Development of Nursing:
TK Adranvala’s Negotiations with Ideological, Social and Political Constraints, 1947-1966

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Introduction

Prior to India’s independence from Great Britain in 1947, the intervention of colonial British officials and missionaries laid the foundation of the modern nursing framework and created the ideal modern Indian nurse who represented the ethos of professionalism and selfless service. When I use the term professionalism, I would like to clarify that the Indian nurse had to be educated and have a nursing degree from a public institution. In addition to being well-educated, ideal the modern Indian nurse was supposed to be dedicated to her profession and give more priority to selflessly care for her patients.

Post-Independence, not only did the first generation of elite Indian nursing leadership inherit the colonial nursing infrastructure, but more importantly, they pushed forward the ideal of the colonial modern Indian nurse from late 1947 till the mid 60’s. These elite Indian leaders received aid from American philanthropic organizations like the Rockefeller Foundation to develop nursing education and services post-Independence. Since the Indian nursing profession is both rooted in the colonial and post-Independence period, how did the nursing profession in India span across the colonial and post-independence divide in India? In the process of the elite Indian leaders pushing forward their aspirations for nursing obtaining a professional and respectable status in post-Independence India, how did their vision collide with the colonial ideal of nurses as selfless providers of medical services? While their aspirations empowered them to develop nursing educational programs, what forces constrained the elite Indian nursing leadership from achieving their aspirations?
To understand the limitations of the elite Indian nursing leadership, I examine the development of the nursing profession in India from 1947-1966 through Miss Tehmina K. Adranvala as she was one of important first generation of elite nursing leaders who played a key role in the development of a better, well-educated and respectable nursing profession in India from 1947-1966. Tehmina K. Adranvala was born on July 1908 in the city of Poona, in the Indian state of Mahrashtra. However, even this apparently straightforward fact is contestable. On Adranvala’s travel grant application to the Rockefeller Foundation for a fellowship to the United States of America in 1947, she wrote her birthday as “1.7.1908,” the 1st of July, 1908. However in Miss Dhaulta’s article in the Nursing Journal of India (NJI), she cited Adranvala’s birthday on the 9th of July.¹ The confusion about such basic facts reflects how little is known about Adranvala’s upbringing, her parents or her siblings. Miss Jaiwanti P. Dhaulta, the Secretary of the TNAI, wrote a short biography to commemorate Adranvala after she passed away on November 29, 2000. Adranvala identified herself as an Indian Parsi, an ethnic community in South Asia that is considered Zoroastrian Indian. She was bilingual, as she knew how to speak in both English and Gujarati.²

One may ask, why study Adranvala? Why is she important to discuss? In 1948, Adranvala took over the position Miss E.E. Hutchings held and became the first Indian “Chief Nursing Superintendent in the Office of the Director General of Health Services, New Delhi, India” in 1948, thus becoming the first Indian nurse to hold the main position

¹ RF Record Group 10.2 Series IHD Nurse TG, Fellowship Recorder Card for Adranvala’s Nursing Travel Grant; Dhaulta, Jaiwanti P. “Passing away of a Nurse Legend” NJI, vol. 92, no.1 (2001), pp. 3.
² Record Group 10.1, Series 464L, Box 292, Folder 4560, Fellowship File for Adranvala’s Application for Travel Grant on April 27, 1947.
in Indian nursing. Adranvala also was later promoted to the senior post of the Nursing Advisor to the Ministry of Health, Government of India, in 1958 thus being the first Indian Nursing Advisor to serve the Ministry of Health until her retirement in 1966. The post of the Nursing Advisor was important because the Advisor was “responsible for advising the Government of India on all matters concerning Nursing Service, Nursing Education and specialization in nursing.” Not only did the Nursing Advisor develop national and international nursing projects, but she also supervised, coordinated and planned the entire country’s “nursing manpower requirements” for nursing education.

Adranvala was also involved in various nursing organizations. She joined the nursing organization, the Trained Nurses Association of India (TNAI) as a general member in 1934 and she was elected as the President of the TNAI, a position she held from 1948-1954. In addition to being the first Indian President of the TNAI, Adranvala was the first Secretary of the Indian Nursing Council (INC) in 1948. From 1949-1966, she served as a Member of the Managing Committee of the Indian Red Cross Society.

Adranvala was actively involved as a Member and Chairperson for various committees of the TNAI, and the ICN and she served as a Member for the Bombay and Maharashtra Nursing Council. She was even elected as the Second Vice President of INC in 1961.

In addition to playing an important role at the Indian national and local level, Adranvala was equally involved with various international projects. In 1951, she served

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7 Dhaulta, Jaiwanti P. “Passing away of a Nurse Legend”, pp 2-3.
as the Chairman of the WHO Expert Committee on Nursing, a conference which was held in Geneva. She was appointed as the Nurse Advisor to the WHO Nursing Project in Kathmandu, Nepal in 1966. Adravnala even visited various countries like “Belgium, Denmark, Norway, Sweden, Canada and USA” to engage in discussions with international nursing leaders. Since Adranvala had to coordinate with the Indian national and state governments, international nursing organizations like WHO and the Rockefeller Foundation, doctors and Indian nurses, Adranvala played a significant role as a mediator who bound them together and raised national and local awareness about the nursing profession to the public eye.

Not only is it important to study Adranvala because she held a high authoritative position, but also, since she was very active in the nursing profession, Adranvala helps provide insight into the role of an Indian nursing leader had in the larger framework of the management and development of the Indian nursing profession post-independence from 1947 till the late 1966. Unfortunately, not much has been written by Adranvala and I do not know Adranvala’s full story. I do not know what Adranvala did before 1948 when she rose to esteemed positions such as the Chief Nursing Superintendent and the Nursing Advisor to the Ministry of Health or the President of the TNAI. However, since Adranvala took over the position of the Chief Nursing Superintendent and the President of the TNAI, which were held by Miss E.E. Hutchings and Alice Wilkinson respectively (who were both colonial white British women), this marked a profound change which echoed across the Indian subcontinent and history as it represented the transfer of authority from the colonial nurse to the colonized nurse. The fact that not much is known

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8 RF Record Group 12, Rockefeller Foundation Records, Officers’ Diaries, Reel M Ten 4, Frame 589, “Index, 1951”, Mary Elizabeth Tennant Diary, pp.147.
9 Dhaulta, Jaiwanti P. “Passing away of a Nurse Legend”, pp 3.
about Adranvala’s involvement in nursing prior to 1947 reflects the racial and gendered dominance of Western colonial leaders as they marginalized the voice of the colonized. British doctors Margaret Balfour and Ruth Young discussed the development of Western scientific medicine in India and Alice Wilkinson, who was the President of the TNAI from 1941-1947, discussed colonial nursing developments by British nursing officials and missionaries. Whereas Balfour and Young described Indian women who accepted Western medicine, Wilkinson mentioned important nurses like Adranvala who were in high positions. They both mainly described and glorified the efforts made by British missionaries and officials in bringing their superior medical and nursing knowledge to Indian women. Although historians Lata Mani, Geraldine Forbes, Antoinette Burton and scholar Anne Rafferty depict the relationship between the colonial and colonized women and understand how British imperialistic policies of bringing Western medicine affected the development of Indian women, “further research remains to unearth the voices of the many Indian and Anglo-Indian nurses”. Since nursing leaders like Adranvala directed nursing and health policies which trickled down and affected nurses at the local level, recognizing the voice of the Indian nursing leaders will assist in understanding how they played a crucial role in dictating the direction of Indian nursing post-independence.

Since Adranvala was one of the first generation of nursing leaders who had the responsibility to develop the nursing profession in an independent nation, she provides


important insight into understanding how and why the nursing profession developed in the India after 1947. Adranvala inherited a colonial legacy which continued to mark her efforts in professionalizing Indian nursing. By conducting further research, I found out that Adranvala was an extremely well educated nurse- not only did she study at the J.J. Hospital, but she also studied in London, at prestigious universities such as the oldest maternity home Queen Charlotte’s Hospital and the Royal Sanitary Institute of London.\(^\text{12}\) As a result of having benefited from higher education, Adranvala represented the new Indian educated nurse who used education as a strategy to help nursing gain a professional status in the Indian health care system. However, the path towards developing the nursing profession was not easy as there were numerous problems the Indian nursing leaders faced which eventually led to the turnover of Indian nurses. Adranvala’s story illuminates the struggle of an elite Indian nursing leader to develop nursing as a profession from 1947-1966.

Despite scholarly research on the development of Indian nursing post-independence being minimal, there has been research scholarly research about the social history of nursing where scholars have blamed social and cultural factors for limiting the professionalization of nursing. As a result of the double-standard that the modern nurse should follow the ethos of professionalism and the traditional notion of selfless service, historian Melosh argues that nursing could never develop into a profession as the professionalizing ideology limited the capabilities of the elite nursing leaders.\(^\text{13}\) Historian Reverby discusses how ideological, cultural and structural limitations constrained

\(^{12}\) RF Record Group 12, Rockefeller Foundation Records, Officers’ Diaries, Reel M Ten 2, Frame 185, “Index, 1941”, Mary Elizabeth Tennant Diary, pp. 4.

American leaders’ ability to transform their ideals into practices. She also cites how the professional ideology pushed nurses further away from their care-giving function.¹⁴ Whereas Melosh and Reverby take a social focus of American nursing, arguing that the pursuit of a professionalizing ideology limited the nursing leaders’ ability to transform nursing into profession where nurses were both educated and devoted to their profession, contemporary independent researcher Healey takes more of a political focus. Healey has done the first extensive study on the development of the nursing profession from 1907-2007 in India. Healey argues that the Indian Government was largely responsible for limiting Indian nursing leadership because they only theoretically supported the development of nursing post-independence.

The constraints which limited Indian nursing leadership from reaching her heightened aspirations of nursing achieving a professional status needs to be understood further. During her career from 1947-1960, Adranvala shows us how elite Indian nursing leaders were constrained by intersecting complex historical, social, political and ideological limitations which spanned across the colonial and post-Independence divide. Not only were there historical and ideological constraints created by colonial officials which carried into Adranvala’s career, but more importantly, there were political and social constraints within her career which affected how the nursing profession shaped up in the 70’s and 80’s. Although like Reverby, I am arguing that there were limitations imposed upon the elite nursing leadership, I differ from Reverby as I draw attention to broader social and political constraints with a tighter focus on Adranvala, a key nursing leader. In addition to addressing larger questions about postcolonial structures of

nursing, I discuss how these limitations affected Adranvala, one of the Indian elite nursing leader’s ability to direct the development of nursing.

My research has been drawn from two archives: the *Nursing Journal of India* (*NJI*) and the Rockefeller Foundation Archive in Sleepy Hollow, New York USA. The *NJI* was a journal established by British nurses in 1908 and it is currently still in use. The *NJI* depicts a monthly record of nurses’ organizational work and it also provides nurses the opportunity to exchange their thoughts and concerns about the nursing profession. I have looked at articles in the *NJI* that were written by Adranvala from the 50’s-late 60’s. From the Rockefeller Foundation Archive, I have used letters that were written/received by Adranvala to RF officials as well as other notes/letters that RF officials wrote to each other from 1948-1966. I also accessed diary entries from RF official, Mary Elizabeth Tennant, the Nursing Consultant of the Rockefeller Foundation in India, from 1941, 1950, 1951 as she mentioned Adranvala.

In Chapter 1, I will discuss the pre-independence nursing context. Not only will this chapter show how colonial intervention constructed an image of the ideal modern, Indian nurse but also, as a result, colonial officials and missionaries produced ideological structures which created a flawed racist and gendered nursing hierarchy. Thus, colonial intervention created a certain expectation of how the nursing profession should develop in India post-1947. This chapter will show how the post-independence nursing framework in India was deeply influenced by colonial nursing framework and how independent India inherited a weak, flawed foundation for the nursing profession to build off of in 1947.
Chapter 2 will look at Adranvala’s public life through her articles she wrote in the *NJI* to understand Adranvala’s vision of nursing that she portrayed to the audience and how she translated a certain image of the post-colonial Indian nurse. This chapter shows how the Indian elite nursing leaders’ approach towards developing the nursing profession was influenced by the colonial intervention. By carrying over the colonial construction of the modern Indian, Adranvala played the role of a modernizer who modernized the history of Indian nursing.

In the process of discovering how Indian nursing leaders, particularly Adranvala, worked with local, national and international agencies, Chapter 3 will discuss Adranvala’s relationships with Indian doctors, the Indian Government (GoI) and Rockefeller Foundation (RF) officials. Not only does this chapter show how all these agencies had higher authority than Adranvala but more importantly, as a result of the differing goals between the elite nursing leaders, the GoI, and RF officials, political tensions arose which made it difficult for Adranvala to collaborate with them. Although Adranvala used her power to negotiate between the GoI and RF, she ended up playing a losing battle as she could not satisfy the RF.

The last chapter will flesh out how Adranvala’s belief in the modern nurse served as her “blind spot.” Adranvala’s persistence of clinging onto the modern professional nurse adversely strained her relationship with lower and middle-class nurses. In addition, Adranvala’s decisions to promote of the educated Indian nurse created unintended consequences which prevented her vision of a professional and selfless Indian nurse from sustaining itself for the following generations.
The limitations reveal the complexity of the nursing profession; at one point, these limitations enabled Adranvala to have authority however on the other hand, they limited Adranvala’s effectiveness as a nursing leader. Although Adranvala wanted to hold onto the ideal of a modern Indian nurse being a professional and selfless care-giver, it was a result of the dual complexity these intersecting limitations imposed on Adranvala which constrained her ability to achieve her aspirations. Thus, by building on Adranvala’s thin biographical foundation, I will illustrate key episodes in Adranvala’s life to reveal how difficult it was for an elite Indian nursing leader to develop nursing as a profession in post-Independence India. Adranvala’s story represents the struggle the elite Indian nursing leaders had to face; not only did they have to bear the flaws of the colonial nursing framework they had inherited, but also, it was the inability to break away from the colonial nursing ideal and the constraints they faced from 1947-1966 which made it impossible for elite Indian nursing leaders to achieve their ideal model of the Indian nurse.
Chapter 1: Colonial Influence

Reflecting upon the development of ‘modern’ nursing in India under British colonialism helps to illustrate the post-Independence Nursing landscape which Indian nursing leaders like Adranvala worked. In addition, to receiving assistance from Britain, India received assistance from American philanthropic organizations like the Rockefeller Foundation and the Ford Foundation to develop public health, agricultural and medical programs in India. Although certain colonial ideas were reinforced by American funding, I would like to point out that the nursing framework in India prior to 1947 was largely established by colonial British officials and missionaries. Since India received aid from both Britain and USA, it is important to reflect upon international nursing trends to see how they were brought over and influenced the direction in which the nursing profession developed in India. In the chapter, I will show how the “developments of [nursing in] the colonial period determined the post-colonial history of the nursing profession in India.”

Although like Healey, I claim that the colonial developments of the nursing profession in India heavily influenced the post-independence infrastructure of nursing in India, I differ from Healey in my presentation as I do not just recount the colonial developments; instead, I show how these colonial developments defined what the modern Indian nurse embodied. In the first half of my chapter, by providing a historical account of the development of nursing from the late nineteenth century to 1947 in India, I will show how British officials constructed the image of a nurse who represented the ethos of professionalism, modernity, selfless devotion, global sisterhood, and respectability. However, as a result of trying to mold the Indian nurse into this ideal modern nurse, they

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shaped certain ideological structures which created a flawed, racist gendered nursing hierarchy. The nursing infrastructure in post-Independence India was deeply influenced by the colonial nursing framework; not only did colonial intervention define the modern Indian nurse that set up an expectation about how the Indian nurse was supposed to be post 1947, but more importantly, colonial intervention created a weak foundation upon which nurses post 1947 could build.

What is modern nursing? Florence Nightingale, who is famously known as the Lady of the Lamp, is seen as the “founder of modern, lay nursing.”

What made ‘modern’ nursing different from the Victorian era of nursing was its association with respectability and institutional care being provided to the ill in public institutions like hospitals. Until the nineteenth century, caregiving for the sick was confined to the private realm of the household. Since a woman was supposed to provide selfless care for her family members, nursing was seen as an extension of her domestic work. Summers states that caregiving for the sick shifted from the private home to the public space during the eighteenth and early nineteenth centuries, especially with the establishment of hospitals for the poor.

Despite the effort to provide care for the sick, regardless of status, upper and middle class people were “nursed by relatives and servants at home” thus showing how social and economic barriers still prevailed in Britain. The poor avoided going to the hospitals as neither the hospitals nor the nurses had a good

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reputation: whereas the hospitals in Britain during the nineteenth century were considered “filthy and stank,” nurses “were reputed to be drunk and disorderly.”

For Nightingale, it was important to make nursing an acceptable profession for women and this was possible if nursing became associated with respectability. Since Nightingale was from a wealthy family, her entry into the nursing profession helped improve the image of nurses in England and bring respectability to the nursing profession. Due to the domestic nature of the profession, since nursing was associated with personal work that was performed within the private realm of households, Nightingale claimed that “nursing was a part of the woman’s sphere,” thus making nursing acceptable as it still preserved the Victorian spheres of influence for men and women. Nightingale was successful in making nursing a respectable profession for middle-class families in large part due to her decision to link the “high status of philanthropic ladies such as Nightingale herself [...] to the religious vocation of the nursing nuns.” By urging women to join nursing for philanthropic and religious motives, Nightingale helped spur on the notion that nurses should be motivated by their desire to serve their patients.

In addition to creating the image that nurses were supposed to be respectable and selflessly devoted towards taking care of their patients, Nightingale also contributed towards regularizing the nursing profession. When she was the superintendent for the

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7 Ibid, pp. 184
Institution for the Care of Sick Gentlewomen in Distressed Circumstances, she reorganized services for patients, such as providing bells for patients to ring when they needed aid. During the Crimean War, with the spread of cholera, and a lack of adequate care for the soldiers, Nightingale’s services rose to prominence. Thus, not only did Nightingale help systemize the nursing profession, but also, she introduced the concept of having “women nurses in the Crimean War” who were paid for their services. A feminine caregiver was not paid for her nursing services; however under Nightingale’s model of nursing, nurses were paid for their services. Thus, Nightingale helped expand nursing from being a duty in the private household to a trade in the marketplace where nurses received wages for their labor.

In addition to regularizing and systemizing nurses’ duties, Nightingale also introduced institutional training for nurses. According to Nightingale, “adequate nursing required the creation of adequate nurses-training.” Nightingale advocated for nurses to be trained with “theoretical knowledge [that was] based in colleges and universities rather than in hospitals.” Melosh explains that the concept of training and educating nurses was ‘modern’ because it changed how nurses provided caregiving to patients. As a result of being disciplined and obtaining theoretical knowledge about caregiving, nurses would be able to provide better, professional care for their patients. In 1860, the Nightingale Fund Training School for Nurses, the first nursing school where nurses could obtain a

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14 Ibid, pp. 38.
professional education, was established at St. Thomas Hospital in London.\textsuperscript{15} Thus, modern nursing became associated with obtaining professional education at universities.

Nightingale played an instrumental role in institutionalizing care for the sick and professionalizing the nursing culture. Not only was Nightingale’s construction of the nurse and the nursing profession adopted in Britain, but they were also adopted by other countries in the West such as the United States and Australia. As a result of Nightingale’s contributions, modern Western nursing became associated with the ethos of duty/selfless sacrifice, professionalism/institutional education and respectability.

