were largely home bound and were denied opportunities for education or even access to medical care. The women who were appointed to the committee were leading doctors and social activists of their times in a society which was dominated by men. Their appointment to a committee dominated by men was a testimonial of their accomplishments. These were Mrs. Khadija Shaffi Tyabji, Dr. (Mrs.) D.J.B. Dadabhoy and Lt. Col. (Miss) H.M. Lazarus. Two of the women, D.J.B. Dadabhoy and H.M. Lazarus, were doctors and were a part of the health care services for women in colonial India.

The first section of the paper will examine the articulation of health care services for women in colonial India. The second section of the paper will be on the three women mentioned.

The end of the colonial rule in India in 1947, was a time when access to health care facilities for the general population was minimal. This was also reflected in their health status. The Western system of medicine was introduced in British India in the early 19th century. Access to health care service for the natives was limited. The Bhore Committee was constituted due to various reasons ranging from economic, to international pressure to curtail the spread of disease, the spread of the Western medicine as an attempt to civilise the 'savages' and to appease the growing nationalist movement , the deaths due to the Bengal famine of 1942 and the general

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dissatisfaction with the British rule (Arnold, 1993; Harrison, 1994; Amrith, 2006; Sehrawat, 2013). The Bhore Committee was constituted to survey the health of the population and to make recommendations for the future development of health services.

The Health Survey and Planning Committee also known as the Bhore Committee Report (hereafter BCR) (Government of India 1946) is the cornerstone for providing medical care to India's population. The Bhore Committee was constituted in 1943 to recommend the best way to achieve health for the Indian population post-Independence in 1947. The Committee when it was constituted India was still under the British government. The constitution of the Bhore Committee was an effort by the colonial administrators to appease the nationalists. There were twenty-five members in all out of which three were women of Indian origin. Bhore himself had no experience in health care, the other members were from the Indian Medical Services, experts in public health, government officials and socially prominent people. Two thirds of its members were leading social and political and medical figures of Indian origin. They were also helped by a group of international advisors from Australia, United Kingdom, United States of America, and USSR. The Committee comprised of five consulting committees: public health, medical assistance, professional education, medical research, and industrial health. Each one of these areas would have a group of specialists who would oversee gathering the data (Bhore, 1946, p. I, p. 3).

Previous studies on the Bhore Committee have analysed the reasons for its formation and for the inclusion of select advisors (Amrith, 2006; Murthy *et al.,* 2013;). Amrith (Amrith, 2006) argues that the setting up of the Bhore Committee was an attempt to satisfy the nationalists and to gather support for themselves. Duggal 's (1991) and Banerji's (2009) work is on the legacy of the Bhore Committee in terms of health policy the impact of the Bhore Committee on the health policy in India. They contend that India has not been able to achieve the vision of the health care infrastructure that was recommended by the BCR as early as 1946.

David Arnold (1993) examines the gendered aspects of health care delivery of the colonial Western medicine for men and women. He contends that till the 1850s it was oriented to men and women were not an area of concern. But the Contagious Disease Act of 1860 brought prostitutes into the focus to keep the soldiers healthy. There are others who document the entry of pioneering Indian women doctors. Mukherjee (Mukherjee, 2005-2006) writes on Kadambini Ganguly, the first Indian female doctor trained in the western medicine and the challenges that she faced. She also discusses the story of Haimavati Sen, the first Vernacular Licentiate in Medical and Surgery and Anandibai Joshee, the first lady to go abroad for medical education. Mukherjee discusses the gender discrimination and racism that these women faced during their training and work life. Raman and Raman (Raman and Raman, 2019) look at women doctors and women's' hospitals in Madras in the late 19th and early 20th century. They too discuss the contributions of Anandibai Joshee, Rakambai, Annie Jagaanadhan, Kadambini Ganguli amongst others.

