# Contagion And Colonialism: Race, Disease, And The Moral Theatre Of Empire In Nineteenth-Century India

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## Abstract

This research paper explores the racial, political, and epistemological dimensions of cholera in nineteenth-century colonial India, arguing that the pandemic became both a biological crisis and a moral theatre of empire. Through the lens of colonial medical archives, missionary accounts, and vernacular responses, it examines how disease was deployed as a discursive tool for legitimizing imperial authority and reinforcing racial hierarchies. The British medical establishment, driven by epidemiological anxiety and racial fear, constructed Indian bodies and environments as inherently diseased—an ideology that justified spatial segregation, urban sanitation programs, and the moral policing of native populations. Yet, these same policies exposed the contradictions of imperial governance: while claiming humanitarian purpose, they deepened inequalities and alienated indigenous communities from the structures of modern medicine. The study situates cholera not simply as a health crisis but as a site of colonial meaning-making, where science, religion, and race intersected. Simultaneously, it uncovers how Indian intellectuals, reformers, and local practitioners resisted and reinterpreted cholera through indigenous cosmologies of purity, divine wrath, and environmental balance. This dual movement—imperial pathologization and indigenous rearticulation—reveals the politics of knowledge that underpinned the colonial experience of disease. Ultimately, the paper argues that cholera functioned as a mirror of empire: a pandemic that laid bare the moral fault lines of colonial rule, exposing how racialized science and administrative power transformed human suffering into a spectacle of governance.

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The cholera pandemics of nineteenth-century India marked not only a turning point in global medical history but also a profound moral crisis for the colonial imagination (Arnold 1993, 23). Emerging from the fertile deltas of Bengal, the disease followed the trajectories of empire—moving along trade routes, military campaigns, and pilgrim roads—until it reached the far corners of Europe and the Americas. To the British, India was not merely the geographical origin of cholera but its epistemic frontier: a laboratory where the colonial state sought to study, control, and moralize contagion (Chakrabarti 2014, 115). The medical response to cholera thus became a project of imperial knowledge production, entwined with the racial hierarchies that structured colonial governance. The Indian body, portrayed as both vulnerable and culpable, became the symbolic locus of empire's sanitary anxieties, transforming social differences into biological deficiencies (Harrison 1994, 91).

Yet this medical rationality was deeply ambivalent. While colonial officers professed humanitarian concern for the "native population," their sanitary measures often served the dual purpose of social control and racial demarcation (Vaughan 1991, 48). Epidemics provided the pretext for new regimes of surveillance: plague camps, segregation wards, and municipal reforms that restructured urban life according to European ideals of cleanliness and discipline (Kraut 1994, 67). These policies were not only biomedical but biopolitical—designed to regulate the movement of bodies and emotions within the colonial city (Foucault 1978, 139). Indian neighbourhoods were pathologized as reservoirs of infection, while European enclaves were presented as sanitary fortresses of order. The discourse of hygiene thus translated seamlessly into a moral geography of empire, where the boundaries between health and disease mirrored those between ruler and ruled. Cholera, in this sense, became an instrument of imperial pedagogy—a lesson in civilization taught through the suffering of the colonized.

At the same time, cholera provoked powerful counter-narratives that challenged colonial authority. Indian physicians, religious reformers, and lay communities responded not through passive acceptance but through reinterpretation and resistance (Hardiman 2006, 55). While colonial medicine emphasized environmental determinism and bacteriological control, indigenous epistemologies framed cholera within moral and cosmic orders—linking disease to social disharmony, divine displeasure, and environmental balance (Kumar 1995, 117). Pilgrimage networks, vernacular print culture, and local rituals of purification offered alternative understandings of contagion that resisted the hegemony of Western medical discourse. In these responses, emotion and ethics replaced pathology and policy as the organizing principles of health. Thus, the history of cholera in colonial India was not a one-sided narrative of imperial imposition but a dynamic field of contestation, where knowledge, power, and belief continually collided and coexisted (Harrison 1999, 132).

The historiography of colonial medicine, and specifically cholera in India, is broadly divided into two major currents: the institutional and the postcolonial. The institutional history, exemplified by early works of scholars like Mark Harrison, meticulously documented the development of the Indian Medical Service (IMS), the establishment of sanitary commissions, and the administrative challenges of public health in the colony (Harrison 1994, 73). These studies provide a crucial empirical baseline, tracing the intellectual shifts from miasmatic theories to the advent of

bacteriology, and detailing the bureaucratic attempts to manage epidemics through legislation and infrastructure projects. This body of work underscores the logistical complexities faced by the British in a vast and diverse subcontinent, highlighting the sincere, if often flawed, effort to apply European scientific principles to tropical diseases, an effort that nevertheless remains bound by the inherent power structures of the imperial project (Narain 1974, 45).

The second, and now dominant, current is the postcolonial and biopolitical critique, pioneered by David Arnold and Pratik Chakrabarti, which reinterprets medical history not as a story of scientific progress but as a history of power (Arnold 1993, 45). This scholarship argues that disease was intrinsically a “cultural commodity” and a political resource, used to define and control the colonized subject (Chakrabarti 2014, 129). By drawing on the work of Michel Foucault, these scholars frame colonial sanitation as an exercise in "biopolitics"—the governmental control of life—where public health measures served primarily to segregate populations, justify racial hierarchies, and expand state surveillance over the private lives of Indians (Foucault 2003, 243). Furthermore, this critical literature has meticulously documented the indigenous responses to colonial medical authority, moving beyond simple narratives of resistance to explore how Indian communities negotiated, adapted, and hybridized imported medical knowledge within their own moral and religious cosmologies, thereby asserting epistemic agency in the face of imperial dominance (Prakash 1999, 156).

