Social History of Medicine in Colonial India

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Lecture 02

Epidemics, Colonial Cultural Stereotypes and Accommodative Approaches

Hello and welcome to this lecture, Lecture number 17, which is a very interesting one because in this lecture we are not going to talk just about diseases and disease control, but several other factors. As I have been saying already repeatedly, public health and medicine generally and in this case epidemics, they are not just about encounters between diseases, pathogens and remedial measures. All of these: dealing with the disease, the discussions and discourse about sanitation and the measures - all of these offered ample opportunity for a lot of cultural framings, cultural caricatures, denunciation, contestations, protests, cultural hurt, reactions - all that. The circumstances all of this - the circumstances of the disease - whether it is the land form or the people's habits, whether it is eating habits or excreting habits - all of these were projected in very stigmatizing ways. For instance, entire regions like Bengal which had recurrent prevalence of cholera and malaria fevers were often stigmatized as being essentially unhealthy places. To give another example, Burdwan again in the Bengal region, was initially seen as a vibrant and luxuriant place, but in course of time the people were seen as a victims of nature both mentally and physically - people's minds were sapped by the environment and their bodies emasculated by the powers of nature. Particularly diseases like malaria were represented as emasculating weakening diseases that threatened reproduction and made individuals weak and sickly. This means that malaria not only with its mortality, removed lot of people, but even if they survived, it reduced the vitality of the survivors and sapped their vigor and their fertility.

The victims of the disease were portrayed as for instance, in this case by Bengal's Sanitary Commissioner in 1899 - the victims were seen as “wretched beings of sallow and ghastly continents looking twice their actual age with weak attenuated frames shrunken limbs and with their muscles thin and powerless..” . And also this kind of discussion also contributed to the recurrent colonial ideology of the manly races from the

martial races - there was this distinction made between the so-called martial and manly races of the north and northwest for instance, the Sikhs and the Pathans and on the other hand Bengalis who were seen to be weak and effeminate. And this weakness and effeminacy was correlated to their diet - Bengalis' rice diet and also to their climate which is damp and unfavourable to health, the rainy season being prolonged, and the atmosphere contaminated by exhalations from swamps and with several of the districts intersected by rivers and creeks. Even within Bengal, (earlier we saw the distinction made between Bengalis in the east and Sikhs and Pathans on the west or the northwest, but even within Bengal), there was a distinction made between those on the western part mostly Hindus and who fed on rice and those in the eastern part who also ate meat apart from rice - who were seen to be more sturdy more strong than the Bengalis on the eastern part. Thus this is was correlated with race and religion and this in its own way added to the communal tensions. As we know the British used or instigated the communal tensions - their time-tested successful ploy of 'divide and rule' based on various kinds of divisions particularly religion - in this case Muslims and Hindus. And these kinds of discourses also contributed in their own way because it was not only the British who were saying these things, but many of these things were also internalized. This internalization is a very important aspect in these discourses. Many of them - the Bengalis - themselves came to believe and internalize some of the things that were said. For instance, middle-class Bengali Hindus in the western part of Bengal began to see themselves as a dying race in contrast to the Muslims in the western part whose members or whose numbers were on the ascendant. The famous historian R.C. Dutt went on to say that "all those physical causes which enfeeble and enervate and make man incapable of having mastery over nature are found to exist and work this country to an alarming extent". Similarly a Bengali doctor Gopalchand Roy when he wrote about Burdwan fever, he gave very negative and mournful and pessimistic images. These kinds of images and ideas were time and again, repeated and they were widely circulated.

Many diseases apart from malaria, many other diseases in India were also attributed by the British medical men to the peculiarities of Indian climate, geography and landscape. Sometimes the effect of these environmental idiosyncrasies such as monsoon were also aided by peculiar customs of Indians like pilgrimages, bathing, festivals and fairs. Therefore, there was (this is where the cultural element and considerations come), the officials were reluctant to implement measures that might violate Indians' sensibilities or their views or social customs and status, caste considerations and other such things. This was conveniently used as an excuse for not acting adequately - because it was felt that some long-held habits and deeply ingrained customs were too difficult to change and it would be unwise. Both internally this was an argument and also externally it was presented to the outside world also as one of the reasons for their hesitation. It was not entirely untrue .. in many cases it was really the case and therefore, not only could it be

used as an excuse for inaction, but it could also be used to blame the Indians for much of the sad state of the health and disease.