Due to cultural and social reasons women's access to health care in the nineteenth century was limited. Women did not seek medical support during illness or even during childbirth. As per the BCR there was high morbidity and mortality, particularly among mothers and children with a Maternal Mortality Rate (MMR) at 20 per 1000 live births in 1938 due to serval reasons including lack of skilled medical assistance. In 1947 there was a short supply of women doctors with only seventy or eighty women doctors out of which only twelve were skilled to provide medical assistance and health care for expectant mothers, post-natal care, and care for the new-borns. Child marriages and purdah were widely prevalent at the time of the BCR. The proportion of early marriages *i.e.* below 15 years of age had decreased from 1881 onwards. In the 1931 census there was a sharp rise in early marriages due to the impending implementation of the Sarda Act in April 1930. This increased the risk of maternal deaths.

The earliest efforts to provide medical care for women was by Christian missionary organisations in Madras in 1620s. These were set up by the Danish to spread the Gospel. Some of these for example in Tranquebar (now Tamil Nadu) and Pondicherry, included missionary doctors. Pondicherry too had missionary hospitals in 1620. Medical care was associated with religion.

The first instance of providing medical care to women by the British was for prostitutes whose services were used by the British soldiers. After the Revolt of 1857, the British took several steps to portray themselves as progressive. Lal (1994) citing David Owen, Bernard Cohn points out that for the British the promotion of 'moral and material' progress was important to establish their

control over the subjects. They thus undertook philanthropic missions like providing medical care and relief for the natives. They also undertook task of reformation of Indian women. These women were perceived as being subject to practices like sati, infanticide, early marriages, and lack of medical care. The British in 1860, as a part of their efforts to 'civilise the barbarians' in a perfunctory manner started the training of dais and midwives by missionaries leading to an increase in women medical missionaries by the latter half of the nineteenth century. These women medical missionaries were amongst the earliest as a part of the colonial efforts to offer systematic health care to women through special facilities set up for women (Lal, 1994, 30).

At the time these reforms were undertaken the image of the upper- and middle-class Indian women, in the British mind, was one of women in purdah and without access to adequate health care. These women were confined to the *zenana* and had very limited contact with the outside world. This meant that access to health care was limited and the British presumed that they were ill and not cared for. To 'rescue' these women the female missionaries, missionary wives and doctors from Britain took it upon themselves to reform them. In the latter half of the nineteenth century, for the first-time medical missionary women undertook the task of health services reform and medical aid for the *zenana* women. The London Missionary Society for instance focussed on helping Indian women. In 1870, Clara Swain, the first medical missionary to India, in addition to providing health care services also began instructing native Indian Christian women in medicine and practical hands-on training. Another medical missionary Fanny Butler, from the London School of Medicine for Women was sent to India in 1880, by the Church of England Zenana Missionary Society. Rose Greenfield, Sarah Hewlett, Edith Brown, and Elizabeth Beilby were other such medical missionaries. These were the earliest efforts for provision of an organised systematic health care for native women. By the mid 1870s and early 1880s, efforts by medical missionaries like Mary Scharlieb and women activists like Pandita Rama Bai Sarasvati led to the acceptance of Indian women at the Madras Medical College and in Bombay, Calcutta, Agra, and Lahore (Mukherjee, 2005-2006).

In addition to the *zenana* mission, the National Association for Supplying Female Medical Aid to the Women in India (hereafter The Association) or the Dufferin Fund as it was popularly called, was started in 1885. This was started in 1885, at the behest of the Queen of England who charged Lady Dufferin with the task of providing medical aid to women. The Association's objectives were to train Indian women as doctors, hospital assistants, nurses, and midwives. The second objective was to supply medical care through dispensaries, cottage hospitals and exclusive female wards in existing hospitals. It especially focussed on the *zenana* women. The third objective was to provide medical care at home and hospitals through trained nurses and midwives. The Association was not allied either with the missionaries or the government. It however did rely on the government for funds and on the government personnel and their wives including the Indians for manpower. The Association over the next few decades made significant inroads into establishing medical facilities for women. It spread all over India and provided medical care to over one million children and women in 1910. It also made a significant contribution in training women doctors, nurses, and midwives. The earliest lady doctors from India included Kadambini Ganguly, Jamini Sen and Haimabati Sen. Lady Dufferin was not the only such woman; there were other Vicereines like Lady Curzon, Lady Minto, Lady Chelmsford, and Lady Reading who undertook the task of reformation of health care for women in India. These women reformers set the agenda for better and institutionalised Western system of medicine healthcare for women.