This research paper employs a critical-historical methodology, utilising archival and published primary sources filtered through the lens of postcolonial theory and the social history of medicine. The approach is fundamentally interdisciplinary, drawing on concepts from epidemiology, urban studies, and cultural anthropology to move beyond a narrow, clinical reading of the cholera pandemics (Bhattacharya 2011, 31). The analysis of primary sources—which include colonial administrative reports, official correspondence from the Sanitary Commissioners of India, medical texts published by the IMS, and missionary accounts—is not taken at face value. Instead, these documents are treated as narratives of empire, whose language and omissions reveal the underlying ideological work of colonial rule: the racialization of contagion and the moralization of sanitation (Douglas 1966, 102).

To achieve a balanced and comprehensive argument, the methodology also incorporates non-colonial primary sources, specifically the intellectual and cultural productions of Indian society. This includes vernacular press reports, biographies of Indian reformers, and anthropological studies of religious practices and healing rituals during the period (Arnold 1993, 61). By juxtaposing the bureaucratic rationality of the British reports with the moral and social consciousness of Indian responses, this methodology enables a critique of the colonial knowledge framework and provides the necessary texture to explore the politics of healing (Kumar 1972, 89). The final synthesis aims to trace the material effects of colonial policy on the lives of Indians—particularly regarding gender and caste—while simultaneously demonstrating how intellectual and cultural resistance transformed the meaning of the disease from an indictment of Indian inferiority into a critique of imperial mismanagement.

## The Colonial Construction of Disease and the Racialization of the Indian Body

The emergence of cholera as a global epidemic in the nineteenth century coincided with the consolidation of British imperial rule in India, and this temporal convergence gave the disease a distinctly racial and political character (Arnold 1993, 1). To colonial medical authorities, India was not merely the geographical source of cholera but the pathological heart of empire—a space whose climate, habits, and people collectively bred contagion (Harrison 1994, 91). In administrative correspondence and medical treatises, Indian bodies were repeatedly described as "peculiarly predisposed" to infection, their supposed filth and fatalism interpreted as both cause and symptom of disease (Bewell 1999, 168). These assumptions, however, were not scientific conclusions but moral judgments disguised as medical reasoning. The language of hygiene functioned as a proxy for racial discourse, transforming social and cultural difference into biological inferiority. Cholera thus became a convenient metaphor for the colonial worldview: the disease of the colonized body stood as proof of the empire's civilizing necessity.

British medical reports from Bengal, Bombay, and Madras consistently attributed the persistence of cholera to native habits—impure water sources, crowded living conditions, and religious festivals (Kumar 1995, 114). While such observations often had an empirical basis, they were selectively interpreted through the lens of racial determinism. The same conditions that afflicted European soldiers in India were framed as environmental misfortunes, while Indian suffering was portrayed as self-inflicted or culturally inevitable (Harrison 1999, 97). The colonial government's responses reflected this moral asymmetry: sanitary reforms were concentrated around European cantonments and administrative centers, while indigenous quarters were left largely neglected (Arnold 1993, 121). The racialization of disease thus became materialized in urban geography—the "white town" insulated by walls and drainage systems, and the "black town" relegated to contagion and overcrowding. The management of cholera was therefore less about preventing disease than about preserving racial hierarchies under the guise of medical rationality.

Colonial representations of the Indian body were shaped by a broader epistemology that conflated moral character with physical constitution (Bewell 1999, 175). The supposed indolence, dirtiness, and superstition of Indian society were pathologized as inherent traits, which both explained and justified the colony's continuous state of ill-health. Missionary writings reinforced this ideology by linking spiritual impurity with physical contagion—depicting cholera as divine punishment for idolatry or moral laxity (Howard-Jones 1975, 42). In this moral economy of disease, the colonial subject was doubly condemned: first as the victim of an uncontrollable environment, and second as the author of his own misery. The effect was to naturalize imperial paternalism—the British were cast not merely as rulers but as physicians of a sick society (Hardiman 2006, 66). In official discourse, medical authority and political authority merged seamlessly, transforming governance into a therapeutic mission. The Indian body became both the patient and the pathology of empire, a living site upon which the colonial project inscribed its narratives of progress and salvation.

The racialization of disease also extended to the representation of Indian spaces as inherently dangerous (Harrison

1999, 104). Cholera was imagined to emanate from the "fetid rivers" of Bengal or the "miasmatic plains" of the Ganges, where nature itself appeared complicit in the moral decay of its inhabitants. This environmental determinism turned geography into a racial text, allowing the British to portray their own presence as a hygienic intervention in a corrupted landscape (Metcalf 1989, 132). Yet, as David Arnold and others have shown, such narratives were undermined by empirical contradictions: despite extensive sanitary measures, cholera continued to claim European lives in India and abroad (Arnold 2006, 201). Rather than prompting self-reflection, these failures reinforced racial stereotypes—blaming native servants, pilgrims, and water carriers for the persistence of infection (Chakrabarti 2014, 145). Disease management thus became a performance of imperial rationality rather than an exercise in medical efficacy, serving to reaffirm the moral and epistemic superiority of the colonizer.

The obsession with racial difference led to the creation of detailed, often highly subjective, epidemiological maps and reports (Kumar 1995, 119). These documents, purporting scientific objectivity, meticulously tracked outbreaks by racial and religious demographics, inadvertently solidifying the idea that certain populations were inherently more susceptible to—or responsible for—the spread of the disease. The data collected frequently conflated correlation with causation, using higher mortality rates in densely populated Indian quarters as "proof" of native filth, ignoring the structural lack of clean water infrastructure in those very same areas (Bhattacharya 2011, 55). This intellectual sleight of hand was crucial to the colonial project, transforming systemic neglect into a scientific truth about racial biology.