It was these very ideas that British colonial officials brought and replicated when they started to develop the nursing profession in India. However, the British and American modern nursing model was largely an urban and elitist phenomenon. “Modern nursing was not universally practiced in the west” and it was also not practiced in all regions of India; modern nursing was largely limited to urban areas.\textsuperscript{16} However, the modern nursing model played a very influential role in professionalizing nursing culture in India. I will depict British colonial developments in India and start with how their efforts to professionalize nursing in India constructed the modern Indian nurse who was educated and professional. Historian Lal states that prior to 1885, colonial officials in India did not pay much attention to the health of Indian women.\textsuperscript{17} Although Florence Nightingale never went to India, her ideas influenced the creation of the Royal Sanitary Commission on the Health of the Army in India in 1859. As a result of the report issued by the Royal Sanitary Commission in 1863, the Indian Nursing Service (INS) was created

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\textsuperscript{15} Arora, P. “Perspectives on Indian Nursing”, NJI, vol. 47, no. 9, (1976), pp. 223.
\textsuperscript{16} Healey, Madelaine. : A History of Nursing and the State, 1907-2007, pp. 29.
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in 1888 to provide proper nursing care for British soldiers. In 1903, the INS was renamed as the Queen Alexandra’s Military Nursing Service for India (QAIMNS). The Indian Military Nursing Service (IMNS) was established during World War I. Nurses were recruited for the first time in the QAIMNS in 1914 and served during World War I. In 1942, due to the severe “shortage of trained nurses, the Auxiliary Nursing Service (ANS) was established where nurses were provided a training of six months in civil hospitals and were later sent as assistant nurses to serve the colonial army.

In addition to professional nursing organizations, institutional nursing colleges were also established in India. Prior to 1947, “post-certificate courses were first offered in nursing administration, supervision and teaching” at the College of Nursing in New Delhi, College of Nursing, CMC Hospital Vellore and the Government General Hospital in Madras. However, it wasn’t until 1946 that the first four-year bachelor program for nursing was established in India at the Colleges of Nursing in Delhi and Vellore. In addition to bachelor nursing programs, programs where nurses could obtain higher education in nursing were also offered. The first Master’s degree course that was developed in India was a two-year postgraduate program which was established at the University of Delhi in 1959. In addition, courses where nurses could obtain further specialization were established. In one of her articles for the NJI, Adranvala wrote that a midwifery tutor course was established in Delhi in 1956. Further courses in Public

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18 Healey, Madelaine. Regarded, Paid and Housed as Menials’: Nursing in Colonial India,’ pp. 57.
19 Nair, Sreelekha. Moving with the Times: Gender, Status and Migration of Nurses in India, (Routledge, 2012), pp. 29-30.
22 Adranvala, Tehmina K. “A Review of Post-Basic and Post-Graduate Training of Nurses,” NJI, vol. 56, no.9, (1965), pp. 247; Note: In this article, it said the first Master course was developed in 1959. However in an article,” Vital Aspects of Nursing: The Historical Perspective” she wrote in 1982, she stated the first Master course began in 1960.
Health Nursing, Psychiatric Nursing and Pediatric Nursing were established. Since the State Nurses Registration Council stressed the importance of having uniformity in the standards of nursing education provided in India, in 1947, the INC was awarded the responsibility for standardizing the curriculum for nursing education in all Indian states. The model of the educated nurse that these colleges and universities sought to create was based on these that British and American colonial officials put in place. By providing Indian women with professional training in Western theoretical and scientific concepts of caregiving, colonial British and American officials believed that education would allow Indian nurses to transcend the perception of nursing as a low-caste profession.

Although colonial officials were successful in synchronizing Indian nursing with an institutional and professional nursing culture, they “came up against […] very different local ideas about gender and caring.” In India, the female who provided the caregiving services that the modern, urban Western nurse offered was the indigenous, rural midwife, known as dai. Dais, who were women of low-caste, provided feminine care and mainly worked in villages where they assisted in childbirth and engaged in midwifery services. In order to reach the ideology of having a professional modern Indian nurse, British colonial officials had to deal with caste and pollution. Since the dai was the main provider of care-giving in India, colonial officials had to work with their structural limitations of training the dai.

Prior to the institutional nursing culture that British colonial officials and missionaries brought, what were indigenous ideas of caregiving? In an ancient Sanskrit

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24 Basavanthappa, B.T. Medical Surgical Nursing, pp. 5.
text, the *Susruta Samhita*, which is supposedly dated between 600-350BCE, four types of midwives are described, one of which was “good at giving birth to a child (prajananakusalah)”\(^{26}\). The text suggests that the midwife was supposed to be a female who assisted with childbirth and was central to the health of the Indian population. Leslie and Wujastyk, who have both studied Sanskrit and the latter studied the history of medicine prior to India’s independence, conclude that Indians had care giving techniques and nursing was seen as an important part of the Indian health care system.\(^{27}\)

Anthropologist Geeta Somjee explains how the *dai* was the primary caregivers to the sick before the re-emergence of public medical institutions in India around the nineteenth century; Somjee recounts how Indian public hospitals disappeared in AD 1000.\(^{28}\) During the colonial context with the development of institutions and the rhetoric of the professional nurse, colonial officials came into contact with the *dai* and colonial beliefs about Indian caregiving was understood through the figure of the *dai* because she *provided* affordable midwifery services to Indian women of all castes.

During the nineteenth century in Europe, with the development of germ theory, Europeans believed that disease was caused by specific pathogens. Thus, it became important to control the spread of the germs through sanitary measures. However the British perceived such hygienic measures to be absent in the health practices of the colonized Indian people. The *dai* had knowledge about superstitious rituals, “*bhuts* (ghosts) and the evil eye” which were deemed primitive in comparison to the progressive

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\(^{28}\) Somjee, Geeta. “Social Change in the Nursing Profession”, pp.34.
scientific and hygienic techniques practiced by the Western nurse. The *dai* was not a nurse; understanding the role of the *dai* involves distinguishing between the professional nurse and the midwife. The European midwife was defined as a birth attendant whose primary duty was to assist in childbirth and her duty ended after the child was born. Although the *dai* had the same duty as a European midwife did, British colonial officials saw the *dai* as the lesser midwife because she dealt with more types of pollution. As historian Forbes distinguishes, unlike a *dai*, “cleaning up […] and nursing the mother were not part of” the duties of the European-trained midwives.

The *dai* was seen as “a considerable threat” to the modern, trained European nurse and the superior “cultural project of Western medicine” because she violated all of the ideals that the Western represented. Whereas the *dai* represented “ignorance, dirt, […] [and] superstition,” which were characteristics of inferior forms of caregiving, the Western nurse represented an “idealized Western cleanliness and rationality,” which were characteristics of modern and ‘good nursing’. Scholar Fitzgerald, who specializes in midwifery, explains how ‘western’ nursing became associated with modernity, professionalization and hygiene, while ‘eastern’ nursing became associated with superstition, pollution and uncleanliness. Because of the *dai*’s backward belief and practices, the *dai* was portrayed by colonial officials as the degenerated form of the Western nurse and was “used as material evidence of what might happen to the physical

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vitality of [the Indian] race” if the *dai* did not reform her labor services. Because the *dai* was stigmatized as a polluting figure, it was important for the Indian nurse to be associated with modernity, not the backwards *dai*. Thus, not only was it important to train Indian nurses to make them distinct from the *dais*, but also, it was vital to train the *dai* so the indigenous care-giver in India could also be associated with modernity.

Just as the movement began to create institutions to create professional Indian nurses, so did the movement to separate the Indian nurse from the *dai*. This was performed by disciplining the *dai* and cultivating her into a trained female midwife so Indian nurses would be associated with modernity, not backwards indigenous care. Programs to develop modern midwifery in India and train Indian *dais* began to develop in the nineteenth century. In 1854, the Government of Madras “sanctioned a training school for midwives which offered a diploma in midwifery.” According to British doctor Margaret Balfour, the Madras Maternity Hospital was significant for two reasons: not only was it run by the first female hospital matron, but also, it was also, the first hospital to train Indian women as proper midwives. Missionaries began to train indigenous women in midwifery practices in the late 1860’s. Towards the end of the nineteenth century, hospitals in cities such as Bombay, Calcutta, Bengal and Punjab had training programs for female nurses in addition to midwives. Thus, by developing modern midwifery programs, not only were colonial officials successful in differentiating the

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modern trained Indian nurses and midwifes, but more importantly, they helped construct the notion that an Indian nurse needed to be trained so she was seen as respectable and not associated with pollution.

In addition to the notion that Indian nurses needed to remain distinct from the traditional backwards *dai*, colonial intervention also cemented the notion that the Indian nurse needed to provide selfless service to the sick and be as devoted to her profession as a nun was. The “association of religious sisterhood” strongly influenced the development of the Indian nursing profession. Various Anglo-American Protestant missionaries ran schools to train Indian women as nurses. Around 1867, St. Stephen’s Hospital in Delhi started to train Indian women as nurses and a “systematic training course” was later launched in 1874 by European nurse-deaconess, Deacon Foltz.

The involvement of private philanthropic groups and Christian missionaries furthered solidified the intertwinment of religion and nursing care within India. In 1906, the Vicerine, Lady Minto founded the Indian Nursing Association. The Minto Nurses’ were private nurses who provided nursing care predominantly to European families. Also, in Bombay, “several of the hospitals [which were] funded by Indian philanthropists,” trained nurses. One of these hospitals was the Jasmetiji Jeejeebhoy Group of Hospitals, which was a government hospital and it was also known as the J.J. Group of Hospitals. “The Sisters of the Anglican Community of All Saints,” came from England to Bombay to develop nursing care within hospitals and in 1880, they assisted with nursing in the J.J. Group of Hospitals. Due to the involvement of colonial Christian

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41 Ibid, page 58.
nuns and missionaries, many Christian converts joined the nursing profession. In the state of Kerala, which is in South India, not only was there a large Christian population, but also, majority of Indian women became nurses in Kerala. Thus, nursing in India became associated with Christianity and the religious ethos of sacrifice and selfless devotion. With nuns working in places with poor working conditions and earning low salaries, they “created a tradition of low pay” and a dedication towards serving the poor.42 However the notion of nursing being involved with feminine qualities such as selfless service and care-giving created a duality. Whereas the modern Indian nurse was supposed to embody professionalism and seek power to be recognized as a professional, which was a more masculine quality, the image of the modern Indian nurse contradicted with the caring feminine values that nursing was “supposed to espouse.”43 This duality of the modern Indian nurse will create problems which will be depicted in Chapter 4.

In addition, by connecting with Indian women on the similarity of gender, British colonial women played a vital role in the spread of Western hygienic nursing. There was a need to protect the health of Indian women and children; however colonial officials and missionaries came into conflict of local Indian traditions, especially, the custom of purdah nishin, where Indian women were secluded within the private realm of the household. Since the woman was considered the center of the household, colonial officials knew that they would not be able to influence Indian values “until the women had been touched.”44 To British and Christian missionaries, the purdah nishin custom depicted how Indian women were “degraded victim[s] of […] uncivilized cultural

practices,” thus providing evidence of their own cultural and racial superiority. In addition, because it was not considered acceptable for respectable Indian women to pursue a career in medicine, colonial British officials stressed on the idea of having a separate medical system for women, thus furthering the need for female doctors and nurses in India. Although strict purdah was not applicable to all Indian women, it was popularly believed by colonial officials that indigenous women did not like consulting male physicians. The higher the caste of the woman, the more undesirable was it to have services provided to her by men. Even though official government statistics showed that Indian women of “all ‘communities’” went to European and male-staffed government hospitals, Lal points out that the attendance of women was relatively low in comparison to men and children. However, attempts were made to spread Western medicine by incorporating Indian women. The Dufferin Fund, also known as the National Association of Supplying Female Medical Aid to the Women of India, which was “launched by the Vicerine, Lady Dufferin, in 1883, at the direct request of Queen Victoria,” provided financial assistance to support tuition for doctors, nurses and midwives. Lal regards the Dufferin Fund as “the first systematic attempt to extend Western medicine to Indian women.” Whereas colonial women were used as agents of

the Western civilizing mission, indigenous women became an important tool through which colonials could spread Western ideas.

The cooperation between British and Indian nurses “over the financing of Indian female medical aid” depicted a feminist movement which “[transcended] cultural and national boundaries” as they were working together to fight for advancing women’s rights. As Burton shows, such claims to global sisterhood reproduced sharp inequalities across racial divides. Whereas upper class British women developed programs to promote Indian women’s education and training, upper class Indian women also entered the political arena during the 1920’s-30’s as they participated in the nationalist movement. By focusing on Indian and British women as a collective group, solidarity developed between both British and Indian nurses and rhetoric about “global sisterhood” was produced.52 This is visible in the creation of professional organizations in India; these professional organizations, which were similar in “structure and purpose to those in Britain and the US,” were created to unite all trained nurses as one group.53 In 1908, the nursing organization, the Trained Nurses Association of India (TNAI) was formed at the conference of the Association of Nursing Superintendents in Bombay.54 The TNAI, which was dedicated towards uplifting and promoting the social status of nurses, was representative of an international female nursing culture. This was very influential because prior to World War I, “there were no women leaders, no women’s political

organizations and no formalized integration of women into political institutions.”\textsuperscript{55} Not only did these professional organizations provide colonial and indigenous nurses the opportunity to enter the public arena, but more importantly, they provided them the opportunity to voice their opinions about the nursing vocation through the publication of nursing journals. By publishing the \textit{NJI}, the TNAI helped to encourage both British and Indian “nurses to view themselves as ‘competent, sensible, potentially important persons.”\textsuperscript{56} Although British and Indian nurses differed on the inequalities of race, through the professionalization of nursing, ideally British and Indian women were supposed to see themselves as sisters.

One reason nursing was perceived as “‘dirty’, low-status work,” was because lower-class women were recruited as nurses.\textsuperscript{57} Fitzgerald mentions that the deserted wives of British soldiers turned to nursing in order to provide stability for themselves and their children.\textsuperscript{58} Especially during and after the Crimean War in the mid-19\textsuperscript{th} century, the majority of British women who were recruited as nurses were either widows, orphans, single women, who were all, as Sreelekha Nair states, outcasts of society.\textsuperscript{59} By pointing out how a “sister, head or upper nurse” was equivalent to that of a mistress in a middle-class household, Summers depicts how the intimacy and involvement of touching between a nurse and a patient, made society deem nursing as equivalent to a


\textsuperscript{59} Nair, Sreelekha. \textit{Moving with the Times: Gender, Status and Migration of Nurses in India}, pp. 27.
disrespectable form of labor like prostitution.60 Whereas for Nightingale and British women, it was important to maintain respectability by dissociating nursing from prostitution and lower class, the stakes for maintaining respectability in India were even higher due to the notions of pollution and caste.

In India, Healey mentions that the “process of recruiting nurses was similar to the West”; just as in the West, outcasts of society like widows and destitute women were recruited as nurses similarly in India, prior to the 1930’s in India, “majority of candidates for nursing were widow, orphans, or destitute converts who had no other option” as a career other than nursing.61 In India, widows were perceived as tainted women whose “impurity could never be removed” and thus they were marginalized and excluded in Indian society.62 Understanding the stigmatization associated with nursing as a result of the employment of lower caste women helps in understanding why many upper caste, ‘respectable’ Hindu and Muslim women did not revert to nursing. The handling the sick and the “contact with bodily fluids” was seen as “unclean, contaminating work;” this was work that the lowest servant caste of India, also known as the untouchables, performed and it was considered filthy.63 Associating nursing with servant work was also an issue that nursing reformers in the West faced however in India, because of the caste dynamic, this furthered the stigmatization of nursing. ‘Respectable’ Hindu and Muslim women were not supposed to be involved with polluting work and thus, majority of the Indian nursing recruits were European women or those from the Anglo-Indian Christian

60 Nair, Sreelekha. Moving with the Times: Gender, Status and Migration of Nurses in India, pg 22.
community. Fitzgerald notes that only extreme forces such as poverty made Hindu and Muslim women resort to nursing.  

Although colonial British women struggled to disassociate nursing from its low-status image in India and it would remain an ideological structure that Indian nursing leaders post-independence also had difficulty with, they made attempts to uplift the status of nursing by involving women from upper classes. By accounting the involvement of upper class Indian women during the nationalist movement of the 1920’s and 30’s, Forbes provides an explanation as to why emphasis was placed on women from the higher classes. It was essential for picketers to “demand respect from the public;” by involving elite Indian women, not only would the picketing movement gain respectability but in turn, these elite women would be able to serve as a role model and influence other women.”  

Thus, women like Adranvala, Muthulakshmi Reddi, who was the first Hindu woman doctor, Rajkumari Kaur, who would later become the first Indian Union Minister of Health, post-independence, became involved in the nursing profession. By gradually bringing in elite indigenous women into the nursing profession, they helped solidify the importance of an Indian nurse in maintaining respectability which was associated an upper-class status.

Thus, colonial intervention constructed an ideal image of an Indian nurse who was involved with the ethos of professionalization, modernization through the separation of the backwards dai, respectability, selfless devotion towards and global sisterhood. However in the process of creating the modern Indian nurse, racist ideological structures were created which formed a flawed nursing framework in India. As a result of Indian

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nurses adhering to the colonial construction of the modern Indian nurse, they end up replicating the colonial racist nursing structure post-Independence. In colonial India, nursing was divided along cultural lines as nurses who had been trained in Britain were given preferential treatment over indigenous nurses. One way, Indian nurses were discriminated was on the basis of language as English was seen as the superior language because it belonged to Western civilization. Despite having a uniform standard for educating and training Indian nurses, Indian nurses were taught in both regional languages and English. As a result, various grades of training were developed for nurses and midwives. Whereas ‘A’ or ‘Senior’ grade nurses were those who had been taught in English, ‘B’ grade nurses were those who were taught and had examinations in their regional languages.  

66 By degrading nurses who studied in regional languages as “B” grade nurses, Indian nurses who knew English were made superior to nurses who did not know English.

In addition to the underlying cultural superiority, Indian nurses were also discriminated along racial lines. Despite both being women, the British nurse was superior to the Indian nurse because she was of the British race which was superior to the Indian race. Thus, there were racial hierarchies within the same gender; the Western Christian or Anglo-Indian nurse was given more preference over the Indian nurse. Despite the fact that colonial officials wanted to develop and train Indian nurses according to their standards, they still discriminated against Indian nurses. An example of this was in colonial recruitment for nurses in India. With the creation of various nursing organizations like the IMNS, QAIMNS in India which may have deemed an

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excellent step towards recruiting Indian nurses as staff, it should not overlooked how majority of these nurses were Eurasian. Because “Indian nurses were not recruited until the First World War,” they were discriminated by colonial officials, as they were not considered professional enough to be recruited as nurses.  

Not only were Indian nurses discriminated against by colonial officials on the basis of race, but also they were discriminated against by Indians themselves. One British matron told Adranvala that the reason why Indian patients saw her as higher in status was “because she was British and not because she was a nurse.” The fact that the British nurse was regarded as having a higher status by Indian patients depicted how Indians gave preference to foreign nurses over Indian nurses. Even at a national level, the Indian government showed racial discrimination towards Indian nurses. In 1946, Janet Corwin, who was a nursing advisor at the Rockefeller Foundation’s office in Delhi, noted that Indian government authorities “tended to discourage those other than Anglo-Indians and domiciled Europeans from becoming nurses.” Because they were superior in race, Eurasian and Anglo-Indian nurses had more advantages than Indian nurses.

