Public Health and Sanitation in Colonial Lahore, 1849-1910

by

Maysoon Sheikh

A thesis
presented to the University Of Waterloo
in fulfillment of the
thesis requirement for the degree of
Doctor of Philosophy
in
History

Waterloo, Ontario, Canada, 2018

Author's Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

The British annexation of the Punjab in 1849 had important consequences for the city of Lahore. Indeed, the British occupation prompted Lahore's transformation into a "modern" colonial city. New designs for urbanization, environmental reform, and sanitary improvement were implemented by the city's new administrators, resulting in important changes in Lahore's physical and social environment. At first, the impulse to redevelop the city stemmed largely from colonial anxieties about threats to the health of the army and Lahore's British residents; however, by the late nineteenth century, this "enclavist" approach was replaced by a more extensive public health scheme that was geared towards managing and safeguarding the city's entire population. With British regulations now aimed more directly at Indians, new geographic and social spaces fell under colonial jurisdiction. Particularly during outbreaks of epidemic diseases, Indian bodies and locally-inhabited spaces came to be targeted more explicitly under colonial surveillance, leading to the imposition of seemingly intrusive and restrictive state policies. But, as this study will demonstrate, the British government's reform-driven agenda was often disrupted by local actions and behaviours that influenced the proper functioning of colonial rule. Guided by an unapologetic indifference – although not necessarily opposition – towards colonial "modernity", local intervention into British plans for Lahore reshaped colonial knowledge about the city and its inhabitants. This way, Indians continually shifted relations between themselves and their colonizers and demonstrated, perhaps most importantly, that the scope of British rule in Lahore was often noticeably limited. With a particular focus on issues related to public health and disease, this dissertation draws attention to the important role that Indians played in Lahore's development during the mid to late nineteenth century and highlights the range of spatial, moral, and social factors that worked to produce local responses to colonial objectives in the city.

Acknowledgments

Table of Contents

List of Illustrations

Introduction

<u>Introduction</u>

      Colonial Lahore has featured as an important subject of academic interest over the

last decade. Among the studies that have examined the history of the city under British

rule are William Glover's *Making Lahore Modern* (2007) and, more recently, Ian Talbot

and Tahir Kamran's *Colonial Lahore: A History of the City and Beyond* (2016).[1] Both

works highlight Lahore's position within the larger narratives of India's colonial past,

particularly as a case study for the ambivalent relationship that existed between the

colonizers and colonized. The growing academic preoccupation with the city, however,

should come as no surprise. Following the British annexation of the Punjab in 1849,

Lahore emerged as a leading administrative, cultural, and political centre in North India.

The city, moreover, was a key hub of communications and trade under the British and

served as a strategic colonial stronghold throughout the nineteenth and early twentieth

centuries. Indeed, as the capital of the Punjab (one of British India's most economically

prosperous provinces), Lahore became intimately connected with a new style of

administration known as the Punjab School – noted for its paternalistic and authoritarian

attitude towards governance and by its preoccupation with material development - that

was idealized by many in India as a model system of rule.[2] However, as Glover, Talbot

and Kamran maintain, Lahore's development into a "modern" urban city cannot be

credited solely to the colonial presence; rather, they argue that Lahore's rise to

---

[1] William Glover, *Making Lahore Modern: Constructing and Imagining a Colonial City* (Minneapolis: University of Minnesota Press, 2008); Tahir Kamran and Ian Talbot, *Colonial Lahore: A History of the City and Beyond* (Oxford: Oxford University Press, 2016).
[2] Farina Mir, *The Social Space of Language: Vernacular Culture in British Colonial Punjab* (Berkley: University of California Press, 2010), 30.

prominence owed much to the contributions of the city's indigenous population.[3] In this regard, these studies offer critical insight into the view that colonial objectives were never simply imposed onto the city and, instead, depended considerably on collaborative projects between Indians and the British.[4]

Glover, Talbot and Kamran provide a valuable analysis of the colonial history of Lahore and serve as an excellent starting point for my examination of public health in the city during the nineteenth century. While my dissertation fits within a growing movement in historical scholarship to redefine the role of medicine in India – characterized by important studies such as Mark Harrison's *Public Health in British India: Anglo-Indian Preventive Medicine 1859-1914* (1994) and David Arnold's *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (1993) – my focus on Lahore works within the bounds of a more recent academic trend that adopts a regional approach to the history of the colony.[5] This way, it reinforces the importance of recognizing the diversity of Indian society under the British and draws attention to the specific ways that regional variations affected the larger processes of colonial rule. A more detailed survey of Lahore in chapter one highlights some of the distinct characteristics of the city which, as we will see throughout this study, played a critical role in defining the colonial experience in Lahore. More specifically, such an analysis offers new insight into British and indigenous responses to health and disease in the city by shedding light on the social, cultural, and political implications of the colonial state's

---

[3] Glover, 12; Kamran and Talbot, 4.

[4] Ibid.

[5] David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century Indian* (Berkley: University of California Press, 1993); Mark Harrison, *Public Health in British India: Anglo-Indian preventive medicine 1859-1914* (Cambridge: Cambridge University Press, 1994).

medical objectives. As such, another important concern in this examination of Lahore is the British understanding of the city and its inhabitants and the way this knowledge shaped relations between the colonizer and the colonized. To appreciate this approach better, it is important to identify some major themes and methodologies that have shaped the study of British India over the last few decades.

<u>Historiography</u>

The historiography of colonial India underwent considerable changes in the 1980s when theoretical developments in postcolonialism and deconstructionism redefined academic discourses about the production of Western knowledge in the colony. Scholars began to argue that colonial governance in India relied critically on "Orientalist" constructions that made the colony knowable through essentialist representations.[6] British observations about India, in other words, had been shaped by highly specific information that was gathered and contained in official colonial documents like the census, geographical surveys, and archeological reports. This knowledge, moreover, was transformed into "technologies of rule" and exploited by seemingly benign administrative organizations and institutions to govern indigenous society.[7] Arguments like these were largely prevalent among a pioneering generation of scholars such as Edward Said and Bernard Cohn who maintained that the colonial pursuit of knowledge was driven primarily by utilitarian motives (for example, to carry out economic and political goals, reinforce racial differences, and legitimize colonial rule by asserting the value of Western

---

[6] Edward Said, *Orientalism* (New York: Pantheon Books, 1978), 12.
[7] Norbert Peabody, "Knowledge Formation in Colonial India," in *India and the Empire,* ed. Nandini Gooptu and Douglas Peers (Oxford: Oxford University Press, 2012), 75.

civilization).[8] Said's *Orientalism*, in particular, had a profound impact on the study of colonial history. By conceptualizing knowledge as an important category of analysis, Said demonstrated the ways in which colonial discourses facilitated the West's power over the East.[9] For him, the European representation of the "Orient" in official texts was an essential element in the expansion of colonialism because it created stereotypical images of the East - as "irrational", "backward", and "inferior"- that were used to justify colonial military control, economic exploitation, and cultural dispossession.[10] Similar observations were made by Cohn whose view of the Empire as an intellectual and cultural phenomenon stressed that the British interest in Indian languages, law, and religion was a critical first step towards colonial domination.[11] According to him, acquiring knowledge about the colony allowed the British to adopt a "Western" understanding of India and its inhabitants that aided their plans for conquest.[12] Indeed, this generation of academics regarded historical knowledge about India as more than just a record of the colony's past; for them, the colonial archive was the foundation of British hegemony in South Asia.

