EPIDEMICS IN COLONIAL PUNJAB: GOVERNANCE, MEDICINE, AND RESISTANCE

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ABSTRACT

This research investigates the outbreaks of major epidemics—malaria, plague, influenza, cholera, and smallpox—in Colonial Punjab from 1849 to 1947. It analyses the patterns of mortality, transmission, and eruption, arguing that these epidemics were not merely biological events but were intrinsically linked to the administrative, political, and developmental agendas of the British Raj. The core argument is that the colonial state utilised these health crises to establish and reinforce its authority through a discourse of Western medical superiority, implementing policies of segregation, sanitation, and inoculation that were applied differentially to European and native populations. Drawing on the Foucauldian concept of knowledge/power, this study posits that colonial medical interventions were a form of governance that, while for public health, served to demarcate the rulers from the ruled. This dissertation examines the implementation of colonial disease Acts and health policies, such as evacuation, quarantine, and medical examinations. It concludes that these measures, often enforced with coercion and cultural insensitivity, provoked a wide spectrum of responses from the native population, ranging from collaboration and negotiation by local elites to widespread evasion, rumour, and violent, active resistance from the general populace (Tandon 2003). This study fills a research gap by focusing on the socio-political dimensions of public health and native resistance in Punjab, exploring how state-imposed medical 'order' inevitably clashed with the socio-cultural, economic, and religious fabric of Indigenous society.

KEYWORDS: Epidemics, Colonial Punjab, Public Health, British Raj, Social Resistance

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This essay examines the complex interplay of disease, state power, and public response in Colonial Punjab from the mid-nineteenth to the early twentieth century. It argues that the colonial state governed its subjects through discursive methods of Western medical dominance and the creation of a systematic knowledge bank, particularly during the severe epidemics of malaria, cholera, smallpox, and plague. These interventions, however, were not passively received. The state's efforts to manage disease through policies of segregation, evacuation, and medical examination were met with serious and multifaceted resistance from the native Indian population, revealing the tensions inherent in colonial governance (Arnold 1993).

The larger context of this study is the colonial scenario of the Indian subcontinent, where the region's resources and environment were often framed as inherently favourable to disease, justifying British intervention. Initially, health strategy in India was driven by the need to protect British troops (Yong 2005). Over time, this expanded, but with clear priorities: administrative capitals, cantonments, and hill stations received the highest importance, while rural communities, where most of the population resided, received the least attention. This differential application of medical care and sanitation exposed the core priorities of the colonial regime, which avoided linking epidemic outbreaks to the consequences of its own rule, such as the construction of canals and railways or the disruption of local ecologies.

The epidemics in Colonial Punjab were especially severe, with mortality rates often exceeding those in other parts of India. Malaria alone claimed over twenty-three million lives, while plague, smallpox, and cholera added millions more to the toll. The British administration's forcible supervision of the situation frequently violated the cultural and religious sensibilities of the populace, leading to a spectrum of responses. While some educated middle classes offered reserved cooperation, common people often reacted with initial opposition and even violent outbreaks. This resistance was not merely superstitious fear but was often a rational response to coercive and disruptive state policies that threatened livelihoods and social structures.

This study engages with several disciplines, primarily the social and political history of medicine. It builds on the work of historians who have examined the political perspectives of colonialism, recognizing the British as beneficiaries who used provincial resources for imperial objectives (Metcalf 1998). It also engages with scholarship on Punjab's economic development, particularly the canal colony network, arguing that these "modernising" infrastructures were themselves contributing factors to public health crises (Zurbrigg 2018). While nationalist historians have explored anti-colonial-resistance, and medical historians have provided descriptive accounts of disease, this work bridges a gap by focusing specifically on the socio-political reaction to medical governance in Punjab.

Much of the existing literature on the social history of epidemics has focused on how disease was perceived or how it affected prevailing beliefs. Scholars like David Arnold (1993) and Mark Harrison (1994) have powerfully argued that Western medicine was used to establish a state-centred system of scientific knowledge and power. This essay utilizes their insights but applies them to the specific, and overlooked, context of Colonial Punjab. It addresses a research gap by moving beyond a simple narrative of state intervention and public reaction, instead

exploring the specific mechanisms of colonial power and the varied, rational forms of native resistance that emerged in response.

