

THE UNSEEN GERMS OF POWER: MEDICALIZATION, COERCION, AND THE CONTESTED PUBLIC SPHERE IN COLONIAL PUNJAB (1860–1947)

ASAD IMTIAZ*

ABSTRACT

The local people in the Punjab faced profound, multidimensional distress due to British discriminatory medical policies, which functioned as a sophisticated tool of governance and control during the major epidemics of 1860–1947. Four major outbreaks—malaria, smallpox, cholera, and plague—provided the pretext for the colonial state to deploy "medicalization," extending surveillance over non-medical realms such as local customs, religious rituals, and personal behavior. The core problem lies in the deliberate use of racial and class stereotypes to justify coercive measures, strict movement restrictions, and the systematic suppression of marginalized groups like *Tawaifs* and *Hijras*. This alliance between state power and medical professionals sought to reinforce colonial hierarchies, protect European personnel, and advance Western medical knowledge while actively discrediting and dismantling indigenous *Ayurvedic* and *Unani* healing systems. The impact was disastrous, resulting in high mortality, widespread emotional trauma, economic disruption, and intense local resistance against medical authoritarianism.

KEYWORDS: Medicalization, Colonial Punjab, Epidemics, Censorship, Social Control.

* Independent Scholar. Email: asadranjha103@gmail.com
DOI: <https://doi.org/10.65463/13>

I initiate this inquiry into the history of colonial Punjab by asserting a profound, often overlooked, reality: during the recurrent epidemics of smallpox, malaria, cholera, and plague (1860–1947), British public health policy mutated into a powerful, insidious tool of governance. This system utilized discriminatory health policies to achieve political ends—controlling the indigenous populace, suppressing specific marginalized sections, and enforcing rigid racial differentiation. The true crisis lay not solely in the disease itself, but in the colonial state's calculated response, which applied the concept of "medicalization" to bring vast swaths of indigenous life—from personal hygiene and family customs to trade routes and traditional healing—under the coercive authority of the "medical gaze." My research centers on demonstrating that this systematic manipulation of the public health sphere served the core interests of maintaining colonial hegemony and ensuring economic profitability, rather than prioritizing the welfare of the Punjabi populace.

The larger context of this debate involves understanding how the colonial project leveraged modern science to legitimize authoritarian control. Epidemics, with their inherent alarmist nature, offered the perfect moral and scientific pretext for state intervention that would have been unacceptable in peacetime. This allowed the administration to overlook its own culpability in disease spread—through the construction of disruptive irrigation networks and railway lines—and instead deflect blame onto the victims, labelling indigenous customs and poor sections of society as the "biological underclass" (Tandon 2015). This strategic deflection, coupled with the necessity of protecting European staff and military personnel, resulted in starkly segregated and discriminatory practices in hospitals,

vaccination campaigns, and public spaces. My work systematically traces the legal, political, and social instruments deployed by the British to execute this medical-authoritarian regime, from the establishment of lunatic asylums to the enactment of restrictive ordinances.

My essay aims to provide a nuanced historical account of the multidimensional impact of these policies on colonial Punjab, moving beyond mere mortality statistics to explore the deep wounds inflicted upon the social and cultural fabric of society. I will examine how coercive sanitary campaigns and cordoning off measures devastated the livelihoods of farmers and daily wage earners, and how specific groups like *Hijras* (transgender) and *Tawaifs* (prostitutes) faced excessive surveillance and stigmatization, leading to a disastrous change in their social standing. By tracing these patterns of coercion and their resulting local resistance, I seek to clarify the complexities of the medical field's co-option by colonial power, highlighting how the public sphere in Punjab was fundamentally reshaped by what I describe as the systematic weaponization of health policy.