I am not saying that that Anglo-Indians did not face racial discrimination; they did. However I am focusing on the preference for the “superior” white nurse which put the Indian nurse at a disadvantage. Dr. Hilda Lazarus, an Indian Christian doctor who was the first “Indian woman appointed to the Women’s Medical Service” and the first Indian director at the Christian Medical College in Vellore, believed that the preference for Christians and Anglo-Indians ended up discouraging Indian women who wanted to

become nurses. In the colonial period, despite the increase in the number of programs being created for Indian nurses, the fact that European and Anglo-Indian women were the main nurses recruited by Indian governmental and municipal hospitals, showed how the programs were not effective in recruiting Indian nurses. Thus, as scholars Healey and Nair depict, a “brutal internal hierarchy” was created which not only demotivated Indian nurses but also, was a structure they had to fight against. Unfortunately, racial discrimination still was prevalent in nursing post-independence. Juliette Julien, who was the leader of USAID’s nursing programs in India, did not think Adranvala was a competent leader and the reason he felt so was because of his racist attitude. As a result of prevalent racist attitudes, it led to strains in the relationships American nursing officials shared with Adranvala, which will be discussed in Chapters 3 and 4.

In addition to the ideological structure of racial discrimination, colonial officials ensured Western nursing practices were carried over through educating Indian nurses overseas. Although colonial officials made developments towards building a modern, professional nursing culture in India, professional programs which provided nurses the opportunity to pursue further studies in nursing were not available in India until the late 1940’s. Adranvala provided an important insight that a number of Indian nurses, who wanted to pursue higher education, studied abroad in Britain taking courses in “nursing education, public health nursing or midwifery.” She mentioned that in Britain, a few

71 Nair, Sreelekha, and Madelaine Healey. A Profession on the Margins: Status Issues in Indian Nursing, pp. 5.
Indian nurses took international courses at Bedford College. Not only did colonial authorities provide opportunities to study overseas, but also, American philanthropic organizations did so as well. India received assistance organizations like the Rockefeller Foundation, USAID, and the Ford Foundation in developing public health, agricultural and medical programs in India. The Rockefeller Foundation, which was successful with its international public health programs, started to engage in medical and public health in India in 1920. In 1935, the Government of India invited the Rockefeller Foundation for assistance in training female nurses in India. The Rockefeller Foundation also provided fellowships to Indian nurses so they could study overseas; the Foundation believed that once Indian nurses returned from their nursing training abroad, they would “contribute to the strengthening of the knowledge base and skills of local nursing students.” As scholar Kavadi points out, “between 1943 and 1946, six nurses returned to India after studying on RF fellowships.”

As a result of studying overseas, these new educated middle-class Indian nurses were “exposed them to the most contemporary Western thinking about public health, education and specialized nursing.” By providing fellowships, colonial and American officials replicated the Western professional nursing model as they created the new Indian nurse who been “thoroughly schooled in” Western professional and institutional nursing ideals. These urban educated Indian nurses were greatly influenced by Western

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77 Ibid, pp. 133.
78 Ibid, pp. 145.
modern nursing ideals that a spirit of loyalty was instilled in them to follow the nursing beliefs and techniques of the West.\textsuperscript{80} Indian women adopted the institutional and professional nursing ideal to the extent that that they supported the effort to remove the \textit{dai} and replace her with the Indian modern nurse and midwife who was trained in techniques that a European nurse and midwife had. By the mid-1930s, legislations were passed which required nurses and midwives to be registered and councils were formed to oversee this. In 1934, the All-India Women’s Conference (AIWC) passed a resolution which made it mandatory for \textit{dais} to register for training.\textsuperscript{81} By passing legislations which required the training of \textit{dais}, not only did this show how the new Indian nurse accepted colonial scientific practices superior to her own indigenous traditions, but also, she pitted herself against her “lower-caste and less fortunate […] \textit{dai}.”\textsuperscript{82}

These new Indian nurses portrayed themselves as ‘modern’ Indian caregivers who supported “the progressive elements of society against age-old customs.”\textsuperscript{83} Thus, the new Indian nurse became a part of the “new [professional] women’s network” who attempted to modernize Indian nursing by adopting trends of the West and eliminating traditional aspects of care-giving.\textsuperscript{84} For example, indigenous nurses were encouraged by these Indian educated nursing leaders to wear the Western winged cap and white dress. Dr. Hilda Lazarus discouraged Indian nurses and doctors from wearing a saree, an Indian garment that is draped around, as “its sweeping length and flowing pleats [helped] more

\textsuperscript{80} Fitzgerald. “Rescue and Redemption: The Rise of Female Medical Missions in Colonial India During the late Nineteenth and early Twentieth Century”, in Anne Marie Rafferty, Jane Robinson and Ruth Elkan (eds), \textit{Nursing History and the Politics of Welfare}, (London and New York: Routledge, 1997), pp. 75.
\textsuperscript{81} Forbes, Geraldine. \textit{Managing Midwifery in India}, pp. 152.
\textsuperscript{82} Ibid, 163.
\textsuperscript{83} Ibid. pp. 152.
\textsuperscript{84} Ibid, pp. 163.
in swabbing up the infected hospital floors.”85 Dr. Lazarus mentioned this was in response to some local objection in wearing the Western nursing uniform. Not only did this show how the new Indian nurse tried to civilize her Indian sisters to adopt Western nursing customs, but in the process she also disregarded local beliefs. The creation of the new Indian nurse was very crucial towards the development of the nursing profession as it was these elite nurses who ended up taking over control post-independence. Thus, as scholar Packard notes, colonial authorities created “a first generation of political leaders who tended to fall in line with the developing agendas of the West.”86 By promoting Western ideals, these new Indian nursing leaders marked themselves as committed to shaping Indian nursing according to the Western professional nursing model. How Adranvala carried the model forward through her articles will be discussed in Chapter 2. However in the process of pushing for the “outwardly focused, [...] professionalizing nursing culture,” these nursing leaders did not focus “the concerns of working nurses” and disregarded local beliefs which created a barrier for them to effectively push for reforms in the post-independence nursing landscape in India; this will be discussed in Chapter 4.87

Another ideological structure which created an obstacle in the mission for developing the nursing profession was the subordination of the nursing profession to the medical profession. Even though Nightingale desired a professional nursing vocation that was independent, her vision of nursing “was settled by subordination.” 88 When

88 Abrams, Sarah Elise. “Seeking jurisdiction: A Sociological Perspective on Rockefeller
Nightingale was trying to promote hygiene and cleanliness in hospitals, she “realized that she could accomplish little without the confidence of doctors.” Despite how nursing was an “essential part of medical care,” the fact that Nightingale needed the support of medical authorities to make reforms proves that they exerted greater power than nurses. Thus, nursing developed subordinate to the medical profession and colonial officials struggled against this hierarchy which was upheld in hospitals.

However it is important to note that the subordination of nurses is not a product of Western medicinal practices. The Carakasamhita, which is an ancient Indian medical text, differentiates between the characteristics of a ‘doctor’ and his ‘assistant.’ Whereas a doctor’s characteristics are “excellence in theoretical knowledge, extensive practical experience, dexterity and cleanliness,” the assistant was expected to know how to “attend to or wait upon someone”, have “dexterity, loyalty to the doctor, and cleanliness.” The very fact that the text deems the assistant’s first allegiance […] not to the patient but to the doctor,” signifies how the medical profession was seen as the superior central force in the health care system in India. This starts the formation of a hierarchy which provided more autonomy to the doctors and subordinated the assistants to loyal servants of the doctors. Although in either the Carakasamhita or the Susruta Samhita, there was no mention of the assistants being equivalent to female nurses, there was a clear gender ideology in caring for the sick: whereas doctors were expected to be males, the roles of assistants were determined according to the gender of the patient: male assistants served...
male patients whereas female assistants tended to female patients. This shows how men were also involved in care giving, thus showing how care giving in India was not a female dominated profession.

It is not clear how in the context of India, the doctor/nurse hierarchy became mapped onto the doctor/assistant relationship and nursing became the “lesser of the professions in comparison to medicine.” However the maintenance of the professional subordination of nursing can be explained through the implicit gender hierarchy that existed alongside. Since men have been seen as superior to women, this logic of gender mapped onto the doctor being superior to the nurse. Although both doctors and nurses were in contact with the body of the ill, since Indian doctors were mostly men and Indian care-givers were the feminine dais, doctors were superior to nurse. In the Indian context, caste also had a role in the subordination of the nursing profession. Prior to the influx of colonial medicine, Indian doctors were from the Brahmin, upper-class in India. Since they were from a higher caste, they were seen as “pursuing a noble profession of healing others” whereas Indian feminine caregivers, who were of the lower-class, were seen as polluting figures. Somjee explains how the work of male care-giving was also seen as undesirable and since doctors were awarded with a higher status that protected them from shame, with the infiltration of colonial medicine in India, the elevation of doctors was only furthered.

Colonial officials had to struggle with the ideological subordination of nursing as it was difficult to convince Indians to choose the nursing profession over the medical profession.
profession. Prior to 1947, there were more Indians in the medical and teaching profession than there were in the nursing profession. The subordination of nursing to the medical profession even continued post-independence. In the *Nursing Journal of India*, a nurse, Miss J.D. Powar, made a controversial statement about the relationship between doctors and nurses, equating the status of a nurse “as a ‘servant,’” and this spurred an outrage in the Journal column where educated Indian nurses rushed to defend the image of nurses. Whereas Mrs. K Dhiman corrected that a “nurse is a co-worker of the physician” and should not be regarded “as a servant to the physician,” Miss Saramma K.V. stated that doctors and nurses “perform their duties by co-operating with each other.” Their statements portrayed the need to equate the status of a nurse to a doctor and change the perception of the nurse. Considering the anxiety around the status of nursing and the attempt to dissociate nursing from its low-status, it was natural for these nurses to come out in the support of the status of nurses. However the fact that such a comment about the inferiority of nurses was made and that too by a woman, depicts that this belief still existed in India and also shows how women were responsible for propelling such hierarchical differences.

In addition to the subordination of the nursing profession, the authoritative presence of colonial nurses prevented Indian nurses from developing leadership skills. Due to the colonial presence of missionaries and reformers in India prior to 1947, the majority of nursing leadership positions were held by European women. According to a report that was published in the International Nursing Review in 1930, there was no

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“Indian president, secretary or NJI editor until 1948.”99 It was only after India’s independence in 1947, that Indian nurses were able to rise in the nursing hierarchy and assume leadership roles.100

Even though India gained independence in 1947, decolonization left intact the racial hierarchical inequalities between Western and Indian nursing leaders as international nurses still played an important part in developing Indian nursing. In 1947, due to the violence and mass emigration of refugees that resulted after the partition of India and Pakistan, the Congress Party of the Government of India faced a health crisis as there was a lack of resources to develop the Indian health system.101 However there was high national interest in developing the nursing profession in India. In addition to officials from the Rockefeller Foundation, “a new cadre of [international] health experts” like officials from USAID and UNICEF were brought over to India.102 I would like to draw attention to how these health officials were distinct from their “former colonial rulers” as they were American not British.103 Whereas the USAID provided “financial aid” to develop nursing colleges, the Rockefeller Foundation provided “expert assistance to the Colleges of Nursing in New Delhi and Vellore” and “sponsored Indian nurses for advanced education in North America.”104 Although the Foundation wanted to encourage more Indian nurses becoming nursing leaders, having officials like Mary Elizabeth Tennant serve as the Nursing Consultant of the Rockefeller Foundation in India and Anna Noll “serve as the advisor at the Delhi College of Nursing and Rockefeller Nursing

103 Ibid, pg 103.
Representative in India from 1947-58” prevented Indian nurses from being completely independent.\textsuperscript{105} Having foreign American officials serve as consultants and advisors helped reinforce the racial hierarchy that existed under British Colonialism because it continued the notion that the Western nurses had more nursing experience and expertise which needed to be imparted to the less developed Indian nation. The presence of foreign officials during the pre-colonial and post-colonial period in India re-affirmed the superiority of Western medicine and leadership. According to Randall Packard, the presence of international health agencies like the WHO and UN organizations, prevented former colonies from breaking away from the colonial power’s thoughts and practices.\textsuperscript{106} By relying on foreign consultants and advisors, the elite generation of Indian nursing leaders from late 1947 to the mid 60’s had only substantial power.

\textbf{Conclusion:} Thus, colonial intervention created an ideal image of what the modern Indian nurse should be like. However, in the process of molding the Indian nurse into the Western nurse, British and American colonial officials ended up creating structural practices such as the racial discrimination of Indian nurses, the subordination of nursing to the medical profession, the creation of the new Indian nurse who embodied colonial practices, and the restriction upon the development of Indian nurses’ leadership skills. All of these structures created a flawed nursing profession in India that was divided along race and caste. In addition, the professional, institutional nursing ideal which colonial officials created did not fit well with the Indian context. As Miller notes, there were many obstacles which prevented India from becoming a modern society which included

“India’s caste structure, [and] underdeveloped industrial capacity.” ¹⁰⁷ Thus, colonial intervention created a flawed and racist foundation of the nursing infrastructure which Indian nursing leaders could build off of once India gained independence in 1947. The fact that Indian nursing leaders post-independence were fixated on these colonial nursing ideals did not help either. Since the Indian nursing leaders from 1947 to the late 1960’s willingly accepting the nursing framework left by British colonial officials, it showed how difficult it was to break away from the colonial structures that India inherited as they were deeply engrained. As a result of Indian elite nursing leaders like Adranvala carrying over of these structures, they faced numerous difficulties in developing the nursing profession from 1947-1966.

Chapter 2: The Public Vision of Adranvala as the Elite Nursing Leader of India

After understanding the nursing framework that was inherited by India in 1947, how did the elite Indian nursing leaders choose which direction they wanted to develop the nursing profession in India? Did the colonial construction of the modern Indian nurse and the ideological nursing structures shape Adranvala’s authoritative position? As the first Indian Nursing Superintendent of the DGHS of the Government of India, did Adranvala maintain the structural elements that were left by colonial authorities? Or did she go against them? In her Address she delivered as the President of the TNAI in 1951, Adranvala expressed her vision of how she wanted nurses to be seen by the Indian society: she did not want nurses to be looked upon in a condescending light, but rather, she wanted them to be recognized as “colleagues worthy of consultation, of their having opinions and ideas […] considered […] not only in the […] field of […] nursing, but [also], in the whole field of health education.”¹ Adranvala clearly wanted to provide upwards-social mobility to Indian nurses so they would be respected. In order to change the Indian public perception of nurses, Adranvala knew she had to change how Indian nurses perceived themselves and their own colleagues. Adranvala understood the vitality of reaching out to Indian nurses as she believed the future of Indian nursing was “largely in the hands of [Indian nurses].”² If Indian nurses themselves believed that nursing was a respectable profession, they would be more dedicated towards advancing nursing in India and changing the social perception of nurses. One way Adranvala connected with Indian nurses was through her articles she wrote in the *NJI*. She wrote various articles in

¹ Adranvala, Tehmina K. “President’s Address.” *NJI*, vol. 42, no. 1, (1951), pp. 7.
the *NJI* where she explained the history of the development of the nursing profession in India. By writing articles in the *NJI* not only did Adranvala help nursing remain significant in the public eye, but importantly, she translated a vision of the modern Indian nurse which resembled the vision British and American colonial officials developed in India. Through her articles, not only did Adranvala maintain the colonial construction of the modern Indian nurse, but by doing so, I would like to argue how she played the role of a modernizer who was transmitting modern nursing to all Indian nurses and was modernizing the history of Indian nursing.

Adranvala stressed on the importance of Indian nurses being trained in universities and enrolling in college nursing programs. In her article, “Trends in Nursing Education,” in the *NJI*, Adranvala stated that the establishment of “courses for [Indian nurses] was a very important milestone in the development of nursing education in India.”³ By stating that “nursing is a calling based on education,” not only did Adranvala show how she was a strong proponent of the professional nursing culture that was advocated by the British and American nurses, but also, she emphasized the necessity of professionally training Indian nurses. In her article, “Developments in Nursing 1947-1957,” Adranvala mentioned that Indian nurses “were given administrative responsibilities”; however, because they were not educated, “they were utterly unprepared” as a result, this led to an “awareness of the need for well qualified nurses.”⁴ Therefore by stressing on the importance of education, Adranvala showed how she believed taking institutional nursing courses would develop the skills and confidence needed in Indian nursing leaders to “take up positions of responsibility” that would be

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offered to them in Indian hospitals and universities. The only way to raise the inferior status of Indian nurses was to follow the superior nursing techniques of the West and Adranvala placed much emphasis on this, especially on the importance of an educated trained nurse.

In all of her articles, she mentioned nursing programs and nursing universities that were being developed in India. In her article, “Nursing in India 1908-1960,” she mentioned how the School of Nursing Administration in Delhi was created by the Government of India in 1943 to “prepare nurses for administrative duties in military hospitals.” In her articles she mentioned the various different types of courses that were created. For example, she wrote one article just on the development of courses in India. In 1965, she mentioned how there were four courses currently offered in the subjects: Nursing Administration, Nursing Tutor, Midwifery Tutor and Public Health Nursing.

Adranvala’s support for the modern professional nursing culture should not come as a surprise. As a result of studying overseas, Indian nursing leaders like Adranvala, were “exposed to the most contemporary Western thinking about public health, education and specialized nursing.” Adranvala studied at the University of London where she was awarded a Sister Tutor Diploma and a Hospital Administration Diploma in 1947. Her own degree in Administration may have shaped the emphasis she placed on nurses being formally trained “in the principles of administration.” After receiving formal training, these newly educated nurses would be able to pass on their knowledge to other nurses and understand how to run a nursing school effectively. By further propelling the

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9 Dhaulta, Jaiwanti P. “Passing away of a Nurse Legend”, pp. 3.
importance of nursing education, Adranvala maintained the professional elitist nursing culture of nursing just like her colonial nursing officials. Healey mentions that Adranvala was one of the “the most significant and successful proponents of this approach.”

Adranvala furthered the institutional and professional nursing culture by stressing on the importance of creating graduate and specialty programs for Indian nurses. While discussing how more basic and post-graduate nursing courses were being made post 1947, Adranvala mentioned courses which were established for Indian nurses in pediatric, tuberculosis and psychiatric training. To Adranvala, the establishment of these courses seemed to mark a huge advancement. Not only would these courses help prepare Indian nurses for leadership roles, but also, Adranvala claimed that Indian nurses were provided with the opportunity to “work in various fields” which were not previously available to them. For example, Adranvala mentioned that Indian nurses who studied tuberculosis nursing would now be able to treat tuberculosis patients. With such broad and specific nursing courses being available, Indian nurses would be able to expand their understanding of nursing and have a better perspective about which field of nursing they were interested in. Since Adranvala took a Tuberculosis Nursing course at the “Brompton Hospital for Diseases of the Chest,” which is now known as the Royal Brompton Hospital in London in 1934, she may have believed it was beneficial for Indian nurses to follow-suit.

In addition to maintaining the need to have a professional nursing culture, Adranvala also maintained the need for the Indian nurse to align herself with the modern

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14 Ibid, pp. 328.
15 Dhaulta, Jaiwanti P. “Passing away of a Nurse Legend”, pp. 33; RF Record Group 10.2 Series IHD Nurse TG, Fellowship Recorder Card for Adranvala’s Nursing Travel Grant.
Western nurse and remain distinct from the traditional *dai*. In her article, “Nursing in India: 1908-1960,” she mentions how the training of *dais* started “before the training of nurses” however the fact that she mentioned that “nurses had little or no part in it” showed how Adranvala was trying to make the nurse distinct from the *dai*. In Chapter 1, I showed how the figure of the *dai* was involved with polluting tasks and represented traditional Indian forms of care-giving that were backwards.\(^{16}\) By writing that nurses had no part in the training of *dais*, I interpret Adranvala as trying to disassociate Indian nurses from the *dais*. When discussing the initial stages of the development of Indian nursing, Adranvala mentioned that the earliest steps to promote Western modern nursing was “with the attempt to train dais,” not nurses.\(^{17}\) By mentioning how the training of *dais* started before the training of Indian nurses, it seems to me that Adranvala was showing how the modern Western concept of nursing could only be instilled if the indigenous *dai*’s concept of nursing was modernized. Thus, not only did Adranvala maintain the clash between indigenous and western ideas of caregiving, but more importantly, she supported the training of the *dais* to modernize midwifery practices in India, thus pitting herself and Indian nurses against the *dais*.