The Dufferin Fund and the efforts by other Vicereines were all a part of the philanthropic mission. Medical relief and charity featured prominently in these efforts. The bestowing of titles and awards like the Kaisar-i-Hind Medal for public service were all a part of these efforts. They also started honouring Indian princes with titles. To gain status and recognition many of the Indian royals shifted from the Unani and Ayurvedic systems of medicine to the Western system of medicine. Not just the royals but members of the Indian elite too began contributing to these efforts to gain power and recognition.

While efforts by the British to spread medical care for women had racial and gendered overtones. The flip side was that it enabled many Indians to benefit from access to the English-speaking world. This also paved the way for some Indian women to access western education and knowledge. But the Indian men were restricted to hospital assistants unlike their British

counterparts who got degrees in medicine and surgery. Women too were restricted to hospital assistants or certificate ranks or as midwives. Education for women was very rare with only 0.84 per cent (1881-82) of school going women attending schools (Report of the Health Survey and Development Committee, 1946).

Cultural and social traditions further restricted even the educated women to the home and hearth. S. Sarkar and T. Sarkar (Sarkar and Sarkar, 2011) contend that generally discussions on social reform should not be limited to well-known iconic reformers of both genders. By the mid 1800s an emerging middle class of educated, forward looking and wealthy Indians played an important role in reformation. These included traders, shipbuilders, and merchants and several of them were Parsis, and Muslims, settled in Western part of India. They were politically aware and were involved in social reforms for women in education, marriage among other things. The Muslims following the Parsis began establishing schools for children. Further discussions on social reforms do not focus on the role of women in bringing about change (apart from a few like Pandita Ramabai). These women benefited from access to the print media and education at home by fathers and husbands. They then wrote and published their views on diverse issues like early marriage, widow remarriage, polygamy, and education. Some of these women wrote in languages like Bengali and Marathi. With the rise of the nationalist movement some of these women also started attending schools from the mid nineteenth century. Some of them even attended college and got degrees in science and medicine. By the twentieth century we find more women beginning to participate in public life and leading in social reform (Sarkar and Sarkar, 2011, 1-18).

The three women discussed in the succeeding section were women who participated in social life and greatly benefited from exposure to a Western culture and education. Their achievements despite a restrictive atmosphere were inspirational for many. Two of the women discussed Khadija Shaffi Tyabji and Dossibai Jehangir Ratenshaw Dadabhoy

belonged to the Muslim and Parsi communities respectively of Bombay. Dr. (Lt. Col.) Hilda Lazarus was an Indian Christian missionary and was closely associated with the Dufferin Fund.

Mrs. Khadija Shaffi Tyabji (1880-1976):

There is very little information available on Mrs. Khadija Shaffi Tyabji unlike her more well-known female cousins[1] . She belonged to the Tyabji family that was well known for its support of education and social reforms for women. She was born in 1885 to Al-Haj Mulla Najmuddin Tyabji and Durrat-ul-Sadaf binte Feyzhyder. Her father was the brother of the well known Badruddin Tyabji. She married her cousin Mohammed Shaffi Camaruddin Tyabji but was widowed at an early age. She had two children Camar Tyabji and Sultana Ahmed Patel. Khadija as a Muslim woman gave up the veil and led a very active social and political life.