During the 1990s, however, a growing movement within postcolonial scholarship questioned the assumption that colonial knowledge was distinctly European in origin.[13] Scholars like C. A. Bayly and Eugene Irschick criticized the simplistic view that there

---

[8] Said, 14; Bernard Cohn, *Colonialism and Its Forms of Knowledge: The British in India* (New Jersey: Princeton University Press, 1996), 16.
[9] Said, 15.
[10] Ibid.
[11] Cohn, 16.
[12] Ibid.
[13] Rachel Dwyer, Gita Dharampal-Frick, and Monika Kirloskar-Steinbach, eds., *Key Concepts in Modern Indian Studies* (New York: New York University Press, 2015), 145-146.

was a predictable and fixed relationship between knowledge and power in the colonies.[14]

Instead, they argued that the importance ascribed to state authority had been overstated

and that the production of Western knowledge in the colonies operated on a much more

fragmented and ambiguous framework than had been previously recognized.[15] According

to them, the development of colonial knowledge relied on an interactive process that

included the involvement of indigenous agents and native structures of information.[16]

This way, they opposed the view of scholars like Nicholas Dirks who, although they

acknowledged the influence of local informants in the development of colonial ideology,

nevertheless assigned them a passive role in their own history.[17] In Dirks' analysis, it was

still the intellectually engaged European who formulated purportedly authentic

knowledge about the colony.[18] Bayly and Irschick, on the other hand, asserted that the

production of the colonial archives depended considerably on the state's ability to

procure indigenous insights and opinions which helped establish a dialogical relationship

with the colonized.[19] For them, colonial subjects possessed significant power themselves

and this often allowed them to shape relations with the colonizers on their own terms.[20]

Bayly and Irschick's contributions to historical scholarship challenged the idea that

knowledge formation was an essentializing Orientalist project, and instead demonstrated

---

[14] C. A. Bayly, *Empire and Information: Intelligence Gathering and Social Communication in India 1780–1870* (Cambridge: Cambridge University Press, 1996), 7; Eugene Irschick, *Dialogue and History: Constructing South India, 1795-1895* (Los Angeles: University of California Press, 1994), 6-7.
[15] Bayly, 9; Irschick, 8.
[16] Ibid.
[17] Nicholas Dirks, *Castes of Mind: Colonialism and the Making of Modern India* (New Jersey: Princeton University Press, 2001), 9.
[18] Ibid.
[19] Bayly, 12; Irschick, 6.
[20] Jukku Joukhi, "Orientalism and India," *J@rgonia* 4, no. 8 (2006): 2.

that the foundation of colonial knowledge was grounded in negotiation and compromise with indigenous groups.[21]

This shift in research concerning the production of colonial knowledge led to the emergence of rich and diverse scholarship within colonial studies. Among them were new developments in the historiography of health and medicine that linked the colonial experience to questions about modernity, nationhood, and power. During the 1980s, for instance, studies related to the history of medicine in the colonies began to focus on the ways in which medicine served as a "tool of Empire" that allowed colonizers to legitimize and expand their authority.[22] This view was driven in part by the emphasis on knowledge production that followed the publication of Said's *Orientalism*. His work, after all, had proposed a distinct narrative for colonialism that reinforced the hegemonic nature of Western medical knowledge and prioritized its role in the establishment of colonial rule.[23] In this regard, the movement was also influenced by the work of Michel Foucault who highlighted the colonial state's ability to exert control over its subjects by implementing administrative strategies such as surveillance and regulation.[24] Foucault's analysis, in particular, led scholars to argue that medical knowledge constructed specific ideas about the colonized - especially about the functioning of their bodies - that shaped the disciplinary objectives of the colonial regime.

---

[21] Bayly also argues that the colonial state frequently operated despite the absence of information about the colonized, resulting in the establishment of draconian measures that were oftentimes the outcome of fear and uncertainty. Bayly, 8-9.

[22] Daniel Headrick, *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century* (Oxford: Oxford University Press, 1981).

[23] Indra Sengupta and Daud Ali, introduction to *Knowledge Production, Pedagogy, and Institutions in Colonial India,* ed. Indra Sengupta and Daud Ali (New York: Palgrave Macmillan, 2011), 4.

[24] Michel Foucault, *Discipline and Punish: The Birth of the Prison,* trans. Alan Sheridan (London: Penguin Books, 1979), 18.

This approach to colonial medicine expanded in the late 1980s and 1990s when scholars re-examined the "objective" and "effective" nature of Western medical knowledge.[25] Academics pushed past the Saidian and Foucauldian critique of knowledge and power to align themselves with a growing initiative to reconstruct "history from below".[26] Influenced by later trends within the Subaltern Studies movement – which focused on the perspective of marginalized groups to understand colonial encounters – scholars began to reexamine the role that indigenous people played in the colonial experience.[27] Historians of India and the British Empire, in particular, focused their attention on studying medicine as a social phenomenon that was influenced by wider intellectual contexts. As such, they highlighted the important role that local conditions played in shaping Western medical knowledge and facilitated the move away from studying medicine solely in terms of great men or great ideas.[28] Douglas Haynes, for instance, demonstrated how Britain's colonial experience helped institutionalize the medical profession in the metropole by creating a cultural and political space that legitimized new fields of knowledge.[29] By the same token, studies by David Arnold and Mark Harrison illuminated the complex relationship between health and society in India, offering a more nuanced perspective of the development of colonial medicine in the

---

[25] Andrew Cunningham and Bridie Andrews, eds., *Western Medicine As Contested Knowledge* (Manchester: Manchester University Press, 1997), 6.

[26] Dipesh Chakrabarty, "Subaltern Studies and Postcolonial Historiography," *Nepantla: Views from South* 1 no. 1 (2000): 10.

[27] Although Said and Foucault's work played a critical role in the establishment of the Subaltern Studies Group in the 1980s, their views were criticized for unwittingly silencing and marginalizing the voices of colonial subjects.

[28] Douglas Haynes, "Victorian Imperialism in the Making of the Medical Profession: An Argument," in *Decentering Empire: Britain, India and the Transcolonial World,* ed. Durba Ghosh and Dane Kennedy (Himayatnagar: Orient Longman, 2006), 130.

[29] Ibid., 134.

colony.[30] Arnold, for example, highlighted the ambiguous nature of Indian responses to

the seemingly intrusive and hegemonic policies imposed by the colonial state.[31]

Similarly, Harrison pointed to the way colonial medicine relied on dialogues between

Western and Indian knowledge in order to establish itself in the region.[32] Together, they

problematized earlier approaches to the study of medicine in the colonies – such as

Radhika Ramasubban's work which characterized the colonial medical establishment as

indifferent to the health of the Indian population and as discouraging native involvement

in public health[33] – by demonstrating that British medical objectives were never defined

exclusively by the colonizers.

One of the most important implications of these debates was that it allowed

imperial medical historians to de-centre the testimony of elite sources. By "reading along

the archival grain", scholars began to envision the archive as a historical site in and of

itself that could be re-examined to reveal not just the hegemony of the imperial state but

also its failures and anxieties.[34] This, in turn, led them to find new meaning in the

perspectives of previously neglected groups such as women, patients, and indigenous

practitioners. In fact, a number of scholars have engaged with such discourses about

indigenous societies and institutions and have contributed to growing scholarship on the

influence of local cultural contexts. For instance, Projit Mukhatji's *Nationalizing the*

Body: The Medical Market, Print and Daktari Medicine (2011) examines the emergence

of Indian practitioners of Western medicine in Bengal during the late nineteenth and early

---

[30] Arnold, *Colonizing the Body,* 7; Harrison, *Public Health in British India,* 6.
[31] Arnold, *Colonizing the Body,* 2-3.
[32] Harrison, *Public Health in British India,* 4.
[33] Radhika Ramasubban, *Public Health and Medical Research in India: Their Origins under the Impact of British Colonial Policy* (Stockholm: SAREC, 1982), 54-55.
[34] Ann Stoler, *Along the Archival Grain: Epistemic Anxieties and Colonial Common Sense* (Princeton: Princeton University Press, 2009), 1-4.

twentieth centuries. Here, he considers the re-appropriation of colonial medicine by

daktari physicians and investigates the way such activities challenged British medical

intervention in the region (particularly within the context of a burgeoning medical market

and vernacular press).[35] Similar work has been done by Mridula Ramanna in her seminal

study on public health in colonial Bombay as well as by Ishita Pande in her examination

of medicine in nineteenth-century Bengal. Ramanna's investigation into the contributions

of Western-trained indigenous doctors and local philanthropists offers key insight into the

role of Indians in the public health history of the city.[36] By the same token, Pande's

analysis of the creation of "black doctors", particularly those who engaged in colonial

medical discourses, reveals how Indians attempted to overcome ideas about their

"civilizational backwardness."[37] Other scholars have moved beyond an analysis of native

participation in colonial medicine to examine indigenous medical systems more closely

under British rule. Kavita Sivaramakrishnan, for example, studies the professionalization

of Ayurveda in the Punjab (through its alignment with language and religion and via the

establishment of medical associations) as a means of legitimizing the system's scientific

authority.[38] She demonstrates, moreover, how native physicians renegotiated a space for

themselves as mediators between government officials and the Indian public, thereby

fostering a new identity and authority for indigenous medicine.[39] Sivaramakrishnan thus

reveals that pre-colonial medical systems in India were never completely marginalized by

---

[35] Projit Mukharji, *Nationalizing the Body: The Medical Market, Print and Daktari Medicine* (London: Anthem Press, 2011), 13.