Why did Adranvala take such a step against the local *dai*? Once again, I would like to point out that we can derive what Adranvala considered proper nursing through her own trajectory. In addition to obtaining a certificate for the General Nursing and Midwifery course she took at the J.J. Hospital, Bombay on April 22, 1930, Adranvala studied at Queen Charlotte’s Hospital in London from 1932-1933 and obtained a CMB

Certificate on May 27, 1933. CMB stands for the Central Midwife Board. In 1905, a woman in Britain was only regarded as a competent and trained ‘midwife’ unless she had a CMB certificate from the Central Midwife Board. As a result of having obtained a CMB certificate as well as a “Midwifery and the Health Visitors course at the Royal Sanitary Institute,” Adranvala developed the mentality that Indian nurses who were interested in childbirth needed to be trained as professionally trained midwives. As I showed in Chapter 1, the dai was illiterate in Western forms of care-giving and provided her services in the private home, whereas Indian nurses were educated in institutions and practiced care-giving in urban hospitals. By writing how the “training of indigenous dais has been a continual” program that post-colonial Indian nurses continued, I would like to argue that Adranvala thought it was necessary to modernize the dai by training her in Western forms of care-giving. Thus, Adranvala acknowledged the need to modernize traditional Indian forms of care-giving with the modern Western forms of care-giving.

In addition to maintaining the professional nursing culture and the distinction between the modern Indian nurse from the indigenous dai, Adranvala also maintained the colonial ideal that the nurse should provide selfless service to the poor and perform her task with devotion. According to historian Melosh, the professional concept of nursing was nothing more than a detached competent form of professional care. On the other hand, traditionalists viewed nursing as an intense, humanitarian form of care. Indian

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18 RF Record Group 10.2 Series IHD Nurse TG, Fellowship Recorder Card for Adranvala’s Nursing Travel Grant; RF Record Group 10.1 Series 464L Box 292 Folder 4560, Fellowship File for Adranvala’s Application for Travel Grant on April 27, 1947.
20 RF Record Group 12, Rockefeller Foundation Records, Officers’ Diaries, Reel M Ten 2, Frame 185, “Index, 1941”, Mary Elizabeth Tennant Diary, pp. 4.
nursing leaders like Adranvala represented both ideologies, thus following the paths of both British and American nursing leaders. It is clear how Adranvala was a supporter of nursing professionalism as she advocated for Indian nurses to undergo nursing training; however she also wanted nursing students to care about their patients. Scholar Hallam, who studied the representation of nursing in popular culture and media, discusses how nurses were viewed as angels in Great Britain. Since Adranvala was educated in Britain during the 1930’s, it makes sense that she also gave emphasis to the selfless services of nurses. Healey asserts that Western nurses believed the “nobility of nursing lay in a willingness to tend to every need of the human body.”

Throughout the articles she wrote in the NJI, Adranvala expressed and supported this belief that Indian nurses should personally care for their patients. For example, by writing that nursing care was not just based on “hospital routines,” but rather on “individual needs,” Adranvala emphasized the importance of nurses attending personally to each patient. By preserving the notion that nurses should care for their patients and perform their personal tasks with dignity, Adranvala still preserved gender norms as the nurse was supposed to exhibit feminine traits such as caring. By maintaining the colonial nursing ethos of professionalism, selfless sacrifice and acceptance of the Western nursing form of care-giving in public hospitals, Adranvala represented the ideals she thought made an Indian nurse qualified to be as a “modern Indian nurse.”

Another reason why she portrayed such an image of the modern Indian nurse was because of her audience. According to Adranvala, the reason why nursing was evolving

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into a valuable profession in India was linked to the implementation of the nursing ideals which were developed during British colonialism. Since her audience of the NJI was an elitist, feminist audience who obtained the same training as Adranvala obtained and understood nursing in its modern form like Adranvala did, Adranvala tailored her views towards her particular audience. By exposing and glorifying the changes that were being made in India to make nursing a more respectable profession, it can be understood that she was trying to gain acceptance from the nurses for the western professional model of care. While Adranvala’s views paralleled the trajectory of the nursing profession in India from the late 1947 to the late 1960’s, I also believe that Adranvala portrayed her vision of what she wanted Indian nursing to be like.

While Adranvala was a firm supporter of the professional culture, she also understood that public health was not just limited to the urban, middle-class. Many of the first generation of Indian nurse leaders battled to disassociate nursing from its urban image.26 It seemed as if Adranvala was one of these leaders. Adranvala gave recognition to the perception of nursing being an urban phenomenon by writing “that [in the past] it was thought that nurses were concerned with hospital nursing only.”27 By writing that “nursing [could not] fulfill its whole function within hospital walls,” Adranvala recognized nursing as a service that needed to be provided to the entire community.28 In her letter to Miss Tennant, Adranvala wrote that the “most hopeful development in the College [of Nursing, Delhi] “was that [occurring] in the rural and urban public health

Because Adranvala mentioned both rural and urban work, it seems like Adranvala advocated for a widening the nursing field so that nursing was not limited to hospitals in cities. In various articles that Adranvala wrote for the *NJI*, she mentioned how nursing was working its way into penetrating into the rural community in India. In her 1958 article where she discussed the developments in Indian nursing from 1947-1957, Adranvala mentioned that “nurses, health visitors and auxiliary nurses-midwives [were] living in villages, helping in ante-natal and well-baby clinics.” In 1968, with the establishment of a State Nursing Services, which assisted in recruiting Indian nurses as staff, Adranvala wrote how the salary of nurses and their working conditions was standardized, thus making it possible to “post nurses in small hospitals in remote places.” The fact that Adranvala mentioned nurses working in remote areas in two articles that were written in a span of 10 years, showed how she gave public significance to the importance of public health nursing.

Although Adranvala acknowledged there were Indian nurses who did not like working in rural villages and rather preferred working in urban cities, by mentioning the success of nurses working in rural communities, I interpret Adranvala making a public effort to promote the importance of public health nursing. By citing how acquiring “permanent accommodation for village work in Chawla” was a “great encouragement,” to me this depicted how Adranvala thought nursing in villages was a vital task which needed to be carried out in India. In addition, it also portrays Adranvala was making the efforts to develop public health nursing initiatives. Adranvala mentioned how a

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29 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on March 10, 1951.
32 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on March 10, 1951.
A public health course was developed at the College of Nursing in Delhi and later moved on to the All-India Institute of Hygiene and Public Health in the city of Calcutta. Like her British and American nurses, Adranvala saw public health as a necessity that needed to reach to all social classes within India. Who could be more effective than a nurse in spreading the importance of public health? By teaching their patients in their homes on how to maintain healthier lives, not only could nurses help in “preventing illness,” but more importantly, they could penetrate within the private realm of households and modernize existing nursing practices. By providing modern care-giving services in rural areas, these Indian nurses could compete with and modernize care-giving that was provided by local _dais_.

Adranvala also made efforts to dissociate nursing from its low-caste and polluting image and transform it to a respectable profession. One way she did so was with education. While discussing nursing developments in India prior to 1947, Adranvala mentioned that organizations like the Seva Sadan in the city of Poona encouraged Hindu women to train as nurses. She stated how these Indian organizations made efforts to recruit Indian women from the respectable upper class. By mentioning how upper class Indian women were recruited as nurses, I interpret Adranvala as maintaining the nursing ideal of respectability and showing how the status of nursing would only improve if educated, higher class women would be recruited into the nursing profession. In both Britain and America, it was believed that that “better educated nurses might transcend and ultimately remedy” the damaging image of nurses. By constantly mentioning the

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need for a professional elitist nursing culture in India, Adranvala depicted how educating and training nurses was the only way nursing would become a respectable profession; nurses would only be considered as professionals if they had up-to-date theoretical knowledge. Another method Adranvala used to maintain respectability for nursing was through the colonial nursing ideal of sisterhood. Adranvala expressed her concern how Indian nurses were not interested in advancing the nursing status. In her speech she delivered as the President of the TNAI in 1941, Adranvala stated the factor that defeated them the most in making nursing a respectable profession was the “apathy of the nurses themselves.”37 As stated above, if nurses themselves did not take interest in uplifting their status and portray to Indian society that nursing was a respectable profession, how would they be able to change the social perception of nursing being a low-status profession? Adranvala called out to Indian nurses to iron out their differences and “speak with one voice.”38 Adranvala maintained the sisterhood nursing ideal as she stressed how all Indian nurses and nursing leaders should work together as one body to fight against social oppression.

Adranvala also took steps to ease tensions that existed between Indian nursing leaders and doctors and making nursing as a respectable as the medical profession was in India. From chapter 1, I discussed how nursing was seen as the lesser profession in comparison to the medical profession. Since Indian nurses were inferior to Indian doctors, Indian nursing leaders post-independence took action to uplift nursing to the same level of respectability that the medical profession proclaimed.

37 Adranvala, Tehmina K. “President’s Address”, pp. 7.
Replicating the Western the medical standard curriculum in nursing university programs was one way how Adranvala chose to help characterize nursing as a respectable profession. This was not an effort she started after obtaining the post of the Nursing Superintendent to the GoI; in fact, she did this before when she worked at the J.J. Group of Hospitals. In 1941, when Mary Elizabeth Tennant came for a tour of the J.J. Group of Hospital, Adranvala held the position of the Matron. Tennant mentioned that the educational requirements of the nursing students at the J.J. Hospital were “similar to that of the KEM Hospital.”

KEM Hospital, also known as the King Edward Memorial Hospital, was a “teaching hospital for the Bombay Medical College.” Being the Matron of the J.J. Hospital, Adranvala played a significant role in shaping the hospital’s policies. Sushma Kumar Saini and Charanjeev Singh who have studied the hierarchical structure of authority in Indian hospitals stated that in Government Hospitals, a Matron “was responsible for the administration and management of nursing services in a specified area […] [that was] assigned to her.” Thus, Adranvala had the power to make administration decisions about the J.J. Hospital. She played an important role in in shaping nursing policy at the J.J. Hospital. By making the entire nursing curriculum similar to the medical curriculum KEM followed, Adranvala’s policy showed her desire to make nursing just as respectable a profession as a medicinal profession was considered in India. Adranvala wrote that the development of nursing” was continuously influenced by “developments in medical science.”

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39 RF Record Group 12, Rockefeller Foundation Records, Officers’ Diaries, Reel M Ten 2, Frame 185, “Index, 1941”, Mary Elizabeth Tennant Diary, pp. 5.
40 Ibid, pp. 5.
42 Adranvala, Tehmina K. “Nursing Profession in India”, pp. 385.
nursing would be respectable if it had the same developmental strategies that the medical profession took.

Not only did Adranvala take effort to replicate the medical curriculum, but she also made the effort to reproduce the respectability professors had in medical colleges to professors in nursing colleges. In a letter Adranvala sent to Dr. B.B. Dikshit, who was the Director of the All India Institute of Medical Sciences (AIIMS) in Ansari Nagar, New Delhi, she enclosed what was discussed at the Advisory Committee Meeting held on Monday, February 27, 1961. During this time, there was discussion to move the College of Nursing at Delhi to AIIMS. From her minutes of the meeting, it is seen that the purpose of the meeting was to discuss the qualifications of a full time nursing teaching staff which included the Principal, Lecturers and Departmental Sisters. Not only as the Nursing Advisor of the GoI, but also, since Adranvala was the Convener during the meeting, Adranvala played an important role as she brought everyone together in one room to facilitate discussions. At the meeting, the minutes provide insight that there was going to be three major fields of study that were going to be offered at the nursing college in AIIMS and they were Nursing Administration, Teaching and Public Health Nursing. In the minutes, it was deemed important that one of the full time nursing teaching staff had specialty in these fields. In her letter, Adranvala discussed how she wanted the nursing staff at AIIMS to be designated. She suggested that the Principal should be addressed as the Professor of Nursing and the Lecturers should be addressed as Assistant Professors. These were the same titles that professions in the Medical College were associated with. By providing nurse teachers the same title designation that medical teachers of AIIMS were awarded with, Adranvala explained that “there will be no
question as to why the Lecturers for the nursing course [will] be paid more than Lecturers for medical course.” By suggesting that the nursing teaching staff should have the same professional titles the medical staff had, Adranvala attempted to provide them with a better social standing. If professors who taught nursing were awarded with the same titles as professors teaching medicine, there would be no distinction between both professors. Thus, not only would they command the same respect as faculty which taught medicine, but also, they could obtain higher salaries. By attempting to provide nurses with a better social standing, if not the same social status, as doctors, Adranvala showed how the first step towards equality was through rhetorical acceptance of both professions. By offering suggestions about what should be done, Adranvala made the attempt to work with Dr. Raja to improve the status of nurses.

In addition to reaching out to Indian nurses and working with Indian doctors, Adranvala also worked with international officers like the Rockefeller officials and the Indian government to bring about the changes needed in the Indian nursing profession. The Second Five-Year Plan of 1956-1961, provides the most detail in terms of national attention and planning towards nursing and there was section, under Chapter 25, “Health,” dedicated to nursing, titled “Nursing and other Training Programmes.” While the need to expand facilities for “the basic nursing course of three years’ duration,” was recognized, there was also a promotion for “adequate facilities” for nursing; since the plan cited how nurses left the nursing profession “after marriage if full-time service” was

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insisted, there was endorsement for part-time work.\textsuperscript{44} Due to the explicit detail about nursing in the Second Five-Year Plan, since Adranvala held the rank of the Nursing Advisor to the Government of India, Healey concludes that Adranvala wrote the portion about nursing.\textsuperscript{45} By including a provision for part-time work for Indian nurses in the Second Five-Year Plan, it can be seen how Adranvala was trying to improve nursing working conditions and reduce the amount of hours Indian nurses worked.

In addition, her involvement in the Five-year Plan shows how Adranvala was trying to work with the government to garner maximum public attention towards nursing. To the public, she was trying to dictate how important nursing was for the Indian health system, and she would take any measures to spread this message, even if it meant drafting national Five-Year plans. Being a lady of important stature, she was present at numerous international meetings. At the World Health Assembly in 1956, in addition to a lot of European nursing leaders like Canadian nursing leader Creelman, Adranvala was also present. At the Assembly, by discussing and exchanging ideas on “how to deal with the worldwide nursing shortage,” Adranvala brought public national and local attention towards issues faced by the elite nursing leaders.\textsuperscript{46}

Despite the development of colleges and the promotion of public health in rural communities, Adranvala did not paint a picture-perfect image that all was well with the development of Indian nursing in the late 50’s and 60’s. Adranvala still pointed out problems Indian nursing leaders were facing. In addition to hospitals being overcrowded and a lack of staff and supplies, Adranvala mentioned some traditional features, which


she felt hindered the development of nursing. By mentioning how “special prejudice against nursing” was “far from dead,” Adranvala depicted Indian nurses were stigmatized due to the nature of their profession and their low-status association. This depicts how even with the effort of professionalizing nursing, Adranvala and other Indian nursing leaders of late 1947-late 60’s’ had to constantly struggle with the low-status association of nursing.

Despite addressing the problems the elite nursing leaders in India were facing, Adranvala only briefly mentioned these difficulties. After mentioning the difficulties, Adranvala was quick to place emphasis on how progress was being made in developing the nursing profession post-independence. In her articles she always ended writing how nursing was becoming “an integral and essential component of a modern [Indian] health service.” As a result of the increasing importance of providing health services in the rural and urban communities, Adranvala mentioned during the time period from 1948-1965, there was a large demand for nursing services. By citing this trend as “new,” and displaying how there was a waiting list of nurses instead of an “acute shortage of candidates for nursing training,” Adranvala understood that Indian nurses services were starting to get recognized for their services. Perhaps this was Adranvala’s way of trying to show how that was an increase of public respect towards nursing so nurses would be motivated to join the full-fledged profession. By writing how terms like “hospital schools,” “Nursing Education” and “Nursing Students” [were] words which” now had “substance” in India in the 1950’s, Adranvala portrayed a skewed picture of the nursing

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48 Ibid., pp. 328.
In this way, Adranvala hinted how Indians were becoming more ‘modern’ in their nursing standards as they were starting to accept the professional nursing culture in hospitals. In addition, she mentioned how Indian states were establishing nursing services and standardizing pay for nurses. In her 1968 article, she cited how most states appointed a “Chief Nurse” who would help administer nursing services under the control of “the State Administrative Medical Officer.” Even though she admitted that more needed to be done to develop policies which established a good standard of nursing, Adranvala showed how effort was being made to integrate nursing into the community and how nursing was developing in a positive direction and changing for the better.

Adranvala not only cherished the nursing ideals of the West, but she also looked up to her American nursing counterparts. In her Address she delivered as the President of the TNAI in 1951, Adranvala found it encouraging that nursing was being recognized as an important profession at the international level. However she mentions that “things [were] not so rosy at the National level;” for “financial reasons, the government of India […] discontinued the grant for scholarships.” The lack of financial support could be used to explain why Adranvala was supportive of American philanthropic organizations. After all, they provided financial aid to India at a time when India was a newly formed country. In fact, Adranvala glorified the aid being provided by international organizations. In addition to mentioning UNICEF’s “excellent teaching equipment” and financial support, she also thanked USAID, the Colombo Plan, and the Rockefeller Foundation for providing fellowships to study overseas as well as providing experts and

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52 Adranvala, Tehmina K. “President’s Address”, pp. 8.
consultants whom Indian nursing leaders like herself could rely on. According to Adranvala, the WHO made the largest contribution.53

By mentioning the assistance provided by international organizations, not only was she trying to maintain public enthusiasm in nursing, but more importantly, she maintained the ideological structure of reproducing Western nurses by creating new Indian nurses who were thoroughly schooled in Western thinking about nursing. By constantly mentioning how Indian nurses went overseas for training in nursing, Adranvala made it seem like studying overseas was an “essential component of a leader’s resume” as it made them look for prestigious as they obtained degrees from abroad.54 Thus, by mentioning how fellowships were provided to Indian nurses to obtain overseas nursing education in America, Adranvala furthered the professional modern nursing culture as she attempted to pass on Western nursing concepts to Indian nurses so they could modernize Indian nursing. Through her effort to maintain the nursing ideals and ideological structures that were left by colonial officials, not only did Adranvala show appreciation for the efforts of her Western counterparts, but more importantly, she continued the heavily professionalized model for which British nurses advocated for.

However, Adranvala was still skeptical of embracing all Western nursing concepts, especially that of the apprenticeship system. Adranvala expressed displeasure that the Nightingale “principle of an independent schools […] was lost sight of” and an the apprenticeship system developed in India where in nursing students were trained in hospitals.55 Adranvala wrote that the “apprenticeship form of training […] constantly

55 Adranvala, Tehmina K. “Nursing Profession in India”, pp. 385.
subordinated the student’s needs to that of the hospital.” 56 Since the apprentices were mainly nursing students, working around the needs of the hospitals “offered little challenge to [the nurse’s] capacity for applying thought to the problems of ill health and their prevention.”57 Adranvala clearly portrayed a negative view towards the apprenticeship model as she wanted nurses to have good quality education and be able to apply their newly gained knowledge, not be exploited.