Historian Ravindar Kumar (in Mukherjee, S., 2005-2006) listed the Tyabjis amongst the most influential families in the nineteenth century in colonial India. They were originally from Gujarat and settled in Bombay. The Tyabji family had several luminaries who actively contributed to the social, political, and economic life of the country. Some of these include Abbas Tyabji, Chief Justice of the High Court of Gaekwad, a close lieutenant of Gandhiji; Badruddin Tyabji, the third President of the Indian National Congress in 1887, an elected member of the Bombay Municipal Corporation in 1873, a judge of the Bombay High Court in 1895 and a wealthy industrialist; Mrs. Fais Tyabji a politician and a woman leader in Pakistan; Haflin Tyabji the first woman magistrate appointed in Pakistan; Mrs. Camar Tyabji one of the originators of the East and West movement in Bombay; Mrs. Hamid Ali the President of the All India Conference for Educational Reform.

The Tyabji family was progressive and supported the education of women. Khadija Shaffi Tyabji grew up in such an atmosphere. In the mid 1870s the Tyabji children, both girls and boys, were all studying in mission schools. The Tyabji women were amongst the earliest to Muslim women in India to discard the purdah and to pursue higher education. They were also encouraged to lead an active outdoor life riding, playing badminton, and going out on excursions. The women were involved in several philanthropic activities in hospitals, schools, etc. The family had a long tradition of supporting women's

1. The Fyzee sisters Atli, Nazli and Zahra were ahead of their times. They were prolific writers and were actively involved in various social causes like establishing schools for girls and encouraging women to exercise and play outdoors. Nazli herself divorced her husband when he took a second wife. Atli was unmarried and travelled extensively for educational purposes.

education. The women were educated and were not bound by feudal values. This was also the time when there were movements for Muslim women's education[2] . The Tyabji women were educated in the English medium in elite schools in India and abroad. As Moin Shakir and Theodore Wright have rightly observed: "It was perhaps the impact of Bombay and the compulsions of the trade that led Tyabjis to reject the increasingly dysfunctional feudal values of the North Indian and the Deccan nobilities but exemplified the commercial skills and adaptability of the Weberian prototype. In short, they were the early members of the new Indian Middle class" (Khan, 2014). Khadijaalong with her cousins Nazli and Atiya Fyzee were intellectuals and social reformers. Her other cousins Sakina Lukmania and Safia Jabir Ali were Gandhian activists and nationalists (Tyabji, 2023).

Shaffi Tyabji was on the Council of the All-India Muslim League (AIML) from 1837-47. The Council was described as the 'The Parliament of Muslim India' (Pym, 1930). The AIML was very actively involved in humanitarian work and in the emancipation of Muslim women. She was a part of the movement for the emancipation of Muslim women. There were movements against purdah, promoting education and abolishing polygamy.

Khadija was also a part of the National Council for Women in India (NCWI) started in 1925. The NCWI was a part of the International Council of Women and was at the forefront of championing the advancement of women in all fields. They advocated education for women and an active participation of women in public life. At the NCWI she worked on issues of reform. In 1928 she became the executive in the Social Service League of the Red Cross. She was a member of the Seva Sadan [3] Council and was involved in training women nurses. Khadija went onto found the pioneering Muslim Purdah Nursing Division for medical care of women in purdah.

In 1930, she was appointed as the Vice Chairman of the National Council for Women. In 1940 she was elected as the President of the All India Educational Conference in Poona.

She was an elected member of the Bombay Municipal Corporation and was elected a Commissioner of the Bombay Municipal Corporation. She was also the first elected Muslim lady at the Schools Committee.

In 1935 she was honoured with the Kaisar-i-Hind Silver medal and in 1941 she was again honoured for her outstanding work towards women's reforms with a gold medal (Government of the United Kingdom, 1941). In 1943 she was appointed to the Bhore Committee. She was a part of the Public Health Advisory Committee, a sub-Committee in the Bhore Committee.

