Tropics of Disease: Epidemics in Colonial India

BURTON CLEETUS

Burton Cleetus (burtoncleetus@gmail.com) teaches at the Centre for Historical Studies, Jawaharlal Nehru University, New Delhi.
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While the scientific understanding of diseases has advanced throughout history, disease as a cultural entity has remained the same in many ways.

In the midst of the global crisis caused by the COVID-19 pandemic, governments all over the world have introduced drastic measures aimed at reordering the lives of their citizens. The pandemic has led to some spaces, and people, being marked out as the “morbid other,” manifesting in acts of racism because certain people, and certain spaces are deemed responsible for the origin and spread of the disease. The “locale” in the current crisis is Wuhan, a province in the Republic of China, which suddenly emerged as the epicentre of global morbidity. The concept of “disease” and the fear of its spread has remained central to the concerns of modern states. The emergence of the “state” as a significant entity over the last few centuries was, in fact, possible through the vast collection of information on birth, morbidity and death, and towards the control and regulation of the bodies of its subjects (Lynch 2016). In its 21st century manifestation, though globalisation generated centralising tendencies, the state constantly produced new and diverse versions of the margins that posed a relentless threat to the foundations of the mainstream. Disease as a biological condition therefore came to be associated within environmental, cultural, sociopolitical and the dietary practices of communities and groups.

Yet, one of the cardinal beliefs in the constitution of being modern is to visualise disease and
medicine as secular, scientific entities, devoid of cultural meanings. In sharp contrast, premodern communities apparently positioned morbidity within the broad contours of faith and religion and hence lay outside the boundaries of “rational medicine.” However, diseases have been central to the cultural life of any society, whether ancient or modern (Rosenberg 1992). As Rosenberg argues, the idea of a disease at any given time or place is not necessarily stable. It would have undergone arbitration between divergent social and cultural groups, classes, and institutions. In the popular Malayalam novel Odayil Ninnu written by P Kesavadev in 1942, the protagonist of the novel struggles with hard labour, economic miseries and subsequently dies of tuberculosis. In a variety of literary representations of the mid-20th century and after, tuberculosis signified human misery associated with industrialisation and the spread of urbanisation in India.

By the closing decades of the 20th century, cancer emerged as the quintessential disease of the emerging Indian middle class. Unlike its urban counterpart, cholera was primarily a disease of the countryside. It struck the villages and wiped out communities. Cholera symbolised rural vulnerability in the face of illiteracy, poverty, filth, and underdevelopment. As AIDS spread in India, it was considered to be the result of the insatiability of the morally insane, for sex and drugs.

**Diseases in the Ancient World**

Diseases never had meanings that are purely bodily. In fact, dominant ideologies and religious beliefs, across time, have always had a major impact in shaping the meanings of diseases, and the manner in which they originate and circulate. In ancient Greece and in the Christian world, lepers were treated as social outcasts. The disfigurement of the body was seen to have resulted from the follies of human life. Leprosy was therefore seen as a reflection of the wrath of god, bestowed on the body of the individual, as a warning to future sinners and as a symbol of the providence of god (Bashford and Hooker 2001).

Yet, in the premodern world of health and healing, beyond the religious ethic, there was an environmental logic to the aetiology and cure of diseases. In its wider manifestation, the world of medicine and that of religion had shared ideas. Both were sustained by the cosmic unity of the elements; fire, water, air and earth, expressed through the broad category called nature. Everything from animals to plants and to human beings shared these essential elements. Fire drives the universe as well as the human body and transforms them through various stages of growth and nourishment (Engler 2003). The derangement of the bodily balance maintained through humours causes diseases. Such a theory of disease causation was central to the medical traditions of most ancient societies from Greece to India and China though, of course, with different variations.

The binaries between hot and cold and between good and evil also found parallels in the manner in which the religious and the therapeutic was conceived. Darkness symbolised evil, which extinguished the cosmic heat. It possessed the body, made it pale, drained vital
energy and collapsed the internal harmonious relationship within the body as well as that of the universe (Chi Hung 2015). In contrast, excessive heat could also manifest as disease. British surgeon and ethnographer J Z Holwell (1767) elaborates on the practice of smallpox inoculation in the Bengal province of the British presidency and explains how the practice was closely interlinked to the belief in goddess Sitala. She was the goddess of fire, of rage and of the pox. The affliction of smallpox and its spread was supposed to be a result of the devi’s anger. Yet, integral to this religious idiom is the complex process through which belief in the devi encompasses both prophylaxis and prognosis of the disease, explained through the visitation of Sitala. The goddess was, thus, the disease as well as the cure. She was the heat within and the heat outside (Naraindas 2003). Thus, belief systems also offer possibilities to understand the ways in which disease and cure were imagined and structured. However, for the British administrators in India, Sitala, the pox, its origin, and the practice of variolation all conjoined to represent a morbid Indian society.