By promoting the image of the modern Indian nurse, Adranvala ended up playing the role of a mediator who would transmit modern nursing in India. Adranvala’s stress on nursing education was indeed as a result of being educated overseas where she was influenced to believe in the Western ideals of a nurse; however it must not be ignored that she continued to promote Western nursing ideals herself. Healey claims that “nurses working in India viewed themselves as the emissaries of the reformed models of nursing that developed in the West” and I think this claim rings into the case of Adranvala.58 In her Address as President of the TNAI, Adranvala stated that “we have by to follow [nursing] trends in other countries.”59 To me, this showed how she portrayed herself to the TNAI and the public as one of the leaders who would help develop Indian nursing leaders by following what the West did and modernize Indian care-giving practices. When asked about the purpose of a travel grant in her application, Adranvala stated that she wanted to “study methods of education and administration.”60 The purpose of her trip reveals how she made the effort post-independence to further immerse Indian nursing with Western ideals. In her travel grant, Adranvala mentioned her desire to travel to the

56 Adranvala, Tehmina K. “Nursing Profession in India”, pp. 385.
59 Adranvala, Tehmina K. “President’s Address”, pp. 6.
60 RF Record Group 10.1 Series 464L Box 292 Folder 4560. Fellowship File for Adranvala’s Application for Travel Grant on April 27, 1947.
“University School of Nursing” in Toronto and Yale University in New Haven, United States to understand how nursing education and hospital administration was carried out.\(^6^1\) By understand how nursing education was provided in a country other than Britain, not only did it show her acknowledgement of the superiority of Western science, but more importantly, it also showed how she played the role of a mediator who would modernize Indian nurses at any extent, even if it meant taking the extra step of studying how American universities taught nursing.

By writing the history of nursing, Adranvala played a crucial role in modernizing the history of the development of the Indian nursing profession. In her article, “Developments in Nursing 1947-1954,” she writes that Indian nursing “in its traditional role of [the] sick […] was introduced in Indian hospitals in the latter half of the century.”\(^6^2\) In her article, “Nursing in India: 1908-1960,” where she describes the form of care-giving prior to British colonialism, she writes how there was “more private practice of midwifery in middle and upper class homes.”\(^6^3\) Although in this article, she later mentions the *dai*, by writing “there was no community nursing,” it seemed to me as if Adranvala was erasing the *dai* from the history of care-giving in India. What is interesting is that in her articles she wrote during the 1950’s-1960’s, Adranvala mentions the “*dai*” only one or twice; however in her article, “Vital Aspects of Nursing: The Historical Perspective,” which she wrote about the history of Indian nursing, she does not mention the “*dai*” at all. Instead, while describing the development of nursing prior to the arrival of colonial officials; she describes Indian care-givers as “nurses” and

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\(^6^1\) RF Record Group 10.1 Series 464L Box 292 Folder 4560. Fellowship File for Adranvala’s Application for Travel Grant on April 27, 1947.


The fact that Adranvala refused to acknowledge a deeper history of care-giving and account for traditional forms of care-giving that were provided by the *dai* prior to the professional nursing culture which was brought by colonial officials suggests that Adranvala saw herself as the modernizer of the post-Independence nursing field who was trying to modernize the history of Indian nursing. In the sentence above Adranvala mentioned how Indian nursing was founded in hospitals, which were institutions associated with Western modern nursing. I would like to argue that Adranvala left no stone unturned in trying to portray how the Indian nursing profession was “modern” and not as backwards as it was deemed by colonial officials. Thus, by not mentioning the *dai*, I interpreted how Adranvala made efforts to fully modernize the history of Indian nursing to the point where it resembled the development of modern nursing in the West.

Although Adranvala wrote how Indian organizations like the Seva Sadan made the efforts to recruit Hindu Indian nurses, what is interesting is that sources which have recounted the development of the Indian nursing profession, have proclaimed this was done by colonial and official officials. In Alice Wilkinson’s *A Brief History of Nursing in India and Pakistan*, there is no mention of Indian organizations recruiting upper-class Indian women as nurses. However, one can argue that since Wilkinson was a British colonial woman who was trying to replicate British nursing ideals in India, she would only glorify the efforts British colonial officials made in modernizing Indian nursing. Since Wilkinson represented the domination of Western leadership, her source does not provide much significance. Healey mentions how Indian nursing was “largely marginalized by the Western leadership” as there have been few materials written by Indian nurses themselves and therefore, she mentions examples of Indian nurses and

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doctors who promoted modern nursing in India.\textsuperscript{65} The fact that Madelaine Healey, who wrote about the development of Indian nursing in a contemporary period, mentions the involvement of an Ramabai Ranade’s Seva Sadan in recruiting Indian women as nurses, confirms the validity of Adranvala’s statement about Seva Sadan.\textsuperscript{66} If Healey, a contemporary was trying to provide Indian nurses with a voice, mentions the involvement of Seva Sadan, an Indian organization in recruiting Indian women as nurses, perhaps by writing about the involvement of Indian organizations, Adranvala was trying to “Indianize” the history of nursing and bring to the forefront how Indian people were just as involved as colonial officials were with recruiting Indian nurses to promote the Western nursing model.

\textbf{Conclusion}

Through her articles in the \textit{NJI} which described the development of new bachelor and graduate nursing training degrees, midwife training programs, public health programs, distribution of health services to the rural community, the assistance of international organizations or the development of standard nursing curriculums, Adranvala translated a certain vision to Indian nurses that the ideal Indian nurse should be educated, modern/distinct from the \textit{dai}, selfless, and engaged in global sisterhood. Adranvala ended up projecting an idea of the modern Indian nurse that aligned very closely with everything her training taught her that a nurse should be. Her articles show that she did not deviate from the western nursing model but rather fully affirmed and elevated this model.

\textsuperscript{65} Healey, Madelaine. “Regarded, Paid and Housed as Menials’: Nursing in Colonial India,’ pp. 57.

\textsuperscript{66} Healey, Madelaine. “Regarded, Paid and Housed as Menials’: Nursing in Colonial India,’ pp. 58.
Adranvala’s articles provide insight into the mentality of the elitist nursing Indian leader from late 1947-1966 in India. Having benefited from colonial nursing education, once Adranvala was the chosen elite to lead the nursing profession in 1948, Adranvala chose to remain committed to professionalizing nursing education and maintaining the colonial construction of the Indian modern nurse. By maintaining the colonial construction of the Indian modern nurse, Adranvala carried over and further solidified the colonial nursing framework in India post-Independence. Through her maintenance of the ideal nurse, not only did Adranvala reproduce norms of British imperialism, but more importantly, she emphasized on the colonial of the modern Indian nurse which she expected Indian nurses to follow. Thus, not only did Adranvala play the role of a modernizer who was trying to modernize all Indian nurses so they could be equivalent to Western nurses, but by writing articles about the history of the profession, she modernized the history of the Indian nursing profession.
Chapter 3: Political Tensions in Adranvala’s Local, National and International Relationships

Whereas the audience of Adranvala’s articles was other educated Indian nurses who shared the same view about nursing as she did, her private letters catered to a different audience which comprised of her international nursing colleagues from the RF. From Adranvala’s letters as well as the diary entries of various Rockefeller officials like Mary Elizabeth Tennant, Virginia Arnold, it was evident that she played a different role in coordinating efforts between Indian doctors, the Government of India (GoI), American Rockefeller Foundation (RF) nursing officials. Although post-Independence opened up new boundaries for Adranvala and gave her the authority to work with large power structures such as the GoI and RF, Adranvala found herself caught in a cross-road. Not only did the Indian doctors, GoI and RF have higher authority than Adranvala, but also, they all had different interests and visions about how they wanted the nursing profession to develop. Despite being politically and structurally constrained, Adranvala tried to manage these conflicting relationships and achieve consensus with the doctors, GoI and RF who all had higher power than her. Understanding the complex political realities Adranvala found herself in will help provide an insight into the difficulties Indian nursing leaders had; not only were there larger political structures which limited Adranvala’s scope of power, but more importantly, it was the tension of negotiating between the differing goals between RF officials and GoI which made it impossible for Adranvala to keep both the GoI and RF satisfied. In Adranvala’s effort to negotiate, she ended up playing a losing game as she could not keep the RF satisfied.

As I discussed in Chapter 2, Adranvala tried to work with Indian doctors to enhance the nursing profession in India. In a 1951 diary entry, Tennant mentions that if
Miss Craig continued to hold poor relationships with both “foreign and Indian staff,” then both Dr. K.C.K.E. Raja and Adranvala would have to “do something to correct it.”¹ Miss Craig was an American nurse who was the principal of the College of Nursing in New Delhi, India.² This implies that on the surface, an Indian doctor and Indian nurse superintendent had equal authority in the decision about the Indian nursing staff. Is this incident important enough to conclude that both nursing leaders and doctors had equal authority in all matters?

The subordination of nurses to doctors within the medical field that I discussed in Chapter 1 was maintained in the post-Independence period. In Adranvala’s letter to Tennant, she writes that Dr. Raja “would approve of [Adranvala’s] proposal to appoint Miss Noll in the College of Nursing.”³ Because Adranvala needed Dr. Raja’s approval of her request for nursing staff, the latter had greater authority in making decisions about nursing programs. Scholar Jeffrey points out how that there was not enough room for nursing leaders in the post-colonial discussion of health as doctors and planners were prominently responsible for the Indian health system.⁴ This is supported by Healey, who argues that the neglect of the nursing profession was to some degree the result of medical power.⁵ It is important to realize that it was not just Indian nursing leaders who had to respond back to doctors; Healey states that international nurses also had to “answer back

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¹ RF Record Group 12. Rockefeller Foundation Records, Officers’ Diaries, Reel M Ten 4, Frame 589, “Index, 1951”, Mary Elizabeth Tennant Diary, Diary Entry on March 26, 1951, pp. 60.
³ RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on March 10, 1951.
to doctors who were in charge of [nursing] programs.”6 Neither international nursing
officials nor Indian nursing leaders had greater authority over Indian doctors. Thus,
despite Adranvala’s attempt to make nursing as respectable of a profession, she could not
fight against the dominance of the Indian physician in the medical system.

Although the letter exchanges between Adranvala and RF officials and Tennant’s
diary entries do not show any direct animosity between Indian doctors and nursing
leaders, it would be surprising if such did not exist. Indian nursing leaders in the 1950s
and 1960s were “a group of rare and exceptional women” and very few of them were
married.7 When asked about her status in her application, Adranvala wrote single and she
remained single her entire life.8 Indian women of different religions, castes, etc faced
different restrictions however the ideal “Indian femininity [was equated] with marriage,
domesticity, […] and legitimate motherhood.”9 By remaining single, Adranvala, like
other nursing leaders, disrupted the notion of the ideal, Indian woman as they refused to
shape their lives according to gender stereotypes. Melosh explains how doctors and
nurses brought “different expectations” in terms of their professional behavior; however
she did not feel that this “set work and gender roles at odds.” Describing doctors as men
who were “decisive, stoical, objective,” Melosh argues that as women, nurses defied
“cultural prescriptions for female warmth” in order to “meet the demands of “hospital
discipline.”10 Since Adranvala was a female nurse who had high authority, this could

6 Ibid, pp. 127.
7 Ibid, pp. 164-165.
8 RF Record Group 10.1 Series 464L Box 292 Folder 4560. Fellowship File for Adranvala’s Application
for Travel Grant on April 27, 1947
9 Dharadker, Aparna Bhargava. Theatres of Independence: Drama, Theory, and Urban Performance in
India, (University of Iowa Press, 2009), pp. 235.
10 Melosh, Barbara. The Physician’s Hand”: Work Culture and Conflict in America, pp. 58.
have been seen as a threat to the Indian male doctor, who was a part of the Indian male patriarchal society, where the man was expected to earn, not the woman.

Just as Adranvala was subordinate to but held influence over doctors, she also held a similarly tension-filled relationship with the GoI. On the one hand, she had positive relationships with the GoI and influenced their decisions. The GoI was interested in promoting nursing post 1948 because it was seen as an alignment of the “construction of the Nehruvian developmental state, which aimed to [...] bring rapid improvements to the health and education of the population.”\(^\text{11}\)

Just like Adranvala, the GoI viewed “education as an instrument of social change [...] and social equality” and advocated for nurses being educated.\(^\text{12}\)

In 1958 a diary entry of Virginia Arnold, the Assistant Director for Medical Education and Public Health for the RF, indicates that the Ministry of Health started providing support for “to schools of nursing for the introduction of public health nursing.”\(^\text{13}\)

The Ministry of Health and Family Welfare was a government program that was established to regulate health policies in India. Although the credit for pushing the Ministry of Health should not be entirely given to Adranvala, given the fact that she held the position of the Nursing Advisor to the Ministry of Health of the GoI, it is assumed that she was one of the key players for probing the Ministry of Health to support nursing services in India.


However, the relationship between the nursing leaders and the Indian government was difficult. In 1948, Adranvala asked the W.H.O for four nursing visiting teachers for the College of Nursing, New Delhi. She wanted Miss Candice Heinly as one of the four nurses because she felt that this would give them “breathing space to convince the various Govt departments that we need these extra teachers for the college.” Even though she expressed doubt about whether the Government would provide consent to create “a single additional post at the College for next year,” the fact that the GoI dictated the final decision regarding what positions needed to be created and who could stay in what post, showed how the GoI influenced the direction of the development of nursing.\(^{14}\)

A diminishing support for financial assistance can be seen. In Arnold’s diary entry from February 7, 1958, she mentions that Adranvala was not in favor of a BSc nursing program in Lucknow because there was a lack of government support.\(^{15}\) As a result, Adranvala decided not to build a nursing program in Lucknow. Adranvala’s appeals to the GoI for resources and support demonstrates how the direction of the development of the nursing profession was partly dependent upon the GoI. If the government did not provide the financial assistance and attention towards developing the nursing profession that was needed, there was a limit to what Adranvala could do.

Due to the GoI’s higher authority over the elite Indian nursing leaders, not only did their decisions influence how the nursing field was shaped, but also, the GoI’s goals and beliefs which affected the decisions they made about the nursing profession are important to note. Healey points out that the “working relationship between nurses and

\(^{14}\) RF Record Group 62, Series 464 1948, Box 423, Folder 2852. Letter to Miss Tennant from Miss Adranvala on November 3, 1948.

government was very difficult” as they were unwilling to provide too much authority to nurses. Jeffrey states that the “health policy framework of independent India” was based on the colonial framework, as the power to perform activities relied on the state’s allocation of for medicine and public health. Although the GoI wanted to develop the medical and nursing system in India and thus collaborated with RF, the GoI did not like encroachments by the RF and other American philanthropic organizations, where they had more power than the GoI. Jawarharlal Nehru, who was the first Prime Minister of India, saw the involvement of American organizations like the RF as taking up the “responsibility for government tasks” and “[interfering] in Indian affairs.” Nehru did not approve of the RF dealing directly with universities instead of the GoI. The GoI had a different vision about the development of the nursing profession; in their vision, there was room for RF nursing officials however, not at the expense of the power of the GoI. In addition, Nehru did not like how Indians were being sent abroad for obtaining medical and nursing training. This showed how the GoI wanted Indians to be trained however they did not like sending them to America for training.

Not only did the GoI have differing aspirations and goals about the nursing profession, but more importantly, these differing goals created internal political conflicts within between the GoI and elite Indian nursing leaders. Scholar Kavadi who studies the history of colonial medicine in South Asia, pointed out how the GoI and leading nurses in the Ministry of Health had differing opinions. Whereas Nehru “deemed it undesirable for Indians to go the US for training,” Miss Rajkumari Amrita Kaur, who was the first Union

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Minister of Health in the Health Ministry of India had a different opinion from the GoI. She welcomed aid that was being provided by the RF which allowed nurses to obtain nursing education abroad.\textsuperscript{19} Adranvala was a part of the Ministry of Health and her views about studying abroad coincided with elite nursing leaders like Kaur who were favorable towards overseas nursing education in America. This clashed with the GoI’s view. To curb American influence in medicine in India, the GoI forbid educational institutions in India “from directly approaching any foreign government or agency for aid and assistance.”\textsuperscript{20}

In addition, the level of dedication the GoI showed towards developing the Indian nursing profession did not match the level of dedication that leaders like Adranvala had. Despite the fact that the Government did initially show a high level of interest in improving nursing conditions in India, their support for nursing was mainly rhetorical. Using the following statement from Janet Corwin’s Semi-Annual Report from July 1-December 31, 1946, Healey demonstrates this. Despite reporting how the central government provided scholarships for Indian nurses to study overseas for an Honors B.Sc Honors Nursing Course, Corwin concluded that the College of Nursing was an “Exhibit […] of the Health Department of the Government” of India as many visitors were brought there.”\textsuperscript{21} In other words, Healey shows how the Indian government wanted to be seen as progressive in regards to their advancement of nursing in India. By using the College of Nursing as an “exhibit,” the GoI employed particular nursing programs to

\textsuperscript{20} Ibid, pp. 142.
display their investment in the development and modernization of the Indian nursing profession without providing the material means to accomplish these goals.\textsuperscript{22}

This is not to say that there was no effort taken by the Government to enhance nursing conditions within India. Post-Independence, the GoI created various committees to overlook the development of nursing in India. The famous Committee was the Bhore Committee, which was also known as the Health and Development Survey Committee. It was formed in 1946 and was very important as it “provided the framework for health policy in independent India.”\textsuperscript{23} The Bhore Committee was created to review health conditions within India and provide suggestions to increase modern hospitals within India.\textsuperscript{24} Not only did the Bhore Committee create the All-Indian Nursing Council (AINC) that would co-ordinate activities of nursing council, but the Committee recognized the importance for nurses to be professionally trained, and recommended the establishment of nursing degree programs. In 1954, the GoI created Shetty Committee and Adranvala was the Member Secretary for the Committee. In addition to looking into educational and professional practices of nurses, the Shetty Committee also emphasized the importance of increasing the amount of nurse and recommendations to improve existing conditions were provided.\textsuperscript{25} Some suggestions were creating a “minimum pay scale for nurses,” appointing nursing superintendents to the offices of the directorate of health services in each state.” Healey states that the Shetty Committee was “good evidence for the initially high level of political respect for concerns of the nursing profession.”

\textsuperscript{22} Healey, Madelaine. \textit{Indian Sisters: A History of Nursing and the State, 1907-2007}, pp. 133.
\textsuperscript{23} Kavadi, Shirish N. \textit{The RF and Public Health in Colonial India 1916-1945: A Narrative History}, pp. 131.
\textsuperscript{24} Nair, Sreelekha. \textit{Moving with the Times: Gender, Status and Migration of Nurses in India}, pp. 33.
\textsuperscript{25} Ibid, pp. 34.
leadership.” In 1959, the Ministry of Health and the GoI created the Mudaliar Committee to examine developments that took place after the Bhore Committee made recommendations and further develop health programs in the third Five Year Plan. However, Nair states that “nursing was only a part of the committee’s area of concern.” Nurses were not on the board of the Bhore Committee and the Mudaliar Committee, thus confirming that the GoI did not attempt to include nurses in their plans for developing the profession.

