CHAPTER-6

Social and Economic Impact of Health and Medical Policy

The medicinal policy of the British Government undertaken during the colonial period had left enormous impact on social and economic field of North Bengal during the colonial and post- colonial period. This chapter would focus on certain areas like agriculture and industry which were affected by the diseases and the health policy adopted by the British Government. It would also highlight the impact of health policy on the general people, individual, family and society at large. The disastrous effect of health policy was visible from miserable conditions of hospitals, dearth of medicines and medicinal instruments, paucity of scientifically trained medical men, inadequate medical fund etc. The failure of the formulation and application of health policy was also viewed from recurring occurrence of diseases followed by appalling death rate throughout North Bengal. The purpose of the chapter is to disclose the fields related to health care of North Bengal which were deprived and suffered due to the indifference on the part of the British Government. It would also emphasize on the role played by the individuals, peasants, landlords, kings and missionary and charitable societies for improving the health care system of North Bengal. The role played by the women is also another important subject of discussion of the chapter.

North Bengal or the Rajshahi Division of Bengal before 1947 was extremely insalubrious and the municipalities as also the district boards were suffering from scarcity of funds. It was, therefore , beyond their capacity , with the limited resources at their control ,to initiate large measures of sanitation. Good drinking water was prime necessity of life. But the public bodies had no sufficient money to make arrangement for providing good drinking water to the rural mass. Many rivers had silted up and created stagnant and pools of water,

and those were utilized as reservoirs for soaking jute, washing cattle , clothes and utensils and for drinking purposes as well. There was abnormal illness and unhealthiness throughout the division. The mortality rate in some parts of it was unusually high. [1] Thus the Rajshahi division was suffering from diseases and due to economic crisis the local boards became helpless in combating the diseases.

In Rajshahi Division the number of deaths from different diseases was 171664 in 1885 or at the rate of 22.19 per 1000 people. A picture of mortality could be clearly comprehended from the following statistical data of the seven districts of North Bengal. [2]

Mortality in the seven districts of North Bengal in the year 1886 (Ratio per mille)

Jalpaiguri	31.01
Pabna	27.68
Rangpur	27.12
Rajshahi	24.86
Dinajpur	23.92
Bogra	22.21
Darjeeling	16.35

Source: Nineteenth Annual Report of the Sanitary Commissioner for Bengal for the year 1886. [3]

Among the people who suffered from different diseases fever had taken the supreme position among them. It could be proved by a report of the Eden Sanitarium , Darjeeling during 1890 and it showed that 25% of the total number of people who got admission there was suffering from malarial fever.

Annual return of patients treated in Eden Sanitarium during the year 1890

Names of diseases	Male	Female	Children	Total	Cured	Relieved	Died
Dysentery	2	1	3	6	4	-	2
Malarial fever	55	11	9	75	72	2	1
Debility	21	23	8	52	48	4	-
Syphilis	8	-	-	8	5	3	-
Gonorrhoea etc.	7	-	-	7	5	2	1
Others				190			

Source: Report on the working of the Eden Sanitorium, Darjeeling during the year 1890. [4]

Among 338 people who were being treated did not belong to North Bengal alone. Among them 183 people came from Calcutta, 105 from Darjeeling , 4 from Sikkim, 9 from Jalpaiguri, 3 from Krishnanagar, 3 from Cooch Behar, 4 from Burdwan, 12 from Howrah and 2 from Dacca. [5] Thus fever was a widely disseminated disease of Bengal.

Though malarial fever attacked rich and poor at the same time, the great majority of people who died belonged to the poorer classes of rural North Bengal. Thousands of people died for want of proper nourishment. The greatest mortality among the poor was due to mainly three reasons- their bigger number, their inability to budge temporarily to more healthy areas and their incapability to obtain better medical attention, medicines and diet during their ailments.

Comparative mortality from fever in the urban and rural circles

	Deaths From fever in Ratio per 1000 of population							
Circle	**1888**	**1887**	**1883 To 1887**	**1878 to 1887**	**1888**	**1887**	**1883 To 1887**	**1878 To 1887**
Urban	24836	25195	30669	35266	10.40	110.45	12.72	14.63
Rural	1067266	1062573	982772	864015	16.76	16.66	15.44	13.57

Source: Twenty-first Annual Report of the Sanitary Commissioner for Bengal for the year 1888, by W H Gregg. [6]

The above statistics had made it clear that the ravages of fever were not so much in virulent form in urban areas and much widespread in villages. Reports of the year 1889 also exhibited the fact that the devastation of fever was unrelenting. During 1889, 589252 males and 512269 females or a total of 1101521 persons died from fever. Mortality rate was higher in several districts like Jalpaiguri (28.18), Dinajpur (25.74), Darjeeling (24.93), Rajshahi (22.74), Rangpur (22.07) and Malda (21.20). [7]