The Tropics and the Generation of Disease

European expansion into the non-European world primarily meant the introduction of the benefits of science, and as its extension medicine, from Europe to its colonies. However, far from being one-way traffic, scholars trying to understand the relationship between colonialism, science, and medicine, have of late, argued that the colonial state existed through an elaborate network of institutions intended to control and regulate the bodies of its subjects (Said 1978; Chatterjee 1993; Cohn 1996). Medicine, therefore, remained central to the concerns of the state and the manner in which it expounded its administrative and political structures.

Backed by the writings of Marco Polo, Ibn Batuta, Nicolo Conti, and others in the medieval period, Europeans constructed a battery of ideas and images of the East, which came to solidify during the period of colonial expansion (Said 1978). The East was the land of monsters, diseases, and vices, yet of desire. Within the excessive growth in the tropics also lay the wilderness of life and death. From this fear of the orient emerged the new theory of disease causation. A medical topography was constituted, which divided the world into morbid lands and healthy lands.

The tropics were the diseased other. Within colonial contexts, disease came to be viewed as an entity in itself. It has a cause, takes birth, matures and travels. The idea that disease has a local origin, and spreads through individuals was believed by the ancient Greeks and the Jews, yet it gained a definite meaning in the age of colonial expansion. Colonialism was about exchange, and it brought the world together in an unprecedented manner. In this massive global project of the movement of products and ideas, the most devastating was the exchange of disease. Bashford and Hooker (2001) have argued that colonialism, like contagious diseases, was also about contact, self-multiplication and, less frequently, destruction. Isolated communities in the non-European world who were not exposed to the outer world were almost completely wiped out when they encountered new diseases.
because they did not have the required immunity to face new diseases that came along with the Europeans. The native population of the Americas, Australia, Asia, the Caribbean and Africa were ravaged by the arrival of new diseases through colonial intervention and the world came to be united through diseases.

The humoural theory that was predominant in most of the precolonial world came to be replaced by a new understanding of the environment. Under this new understanding, tropical lands were seen to have ideal conditions for the unregulated growth of diseases, with their rampant heat, rain, humidity, stagnant waters, and polluted airs. In the 19th century, this condition of the tropics came to be understood as “miasmatic” because, in the tropics, everything decomposes and is subjected to putrefaction (Naraindas 1996). From “miasma” came the idea of “malaria”—a generic term that defined fevers in much of the 19th-century tropical world.

This understanding fanned the idea that the entire tropical zone was a space of disease, and forced the Europeans to increasingly withdraw into their enclaves. Adding to their anxiety was the fact that young European men who reached the colonial world, mostly as sailors and soldiers, wandered outside these enclaves, and consumed food and alcohol from the bazaars and engaged in sexual liaisons with local women. They died in large numbers due to a variety of ailments that included enteric fever, cholera, and venereal diseases. A series of measures were taken by the East India Company to regulate the association of English men with locals, which included the introduction of short service commissions in the army, the creation of the cantonment system, and the allocation of alcohol from the camp itself. The Contagious Diseases Act was passed in 1868 to enforce regular inspection, and forceful confinement of Indian sex workers, so as to prevent European men from being exposed to venereal diseases. Within the cantonments, stagnant water was drained off, and the grass cut to the last blade (Arnold 1993). Thus, in the midst of the fear of disease, the colonial administration considered it best to create islands of cleaner spaces away from Indian social and cultural life. The British public health initiatives were, for long, confined only to the colonial enclaves and the cantonments, and they overlooked the healthcare requirements of the Indians (Ramasubban 1998).

Contagion and the State

By the middle of the 19th century, as the colonial state extended the arms of its administration, existing racial prejudices solidified along with the prevailing notions of diseases. Indian servants were considered to be the carriers of the contagion, and Indians, in general, came to be despised as untidy and deceitful. Religious and cultural practices, personal behavioural traits, as well as communitarian social life, all came to be seen as expressions of Indian morbidity. The colonial state, in turn, passed a series of legislations aimed at restricting religious gatherings so as to prevent Hindu devotees from carrying cholera bacillus to their villages and homes. By the mid-19th century, cholera loomed large over most parts of the world. It was seen as purely of Indian origin and was considered to
be the deadliest of all diseases of the 19th century. Concerned by the fear of being overcome by cholera, European nations met to discuss the spread of the contagion, and the first sanitary conference held in Paris in 1851 accused British India of being responsible for the origin and spread of cholera (Arnold 1993).