[36] Mridula Ramanna, *Western Medicine and Public Health in Colonial Bombay, 1845-1895* (Himayatnagar: Orient Longman, 2002), 3-6.

[37] Ishita Pande, *Medicine, Race and Liberalism in British Bengal: Symptoms of Empire* (London: Routledge, 2010), 186.

[38] Kavita Sivaramakrishnan, *Old Potions, New Bottles: Recasting Indigenous Medicine in Colonial Punjab, 1850-1945* (New Delhi: Orient Blackswan Private Ltd., 2005), 14-15.

[39] Ibid., 54.

the state and that British officials often relied heavily on local practitioners to maintain

public health in the region. This growing movement among historians to focus on Indian

intervention into local health practices has allowed studies in colonial medicine to be less

preoccupied with the aims of formal, state medicine.[40] As such, the field has been

repositioned to allow scholars to highlight the importance of investigating the cultural,

social, and political conditions that shaped the development of medical knowledge in

India.

My examination of Lahore is situated within this larger engagement with

indigenous intervention that has characterized postcolonial scholarship over the last few

decades. More specifically, my study seeks to complicate ideas about the development of

medical knowledge in the city by focusing on the process of self-representation that

informed the perspectives of the colonized. This will be explored in more detail in

chapters four and five where my analysis of epidemic diseases will highlight the way

Indian identities were shaped. Although I use a predominantly imperial lens to examine

the public health history of Lahore, my study nevertheless engages with the critical theme

of indigenous agency. Many scholars have interpreted the concept according to two main

frameworks: resistance and subversion.[41] While the former hinges on native opposition to

colonial rule, the latter points to the moments when colonial authority failed to execute as

---

[40] Sarah Hodges is among those scholars who move away from focusing on the aims of the state to study colonial medicine, looking instead at the specific local conditions that shaped debates about public health in India. More specifically, she analyzes how organizations and movements outside the state became influential participants in debates concerning birth control in South India during the interwar years. Sarah Hodges, *Contraception, Colonialism and Commerce: Birth Control in South India, 1920-1940* (Burlington: Ashgate, 2008), 1-3.

[41] David Jeffress, *Postcolonial Resistance: Culture, Liberation, and Transformation* (Toronto: University of Toronto Press, 2008), 42-43.

it was intended.[42] Both theories serve as a reminder that colonialism was never an all-encompassing or unidirectional force that guided India onto a path of "progress".[43] Rather, the colonial encounter has been increasingly recognized as a much more complicated process, one that relied critically on interactions and collaborations with India's indigenous population. This has led many scholars to argue that colonial governance did not always rely on force and discipline to function efficiently and instead prevailed largely as a result of local support.[44] For this reason, they contend that the social and spatial boundaries between colonizer and colonized were frequently blurred and crossed during moments of collaboration, ultimately demonstrating that the relationship between the two was one of mutual interdependence.[45] Although such interpretations of indigenous agency have been an important part of my analysis, I consider them with caution for two reasons. First, these arguments risk acknowledging only the "resistances" of the elites who, more often than not, were the main participants in colonial exchanges. As such, they often overlook the activities of marginalized groups who engaged in colonial discourses in their own way. Second, ideas about resistance, collaboration, and subversion continue to work within the dominating structures of colonialism to explain relations within Indian society.[46] In other words, these interpretations run the risk of reinforcing the longstanding Eurocentric view that the colonial state and its policies are the main determinants of Indian agency.[47] Bearing this in mind, I position my work within a growing trend in postcolonial studies that seeks to

---

[42] Ibid.
[43] Nandini Gooptu and Douglas Peers, introduction to *India and the British Empire,* 2.
[44] Ibid.
[45] Ibid., 2-3.
[46] Jeffress, 19.
[47] Ibid.

move beyond these narratives and consider not just other possible relationships between colonizer and colonized – transformation, hybridity, appropriation, and negotiation to name a few – but also interactions between Indians themselves as key contributions to the colonial encounter.[48]

<u>Indian Agency</u>

My examination of colonial Lahore works within the bounds of this discourse to study the multifaceted relationships in the city. More specifically, I investigate the ways in which Indian agency problematized colonial understandings of indigenous resistance. After all, native intervention was never consistent or homogeneous, sometimes responding to and challenging British models and representations of Lahore while other times playing a completely autonomous role in the physical, social, and cultural transformation of the city. This latter point is particularly important because it stresses the need to understand Lahore's history without interpreting it solely in response to British colonialism. To do otherwise would reinforce a binary that postcolonial scholars have attempted to challenge for several years: that between "tradition" and "modernity". Historians of India today are cognizant of the limitations of this binary because it upholds a long-standing, albeit antiquated, approach that identifies the British Empire with "modernity" and the colony with "tradition".[49] There are, of course many problems with this view. For one, it perpetuates the idea that there is a single definition for modernity which stands in contrast to the principles associated with tradition. Furthermore, it imagines modernity as a fixed and normative concept that is distinguished primarily by the experiences of the West; this in turn, locates India (and colonized peoples more

---

[48] Gooptu and Peers, 7.
[49] Ibid., 9-10.

12

generally) on an evolutionary scale that uses the West as a model for successful

governance and development. But, as historians like C. A. Bayly, Dilip Gaonkar, Douglas

Peers, and Nandini Gooptu have argued, modernity is flexible and complex and it is more

useful to think about the existence of plural or alternative modernities that overlapped

and engaged with one another to create multiple narratives.[50] This makes it possible to

recognize the legitimacy of a modernity that developed outside the control of the colonial

state and was determined by specific local contexts.[51]

Using this as a guide, I propose that Indian intervention in Lahore produced an

alternative modernity that embodied its own range of spatial, moral, social, and physical

dimensions. Although the British occupation of India certainly shaped the character and

objectives of this modernity, it did not develop simply in response to the imposition of

colonial rule. By the same token, native agency cannot be regarded as being

fundamentally opposed to "modern" colonial ideals – exemplified by post-Enlightenment

principles such as scientific development, urbanization, administration, and

industrialization - because it was not intrinsically defined by an absolute or singular idea

that contradicted British ideologies. Indian responses to colonial objectives were fluid

and unlimited but also purposeful and coherent. They crossed boundaries, both real and

imagined, and re-conceptualized concrete spaces, ideas, and principles to make them

conform to their own spatial and social paradigms.[52] As such, Indian agency existed in

---

[50] C. A. Bayly, *The Birth of the Modern World, 1780-1914: Global Connections and Comparisons* (Oxford: Blackwell Publishing, 2004), 7; Dilip Gaonkar, "On Alternative Modernities," in *Alternative Modernities,* ed. Dilip Gaonkar (Durham and London: Duke University Press, 2001), 1; Gooptu and Peers, 12.
[51] At the same time, it is impossible to reject the legacy of Western discourses on modernity. As Gooptu and Peers argue, to do so runs the risk of idealizing untainted indigenous modernities. Gooptu and Peers, 10.
[52] Sara Upstone, *Spatial Politics in the Postcolonial Novel* (Burlington: Ashgate Publishing Company, 2009), 10.

distinct ways throughout India and was contingent upon shifting representations of space and people that evinced new meanings at different times and places. This type of subjectivity, moreover, meant that agency could be exhibited in distinct ways and by various groups of people. The elite, for example, asserted a type of instrumentality when they sought parallels and precedents between Indian and Western intellectual histories while lower class groups expressed agency when they restructured the narratives that marginalized or silenced them. Although it can be argued that this all-encompassing interpretation of Indian agency risks limiting its value, I suggest instead that it enhances the efficacy of the concept by highlighting its ability to serve different purposes. Indeed, all Indians could demonstrate agency but they were not all empowered the same way nor were they pursuing the same goals. Rather, agency operated uniquely in different situations and within specific parameters - class, gender, caste, ethnicity, etc. – to affirm the existence of multiple structures of liberation. Despite its ability to produce distinct experiences, however, native agency was constant in that it empowered any Indian who laid claim to it.