This work is geographically and chronologically focused on the territory of Colonial Punjab, directly administered by the British from 1849 to 1947. Theoretically, it utilizes the framework of Michel Foucault, particularly his concepts of knowledge and power as components of discourse (Foucault 1972). The British, by defining, counting, and "managing" epidemics, produced a discourse that positioned the Indian environment and its people as inherently diseased and in need of colonial control. This medical knowledge was not neutral; it was an instrument of power that justified the expansion of state hegemony and the imposition of policies that treated Indians as inferior subjects.

The methodology relies on a detailed analysis of both primary and secondary sources. Primary sources are the foundation of this research, drawn from the Proceedings of the Punjab Government (Home: Medical and Sanitary), Imperial and District Gazetteers, colonial census reports, and administrative reports on specific diseases. These official documents provide insight into the British administrative mindset, its priorities, and its documentation of native resistance. Contemporary periodicals, such as *The Tribune* and the *Khalsa Advocate*, offer a crucial counter-perspective, revealing the public's grievances. Secondary sources, including scholarly books and articles, provide the broader theoretical and historical context for this analysis.

Patterns of Epidemics in Colonial Punjab

Fever epidemics, primarily malaria, were a dominant feature in the medical and sanitation records of colonial India, and Punjab was no exception. Between 1850 and 1947, fifteen major malaria outbreaks claimed over fifty-one million lives in the province. The 1908 epidemic was so severe that the *Khalsa Advocate* commented, "Malaria is still regrettably excessively common... so harmful in its effect and so confusing in its outcome to the entire system." The worst-affected districts, such as Lahore and Gujranwala, saw over 2.2 million deaths between 1901 and 1911, with the disease's intensity varying across Punjab's diverse territory but remaining a constant, devastating presence (Christophers 1911).

The plague, however, crushed all previous epidemics in its severity. First appearing in October 1897, it arrived in multiple waves, with the period from 1897 to 1918 being the most aggrieved. At its peak in 1906–1907, the plague claimed 675,307 lives in a single year. The mortality rate was exacerbated by the public's resistance to vaccination and the perceived ineffectiveness of rat-eradication campaigns. The lack of medical officers during World War I and "financial inflexibility" for anti-rat campaigns in the 1920s further demonstrated the state's fluctuating commitment. The disease's toll was personal and profound, as reported in the Jhelum *Tahsil*, where a young man died and was buried in the very grave he had just built for his sick sister (Tandon 2015).

Concurrently, the 1918 influenza epidemic, arriving alongside the plague, claimed 898,947 lives in Punjab in that year alone. The *Khalsa Advocate* wrote with despair: "Death, the ancient enemy of man found its ally in influenza... When someone contracted it, he just has to wait and then pass away." Cholera also remained a recurrent threat, with twelve significant outbreaks between 1866 and 1921. These outbreaks were particularly prevalent in districts like Lahore and Gujranwala, where administrators blamed the spoiled water

supply, a problem made worse by the mass gatherings at local religious fairs (Cunningham 1873).

Smallpox remained a persistent threat, claiming over 850,000 lives between 1868 and 1947. Unlike other diseases, vaccination offered a viable preventative measure, yet its adoption was fraught with conflict. In many districts, the populace actively preferred traditional variolation over state-mandated vaccination. The British administration's early attempts to explain these outbreaks were heavily influenced by preconceived notions and a desire to defend colonial rule. They frequently attributed epidemics to the "poorly dressed, poorly fed, poorly housed" condition of the Indians, or their "irresponsible eating and drinking of unclean water," effectively blaming the victims while ignoring the systemic failures of colonial governance.