By the closing decades of the 20th century, however, plague emerged as a major source of concern for the colonial state. Rodents entered through goods that reached the ship decks, and subsequently spread through flies. As trading ships left Hong Kong, and passed through Colombo, Bombay, Karachi, and into the Mediterranean, it ravaged most of the port cities (Catanach 1989). Unlike other diseases, plague directly threatened the interests of trade and therefore, colonialism itself. The colonial state introduced stringent quarantine measures as a prophylaxis against the plague. The physical inspection of the bodies of suspected victims and the regulations imposed by the state led to widespread discontent among the major religious communities, that is, the Muslim and Hindus, in India. This led to the assassination of the Plague Commissioner of Pune, W C Rand, and his assistant Lieutenant Ayerst by the Chapekar brothers in June 1897 (Arnold 1993).

In the aftermath of the internal rebellion of 1857, and against the backdrop of global criticism, owing to the increasing incidence of cholera, the British administration in India introduced a series of measures towards reorganising the sanitary and public health departments in India. Municipal administrations were constituted at the provincial centres, with the objective of cleaning the streets, removing night soil, providing safe drinking water, and draining stagnant water. All these measures were expected to prevent the spread of diseases. This was also accompanied by novel methods, such as the systematic collection of vital statistics of the inhabitants. The vast battery of information collated through official methods (primarily with the introduction of the census in 1881) gave the state the means to introduce new kinds of regulations and restrictions to assert its control.

These developments coincided with the discovery of the germ theory of disease by Louis Pasteur, which was further developed by Robert Koch. This marked a sharp deviation in the idea of disease, moving its causation away from the environment to germs. Such a realisation undermined the earlier relationship between the environment and disease that sustained the miasmatic theory of disease. However, within colonial contexts, earlier notions of disease causation continued, and the School of Tropical Medicine came to be established in London in 1899.

The increasing personalisation of disease occurred with the idea of “hygiene.” Global campaigns against diseases in the third world presented this notion during the interwar period. One of the major initiatives, among many others, came from the Rockefeller foundation, a private philanthropic initiative of the United States, primarily against the hookworm. A large number of the states in princely India and parts of British presidencies collaborated with the foundation in its campaign against the hookworm. Individual bodies became the site of disease as the hookworm entered the body of the healthy individual.
through their nails, circulated through their blood, and finally, it arrived at the stomach. The worm ruptured the inner lining of the intestines, leading to internal haemorrhage and loss of blood. This led to malnutrition, weakness and death. This reinforced the idea that unhygienic habits and weak bodies of the global South continued to threaten health concerns of the world.

**Current Concerns**

The idea that cultural behaviours and habits primarily cause diseases has continued. One finds in the current discourse related to the COVID-19 pandemic the recurring concerns that pervade disease causation in the last few centuries. That Wuhan immediately rose to prominence has brought back the earlier notion of the East as the land of monsters, mysteries and death.

From the 18th century, onwards Chinese goods were considered by European tradesmen as inauthentic. For example, China root was seen as a poor substitute for sarsaparilla, a plant used for rheumatoid arthritis, found in Latin America and the Caribbean (Rosenberg 1992). However, by the early decades of the present century, there was increased attention on China as the production centre of the world. The sudden rise of China as an alternative to Western nations as the epicentre of the global economy also brought to focus the nature of the Chinese state system, and the life of its people. The basic argument was that the country’s economic advancement was based on a fragile social and cultural base. Its social and political norms were, hence, seen to be antithetical to the values of modernity and were not subjected to internal reform. Chinese society was marked as unethical and brutish in its consumption habits. This led to the creation of narratives that the rise of the COVID-19 virus, apparently emerged from the mutation of the cells resulting from the consumption of the flesh of reptiles, bats and other wild animals.

Hence, as Rosenberg (1992) argues, epidemics have been at the centre of emerging ideas of what a disease is, how it originates, and the manner in which it spreads. As in all previous histories of the notion of disease, the narrative surrounding COVID-19 is also an iteration of the earlier notion of diseases originating from the violation of the cosmic order. This is because several Western nations see it as a price that humanity as a whole pays for the wrongdoings of people in one part of the globe, that is, China. Thus, this disease, like any other, was not just epidemiological. Rather, it was positioned within prejudicial, ethical, and moral premises.

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