Native intervention in local affairs also continually shifted relations between the British and Indians. As we will see in chapter three, for example, local actions and behaviours disrupted British plans to re-order the walled city of Lahore by creating spaces that appeared to be too inscrutable to fix.[53] Similarly, an examination of opium dens in chapter six reveals how Indians disassembled the logic of colonial spatial projects by exposing them as unreal and mythic.[54] In both cases, native agency produced geographic structures that re-privileged space as "chaotic", although not in terms of

---

[53] Glover, 57.
[54] Upstone, 12.

instability or violence. Rather, by finding meaning in its own diverse patterns and

experiences, local agency revealed colonial ordering to be an incomplete project.[55] This

was perhaps most evident in the new avenues of resistance, particularly non-

confrontational resistance, that prevailed within the customs, knowledge, and sometimes

seemingly harmless behaviours of the colonized.[56] James Scott has described these

'everyday forms of resistance' as less visible means of undermining power than that

associated with more overt revolt.[57] Instead of calling for radical ways to transform the

material and social conditions of society, everyday forms of resistance often operated

without a conscious awareness of the profound impact they could have on dominant

social orders.[58] In Lahore, these actions and attitudes not only undermined British ideas

about spatial, social, and moral ordering but also altered the structures of power that

sought to define the city.

Space as a Category of Analysis

Observations like these demonstrate that an examination of Lahore's

transformation into a colonial city must also work within a framework that considers

space as a category of analysis. This is especially relevant now that spatial concerns have

become even more intertwined with studies of power, identity, and resistance.[59] Since the

1970s, in fact, academics have examined the ways in which colonial authority was

established and legitimized through what appeared to be absolute boundaries and fixed

---

[55] Ibid., 12-13.
[56] Douglas Haynes and Gyan Prakash, "Introduction: The Entanglement of Power and Resistance," in
Contesting Power: Resistance and Everyday Social Relations in South Asia, ed. Douglas Haynes and Gyan
Prakash (Los Angeles: University of California Press, 1991), 2-3.
[57] James C. Scott, *Weapons of the Weak: Everyday Forms of Peasant Resistance* (New Haven: Yale
University Press, 1985), xvi.
[58] Ibid.
[59] Upstone, 2-3.

spaces. Edward Said's *Orientalism,* shaped by Foucault's conception of 'biopower' and

Antonio Gramsci's notion of an ideologically determined hegemony, emphasized the

importance of 'imaginative geography' in the exercise of power.[60] For Said, landscapes

were constantly reimagined to reconcile territorial ambitions and, as a result, they

mediated discourses about control and ownership.[61] Although this meant that boundaries

were open to (re)interpretation, any geographic space nevertheless appeared to become

fixed once its meaning was reinvented and recognized.[62] Said's analysis has been

particularly useful for examining the establishment of power in colonial settings,

especially because it highlights the way the territorial ambitions of colonizers

consolidated control over the colonized.

Such observations have also been made by Prashant Kidambi in his work on

colonial Bombay as well as by Stephen Legg in his study of nineteenth-century Delhi.[63]

Kidambi's *The Making of an Indian Metropolis: Colonial Governance and Public

Culture in Bombay, 1890-1920* examines the impact of British interventionist policies on

Bombay's built environment, particularly during the plague epidemic of the 1890s.[64]

Here, he focuses on various urban renewal projects that were implemented by the

colonial government in response to the outbreak of disease (such as sanitary housing for

the poor and the construction of new infrastructure).[65] In doing so, he demonstrates that

the state's regulatory ambitions were intimately connected to concerns about Bombay's

---

[60] Gary Fields, "Enclosure Landscapes: Historical Reflections on Palestinian Geography," *Historical Geography* 39, no. 1 (2011): 189.
[61] Said, 12.
[62] Ibid., 54.
[63] Prashant Kidambi, *The Making of an Indian Metropolis: Colonial Governance and Public Culture in Bombay, 1890-1920* (Burlington: Ashgate, 2007), 9-10; Stephen Legg, *Spaces of Colonialism: Delhi's Urban Governmentalities* (Oxford: Blackwell Publishing, 2007), 9.
[64] Kidambi, 9-10.
[65] Ibid.

built environment.[66] Similarly, an important part of Legg's Foucauldian analysis of the

production of space in Delhi considers strategies of colonial urban planning in the British

attempt to discipline the subjects of the Raj.[67] This objective, according to Legg, required

a spatial ordering of Delhi that produced multiple governmentalities to deal with the

city's diverse conditions.[68] Such an approach, in fact, has been critical to my study of

Lahore, especially because it allows for greater insight into the relationship between

material space, knowledge, and power. More specifically, I employ Legg's Foucauldian

reading of colonial power to examine state control over disease and disorder in the city.

As we will see in chapter two, for example, colonial spatial arrangements in Lahore often

disguised more ambitious British objectives. Indeed, on the surface, changes to the city's

urban landscape were represented as a response to the larger sanitary reform movement

that was sweeping Europe and the colonies during the nineteenth century. What is often

overlooked, however, is that these reforms simultaneously promoted official narratives of

progress and order that sought to reinforce colonial authority over Indians. This then

suggests that power relied heavily on control over geography, although this ordering of

space was also gauged by a constructed measure of progress that invariably (re)shaped

the local landscape.

Nevertheless, while the concept of space has proved important for understanding

how power was perpetuated and justified by colonial rulers, it must not be regarded as an

absolute or complete entity. As Sara Upstone stresses in her study of spatial politics, the

---

[66] Ibid., 10.
[67] Legg, 9.
[68] Ibid.

colonial strategy of utilizing space as a means of extending power was only ever a myth

and the sense of order it presented was not only imaginary but also unnatural:

> Nowhere – in the colony or the imperial heartland – does the order attempted by
> the colonist successfully exist. What does exist, instead, is quite clearly a
> '*strategy* of totalisation'…a constructed, intentional, aim but one that is ultimately
> beyond the realm of realization.[69]

Imperial designs for indigenous spaces, in other words, were only ever logical and

coherent in theory; in practice, these plans reflected an enterprise that was marked by

internal discord, financial strain, and an overextended bureaucracy.[70] It is here, in the

disconnect between the colonial power's aspirations and the implementation of its

"modernizing" goals that the inconsistencies and contradictions of colonialism become

apparent. Therefore, city planning and the politics of urban design must be regarded as

uneven social and cultural processes that were rarely cohesive and constantly subject to

revision and amendment.[71]

The same, in fact, could be said for the larger narrative of colonial rule in Lahore.