Whereas the GoI provided support for the creation of nursing committees, scholarships for overseas education, development of nursing courses which depicted their interest in improving nursing conditions in India, the interaction that existed between Indian nursing leaders and the GoI was “theoretical, opportunistic support combined with egregious practical neglect.” The rhetorical support for nursing which existed for the development of nursing in India slowly started to wane. Alongside a diminishing financial support, the GoI’s lack of support for a nursing degree program in Lucknow is one example how the GoI was not interested in furthering the nursing profession. This incident occurred during the time period of the Second-Year Plan, when ironically, the GoI expressed a lot of support shown towards Indian nurses on paper. The conflicted nature of the GoI’s support and their bias towards doctors’ medical education above nursing education continued in later policies. Through the Five Year Plan of 1974-1979, which awarded 169 lakh to develop medical education in India and 16 lakh was provided

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27 Nair, Sreelekha. *Moving with the Times: Gender, Status and Migration of Nurses in India*, pp. 34-35.
29 Ibid, pp. 133.
for developing nursing institutions, Healey demonstrates how national attention towards developing medical institutions in India hurt the nursing profession.\(^{30}\)

International organizations like RF were as responsible for the shortcomings of Adranvala’s ability to collaborate effectively. Just as Adranvala was limited by the GoI’s dual nature and differing opinions, Adranvala also had a mixed relationship with the RF as they both had differences in opinions and power. Post WWII, there was the movement to improve global health and maintaining international relationships became very critical. Cold War politics informed why RF intervened in the Indian public health system post-Independence. On January 20, 1949, President Truman announced the Four Point Program, which dictated that the US needed to support ‘emerging people’.\(^{31}\) Due to the Cold War that existed between America and the Soviet Union, the former wanted to contain the spread of communism. America saw India as the “essential democracy”; by aligning with the Indian nation and providing it with financial assistance, American officials thought that the “performance of the Indian” economy “would affect the attitudes of peoples throughout the developing world” and show them how aligning with the democratic United States would raise their living standards.\(^{32}\) The Rockefeller Foundation, which was successful with its international public health programs, started to engage in medical and public health in India in 1920.\(^{33}\) In 1935, the Government of India invited the Rockefeller Foundation for assistance in training female nurses in India. After India’s independence from Britain, the RF continued playing an important role in developing the nursing profession. The RF saw the dominance of medical power as a


\(^{32}\) Ibid, pp. 52.

\(^{33}\) Ibid, pp. 55.
“hindrance to developing leadership qualities in [Indian] nurses.”³⁴ Thus, one of their goals was to encourage Indian nurses to take leadership roles and reduce their dependency upon foreign nurses.

Since Adranvala constantly remained in touch with Rockefeller nursing officials, it seemed as if they shared a pleasant relationship. Healey claims that there was no conflict between international nurses who arrived in India and Indian nurses; in fact they were enthusiastically welcomed, especially by the TNAI.³⁵ After all, international nursing leaders from the Foundation and WHO and Indian nursing leaders like Adranvala, shared the same commitment to the Western ethos of professionalism and they both believed that “degree education will encourage parents of better status to allow their daughters to enter the profession.”³⁶ In addition to providing support for having institutional nursing programs in India, the RF was interested in encouraging Indian nurses to study overseas and they provided fellowships so Indian nurses can obtain nursing education in the United States in subjects such as teaching, public health, and administration.³⁷ Both the RF officials and Indian nursing leaders like Adranvala believed that giving nurses fellowships to obtain both undergraduate and postgraduate education overseas would help them “make a real contribution in India.”³⁸

The letters, which were mainly correspondences between Adranvala, Mary Elizabeth Tennant and Miss Noll, provided a glimpse into how they shared a good professional relationship and had warm thoughts about each other. Mary Elizabeth

³⁶ Ibid, pp. 130.
³⁷ Ibid, pp. 121, 124.
Tennantd serve as the Nursing Consultant of the Rockefeller Foundation in India and Anna Noll “serve as the advisor at the Delhi College of Nursing and Rockefeller Nursing Representative in India from 1947-58.” Miss Adranvala seemed to especially share a pleasant relationship with Miss Noll. In a letter to Miss Tennant on March 10, 1951, Adranvala mentioned how Miss Noll was no longer working in India; since Miss Noll accepted a position at the College of Nursing, Wayne University where she was going to work for approximately 2 years, she would not be able to return to India. Adranvala stated Miss Noll’s departure as a real loss as Miss Noll helped “[her] greatly in many aspects of [her] work.”

In addition to having seemingly pleasant relationships, Adranvala was given the autonomy to work with nurses who wanted to come to India and engage in nursing work. For example, when Miss Florence H. Martyn, a “Canadian missionary” completed her master’s degree at Catholic University, Washington DC and wanted to work in India, Tennant advised that she speak to Adranvala. Even when Miss Meher Ansari, a Muslim nurse, wanted to gain more expertise within public health nursing, Tennant advised that she speak to Adranvala about what she “should do upon her return to India.” Not only did Rockefeller officials point nurses towards Adranvala, but they also sought her advice about where Indian nurses could be placed in India to gain good proper training. In Adranvala’s letter to Miss Tennant in 1951, Adranvala suggested that Miss

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40 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on March 10, 1951; RF RG 12, Rockefeller Foundation Records, Officers’ Diaries, Reel M Ten 2, Frame 185, “Index, 1941”, Mary Elizabeth Tennant Diary, pp. 59.
41 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on March 10, 1951.
43 RF RG 12, Rockefeller Foundation Records, Officers’ Diaries, Reel M Ten 4, Frame 589, “Index, 1951”, Mary Elizabeth Tennant entry on February 23, 1951, pp. 42.
Shroff took her “midwifery training in Bombay” and even advises that Miss Shroff works in Vellore “for a short period before taking up an appointment in the College of Nursing,” New Delhi. Therefore, not only was it evident that Adranvala could influence which foreign nurses could work in India, but also, it showed how her expertise was valued by Rockefeller nursing officials.

Relationships between leading Indian nurses like Adranvala with a global NGO were not as straightforward as these supportive exchanges might suggest. Healey over-generalizes the relationship between Indian nursing leaders and international nursing officers as she does not mention underlying political and hegemonic tensions between Indian nursing leaders and the Rockefeller officers. Although the letter exchanges between Adranvala, Miss Tennant and Miss Noll depict how she shared a pleasant professional relationship with them, her letters to other RF officials show her relationships with RF officials were much more complicated. Although both Adranvala and the RF shared the same vision, what differed were their interests in executing the steps to achieve the vision. Whereas Adranvala remained a firm supporter of fellowships, the Foundation’s support wavered as they did not show support for fellowships at all times. Abrams explains how there were differing opinions between American nursing leaders and the RF officials as the “issues for American nurse leaders were not the same as for the officers of the foundation.” Similarly there were differences between the RF officials and Indian nursing leaders and this could be seen through their wavering support for fellowships. In 1966, when Adranvala discussed with

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44 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on March 16, 1951.
LeRoy R. Allen about whether or not Kerala could receive additional fellowships for the faculty of the College of Nursing, Trivandrum, he stated that he did “not believe it would be possible to provide fellowships at this time” for nurses in Kerala.\(^{46}\) Le Roy R. Allen was the Representative in India and Consultant for AIIMS from 1960-1967.\(^{47}\) In Arnold’s letter to LeRoy Allen in 1966, she wrote that she might have been at fault for giving Lucy Peters, the impression that the Foundation “would consider fellowships for Trivandrum.”\(^{48}\) From Arnold’s letter, it is clear that the RF had no intention of providing fellowships for nurses in Trivandrum. If the RF was an avid supporter of fellowships, why did they not want to provide fellowships to nurses in Trivandrum? Kavadi suggests that the Foundation may have stopped providing fellowships in areas where the local people had already accepted the Western system of public health.\(^{49}\) Regardless, the Foundation’s decline of support for fellowships and Adranvala’s unwavering support for fellowships confirms how both the Foundation officials and Indian nursing leaders had differing goals for nurses in India.

As a result of the clash of these differing political perspectives, power struggles were created as each tried to assert their own power to get what they wanted. As I illustrated in Chapter 2, Adranvala firmly supported fellowship programs. Thus, Adranvala did her best to push the Rockefeller officials into providing fellowships for Indian nurses. Arnold wrote that Adranvala did not want to officially forward the letter that she received from the Kerala Government to the Rockefeller Foundation unless the

\(^{46}\) RF. Record Group 1.2, Series 464C, Box 54, Folder 495, Letter to Virginia Arnold from LeRoy R. Allen on August 12, 1966.


\(^{48}\) RF. Record Group 1.2, Series 464C, Box 54, Folder 495, Letter to LeRoy R. Allen from Virginia Arnold on August 18, 1966.

\(^{49}\) Kavadi, Shirish N. *The RF and Public Health in Colonial India 1916-1945: A Narrative History*, pp. 133.
RF officials she worked with, like LeRoy Allen and Virginia Arnold “[could] respond favourably” for providing Keralite nurses with fellowships. Adranvala was trying to put pressure on LeRoy Allen so he could grant permission for scholarships to the nursing staff at Trivandrum. This depicted how Adranvala tried to use her upper hand and put pressure on RF officials to push forward her own decisions.

However at times, Foundation overpowered her decisions. Virginia Arnold explained to LeRoy Allen in 1958, she wrote: “Because of our interest in other areas in India, I tend to put the Delhi College of Nursing at the Bottom of our List of priorities.” What is interesting is that earlier in September of 1958, Adranvala “was assured of the Foundation’s continuing interest in nursing education […] India.” On one hand, where Adranvala was assured that the Foundation was still interested in providing India assistance, on the other hand, they showed disinterest towards supporting the College of Nursing, New Delhi. Kavadi suggests that as a result of various tensions, RF ceased their medical fellowship program in 1957-1958. In 1958, the RF introduced a revised grant for research fellowship where medical students could study in India, rather than going abroad. It is not known whether this included nursing fellowships and whether this was the reason why the RF was not interested in providing fellowships to nurses in Trivandrum. However this confirms how RF affected which policies were taken into effect.

Just like the medical professionals and the Indian government, the Foundation had higher authority over Adranvala. Juliette Julien and Arnold convey that Adranvala had less power to make decisions than Miss Craig. Whereas Julien stated “that Miss Adranvala practically admitted that she could not always stand up to Miss Craig,” Arnold felt that “Miss A [relied] heavily on Miss Craig,” although he stated one could not discern what Miss Craig’s actual thoughts were. Miss Craig was an American nurse who was the principal of the College of Nursing in New Delhi. As a result of Adranvala being dependent on Miss Craig, not only did this depict how an RF official had higher authority than Adranvala to make decisions but also, Adranvala could not remain consistent with her views and had to bow down to the wishes of RF officials.

Earlier in 1961, Adranvala supposedly was against the transfer of the College of Nursing to AIIMS. In a letter written to Dr. LeRoy Allen on January 17, 1961, the fact that Virginia Arnold wanted to discuss “Miss Adranvala’s apparent change of view in regard to the transfer of the College of Nursing to AIIMS,” implies that Adranvala was initially ready for the transfer but changed her view in January of 1961. From Arnold’s diary entries, it seemed as if the decision against the move was Miss Craig’s, not Miss Adranvala’s. In Arnold’s diary entry on January 12, 1961, she wrote that Julien confidentially informed her “it was Margaret Craig and Edith Buchanan who prevented the move of the College to the AIIMS.” Julien stated that this information “was given by

Miss T.K. Adranvala,” a decision which Adranvala regretted.\textsuperscript{57} This showed how Adranvala was in favor of the College moving to AIIMS, which was a move which Miss Craig was not in favor with. Since Miss Craig was the main driving force behind the decision, it depicts how she had higher authority than Adranvala to make certain decisions. However, later in April of 1961, Arnold noted in her diary entry that Miss Adranvala was now in favor of the move of the College of Nursing to AIIMS and hoped that “it [would] be accomplished sometime soon.”\textsuperscript{58} From January to April, some change happened which resulted in the College of Nursing being transferred to AIIMS. The fact that Adranvala had to modify her beliefs depicted how Adranvala was weak in power and was subordinate to the wishes of Rockefeller officers.

As a result, political tensions arose from differing interests and beliefs between Indian and American nursing leaders. In Tennant’s diary entry for March 6, 1951, she took note of differing opinions: whereas Noll wanted more efforts made towards developing hospital schools and recruit programs in India, Miss Atula Shroff felt that more effort should be taken to “strengthen the College of Nursing” so teachers and administrators could become better prepared to develop nursing services in hospitals.\textsuperscript{59} Miss Shroff was an Indian nurse who had received fellowship from the Foundation to study at the University of Washington in 1951.\textsuperscript{60} The difference in opinion showed how there was a clash of ideals between international nursing leaders and Indian leaders on how the direction of Indian nursing should develop; whereas Noll wanted recruit

\textsuperscript{57} RF General Correspondence, 464C. 464. 1961. Reel 721.
\textsuperscript{58} RF Record Group 2 General Correspondence, Series 1961, Sub-Series 464C, Folder- Reel # 45. Reel Frame # Reel 726. Microfilm. VA Diary Entry between April 16-28, 1961.
\textsuperscript{59} RF Record Group 12. Rockefeller Foundation Records, Officers’ Diaries, Reel M Ten 4, Frame 589, “Index, 1951”, Mary Elizabeth Tennant Diary, 1951, pp. 51.
programs to hire quality nursing personnel, Shroff wanted to strengthen the development of educational institutions in India. The difference in opinions can be explained by the differing interests that existed between the RF and GoI. While describing the differing views in developing medical education in India, Kavadi explains that whereas the Indian GoI was more interested in “creating more facilities to produce more doctors,” the RF was more interested in “enhancing the quality of medical personnel.”

The differing vision of having greater quantity versus quality already set a shaky foundation for which both could collaborate.

Not only did Adranvala have different clashes with the GoI and RF nursing officials individually, but also, the GoI and RF had their own set of difficulties as well. As depicted earlier in the chapter, the GoI did not like when RF officials took on responsibilities, which the GoI was supposed to take as they felt RF officials were encroaching upon their authority. Historian Kavadi argues that the GoI and RF officials could not collaborate because the GoI had different goals in developing the medical profession. As depicted above, it was clear that the GoI had a different vision and did not show enough support for working to make nursing a respectable and sustainable profession in India. However I would like to argue that the RF also had an equal influential role for displaying political bureaucracies which affected how the nursing profession developed post-Independence. RF officials were disturbed by the Indian Government’s “naïve enthusiasm” and “superficial thinking” as they expected full

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support from the GoI. The GoI’s lack of interest was crucial in discouraging the Foundation officials as they felt the GoI wasn’t taking enough actions to improve the nursing profession in India. Thus, as a result of these differing beliefs, both the Indian governments and RF clashed with each other, making collaboration further difficult. In a letter to Tennant, Noll explained how certain state governments were poorly responding back to the Foundation’s request for fellowships. Noll mentioned how the RF did not receive a reply back from Travancore-Cochin regarding Mrs. Rukmini Amma’s travel grant. Kavadi explains that the state governments criticized how the RF selected candidates for fellowships. This showed how there was discontent even at the local level regarding RF’s health policies in India. Not only was there distrust and discontent on the side of the national and local Indian governments, but also wariness was present on the side of the RF. Kavadi explains how the RF was concerned about the centralizing tendencies of the Ministry of Health and GoI.

Taking into consideration the difficulties Adranvala had with the GoI and RF individually and the challenges the RF and GoI had with each other due to their mistrust and differing interests, how did Adranvala fit in this framework as the intermediary between the GoI and the RF officials? Working with two different opposing interests, Adranvala had to play the role of a mediator who had to find a compromise on which everyone could agree. This can be seen through the discussion around Miss Craig as her contract to work in India was going to end in 1951. Through the letter correspondences between Adranvala, Tennant and Robert Briggs Watson, there was considerable

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64 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Anna Mary Noll on January 3, 1951.
discussion over whether or not Miss Craig’s contract should be extended and whether she
should continue her position as the principal of the College of Nursing in New Delhi,
India. Rockefeller officials clearly were not in support of Miss Craig staying in India.
Watson, who was a physician who had specialty in malaria research and public health
administration and he also served as a member of the International Health Division of the
Foundation from 1942-1966, stated the College would “suffer if she [continued] further
association with it.”

Not only did majority of the RF officers dislike Miss Craig, but also Indian
officials like Dr. Raja and Adranvala “felt considerable concern about Miss Craig
continuing as principal.” The reason why RF officials and Adranvala were not in favor
about Miss Craig staying in India was because of Craig’s difficult personality. In
Watson’s letter in 1951, he mentioned how Adranvala was having difficulty in recruiting
Indian nurses as “they simply [would not] work under Miss Craig.” As a result, RF
officials did not want the College of Nursing in New Delhi to suffer because of Miss
Craig and they thought it was best for Miss Craig to leave the College. However, much
to the dismay of RF officials like Watson, Miss Craig did not leave her position in the
College of Nursing as the “GoI [...] agreed to [extend] Miss Craig’s contract for another
five years.” If the RF officials and Adranvala did not want Miss Craig to stay in India,
why was it decided that Miss Craig should stay in India?

66 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Betty from Robert Briggs
Watson on April 4, 1951.
67 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Betty from Robert Briggs
Watson on January 30, 1951.
68 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Betty from Robert Briggs
Watson on January 30, 1951.
69 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss
Adranvala on May 2, 1951.
The extension of Miss Craig’s contract depicts how discontentment and tensions arose between Indian and American nursing leaders as a result of their differing interests and beliefs. Watson was surprised by the decision to renew Miss Craig’s contract. Whenever Watson had discussions with Dr. Raja and Anne Marie Noll, they always talked “in terms of whether Miss [Craig’s] contract would be discontinued or continued for a period of not more than 2 years.” Watson wrote to Adranvala that “we [the foundation] are always willing to review a decision taken.” This very statement showed how Watson was not content with the decision made and was indirectly trying to persuade Adranvala and the Indian Government to reconsider their decision. Just as Adranvala tried to exert greater authority over the RF officials, the converse was also true. When RF official’s decisions were not approved of, they tried to make Indian nursing leaders reconsider decisions they made.

Although Adranvala was limited by the external higher power structures which worked against her, she made the effort to work with them and negotiate between the conflicting power dynamics between the RF and GoI. Despite Adranvala’s misgivings about Miss Craig, Watson mentioned how “Miss Adranvala [had] refused to consider the post.” It is not clear why Adranvala would not consider another individual for the post when the Rockefeller officials, Dr. Raja and she herself did not approve of Miss Craig. Since the GoI agreed to the proposal to renew Miss Craig’s contract, it is not clear

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whether Adranvala pushed the GoI to extend Miss Craig’s contract or whether the GoI persuaded Adranvala to accept Miss Craig’s contract.

However Adranvala’s letter to Miss Tennant provide some clues as to why the decision was made to keep Miss Craig. When the GoI decided to renew Miss Craig’s contract for five years, Adranvala explained the decision to Miss Craig as follows: “There was no question in our minds that for the development of certain aspects of the College, […] we need Miss Craig.”

Although it is hard to understand who Adranvala was referring to in the terms “our” and “we,” it is assumed that Adranvala positioned herself on the side of the GoI and nursing leaders. By highlighting how Miss Craig’s services were useful to the College of Nursing in New Delhi, Adranvala and the GoI recognized the importance of keeping Miss Craig. Adranvala knew Miss Craig made great contributions and chose to judge Miss Craig based off her contributions and capabilities, not her personality. In addition, Adranvala explained how extending Miss Craig’s contract for five years would provide enough time for an Indian nurse to assume the position of the Vice-Principal. This depicts how Adranvala wanted Indian nurses to assume senior leadership roles. By accepting the extension of Miss Craig’s contract, not only was Adranvala providing Indian nurses more time to develop their leadership skills, but more importantly, she was working with the GoI and Indian nursing leaders to come up with the best solution to improve the quality of the College of Nursing in Delhi.

