Social History of Medicine in Colonial India

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Lecture 03

Epidemics, Cultural Dimensions of Indian Responses and Role of Media

Hello and welcome again to another lecture, lecture number 18 and we are still on the topic of epidemics and particularly on the cultural dimensions of it. Throughout the course we have been saying there is much of culture to medicine apart from all the politics and the economic and other aspects and within epidemics itself we have already covered some bit of the cultural side. For instance, we had a lecture on how the colonial state responded, accommodated, moderated some of its approaches based on some of the cultural responses. And also when we were talking about particular diseases like smallpox, we made some references to some cultural aspects. This lecture is exclusively on the cultural dimensions - as far as Indians are concerned. How Indians were worried, had reservations, how Indians protested for particular aspects of what they saw was cultural invasion. The first point there says the colonial state's approach to epidemics in particular generally to any disease. But especially during epidemics the state was more visible and more prominently present.

The state's responses spurred many cultural reactions and lots of concerns and reservations. Some were particular to particular diseases as we will see and some were generally broad concerns about the state's excessive intrusiveness in several aspects of their daily lives, their habits, their food, the other aspects of their culture and tastes. In this context the word medicalisation is very significant. We will be discussing it in detail in one of the tutorials but it's important here to mention in short what this medicalisation means.

Basically it's more and more areas of life which we would think belongs to some other domain, either something general or something about your private biological life assumes a medical dimension. For instance, the food you take, the excretion. One can't say it's my personal matter where I do my excretion. It becomes a matter of public

health because for instance, open defecation is not just about the person's freedom to defecate wherever he or she wants. It's also about how it affects others and also for instance, the state felt it had a responsibility towards the population and therefore had to intervene in case of early marriage. One can't say it's my personal problem at what age I start to have sex and all that. It may be a personal issue of your body but then it also involves the state in several areas like this. For instance, bath - taking bath may be personal matter but then where you take bath and how /what water you take, use if you are using the same pond for either bathing yourself or your animals and then the same is also used for (same water source is also used for) drinking water and the other such things.. Many of these what we would consider as our private matters, our bodily concerns become medicalised because they involve public health, disease, spread of disease in some way or the other and importantly the state has to step in. The long arm of the state would extend in the name of public health.

Coming to particular diseases, smallpox for instance, had a lot of cultural baggage - specific cultural baggage attached to it. For instance, the disease itself was seen as kind of a manifestation of the displeasure of a particular goddess, Sithala and even the manifestation, particular manifestations were also attributed to the goddess, for instance, the fever and the bumps with that liquid filled (which become filled with pus eventually) - these kinds of signs were seen as manifestations of the presence of the goddess to some extent - having some kind of a displeasure. Some kind of an anger of that goddess is expressed in that person through these kinds of tell-tale signs and therefore, whatever else you do, one of the primary responses from this cultural point of view, was to find out some ways of now assuaging, pacifying that god who is not too happy - the goddess - some kind of a propitiation, which would involve rituals, the use of sacred materials like neem leaves or stem and some kind of offering to the goddess, chanting of mantras, all this to please and placate the goddess. Before vaccination people were resorting to variolation. Variolation had its own process which we described in the lecture on smallpox. But along with the actual process of making incision and applying the materials - along with all those specific actions, mechanisms - these accompaniments had to be there: the use of particular kinds of material like neem leaves and other such things. Even the tikadas though they were very clear about what exactly they were doing, what exactly was addressing the precise problem, that is the use of the variolous matter and the way they applied it and the periodicity with which they did - they were very clear about those mechanics and the mechanisms. But even they were quite open and in fact they had to do, because that was the cultural dimension of it. It gives a sense of belonging, there is no alienness, they were open to these cultural considerations. But on the other side, in contrast to all this when vaccination came, it was very decidedly, it was very visibly, ‘ungodly’. There was no role for any gods or goddesses and it was very clear what was happening. The cow pox matter was doing its job and the way it was administered, the agency through which it was administered did not have much

