Kerala History and Studies Journal
Published by the Kerala History Conference
ISSN No. XXXX-XXXX

Colonial Medicine and Women's Healthcare in Travancore: A Historical Analysis of Gender, Caste, and Medical Accessibility (1896-1950)

Author(s) Dalia Varghese

Publication Vol. 1 / Issue 1 / 2026

Stable URL https://journal.keralahistoryconference.org/article/12

Date of Release 28.11.2026

IP Address 216.73.216.174

Downloaded 27-Nov-2026 04:44 IST

Colonial Medicine and Women's Healthcare in Travancore: A Historical Analysis of Gender, Caste, and Medical Accessibility (1896-1950)

Dalia Varghese
Research Scholar
Department of History, PSMO College,
Tirurangadi, University of Calicut

Assistant Professor
Department of History,
St. Thomas College (Autonomous)
Thrissur, University of Calicut

Introduction

Travancore is remembered for its numbers. By the late 1940s the state recorded lower infant mortality and higher female literacy than most provinces of British India, and historians of what came to be called the Kerala model have traced those figures back to decisions taken by the durbar well before independence.[1] The same half century has a second history, less often told alongside the first, in which the state took to itself an authority over birth, sickness and death that no earlier government in the region had attempted to claim. Hospitals reserved for women opened. A register of qualified practitioners was drawn up, vaccination was made compulsory for whole categories of subjects, and sanitary officials were given statutory power to enter a dwelling and remove the people living in it. This paper explains the expansion in the distribution of medical authority among women in Travancore between 1896 and 1950.

The argument is that Western medicine reorganised the existing hierarchy instead of dismantling it. Access to state medicine ran along the same lines of caste, wealth and residence that already governed access to schools, temples and public roads. Mission medicine reached further down the social order, and did so as one part of a project of religious conversion. Formalisation of qualification, completed by the Travancore Medical Practitioners Act of 1944, withdrew legal recognition from the women who had attended the majority of births in the state.[2] Set against all this is evidence, uneven but real, of women acting for themselves. They petitioned for female doctors.

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

They chose between government, mission and indigenous care according to the complaint. A few entered the profession.

Two clarifications about scope. The paper takes 1896 as its point of departure because the Women and Children's Hospital at Thycaud in Thiruvananthapuram opened in that year, but the institutional groundwork was laid earlier, and section 4 accordingly reaches back to 1836.[3] Second, and this matters more than it may appear, Travancore and Cochin were separate princely states until their merger in July 1949. Evidence from one is not automatically evidence about the other. Cochin material is used twice in what follows, because the Cochin records happen to be fuller on two particular questions, and on both occasions it is identified as Cochin evidence and its bearing on Travancore is argued rather than assumed.

Sources and Their Limits

Three bodies of printed material underpin this study. They are set out in table 1, with the repository and the principal yield of each.[4] Nothing in the argument below rests on manuscript material that has not been printed.

Table 1. Principal sources consulted

Source	Coverage	Repository	Principal yield
Travancore State Administrative Reports	1879–1950	Kerala State Archives, Thiruvananthapuram	Institutions opened, patient movement, epidemic incidence, departmental priorities
Travancore State Manual (Nagam Aiya)	to 1906	Printed, Travancore Government Press	Medical administration at the start of the period

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

Travancore State Manual (Velu Pillai)	to 1940	Printed, Government of Travancore	Medical administration at the close of the period
Census of India, Travancore volumes	1901–1951	Superintendent of Census Operations	Demographic frame; limited health indicators
London Missionary Society, South Travancore district reports	1896–1950	Council for World Mission Archive, SOAS, London	Mission medical work; encounters with women excluded from caste-Hindu provision
Proceedings of the Sri Mulam Popular Assembly	1904–1947	Kerala State Archives	Public demand for dispensaries and for women practitioners
Travancore Government Gazette (legislation)	1880–1946	Printed	Vaccination proclamation, epidemic regulation, Medical Practitioners Act, Public Health Act

The limits of this record deserve statement at the beginning, because they decide what can be argued from it. Official reports count admissions and attendances. They were not designed to record who was refused, who was discouraged and who never came, and they say nothing at all about women who did not present at a government institution. After the first decades they seldom distinguish patients by caste, and almost never by caste and sex together, which makes the differential access described in section 10 hard to quantify even where other evidence makes it plain.

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

Mission reports have the opposite defect. They are thick with individual encounter, but they were written for subscribers in Britain, and their hostility to indigenous practice is so uniform that it should be read as a convention of the genre rather than as observation.

Neither body of material carries the words of the women who used these services. What survives of women's own voice comes through petitions and assembly representations, shaped by the formulas of official address before ever reaching the page. Geraldine Forbes has made the point generally: the historian of women's medicine in India works from records made by those who administered care, not by those who received it.[5] Travancore is no exception. That silence is itself a finding, and it is one this paper has had to work around rather than solve.

For this reason no attempt is made here to reconstruct maternal mortality or life expectancy. Such a reconstruction needs vital registration of a completeness the state did not reach before 1950. Claims of that order in the existing literature should be treated with care. Where the argument that follows concerns the direction of a change rather than its size, that restriction comes from the sources and is stated as such.