Although Adranvala obtained financial support from the GoI, she could not lose the support of RF officials. Not only did RF officials have higher authority in terms of

74 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on May 5, 1951.
75 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on May 5, 1951.
providing Indian nurses with fellowships to study overseas, but also, they also had the power to decide how they wanted to allocate resources. In a letter to Tennant, Miss Noll wanted information about how much Miss Craig wanted “to spend at the College.” In addition to the necessity of obtaining rhetorical and financial support from the GoI, it was equally important for Adranvala to also have the support of RF officials so she could continue her goal of professionalizing Indian nurses. Therefore, Adranvala ended up playing the role of the mediator who tried to settle for a middle ground. Not only did she attempt to work with the GoI, but also, Adranvala worked with Rockefeller officials to fulfill their interests and desires. In Watson’s letter to Adranvala, he expressed how he and RF officials were “agreeable to [Adranvala’s] suggestion that the situation at the College be reviewed at the end of the year.” Since Adranvala knew that the RF officials did not like Miss Craig and would be upset with the decision to keep Miss Craig, Adranvala placated Watson by providing him the chance to relook and possibly change the decision.

Despite all the political constraints which stood against Adranvala, her ability to leverage and negotiate between the GoI’s and RF’s differing interests should be applauded. Since the RF and GoI held higher authority over Adranvala, it certainly was not easy to work and collaborate with them. However, because Adranvala was able to assert her own opinion and still negotiate between what the RF and GoI wanted, this depicted how Adranvala had a great deal of leverage which not many Indian nurses had.

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76 RF Record Group 62, Series 464 1948, Box 423, Folder 2852. Letter Excerpt from Miss Noll to Miss Tennant on May 14, 1948.
77 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Adranvala from Watson on June 5, 1951.
Her expertise and her training overseas in modern nursing created conditions of possibility, which allowed her to attain such a position of power.

While Adranvala played a complex political role of the mediator who tried to assert her own opinion as well as negotiate between two existing powers, it is important to pay attention to the effect she had through her decision. As a result of trying to assert her power by negotiating between the RF and GoI, Adranvala found herself fighting against a lost battle, as ultimately, she could not please the RF. With the decision made to renew Miss Craig’s contract, although Adranvala was able to keep the GoI happy, she was not able to keep the RF happy. Instead, she made Rockefeller officials upset, especially Watson. Although to Adranvala, Watson calmly wrote that the Foundation was willing to review the decision to extend Miss Craig’s contract, in a private letter to Betty, he displayed his real feelings. Not only did Watson write how he disagreed with Adranvala’s positivity regarding Miss Craig’s contract renewal, but also, he expressed his anger as he wrote the Foundation “should confine our help to the College to fellowships.”

Although Adranvala wanted to appease Watson, her decision ended up backfiring on Adranvala as he became upset and decided to confine RF’s assistance just to nursing fellowships. In an example above where I explained how Adranvala used her authority to push the RF to provide fellowships for nurses in Kerala, it showed how Adranvala wanted nurses to receive fellowships so they could study abroad. Since the RF provided monetary assistance to sponsor Indian nurses for overseas education, Adranvala was very dependent upon the RF for fellowship support. In addition to sponsoring overseas

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78 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Adranvala from Watson on June 5, 1951.
nursing education in the United States, the RF provided “expert assistance to the Colleges of Nursing in New Delhi and Vellore.” Thus, not only was Adranvala dependent upon RF for financial support but she also needed their support to provide foreign nurses who could assist Adranvala in developing Indian nursing universities and programs. In an example above, I discussed how Adranvala was not in favor of continuing a B.Sc. program in Lucknow because of the GoI’s lack of support. If the BSc program did develop, Arnold noted in her diary that Adranvala asked if the RF could send staff from America to help develop the nursing program. In addition to being dependent upon the RF to provide foreign nurses, this example also depicts how Adranvala was dependent upon the RF if the GoI did not provide the support she needed. Thus, it was crucial for Adranvala to have larger support from the RF.

However by supporting the GoI’s decision to keep Miss Craig, Watson limited the type of assistance Adranvala could receive for the College of Nursing in Delhi to fellowships. If Adranvala needed assistance in developing the nursing staff in the College of Nursing in Delhi, she would not be able to request for foreign nursing staff to come to the College of Nursing. As a result of trying to obtain a compromise and please both the GoI and RF, Adranvala was denied additional RF assistance. Miss Craig’s incident sheds light onto how difficult it was for the first generation of nursing leaders in India to work with the power structure around them. Despite being constrained, Adranvala did her best to negotiate the two power dynamics; however in order to pacify and achieve harmony between the GoI and RF, Adranvala ended up having to lose the support of RF.

Conclusion

The nursing field, which Adranvala occupied from 1947-1966, created a complex tensed political atmosphere for Adranvala, the elite Indian nursing leader. The fact that doctors, Indian GoI, the RF officials had higher power over Adranvala, helps explain why the elite Indian nursing leaders had only substantial control over the direction of the nursing profession till the mid 60’s. Not only did they have higher authority over Adranvala, but also, they all had different goals about the nursing profession, which made it difficult for Adranvala to collaborate with all. Despite being constrained in terms of authority, the tensions made it possible for Adranvala to push forward her decisions, buy more time for Indian nurses to develop and negotiate between the two larger power dynamics, the GoI and RF. Although Adranvala tried to work with each of them and negotiate between the GoI and RF, Adranvala ended up battling against a losing game as she took decisions where she could not satisfy the RF. Thus, not only did all of these political forces place Adranvala in a limited power framework, but more importantly, they made it limited Adranvala’s effectiveness. In the process of negotiating between the GoI and RF, she could not keep both happy and ended up losing support from the RF.
Chapter 4: Adranvala, the Conflicted Modern Indian Nurse

If Adranvala’s relationships with the doctors, GoI, and RF officials were tensed, Adranvala’s own personal life was equally problematic. Adranvala who was educated in Britain, developed an understanding of how the modern nurse should be. While trying to impose these values upon Indian nurses, she also tried to work within the Indian context. However, Adranvala’s ideas of nursing made her conflicted. On the one hand, Adranvala’s idea of the modern Indian nurse enabled her to retain a position of power and develop nursing programs and nursing universities. However, as much as Adranvala’s understanding of the modern Indian nurse allowed her to push forth the professionalizing nursing culture in India, it also served as her “blind spot”. As a result of Adranvala clinging on to a modern identity, she could not separate herself from her Western thinking and ended up creating class differences as she could not connect with her lower-class Indian nurses. In addition, Adranvala’s decisions to promote the educated Indian nurse created unintended consequences which reproduced colonial racial nursing hierarchies and created an Indian nurse who was dissatisfied with the working conditions in India. As a result, Adranvala’s vision of a professional and selfless Indian nurse could not sustain itself for the next generation.

What were Adranvala’s views about how she wanted to shape the nursing profession? From Chapter 2, I displayed how Adranvala advocated for the Indian nurse to represent the ethos of professionalism, modernity, selfless service, global sisterhood and respectability. Since Adranvala reproduced much from the colonial construction of the modern nurse, it is clear that Adranvala wanted Indian nurses to have the same qualifications that the modern, Western nurse had. In her letter she wrote to Miss
Tennant in 1951, Adranvala explained that the situation of renewing Miss Craig’s contract would not have occurred if there would have been more nurses on the staff whose qualifications and experience matched those of Miss Craig’s.¹ Not only did Adranvala want to develop the Indian nurse to have the same professional experience a Western nurse had, but she also wanted to focus on furthering the link between nursing education and nursing service and developing public health nursing in India.² Adranvala was a firm supporter of developing public health nursing in India and she wanted it to develop from scratch. In her letter to Tennant, Adranvala expressed her discontentment with the way the nursing profession had been set up in India. Adranvala states that if more Indian nurses had matched Miss Craig’s qualifications, the Indian nursing profession could have started with a “more democratic set up” which would have made the elite Indian nursing leaders ready to replace the foreign nurses with Indian nurses.”³ What Adranvala referred to when she used the term ‘democratic’ is not known; however this hinted that Adranvala wanted to change the way Indian nurses were recruited.

Although Adranvala had her own thoughts about she wanted to develop the nursing profession, it is important to ask whether or not she was aware of the conditions of the local environment in which she wanted to implement her thoughts in. For a leader to successfully implement changes, it is important for a leader to have local support and deal with resistance to change. Healey believes Adranvala had a “realistic awareness of basic needs at the hospital level.”⁴ Despite all the efforts the nursing leaders made to institutionalize and professionalize Indian nursing, Adranvala was aware that the nursing

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¹ RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on May 5, 1951.
³ RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on May 5, 1951.
profession was not developed as a respectable profession. Healey explains how in 1953, Adranvala wrote that the standard of nursing education in India was low. It was nursing students’ not full-trained nursing staff who provided 75% of the care to patients in hospitals. In addition the state gave more priority to hospitals demands than to nurse training. Whereas Adranvala favored quality education and did not want Indian nurses to be exploited, she recognized that public hospitals were misusing Indian nurses under the apprenticeship program. For the hospitals, nursing students were seen as cheap labor. By hiring nursing students, local hospitals would not need to hire full-time staff. As a result, Adranvala was not in favor of the apprenticeship system; not only did she feel that Indian nurses were not offered the opportunity to apply what they learned to the actual “problems of ill health,” but more importantly, she acknowledged how hospitals “[relied] on students for service.” In addition, in her private letter to Miss Tennant in 1951, Adranvala admitted her fear of “whether [they] were any nearer to the development of better nursing in [India].” Adranvala explained how there were “existing practices, beliefs, so much narrow thinking and poor material to contend with” in India. Adranvala acknowledged the ongoing stigmatization of nursing as a low-status profession and accepted how it was negatively affecting the nursing profession.

Not only did this depict how the elite Indian nursing leaders, like British colonial nurses, continued to struggle against the low status image of nursing, but more importantly, it depicted tensions between Adranvala’s public printed views and her private doubts. In the articles she wrote for the NJI, Adranvala constantly emphasized

7 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on September 9, 1951.
how the image of nurses was improving. However the fact in her private letters, it is very clear that there were more difficulties in developing the nursing profession than there were positive developments. Since Adranvala was trying to portray how nursing was beginning to be accepted in a positive light to the public, this showed how Adranvala had to portray a certain image to the public, even if she had to contradict reality and paint a false, glorified picture. The conflict between her private/public life not only reveals the complexity of the nursing profession in India, but also, it hints towards Adranvala’s complexity as a nursing leader.

When deciding who should take senior nursing leadership positions, Adranvala consistently seemed to display a preference for foreign nurses, rather than Indian nurses. In her letter to Miss Noll, Adranvala mentioned the need for two nursing teachers at the College of Nursing for 1948: one for Nursing education and one for Public Health. However what was interesting was the fact that although the GoI sanctioned the posts, Adranvala recommended a white nurse, Miss Heinly, for one of the posts. In the letter Adranvala expressed how she had no doubt they would “have to recruit from abroad” as there were “no Indian nurses who [could] fill these posts.” The fact about few Indian nurses being available might seem plausible given the context that the first “B.Sc course in Nursing was introduced in 1946 in India.” Since this letter was written in 1948, which was only two years after the first B.Sc. course was introduced in India, it is understandable that there may not have been enough qualified Indian nurses available. In

8 RF Record Group 62, Series 464 1948, Box 423, Folder 2852. Letter to Miss Tennant from Miss Adranvala on October 27, 1948.
9 RF Record Group 62, Series 464 1948, Box 423, Folder 2852. Letter to Miss Tennant from Miss Adranvala on November 3, 1948.
another letter written to Miss Tennant, Adranvala expressed her concern over the staff of the College of Nursing, deeming it as “pressing.”

In her letter to Miss Tennant in 1951, as a result of obtaining three nurses from New Zealand, Adranvala described the present situation of the nursing staff as satisfactory. However when describing how the nursing leaders in India “will be in difficulty again” once these nurses from New Zealand left India, it seemed as if Adranvala felt that India could not function without foreign nurses. Virginia Arnold notes that Miss Adranvala asked the Foundation to send staff as Adranvala felt “India could not produce qualified staff.” I found this to be troublesome as Adranvala’s statement implied that she had more faith in the talent and ability of foreign nurses, not Indian nurses. An interesting contrast is displayed in Miss Tennant’s reply to Adranvala. Whereas Tennant suggested an American nurse, Miss Buchanan to take the position since Adranvala did not think an Indian nurse was ready, she did speak highly of Indian nurses, Miss Desai and Miss Joseph. Whereas Miss Tennant showed support for Indian nurses, Adranvala did not. In the examples provided above, Adranvala seemed to prefer hiring Western nurses over Indian nurses.

However should this be enough to make the conclusion that Adranvala did not provide Indian nurses with any advantages? On the one hand, Adranvala showed preference for hiring foreign nurses in senior leadership positions as Indian nursing

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11 RF Record Group 62, Series 464 1948, Box 423, Folder 2852. Letter to Miss Tennant from Miss Adranvala on November 3, 1948.
12 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on September 9, 1951.
14 RF Record Group 62, Series 464 1948, Box 423, Folder 2852. Letter to Miss Tennant from Miss Adranvala on November 3, 1948.
15 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Adranvala from Miss Tennant on March 27, 1951.
universities; on the other end, she devoted her life to supporting the advancement of Indian nurses. As stated in Chapter 3, Adranvala supported Indian nurses obtaining fellowships so they could receive training abroad. Adranvala also wanted Indian nurses to take senior administrative and leadership positions. In 1951, when expressing her desire to have more Indian nurses who meet Miss Craig’s qualifications when the College of Nursing in New Delhi was established, Adranvala states that Indian nurses “could have started to replace” foreign nurses in their leadership positions.16 This showed how Adranvala did want Indian nurses to eventually take leadership positions.

In Adranvala’s letters, she discussed a couple of Indian nurses who seemed qualified for senior nursing leader positions in the nursing colleges that were established in India. In a 1948 letter to Miss Tennant describing the need for foreign nurses, Adranvala did acknowledge how Miss Abana, an Indian nurse was qualified. Miss Abana was the Senior Sister Tutor at the College.17 She explained that except for Miss Abana, “none of the Indian staff [has] worked more than a year at the College.”18 Adranvala wanted nurses who were qualified and from this statement, it seems as her definition of a nurse being qualified to teach at the College of Nursing was a nurse who worked for more than a year at the College. This is understandable as one would obviously want a nurse with experience; since Miss Abana had more than a year’s worth of experience, Adranvala saw her as a suitable candidate. In addition, by mentioning that

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16 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on May 5, 1951.
18 RF Record Group 62, Series 464 1948, Box 423, Folder 2852. Letter to Miss Tennant from Miss Adranvala on November 3, 1948.
Miss Uthaya, was considered as a candidate of the Indian Labor Ministry, shows how Adranvala did consider some Indian nurses to be suitable for leadership positions.\(^{19}\)

Even when Adranvala asked for foreign nurses to take senior positions in India, this could be seen as her way of providing assistance to Indian nurses within the Indian context. She felt that foreign nurses would be able to assist Indian nurses in developing “their capacities and [assuming] responsibility.”\(^ {20}\) By asking for foreign nurses to come to India on behalf of the Foundation and WHO, Adranvala believed Indian nurses could learn from them the skills needed to take on higher positions and thus, she made a decision which she thought would help Indian nurses prepare for senior administrative and leadership nursing positions. She was doing the best she could to work with international framework to provide the best for Indian nurses within the Indian context.

However, the question now arises that if she thought Indian nurses were suitable, why did not she recommend them? Adranvala’s decision can partly be explained by the migration of Indian nurses to various urban cities. In the 1948 letter where Adranvala referenced Miss Abana, she stated, “[These] frequent changes are doing the course no good.” Reflecting upon Adranvala’s following statement, “none of the Indian staff [has] worked more than a year at the College” helps in understanding what Adranvala referred to as “these frequent changes.”\(^ {21}\) Thus, the “frequent changes” implies that Indian nurses were not staying in position for too long; they continuously shifted from position to position, which at times, even required them to relocate to a different city. In Adranvala’s letter to Miss Tennant in 1951, she described how only two college

\(^{19}\) RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on September 9, 1951.
\(^{20}\) RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on May 5, 1951.
\(^{21}\) RF Record Group 62, Series 464 1948, Box 423, Folder 2852. Letter to Miss Tennant from Miss Adranvala on November 3, 1948.
graduates came back to work in Bombay in the areas they specialized in. Two other nurses moved to the Tuberculosis Clinic in New Delhi to work under the WHO nurse Miss Hudson. Adranvala even stated how another Indian nurse moved to Delhi as she was appointed as a Public Health nurse was going to assist a WHO nurse. Indian nurses were moving out of Bombay to other urban cities for better career opportunities. Not only did this signal the migration movement of nurses within India which would soon lead to the emigration of nurses moving abroad for better pay and career opportunities, but more importantly, it also explains why there was a lack of Indian staff being available to appoint for further leadership positions.

Whereas Healey argues that the elite Indian nursing leaders “did not seek to include Indian nurses on equal terms,” I would like to argue that Adranvala did care about preparing them for senior leadership positions and did attempt to work within the Indian context. Taken into perspective the development of nursing degree programs for Indian nurses, Adranvala felt that Indian nurses needed more time to develop the expertise needed to obtain senior leadership positions. Adranvala worked around the Indian nurses’ lack of leadership skills by providing them with more time to develop. When explaining the decision to renew Miss Craig’s contract for five years, the fact that she mentions why a period of five years was suggested is very crucial. Adranvala felt that five years was a reasonable time period to find and prepare an Indian nurse to take up the position of the Vice-Principal of the College of Nursing in Delhi. This suggests that Adranvala was willing to provide Indian nurses with a longer time to gain the necessary

22 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on September 9, 1951.
24 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on May 5, 1951.
experience. Thus her preference of hiring foreign nurses can be seen as Adranvala buying more time for Indian nurses to develop and grow.

Although Adranvala’s efforts to work around the Indian context may have seemed like Adranvala’s strategy to provide them with enough time to develop into the modern nurse, her actions were indeed complex. Considering the examples provided above were from letters Adranvala wrote between 1948-1951, the fact that in 1961, Adranvala planned to ask the RF for a U.S. nurse to serve as the Director of the nursing program at AIIMS, indicates her continuing reliance on Western nurses for support.25

Although Adranvala supported Indian nurses receiving further education and being promoted into senior nursing leadership positions, when she had the chance to promote Indian nurses such as Miss Abana and Miss Uthaya, she did not do so. While Adranvala was limited by the migration of Indian nurses, she did try to give Indian nurses more time to develop their leadership skills. In effort to prepare Indian nurses so they could develop the experience needed to assume senior leadership roles, Adranvala chose to bring in foreign American nurses and post them in senior Indian nursing leadership positions at universities. I am not arguing that Adranvala was racist; instead, I am displaying how difficult it was for Adranvala to work within the complex nursing framework she had inherited from colonial officials. She wanted Indian nurses to develop their leadership skills; however in order to give them more time, Adranvala also had to post nurses in new senior leadership positions that were being created with the development of Indian colleges. Thus, by bringing in American and other foreign nurses to India and granting them the senior leadership positions, Adranvala’s decision ended up

replicating the colonial racist nursing hierarchy where a foreign nurse held a higher position of authority over an Indian nurse.

The difficulty in determining why Adranvala did not promote Indian nurses into leadership positions can be explained by Adranvala’s internal complexity regarding her identity. In her application to the Rockefeller Center, despite the fact that although she identified her race as “Indian (Parsi)” and citizenship as “Poona” (which is a city in India), she wrote down her nationality as “British.” Why would an Indian nurse write her nationality as British? If she connected very well with the European culture, especially that of the British, why did not she work as a nurse in Great Britain? Why did she choose to work in India if she did not consider her nationality as an Indian? The fact that she chose to work in India, with the Indian government reflected how she wanted to help develop the nursing profession in India. However Adranvala’s confusion between identifying herself as British as well as identifying herself within her Indian Parsi community depicted Adranvala’s crisis in trying to create her own identity.