Natural calamities were strongly correlated with epidemic outbreaks, particularly malaria. The Sanitary Commissioner noted in 1884 that irregular rain combined with stagnant subsurface water was the predicted cause. Heavy rains and floods in Multan and Muzaffargarh in 1884 were directly followed by a malaria epidemic. The seasonal rhythm was undeniable: at least ten of the fifteen major malaria epidemics peaked in October, following the monsoon rains, when flooded areas and high subsoil water levels created ideal mosquito breeding grounds (Zurbrigg 2018).

The expansion of canal irrigation, a cornerstone of British developmental policy in Punjab, was ironically a major contributor to the health crisis. The Sanitary Commissioner observed in 1890 that the gradual expansion of canal irrigation in Sialkot, Gujrat, and Gujranwala coincided directly with an increase in malaria cases. The Chenab Canal, celebrated as an engineering marvel, was blamed for the rise in malaria in Jhang. This link was so well-known that a local proverb emerged: "*Jahan Jawe Pani Nahar, Wahan Jawe Bimari Bahar*" (Disease is prevalent everywhere the canal runs). Waterlogging from these massive, unlined canals created permanent marshy areas conducive to mosquito breeding (Bentley 1925).

The construction of railway lines, vital for imperial control and agricultural export, also created mobile hotspots for disease. Thousands of labourers, required for these massive projects, lived in crowded, unclean circumstances that ensured the rapid spread of epidemics. These workers were often "deprived, feeble, and starving," making them highly vulnerable. On one construction portion, cholera killed 30 per cent of the workforce in weeks. At the Adamwahan construction colony for the Empress Bridge (1874–1878), 75 per cent of the labourers were sick with malaria fever, demonstrating how colonial development directly manufactured disease environments.

Pilgrimages and religious congregations were frequently blamed by the British for spreading disease, particularly cholera. Pilgrims, often "hungry, weary, very dirty and crowded together," were seen as the primary vectors. For over 50 years, outbreaks were traced to visitors at fairs and holy sites like the Katas Raj Temple. Similarly, the movement of troops—the very instrument of colonial control—was a known factor. In 1872, soldiers returning from a mission were blamed for spreading cholera to Jhelum, Rawalpindi, and Lahore, as the sick were left off en-route and the dead were buried along the way (Cunningham 1873).

British authorities were often unwilling to link epidemics to the famines and food shortages created by their own economic

policies. The fever outbreak of 1863–1864 followed a shortage in 1861–1862 that saw food grain prices rise dramatically. Again, unreasonable prices in 1877–1878 were followed by fever outbreaks that killed half a million people. The failure of the *kharif* harvest in 1907 led to scarcity and a subsequent fever outbreak. These famines, or "shortages," weakened the population, leaving them with no physiological resistance to the diseases that followed (Zurbrigg 1992).

The movement of people, in general, was seen as a vector, and specific social groups were often scapegoated. In 1872, a *Maulana* from Lahore was blamed for a cholera outbreak in Gujrat. In 1900–1901, famine-troubled residents of Hissar were blamed for spreading cholera to Jhang. District officials also believed that low-caste groups, such as *Nais* (barbers) and *Chamars* (leather workers), propagated the plague. It was claimed they took the clothing of the deceased as a perquisite and transported it to other locations, a theory that conveniently ignored the primary vector of rat fleas.

A significant disparity existed between rural and urban mortality rates, particularly for malaria. In 1882, the fever death rates were comparable, but by the 1920s, the rural rate was significantly higher. This was because the rural population was more exposed to the marshy, wet environments created by canals and floods, which were ideal for mosquito breeding. Furthermore, medical aid was scarce in villages, and drainage or sanitation projects were non-existent. People lived in packed homes with little understanding, or administrative support, for sanitary improvements.

Cholera and plague followed a similar pattern, with rural mortality rates being significantly higher. The rural cholera death rate was over four times that of urban areas, primarily due to contaminated water from *katcha tanks* (mud tanks) and unprotected wells. In contrast, urban wells were more likely to be lined with stone. Plague also spread more quickly in rural areas due to inadequately ventilated, overcrowded housing where grain was stored, attracting rats. Cities, with more *pukka* (brick) homes and less household grain storage, offered fewer havens for plague-carrying rodents.