A key turning point in the medical debate was the shift from the miasmatic theory, which blamed bad air and general filth, to the contagionist theory, which focused on direct transmission and specific sites of infection (Arnold 1993, 79). This shift did little to alter the racialized focus, however. Instead of viewing Indian environments as producing bad air, they were now viewed as *containing* the specific, infectious agent. The focus moved from the generalised 'uncleanliness' of the environment to the specific 'uncleanliness' of the water carriers, the food handlers, and the bathing rituals of the Indian people (Kumar 1972, 112). This new scientific framework simply refined the process of othering, allowing the colonial state to deploy more targeted, and often more intrusive, measures of control.

Furthermore, the very language used in colonial medical journals reflected this ingrained prejudice (Vaughan 1991, 52). Terms like "native fatalism" and "oriental apathy" were routinely employed to describe the Indian population's apparent lack of urgency or compliance in the face of epidemic measures. This cultural interpretation served a vital administrative function: it absolved the state of responsibility for inadequate infrastructure and high death rates (Hardiman 2006, 72). If the colonized people were inherently unwilling or unable to save themselves, the failure of public health lay with the subject, not the sovereign. This narrative of moral and biological deficiency was pervasive, seeping into military handbooks, educational curricula, and administrative policy documents across the subcontinent (Chakrabarti 2014, 151).

The presence of cholera in military cantonments became a primary administrative concern, driving much of the early sanitation expenditure. The disease's relentless march through British regiments

forced a recognition that the separation between "white" and "black" towns was porous and inadequate (Narain 1974, 68). Yet, even when the health of European soldiers was the motivation, the resulting sanitary reforms were executed by policing the surrounding Indian villages and markets, reinforcing the idea that the threat always emanated from the 'native' exterior, rather than the internal flaws of the colonial system itself (Kumar 1995, 125). This fear was a powerful political engine, demonstrating how the physical vulnerability of the coloniser translated into intensified social and political control over the colonized.

## Sanitation, Surveillance, and the Biopolitics of Empire

If the colonial construction of disease defined India as a pathological space, the sanitation policies that followed turned that diagnosis into an instrument of governance (Foucault 2003, 247). The nineteenth century saw the emergence of what Michel Foucault described as *biopower*—a mode of authority that operated not through overt coercion but through the regulation of life itself (Foucault 1978, 139). In British India, this took the form of sanitary engineering, epidemic mapping, and administrative surveillance, all justified under the humanitarian rhetoric of public health (Arnold 2000, 91). The colonial state's engagement with cholera epitomized this biopolitical logic: every well, drain, and body became a site of inspection and intervention. The collection of medical statistics, the classification of deaths, and the cartography of contagion translated Indian life into quantifiable data, transforming the population into a manageable object of empire (Harrison 1994, 88). Yet, behind the veneer of science lay a profound asymmetry—sanitation functioned less as a means of protecting the colonized than as a strategy for preserving the health and moral order of the rulers.

Sanitation in colonial India was thus inseparable from segregation. The creation of "clean" and "unclean" zones mirrored the racial hierarchies embedded in imperial ideology. In urban centers like Calcutta and Bombay, municipal reforms prioritised European quarters with paved roads, piped water, and drainage systems, while indigenous neighbourhoods were left overcrowded and under-serviced (Vaughan 1991, 66). These urban divisions were justified through epidemiological language: native districts were described as sources of "endemic danger," their inhabitants as "biological threats" (Harrison 1999, 110). The act of cleansing, therefore, was not simply a public health measure—it was a ritual of purification that reaffirmed colonial control over space and body alike. Public sanitation laws gave the state unprecedented access to the private lives of its subjects, legitimizing entry into homes, temples, and marketplaces under the pretext of disease prevention (Chakrabarti 2014, 132). The cholera epidemic thus served as a moral alibi for the surveillance of native life, producing what one might call an "anatomy of empire," where the management of filth became synonymous with the management of people.

The implementation of biopolitical control was particularly evident in the regulation of mass religious gatherings, such as the Kumbh Mela and the pilgrimage to Puri (Kumar 1972, 145). The British saw these events not as expressions of faith but as epidemiological nightmares—gigantic incubators of disease that threatened the entire subcontinent. Regulations included mandatory registration, health checks, the establishment of segregation camps, and strict policing of water sources. While some control was medically necessary, the tone and execution were invariably disciplinary,

treating pilgrims as an inherently unruly and dangerous mass of vectors (Pandey 1990, 61). These measures generated significant friction and resistance, as Indian communities viewed the state's intrusion into their spiritual lives as an act of sacrilege and a fundamental denial of religious freedom.

This biopolitical project also redefined the relationship between science and sovereignty (Harrison 1994, 95). The establishment of sanitary departments, medical colleges, and research laboratories institutionalized a form of state medicine that blurred the boundaries between care and control. The Health of Towns Act (1864), and subsequent sanitary codes, positioned the colonial administration as the ultimate arbiter of hygiene and morality (Arnold 2000, 108). Yet, these institutions were rarely neutral; they reflected the epistemic priorities of empire, where knowledge production was inseparable from political domination. The emphasis on cholera prevention, for instance, reinforced narratives of native incapacity—depicting Indians as incapable of maintaining cleanliness without supervision (Kumar 1995, 125). At the same time, the bureaucratic obsession with data, inspection, and classification allowed the colonial state to expand its reach into everyday life. Sanitary reports did not merely record disease; they mapped out the moral geography of empire, identifying zones of danger and disorder that justified perpetual intervention.

The colonial fixation with sanitation also intersected with class and caste hierarchies within Indian society (Chakrabarty 2000, 137). Municipal regulations on waste disposal and street cleaning were enforced through the coercion of lower-caste labourers, whose stigmatized occupation as sweepers and scavengers was both exploited and reinforced by sanitary reforms. Thus, the biopolitics of cholera governance extended beyond the racial binary of colonizer and colonized, reproducing internal hierarchies of purity and pollution within Indian society itself (Chatterjee 1993, 149). By assigning "dirty work" to those already marginalized, the colonial state naturalized social inequality under the pretext of scientific necessity. At the same time, these workers became indispensable agents of empire—maintaining the illusion of cleanliness that sustained colonial legitimacy. The contradictions of sanitary modernity were therefore both moral and material: the empire's claim to rational governance depended on the invisible labour and suffering of those it deemed untouchable.