I categorize the existing scholarship into three essential thematic groups, establishing the historiographical foundation for my critique of colonial medical policy. The first group, characterized by descriptive accounts of epidemic history in Punjab, provides the empirical data on which my analysis rests. Scholars like Sasha Tandon and Mark Harrison offer meticulous details on the patterns, areas, and mortalities of cholera, malaria, plague, and smallpox, exploring the factors responsible for disease spread (Tandon 2015; Harrison 1994). Tandon specifically discusses the colonial authorities' initial unawareness of micro-parasites and the gradual development of preventive measures, while

Harrison details British public health policies during epidemics. I find these works crucial for establishing the chronological and geographical context, particularly in understanding how colonial projects—such as canalization and the movement of troops—inadvertently contributed to the outbreaks they claimed to control.

The second group shifts focus to the medical intervention in the socio-cultural sphere, utilizing theoretical frameworks to interpret the meaning of colonial control. The seminal works of Michel Foucault—specifically *The Birth of the Clinic* and *Discipline and Punish*—provide the central theoretical lens, illustrating how the human body and behavior were brought under the network of the "medical gaze" (Foucault 1976). David Arnold builds powerfully upon this, coining the concept of "Colonizing the Body" to highlight the state's role in using medicine to manage epidemics and enforce racial and class hierarchies (Arnold 1993). Scholars like Srirupa Prasad confirm this by examining the medicalization of local customs and hygiene, revealing how medical judgments were often substituted for judgments of 'sin' or 'criminality' to justify interventions into non-medical realms (Prasad 2015).

The final group of historians directly addresses the core issue of British discriminatory medical policies and the resulting local resistance. Scholars such as Poonam Bala and Anil Kumar argue forcefully that health policies during epidemics were explicitly used as a mechanism for social control, focusing on protecting the British economic base and military personnel while neglecting the indigenous population (Bala 2012; Kumar 1998). This group documents how local practices—specifically *Ayurvedic* and *Unani* healing—were suppressed and dismissed as unscientific to promote the

perceived superiority of Western medicine. I contend that the research gap lies in the synthesized, focused application of these three streams: while the components exist, I propose to systematically apply Foucault's framework to the archival records of Punjab to demonstrate the long-term, structural impact of medicalization policies on specific, vulnerable indigenous communities.

My research paper employs a qualitative, historical methodology anchored in the theoretical framework of Michael Foucault's power/knowledge nexus, specifically drawing from his concept of the "Medical Gaze" (Foucault 1976). I utilize Foucault's work to analyze how colonial institutions, possessing a rigid power structure, implemented discriminatory medical policies during epidemics, creating a specific discourse that suppressed local practices and racially differentiated the indigenous population. This framework is essential for understanding how medical knowledge, ostensibly objective, became entwined with political power to regulate social behaviors and justify interventions in non-medical spheres, such as family life and traditional customs (Foucault 2000).

I use Lauren K. Hall's work on the *Medicalization of Birth and Death* as a thematic model, focusing on how culturally specific processes were transformed into procedures driven by medical bureaucracy and external, westernized intervention (Hall 2019). This guides my analysis of how traditional *Ayurvedic* and *Unani* healing practices were violently disrupted and replaced by Western medical intervention, often to the detriment of the indigenous population's agency and autonomy. My primary sources provide the empirical bedrock for this analysis, allowing me to confront the official narrative directly.

My primary evidence includes meticulously cross-referenced Punjab Government Administration Reports, Sanitary Administration Reports (1867–1921), and Proceedings of the Civil Secretariat (1872–1919), which detail the state's policies, motives, and self-justifications. I supplement this with contemporary indigenous critiques from newspapers like *The Tribune* and *Khalsa Advocate*, which articulate local grievances and resistance against coercive sanitation and vaccination campaigns. To overcome the inherent bias and sanitization in official records, I apply a triangulation method, comparing the bureaucratic rationale provided in the *Proceedings* (e.g., for quarantines) with the reported realities of suffering and resistance found in local presses, ensuring that the marginalized voices find representation in the historical narrative.