Conversely, smallpox demonstrated a higher mortality rate in cities. This is a counter-intuitive finding, as the Vaccination Act was first implemented in urban areas and one would expect residents to be better protected. However, the data suggests otherwise. This may be due to higher population density facilitating transmission. It also suggests that the degree of awareness and acceptance of vaccination, even in urban centres, varied significantly based on social status, gender, and community, indicating the complex and contested nature of this flagship colonial medical intervention (Minsky 2009).

State Governance During Epidemics in Colonial Punjab

The British response to these epidemics was guided by a new idea of government, in which the state was theoretically responsible for public health and sanitation (Harrison 1994). However, this responsibility was applied selectively. The state's actions revealed a colonial logic that framed Indians as living in an unclean, polluted environment, thereby "needing" constant surveillance and intervention. Those suspected of being contagious were segregated in tents and huts, and their homes were aggressively disinfected. This framework, developed over decades, was methodically applied during the plague epidemic of 1897, which became a severe test of the British capacity to manage its population (Tandon 2015).

A primary concern was the protection of European enclaves. Special efforts were made to keep disease away from cantonments, civil lines, and hill stations—the foundations of the Empire (Yong 2005). As early as 1874, roads were changed to prevent natives from having to enter cantonments. In 1875, the military in Sialkot established a barrier around the cantonment. By 1879, committees were established to examine the hygienic conditions of all villages within a five-mile radius of the major cantonments at Mian Mir and Rawalpindi, creating a sanitary *cordon* to protect the colonisers from the colonised.

Early attempts to control malaria among the local population involved segregation and sanitation. During the 1873 Rawalpindi fever epidemic, patients were housed in huts and tents for twenty-one days, and communication between the infected and uninfected was cut off. Polluted *mohallas* (residential communities) were cleaned, and the bedding of the afflicted was sterilized. This approach reflected the prevailing miasma theory, but its forceful application caused significant social disruption for the native population, who were subjected to measures far more intrusive than those applied to Europeans.

The distribution of quinine became a central strategy in battling malaria, especially as scientific understanding shifted. In the 1870s, government hospitals and dispensaries handled the task. By 1890, the state expanded this network, using *tahsildars* (local revenue officers) and vaccine workers to distribute the drug. In 1898, the postal service in the Lahore Division was mobilized to make quinine accessible to a wider populace. This shift from segregation to prophylaxis represented a more modern medical approach, though its implementation was often limited by budgetary constraints and logistical challenges in reaching remote rural areas.

Alongside medical interventions, environmental actions to eradicate mosquitoes and their breeding grounds were launched, though with mixed results. The first comprehensive investigation was conducted at the Mian Mir Cantonment—again, protecting the military was the priority. Drainage projects began in Lahore in 1885, followed by Rawalpindi and Sialkot. However, many of these projects were not completed until years later, hampered by material shortages during World War I and the diversion of funds to combat the plague. The scope of these environmental interventions was always constrained by budgetary factors rather than public health needs (Harrison 1994).

For smallpox, the British employed a dual strategy of segregation and, most importantly, vaccination, which was seen as the long-term solution. As with other diseases, victims were isolated in tents, huts, or special wards. In Lahore, a hospital was built specifically to segregate infected Europeans and Eurasians. The primary intervention, however, was the arm-to-arm vaccination programme, one of the first major public health initiatives in Punjab. The state saw this as a generous and humanitarian practice, a clear marker of its "civilising" mission (Bhattacharya, Harrison, and Worboys 2005).

The Punjab government established a complex framework for vaccination, dividing the territory into rings, each with a Superintendent General directing a medical organization. In 1881, these disparate facilities were combined into a single vaccination department. Native supervisors were appointed to work with *Zaildars* and *Lambardars* (village leaders) to provide support to the immunisers, demonstrating a

"top-down" model of implementation. By 1886, the Sanitary Commissioner began delivering lectures on the benefits of vaccination, a shift towards public persuasion rather than pure coercion (Minsky 2009).