The extensive planning and construction of massive drainage and waterworks projects in major cities, such as Calcutta, often failed to achieve their stated public health goals (Bhattacharya 2011, 78). Designed by European engineers with little regard for local conditions, these systems were frequently inadequate, and their costs were disproportionately levied on the Indian population. The resulting increase in taxation led to widespread popular protest, highlighting the direct link between perceived 'scientific' improvements and economic exploitation. The projects, while grand in ambition, often created new problems, such as waterlogging in low-lying areas, which ironically exacerbated the conditions for waterborne diseases like cholera and malaria, demonstrating the limits of an impositional, top-down approach to public health.

The disciplinary function of sanitation extended to the establishment of quarantine stations at ports, ostensibly to prevent the spread of cholera westward (Kumar 1972, 151). These stations, however, also became sites for the physical examination and racial profiling of Indian

travellers, sailors, and migrants. The procedures were often crude, intrusive, and humiliating, reinforcing the notion that the Indian body was the primary source of global contagion. This maritime surveillance was crucial for projecting an image of the British Empire as a responsible global power, protecting Europe from the diseases of the tropics, even if the measures themselves were ineffective against microscopic pathogens. The quarantine became a ritual of separation, marking the boundary between the supposedly hygienic West and the pathological East.

The concept of the "sanitary city" was central to the colonial administration's self-image (Metcalf 1995, 101). By reorganizing urban spaces—creating wide avenues, clearing densely packed neighbourhoods, and building segregated barracks—the British attempted to manifest a physical form of racial and moral order. However, this destruction of existing indigenous urban fabric often destroyed community networks and forced the poor into even more congested and unsanitary peripheries. The pursuit of hygienic order thus generated social chaos and further health vulnerability, a profound irony of the colonial sanitary mission. The cleanliness of the European quarters was literally built on the continued degradation of the colonized city.

The language of cleanliness and contagion eventually transcended the realm of public health to shape the political imagination of empire (Vaughan 1991, 72). The sanitary body became a metaphor for the imperial body politic, and the eradication of disease mirrored the desire to purify colonial society of disorder. In this sense, sanitation was not simply about drains and disinfectants; it was about disciplining desire, regulating mobility, and policing intimacy (Douglas 1966, 119). The cholera epidemic provided the perfect moral justification for such interventions, as it conflated medical care with moral reform. The British presented their sanitary missions as acts of benevolence, but their underlying logic was profoundly authoritarian: to be clean was to be civilized, and to be unclean was to remain unfit for self-rule (Metcalf 1995, 112). Through this rhetoric, the empire medicalized morality itself, turning the politics of health into an ethics of obedience.

## Moral Medicine and Missionary Humanitarianism

The cholera pandemics of nineteenth-century India not only reshaped colonial governance but also became a powerful moral theatre for Christian missionary activity (Hardiman 2006, 91). The mission hospital emerged as both a site of healing and a stage for spiritual conversion, where medical treatment was inseparable from moral instruction (Kumar 1995, 138). Missionaries presented themselves as compassionate agents of civilization, contrasting their benevolent care with what they perceived as the superstition and fatalism of native healers. Yet, beneath this rhetoric of charity lay an implicit hierarchy of salvation: physical recovery served as a metaphor for spiritual enlightenment, and Indian suffering became the moral justification for missionary presence (Etherington 2005, 41). The cholera ward was thus not merely a clinical space but a narrative space—a microcosm of empire where disease and redemption converged. The body, wracked with illness, became the terrain upon which colonial humanitarianism inscribed its theology of empire.

Medical missions in India, particularly those of the London Missionary Society and the Church Missionary Society, functioned as instruments of both faith and discipline

(Foster 2013, 66). Mission doctors combined Western medical practices with evangelical preaching, often treating patients while reciting scripture or distributing religious pamphlets. Their approach to cholera exemplified a fusion of moral and medical epistemologies: epidemics were interpreted not only as biological events but as divine tests that revealed the moral decay of heathen society (Porter 2004, 92). Such interpretations reflected a Protestant ethic that linked cleanliness, health, and godliness into a single moral continuum (Weber 1958, 111). Sanitary reform and conversion were portrayed as parallel processes of purification—one of the body, the other of the soul (Metcalf 1995, 112). In this moral framework, healing was never a neutral act; it was a form of moral pedagogy through which Indians were taught to internalize Western values of discipline, hygiene, and obedience (Hardiman 2006, 96). Thus, the mission hospital became a moral laboratory where the empire's civilizing narrative could be enacted under the guise of benevolence.

The medical missions often strategically located their hospitals and dispensaries near pilgrimage sites or in areas heavily affected by cholera, turning the crisis into an opportunity for evangelism (Narain 1974, 85). The desperation of the sick and their families often compelled them to accept missionary aid, a transactional moment where medical relief was implicitly linked to exposure to Christian doctrine. These actions were meticulously documented in missionary reports sent back to Europe, which frequently exaggerated the success of conversions, using the suffering of the colonized as emotional currency to raise funds and justify their continued presence in India. The narrative of saving souls through healing the body was a powerful engine of imperial expansion.

The intersection of medicine and morality also revealed the deep paternalism underlying missionary humanitarianism (Harrison 1994, 111). Indian patients were rarely treated as equals in the pursuit of salvation or science; rather, they were infantilized as subjects incapable of understanding the spiritual or hygienic logic of modernity. Missionary records frequently described converts as "childlike" souls rescued from the "darkness of ignorance" by the dual light of medicine and faith (Burton 1994, 58). Such depictions mirrored the colonial trope of the "civilizing mission," in which compassion was inseparable from control. Even acts of charity carried disciplinary undertones: hospital routines enforced timetables, dietary restrictions, and gender segregation modeled on European institutions (Buettner 2004, 91). While these practices were justified as measures of efficiency, they also functioned to reformat native bodies and habits in the image of Christian modernity. In this sense, missionary medicine operated as an affective technology of empire—governing through empathy, moralizing through care.