And, again as I say, we should also keep a note of things that are happening around. So, while we are focusing on the world of medicine and disease and sanitation and other things, from time to time, we also have to remind ourselves about the other broader things happening. By this time, especially after 1885, the freedom movement was picking up with the formation of the Indian National Congress. There were lots of prayers and petitions and demands and protests - all of which did not go with without some kind of effect or some kind of concessions from time to time. From time to time we have concessions in the form of Government of India Act. For instance, there was one in 1909 and in this case is the 1919 Government of India Act called as the Montague-Chelmsford Act. One of the provisions of this 1919 Government of India Act was the introduction of dyarchy in the provinces through which certain subjects like sanitation, health and other things were transferred to the local Indian Ministers in the Province - by this time as part of the concessions Indians (there was was an electorate which included Indians) found ways into the administration - there were Indians who even served as Ministers. These are all the developments that are happening on the political front. But the point here is that medicine along with other such responsibilities was one of those 'transferred subjects' while the British Executive Council continued to control more important subjects - or what they thought were more important subjects - like revenue and defense - those were called 'reserved subjects'. But this devolution again was presented as a move, a very generous move, on the part of the British towards enhancing responsible government and giving a chance for Indians to be showing their responsibility and play a role, and to make them more accountable. But in real terms, what happened due to this so-called devolution was that it was basically the shifting of the responsibility without the accompanying supply of adequate funds. Funds is always a recurring theme - this provided another opportunity for shifting the responsibility or blame to the Indians. But all of this passing of the buck and the so-called restraint, hesitations were all coloured with supposed cultural concerns and restraints and the care that the British had to take to keep a safe distance and not to step on wrong toes. And actually in some cases, the British expected that the same cultural factors about which they were always careful, anxious to tread carefully - they thought some of them may actually work the other way around - in a positive way. For instance, when smallpox vaccination was introduced, as we saw during that lecture on smallpox, the vaccine basically was based on cow pox and the material was actually taken from cow, that is how the word vaccine itself comes from the Latin word vacca. And given the special and sacred stature that cow had in Indian sensibility, especially Hindu sensibilities, there was an expectation that people would very eagerly take up vaccination because of some element, aspect, part of the sacred cow's body was getting into their own body. But it did not work that way and that again, gave an opportunity for further distribution of

certificate - cultural certificate! In this case, this was seen as a proof of Indians 'depravity and perverse ingratitude' for all the generous things the British were introducing. This was a proof of their 'blind adherence to ancient usage' and also this was a proof of the 'degrading effects' of Hindu religion. See the kind of denunciation, cultural denunciations and caricatures that discussions on health allowed the British to make. By this time, variolation itself was cast and coloured in a very negative way. As I had mentioned in that lecture, it was now seen as barbaric and criminal and culturally also seen to be inferior to vaccination in terms of the scientific approach - vaccinations seemed more scientific though as I said it was still empirical without understanding the real reason or without the ideas of immunity and antibodies and antigens at that time - but comparatively it was seen as more scientific and also more secular without the need for any kind of chanting and other kinds of rituals and offerings and other things. The hesitation towards a vaccine on the part of Indians was also read through this lens of cultural preference or steadfast attachment. And all of these kinds of cultural preferences and other factors - they were not just presented as critiques. This is not just a matter of caricaturing and essentialising on the part of the British - they also affected the British and their approach itself. It influenced the initial approaches to a considerable extent and prompted them to adopt more mild and more negotiated approaches. One of the reasons for that, was to not invite a second mutiny and be very careful about it. Also to bring about some level of participation to ensure some level of success for some of the measures like vaccination or sanitation. The point about concern about rubbing on wrong shoulders was particularly felt now because some nationalists for instance, like Balgangadhar Tilak and others channeled the discontent that was created through these medical and sanitary interferences into the larger stream of protest against British colonial rule itself. And the colonial state was concerned that this was also going against the divide and rule game - now Hindus and Muslims were getting together against the British because of the common concerns and displeasure created through these kinds of cultural invasions. We will see some of them for instance, with regard to vaccination where there were particular objections. As I was mentioning, vaccination was primarily based on material from cow and it is not very easy to take a calf everywhere. What they would do is to start with the material from a calf and then do vaccination on one person. Then material from there would be transferred to another person by what is called arm-to-arm vaccination which involved transmission of bodily fluids. You can imagine what kind of a cultural displeasure it would have evoked because one is about touch-related pollution and then the even-more the disturbing aspect of transmission of a bodily fluids. Many households were not very happy with giving the lymph from their children's arms, and those who are particularly caste-conscious were also very reluctant to take lymph which is probably taken from arms of low caste children. Therefore they had to resort to ways of getting lymph directly from the calf - they explored the possibility of extending the stock of calf lymph

indefinitely. This would involve cost but then with comparatively little expense they tried to keep the calf option. This is an example of how because of the opposition to arm-to-arm vaccination, they had to resort back to the other option. But here again - whichever way you go - there is some problem. But all said and done, it's from calf - now it's not about the recipient's body but about where it is coming from - taking that from the cow was seen as an insult, as a violation of their sacred animal. So, again that had to be abandoned and also there was some concern about - scientific concern about - the lifespan of the calf lymph itself. And there was also this calculation: probably this objection could be also neutralized if it was taken from buffalo which has kind of related material and it's not exactly from cow. That was one of the options considered but the more viable option was using lymph preserved with lanolin and glycerin - whereby you don't actually see the cow or the calf. What you see is, as you see now - some kind of a material. As I keep saying, we should always be careful about not confusing what we know of certain things with what was there. The moment we talk about vaccine we think of vaccine in some kind of a bottle or a syringe and some kind of a colorless liquid. We have to go back to that time when these kinds of things were not available - this kind of storage and transport and packaging was not available. So, one of the earliest ways it was done was preserving the lymph with lanolin and glycerin. Then it could also be individually administered without the need to do it from arm-to-arm or without involving the transmission of bodily fluid. It was a substance which was individually administered to each person. That was one way through which vaccination could eventually hope to succeed. And, of course, there were other ways - culturally again. This not from a practical manpower point of view alone - the use of tikadars - because they had a cultural standing and enlisting them could also reduce the level of cultural alienness - that was another strategy.