To improve acceptance, the state sought the cooperation of local elites. Municipal committee members in Lahore, Multan, and Sialkot were encouraged to dispel anti-vaccination biases. In Multan, Seth Ganga Ram was noted for taking an active interest. In Jandiala Sher Khan, committee members attempted to spread awareness about vaccination's benefits. The native king of Faridkot set a public example by having his children vaccinated. This strategy aimed to use existing social hierarchies to legitimize and enforce colonial medical policy from within native society.

Despite these efforts, the immunisation programme made only slow progress. It was hindered by deep-seated societal prejudices, the logistical challenges of covering vast territories, and the often "depressing" behaviour of the vaccinators themselves, who performed their duties with little consideration for the public. For high-caste Hindus, the arm-to-arm method was particularly offensive, as it involved the transfer of bodily fluids, often from individuals of a lower caste. This religious and social objection proved to be a major barrier to the program's success (Bhattacharya, Harrison, and Worboys 2005).

The state's ability to treat cholera was limited by a persistent ambiguity in its scientific understanding. Although Robert Koch identified polluted water as the primary cause in 1883, it took the British in India over a decade to fully accept this. This uncertainty meant that some administrators promoted water supply upgrades while others remained focused on sanitation and cordons. As late as 1896, the Punjab Sanitary Commissioner expressed this ambiguity, stating, "contaminated drinking water is the commonest" route, but that "other routes of transmission" exist.

This confusion led to a continued emphasis on segregation and quarantine. In Sialkot in 1867, the sick was forcibly evacuated from villages. In Lahore in 1914, patients were isolated in their homes or in hospitals. They were forbidden from conducting societal commitments, and public gatherings like marriage processions and fairs were banned. This reliance on cordons, which had been discredited in Europe, reflected a coercive, police-based approach to public health that prioritized containment over treatment and directly interfered with the social and economic life of the populace (Arnold 1993).

Disinfection of homes and personal belongings was another key strategy. In Sialkot in 1867, diseased homes were sterilized and replastered. In Lahore, contaminated homes were fumigated with sulphur. The sick was compelled to change and wash their garments, and in 1886, patients' bedding was often burned. While water supply systems were eventually implemented in most urban centres, the immediate response was often destructive and punitive. Later, anti-cholera vaccinations were introduced, particularly at fairs, but the primary response for decades remained one of isolation and disinfection.

Peoples and Epidemics in Colonial Punjab

For the Punjabi populace, epidemics were a pervasive and recurring event for three-quarters of a century, and the state's response often aggravated the suffering. The forcible handling of the matter, which offended cultural and religious sensibilities, provoked a wide range of answers. While

official sources tend to focus on urban unrest, the local press, including *The Tribune*, documented the widespread dissatisfaction among all classes. These responses were not uniform but varied depending on the status of the community and the nature of their interactions with British officials (Tandon 2015).

The forced evacuation of infected areas into segregation camps was a major source of grievance. These camps were often poorly managed and undersupplied. In Zaffarwal, during the 1901 plague epidemic, *The Tribune* reported that residents were "compelled to reside in temples, open spaces, and under trees" due to a lack of housing. There were constant complaints of shortages of water, food, and milk. Official sources even acknowledged the "incredibly unsanitary layout" of the plague camps in Lahore, where makeshift *Chhappars* (huts) were built on barren sand *Tibbas* (hillocks) with no wells or trees nearby.

Contemporary sources reveal numerous examples of compulsion, callousness, and incompetence by local officials. Vaccination procedures were conducted "quickly and with little consideration for the people's convenience and religious observances," and some children died because of mishandled vaccinations. This confrontational attitude bordered on apathy. During the 1876 Cholera Epidemic in Mianwali, the land tax was not remitted. In Sialkot, villagers whose homes were burned during sanitation operations were denied compensation, fuelling a deep sense of injustice.