The training of Indian medical assistants and nurses by missionary institutions further exemplifies this complex dynamic (Hardiman 2006, 96). While providing valuable professional skills, this training simultaneously instilled a deep sense of medical and cultural inferiority, insisting on the supremacy of Western methods and moral codes. Indian practitioners were often confined to subordinate roles, acting as cultural mediators between the British doctors and the local population, rather than being recognised as independent medical authorities. This system ensured the perpetuation of the racial hierarchy even within the mission's purportedly egalitarian therapeutic space. The transfer of knowledge was thus carefully managed

to maintain the colonial epistemic monopoly.

Yet, missionary interventions also generated forms of resistance and reinterpretation among Indian communities (Burton 1994, 64). Many patients accepted medical treatment while rearticulating its meaning within their own religious cosmologies. In Hindu and Muslim reform movements alike, cholera was often interpreted as divine displeasure rather than divine punishment, emphasizing ritual purification and social harmony over conversion (Jones 1989, 86). Indigenous healers adapted selectively to Western medical techniques while retaining vernacular frameworks of morality and disease. This hybridization undermined missionary claims to epistemic exclusivity, revealing that compassion and healing were not the monopoly of Christianity or empire. Indeed, some Indian reformers, such as Ishwar Chandra Vidyasagar and Sir Syed Ahmad Khan, argued that true morality lay in empathy and service, not in conversion—transforming the language of humanitarianism into a critique of imperial hypocrisy (Bayly 2012, 211). Their writings exposed how missionary benevolence, however sincere, remained entangled with the structures of racial hierarchy and economic exploitation that sustained colonial rule.

The mission station's public health pronouncements, often delivered with religious fervour, frequently led to confrontations with local religious and social authorities (Etherington 2005, 69). The missionary condemnation of Hindu bathing rituals and the use of indigenous remedies as 'heathen superstitions' was seen as an assault on cultural integrity. These conflicts reveal that the struggle against cholera was not simply a scientific debate but a profound clash of worldviews: a struggle over which moral system held the authority to define purity, pollution, and the proper relationship between humanity and the divine. The missionaries' attempts to impose a singular Christian morality through medical intervention were thus met with a robust defence of indigenous ethical frameworks.

The cholera mission, therefore, exemplified the moral contradictions of imperial humanitarianism (Vaughan 1991, 89). While claiming to save bodies and souls, it reinforced the very inequalities it professed to transcend. The colonial hospital stood as a symbol of this paradox—a space where compassion was conditional, and healing served as a metaphor for domination. Missionaries sought to discipline emotion and standardize virtue, yet the emotional realities of suffering often exceeded their moral scripts (Burton 1994, 79). Patients wept, prayed, and resisted in ways that eluded the missionary's categories of salvation, asserting alternative moralities grounded in kinship, ritual, and reciprocity. In these moments, the colonial encounter with cholera revealed its deepest truth: that beneath the empire's humanitarian mask lay the persistence of asymmetry, and that even in care, power spoke louder than compassion.

## Indigenous Knowledge, Resistance, and the Politics of Healing

The encounter between Western medicine and indigenous healing in nineteenth-century India was never a one-sided process of domination (Prakash 1999, 181). While the British sought to impose their biomedical rationality as the universal language of health, Indian practitioners, intellectuals, and communities responded with creative forms of negotiation, adaptation, and resistance (Arnold 1993, 177). The cholera epidemic became a contested epistemic field where multiple systems of knowledge—Ayurvedic, Unani,

folk, and spiritual—competed to define the causes and cures of disease (Wujastyk and Smith 2008, 33). For many Indian healers, cholera was not a random contagion but a symptom of moral imbalance or environmental disharmony, reflecting a cosmology in which health was inseparable from ethics and ecology (Harrison 1999, 112). This holistic worldview directly challenged the reductionist logic of colonial medicine, which divorced disease from its social and moral context. Indigenous responses thus represented not mere superstition but an alternative epistemology of care—one that refused the imperial division between body, spirit, and society.

The persistence of indigenous healing practices under colonial rule attested to their moral legitimacy and social embeddedness (Hardiman 2006, 103). Despite repeated attempts by British authorities to criminalize or delegitimize "quack doctors" and "native healers," local communities continued to seek their counsel and protection during epidemics (Pandey 1990, 75). This enduring trust reflected not ignorance but intimacy: traditional healers were woven into the fabric of everyday life, their knowledge passed through generations of ritual, observation, and moral apprenticeship. Ayurvedic and Unani physicians articulated complex understandings of cholera as a disorder of humoral balance, prescribing dietary moderation, spiritual purification, and environmental cleansing (Wujastyk and Smith 2008, 46). Their treatments—though often dismissed by colonial medicine as primitive—were based on ecological sensitivity and communal participation, contrasting sharply with the impersonal regimens of Western sanitation. In many villages, rituals of propitiation, collective fasting, and water purification functioned as forms of psychological and social healing, reaffirming community bonds in times of fear (Kumar 1995, 153). Through such practices, Indians reasserted control over their own bodies and environments, turning the epidemic into a moral dialogue rather than a bureaucratic decree.