room for these kinds of accompaniments, which meant the entire process was too secular, too ungodly and too disrespectful and ignoring the sensitivities and the sensibilities of the goddess who was thought to be behind the disease or whose displeasure was manifested through that disease. And also, there were other cultural elements which produced a displeasure which was that method itself, as we were discussing earlier, they tried the arm-to-arm vaccination, this was seen from a cultural point of view as very polluting and offensive due to transfer of one individual's body fluids to another and also if it is involving the transfer of material from person of one caste to another caste - for instance, the person of one caste may have a particular aversion to material from a person of a lower caste being injected, being put into his or her child's body. And also, one of the alternatives, as we were discussing in that lecture was how the state mechanism tried to adjust, change course according to these reservations in response to these kinds of concerns. In that alternative - in this case - was introduction of the calf's lymph directly. But then that again had its own set of reservations, repercussions that was seen as an insult to the animal which was held very sacred. Overall, all these things put together, it provoked a sense of distrust towards vaccination itself irrespective of how less painful it was compared to variolation and other things. But because of some of the things which were missing in this, things which were in variolation - those accompaniments which are missing, or some of the new things like this kind of transfer of bodily fluids, there is lot of cultural discontent and which in turn spurred all kinds of rumors about the true intent of the colonial state in introducing vaccination. Vaccinators were suspected especially the British were suspected of trying to make a mark on Indian bodies or trying to introduce, insert into Indian bodies something alien, something foreign. Therefore vaccination was an important site for all kinds of cultural battles and resistance. But in course of time, there was greater acceptability because many among the Indians themselves - especially Indian practitioners of western medicine, the people who went to the places like Calcutta Medical College or Madras Medical College or products of those kinds of new educational avenues that are open, basically Indians who were doing western medicine and also people from the non-medical world, but people who were influencers of public opinion, prominent members of the Indian middle classes, social reformers and others - when they came out and spoke in favor of.. (it helped). Again there is a cultural element, they were Indians.. that itself mattered to some extent. Culturally at least, they were not alien, they were fellow Indians who were advocating (getting it done because it is being recommended by someone who is more like you, there is also some cultural element). And also, as we saw, even the colonial state for that, and other logistical reasons did not hesitate to use the tikadas, the original variolators themselves to do this job. One was for manpower and second was that they could be trusted for that cultural capital because the people were already used to those people doing the variolation. And another thing, again from a cultural point of view, which made smallpox vaccination more acceptable

was that now even the calf could be disposed of. Initially it (lymph) could be taken only from the calf, but then, later on it could be preserved in lanolin or glycerin or other substances. (It is coming closer to what we now know of vaccines - when you see a vaccine you just see some bottle or some kind of syringe or something - we do not see a cow or some other biological material or from whatever, from where it came). This also helped acceptance - from a cultural point of view.