Historiographical Position

The historiography of medicine in colonial South Asia has travelled a long way from the account of benevolent transfer that held the field before the 1980s. David Arnold set the terms of the present debate by treating the body as the surface on which colonial authority was most directly exercised, through vaccination, quarantine and the management of plague and cholera.[6] Mark Harrison qualified that picture. He showed how small, underfunded and internally divided the sanitary establishment in British India actually was, and how much of its published programme never left the page.[7] Alison Bashford has since traced the connections between hygiene, race and the drawing of boundaries across the imperial world, arguing that public health worked as a technique of separation as much as of cure.[8] Ania Loomba on colonial discourse, and the collection edited by Roy MacLeod and Milton Lewis on medicine and empire, supply the wider frame.[9]

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

Work on women has followed a parallel course. Maneesha Lal's study of the Countess of Dufferin's Fund, founded in 1885 to supply female medical aid to the women of India, showed that the scheme rested on an assumption nobody at the time examined closely, that Indian women would not accept treatment from male practitioners, and that the assumption served imperial self-justification quite as well as it served patients.[10] Forbes has reconstructed the careers of the first generation of Indian women doctors and the ceiling they met.[11] Supriya Guha and Sean Lang have examined the medicalisation of childbirth and the making of the indigenous midwife into a figure of danger, a construction that came before the evidence which might have supported it.[12] This paper is indebted to all four.

The intended contribution lies in a gap those studies leave open. Almost all of the literature just described concerns directly administered British India. Travancore was not directly administered. Its medical department answered to a Hindu durbar that pursued Western medicine as an instrument of its own prestige, that sought international recognition for its public health work, and that maintained at the same time the caste order on which its legitimacy rested. The usual opposition between coloniser and colonised does not map cleanly onto this. The agency imposing vaccination was indigenous. So was the hierarchy deciding who reached a hospital bed. And the resistance encountered was not anti-colonial in any straightforward sense. Robin Jeffrey on Travancore politics and on the making of the Kerala model, and Koji Kawashima on relations between the durbar and the missions, are the indispensable guides here.[13]

One borrowing needs acknowledging. Robert Redfield's distinction between great and little traditions, and Milton Singer's application of it to Indian modernisation, are used below in a narrow sense only, to separate the textually codified Ayurveda of learned families from the local healing practised in villages, much of it by women.[14] The distinction is imperfect, since the two were in constant traffic with each other. It earns its place because it identifies which body of knowledge the colonial state was willing to bargain with and which it simply did not see.

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

Medical Practice in Travancore before 1896

Indigenous Systems and Women's Healing

Kerala had a developed medical culture long before European practitioners arrived. Its Ayurveda descended from the classical compendia attributed to Charaka and Sushruta, though the text most closely studied in the region was the Ashtangahridaya of Vagbhata, and transmission ran through a small number of hereditary physician families rather than through any institution.[15] One correction is needed to a claim that circulates in general accounts. Ayurveda was not codified in the Rigveda. Healing material in the Vedic corpus is concentrated in the Atharvaveda, and systematic codification belongs to the classical samhitas of the early centuries of the common era.

Learned Ayurveda was not the medicine most people met. Illness in ordinary practice was explained in several registers at once, and treatment could combine humoral correction with ritual remedy without anyone feeling a contradiction. The Cochin census report of 1901 describes a sick person's bedside attended in turn by an astrologer settling the cause, an exorcist addressing the malevolent agency and a vaidyan treating the symptom.[16] That passage concerns Cochin, not Travancore. It is quoted here only because it is the fullest contemporary description of a pattern that observers in Travancore recorded in vaguer terms.

A large part of this practice belonged to women, and none of it was written down. Childbirth was attended by the vayattatti, the local midwife, with older women of the household assisting. Post-partum care ran to weeks: confinement, oil bathing, dietary restriction, medicated preparations. Knowledge of abortifacients, of lactation, of infant ailments and of the management of menstruation circulated among women and passed by apprenticeship within families and neighbourhoods. It produced no texts and no certificates. That is precisely why it was invisible to the state which later set out to regulate medical practice, a point section 12 returns to.

The Formation of a State Medical Department

Travancore took up Western medicine early by the standards of the princely states. An allopathic hospital was working by 1817, and a state medical department was

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

constituted in 1836.[17] Two dispensaries had opened in 1819, one at the palace and one at the lines of the Nair Brigade. The order of provision is worth pausing on, because it set a pattern that held: court and army first, administrative town next, countryside last.

Ayilyam Thirunal laid the foundation stone of the Civil Hospital at Thiruvananthapuram, later the General Hospital, in 1865, and the closing decades of the century saw specialist provision multiply, including a school for training hospital assistants, an eye hospital in 1906 and radiographic equipment at the General Hospital from 1903, replaced by better apparatus in 1927.[18] Table 2 sets out the sequence. This programme was a claim to standing among the Indian states at least as much as a response to any measured need. Indigenous practitioners were left out of it. Through most of the nineteenth century the vaidyan was called on by the state only during epidemics, when trained staff ran short, and was otherwise no part of official medicine at all.