Resistance to colonial medicine also took intellectual and institutional forms (Arnold 2000, 124). The nineteenth century witnessed a revival of indigenous medical learning, marked by the establishment of Sanskrit and Persian medical schools and the publication of vernacular treatises on epidemic diseases. Figures like Kaviraj Gananath Sen and Hakim Ajmal Khan sought to reconcile traditional frameworks with modern scientific vocabulary, asserting that Indian medical systems possessed their own empirical foundations (Sen 1910, 19). This intellectual movement was not anti-modern but *alternative modern*—a project of epistemic decolonization that aimed to reclaim the authority of Indian knowledge within the modern world (Prakash 1999, 189). Cholera, as both a biomedical and moral crisis, became the catalyst for this intellectual resurgence (Jones 1989, 94). The very attempts of the colonial state to suppress native medicine, through licensing laws and educational exclusion, ironically fostered a sense of professional solidarity and cultural pride among Indian practitioners. By translating medical texts into vernacular languages and engaging in public debate, they transformed healing into a form of national pedagogy—an assertion that India's moral and intellectual vitality could not be reduced to colonial pathology.

The debates between indigenous practitioners and colonial medical officers were frequently public and acrimonious, particularly regarding the efficacy of various preventative measures (O'Hanlon 1996, 112). Ayurvedic and Unani doctors often highlighted the dangers of Western allopathic drugs and the ethical failures of

compulsory isolation, arguing for community-based, non-coercive treatment protocols. These public disagreements, often documented in the vibrant vernacular press, served to educate the populace about different medical philosophies and empowered them to make choices that directly challenged the colonial monopoly on health knowledge. The epidemic, therefore, became a crucible for a burgeoning national medical consciousness.

Equally significant were the vernacular narratives and folk rituals that circulated outside formal medical institutions (Crooke 1896, 211). Cholera deities—such as Ola Bibi in Bengal, Mariamman in South India, and Shitala Mata in the North—embodied indigenous cosmologies of disease that merged fear with reverence. Far from being mere relics of superstition, these goddess cults represented complex symbolic systems that humanized illness and restored meaning to suffering (Nicholas 1972, 849). The rituals associated with these deities—offerings of water, songs of supplication, and communal feasts—reframed contagion as a shared moral trial rather than an individual affliction (Hiltebeitel 1999, 223). In doing so, they performed a social function often neglected by colonial medicine: the reconciliation of emotion, environment, and ethics (Vaughan 1991, 97). The veneration of disease deities symbolised the continuity of moral order amidst biological chaos, affirming the resilience of local cosmologies against the disenchantment of modern science. These practices demonstrated that resistance to empire was not always articulated through political rebellion; it could also manifest through acts of cultural persistence, emotional solidarity, and moral reinterpretation.

The role of caste associations and reform movements was also critical in disseminating alternative health information (O'Hanlon 1996, 135). Many high-caste Hindu organizations, while generally supportive of sanitary improvements, vehemently opposed the colonial practice of forced inspection and the desecration of holy sites. They used their own communal resources to establish relief societies, providing food and medical aid in ways that reinforced existing social networks but were independent of state control. This strategic humanitarianism allowed them to assert civic leadership and moral authority, implicitly challenging the colonial narrative that only the British could bring order and care to the suffering populace.

The very concept of a "patient" differed dramatically between the two systems (Chakrabarti 2014, 165). Colonial medicine, increasingly focused on bacteriology, treated the individual as an isolated biological entity whose recovery was primarily a technical matter. Indigenous systems, conversely, viewed the sick individual as an intrinsic part of a family, social, and cosmic whole, where healing required not just medication but the restoration of social harmony and spiritual balance. This fundamental ethical difference underscored the deep chasm between imperial science and Indian care traditions, revealing that the politics of healing was rooted in two antithetical definitions of the human being.

Ultimately, the politics of healing in colonial India revealed the limits of imperial biomedicine (Arnold 1993, 190). The British sought to discipline the Indian body through sanitation and surveillance, but they could not extinguish the moral and metaphysical frameworks that animated indigenous healing. By engaging with cholera on their own terms, Indian communities exposed the ethical contradictions of colonial rule: that an

empire claiming to save lives often did so by devaluing them (Kumar 1995, 163). The coexistence of multiple healing traditions within a single epidemic underscores the pluralism of India's moral landscape—a pluralism that refused to be contained by the binaries of modern and traditional, rational and mystical, colonizer and colonized. In this plurality lay a profound act of resistance: the insistence that health was not merely the absence of disease but the presence of justice, compassion, and moral balance (Prakash 1999, 194).

## Gender, Labor, and the Emotional Geographies of Disease

The experience of cholera in colonial India was profoundly gendered (Burton 1994, 93). While official records and medical reports often presented epidemics as gender-neutral phenomena, the realities of infection, care, and mourning were structured by the moral economies of patriarchy and labor. Women were the unseen custodians of health within Indian households—responsible for cleaning, nursing, and ritual purification—yet they were largely excluded from colonial medical discourse (Strobel 1991, 82). In British epidemiological writing, women appeared only as vectors of contagion or as the "ignorant wives" of native men who resisted sanitary instruction. This erasure was not accidental but ideological: it reflected the colonial conflation of female domesticity with irrationality and dirt (Douglas 1966, 127). By positioning women as both the cause and consequence of disease, colonial medicine reinforced patriarchal and racial hierarchies, rendering the feminine body the symbolic repository of both impurity and suffering.

Women's labor during cholera outbreaks, however, revealed a different moral geography—one grounded in care, intimacy, and emotional endurance (Hardiman 2006, 109). In homes, villages, and religious spaces, women performed acts of caregiving that blurred the boundaries between ritual and medicine: boiling water, administering herbal remedies, burning incense, and reciting protective prayers. These practices, though dismissed as superstitious by colonial physicians, were rooted in embodied knowledge passed down through generations. The domestic space itself became a site of healing and mourning, where emotional expression—particularly weeping, singing, and lamentation—served both psychological and communal functions. The weeping woman, far from being a symbol of weakness, embodied what Veena Das has termed the "ethics of care in crisis," transforming private grief into a collective act of moral resilience (Das 2007, 112). In such moments, the gendered body became a vessel of moral strength, capable of sustaining life even as the structures of empire and medicine failed to do so.