Coming to plague, there were quite a lot of cultural issues. One of the earliest methods of addressing plague, historically was segregation and segregation itself was seen as a kind of a challenge to ritual purity and family pride because people were being removed from their families - there is a rootedness in the family and uprooting of the individuals from the family - and then when they are put together (in hospitals), not always would they be put according to particular caste - all kinds of people were. It was basically like a relief camp, like as we know like refugee camp and relief, these kinds of camps, they would not be very particular about classifying people according to colour or caste and other things. That is again violating , for instance, in this case the caste segregation. Similarly in this case, also there was a vaccine, that also was seen as a way of intrusion. Vaccination was again seen as, (there were again rumours in this case also that vaccination was basically), injection of poison into Indian bodies to actually to kill them rather than to save; or rather to spread kinds of conditions, diseases which would see to it that more and more Indians are eliminated - it is a kind of a coloniser's ploy to directly invade the Indian body and do harm. There was particular objection of women being taken - the wives or mothers being taken away from their children or husbands and alone. You can imagine what kind of a cultural shock it would have been like - some stranger from somewhere coming in, telling him: ‘we have to take your wife into some place where all kinds of other people also will be there, isolation centres or hospitals’ - this was an attack on womanhood and traditional family life. Also as we saw in that lecture, main lecture on plague, some of the symptoms were kind of bulges in different parts of the body like groins and armpits. When people were examined in places like railway stations, their armpits were examined and this applied to women also and without proper kind of screen or any such a kind of assurance of privacy, this was like real, really shocking intrusion - particularly an assault on women and their privacy. Quite expectedly there were riots and mass exodus of people, trying to escape from where they were - because of fear that they might be inoculated which was seen as kind of insertion of some poison into their body or that they will be removed from where they are and uprooted and then kept in kind of hospitals or isolation centres. The kinds of opposition that this provoked were really dramatic and including the shooting of a Commissioner - Plague Commissioner in Bombay Presidency. Similarly there were very specific religious dimensions. Whatever we were talking about was more in general - about women, family, more cultural. But there were very specifically religious dimensions of misgivings about cholera and plague control measures. For instance,

pilgrims who had assembled for instance, for Kumbhamela or any religious festival or fair - they complained that Muslim constables polluted the sacred bathing pool by entering it without removing their boots. There also cases reported that constables allegedly discharged urine into the mouths of pilgrims. Apart from general affront, this also is an affront on ritual purity and violating caste boundaries. Then, there were the complaints of the mishandling of Hindu women by Muslim constables. Now you can see that this is acquiring both gender as well as communal dimension. This was being framed in terms of Hindu women being dishonoured by Muslim male constables. And this is not entirely surprising and can be correlated to the social dynamics that were developing at that time when communalism was very much present and fueled further by the British policy of divide and rule. And also there were several Hindu revivalist movements which are on the ascendant. So, from a health point of view, there were, as we saw in other lectures also, communal flaring up. The media also added their contribution to further flaring up of these communal tensions. Some of the vernacular papers were actually of very staunch Hindu revivalist background. They felt that they had a sacred duty to safeguard and fight and promote the Hindu cause. There were different factors at work and we saw in the other lecture, the British response to all this: all these things resulted in relaxation of the harsh isolation, segregation methods and adoption of more of a consultative (approach) - rather than merely imposing from the top. And it is not that Hindus alone had grudges or complaints. In a different sense, Muslims also had their own grievances. For instance, as you would know, it is one of the incumbent duties of followers of Islam to the extent possible, economically, to make the Hajj pilgrimage to Mecca, at least once in their lifetime to Arabia. But there were lot of restrictions. (This was periodic - Muslims used to go periodically). But during epidemics, they were stranded, their movements were greatly curtailed because of international concerns about the spread of disease and the call for quarantine of ships, especially commercial ships - but also ships which were carrying people because both goods or people were seen to be carriers of these diseases. Sometimes being barred from leaving from a port itself is a bit offending and hurting your plans and all that. It is even worse if you get into the seas and then somewhere in the middle you are stopped and then you are not prepared. Once you go, like you have a plan, you have that expenditure plan - also you are there for 15 days and this is the kind of expenditure that you can foresee. But suddenly you are caught in the middle and then you are asked to stay for 4-5 days extra without everything being provided by the agencies… they were left to fend for themselves. Those kinds of really traumatizing experiences from the Muslim side also.. And there were occasions when these kinds of cultural concerns or fear of cultural reprisals were also used by the British very conveniently to avoid certain things that they could have done. For instance, the system of station hospital was introduced in the 1880s for British troops. This was a change from regimental hospital - each regiment had its own hospital which would be smaller. But then at a higher level this