In 1903, a tragic incident in Mulkowal, Gujrat, exemplified the dangers of the state's medical campaign. Nineteen people received a plague inoculation that was contaminated with tetanus; all of them developed the disease and died. A similar incident occurred in 1907. Furthermore, access to medical care remained woefully inadequate. During the 1901–02 plague epidemic, only 148 villages were fully sanitized. In 1939, a vaccinator in Bhera was sent to combat a smallpox outbreak without a sufficient supply of equipment or vaccine, highlighting the gap between state policy and its practical application.

The epidemic scenario suspended the livelihoods of entire communities. The hardest hit was those who relied on daily wages. Measures like cordoning and evacuation prevented peddlers from selling their goods and *Julahas* (weavers) from accessing their markets. *Brahman* priests, who depended on wedding ceremonies, and *Banias* (moneylenders), who depended on interest recovery, both lost their sources of income. The plague's peak in April and May directly interfered with the harvesting of the crucial *rabi* (winter) crop, threatening the entire agricultural economy.

The fearful flight of people during epidemics led to massive social dislocation. Evacuees crowded into homes in supposedly "safe" areas, with reports of "close to forty people" occupying homes built for ten. This overcrowding, combined with a lack of medical supplies, only worsened the situation. This social chaos also led to a surge in robberies, as homes were left abandoned. The state's measures, intended to create order, instead generated panic, dislocation, and a breakdown of social norms (Arnold 2015).

Responses to state measures were not uniformly hostile; some segments of society cooperated with the British. Local elites and peasants, including *Lambardars*, were instructed on the importance of sanitary measures and tasked with imparting this knowledge to the populace. Missionaries and charitable groups, like the American Presbyterian Mission in Lahore, also offered

medical care. In Gujranwala in 1902, a public meeting was held where plans to fight the plague were discussed and approved, showing a willingness to collaborate.

The educated middle classes—doctors, lawyers, and journalists—often functioned as intermediaries between the state and the populace. They helped to coagulate the relationship, calming public anxiety and collaborating with authorities. In Zaffarwal, a public association was formed to help fight the plague. The *Khalsa Advocate* pleaded with the Lt. Governor to coordinate relief efforts during the 1908 malaria and 1918 influenza epidemics, framing their request as a petition from loyal subjects to a paternalistic government, a common strategy of colonial-era political negotiation.

Despite some collaboration, voices of unrest, particularly in the press, highlighted the public's grievances. *The Tribune* lamented the state's priorities: "The government also invests a lot of time and money to see the matter through the sessions, of the Chief Court. Even though the disease is killing thousands of people every day, the government is doing very nothing to save lives." The *Muslim Outlook* pointed to the blatant racial discrimination at Tara Devi, unable to comprehend "why an Indian cannot be a carrier of cholera... but a European is set to continue on his journey undisturbed".

Among the general populace, resistance was rooted in widespread rumours that reflected a deep distrust of the state's intentions. It was believed that the government was marking vaccinated children to take them as slaves or that they were "removing blood to create a blood mummy." Some believed the British were searching for the *Imam Mahdi* among the infants to murder him. Others suspected that native officers were intentionally spreading the disease by giving out poisoned candies or poisoning village wells. These rumours, while fantastic, reveal a population that viewed the colonial state as a malevolent and extractive force (Arnold 2015).

Resistance often took the form of evasion. People in the Jhang and Lahore districts relocated during the vaccination season, returning only after the vaccinator had left. During the plague, this evacuation was widespread, with residents of Sialkot and Lahore fleeing to the suburbs or their home communities. This mass, unorganized flight was a form of active, non-violent resistance that made the state's cordons and sanitary measures completely unenforceable. It was a grassroots rejection of state control over their bodies and homes.

Certain groups had specific objections, which were often manipulated by those with vested interests. *Brahman* priests, keepers of the Sitala (smallpox goddess) temples, and traditional variolators saw vaccination as a direct threat to their livelihoods and religious authority. They actively worked to stop immunisers from performing their duties. For religious reasons, many, including Jains in the Sialkot District, forbade rat eradication in their homes. For others, resistance was pragmatic: residents refused to evacuate their homes due to the legitimate fear of theft.