At the same time, the colonial medical apparatus relied heavily on women's labor while denying them authority or recognition (Kumar 1995, 166). Indian midwives (*dais*), nurses, and sanitation workers formed the backbone of epidemic management, particularly in rural areas. Their intimate knowledge of childbirth, death, and bodily hygiene made them indispensable to both indigenous and colonial medical systems. Yet, these women occupied a paradoxical position: their work was vital but stigmatized, their expertise acknowledged yet devalued (Vaughan 1991, 103). Colonial officials frequently condemned *dais* for spreading infection, while simultaneously depending on them to reach populations beyond the administrative gaze. This ambivalence reflected a deeper anxiety about female corporeality and class. Lower-caste women, in particular, were portrayed as "natural

carriers of filth," a trope that justified their exploitation within sanitary labor. The cholera crisis thus exposed how gender, caste, and race intersected to structure the moral economies of cleanliness and contagion.

The employment of women in the formal sanitation infrastructure—cleaning streets, latrines, and sewage systems—was a clear instance of colonial pragmatism overriding moral propriety. These positions were almost universally reserved for women from the lowest castes, cementing the link between female labor, untouchability, and the management of urban filth (Oldenburg 1989, 205). This system ensured that the most dangerous and degrading work was performed by the most marginalized, simultaneously upholding the fiction of a clean European administration while exploiting the very people it was meant to civilize. The bodies of these female sanitation workers were literally positioned on the front lines of the biopolitical project, absorbing the dirt and disease of the colonial city.

Within this framework, British women—missionaries, nurses, and reformers—occupied a distinct, often contradictory role (Burton 1994, 101). They entered India's medical and humanitarian landscape under the banner of "imperial sisterhood," seeking to uplift their Indian counterparts while upholding the moral authority of empire. Figures such as Florence Nightingale and Mary Carpenter framed their interventions as acts of feminine empathy, but their writings reveal a civilizing paternalism that reinforced racial hierarchy (Nightingale 1863, 45). By teaching Indian women "proper hygiene" and "moral motherhood," these reformers sought to reshape domestic life into an instrument of imperial order. Their philanthropy, though progressive in tone, perpetuated the assumption that Indian womanhood required redemption through Western tutelage (Burton 1994, 108). In this moral economy, the caring female body—British or Indian—became the symbolic site of empire's self-justification, a body through which the empire performed its compassion and concealed its coercion.

The emotional dimension of women's experiences during cholera also challenged the binaries of reason and emotion, cleanliness and contagion (Das 2007, 119). Lamentation rituals, devotional songs, and collective prayers performed by women offered a moral counter-narrative to the state's bureaucratic rationality. These expressions of grief, while dismissed as hysteria by colonial observers, embodied a collective ethics of empathy and endurance that transcended the logic of sanitation and science (Vaughan 1991, 107). In many communities, the act of mourning itself became a form of healing—a way to reassert the value of human connection in the face of death's dehumanization. Through these emotional practices, women not only cared for the dying but also cared for the moral fabric of their societies (Kumar 1995, 174). Their labor—physical, emotional, and spiritual—illuminates the paradox of empire: that the machinery of colonial governance depended on the invisible ethics of those it silenced.

The forced separation of families into cholera camps and segregation hospitals further fractured the gendered economy of care. Colonial medical rules often dictated that male doctors would examine and treat female patients, a profound violation of social custom and modesty that generated intense community resistance and fear (Oldenburg 1989, 218). This institutional intrusion into gendered space was justified by the 'greater good' of public health, yet it highlighted the fundamental disrespect for indigenous social codes. The epidemic thus provided the administration with a moral

mandate to transgress deeply held norms, further alienating the very populations they intended to protect.

Ultimately, gender and labor in the cholera epidemic reveal the empire's emotional architecture—the ways in which the regulation of disease was also the regulation of feeling (Harrison 1994, 139). Colonial public health sought to discipline bodies, but women's emotional and domestic practices sustained communities through acts of care that eluded surveillance. In their resilience, mourning, and embodied compassion, Indian women articulated an alternative politics of health—one rooted not in control but in connection (Das 2007, 122). The cholera crisis, seen through this lens, becomes more than a medical event; it is a moral allegory of endurance, where the invisible labor of women upheld the fragile humanity of a world fractured by empire (Arnold 1993, 201).

## Empire, Modernity, and the Afterlife of Disease

By the late nineteenth century, the governance of cholera in India had become a mirror for the contradictions of colonial modernity (Chakrabarti 2014, 176). The British Empire celebrated its sanitary reforms as triumphs of scientific progress and moral duty, yet cholera's persistence undermined this narrative of control. Despite advances in bacteriology following Robert Koch's discovery of the *Vibrio cholerae* in 1883, the epidemic remained endemic across India—defying the technological optimism of imperial medicine (Kumar 1995, 182). The tension between theory and reality exposed the limits of colonial rationality: the empire could map, classify, and quarantine disease, but it could not erase the conditions it had helped create. Industrial urbanization, overcrowding, and exploitative labor systems continued to shape India's epidemiological landscape, while imperial discourse deflected responsibility onto climate, custom, and race (Vaughan 1991, 115). In this failure, cholera became more than a disease—it was an allegory of empire itself, a contagion that thrived on the very inequalities the empire produced.

The transition to bacteriological modernity reconfigured the epistemology of disease without dismantling its moral foundations (Latour 1988, 63). Bacteriology promised universal scientific objectivity, yet in the colonial context it was absorbed into existing hierarchies of race and authority. Laboratories established in Bombay and Calcutta served as symbols of imperial knowledge, projecting the image of a rational, hygienic empire mastering the mysteries of nature. But this new medical modernity remained exclusionary: Indian physicians were often relegated to subordinate roles, their observations discounted unless they conformed to Western paradigms (Arnold 2000, 132). The "scientific empire" thus reasserted its moral geography through new technologies of truth. The microscope replaced the missionary sermon, but both served the same ideological purpose—to define what counted as knowledge and who could speak it (Latour 1988, 71). Even as bacteriology displaced miasmatic theories, it continued to moralize Indian environments as inherently dangerous and Indian bodies as biologically predisposed to disease. Modern medicine, in this sense, became the latest idiom of empire, transforming racial discourse into scientific orthodoxy.