Table 2. Medical institutions and legislation in Travancore, 1817–1949

Year	Development
1817	First allopathic hospital in operation
1819	Dispensaries at the palace and at the Nair Brigade lines
1836	State medical department constituted
1865	Foundation of the Civil Hospital, later the General Hospital, Thiruvananthapuram
1880	Proclamation making vaccination compulsory for defined categories
1896	Women and Children's Hospital opened at Thycaud, Thiruvananthapuram
1897	Hospital for chronic diseases opened
1898	Epidemic diseases regulation; power to require evacuation of infected houses
1903	Radiographic equipment installed at the General Hospital

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

1904	Sri Mulam Popular Assembly constituted
1906	Eye hospital opened
1916	Mary Poonen Lukose appointed to the Women and Children's Hospital, Thycaud
1922	Lukose nominated to the Travancore legislature, its first woman member
1924	Lukose appointed Durbar Physician, with charge of the medical service
1928	Rockefeller Foundation mission under W. P. Jacocks begins work
1936	Temple Entry Proclamation
late 1930s	Tuberculosis sanatorium established at Asaripallam, near Nagercoil
1938	Lukose appointed Surgeon General of Travancore
1944	Travancore Medical Practitioners Act; Travancore Medical Council constituted
1121 ME (1945–46)	Travancore Public Health Act
1949	Travancore merged with Cochin

The Women and Children's Hospital and the All-India Context

The hospital for women and children opened at Thycaud in Thiruvananthapuram in 1896. It admitted only women and children, and the medical charge of women was placed in the hands of a woman doctor.[19] It was the first institution in the state to treat women's health as a distinct administrative category rather than as a subordinate part of general provision. The Administrative Reports pass over the opening briefly, and the printed record consulted for this paper does not name the first medical officer, which is a small illustration of how thinly these sources document the women who staffed the institutions they describe.

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

The foundation belongs to a movement then under way across British India. The National Association for Supplying Female Medical Aid to the Women of India, set up in 1885 and known generally as the Dufferin Fund, had made women doctors and women's hospitals an imperial cause, on the argument that seclusion kept Indian women from consulting male practitioners.[20] Travancore was not a Dufferin province. Its durbar was nonetheless attentive to metropolitan opinion, and to comparison with neighbouring administrations, and the Thycaud foundation belongs recognisably to the same moment.

The segregationist rationale cut both ways, and this is where the Travancore evidence is most instructive. Separate provision put hospital treatment within reach of women whose families would never have permitted examination by a male doctor. It also gave institutional form to the proposition that seclusion was a constraint to be accommodated rather than a restriction to be questioned. Lal observes the same of the Dufferin scheme in British India, and Travancore bears her out.[21] Women's medicine entered the state system as a protected enclosure. It stayed one.

Provision widened over the following decades. A hospital for chronic diseases opened in 1897. Institutions for tuberculosis came much later, the sanatorium at Asaripallam near Nagercoil being established on an extensive site in the second half of the 1930s and surviving today as the nucleus of a government medical college; its foundation is generally credited to Mary Poonen Lukose, whose career is the subject of the next section.[22] Tuberculosis fell heavily on women in crowded households, though the returns of the period will not support a sex-disaggregated statement of its incidence. Expansion was uneven on the ground, concentrated in the towns of the central and southern taluks. Because convention restricted women's movement more sharply than men's, and because a woman travelling to a hospital ordinarily needed an escort whose time also had to be found, the same distance weighed more heavily on a woman than on a man.

Women as Medical Practitioners

The clearest evidence for women's entry into the profession is the career of Mary Poonen Lukose (1886-1976). She was the daughter of T. E. Poonen, the first

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

Travancorean to take a medical degree in the Western system and physician to the royal household, and her education shows what even that background failed to remove. The Maharaja's College at Thiruvananthapuram refused her admission to the science course because she was a woman. She took a degree in history instead, in 1909, becoming the first woman graduate of the state, and then went to London. She qualified in medicine at the University of London and trained further in obstetrics at the Rotunda Hospital in Dublin and in paediatrics at Great Ormond Street. She returned to Travancore in 1916 and was appointed to the Women and Children's Hospital at Thycaud. In 1922 she was nominated to the Travancore legislature, its first woman member. In 1924 she was made Durbar Physician with charge of the state medical service, and in 1938 Surgeon General of Travancore, the first woman to head a state medical department in India. The tuberculosis sanatorium at Asaripallam, the X-Ray and Radium Institute at Thiruvananthapuram and a programme of midwifery training were all established under her direction.[23]

Her career carries two implications, and they pull against each other. It shows that the upper reaches of the medical service were not closed to women by rule, and that a woman could exercise authority over male subordinates in a department of the Travancore state a decade before independence. It shows equally how narrow the opening was. Lukose came from a prosperous Syrian Christian family, was the daughter of a physician, and was educated abroad at her family's expense. Each of those conditions was available to a very small number of women in Travancore, and to almost no Ezhava, Pulaya or Paraya woman at all. A woman at the head of the department did not by itself change who could reach its lower rungs. The pattern Forbes describes for British India, in which women doctors were recruited disproportionately from Christian and other minority communities with mission schooling, holds here too.[24]

Below the qualified physician the workforce was gendered downwards. Nursing, midwifery training and, from the interwar years, the work of health visitors attached to public health units drew in larger numbers of women at lower pay and with narrower authority. These were real openings into salaried employment for women with some schooling. They were also structurally subordinate posts inside a hierarchy

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

whose senior positions stayed overwhelmingly male, and they turned on formal literacy in a way that older forms of women's practice never had.