The outbreak of diseases followed by abnormal death rate appeared as a result of the malfunctioning health policy of the Government. Especially the malaria policy of the Government was very much defective and gave rise to many unwanted complications and created unhealthiness. The excessive neglect and indifference and faulty policy of the Government was completely responsible for the dissemination of malaria in every year through out North Bengal. [8] There was abnormal crisis of quinine all through North Bengal. The poor patients of rural North Bengal were facing difficulties in buying expensive quinine. Even the Government also confessed at times that the amount of quinine dispatched to

different dispensaries was not sufficient to cater their requirements. [9] Though fever was spread like wild fire every where, there was dearth of proper satisfactory arrangement for the systematic distribution of quinine. When the packets of quinine reached the post office the shop owners immediately took control of that and sold it at a high price and often in a tainted form for their own profit. [10]

As a result the bulk of the malaria patients were bound to collect the anti-malaria medicines from outside at expensive rate. The situation became so grave that the shop keepers created an artificial crisis of quinine and they imposed high prices for it. [11] The price of quinine became too expensive that the general people were left far away from it. [12] By making a machination with the Kina Bureau, an influential Dutch concern, a controller of the world price of quinine the British Government intentionally made the price of quinine high.[13] Due to the excessive crisis and enormous demand for quinine, the Government started a quinine Rationing Scheme in 1943. But unfortunately the medical practitioners of the rural areas had to face numerous tribulations and problems to collect quinine instead of the initiation of the above scheme. The scarcity of quinine also resulted in outburst of malaria in a virulent form in villages. It was also found that the people who were treated with quinine at the beginning acted as messengers of malaria and spread the germs to others.

The shortage of quinine was also evident from the song of a folk poet. He sang-

Malariae ektire sishu
Prane bujhi mare,
Bangladeshe quinine nai bhai ,
Daktar ki kare?

Its essence was that the children were dying due to malaria. In Bengal quinine was not found and in that condition what were the activities of the doctors? [14]

But in reality the scarcity of quinine was not a correct fact. By making an unnatural condition of deficiency of quinine the government tried to introduce mepacrine as a preventive medicine for fever and replace it against quinine among the people of North Bengal. The British Government sent Quinine to different medical shops only when they were satisfied by the fact that those shops had sufficient storage of mepacrine. But the physicians of Bengal showed their steady unwillingness to accept and prescribe mepacrine as a perfect alternative for quinine.[15]

Though kala azar was a dreaded disease of North Bengal, but there was dearth of sufficient medical practitioners in the treatment of kalazar. The situation became more serious in the rural areas . Consequently, a large number of kala azar patients were referred to Kolkata for treatment. But as the metropolitan hospitals were always exhausted with patients , the rural patients had to be returned back without getting any treatment. Some times kala azar was considered as malaria in North Bengal. It was probably due to the fact that there was dearth of proper arrangement for examination of blood in the rural areas. As a result in the country side and even in the towns, the patients had to suffer for a long period and even had to die.[16]

Kalazar had a disastrous impact on the demographic and economic development of North Bengal. It depopulated whole tracts of Tarai portion of Goalpara, Kamprup and Nawgang districts and so greatly reduced the population of the other parts that some of the tea gardens found it impossible to get more than a fraction of their labour force from the local sources. Depopulation and desertion caused by kalazar adversely affected cultivation. Land lost its value. The decrease of cultivation resulted in an abnormal loss of revenue.

The Government practically was indifferent and inactive towards treatment of kala azar in 1925. The inefficient employees of the Public Health Department did not whole heartedly participate in kala azar centres. The district boards and the municipalities showed their deficiency in recruiting capable doctors, to open kala azar treatment centers and to apply to the government for financial fund. The Amrita Bazar Patrika observed in this connection that "the money was not the patrimony of the bureaucracy and the money could not be used for a better purpose than for serving the lives of those who had paid for it." [17] By 1935 treatment centres were opened by all most all the district boards in areas affected by kala azar.