EPIDEMICS ERUPTION AND MEDICALIZATION PROCESS IN COLONIAL PUNJAB

Colonial Punjab was ravaged by four major epidemics—Malaria, Smallpox, Cholera, and Plague—which broke out intermittently between 1860 and 1947. These epidemics showed specific, often predictable, patterns: Malaria, claiming over 5.1 million lives, peaked in October and was linked to the marshy conditions created by excessive rainfall and faulty drainage, particularly in central districts like Lahore and Gujranwala (Tandon 2015). Plague reached its peak intensity during March and April and had a mortality rate four times the all-India average, proliferating in poorly ventilated, crowded rural housing (Zurbrigg 1992). Cholera outbreaks were frequently attributed to the unsanitary conditions and contaminated water supply at large religious

fairs, while Smallpox remained prevalent in regions where people resisted vaccination in favour of traditional practices (Harrison 1992).

The intensity of epidemics and mortality rates varied dramatically along lines of gender, class, and geography. Rural areas consistently faced a higher prevalence of cholera, malaria, and plague compared to urban centers, largely due to endemic poverty, lack of drainage funds, and reliance on contaminated water from shallow wells. Women were disproportionately affected, with a higher mortality rate (7.5 per mille) compared to men (5.8 per mille), a discrepancy rooted in prevailing patriarchal structures that restricted women's access to inoculation and professional male medical care (Gupta 1987). Furthermore, the poor sections of society were the primary victims, lacking resources for clean water, well-built housing, and protective measures, confirming that disease patterns mirrored pre-existing socio-economic inequalities.

The colonial authorities were often responsible for exacerbating the very outbreaks they sought to control, ignoring the environmental consequences of their large-scale infrastructural projects. Canalization, particularly through systems like the Western Jumna Canal, led to widespread stagnation and waterlogging, creating perfect breeding grounds for mosquitoes and driving malaria rates higher in agricultural districts (Paustian 1930). Similarly, the construction of railways caused extensive ecological disturbance; the resultant embankments blocked natural drainage paths and created burrow pits that became "mosquito hatcheries" during monsoon seasons (Proceedings, Home: Medical and Sanitary, July 1890). The frequent mobilization of troops across the Punjab frontier also acted

as a vector, carrying cholera infection and destabilizing regional health conditions.

Medicalization during epidemics became the preferred method for the state to manage the crisis, primarily by deflecting blame and establishing control. Colonial administrators routinely ascribed the cause of epidemics to the "notoriously filthy" customs and "unhygienic conditions" of the indigenous population, rather than to the actual parasitic agents or administrative failures (Arnold 1993). This medical discourse, exemplified by the targeting of 'Kashmiri Mohammedans' as 'dirty' carriers of cholera, served to label poor and marginalized indigenous communities as the "abode of diseases" and a "biological underclass" (Tandon 2015). This process justified intrusive medical intervention into socio-cultural spheres, effectively using health policy to enforce social order.

MEDICAL FIELD AS A TOOL FOR CONTROLLING PEOPLE DURING EPIDEMICS

The earliest medical policies were characterized by a profound ignorance regarding the actual parasitic agents causing diseases, leading to an alarmist and misdirected response. Colonial administrators, initially subscribing to the "miasma" theory, focused punitively on suppressing "decomposed matter" and human carriers rather than addressing waterborne bacteria or insects (Harrison 1994). Even after Robert Koch's discovery of the cholera bacilli in 1883 and Ronald Ross's work on malaria in 1897, British authorities exhibited deep suspicion and hostility, delaying the widespread implementation of proper sanitary and water-management improvements for over a decade. This delay confirms that the primary initial response was

not effective public health but immediate, coercive control of the population.

The state systematically used the medical field to infringe upon indigenous population's agency by medicalizing local customs, traditions, and religious rituals. Practices like attending religious gatherings, condoling with the sick, and celebrating local fairs were all targeted and deemed "obnoxious" and conducive to disease spread (Harrison 1992). The religious practice of variolation (a traditional smallpox inoculation) was forcibly prohibited and blamed for peak infections, legitimizing compulsory Western vaccination campaigns (Bhattacharya, Harrison, and Worboys 2005). This process was designed to impose a western style of morality, behavior, and hygiene, presenting Western medical measures as scientific and superior while systematically stripping indigenous communities of their long-standing cultural autonomy.