After all, the city had witnessed several transfers of power over the centuries and, with

the imposition of each new ruler, more traditions and customs became a part of its social

fabric. By the time the British arrived in Lahore, the traces of these empires were

entrenched in the city's geography and culture as representations of a complicated

reality.[72] Thus, the social and physical landscape of Lahore reflected a fluidity that

British rule could never censor and this highlighted the multiple narratives of the city's

---

[69] Upstone, 6.
[70] William Cunningham Bissell, *Urban Design, Chaos, and Colonial Power in Zanzibar* (Bloomington and
Indianapolis: Indiana University Press, 2011), 2-3.
[71] Ibid., 9.
[72] Upstone, 6, 8.

past.[73] While colonial spatial ordering, territorial appropriation, and the government's regulatory ambitions certainly obscured Lahore's existing diversity at times, in reality, the old impressions and impulses of the city could never be entirely erased. These foundations elicited a reimagined colonized space that created new power structures and hierarchies in Lahore. In doing so, they reshaped the relationship between colonizer and colonized and demonstrated that British intervention in the city was informed, more often than not, by a fractured colonial system.

---

[73] Ibid.

Chapter 1 – The Development of "Modern" Lahore

<u>Introduction</u>

Since at least the seventh century, repeated conquests and political takeovers in northern India meant that power and sovereignty existed precariously in the region. Lahore, in particular, had witnessed the accession and defeat of several dynasties that included Rajput kings, Persian sultans, Mughal emperors and the Sikh *khalsa* (the order of fully initiated Sikhs), all of who lived and battled within the territory to secure their authority. T. H. Thornton, the secretary to the Government of Punjab in the 1860s, described the city's history as "a chronicle of war upon war, intrigue upon intrigue, crime upon crime."[1] Another British resident argued that "few cities [had] suffered more from desolating hordes and from anarchy than Lahore during the last 120 years previous to the inauguration of English rule."[2] Throughout this process, the city was transformed into a distinct metropolis that was branded with the physical expressions of diverse cultures and traditions. Among the changes that were wrought by foreign rulers, those imposed by the British after their arrival in the mid-nineteenth century have remained an integral part of Lahore's identity even today. Their influence, for instance, has been manifested in the continued use of nineteenth-century buildings such as the Civil Secretariat and Lawrence Hall. While similar observations can be made about other Indian cities (such as Calcutta, Bombay, and Madras), Lahore, as we will see, functioned as a centre of industry, commerce, and trade well before the arrival of the British.[3] Indeed, it is a city that still

---

[1] T.H. Thornton, *A Brief Account of the History and Antiquities of Lahore* (Lahore: Civil Secretariat Press, 1873), 38.

[2] H.R. Goulding, *Old Lahore: Reminiscences of a Resident* (Lahore: Universal Books, 1924), 82.

[3] Here, Calcutta refers to Kolkata, Bombay to Mumbai, and Madras to Chennai. Throughout the thesis, I address these cities by their former names (i.e. those used under British rule). This is because many of the

bears the traces of its past and reflects a complex and multifaceted history that continues

to exert its influence on the experiences and traditions of its inhabitants.

A "Modern" City

Lahore's transition to colonial rule began with the death of Ranjit Singh in 1839

and the ensuing years during which the Sikh Empire became weakened by civil disputes.

This disorder made Lahore more vulnerable to colonial intrigue. In 1846, the British

defeated the Sikhs in the first Anglo-Sikh War and a second loss three years later

ultimately led to the formal annexation of the Punjab in 1849. Almost immediately,

British troops were set up in the civil station of Anarkali and with this began Lahore's

transformation into a colonial city. The first few years of British rule were spent

documenting the political and economic characteristics of the city in order to render it

more susceptible to colonial governance.[4] For example, an exhibition of industrial arts

organized in 1864 offered a survey of regional crafts that was imperative for directing

production in Lahore for commercial purposes.[5] Similarly, important documents relating

to the history of the region were translated into English as part of a British project to

become familiar with the new territory. This was accompanied by the development of

extensive surveys that created a database of information detailing specific knowledge

about the province. In particular, observations about the geography, economy, and

political history of the Punjab featured prominently in mid-century colonial reports and

periodicals like *The Indian Mail* and the *Asiatic Journal.*

---

excerpts from the primary source documents I have used refer to the cities by these older names and so, to
ensure consistency and to avoid confusion, I have done the same.
[4] Naazish Aata-Ullah, "Stylistic hybridity and colonial art and design education," in *Colonialism and the
Object: Empire, Material Culture and the Museum,* ed. Tim Barringer and Tom Flynn (London and New
York: Routledge, 1998), 68.
[5] Ibid., 68-69.

Perhaps the most important use for such information was in the colonial government's plan to redevelop the city. This project was part of a larger nineteenth-century British initiative that called for urbanization, environmental reform, and sanitary improvement in Indian cities more generally. With Britain's economic and political interest in the colony continuing to grow, cities like Bombay, Calcutta, and Lahore became the focus of new colonial objectives that hinged on the material and social significance of geographic space. In many of these cities, older areas were demolished in order to make way for planned urban spaces, resulting in seemingly stark differences between the remaining densely-packed sections (often remnants of the Mughal era) and the new, more organized areas established by the British along "civil lines" (residential neighbourhoods developed specifically for civil officers).[6] It must be noted, however, that colonial urbanism and expansion did not operate identically in these cities. Unlike Lahore, for instance, Bombay and Calcutta featured more deliberate and formal plans for segregation between Indian and British residents. The cities' designs were also established based on their position as key centres of trade which played a critical role in their development as port cities. Lahore, on the other hand, was a prominent city in its own right even before the British occupation in 1849.[7] Long-standing royal presence and patronage in the city, which led it to serve at times as a capital for the Ghaznavid, Ghurid, Sultanate, and Mughal dynasties, meant that Lahore functioned as a hub of development,

---

[6] John Harriss and Craig Jeffrey, *Keywords for Modern India* (Oxford: Oxford University Press, 2014), 25.
[7] This is not to say that other Indian cities did not witness important changes before British colonization. Bombay under the Gujarat Sultanate, and later the Portuguese, and Madras under the Dutch were both subject to economic, religious, and social changes. However, their transition to colonial rule occurred much earlier than the British annexation of the Punjab – 1508 for Bombay and 1522 for Madras - and, therefore, they did not display the same mix of "imperial" qualities that had come to characterize Lahore.

trade, and social and cultural connections since at least the eleventh century.[8] Moreover, its strategic geographic location facilitated its transformation into a prominent city. Nestled within the fertile area of the Indus River basin, Lahore was not only situated along the direct trade route linking India to Central Asia, it was also connected to the Middle East via an overland passage that linked the city to Delhi.[9] As well, its position along the Ravi River meant that Lahore was part of an important riverine network that connected it to Kashmir in the north and the Arabian Sea in the south (via the Indus River).[10] As such, it offered an established foundation that aided British plans for expansion in North India. According to one commentator, for example, even though Lahore was "not very imposing", the city nevertheless "show[ed] an architectural *coup d'oeil* worthy of an imperial city."[11]

The British occupation, however, signaled new changes for the city, especially in terms of infrastructure. Efforts were made to construct a metropolis that expressed "modern" urban ideals defined by commerce, industry, and administration.[12] Although the redevelopment of Lahore cannot be seen exclusively as the consequences of British activities and rule – as we will see, the idea of a "modern" colonial city depended on the influences of the indigenous population as well as those of the colonizer – the changes established after the annexation of the Punjab certainly reflected a triumphalist colonial attitude towards "progress" and development in the city. Nowhere was the colonial influence on Lahore's geography more apparent than in the landscape beyond the city's

---

[8] Glover, 4.
[9] Ibid.
[10] Ibid.
[11] Government of Punjab, *Gazetteer of the Ferozpur District,* 1883, 152-153.
[12] Glover, xiv.

defensive walls, which until 1849, had been scattered with the ruins of older settlements. According to one report from 1884, "[t]he environs of the city in 1849 were a dreary expanse of crumbling ruins, remains of the ancient city of the Mughals."[13] Similarly, Syad Muhammad Latif's history of Lahore described the outer city as "diversified by mounds, kilns, bricks, stones, broken masses of masonry, decaying structures, hollows, excavations and all the debris of habitations that have passed away."[14] For him, the arrival of the British signified a momentous event in the history of India which relieved her from centuries of anarchy and corruption. "There were better days in store for her," he wrote, and it was only through the "magic wand of British civilization" that India would reawaken from a dismal slumber.[15]