It is not known whether other Indian elite nursing leaders who were also educated abroad positioned themselves in the same way that Adranvala did. However, this was certainly not an uncommon characteristic amongst Indians who had been educated overseas. For example, Nehru, who had been educated in England and imbibed English gentlemen values, viewed himself “more as an Englishman than an Indian.” Similarly, Adranvala, was an Indian but because since she was educated in Britain, her views of nursing aligned with the British model of nursing. Adranvala’s identity as a Parsi also

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26 RF RG 10.1 Series 464L Box 292 Folder 4560. Fellowship File for Adranvala’s Application for Travel Grant on April 27, 1947.
provides insight into why she might have this certain progressive ideology. The Parsi community has been seen as more modern than the Hindu and Muslim Community; as historian Forbes explains, the Parsi Community, along with the Christian community, accepted and advocated for the “presence of respectable women in public spaces.”

Because Adranvala wanted to align herself identify herself as a modern Indian nurse, she tried to present herself as a nurse with a modern identity. By acknowledging the superiority of Western medicine, Forbes asserts that Indian women who had been trained in Western medicine, were trying to portray themselves as more progressive and establish their own identity by “sorting out which aspects of tradition they wished to retain and which they wished to cast off.” Through her clothing, Adranvala presented herself as progressive, thus carving her own identity. Creelman, who had worked closely with “this outstanding British-trained Indian nurse and chief nursing officer during the second expert committee on nursing,” found it strange to “see Adranvala in a Western suit.” Scholar Armstrong concludes that “perhaps Creelman underestimated the pressure Adranvala felt to gain acceptance as a modern woman within the medical community.”

In addition to wearing a Western suit, in the NJI article, “Nursing in India: 1908-1960,” there is a picture of Adranvala wearing a saree, a traditional Indian garment, but with a sleeveless blouse. Since Adranvala was one of the elite women in India, she had certain privileges, which middle-class Indian women did not have, and one was her ability to decide which type of clothing to wear. On occasion, by wearing Western suits and a modern version of the Indian saree, which was a style more common among the

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29 Forbes, Managing Midwifery in India, pp. 163.
upper class in India, Adranvala may have been rejecting certain aspects of her Indian identity however her clothing depicted how she was clinging on to the identity of a modern Indian nurse. In addition, the fact that Adranvala remained single her entire life reveals how Adranvala had embraced the concept of a nurse selflessly devoting her life towards the nursing profession.32 Thus, since Adranvala’s portrayal of herself as an Indian nurse who was fully “modernized” in a British/American sense aligned with the professional and modern ideals an Indian nurse was supposed to embody, Adranvala held onto nursing ideals which were completely detached from the indigenous model of caregiving.

However, as a result of clinging onto her vision of the modern Indian nurse being professionalized, Adranvala could not “[divorce] herself from all [Western] trappings.”33 Although Adranvala promoted Indian nurses to be educated, she also could not remove her bias against nurses who did not follow the characteristics Adranvala thought the Indian nurse should have. As a result of obtaining education in Britain, Adranvala had developed an understanding that nurses were to adopt and abide by modern Western nursing standards. In a personal letter to Miss Tennant on March 15, 1951, Adranvala discussed her hesitancy regarding Miss Shroff, who wanted to be posted as a teacher in the College of Nursing in Delhi. Adranvala cited an incident when Miss Shroff, had applied for a scholarship to one the deputies of Mr. Raja and wrote the letter in a careless manner with words crossed out and words jammed in. Even though Adranvala admitted that “such matters are not considered so important today,” it shocked her “old-fashioned

32 RG 10.1 Series 464L Box 292 Folder 4560. Fellowship File for Adranvala’s Application for Travel Grant on April 27, 1947.

33 Merrill, Dennis. *Bread and the Ballot, the United States and India’s Economic Development, 1947-1963*, pp. 16.
sense of propriety that a girl applying to the Central Government for a scholarship” did not rewrite the letter in a neat way.\footnote{RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on March 16, 1951.} This depicts how Adranvala had acquired a Western sense of propriety, deeming poor command over English as improper. When explaining this incident to Tennant, Adranvala hopes that Tennant did not think this instance “prejudice[d] [Adranvala] against Miss Shroff.”\footnote{RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on March 16, 1951.} By using the word “prejudice,” it seems like Adranvala may have harbored a bias against Shroff because Shroff did not display the proper command over English that Adranvala thought a Western Indian trained nurse should have.

Adranvala wanted the modern Indian nurse to be educated, have a sense of propriety, be single, and devoted to the nursing profession. Adranvala’s idea of the modern Indian nurse, which she heavily promoted from 1947-1966, allowed her to develop nursing programs and modernize the history of Indian nursing. Although this type of modern Indian nurse may have coincided and aligned with Adranvala’s own nursing training, it did not align with Indian lower and middle-class nurses. When Adranvala is no longer in power in the 1970’s, the attitudes portrayed by Indian nurses in the 1970’s and 1980’s depicted how Indian nurses from the newer generation advocated a different idea of the modern Indian nurse from what Adranvala had promoted.

When there was strike by Indian nurses in the 70’s in Delhi, who were protesting against unsatisfactory working conditions, Adranvala deemed their behavior as “unethical” and “undignified behavior” as they had neglected caring for their patients.\footnote{Adranvala, Tehmina K. “Professional Behavior: Some Aspects of Nursing Practice ”, pg. 357.} Although Adranvala acknowledged the concerns of the nurses and wrote that they “[had]
many legitimate grievances,” it distressed her that the concerns nurses raised were for themselves, and not for better services for the sick “such as, sufficient linen, better laundering, a clean environment, adequate means to maintain asepsis, [and] proper service of food.” This was not a view that was just limited to Adranvala, in fact other Indian elite nursing officials expressed their disappointment with the nurses going on a strike. In another article about the strike, nurses V.B. Purohit, S.G. Nitsure and A. Gunian did not deem it proper for Indian nurses “to give any support which would result in the neglect of” providing care to their patients. This depicted how Adranvala and other elite nursing leaders were more concerned about nurses promoting cleanliness and hygiene, rather than listening to the demands of the lower and middle class Indian nurses.

Because Adranvala was from the upper-class and was so focused on promoting a professional nursing culture where nurses had to selflessly care for their patients, Adranvala could not focus on the local issues that concerned these lower and middle-class nurses. As a result, Adranvala’s inability to break away from her ideologies of a Western nurse adversely affected her leadership as she could not establish a cordial professional relationship with other middle-class Indian nurses. Adranvala was so focused on pushing forward her definition of the modern Indian nurse that she was out of touch with what the local Indian nurses wanted and she could not understand their concerns. Since Adranvala did not take into account the changing beliefs about the modern Indian nurse, Adranvala ended up created barriers between the lower and middle-class Indian nurses and elite Indian nursing leaders.

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As a result of being so far removed and refusing to give important to the working conditions of the hospitals in which these nurses worked in, Adranvala’s western beliefs put her at odds with the working class of Indian nurses. Whereas Adranvala supported the idea of nurses tending towards the personal needs of patients and working outside of the hospital, Indian nurses seemed to have a different idea altogether. Elda M. Barry, who was the Director of the Schools of Nursing at Vrindaban, also expressed the same belief as Adranvala that Indian nurses should personally tend towards each of their patient’s needs. She wrote an article in the NJI where she expressed her dismay with Indian nurses. Barry was appalled that in the hospitals, “enemas were given [to patients] by sweepers,” not nurses. Clearly upset about Indian nurses being reluctant to provide personal care for patients, Barry claimed “why cannot we dignify all tasks that are necessary in caring for the human body in illness.” The fact that Indian nurses were not personally tending towards the needs of their patients depicted how Indian nurses were still reluctant to engage in ‘polluting work,’ and wanted to distance themselves from such work. This showed how caste and stigmatization issues still existed in India. The Indian nurses who worked at hospitals did not want to follow Adranvala’s vision of the caring professionalized nurse. Thus, Adranvala’s support for the more educated and respectable nurse put her at odds with Indian nurses.

Due to her focus on developing professionalized, caring nurses, Adranvala could not make a separation between the professional lives of nurses versus their personal lives. During the 1970’s, the feminist labor movement of the late 70’s made demands for

consumer protection and better working conditions.\textsuperscript{40} The demands of these 1970 nurses for better working conditions aligned with the labor movement. Majority of the elite Indian nursing leaders of the 50’s and 60’s, such as Adranvala, remained single as they followed the modern nursing ideal of the nurse remaining truly devoted to her profession. Since the older generation of nursing leaders like Adranvala were single, they “experienced trouble recognizing and acknowledging the constraints” of married nurses who were tied to their husband, family and home.\textsuperscript{41} As anthropologist Somjee explains, there was a generation gap between the older and younger generation of nurses; whereas the older generation of nurses had the view that nurses could not do “what married women without careers could do,” the newer generation of nurses “saw themselves as the centre of their family […] rather than one who was totally subsumed in the profession.”\textsuperscript{42}

In the \textit{NJI}, Miss P. Arora stated that “the modern Indian nurse [gave] priority for the family over the job,” referring to the younger generations of Indian nurses of the 70’s and 80’s.\textsuperscript{43} Clearly, this did not go well with Indian nursing leaders as they did not understand why Indian nurses gave more priority to their family. Miss Arora’s frustration with the demands of the younger generation of nurses represented how it was difficult for the older generation of leaders like Adranvala to empathize with the younger generation of nurses and understand their perspective of maintaining a distinction between a nurse’s private and personal life.

It is important to realize that the context with which Adranvala was working with was difficult. When deciding where Miss Shroff could obtain training Adranvala

\textsuperscript{42} Somjee, Geeta. “Social Change in the Nursing Profession”, pp. 46.
\textsuperscript{43} Arora, Miss P. “Perspectives on Indian Nursing”, pp. 223.
suggests that Miss Shroff can get midwifery training in Bombay. However Adranvala mentions that the “conditions of training in Bombay are very far from what we desire.” Adranvala’s statement suggests how nursing training programs in India were still underdeveloped and had problems. Since nursing training programs were not developed in India, Adranvala’s promotion of nursing fellowships could be seen as Adranvala attempting to provide Indian nurses with better training opportunities. This reveals the complexity of the nursing infrastructure Adranvala had to deal with - although Indian nurses were being educated, the quality of training programs in India were still not well developed. Adranvala’s intentions were clearly well-intended as she wanted to provide Indian nurses with opportunities to obtain nursing training overseas.

Although her decision enabled Indian nurses to become more educated, her choices created unintended consequences. While discussing Miss Shroff’s travel grant, Noll suggests that Shroff should use her travel grant to study in India, explaining how it will make “her transition from western standards of nursing to what she will find here” in India, easier. By mentioning how Miss Shroff could assimilate to the Indian context better if she studied there, Noll implies how Western Indian trained nurses were having difficulty working in India once they came back from overseas. When these Western trained Indian nurses returned back to India, they encountered programs like the underdeveloped training facilities which made it difficult for them to transition and adjust to the Indian context.

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44 RF Record Group 62, Series 464 1951, Box 540, Folder 3611. Letter to Miss Tennant from Miss Adranvala on March 10, 1951.

Training nurses abroad could succeed only if these newly trained nurses “had sufficient local support” and “had sufficient ability to adapt their efforts to the local situation on their return.” As stated in Chapter 3, RF nursing officials believed in providing fellowships to Indian nurses so they could obtain both undergraduate and postgraduate nursing education. RF officials believed that once these educated Indian nurses returned to India, they “would be able to make a real contribution” as they will be able to apply what they learned in India and develop modern nursing colleges and hospitals where nurses could work. However as the years followed, it seemed as if the Foundation officers started to question the benefit of foreign fellowships. Kavadi provides insight into how RF official, R.K. Anderson, who was the Regional Director for the Foundation in Delhi, noticed that the nursing fellowship program was not as successful as they wanted. Anderson noted that nurses who came back to India after pursuing a RF fellowship, aroused antagonism from the indigenous population. After studying abroad in America, Indian nurses felt a new sense of authority and enthusiastically enforced the American model of nursing in India, which was disliked by the local indigenous population. The Indian nurses enforced “their American type of nursing into effect more rapidly than local conditions [permitted].” Since, these nurses were so caught up in the mindset of imposing their own strategies, they could not see the effect it had on the indigenous population. Because the Indian trained nurses could not effectively apply their knowledge to the Indian context, these Western Indian trained nurses could not connect with the indigenous population and they created an environment.

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48 Ibid, pp. 133.
49 Ibid, pp. 133.
of distrust which made it difficult for them to work with the local population. As a result of Adranvala’s zeal to professionalize Indian nurses, not only did this further distance her from the real problems local middle-class nurses faced, but more importantly, the decisions she made ended up creating a Western Indian trained nurse who had difficulties adjusting to the Indian nursing working context.

In addition, Adranvala’s decision towards professionalizing nurses and providing them with fellowships places her in a complicated situation where Western Indian trained nurses want to work in urban cities where they have better facilities and opportunities for them to advance their career. Adranvala discusses how nursing leaders feared that after being educated, Indian nurses would be geared away from the nursing profession towards a career in administration. However Adranvala did not harbor such a fear. In fact, she believed that through education, there will be a “greater understanding of the factors that contribute to health and disease”, and with “nurses [seeing] more meaning in their work, […] the end result will be good nursing.”50 Thus, as a result of obtaining higher education, Adranvala thought that nurses would find appreciate their work as nurses and would follow Adranvala’s footsteps in changing the perception of nursing in India.

Adranvala’s belief that in “good nursing” served as her blind spot as she did make the proper judgement that good nursing for Indian educated nurses meant working in urban cities where they could had better facilities and could advance in their career. As a result of promoting “good nursing,” Adranvala could not prevent nurses from moving to urban cities. Since Adranvala mentioned how it was initially difficult to find nurses to work in villages as they displayed “reluctance and resistance,” this depicted how as a

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result of higher education, Indian nurses wanted to work in urban cities where they could receive better pay.

Not only did higher education further propel the elite notion that associated ‘respectable’ nursing with urban locations, but it also started the trend of nurses moving out for further opportunities.51 Earlier, in this chapter, I mentioned how Indian nurses were moving out of Bombay for better opportunities. Not only were Indian nurses moving to urban cities for better opportunities, but also, they did not want to return to the institutional life. In 1951, Adranvala had displayed her concern how “none of the Indian staff [had] worked more than a year at the College” of Nursing in New Delhi.52 Because Adranvala was concerned with the fewer number of Indian nurses staying at the College of Nursing for at least a year, this showed how Adranvala wanted Indian nurses who could assist with running institutional schools.

However, instead of wanting to work in universities, trained Indian nurses wanted to work in public hospitals. In 1968, in the NJI, an article was written about graduate nurses in India which depicted employment patterns amongst Indian nurses. It reported that “more than half of the nursing” bachelor and masters graduates were “employed in hospitals.” Approximately a quarter were working in College of Nursing. Even though “one-half” were involved in “teaching-cum-administration,” the fact that most nurses chose to work in a hospital over a university showed how they were dissatisfied with the institutional life at Indian nursing colleges.53 Kavadi explains how Indian medical and nursing students who returned from training abroad, were mainly concerned about the

52 RF Record Group 62, Series 464 1948, Box 423, Folder 2852. Letter to Miss Tennant from Miss Adranvala on November 3, 1948.
opportunity to work and have access “to facilities [that were] essential [for] them to use their new skills.” As Kavadi points out how the GoI was unable to fulfill these demands and the fact that state governments did not guarantee employment did not help either.54

By mentioning how Indian nurses were moving out of Bombay to Delhi and Calcutta, Adranvala did catch onto how Indian nurses had different aspirations. Not only does the migration signified how Indian nurses were moving away from the selfless caregiving aspect of nursing, but also, it displayed how both the GoI and Indian elite nursing leaders did not invest in proper infrastructure and facilities to help motivate these trainees to stay in one position. Because Adranvala was so caught up in providing professional training for Indian nurses, she could not ultimately concentrate on the real issue of improving the working conditions for nurses and motivating Indian nurses to stay within their position. Thus, because Adranvala continued to enforce a professional nursing culture and did not effectively change her strategy to monitor the changing beliefs of Indian nurses, Adranvala’s vision of the modern Indian was no longer tenable in the following generations.

Conclusion:

Considering how Adranvala was the first Indian Nursing Superintendent and Nursing Advisor to the GoI, having been benefited from break down of the racial hierarchy that existed in colonial nursing, Adranvala wanted to pass down the same benefit she received to other Indian nurses. Adranvala had a vision for Indian nurses to become well-educated and she was successful in furthering the professional nursing culture in India. However, Adranvala’s decision to professionalize nursing created

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unintended consequences. Not only did her decision create a “blind spot” because she could not connect with lower and middle class nurses, but more importantly, as a result of being educated, Indian nurses had other aspirations about how they wanted to shape their nursing career. By providing Indian nurses more time to develop their leadership skills and giving them fellowships, Adranvala took actions which she thought was best to enhance the abilities of Indian nurses, however her strategy did not match what the nurses wanted. As a result of her strategy, after obtaining education, Indian nurses moved away from the caregiving aspect of nursing and wanted better career opportunities. Because Adranvala could not modify her professional strategy, Adranvala’s vision of the modern Indian nurse was no longer tenable in the following generations.
Conclusion

As depicted, there were multiple intersecting factors which influenced why the elite Indian nursing leaders were not able to achieve their heightened aspirations of nursing achieving professional status. One limiting factor was the colonial nursing framework that developed during British colonialism. Although British nursing officials laid the foundation for a professional nursing culture in India, by constructing an expectation of the ideal modern Indian nurse, they produced ideological structures which created a flawed racist and gendered nursing hierarchy.

Thus, not only did independent India inherit a weak flawed foundation to build nursing off of, but more importantly, the elite Indian nursing leaders continued the colonial nursing framework into the post-Independence context. However the colonial nursing framework enabled and provided Adranvala and elite Indian nursing leaders with the opportunity to obtain a position of power. As a result, Adranvala pushed forward the professional nursing culture and through her articles, she was able to modernize the history of Indian nursing.

However in the effort to modernize the Indian nursing profession, Adranvala had to deal with being constrained in terms of authority to Indian doctors, the GoI and RF officials. Although all of these agencies had differing goals and interests, Adranvala was able to use her authority to negotiate with all of the GoI and RF. However, as a result of trying to negotiate between the conflicting interests and goals for the nursing profession, Adranvala could not effectively work with all of them. The political tensions lead to a standstill as Adranvala could not please the RF.

As a result of being educated in Britain, Adranvala could not break away from her colonial education. Although she used her authority to work over the nurses carry over
the colonial construction of the modern Indian nurse and pursue the professional nursing culture in India, she distanced herself from the real life problems of Indian nurses who worked in hospitals. Adranvala’s decision to promote the educated Indian nurse created unintended consequences which reproduced colonial racial nursing hierarchies and generated an Indian nurse who was dissatisfied with the working conditions in India. As a result, Adranvala’s vision of a professional and selfless Indian nurse could not sustain itself for the next generation.

Thus, Adranvala represented the complex difficulties of an elite Indian nursing leader from 1947-1966. Not only did Adranvala have to bear constraints created during the colonial period, but more importantly, it was the continuation of these constraints and additional new constraints which reduced Adranvala’s effectiveness as a leader. On the one hand, these constraints provided her with authority to have a position of power but on the other hand, these constraints also further complicated situations. As a result, the decisions Adranvala took to maintain the professional nursing culture ended up backfiring; neither could she establish a harmonious relationship with national and international agencies nor could she establish a cordial relationship with lower middle class nurses. Thus Adranvaa depicts the story of a helpless first generation Indian nursing leader who could not rise against opposing forces.
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