Medical Missions in South Travancore

The Shape of Mission Medicine

The Protestant missions were the second provider of Western medicine, and in the southern taluks they were for long stretches the first. The largest medical presence belonged to the London Missionary Society, centred on Neyyoor, where a dispensary founded in the 1830s grew into an institution with a wide network of branch stations across south Travancore; its reputation rose considerably after T. Howard Somervell joined the staff in the 1920s.[25] The Salvation Army's Catherine Booth Hospital at Nagercoil, from the closing years of the nineteenth century, was the other substantial mission institution. Lutheran work in the region was smaller and lay mostly among Tamil-speaking communities toward the eastern boundary. The claim that the Lutheran mission exceeded the combined medical presence of the London Missionary Society, the Church Missionary Society and the Salvation Army in Travancore is not borne out by the mission records, and it should be set aside.

Missionary activity in India met official obstruction until the Charter Act of 1813 opened Company territory. Even afterwards relations between the missions and the Travancore durbar stayed contested, as Kawashima has shown for the years from 1858 to 1936.[26] Medical work proved the most effective way of establishing a presence, because it offered something immediate that preaching did not. John Lowe, writing in 1886 out of long experience of mission hospitals, was candid that medical charity opened doors otherwise shut and prepared communities for religious instruction.[27] Historians should take that candour at face value rather than read later ethical categories back into it.

Reaching Women outside Caste-Hindu Provision

What matters here is whom mission medicine treated. Lower-caste women, and Nadar, Ezhava, Pulaya and Paraya women in particular, were excluded in practice from many caste-Hindu spaces and had no means of reaching distant government institutions. The mission dispensaries were nearer and cheaper, and on the evidence

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

of the mission reports themselves they were less likely to turn a woman away. The connection between the London Missionary Society and the Nadar community of south Travancore, which Jeffrey has examined in its social and political dimensions, had a medical component that has drawn less attention than its educational one.[28]

Two qualifications. Mission statistics were compiled for a subscribing public and counted attendances rather than persons, so aggregate totals of treatments overstate the number of individuals reached, sometimes by a wide margin. And the care came with conditions attached. Scripture reading commonly accompanied treatment, women employed as Bible readers worked in the wards, and conversion was the declared purpose of the whole enterprise. What is called for here is description rather than verdict. Mission medicine extended care to women whom neither the durbar nor the caste order had served, and it did so within a framework that treated their existing beliefs as an obstacle to be cleared.

Vaccination, Epidemic Regulation and the Household

In 1880 Travancore made vaccination compulsory for defined categories of the population: government servants, students, pleaders, prisoners, applicants for state medical relief, and dependants of charitable institutions. Aparna Nair's study of smallpox in the state follows the extension of these requirements through the decades that followed, first by epidemic legislation and later through the municipal enactments applying in the towns.[29] Travancore's reputation as a model state rested substantially on this record.

Resistance was persistent, and it had intelligible grounds. An older practice of variolation existed in the region, bound up with propitiation of the goddess held responsible for smallpox, so vaccination was not entering empty ground but displacing an established religious and therapeutic complex.[30] Arm-to-arm transfer of lymph, the method in general use for much of the period, required physical contact and exposure of the upper arm. For women that raised objections of modesty; across caste lines it raised questions of pollution. Doubts about the safety of the operation were not unreasonable by the standards of the day. The durbar's answer included a gesture of some political skill. Members of the royal family were vaccinated in public,

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

which turned the procedure from a foreign imposition into something the state's own rulers had accepted.

Epidemic legislation carried official reach further in. A regulation of 1897 strengthened preventive measures, and the epidemic diseases regulation of the following year gave local authorities power to require the evacuation of infected houses.[31] The Public Health Act of 1121 ME, corresponding to 1945 and 1946, consolidated state authority over drinking water, drainage, latrines, the milk trade, lodging houses and food.[32] The consequence for women was direct, and it is easy to miss if these enactments are read only as public health measures. The dwelling, its water, its waste and its food formed the one domain in which women's authority was least contested. Legislation of this kind made that domain answerable to inspection by male officials, and made the woman of the house responsible for standards she had no hand in setting. Bashford's argument that hygiene operated as a mode of governance is well illustrated by the Travancore sequence.[33]

The Rockefeller Foundation and Maternal Health after 1928

In 1928, at the request of the Travancore government, the International Health Division of the Rockefeller Foundation sent Dr W. P. Jacocks to organise public health work in the state. The programme took in hookworm control, sanitary improvement, health units, training in health education, entomological investigation and epidemiological survey.[34] Its arrival says as much about the durbar's appetite for external validation as about any assessment of need. It also confirms a habit of the period, in which technical authority was assumed to sit outside the society being surveyed.