Latif's idea of an Indian past that was characterized by ignorance and violence before British rule was part of a growing narrative intended to legitimize colonial ambitions in the colony.[16] In fact, the early nineteenth century had witnessed the emergence of a new understanding of history in Britain that reflected changing attitudes towards the developing empire and the people it encountered.[17] Perhaps more importantly, this narrative used an alternate conception of time which featured the "West" as a measure for evolutionary progress while relegating colonial others to a

---

[13] *Gazetteer of the Ferozpur District,* 1883, 150.
[14] Syad Muhammad Latif, *Lahore: Its History, Architectural Remains, and Antiquities, with an Account of Its Modern Institutions, Inhabitants, Their Trade, Custom, etc.* (Lahore: New Imperial Press, 1892), 251.
[15] Ibid., viii, ix.
[16] Because Latif's work was published during the height of British rule in Lahore, it must be used with caution. After all, print media at the time was heavily controlled by the government and this would have made it difficult to publish books that openly criticized the colonial state. At the same time, however, it is likely that Latif genuinely admired British achievements in the city, especially because he recognized that the golden age of Muslim rule had ended. For him, the only way India could regain prestige was by embracing the "superior" economic and cultural improvements introduced by the British. Aizad Sayid, "A Short Biography of Syed Muhammad Latif," *Scribd*, Accessed May 1, 2018, https://www.scribd.com/doc/72430816/A-Short-Biography-of-Syed-Muhammad-Latif
[17] Saree Makdisi, *Romantic Imperialism: Universal Empire and the Culture of Modernity* (Cambridge: Cambridge University Press, 1998), 4.

"wretched state of pre-modernity" waiting to "[begin] their apprenticeship in modernization".[18] As such, it justified intervention in the colonies by establishing the British as agents of a civilizing mission that would restore the "chaotic" pasts of non-European peoples. This had significant implications for cities like Lahore where the British takeover resulted in material changes that sought to reflect the ideals of a "civilized" and "modern" society. The decline and disrepair that were once manifested in the ruins outside the city walls were obscured by the British in their attempt to incorporate Lahore's past into the universal historical narrative.[19] Particularly after the Indian Mutiny of 1857, when British authority faced considerable challenges in the region, it was imperative for Lahore to be displayed as a model of "progress" and "order". These concepts identified variables such as urban development, public health, and social change as critical to the transition of "traditional" societies into "modern" ones (especially within the unilinear conception of history accepted by the British). At least on the surface, then, it appeared that the planning and development of Lahore's geography expressed a distinctly calculated colonial plan.

Although centuries of occupation had left their mark on the city, one commentator in 1883 suggested that, from "an architectural point of view, Lahore [was] essentially a Mughal city."[20] In this regard, it shared many similarities with cities like Agra and Delhi which, under Mughal rule, became thriving intellectual, social, and cultural hubs that encouraged new developments in the arts, commerce, literature, and architecture. Here, industries such as silk weaving, carpet manufacturing, and gold and silver production

---

[18] Ibid.
[19] Glover, xii.
[20] *Gazetteer of the Ferozpur District,* 1883, 138.

witnessed considerable growth while increased cultivation led to the production of important commodities like opium, tobacco, and indigo.[21] Even after the decline of the golden age in the early eighteenth century, Mughal influence remained entrenched within the urban landscape of these "imperial cities".[22] In Lahore, for instance, several monuments signaled the city's Mughal past. A defensive fort, restructured and enlarged during the reign of Emperor Akbar (1556-1605), served as a palace and meeting hall for successive Mughal rulers. [23] It was bordered to the north and west by the Ravi River and secured by thick defensive walls. New buildings were added within the fort over time, including the Shish Mahal by Emperor Shah Jahan in 1631-1632 and a hall of silvered mirrors that was occupied by the empress and her attendants and later used by Ranjit Singh as a reception room.[24] Thirteen gates were built into Lahore's old wall to allow controlled access to the inner city and to keep invading forces out; beyond them lay gardens, bazaars, and densely populated suburbs with private *havelis* (mansions) and gardens.[25] The roads leading from the gates connected the city to other urban centers in the Punjab through small villages in the countryside.[26]

At the height of Mughal rule, Lahore's population exceeded 500,000 people (compared to 176,000 in 1894 under British rule).[27] In fact, a European traveler to the city in the early seventeenth century described it as "one of the largest cities in the whole

---

[21] Glover, 4.

[22] Ibid.

[23] Ibid., 7.

[24] F. S. Aijazuddin, *Lahore Recollected: An Album* (Lahore: Sang-e-Meel, 2004), 54.

[25] Kamran and Talbot, 12.

[26] Sylvia Shorto, "A Tomb of One's Own: The Governor's House, Lahore," in *Colonial Modernities: Building, Dwelling and Architecture in British India and Ceylon,* ed. P. Scriver and V. Prakash (London and New York: Routledge, 2007), 155.

[27] Edwin Lord Weeks, "Lahore and the Punjaub," in *Harper's New Monthly Magazine* 89, no. 533 (1894): 668.

Universe, for it containeth at least sixteene miles in compasse, and exceedeth Constantinople itself in greatness."[28] Despite such claims, however, Lahore's position as an imperial centre was short-lived, a fact that owed much to the absence of a deliberate urban design for the city under the Mughals.[29] After all, as Stephen Dale demonstrates, Mughal political culture was attached primarily to the figure of the emperor rather than to the cities that they established (a characteristic rooted in the nomadic tradition of the early Mughals).[30] Therefore, other than the royal palace, development in cities like Lahore was not shaped by large-scale or comprehensive urban schemes but by immediate concerns such as border security and territorial ambitions.[31] Most pre-colonial construction in the city, then, occurred in an ad hoc manner.[32] Although Mughal stylistic influence remained visible long after their political decline in Lahore, this lack of formal town planning eventually led to the neglect and ruin of many parts of the city.

By the mid-seventeenth century, Lahore had lost much of its imperial status. In 1648, Shah Jahan established Delhi as the new capital of the Mughal Empire in an attempt to secure his power in the region; this drew away a large number of artisans and traders from Lahore who had once called the city their home. Lahore became subject to invasions, pillages, and significant periods of depopulation that "reduced [it] from a mighty city to little more than a walled township in a circle of ruinous waste."[33] One British officer, who described his visit in 1809, remarked:

---

[28] Thomas Coryat, quoted in "Roe and Coryat," *The Calcutta Review* 28 (1857): 262.
[29] Stephen Dale, *The Garden of the Eight Paradises: Bābur and the Culture of Empire in Central Asia, Afghanistan and India (1483-1530)* (Leiden, Boston: Brill, 2004), 462.
[30] Ibid.
[31] Glover, 9.
[32] Ibid.
[33] *Gazetteer of the Ferozpur District,* 1883, 148.