Year after year cholera took the lives of many people. From the month of June, 1943 to October there was continuous rain in Dinajpur. The rain was followed by famine and epidemics. In Dinajpur during 1943-44 many people died due to cholera. The hospitals did not provide sufficient accommodation for cholera patients. As the local authorities were indifferent towards cholera outbreaks the missionary organizations and the peasants also took a great role . In villages of Dinajpur when diseases like cholera, small pox appeared the peasants immediately went there and endeavoured to relief the patients. The peasants like Pratap Mandal of Tapan police station, Fulchand of Maradanga, Sarbeswar Mandal of Chamta Kuri, Gaweswar Barman, Punneswar Barman, Chaitu Barman of Dal Malancha, Haricharan Barman of Hatsaoile, Dhiren Barman of laskarhat played great role at that time. [18]

Medicines were not found during the famine affected areas of Dinajpur. Malaria and dysentery took a dangerous form. The deceased persons also suffered from sufficient quantity of food. The Bengal Relief Committee distributed milk, biscuit, medicines and many other essential materials for daily use to the famine affected persons. [19] The Ramakrishna Mission had taken a great initiative for the interment of dead bodies. Gopal Maharaj and Jyotikrishna Maharaj , the two monks of the Mission kept the dead bodies on the cart drawn

y one buffalo and took them to the Fultuli funeral ghat for their funeral eremony. [20]

During the famine of ninteen fifties lakhs of people lost their lives in hunger at Rangpur. After the famine for about five months no child had taken birth due to malnutrition in Hariar Kuthi and neighbouring areas. Two treatment centres were opened . One (Hariar Kuthi) among them was under the supervision of a registered doctor who used to provide voluntary treatment to the people for about two years. Dr. Nilkanta Dutta and comrade Kalipada Barman(doctor) were the popular physicians of the centre.

Small pox had come as an after effect of the famine. Villages after villages were ravaged and deserted by the disease. Many people were attacked even for two or three times also by it. Houses were left without people and those who were living were also being attacked by the small pox. Due to the scarcity of mosquito nets flies spread infection and created sore. Those who could save their lives used to die when the wound dried and a dangerous feeling of pulling was felt.

There was a crying need for proper vaccination. According to the Report of the Bhore Committee (1946), vaccine lymphs were prepared under miserable conditions. The general people did not know anything about effectiveness of the lymph which was the main ingredient of vaccination. People protested several times as because the vaccinators were not efficient and experienced. Most of them were illiterate and did not have sufficient medical knowledge and training to perform vaccination. Thus those vaccinators were harmful for protecting the lives of the people also. [21] In 1929 small pox had broken out in some tea gardens of North Bengal like Kathalguri Tea Estate and Rheabari Tea Estate . It was due to defective vaccination and re-vaccination process among the garden labourers. [22]

In North Bengal, leprosy was a disease which was mostly found among the people. Thus it became imperative to set up hospitals for leprosy patients in North Bengal where the number of leprosy affected patients were growing more and more. But the shortage of fund of the British Government hindered the process of opening leprosy hospitals in different areas. [23]

The arrangements for treatment of tuberculosis were also insufficient to treat the patients even of a negligible part of North Bengal. [24] In North Bengal tuberculosis hospitals were established at Kurseong and Cooch Behar. But the majority people were deprived of availing special treatment in other areas. There was no seperate arrangement for the tuberculosis patients apart from insufficient arrangements in some district hospitals. In district hospitals also the quality of treatment was very poor. Thus the patients mostly preferred to confine them selves in their homes and spread the germs of tuberculosis among the other members of the family. [25]

The occurrence of various diseases and the indifference of the Goverentment towards the patients in many cases brought losses to the individual, the family, society and even to the community. The districts of North Bengal suffered from various diseases , especially malaria, cholera, small pox, diarrhoea , dysentery and other diseases. Those diseases not only depopulated the affected areas, but also left a worse effect on family also. The peasants escaped from the villages leaving their houses and fields dreaded by diseases and consequently became land less labourers. It affected the structure of society . Families began to break due to poverty and the joint family structure was shattered in different areas. As a result fragmentation of lands also started. Due to poverty and unemployment the moral character of people also was broke down. In the tea gardens among the female labourers the instances of abortions occurred more due to the severity of malarial fever and also for wide spread anaemia.

In 1907 from the report of the Eden Sanatorium it was found that majority of patients who got admission there were people suffering from anaemia.

In regard to malaria mortality about 40% occurred among adults and about 60% among the children under 15 years of age .Thus it brought complete destruction to the families. [26] Regular attacks of malaria in the childhood weakened themselves completely when they grew up. It was a grave loss to the society and nation at a large, because they were the future makers of the country.