Public opposition at times escalated to active violence, particularly against the lower-level native officials tasked with implementing the plague measures. In 1883, vaccinators were assaulted multiple times. During the plague, the public protested, shouted insults, and physically attacked medical officers. For a while, it appeared as though the "fear of the government had reduced." These incidents, documented in government records, indicate the depth of bitterness among the community, especially

among traders and shopkeepers whose businesses were destroyed by the cordons.

A significant uprising occurred in Zaffarwal in May 1901. After three children were immunized without their parents' permission, a mob of 1,500 men attacked Babu Ram Das, the *Naib Tahsildar*. He was beaten, stoned, and "burned alive" in his cottage. This shocking act of violence led to the arrest of fifty people and the dispatch of troops to quell the rioting. It was a clear demonstration that when colonial medical policy crossed a certain threshold of perceived injustice and intrusion, the response could be explosive and deadly.

In February 1902, another clash, known as the Dogra riot, occurred in Sialkot. When officials tried to take a plague-stricken family member to a segregation hut, the Dogra residents of the town attacked the administrators and the Civil Physician. The crowd then set the hospital on fire. In response, the authorities arrested a thousand Dogra residents and placed sixty community leaders (*Chaudharis*) under strict military control. This collective punishment demonstrates how the state responded to public health resistance with overwhelming force, transforming a medical issue into a military one.

Conclusion

Epidemics in Colonial Punjab—malaria, plague, cholera, and smallpox—followed distinct patterns linked to both environmental and administrative factors. Heavy rainfall and, more significantly, the colonial projects of canal irrigation and railway construction created ideal breeding grounds for mosquitoes, leading to catastrophic malaria outbreaks. Unhygienic conditions at religious fairs, exacerbated by population density, were blamed for cholera, while troop movements and famine conditions weakened the populace and facilitated the spread of all diseases. The British administration, however, consistently chose to blame the "attitudes, behaviours, and living conditions" of the locals, attributing high mortality to their "fatalism, superstitions, and unsanitary living" (Tandon 2015).

The British system of rule introduced a new idea of government theoretically responsible for public health, but this was a colonial state where resources were used selectively. The primary beneficiaries of sanitation, drainage, and medical care were the European enclaves: the cantonments, civil lines, and hill stations (Yong 2005). Medical interventions for the native population, such as the smallpox vaccination, were disorganized and often met with resistance, not just from superstition, but from legitimate social and religious objections, such as the high-caste aversion to arm-to-arm vaccination using lymph from low-caste individuals (Bhattacharya, Harrison, and Worboys 2005).

The British implemented several forcible methods to battle the plague, which were ineffective in stopping the epidemic but highly effective in generating panic and resistance. The coercive and differential nature of these policies was blatant. Natives were forcibly detained, their belongings destroyed, and their homes aggressively disinfected. In contrast, Europeans suspected of infection were often politely inspected in their carriages and allowed to travel on. This racial and social inequality, highlighted by the contemporary press, formed the core of public grievance (Arnold 1993).

The measures taken by the British to combat epidemics—controlling movement, limiting social and religious conventions, and violating homes—provoked a spectrum of responses. The native population was not a

monolithic bloc. Local elites and the educated middle class often navigated a path of collaboration, using petitions and public meetings to request aid or mitigate the harshness of state policies. The priestly classes and practitioners of Indigenous medicine, whose authority was threatened, fostered resistance. The general populace, however, finding their livelihoods suspended and their families threatened, engaged in widespread evasion, rumour-mongering, and, in moments of desperation, violent riots.

In actuality, this situation created immense difficulties for the most vulnerable. The closure of stores and cordoning of villages destroyed trade and agricultural production. Farmers were not compensated for property lost during disinfection and were still expected to pay land revenue. The colonial state, in its attempt to impose a medical "order," revealed its fundamental priorities: the protection of imperial interests and European lives more than anything else. The epidemics, therefore, became a crisis not only of public health but of colonial legitimacy, exposing the deep chasm between the rulers and the ruled.

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