The bearing of this work on women's health needs care, because it has been overstated. Hookworm infection produces chronic iron deficiency anaemia, and severe anaemia in pregnancy is an established contributor to haemorrhage, low birth weight and maternal death. That makes it reasonable to infer that a sustained reduction in hookworm burden improved outcomes for pregnant women in the districts affected. It does not follow that any measured fall in maternal mortality in Travancore can be attributed to the Rockefeller programme, and the available reports do not show it. The programme was not designed as a maternal health intervention.

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

Its surveys were not organised to detect such an effect, and vital registration in the state was nowhere near complete enough to carry the calculation. The claim made here is one of plausible mechanism, not of demonstrated outcome, and it is put in that form deliberately.

Caste, Religion and Differential Access

The Cost of Free Treatment

More institutions did not mean uniform access. Ezhavas and other lower-caste patients were treated at the General Hospital in Thiruvananthapuram in 1879 and 1880, but their reception there involved separation within the building, waiting that was not imposed on others, and conduct from staff which the record describes in guarded language.[35] For lower-caste women the disadvantages compounded. Spatial segregation, a shortage of women practitioners to whom they might be referred, the ordinary discourtesy of upper-caste subordinate staff: all of this sat on top of the economic barriers facing their households generally.

Medical relief was free in principle until charges came in around 1940, and the phrase recurs in the Administrative Reports. What it concealed matters more than what it stated. Reaching an institution meant transport or a day's walk, wages lost by the patient and often by an accompanying relative, some provision for children left behind, and in practice small payments to subordinate staff. For a woman in a labouring household those costs were heavy against income, and they fell due whether the treatment worked or not. Free provision a woman could not afford to use was not, in any sense that mattered, available to her.

Religious Community and Medical Choice

Reception of Western medicine varied by religious community. Syrian Christians were its earliest and steadiest users in central Travancore, for several reasons at once: a long association with mission schooling and therefore with English education, a professional stratum with an interest in modernisation, and no governing concern about pollution through contact of the kind that constrained caste-Hindu households. C. Achyuta Menon recorded a comparable pattern in Cochin, where demand for Western medicine came disproportionately from non-Hindu groups.[36] The Cochin

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

evidence enters here as a parallel, not as proof. The two states differed in the composition and distribution of their populations, and the parallel should not be pressed further than that.

For upper-caste Hindu women the difficulty was of another kind. Examination by a male practitioner conflicted with the norms of seclusion their households observed. A hospital ward mixed caste groups in a way that raised questions of purity. And a woman's attendance at a public institution engaged the standing of her family as well as her own health. The effect was delay. Consultation was put off until a condition grew severe enough to override these considerations, which meant that cases presenting from such households were often advanced, and that the outcomes recorded against them were correspondingly worse. This question of bodily access should be read alongside the contemporaneous struggles over dress and over entry to temples and public roads, which came to a head in the Temple Entry Proclamation of 1936 and which turned on the same matter of who might be present in which space.[37]

Choice, Constraint and Medical Pluralism

Women in Travancore were not simply acted upon. The evidence for this is indirect but consistent, and it should be described accurately: what follows is inference from patterns visible in institutional records, not testimony, and it is offered with that qualification standing.

Collective representation is the clearest instance. Requests for more hospitals and dispensaries reached the Maharaja and the Dewan by petition during 1886 and 1887, and once the Sri Mulam Popular Assembly was constituted in 1904 such demands were pressed in its proceedings, including requests for the appointment of women practitioners at particular stations.[38] These representations show communities, and in some cases women's associations within them, stating a preference which the administration then acted on. Appointments of women doctors followed sustained demand of this kind. They did not precede it.

Selective use of the available systems is the second pattern. Attendance records suggest that women went to Western institutions for conditions where the advantage

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

was plain, notably surgical injury, fracture, cataract and epidemic disease, while continuing to rely on domestic and indigenous care for reproductive matters, chronic complaints and the management of childbirth. Read as inconsistency this looks like partial acceptance. Read as strategy it is a sensible allocation of different problems to the systems that handled each most convincingly, and it is the ordinary behaviour of populations with more than one therapeutic tradition to hand.

Pluralism worked on the official side as well. Vaidyans were engaged by government during epidemics, the influenza of 1918 among them, when demand for attendance ran far past anything the trained establishment could meet.[39] Some indigenous practitioners took elements of Western practice into their own work, antiseptic technique above all. Accommodation of this kind, institutional and personal, was widespread. An account that presents the two systems as clean alternatives cannot capture it.

One caution against overstating all this. Choice exercised inside a structure of severe constraint is still constrained. A woman who used a mission dispensary because the government hospital would not treat her civilly has exercised judgement, certainly, but the range within which she exercised it was set by other people. Guha on childbirth and Forbes on medical careers both insist on the distinction, and it is worth keeping.[40]

Registration and the Displacement of the Midwife

The Travancore Medical Practitioners Act of 1944 laid down qualification requirements and constituted the Travancore Medical Council, with a register of those entitled to practise.[41] The measure was presented as a guarantee of competence, and on its own terms it was one. Its distributive effect was something else. Making a documented qualification the condition of lawful practice excluded, by that single route, every practitioner whose training had come by apprenticeship. Women were the largest group so excluded. The vayattatti who attended births had no certificate to produce.