The financial losses included the cost of ailments like hospital charges, doctors' fees, nursing, medicines, the cost of sick leave, the loss of wages during the sickness etc. In the tea gardens of North Bengal Dooars there was tremendous financial loss. As local labourers were not sufficiently available, labourers had to be recruited from Bihar, Santhal Parganas, Chaibasha etc. But as Dooars had an evil reputation for unhealthiness especially due to malaria, labourers did not permanently stay there. A good number of them used to shift from garden to garden and many of them had to die also due to malaria. Thus the planters had to recruit new labourers and the process went on throughout the year. [27] It left a heavy financial burden on the planters. [28]

The labourers in the tea gardens of Western Dooars were absent in the plucking time, at a time when they were most needed. The absence of the labourers in the plucking season was a source of direct financial loss to the gardens. Not more than 65% of the total labour force were available in the plucking season, the rest used to leave due to malaria sickness. [29]

In 1908 Bentley had given a statistics that in a tea garden of North Bengal Dooars having 1350 working coolies, an average of some 50 to 70 women visited hospitals on every day during the rainy season due to fever of their children. [30] Again a large number of women labourers who regularly performed their duties during the winter , but became absent in the plucking season. As their children

suffered intensely from malaria and the infants needed proper nursing , the mothers could not go to their work for that. [31]

Rice had shown a statistical data which stated that about 4% of the working days were washed out due to malaria among the workers in the plantations. If a garden labourer worked about 300 days in a year, he would absent for atleast 12 days from his working place for the suffering of malaria. The loss was about two days per person every year. [32] Sometimes malaria resulted a loss of one week or more. [33]

The diseases especially malaria lost the working ability and efficiency of the workers for an indefinite period . Thus the financial loss was inaccountable. The economic loss could be compensated by the Government in initiating adequate scientific anti-malaria measures . For an example, the United Fruit Company, functioning in highly malarious region in the Gulf of Mexico, experienced a heavy increase in production as the health of the workers of the area was improved. [34] But in North Bengal that kind of initiative was hardly found among the activities of the British Government.

As North Bengal was an agricultural belt, the outburst of diseases also affected the agricultural community. The farmers suffered heavily from malarial fever. Some areas of North Bengal like Pabna and Malda, which were previously healthier areas were found malarious afterwards. [35] Again malaria generally occurred in the harvesting months resulting in the reduction of labourer's income from land. Consequently the labourers became indebted and were involved in court cases by losing their houses and lands. The farmers who used to die due to malaria attack mostly belonged to poorer classes. The death of a farmer in a house meant the total destruction of the family. Agriculture was so much affected by the ravages of malaria that in the seventies of the 19th century the demand of land was abnormally dropped down. [36]

In Malda the decade from 1901 was almost healthy except for the prevalence of fever during the years 1905, 1906 and 1907. The deaths per mile from fevers during those years were 34.64, 34.47 and 34.77 respectively. As a result price of every commodity, rose high in those years. Due to heavy mortality there was shortage of production of bhadoi and robi crops and there was also a scarcity of mango crops. Thus due to fever the agricultural economy of Malda faced a big jolt. [37]

Mc Combie Young stated that there was a high mortality among the workers who were engaged in constructing a branch of the Eastern Bengal State Railway through the Malda district of North Bengal in 1903-1907. [38] During the creation of the line between Kishanganj and Siliguri a large number of labourers became seriously ill. [39]

The Government also had to bear a heavy financial burden due to diseases in the form of medical leave, medical allowances etc. People stationed at malarious areas had to be given special allowances and leave to regain their health. In 1877, in Dinajpur district, among 17 adult Europeans , 15 left the area due to repeated attack of fever and as a result official work was disturbed. [40]

Though different diseases repeatedly visited North Bengal, but there were limited number of hospitals and dispensaries in the rural North Bengal. Most of the hospitals in the rural areas had not proper infrastructure. They had paucity of funds and the beds and medicine that were available were quite inadequate to cope with the necessity of the patients. Money was provided by the government in the budget, but unfortunately no funds were available when required by them. Medical college(North Bengal Medical College situated near to Siliguri), medical school (Jackson Medical School located at Jalpaiguri) and most of the hospitals and health centres were situated in district towns and urban areas and thus they could not benefit the majority people who lived in villages. In villages patients had to be removed to distant hospitals .In many areas the ailing villagers had to

travel to a distance of ten to twenty miles for their treatment and sometimes they had to accept death.

In many villages the health centres were in a disastrously weak condition. Those health centres were existing in theory only, but in practice they could not serve the purposes of the villagers. Except some hours in day time those health centres were closed. There were no doctors or other stuff during night in the health centres. Thus the inhabitants could not get any medical help during emergency. The patients had to go to district hospitals covering a distance of 30-40 kilometre at night also. In remotest areas ambulances were also not available. So the patients had to depend on van rickshaw. Medicines were also not available in some health centres. For every disease red and white tablets were given to the patients.

In some health centres there were no permanent quarters for the doctors. In a primary health centre the post of doctor, a pharmacist and a nurse was allotted . But due to the paucity of sufficient doctors in the village health centres one single doctor had to perform the functions of health care of two primary health centres dividing the days of the week. In some health centres the only one doctor was also absent for a week. The poor villagers were not capable to go to distant places for treatment in many cases. Then they were forced to go to the local kavirajas or ojhas for primary relief from diseases. Thus inspite of the existence of the health centres the influence and prosperity of the local quack doctors and ojhas were increasing regularly. Many health centres were left in broken condition and during night the people involved in unsocial activities took shelter there.