layer of station hospital was introduced both for efficiency and economizing and for better facilities. But that sense of esprit de corps, the sense of belonging, the sense of doctor-patient relationship which was there in regimental hospital would not be there in the station hospital. Some of you who are in hostel can relate this to the difference between having a mess in your own hostel (there is a feeling of 'hostel patriotism' - you go to the same mess - you know your fellow hostel beings) and on the other hand for 5-10 hostels there is one huge mega mess where that sense of hostel feeling is not there. It is only in the mess and then the play area - that is where that sense of hostel feeling is there. But when you go to the that mega mess with six floors/ seven floors - of course, the function of eating is done but then that social feeling, that cohesion - that is missing - but it is more efficient more cost effective. These are some of the general dimensions of the differences between regimental and station hospitals. But whereas it was introduced for the British troops, for the Indian troops it was avoided because apart from general cohesion and sense of being together, particular cultural factors were brought in - saying that Indians would be very averse because they would see that as a violation of their ethnic cohesiveness. People from the same region say from this particular district of Punjab.. from this ethnicity.. would like to be in a regiment.. will be not only be in a regiment, but be treated in a hospital with same kind of people. But in the station hospitals some Rajputs will come, others will come, Muslims will come which Hindus may not like that kind of people/ethnic-mixing. That, of course, would have been there. But there was always a possibility that the troops also could, as in many cases Indians adopted to several things (for instance, in railways people did travel - they did not say 'oh this travel, these railway coaches has got all kinds of people coming in..' once that opportunity was made available people are able to transcend those kinds of narrow sense of belonging), similarly the troops' ability to adapt to innovations were neglected. Basically there are other reasons financial and other reasons which the British had. Though it will be more economizing but first time building station hospitals also involved higher initial capital cost - that is one of the reasons. There are several reasons why they did not want to start station hospitals - they kept on delaying. But this cultural dimension was used as a reason.

And then moving on, the media played a very important role in epidemics and particularly in the cultural crossfire - sometimes by opposing some measures or critiquing some or helping create awareness or just adding fuel to the fire. For instance, many Indian papers condemned the interference in religious affairs like fairs or Kumbhamelas and other things in the name of sanitary measures. And as we had seen, like for instance, the Sanitary Commissioner Cunningham and many others in the medical establishment also subscribed to same kinds of views – they had that anti-contagionist stand and one of the things that bolstered that anti-contagionist stand or the reason why they held on to it was that that would involve the minimum interference. Many Indian newspapers also were against that kind of interference but

there were some papers which were the voice of the British in India. They blamed the municipal corporations for inadequate measures. And as you know from earlier lectures, much of the medical matters were left to municipal corporators - these were basically Indians - basically it was blaming Indians. But Indian papers defended them and they felt that whatever fault was there in the municipalities was because of the less amount of financial openings that were available for them. And many Indian papers, on the other hand, were very critical of the very harsh anti-plague measures - sometimes wondering whether the same kind of harsh intrusive measures would be allowed in England or whether English people, households would tolerate these kinds of excessive interference by the state. But some British-supporting papers said that there was the need for even more intervention more harsh measures because the mortality rates were not showing any signs of dwindling. Then there are other things also that Indian newspapers or journals, magazines opposed. For instance, they opposed the policy of filling up of open water tanks. Open water tanks had lot of social functions and religious functions also. But they, from a medical point of view, were seen as sources of stagnant water causing certain diseases. British-supporting papers wanted them to be closed especially as they had connection to cholera which was now found to be more of a water-borne disease but Indian papers opposed that kind of filling, the closing of open water bodies. The Indian papers pointed out to the lack of (at that early point, that there was no) conclusive, proven theory of cholera transmission. They also condemned the fact that Indians' voice was not allowed to be raised. The Sanitary Commissions were there but then they were - all the voices there - were all western voices of western medical men - not much of Indian voice was there. We conclude this lecture by saying that these kinds of examples point to a very interesting mutually constitutive relationship between disease, disease-control measures, cultural sentiments, their evocation by the media, the responses of the people, the projection and framing of such responses, and how such responses also led to changed approaches/ measures on behalf of the state. On that note we will close here and meet in yet another lecture. Thank you .