The exclusion followed a pattern established elsewhere. Lang has shown for Madras how the indigenous midwife was written up in official and medical prose as ignorant and dangerous, and how that characterisation ran ahead of any evidence that might

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

have supported it; Guha has traced the same figure through the wider Indian material.[42] Once the dai had been fixed as a hazard, replacing her needed no further argument. The Travancore Act completed in law a redefinition already accomplished in print over the preceding half century.

The consequences ran several ways. Women who had held a recognised position and an income in their localities lost both, or kept them informally and without protection. Authority over childbirth passed from a female network to a profession male at its senior levels, so that a process once managed by women in a domestic space became one supervised by outsiders in an institutional one. A body of practical knowledge that had never been written down went unrecorded as its holders stopped practising. Against these losses stands the real benefit of asepsis and of trained attendance in obstructed labour, which prevented deaths that had previously been unpreventable. The criticism advanced here is not of antiseptic midwifery. It is of the manner of the transition, which discarded the existing practitioners instead of training them, and treated their knowledge as an absence rather than a resource.

One complication should be recorded rather than smoothed away. The midwifery training organised under Lukose was among the more serious attempts to bring existing birth attendants inside the new system rather than simply supersede them, and it was directed by the woman then heading the department. The same administration that opened that route closed the older one by statute in 1944. Displacement was therefore not the work of an external authority imposing itself on an indigenous profession. It was carried out by a medical service staffed and in part led by women of the state, which is a reminder that the divisions mattering most in Travancore ran along caste and education rather than along the line between coloniser and colonised.

Conclusion

Between 1896 and 1950 Travancore acquired hospitals for women, a small body of qualified women practitioners, a statutory medical register and a public health administration with powers over the household. The evidence assembled here suggests that these developments redistributed medical authority rather than simply

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

enlarging medical provision. Authority moved from households to institutions. It moved from women to a profession male at its upper levels, and from practitioners answerable to their neighbours to practitioners answerable to a council. Access to the new provision reproduced the stratification of the society that built it, so that caste, wealth, religious community and distance from a town settled which women benefited and by how much.

The period left a real inheritance as well, and it would be a poor history that recorded only the losses. A network of institutions existed. A population had grown used to using it, and women had entered the health workforce in numbers that would rise quickly after 1950. The demographic outcomes for which Kerala later became known were built on that foundation, and Jeffrey is right to place their origins in the princely period rather than in independence.[43] The state's capacity to mount organised responses to epidemic disease in recent decades draws on the same institutional habit, and on the public willingness to use it. It would be an overstatement to attribute those responses to any deliberate synthesis of medical traditions, and no such claim is made here.

Three questions are left open by the sources used above, and each would repay archival work this paper has not attempted. The first concerns the composition of the women's medical workforce below the physician, which the establishment lists and pay abstracts in the Administrative Reports could be used to reconstruct in some detail. The second is what became of registered and unregistered practitioners after the 1944 Act; the Medical Council's own records would be the place to start. The third is how far indigenous women's practice survived the period rather than disappearing from it. That last will not be settled from official papers at all. It needs the oral record, while any of it remains recoverable. Until such work is done the account offered here should be read as an interpretation of the printed evidence, and as a set of propositions to be tested against the manuscript record.

End notes

1. Robin Jeffrey, Politics, Women and Well-Being: How Kerala Became "a Model" (Basingstoke: Macmillan, 1992), 1–14.
2. Travancore Medical Practitioners Act, 1944, Travancore Government Gazette (Trivandrum: Government of Travancore, 1944).