In North Bengal there was dearth of efficient medical practitioners in the countryside of North Bengal. Thus the people were deprived of availing proper medical aid in due time.[41] The better doctors were engaged in cities and due to their absence in the villages the unqualified and some vague doctors dominated

the treatment sector of the rural North Bengal. [42] In most cases the rural people did not get medical assistance due their financial crisis .[43] The doctors generally preferred to stay in cities, because there was scarcity of modern privileges in the villages. The other reasons which made themselves away from the villages were the poverty of the rural people and also the existence of several unqualified doctors. [44]

"In 1938, the per capita expenditure on medical relief in Bengal was only 2 annas and 1 paisa and only Rs. 84 per square mile. The average population served by each hospital or dispensary was 34585".[45] In 1939, a member of the Bengal Assembly criticized the attitude of the British Government which was not liberal in giving proper medical treatment to the villagers. He even thought that "there was a criminal conspiracy with the motive that the poor patients in the rural areas should be allowed to die so that they would not be able to raise embarrassing demands for their comfort and happiness." [46] In rural areas miles after miles were left in helpless condition without any doctor. [47].

The government had taken initiative to cope up with the crisis of deficiency of reputed medical practitioners. They created medical schools with the hope that they would produce numerous medical professionals. But unfortunately most of the schools were left with insufficient medical personnel and poor infrastructure. The Jackson Medical School of Jalpaiguri district had to experience similar situation and ultimately it became closed forever.

In 1921 when his Excellency Lord Ronaldshay visited North Bengal, he viewed that diseases like malaria and cholera and others were predominated in that area and the medical assistance was very much insufficient to check the diseases. Consequently he felt that at that grave situation it became indispensable to produce a large amount of medical practitioners who would be trained at comparatively low rate. Their qualifications might be certainly lower than those

of the Calcutta MBs, but would be sufficient to serve the urgent medical needs of the districts and put off the ailments.

At that time there was no existence of State Medical Faculty and Bengal Council of Medical Registration. Then the tea industry was in a very rising position and the scheme of creating a medical school got massive support of Sir Lancelot Travers. The people of Jalpaiguri district also welcomed the proposal. Accordingly rupees 171000 was collected from the local inhabitants. As a result Jackson Medical School was set up in July 1930.By that time a State Medical Faculty and a Bengal Council of Medical Registration had been established and it became clear that no medical school without the registration of the Council would not get a success. Thus after its formation the school authorities applied for affiliation upto the primary and intermediate examination. Afterwards Bengal Council of Medical Registration sent a committee to investigate the actual condition.

The committee in their report declared the school to be not in a proper position for teaching purpose as it had dearth of sufficient nursing staff, x-ray apparatus accommodation for maternity cases and defective outpatient department Due to the paucity of sufficient funds it was impossible to do the modifications advised by the committee. Thus when the committee visited the school three times more it firmly stated that it could not give affiliation for a long period unless the suggested improvements were made. Although the district boards of Jalpaiuri and Darjeeling British tea gardens, Indian tea gardens, jotedars, and individuals like Nawab Musarruff Hossain, Sir W.L. Travers, the Maharaja (King) of Coochbehar, Bengal Dooars railway, Mr. Jogesh Ch. Bose, Babu Ramdin Daga, Bipul Banerjee, Mohan Lal Ramchandra, G.W. A. Norton, J.R. Gargil contributed money for the medical school, unfortunately it could not ultimately survive due to some political reasons also yet to be unexplored. The medical school was a divisional institution intended to serve to whole of North

Bengal and its sudden discontinuance was a calamity for all the districts of the division. [48]

The hospitals which were set up in urban areas were left in a miserable condition. There was shortage of accommodation in the hospitals of North Bengal. The hospital authorities sometimes denied to admit many serious patients for want of accommodation. Mostly the sick poor people could not get admission in hospitals because they were always occupied by the people who could afford medical attention outside.