Coming to plague we saw anti-plague measures were sometimes too intrusive, too traumatizing also - the kinds of checkings that were done and all that. In course of time, the colonial government sought to reduce the level of confrontation by moderating some of those harsh and intrusive anti-plague measures. The colonial state itself was worried about its own young medical experts who were in fact, criticized in the report of the Plague Commission - these young experts who were all for those kinds of very intrusive strict and rigorous implementation of those kinds of measures - the Commission felt that compulsory segregation and other such steps should be avoided and hospitalization would be effective only if it was done with the consultation of people - there's no point herding people forcibly to places - because that might also matter - the state of mind in which we go. And all of this also brings up another interesting question: can the government leave these kinds of matters to medical and sanitary officers? Because, again, this was not just about medical matter - this was something which was affecting the larger relationship between state and subjects. This is also something you should keep in mind. This is a recurring question - for instance, people ask even today why

should certain departments not be left to experts? How will a Minister or a Civil Servant who has written a Civil Service Exam with say History and some other subject - and why should he be presiding over the health department as Health Secretary or the mining department? That's the question - Why not an engineer be presiding over say a particular department related to engineering or manufacturing say Industries Secretary. This is something we should keep in mind: ultimately everything that is done in a democracy is in the name of the people. Who is answerable to the people.. who is at the receiving end.. In a larger sense, in this case what we can call the larger state-subject relationship, now the government felt that it should play a broader, more important role in deciding the level of interference and not leaving it entirely to specific domain-knowledge-experts.

One of the mitigating effects was moving in the direction of volunteerism - enlisting the support of the people coming voluntarily to get admitted, voluntarily to have their house disinfected rather than these things being done forcibly. They hoped this kind of approach would have a greater public support. But there was a compromise - when you reduce that level of enforcement and those kinds of strict measures there would be some level of death. There always had to be a kind of a balancing game between fear of too much intrusion and repercussions and at the same time the high mortality that could arise because of too little action. They were reconciled to the fact that some number of deaths would be unavoidable. And on the other hand, they could bring about steps to raise both the level of voluntary participation and also general sanitary awareness and also a soft pedal approach to vaccination. Talking about plague vaccination, there was a particular incident which came as a sore point the place called a Malkowal - village in Punjab - 19 villagers died when they were vaccinated. But that was because of the tetanus which was contracted because of the use of contaminated needle. There was nothing wrong with the vaccine material itself. We saw Haffkine was a lead player who introduced this vaccine - he was blamed and was held responsible for this and his name got cleared only many years later. But this incident, accident had a very negative effect. Some of this we have again seen during our COVID experience - how there are people who are hesitant to have the vaccine and how that kind of hesitancy is also fueled by all kinds of rumors about what might happen or certain things that did happen to maybe some friends or others. In this case this was like something not too small - like 19 villagers publicly died and it is very directly related to the vaccination -mthough not to the vaccine itself. There were efforts to rewin the confidence. But at the same time the vaccination was not compulsory - but as in the case of COVID where it was not made explicitly compulsory though we were made to feel that it was necessary through several ways, here also the government tried different ways to make people come. At the local levels, medical officers and administrators held dialogues and consultations with community leaders about how best to implement anti-plague measures instead of unilaterally dumping those measures on them. On the other hand they solicited the

active and intelligent, smart behavior and cooperation from the people themselves. For instance, when large-scale evacuation was involved the village headman were consulted in advance. They even went to the extent of providing traditional medicine - sick people could be taken to a public hospital where a vaid or a hakim would be made available at government expense for the benefit of those who were not very comfortable with the European methods of treatment. Similarly a voluntary system of segregation was arranged in several towns and while doing these segregations, moving to hospitals, caste question/factor was also brought in. Separate caste hospitals were arranged.

Another line of option, another line open was to promote research which could provide other alternatives to harsh plague control measures. For instance, the identification of rats as vectors of plague causing flea gave the option of targeting them - the flea and the rats rather than wholesale evacuation/ isolation of human beings. But again (we already mentioned this in the other lecture, but here), we are talking about everything from cultural point of view - here again there was a cultural element because there were people like for instance, Jains - followers of Jainism and some orthodox Hindus - who were against the extermination of rats because they were generally against cruelty to any living form. The whole point of this lecture was to highlight with just a few examples how there were several cultural touchstones, sensitivities and sensibilities that confronted, influenced and mitigated measures against various epidemics. This is across all - across the people, the medical officials /officers, the colonial state officials - in some way or the other the cultural aspect played either in terms of hurting someone or being hurt or in terms of being more considerate, having more moderating approach.

On that note, we will close this lecture and meet in another one.

Thank you.