> I visited the ruins of Lahore, which afforded a melancholy picture of fallen splendor. Here the lofty dwellings and Masjids, which, fifty years ago, raised their tops to the skies, and were the pride of a busy and active population, are now crumbling into dust, and in less than half a century more will be levelled to the ground.[34]

Under the Sikh Kingdom (1799-1849), some parts of Lahore did return to their former grandeur – Ranjit Singh, for example, commissioned several architectural projects including the construction of a large garden (the Hazuri Bagh) with a marble pavilion near the Lahore fort – but even these structures deteriorated before the British annexation.[35] Over the next several decades, houses fell into disrepair and the long, busy streets of the city began to deteriorate. In fact, the British arrived to find much of the four mile radius south of the walled city in ruins, bearing the remains of old Mughal mosques, tombs, and ornamental gateways.[36] But, colonial officials believed that it was their responsibility to transform the city into its most ideal state "and thus year by year the ruins and graveyards of old Lahore passed under the humanizing influence of western civilization."[37]

During the first decade of British occupation, however, it became clear that the resources and capital that were necessary for planning and building new administrative, social, and military structures in the city were limited. This realization, of course, undermined the idea of an omnipotent and pervasive colonial regime and, as such, references to the difficulties that confronted the British during their early years in the city were often misrepresented in official records.[38] Nevertheless, evidence of these problems,

---

[34] Ibid., 149.
[35] Kamran and Talbot, 9.
[36] *Gazetteer of the Ferozpur District,* 1883, 148.
[37] Ibid., 150.
[38] Kamran and Talbot, 4.

particularly economic constraints, were discernible throughout Lahore and were perhaps

most apparent in the British plan to repurpose the city's existing architecture. The

colonial government, for example, converted remaining buildings from the Mughal and

Sikh periods to serve new functions. The tomb of Anarkali – a large building that served

as the resting place of Emperor Akbar's favourite courtesan who, according to legend,

was buried alive for consorting with the emperor's son - was used as offices for the

Punjab's governing board before it was converted into an Anglican church in 1851; in

1891, it was transformed once more to function as an archive for the Civil Secretariat.[39]

Figure 1.1
Anarkali Church. George Craddock, *Photograph album of Surgeon-General Henry Walter Bellew,* 1870s.
Source: The British Library. Photo 50/1(109).

---

[39] Ibid., 19.

Similarly, the mosque of Dai Anga, named after Emperor Shah Jahan's wet nurse, was used as the private residence of Henry Cope, the editor of the *Lahore Chronicle,* the first English newspaper and press to be established in the Punjab in 1849. Cope sold the house to the Punjab and Delhi Railway Company after which it was eventually converted into the office of the railway's traffic manager.[40] Other buildings that were refitted for colonial use included an old army base from Ranjit Singh's period, which came to house the Public Works Secretariat, and a seventeenth-century mosque that was converted into the office of the Accountant General.[41]

Although occupying Indian buildings was a pragmatic solution to the shortage of funds that otherwise challenged British plans for the city, the move to refit old buildings was often articulated as a conscious decision of the colonial power.[42] Edwin Lord Weeks, an American artist who visited India in 1882, hinted at this impression in his description of the city in *Harper's Magazine*:

> Here are the churches – one of which was once the tomb of Anarkali…[it] is not the only instance in Lahore of that thrifty disposition of the modern Romans to utilize these monuments of a more poetic age…there are several other examples of equally successful adaptations.[43]

Indeed, assigning new identifications and associations to old structures that were significant to the local communities allowed the British to draw physical and visible links between themselves and the colonized.[44] During the early years of their rule in Lahore, this approach proved to be invaluable for developing relations with Punjab's local

---

[40] Latif, 157, 163.
[41] Glover, 60.
[42] Ibid., 18.
[43] Weeks, 663.
[44] Latif, 163.

chiefs.[45] Moreover, the practice of converting old buildings was a longstanding tradition in northern India – the Bala Hisar Fort in Peshawar, for instance, was used by the Pashtun king Timur Shah Durrani, the Mughal emperor Hamayun as well as by the Sikhs - because it was believed to legitimize authority through the physical appropriation (or destruction) of spaces that were once occupied by previous rulers.[46] The fact that Mughal-era constructions echoed Anglo-European architectural values (for example, their massive size, refined structures, and uniform patterns) only validated the British use of such buildings.

However, by the 1860s, the colonial practice of adapting traditional Indian buildings began to decline, a move that was informed largely by the Indian Mutiny of 1857. The shock and impact of the war had unsettled the foundation of Britain's rule in India and efforts to re-establish authority in the colony found expression in an architectural scheme that was influenced by Western civic grandeur and neo-classical design.[47] Whereas British administrators had once fused new landscapes with older ones and accepted Indian insights into plans for the city, the colonial vision for Lahore after 1857 was grounded in a "fantasy" that facilitated a myth of order and structure in the city.[48] Perhaps the most striking example of this was Lawrence Hall, one of the first British structures to be built in Lahore. Completed in 1861-62, the building was named after Sir John Lawrence who served as the financial administrator of the Punjab Board of Administration in 1849 and later as Governor General and Viceroy of India from 1864 to

---

[45] Glover, 18.
[46] Ibid., 19.
[47] Ibid., 173.
[48] Upstone, 5, 6.

1869.[49] Lawrence had been influential in advancing the move towards increased British

intervention in the Punjab even before the Mutiny; alongside his brother, Henry

Lawrence, he founded the Punjab School which upheld a paternalistic attitude towards

administration in the province. Although Henry Lawrence's sympathies lay with the

aristocracy and John Lawrence favoured the interests of the rural population, both

brothers stressed the importance of developing a personal bond between the British and

their Indian subjects.[50]

John Lawrence, in particular, aimed to strengthen the legitimacy of colonial rule

in the region by highlighting the differences between the British and Indians. Therefore,

it was no surprise that the style of the building named after him reflected a move away

from Indian architectural designs. Lawrence Hall, in fact, was planned with a traditional

English banqueting hall in mind and became a meeting place for polite British society. It

functioned as an assembly room and theatre for the European residents of Lahore and

reflected what Latif described as a "frigidly classical" style that was "detached from, and

partially antithetical to, the organizing principles of its surroundings."[51] Its exterior was

framed with Doric columns and rounded arches and a parapet above the entry displayed a

Grecian urn inscribed with Lawrence's name.[52] This emphasis on a distinct Greco-Roman

architectural style was informed by the colonial impulse to proclaim publicly Britain's

imperial authority in the city. After all, Lawrence Hall was constructed only a few years

after the Indian Mutiny and identifying it with the classical style of long-standing ancient

---

[49] Ibid.
[50] John W. Cell, *Hailey: A Study in British Imperialism, 1872-1969* (Cambridge: Cambridge University Press, 1992), 4.
[51] Latif, 310.
[52] Glover, 65.

empires was meant to evoke an "imperial vision" - Thomas Metcalfe describes this as a

means of re-inventing India's past in order to assert British mastery over it - that signaled

ideas about power and prestige.[53] For this reason, there was little room to reflect Indian

sentiments or local participation in the physical form of new buildings in Lahore, at least

not during the first decade after the Mutiny.[54] Many new architectural projects throughout

India in the mid-nineteenth century – such as the Madras Mutiny Hall built in the 1860s -

were devoid of local architectural elements and, as such, created a distinct landscape

Figure 1.2
Lawrence and Montgomery Halls. James Craddock, *Views in Simla, Cashmere and the Punjaub*, 1860s.
Source: The British Library. Photo 211/1(85).

---

[53] Thomas Metcalfe, *An Imperial Vision: Indian Architecture and Britain's Raj* (London: Faber & Faber, 1989), 3.
[54] A. Rehman et al., "Stones of British Colonial Lahore: A Study of Two Remarkable Buildings of Earlier Period of British Architecture," *Pakistan Journal of Science* 65, no. 2 (2013): 307.

in the colony that was marked by colonial aesthetics and insight.[55] In Lahore, these buildings represented not just the beginnings of a new urban environment for the city but also expressed the ways in which physical structures were imbued with symbolic importance.[56]

The development of Lahore, however, could never remain an exclusively colonial endeavour. Despite British efforts to reorder the city based on the logic of colonial spatial ideals, officials realized quickly that the "success" of its urban design depended largely on the cooperation of Indians themselves. In fact, by the final quarter of the nineteenth century, Lahore witnessed an amalgamation of Indian and European architectural schemes that were triggered in part by the British reliance on local knowledge of the environment. Colonial plans for restructuring the city, for example, required a good understanding of India's climate to make new projects sustainable during hot summers and rainy seasons. This was particularly important because of longstanding colonial concerns about the role of tropical heat in compromising the British constitution. Surgeon General William Moore, for example, argued that "exposure to the effects of continued tropical heat during a series of years produce[d] a debilitated condition [in the body's] system."[57] Therefore, ideas about the climate played a key role in the British decision to incorporate certain features - verandahs, thick walls, and high ceilings - into the architectural style of Lahore's buildings.[58] There was a recognition that British developments in the city would have to take into account hybrid designs as well as local knowledge for restructuring the urban landscape. Collaborations between colonial