The internal atmosphere of the hospitals and health centres was decreasing day by day due to the lack of efficient administration. In the hospitals the patients were exploited even by the subordinate staff in many ways. [49] The hospital authorities became inactive inspite of those malpractices and corruption and illegal activities were increasing day by day in hospital premises. The doctors forgot the principle of sacrifice. Even some times they behaved rudely and often patients had to bribe the compounders and at times to the doctors to get medical privileges. The situation became so miserable when the poor patients of the villages had to roam around the urban areas to collect the reference of the rich powerful men of the society for taking admission in the hospitals. In most cases those men did not recommend the poor patients and thus they were deprived of getting proper treatment in due time. [50] In most of the district hospitals, there was absence of scientific method of treatment. In some hospitals several medical equipments were available for various tests, but they were not functioning as there was scarcity of efficient men to run the instruments. [51]

In many hospitals there were no permanent medical supers. Though generally the duty hours of the doctors was from 9 a.m to 2 p.m, but a class of doctors regularly were engaged in private practice in some medical shops from 10 a.m. onwards without giving any importance to hospital duties The patients assembled before the medical shops. The brokers also assembled there- brokers

of doctors, medicine shops, pathological laboratories, X- ray clinics etc. The illegal activities of the brokers were the usual practices of most of the hospitals .The fear of the brokers rebuked the patients coming from distant villages. Taking the advantage of the worn- out health care system of the hospitals the brokers were increasing their power day by day in the hospital premises. Everyday the patients and their relatives were becoming utterly ruined by the brokers. But the hospital authority and the political parties were totally silent about those illegal practices.

The administration within the hospitals was so inefficient and corrupted that the necessary medicines were also not available. The ailing persons collected medicines from outside. The condition of nursing was also very poor in some hospitals. [52] In most cases the nurses were not properly qualified and trained to perform their duties. Thus the patients depended on the ward servants, female attendants and friends and even of their relatives . [53] The patients also had to face ill treatment in the hospitals. The poor patients in the hospitals were exploited by domes, sweepers, guards and sometimes even by the physicians. [54]

There were protests among the people through the newspapers on the abolition of free treatment and the practice of free distribution of medicine in government hospitals from January 1923. Due to increased prices of medical stores and the rise in maintenance charges of government hospitals, the number of free beds were reduced to half. [55]

In rural areas of North Bengal, the emergent need was for more free beds and free medicine. Many poor people were made returned back, and a large number of inpatients were evicted for their inability to pay fees.[56]The government spent money for its administrative expenditure, but not for the betterment of the hospitals.

There was a practice of quackery prevalent in the villages of North Bengal. They were many ignorant quacks who used to play with human lives. [57] Quackery was a serious evil which increased in an atmosphere of ignorance and superstition and also in the villages where registered doctors were very few. [58] The quacks also performed a good number of abortions and as a result the patients had to face untimely death. The quacks were the greatest danger to the society. They played with human lives and the Government, Police and the medical council became silent. [59]

North Bengal was like a dustbin for every variety of quack medicine and adulterated drugs manufactured in different parts of the world. The region was flooded with spurious and cheap medicine from foreign country. [60] People took those drugs avidly, owing to the attractive propaganda of the respective companies. [61] There was also a flourishing trade in old bottles and containers of expensive drugs.[62] Faking of cartons and levels of reputable manufacturers had become a trend. Faking and adulteration of a product would mean financial loss only. but for the patients who were taking those foods and drugs might mean complete death. But it is surprising that the Government was silent and inactive . Hence the adulteration of drugs continued as usual.

There was dearth of improved maternity and child-welfare services in rural North Bengal. The qualified and trained midwives in the villages were rarely found. Most of them had no scientific knowledge of maternity and child care. However, the need for an efficient and comprehensive service of the trained midwives for promoting the welfare of infants and mothers was not fully recognised. The work of the Public Health Department of the Government of Bengal was confined to giving grants to the local authorities for the training of dais, and to certain voluntary organizations for maternal and child-welfare work.

Thus the medical policy of the British Government in North Bengal was formulated not for the people. It was designed to cater their own needs and

purposes. The hospitals were always fulfilled with patients. There was paucity of trained nurses, honest qualified doctors and sufficient necessary medicine in the hospitals. Mostly the hospitals were situated in urban areas. Thus the rural people were deprived of getting medical assistance in the emergent situation also.

The medical sector was completely dominated by the Europeans. All the important posts in the hospitals were occupied by the British medical personnel. As they were alien in India they did not perform their duties wholeheartedly for the betterment of healthcare of the country. North Bengal was not an exception in this regard.[63] According to Dr. Bidhan Chandra Roy, "why medical men belonging to a foreign country, trained in a different environment, and having little or no knowledge of the people and their models of life should continue to occupy all important posts of medical education and public health, in preference not only to equally but in many cases much more competent Indians, particularly when their maintenance means a drain on the public exchequer which a poor country like India can hardly bear."[64]

In Britain the public health movement began for the development of sanitary conditions, nutrition and welfare services for the poor. But in India the picture was completely different. The British initiated their public health activities in India to meet up the medical requirements of the soldiers and British officials. It clearly showed the difference of their motives and intentions in their own country and in India.