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

3. K. R. Nair, Evolution of Modern Medicine in Kerala (Thiruvananthapuram: TBS Publishers and Distributors, 2001), 98-104.
4. Travancore State Administrative Reports, 1879-1950, Kerala State Archives, Thiruvananthapuram; V. Nagam Aiya, The Travancore State Manual, 3 vols. (Trivandrum: Travancore Government Press, 1906); T. K. Velu Pillai, The Travancore State Manual, 4 vols. (Trivandrum: Government of Travancore, 1940); Census of India, 1901-1951, Travancore volumes; London Missionary Society, South Travancore District Reports, 1896-1950, Council for World Mission Archive, School of Oriental and African Studies, London; Proceedings of the Sri Mulam Popular Assembly, 1904-1947, Kerala State Archives.
5. Geraldine Forbes, Women in Modern India (Cambridge: Cambridge University Press, 1996), 157-88.
6. David Arnold, Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India (Berkeley: University of California Press, 1993), 7-10, 116-58.
7. Mark Harrison, Public Health in British India: Anglo-Indian Preventive Medicine, 1859-1914 (Cambridge: Cambridge University Press, 1994), 6-15.
8. Alison Bashford, Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health (Basingstoke: Palgrave Macmillan, 2004), 1-15.
9. Ania Loomba, Colonialism/Postcolonialism, 2nd ed. (London: Routledge, 2005), 8-12; Roy MacLeod and Milton Lewis, eds., Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion (London: Routledge, 1988), 1-18.
10. Maneesha Lal, "The Politics of Gender and Medicine in Colonial India: The Countess of Dufferin's Fund, 1885-1888," Bulletin of the History of Medicine 68, no. 1 (1994): 29-66.
11. Forbes, Women in Modern India, 157-88.
12. Supriya Guha, "From Dais to Doctors: The Medicalisation of Childbirth in Colonial India," in Understanding Women's Health Issues: A Reader, ed. Lakshmi Lingam (New Delhi: Kali for Women, 1998), 228-51; Sean Lang, "Drop the Demon Dai: Maternal Mortality and the State in Colonial Madras, 1840-1875," Social History of Medicine 18, no. 3 (2005): 357-78.
13. Robin Jeffrey, The Decline of Nair Dominance: Society and Politics in Travancore, 1847-1908 (New Delhi: Vikas, 1976); Jeffrey, Politics, Women and Well-Being; Koji Kawashima, Missionaries and a Hindu State: Travancore, 1858-1936 (Delhi: Oxford University Press, 1998), 112-45.
14. Robert Redfield, Peasant Society and Culture: An Anthropological Approach to Civilization (Chicago: University of Chicago Press, 1956), 67-84; Milton Singer, When a Great Tradition Modernizes: An Anthropological Approach to Indian Civilization (New York: Praeger, 1972), 39-52.
15. Nagam Aiya, Travancore State Manual, 2:513-40; Nair, Evolution of Modern Medicine, 12-15.
16. Cochin Census Report, 1901, in Census of India, 1901, vol. 19, Cochin, pt. 1 (Ernakulam: Cochin Government Press, 1903), 115-18.
17. Nair, Evolution of Modern Medicine, 100-102; Travancore State Administrative Reports, 1896-1950.
18. Velu Pillai, Travancore State Manual, 3:449-72; Nair, Evolution of Modern Medicine, 102-6.
19. Nair, Evolution of Modern Medicine, 102; Travancore State Administrative Report for 1071-72 ME (1896-97).
20. Lal, "Politics of Gender and Medicine," 29-40.
21. Lal, "Politics of Gender and Medicine," 55-62.
22. Nair, Evolution of Modern Medicine, 118-20; K. Rajasekharan Nair, "A Pioneer in Medicine: Dr. Mary Poonen Lukose (1886-1976)," Samyukta: A Journal of Women's Studies 2, no. 2 (2002): 117-21.
23. K. Rajasekharan Nair, "A Pioneer in Medicine," 117-21; Jeffrey, Politics, Women and Well-Being, 92-93, 98; J. Devika, Her-Self: Gender and Early Writings of Malayalee Women (Mumbai: Popular Prakashan, 2005), 181; K. S. Mohindra, "Dr. Mary Poonen Lukose," Hektoen International: A Journal of Medical Humanities 7, no. 2 (2015). Accounts differ over whether the post she received in 1924 is properly styled Durbar Physician or acting Surgeon General; the substance of the appointment, charge of the state medical service, is not in dispute.
24. Forbes, Women in Modern India, 161-70.
25. T. Howard Somervell, Knife and Life in India: The Story of a Surgical Missionary at Neyyoor (London: Livingstone Press, 1940), 17-46; London Missionary Society, South Travancore District Reports, 1920-38.

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

26. Laurence Kitzan, "The London Missionary Society and the Problem of Authority in India, 1798-1833," Church History 40, no. 4 (1971): 457-73; Kawashima, Missionaries and a Hindu State, 112-45.
27. John Lowe, Medical Missions: Their Place and Power (Edinburgh: William Oliphant, 1886), 52-58.
28. Jeffrey, Decline of Nair Dominance, 42-68; London Missionary Society, South Travancore District Reports, 1900-1930.
29. Aparna Nair, "Vaccinating against Vasoori: Eradicating Smallpox in the 'Model' Princely State of Travancore, 1804-1946," Indian Economic and Social History Review 56, no. 4 (2019): 465-92.
30. Arnold, Colonizing the Body, 116-58; Nair, "Vaccinating against Vasoori," 470-78.
31. Regulation for the Prevention of Epidemic Disease, 1898, Travancore Government Gazette; Travancore State Administrative Report for 1073-74 ME (1898-99).
32. Travancore Public Health Act, 1121 ME (1945-46), Travancore Government Gazette.
33. Bashford, Imperial Hygiene, 81-114.
34. Rockefeller Foundation, Annual Report, 1928 (New York: Rockefeller Foundation, 1929), 264-70; Nair, Evolution of Modern Medicine, 121-25.
35. Nair, Evolution of Modern Medicine, 102-4; Travancore State Administrative Reports for 1879 and 1880.
36. C. Achyuta Menon, The Cochin State Manual (Ernakulam: Cochin Government Press, 1911), 267-75.
37. Jeffrey, Decline of Nair Dominance, 1-30, 218-40.
38. Travancore State Administrative Reports for 1886 and 1887; Proceedings of the Sri Mulam Popular Assembly, 1904-1930.
39. Travancore State Administrative Report for 1094 ME (1918-19); Nair, Evolution of Modern Medicine, 115-17.
40. Guha, "From Dais to Doctors," 236-45; Forbes, Women in Modern India, 170-78.
41. Travancore Medical Practitioners Act, 1944.
42. Lang, "Drop the Demon Dai," 357-70; Guha, "From Dais to Doctors," 228-36.
43. Jeffrey, Politics, Women and Well-Being, 1-14, 213-25.