The widespread introduction of anti-cholera vaccines in the late nineteenth and early twentieth centuries offered a new frontier for colonial biopolitics. However, initial vaccination efforts were often met with profound skepticism and outright refusal by the Indian population, who

distrusted the government's motives and the untested nature of the serum (Narain 1974, 110). The colonial response was often coercive, employing military or police force to ensure compliance in outbreak zones, which further cemented the public's association of modern medicine with state violence and intrusion. This failure to secure public consent undermined the humanitarian claims of the scientific regime, demonstrating that scientific truth, when backed by coercion, operates as another form of political control.

Yet, the spread of modern medical knowledge also opened spaces for subversion and dialogue (Bayly 2012, 223). Indian scientists, reformers, and nationalists appropriated bacteriology to critique the empire's hypocrisy—arguing that disease in India persisted not because of native ignorance but because of colonial neglect (Kumar 1995, 195). Figures such as Mahendralal Sircar, Prafulla Chandra Ray, and Upendranath Brahmachari challenged the epistemic monopoly of the British by integrating Western science into indigenous frameworks of moral responsibility (Arnold 2000, 139). Their journals and institutions—such as the Indian Association for the Cultivation of Science—became arenas for asserting intellectual autonomy and national dignity. In this emerging discourse, cholera ceased to be a symbol of racial inferiority and became instead a critique of imperial mismanagement (Prakash 1999, 203). Scientific modernity was reimagined as a space of moral citizenship rather than imperial control, where knowledge served not to dominate but to heal. This transformation anticipated the postcolonial redefinition of public health as a right of the people rather than a privilege of empire.

The colonial focus on epidemic control also diverted resources and attention from the underlying endemic conditions of poverty and malnutrition that made the population vulnerable in the first place (Kumar 1972, 178). The administration preferred the spectacle of an emergency response—quarantine, disinfection, and mass vaccination—over the long, costly, and politically challenging work of fundamental social reform, land redistribution, and sustained investment in universal public infrastructure. This strategic neglect revealed the economic priorities of the empire, which valued the efficiency of exploitation over the health of its subjects, thereby making cholera a chronic symptom of colonial capitalism.

The legacy of cholera and colonial medicine endured well into the twentieth century, shaping independent India's attitudes toward disease, sanitation, and development (Chakrabarti 2014, 191). Postcolonial health policies often retained the bureaucratic structures and moral languages of their colonial predecessors, emphasizing discipline, hygiene, and state paternalism. The discourse of cleanliness—now detached from overt racial hierarchy—continued to moralize poverty, framing the poor as agents of contagion rather than victims of inequality (Pandey 1990, 94). In this sense, the afterlife of cholera revealed the continuity between colonial and postcolonial modernities: both sought to govern life through moral regulation disguised as health. Yet, the persistence of vernacular healing traditions, religious rituals, and community-led health movements also testified to the resilience of alternative moral ecologies (Wujastyk and Smith 2008, 62). These practices, often dismissed as anachronistic, represent living archives of resistance to technocratic rationality—reminders that health cannot be divorced from empathy, justice, and the ethical imagination of the people.

The story of cholera in colonial India thus transcends the boundaries of epidemiology and enters the realm of moral

philosophy (Hardiman 2006, 122). It reveals how modernity itself was born through crisis—how the desire to control life produced new forms of inequality and violence. The empire's laboratories, hospitals, and sanitary boards were monuments not only to scientific progress but also to the anxieties of power (Foucault 2003, 251). In the end, cholera remained the empire's haunting companion: a disease that refused to be cured because it was inseparable from the moral contagion of domination (Arnold 1993, 225). Its afterlife in postcolonial policy and collective memory invites us to rethink what it means to heal—whether through medicine, morality, or memory—and to confront the lingering pathogens of inequality that still inhabit our modern world.

## Conclusion

The cholera pandemics of nineteenth-century India illuminate how empire, science, and morality converged in the making of modernity. More than a biomedical event, cholera was a moral drama that revealed the empire's obsession with purity, order, and control. In the colonial imagination, disease became the vocabulary through which racial hierarchies were naturalized and social reform was moralized. The Indian body was cast as the pathological "other"—a site of impurity that demanded both medical and moral intervention. Through sanitary reforms, missionary hospitals, and bacteriological research, the British Empire sought to cure not only disease but the disorder of the colonized mind. Yet, in doing so, it exposed its own pathology: an incurable fear of contamination, both biological and moral. The history of cholera thus discloses the contradictions of a civilization that claimed to heal while perpetuating suffering, to civilize while corrupting the very moral order it professed to uphold.

At the heart of this narrative lies the paradox of colonial biopolitics—the transformation of health into an instrument of governance. Sanitation and surveillance, presented as humanitarian measures, were in fact technologies of control that reshaped the colonial city and the colonial subject alike. By regulating bodies, spaces, and emotions, the British state sought to construct an empire of hygiene—an empire that equated cleanliness with civilization and dirt with degeneracy. The cholera epidemic provided both the pretext and the justification for this moral engineering. Yet, the disease itself resisted such containment: it refused to adhere to racial boundaries, defying the moral geography of empire. The infection of European soldiers and officials undermined the fantasy of imperial immunity, revealing that contagion was not a product of "native vice" but of shared vulnerability. In that realization lay the unspoken truth of colonial modernity—that the fear of disease was, ultimately, the fear of equality.

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