The financial aspect of the problems of public health was also important. The majority of the district boards were in a very uncomfortable financial position. Their resources were too little to sanction the proper discharge of public health duties imposed by statute on those bodies. They had no excess with which to enlarge their public health organization and the government too did not help them with liberal grants. With an income that was almost fixed, the boards could

focus only on one scheme of public health at the cost of diverting funds from projects that were no less imperative. Thus the path of development was thwarted by financial difficulties. Even if a district board had the money , it could not efficiently carry out any public health programme through a district, because of the difficulty of securing adequate supervision over the various items of work scattered over a vast area. In addition the local institutions had to look to government at every step, and without the approval of the government, could not put any scheme into operation.

Upto 1907-8 the medical requirements of Dinajpur district were much ignored. It was very difficult to obtain medical treatment in many part of the district. This was due to the want of fund of the District Boards, the bulk of whose funds were being spent on keeping up communications. The number of dispensaries was too small to meet up the medical requirements of such a large district. The railway dispensary at Parbatipur was not so much worth mentioning and it could not be called a charitable dispensary as it was only for the railway servants and travelers by the line. There were only 11 such medical institutions in the whole district. Among them the dispensaries at Thakurgaon and Phulbari were run by the cost of the District Board and also by the donations of the local people. The male and female hospitals in the town of Dinajpur were collectively maintained by the District Board, the Municipality and by the Government. [65]

In Malda when several fairs occasioned a large number of people congregated there. The District Board then arranged for a supply of sweepers and the protection of the water supply and medical attendance. But with insufficient fund the District Board could not meet the medical and sanitary requirements of that huge population. The town of English Bazar had developed a drainage system. But in the villages it had not been created. [66]

As a result of reluctance on the part of the British Government for setting up dispensaries and hospitals, many native jamindars, jotedars , rajas and

individuals patronized in a large scale for the establishment of medical institutions throughout North Bengal. In Dinajpur the dispensaries at Raiganj, Churaman, Ramganj, Haripur , Sitabganj, Patiram and Raniganj etc were maintained at the cost of some benevolent jamindars. [67] In Malda there was a private dispensary at Chanchal. It was run by Raja Sarat Chandra Roy . The dispensary was supervised by an assistant surgeon, and medical aid was given to the different parts of the Raja's estate by traveling hospital assistants. It was a sufficiently well equipped dispensary of the district. [68] In Jalpaiguri a dispensary was opened at Patgram in 1907 at the request of the local inhabitants who donated about one-third of the cost of the maintenance. The king of Cooch Behar patronized a well equipped dispensary at Debiganj . The Maharaja Gobind Lal Roy of Rangpur, donated rupees 90, 000 for the construction of the Lowis Jubilee Sanitorium for the Indian patients. The Maharaja of Cooch Behar gifted the land where the sanitorium was built. It had two parts, one for the orthodox Hindu patients and the other was a general department for the people who were tolerant to all religion. [69]

The Maharajas of Cooch Behar contributed in an immensurable extent for ameliorating the medical condition of the people of Cooch Behar. In Cooch Behar Maharaja Nripendra Narayan presented the inhabitants of Haldibari with the building and out- offices, furniture, medicines and instruments to start a dispensary there and subscribed one half of the expenses incurred. 70

The Christian Missionaries worked sincerely for the medicinal benefit of the people of North Bengal , especially among the primitive tribes and the lowest classes among the Hindus, the depressed classes and untouchables. They constructed hospitals for both males and females, provided training to the Indian women doctors and nurses and prepared the midwives efficient in assisting in the delivery cases. Thus they helped immensely in improving the condition of the patients of North Bengal and in care of the children, thereby reducing mortality

among both. Hospitals and dispensaries mainly manned by the missionaries were established in several parts of North Bengal. [71]

In Darjeeling district the missionaries contributed immeasurably for ameliorating the medical benefits of the people. At Kalimpong though the Charteris Hospital was financed by the State but it was maintained and governed by the Church of Scotland Mission . It was guided by a medical missionary and two lady nurses. The Mission also patronized a dispensary at Nimbong in the Kalimpong sub-division. It was such an extended hospital that it used to provide medical facilities to over 17,000 patients every year. 72 The Mission maintained another dispensary at Kizom. It was situated in the west of the Tista. In the hospital about 1200 persons got medical assistance annually. A small independent medical mission was developed at Sukiapokri near the Nepalese border. More than 10,000 people were treated annually by the missionaries either at the dispensary or on tour. The Mission spread its acivities among the Nepalese both of the Darjeeling district and Nepal. The dedication with which the Christian missionaries worked for the benefit of the ailing Indians by making available medical staff and medical institutions to them, endeared them to the people. They helped in breaking the social barriers. The religious barriers did not come in the way of providing the much needed medical aid to poor people of North Bengal at places even far off from the city.