Dossibai Jehangir Ratenshaw Dadabhoy:

The second member of the Bhore Committee was Dossibai Rustomji Cowasji Patell also known as Dossibai Jehangir Ratenshaw Dadabhoy. Dadabhoy was a doctor and was a part of the subcommittee on Medical Relief Advisory Committee. She was a well-known obstetrician, gynaecologist, and mentor. As a pioneering Indian woman student of medicine, she overcame the double discrimination of gender and race. The Lancet in 1878 claimed: 'Woman as a doctor is a conceit contradictory to nature and doomed to end in disappointment to both the physician and the sick.' The president of the Royal College of Physicians, Sir Richard Douglas Powell in 1907, echoing the Lancet stated: 'Women ought not to be encouraged to enter a profession for which they were constitutionally unfitted' (Hudson, 2018).

Dadabhoy was born in wealthy Parsi family in Bombay in 1881 and studied in elite schools in India. After her training in medicine in India at the Grant Medical College in Bombay in 1903 worked with Sir Temulji Nariman[4] in Bombay at the first maternity hospital opened in India. She later went to the London School of Medicine for Women. Dadabhoy was amongst the earliest women worldwide to be recognised as the Member of the Royal College of Surgeons (MRCS) in 1910. She was later honoured with a Membership of the Royal Colleges of Physicians of the United Kingdom in 1914. She did her

2. The Ahmadiyya movement and the Aligarh movement. The Ahmadiyya movement focussed more on the social teachings of Islam in the context of progress and change. The Aligarh movement focussed more on education. Both the movements together brought about a sea change in the progress of Muslim women.

3. In 1908, Pars social reformer B. M. Malabari and Dayaram Gidumal founded a home for training Indian women to be nurses. Ramabai, guided and supported the work of the society. This society came to be known as Seva Sadan.

4. Sir Temulji Bhicaji Nariman RCSEd, was an obstetrician from Bombay who co-founded one of the city's first lying-in hospitals in 1887 and was knighted in 1914 for his work during the plague epidemic in India.

MD from the London School of Tropical Medicine. She was the second woman to do so. She was the first woman to teach medicine in India at the Seth Gordhandas Sunderdas Medical College and the King Edward Memorial Hospital in Bombay. Dadabhoy was the Honorary Obstetrician and Honorary Surgeon at the Cama and Albless Hospital in Bombay. She was also the President of the Association of Medical Women in India and the first President of the Bombay Obstetrics and Gynaecology Society (The Heritage Lab, 2023).

Dadabhoy returned to India in 1912 and was amongst the first to actively advocate for reduction of infant and maternal mortality. It was due to her efforts that welfare and birthing centres for the safety of mothers were established. She established obstetrics and gynaecology societies across India which later became the Federation of Obstetrics and Gynaecology Societies of India (FOGSI). FOGSI continues to be active in the twenty first century too and is well known for its work on sexual health, preventive and curative health for mothers. As a part of the Bombay branch of the Red Cross, Dadabhoy established the first blood transfusion centre in India during World War II. She was also amongst the first Indian doctors to use radium to treat cancer.

Dr. Hilda Lazarus:

Dr. Hilda Lazarus was appointed to the subcommittee on the Physical Education Advisory Committee of the Bhore Committee. Hilda Lazarus (1890-1978) was born in a Christian missionary family. Her grandparents had converted to Christianity shunning their Brahman identity and were missionaries in the London Missionary Society. Her father was a well-respected educator. Lazarus completed her BA at the Madras University and later went on to do her MBBS at the Madras Medical College. Lazarus specialised in obstetrics and gynaecology in London and Dublin and was a Member of the Royal College of Surgeons (MRCS). She was the first woman to be appointed to the Women's Medical Service in India (WMSI)[5] which was a part of the Dufferin Fund. She was the secretary of the Dufferin Fund. In India, Lazarus began her work by training nurses and midwives across India as a part of the Dufferin fund to provide medical care to women. She became the Principal of the Lady Hardinge Medical College[6] in Delhi in 1940. During World War II in 1943, Lazarus was appointed as the Chief Medical Officer of the WMS.