The medicalization process was underpinned by explicit racial theories designed to justify discriminatory policies and reinforce colonial hierarchies. British authorities propagated ideas of inherent racial superiority, using perceived differences in hygiene and moral character to label indigenous communities as racially inferior and biologically contagious (Sramek 2014). This ideology resulted in the creation of a two-tiered healthcare system: European patients enjoyed separate, superior hospitals (like the Mayo Hospital wards), while the local Punjabi populace faced limited access and were subjected to research and medical experiments without informed consent (Pande 2009). This structural segregation confirms that health policy was inextricably linked to the maintenance of white racial dominance.

Lunatic asylums were established not primarily for therapeutic intervention but as

a political tool for confinement and social control. Drawing from Foucault's concept of "bio-politics," I propose that mental illness was medicalized and framed as a "deviation from the Western perceived norm" and a sign of moral failure (Foucault 2000). Institutions like the Lahore and Rawalpindi Lunatic Asylums became custodial centers with high walls and strict regulations, often confining political prisoners or individuals who posed a "threat to British colonial authority," effectively using the medical diagnosis to achieve political incarceration and consolidate power (Proceedings, Home: Medical and Sanitary, 1885).

Now we will discuss how the British enacted a web of legal acts to enforce medical discrimination and restrict indigenous movement, providing legal cover for coercive measures. Acts such as the Cantonment Act of 1864 and the Contagious Diseases Act of 1868 institutionalized health checks and compulsory registration for prostitutes, primarily to protect British military personnel (Peers 1998). Furthermore, the Criminal Tribes Act of 1871 and the Punjab Infectious Disease Prevention and Medical Relief Act of 1904 were used to label communities as "habitually criminal" and enforce quarantine, allowing the medical apparatus to restrict people's movement, confine them, and isolate them at will under the guise of public health (Arnold 1993).

The colonial state took extraordinary, targeted efforts to protect the areas where Europeans resided, establishing a clear hierarchy of concern. Cantonments and Hill Stations (like Shimla, the summer capital) were cordoned off immediately upon an epidemic outbreak, and Europeans received precedence for vaccination and quinine prophylaxis. The measures adopted at Shimla are exemplary: travellers were examined at Kalka, and massive loans were provided for

installing piped water systems to "maintain its character as agreeable, and as Capital of British Government in India" (Proceedings, Home: Medical and Sanitary, March 1907). This stark contrast confirms that health policy was overwhelmingly driven by the military and economic benefits attached to protecting European personnel.

EPIDEMICS AND BRITISH MEDICAL POLICIES' IMPACT ON INDIGENOUS POPULATION

The indigenous population suffered systemic discrimination within the medical sphere, exposing them to inferior healthcare and medical experimentation. Hospitals designated for Europeans were inaccessible to locals, who had limited access to equipment, specialized treatments, and essential medicines (Pande 2009). The medical establishment often conducted research and experiments on local people without informed consent during epidemics, utilizing them as subjects for observation in studies on malaria and cholera. Furthermore, traditional healthcare practitioners and midwives (*dais*) faced intense hostility and stigmatization, with their centuries-old *Ayurvedic* and *Unani* practices dismissed as ineffective, perpetuating the colonial notion of indigenous inferiority (Bala 2012).

The coercive sanitation and quarantine campaigns generated a significant housing crisis and imposed severe emotional trauma on the indigenous population. Cordoning off whole villages and forcible evacuation to poorly supplied camps resulted in people being compelled to live in the open, in temples, or under trees, exposed to harsh weather (The Tribune 1901). I find that this fear of segregation often led natives to conceal the sick or secretly bury the dead, resulting in severe punishment when

discovered by officials (Proceedings, Home: Medical and Sanitary, 1878). This emotional trauma, combined with material loss, demonstrates how the state's policies were perceived not as public health measures but as unnecessary persecution, leading to widespread resentment.