There was no obstruction to admission of women patients in hospitals of North Bengal. Despite a minimum number of women patients went to the hospital because of the lack of female staff there. The needs of the female patients were met by the dais (midwives) who were trusted by the people. But the female hospital of Dinajpur proved a failure. Though it was a well-equipped and well maintained hospital and contained suitable accommodation even for the Muslim ladies, and under the control of an efficient lady doctor, but could not attract the patients. Their orthodox attitude prevented them to visit the hospital. In Cooch Behar women of the lower castes did not hesitate to attend the hospital. But the

majority of female in-patients in the Sudder Dispensary were the prostitutes suffering from venereal diseases. 73 The women of the royal family and higher classes of the society avoided the hospitals avoided hospitals used to call the midwives in their houses.74

Once women of North Bengal used to avoid the male doctors. When a disease became serious, then only male doctors were called. In general the women depended more or on female Kabirajas. To get immediate relief from various diseases, they took help from Ojhas, Sapure, Vedimis, midwives etc. Though there was life risk in many cases of quack treatment, but even then the Indian women relied or their treatment and medicines. The male members also did not want to make treatment of their female counterparts by the medical practitioners as they were very much concerned to protect the dignity of the household. In case of pregnancy also male doctors were not called. In this matter the experienced midwives used to treat both rich and poor. As a result women could not get the facility of modern treatment. The death rate of pregnant women and children was high. Due to child marriage the females became pregnant in their childhood and it was also a reason for their early death. Some time wrong treatment was done by the midwives due to lack of proper gynecological knowledge. There was also another side of the coin. The patients in most of the cases preferred to be treated by male doctors instead of females in the hospitals in the 1930s.

But afterwards the scenario changed completely . Women patients started to visit the hospitals and dispensaries in a large number. In Cooch Behar 28 cases of natural labour were attended during the year 1890-91 by the midwife Soudamini Ghose, whose services were in constant request among the babu's wives. 75 Muktakeshi Bannerjee, the midwife attached to the Haldibari dispensary of Cooch Behar attended at 60 cases during the year 1898-99. 76 But the number of female Muslim nurses and midwives were very few. Probably they dishonoured the profession.

There were also some renowned female doctors in North Bengal who devoted their lives for the welfare of the people. Ashrukana Dasgupta of Jalpaiguri and Pramila Mazumdar of Cooch Behar , M. M Khatun of Rangpur , Bidyutprabha Mallick of Rajshahi were important among them. Asema Khatun of Rajshahi was the first student of the Campbell Medical School..M.M. Khatun wrote on patient theory, peculiar activity of "Antine Turner", "Orientalist of Anacardia", "Description of Typhoid patient" etc. in Haneman Journal.77 Bhaktigiri Devi (Ayurvedic Practitioner) Practiced in Pabna though she had no requisite medical degree. Sunity Roy practiced homeopathic medicine in Shirajganj of Pabna district.78

Priyabala Guha who was a student of Campbell medical school, became doctor in 1892 and joined at Taherunnisa Jenova Hospital of Bogra. In 1893 Banatoshini Chandra joined in the local native hospital of Pabna. In 1898 Bidyut Prabha Mallick passed from Campbell Medial School, but she worked in Rajshahi Hemangini Majumdar belonged to Birbhum, she began to practice in Dhubri. She not only used to treat but also fed the patients by cooking herself in many cases. Bidyutprabha worked in the charitable dispensary of Rampur Boalia. But without any fault she had to lose her job to the disappointment of the local male members. The management could not show any allegation against her, but also did not give her the opportunity to defend herself.[79]

Sometimes the female doctors had to experience various troubles also. In 1902 Malda's lady doctor Pramilabala faced a critical situation during her visit to a patient's house. She went to treat local Jamindar Madan Gopal Choudhury's wife and was molested by him. Pramilabala suited a case of molestation against him and in that way the case came in front of the public. Madangopal was proved accused and he had to give one thousand rupees as reparation. But his punishment was very much nomination comparison to his offence and it was analyzed in contemporary newspapers.[80]

Thus the healthcare and medicinal policy of North Bengal left a far reaching impact on its society and economy .By the defective policy of health and medicine the population of the region was steadily decreasing in a large measure. The diseases were mainly prevailed in the rural areas affecting the poor people of the society. The high mortality rate not only brought destruction of the families but also destructed the economy of the villages. As North Bengal was an agricultural area so it got a great joggle. The rural mass were deprived of getting medicinal benefits as most of the hospitals and modern amenities of health care system were located in urban areas. This instigated many individuals and missionaries to set up medicinal institutions at different nook and corner of North Bengal. The women also played a great role to enrich the medical system of North Bengal by serving as doctors, nurses and midwives .

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