Freedom from the British in 1947, led to the appointment of Lazarus as the first Indian Head of Christiaan Medical College (CMC) in Vellore. Lazarus was a devout Christian with a missionary zeal who had worked all over the world and across India. In the late 1930s most, Indian women were trained only as s licentiates with diplomas and there were very few women doctors. The nationalist movement actively campaigned for the training of women as doctors Lazarus became a part of this endeavour. CMC Vellore was a coeducational medical institution and for the Christians closely associated with the British it became an opportunity to prove their nationalism. Lazarus travelled extensively overseas to generate funds for CMC Vellore. Under her leadership the institution began a degree course on nursing. After retiring in 1950 she continued her association with the CMC. Lazarus' legacy to Vellore and by extension to medicine in India remains insurmountable. She was a tough task master and did not bear fools gladly. Her zealousness in guarding her privacy precluded any strong friendships. "Lazarus's legacy, then, as the first Indian director of the work begun by missionaries at Vellore is not to be found in personal tributes or physical monuments but rather in her contribution to indigenizing and professionalising a venerable institution while retaining its strong Christian identity and preserving it for the India of the future." (Brouwer, 2006, 205).

As the Director General of the women's branch of the Indian Medical Service she was given the rank of a Lieutenant Colonel. Lazarus has several awards to her credit - Honorary Fellow, National Academy Medical Sciences; President of the Association of Medical Sciences; President, Christian Medical College Association; President, Association of Medical Women

5. The Association of Medical Women of India (AMWI) was formed in 1907 by a British Annette Benson and the Women's Medical Service India (WMSI) was started in 1912. Both the WMSI and AMWI were formed to counteract the discrimination faced by women doctors in pay and work-related issues and to provide better health care to women of India.

6. The Lady Hardinge Medical college was established in 1916 in Delhi. It was the only medical college in India providing medical training to women in India. It was the first only women medical college.

in India, 1918 and Member of Red Cross, India; Gold Medal in Midwifery, Madras Medical College (during MBBS course); Silver Medal, Kaisar-i-Hind Award; Gold Medal, Kaisar-i-Hind Award; Medal for Serving Sister of the Order of St. John; Padma Shri, 1961; and awarded CEB (Commander Order of the British Empire); in 1943, awarded the Companion of the British Empire. Later in 1945 she was elected as the President of the Association of Medical Women in India. Lazarus was also a member of the Legislative Council and Municipal Council of Madras and the Zila Parishad (Brouwer, 2006). As a devout Christian imbued with missionary zeal Lazarus donated a large part of her salary and property for the development of medical services for the underprivileged.

Conclusion:

The journey of Khadija, Dadabhoy and Lazarus was pioneering and path breaking. Their accomplishments in the larger context of reform was as role models were not just for women in India but also for women across the world. Their life journey offers an alternative view of colonialism and modernity. It gives us a perspective of social reform and feminism that goes beyond the conventional documenting of the role of upper caste men and some women. Dadabhoy and Lazarus were both doctors but their contribution to the formulation of the health policy and as feminists was immense. Khadija Shaffi Tyabji's involvement with politics and education for women makes her a reformer in her own right. The health care of the population was hardly ever an issue that was discussed within the medical establishment. The inclusion of these women gave a new perspective to the formulation of health policy.

These were isolated voices in an inherently male dominated Committee. Lazarus was a missionary and for her medicine was a calling very much like the Protestants of the West as discussed by Max Weber[7]. Dadabhoy was more interested in maternal and child health and worked towards ensuring adequate medical care for women. Khadija was a Muslim woman and a social reformer. Her efforts were directed towards politics and education which gave her the power to ensure adequate health facilities for women, open schools for girls and to ensure overall upliftment of women. There was a sense of understanding the multidimensionality of health. These were amongst the earliest Indian feminists of the colonial era who asserted their agency. They were a part of a committee that continues to be relevant for the health policy of the country even after almost eight decades of India's independence. Their contribution is a part of the feminist history of India even though it's not a part of the mainstream feminist telling of Indian feminism.

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