The regressive sanitation and cordon policies had an immediate and disastrous impact on the livelihoods of the working class. Daily wage earners, traders, and pedlars were prevented from selling their goods or travelling due to cordoning off, resulting in the closure of wholesale markets and significant trade decline (The Tribune 1901). Farmers faced severe economic hardship as they were unable to cultivate their fields during quarantine, and crops requiring immediate sale on ripening were devastated. Socio-religious organizations like Arya Samaj and Brahma Samaj provided voluntary aid, but this localized support was insufficient to mitigate the large-scale economic hardship caused by the British government's failure to provide necessary provisions during forced isolation (Khalsa Advocate 1908).

Certain social communities faced excessive surveillance and systematic suppression, underscoring the medicalization process's role in enforcing rigid colonial morality. The Tawaifs (courtesans/dancers), once respected, were persecuted and stigmatized as the main transmitters of disease among British soldiers, necessitating their compulsory registration under the Contagious Diseases Act of 1868 (Peers 1998). Simultaneously, the Hijra community (transgender persons), previously holding positions of prestige, was labelled as "eunuch imposters" and subject to the Criminal Tribes Act of 1871 and Section 377 of the Indian Penal Code, which sought to criminalize non-binary gender identities and restrict their public presence (Arnold 1993). This

demonstrates the pervasive nature of discriminatory policies aimed at controlling sexuality and gender, leading to the complete social marginalization of these vulnerable groups.

The colonial administration used its authority to systematically suppress indigenous medical practices and forcibly advance Western medicine. Traditional *Unani* and *Ayurvedic* practices were blamed for the spread of epidemics and dismissed as "superstitious" and "backward," providing the pretext for the state to impose Western medical systems (Bala 2012). The establishment of institutions like King Edward Medical College and numerous hospitals served not only to train new Western-allopathic professionals but also to dismantle the existing indigenous healthcare structure. This clash was rooted in a colonial belief in the inherent superiority of Western science, leading to the tragic loss of local medical knowledge and the erosion of the indigenous population's trust in their own healing traditions.

CONCLUSION

The locals in Colonial Punjab were affected in profound, multidimensional ways during the epidemics of 1860–1947. The British authorities used discriminatory health policies not as neutral public health measures, but as a calculated political and governance tool to restrict movement, suppress dissent, and reinforce colonial power structures. The systematic application of medicalization, analysed through Foucault's lens, was pivotal in achieving this, allowing the state to intervene coercively in non-medical spheres, from family customs and religious rituals to the livelihoods of farmers and daily wage earners (Foucault 1976).

The systemic suppression and stigmatization of communities like the Tawaifs and Hijras, coupled with the forcible dismantling of indigenous *Ayurvedic* and *Unani* healing systems, confirm that colonial health policies were overwhelmingly driven by the racial and economic interests of the European elite. The continuous acts of local resistance, though often met with severe punitive action and media suppression, highlight the resilience and agency of the indigenous population who fought against the erosion of their cultural autonomy. This study, by revealing the deep fractures created by medical authoritarianism, offers a crucial historical perspective, underscoring the enduring necessity of upholding ethical governance and social equity when confronting public health crises.

BIBLIOGRAPHY

PRIMARY SOURCES

Gazetteer of Montgomery District. 1884.
Khalsa Advocate. 1908.
Proceedings, Home: Medical and Sanitary.
 August 1876, Number 8.
Proceedings, Home: Medical and Sanitary.
 December 1879, Number 11.
Proceedings, Home: Medical and Sanitary. July
 1890, Number 29.
Proceedings, Home: Medical and Sanitary. March
 1907, Number 69.
Proceedings, Home: Medical and Sanitary.
 November 1883, Number 15.
Proceedings, Home: Medical and Sanitary.
 October 1907, Number 70.
Proceedings, Home: Medical and Sanitary.
 September 1882, Number 14.
Punjab Administration Report 1900-1901.
 Chapter VI, Vital Statistics and Medical Service.
Punjab Administration Report 1903-1904.
 Chapter VI, Vital Statistics and Medical Service.
Punjab Administration Report 1907-1908.
 Chapter VI, Vital Statistics and Medical Service.
Punjab Administration Report 1909-1910.
 Chapter VI, Vital Statistics and Medical Service.
Punjab Administration Report 1912-1913.
 Chapter VI, Vital Statistics and Medical Service.
The Tribune. 1901.