Reference

1. Arnold, David. Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India. Berkeley: University of California Press, 1993.
2. Bashford, Alison. Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health. Basingstoke: Palgrave Macmillan, 2004.
3. Census of India, 1901-1951. Travancore volumes. Trivandrum: Superintendent of Census Operations.
4. Census of India, 1901. Vol. 19, Cochin, pt. 1. Ernakulam: Cochin Government Press, 1903.
5. Devika, J. Her-Self: Gender and Early Writings of Malayalee Women. Mumbai: Popular Prakashan, 2005.
6. Forbes, Geraldine. Women in Modern India. Cambridge: Cambridge University Press, 1996.
7. Guha, Supriya. "From Dais to Doctors: The Medicalisation of Childbirth in Colonial India." In Understanding Women's Health Issues: A Reader, edited by Lakshmi Lingam, 228-51. New Delhi: Kali for Women, 1998.
8. Harrison, Mark. Public Health in British India: Anglo-Indian Preventive Medicine, 1859-1914. Cambridge: Cambridge University Press, 1994.
9. Jeffrey, Robin. Politics, Women and Well-Being: How Kerala Became "a Model." Basingstoke: Macmillan, 1992.
10. Jeffrey, Robin. The Decline of Nair Dominance: Society and Politics in Travancore, 1847-1908. New Delhi: Vikas, 1976.
11. Kawashima, Koji. Missionaries and a Hindu State: Travancore, 1858-1936. Delhi: Oxford University Press, 1998.
12. Kitzan, Laurence. "The London Missionary Society and the Problem of Authority in India, 1798-1833." Church History 40, no. 4 (1971): 457-73.
13. Lal, Maneesha. "The Politics of Gender and Medicine in Colonial India: The Countess of Dufferin's Fund, 1885-1888." Bulletin of the History of Medicine 68, no. 1 (1994): 29-66.

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST

14. Lang, Sean. "Drop the Demon Dai: Maternal Mortality and the State in Colonial Madras, 1840-1875." Social History of Medicine 18, no. 3 (2005): 357–78.
15. London Missionary Society. South Travancore District Reports, 1896-1950. Council for World Mission Archive, School of Oriental and African Studies, London.
16. Loomba, Ania. Colonialism/Postcolonialism. 2nd ed. London: Routledge, 2005.
17. Lowe, John. Medical Missions: Their Place and Power. Edinburgh: William Oliphant, 1886.
18. MacLeod, Roy, and Milton Lewis, eds. Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion. London: Routledge, 1988.
19. Menon, C. Achyuta. The Cochin State Manual. Ernakulam: Cochin Government Press, 1911.
20. Mohindra, K. S. "Dr. Mary Poonen Lukose." Hektoen International: A Journal of Medical Humanities 7, no. 2 (2015).
21. Nagam Aiya, V. The Travancore State Manual. 3 vols. Trivandrum: Travancore Government Press, 1906.
22. Nair, Aparna. "Vaccinating against Vasoori: Eradicating Smallpox in the 'Model' Princely State of Travancore, 1804–1946." Indian Economic and Social History Review 56, no. 4 (2019): 465–92.
23. Nair, K. R. Evolution of Modern Medicine in Kerala. Thiruvananthapuram: TBS Publishers and Distributors, 2001.
24. Nair, K. Rajasekharan. "A Pioneer in Medicine: Dr. Mary Poonen Lukose (1886-1976)." Samyukta: A Journal of Women's Studies 2, no. 2 (2002): 117–21.
25. Proceedings of the Sri Mulam Popular Assembly, 1904-1947. Kerala State Archives, Thiruvananthapuram.
26. Redfield, Robert. Peasant Society and Culture: An Anthropological Approach to Civilization. Chicago: University of Chicago Press, 1956.
27. Rockefeller Foundation. Annual Report, 1928. New York: Rockefeller Foundation, 1929.
28. Singer, Milton. When a Great Tradition Modernizes: An Anthropological Approach to Indian Civilization. New York: Praeger, 1972.
29. Somervell, T. Howard. Knife and Life in India: The Story of a Surgical Missionary at Neyyoor. London: Livingstone Press, 1940.
30. Travancore Medical Practitioners Act, 1944. Travancore Government Gazette. Trivandrum: Government of Travancore, 1944.
31. Travancore Public Health Act, 1121 ME (1945-46). Travancore Government Gazette.
32. Travancore State Administrative Reports, 1879-1950. Kerala State Archives, Thiruvananthapuram.
33. Velu Pillai, T. K. The Travancore State Manual. 4 vols. Trivandrum: Government of Travancore, 1940.

 IP Address: 216.73.216.174 Downloaded: 27-Nov-2026 04:44 IST