SECONDARY SOURCES

Arnold, David. 1993. *Colonizing the Body: State
 Medicine and Epidemic Disease in Nineteenth-
 Century India*. Berkeley: University of California
 Press.
 Bala, Poonam, ed. 2012. *Contesting Colonial
 Authority: Medicine and Indigenous Responses in
 Nineteenth and Twentieth-Century India*. New
 York: Lexington Books.
 Bayly, Christopher Alan. 1987. *Indian Society and
 the Making of the British Empire*. Vol. 1.
 Cambridge: Cambridge University Press.
 Bhattacharya, Sanjoy, Mark Harrison, and
 Michael Worboys. 2005. *Fractured States:
 Smallpox, Public Health and Vaccination Policy in
 British India 1800-1947*. Vol. 11. Hyderabad:
 Orient Blackswan.

Domin, Dolores. 1977. *India in 1857-1859: A
 Study in the Role of Sikhs in the People's
 Uprising*. Berlin: Academic Verlag.
 Foucault, Michel. 1976. *The Birth of the Clinic*.
 London: Tavistock.
 ———. 2000. "Power: The Essential Works of
 Michel Foucault 1954–1984. Vol. 3." Edited by J.
 Faubion. London: Allen Lane.
 Guha, Ranajit. 1983. *Elementary Aspects of
 Peasant Insurgency in Colonial India*. Oxford:
 Oxford University Press.
 Gupta, Das. 1987. 'Selective Discrimination
 Against Female Children in Rural Punjab,'
Population and Development Review 1: 77–100.
 Hall, Lauren K. 2019. *The Medicalization of Birth
 and Death: The Authoritarian Impulse in
 Medicine*. Palgrave Macmillan.
 Harrison, Mark. 1992. "Quarantine, Pilgrimage,
 and Colonial Trade: India 1866-1900." *The Indian
 Economic & Social History Review* 29, no. 2: 117-
 144.
 ———. 1994. *Public Health in British India:
 Anglo-Indian Preventive Medicine 1859-1914*.
 Cambridge University Press.
 Metcalf, Thomas R. 1997. *Ideologies of the Raj*.
 Vol. 4. Cambridge: Cambridge University Press.
 Paustian, W. 1930. *Canal Irrigation in the Punjab*.
 New York: Columbia University Press.
 Pande, Ishita. 2009. *Medicine, Race, and
 Liberalism in British Punjab: Symptoms of
 Empire*. Routledge.
 Peers, Douglas M. 1998. "Soldiers, Surgeons and
 the Campaigns to Combat Sexually Transmitted
 Diseases in Colonial India, 1805–1860." *Medical
 History* 42, no. 2: 137-160.
 Prasad, Srirupa. 2015. *Cultural Politics of Hygiene
 in India, 1890-1940: Contagions of Feeling*. New
 York: Springer.
 Sramek, J. 2014. "White Racial Superiority in the
 Colonial Medical Field." *Medical History* 58, no.
 3: 456-470.
 Tandon, Sasha. 2015. *State, Society, and
 Epidemics in Colonial Punjab 1849-1947*.
 Unpublished Ph.D. Diss., Punjab University,
 Chandigarh.
 Thompson, Paul, and Joanna Bornat. 2017. *The
 Voice of the Past: Oral History*. 4th ed. New York:
 Oxford University Press.

Zurbrigg, Sheila. 1992. "Hunger and Epidemic Malaria in Punjab, 1868-1940." *Economic and Political Weekly* 27, no. 4: 2-26.