---

[55] Glover, 60-61.
[56] Ibid., 61.
[57] William James Moore, *A Manual of Disease for India* (London: J. and A. Churchill 1886), 12.
[58] Rehman et al., 306.

administrators and Indians (usually the elite) were perhaps most apparent in Anarkali, the

civil station southeast of Old Lahore. Although this had originally been the site of a

military cantonment when the British first occupied the city, the new headquarters of the

Lahore Division was relocated five miles east to Mian Mir in 1852.[59] In its place, several
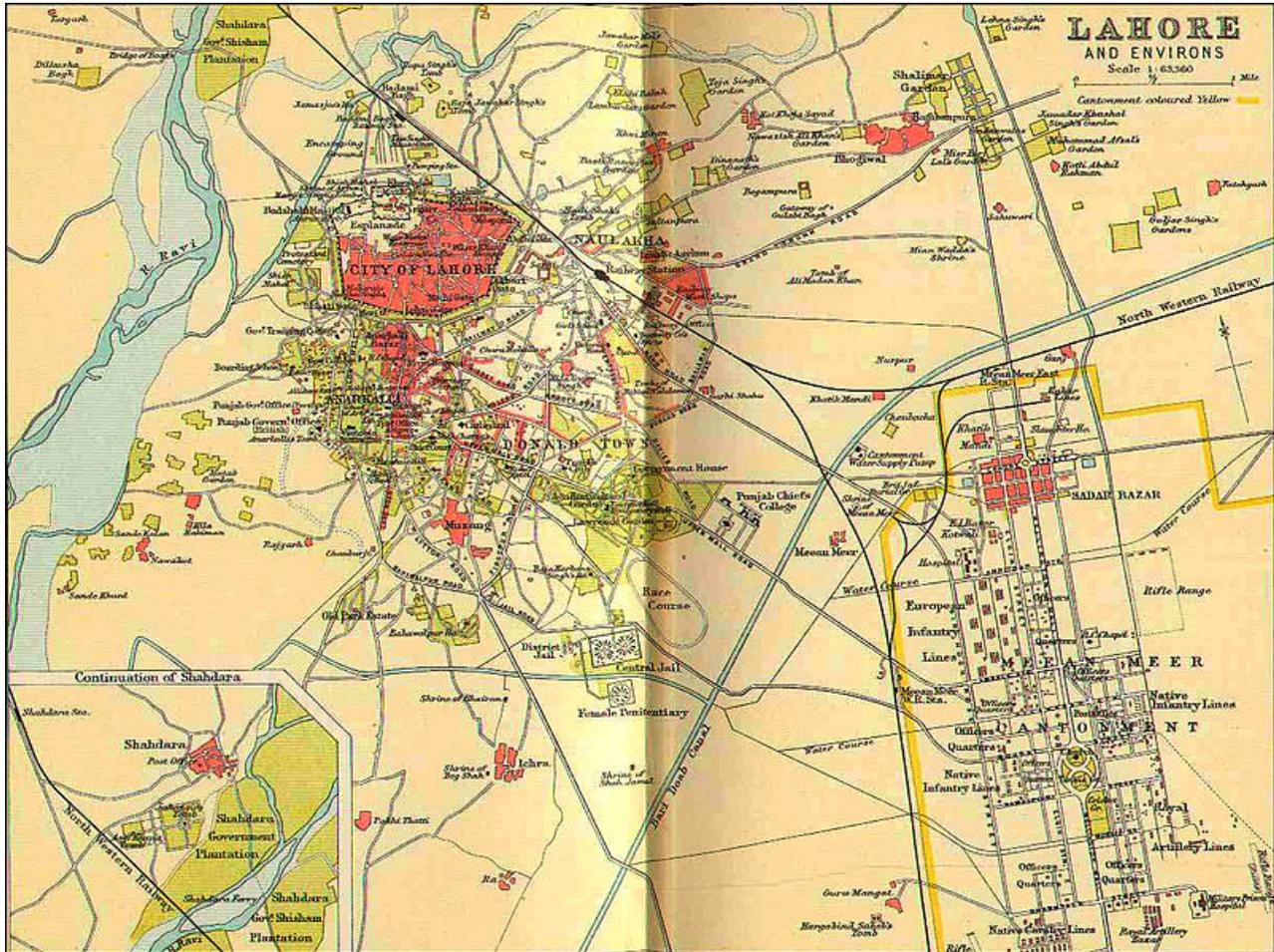

Figure 1.3
Lahore and its Environs, 1893.
Source: Bartholomew, J.G. *Constable's 1893 Hand Atlas to India*. Westminster: Archibald Constable & Company, 1893.

---

[59] David Ross, *The Land of the Five Rivers and Sindh: Sketches Historical and Descriptive* (London: Chapman and Hall Ltd., 1883), 121.

square miles of the civil station were established. Backed by a combination of private, municipal, and provincial funds, Anarkali served as the centre of colonial administration in the city and became home to the Lahore Central Jail, Mayo Hospital, Government College, and the executive and administrative offices of the provincial government. Many of these new buildings displayed a mix of traditional Indian design and the neo-classical style favoured by the British.

In Lahore's civil station, moreover, there were several buildings that demonstrated the ways in which decisions regarding the layout and patronage of new structures became part of a collaborative dialogue. For example, Rai Bahadur Kanhya Lal, a prominent Indian engineer who served with Lahore's Public Works Department, supervised the construction of several local buildings that included the Mayo School of Arts and Montgomery and Lawrence Halls.[60] His obituary, published by the Institution of Civil Engineers in Britain, highlighted his influence on the city and its administrators:

> Kanhaya Lal was soon found to be a most useful man to have at the capital city and chief civil station of the Province. Very many and various were the works he was called upon to do at the head quarters of the administration…it is not surprising that he was constantly looked to, to do something more. Committees of various kinds obtained his services…[61]

Similarly, Bhai Ram Singh, who joined the Mayo School of Art under the tutelage of John Lockwood Kipling (Rudyard Kipling's father), designed many iconic buildings in the city including the Lahore Museum (1888), Albert Victor Hospital (1890), and Punjab

---

[60] Government of India, *Selections from the Records of the Government of India, Home Department: Reports on the Publications Issued and Registered in the Several Provinces of British India during the Year 1877* (Calcutta: Office of the Superintendent of Government Printing, 1878), 122.
[61] James Forrest, ed. *Minutes of Proceedings of the Institution of Civil Engineers; with other selected and abstracted papers* (London: Institution of Civil Engineers, 1888), 94: 314-315.

University Hall (1905-1910).[62] These, in turn, were constructed by Ganga Ram whose

time as executive engineer in the city is often referred to as Lahore's "Ganga Ram"

architectural period.[63] Other examples of collaboration between Indians and the British

were evident in the planning and construction of the Punjab Chiefs' College, designed

exclusively for educating the ruling princes of northern India.[64] Blueprints for the college

boarding houses were examined by representatives of the native states who offered their

own insight into the design and structure of the buildings.[65] Other parts of the campus

layout exhibited key characteristics of colonial and Indian spatial ideals such as a

symmetrical plan for the grounds (as seen in both Victorian and Mughal architecture).[66]

The final design of the central building reflected an Indo-Saracenic style – a term used to

represent an Indo-European cultural hybridity drawn from pre-Mughal, Mughal, and

British sources - which combined diverse architectural features such as arches, screens,

and verandahs.[67] As Glover argues, this style was a fitting choice for the college because

it "incorporate[d] the Punjab's regional aristocracy into an imperial structure of rule

rhetorically tuned to indigenous modes and forms of authority."[68] More importantly, such

hybrid architectural concepts became a material model of the political relationship the

British sought to establish with Punjab's indigenous elite. After all, the collaborative

design of the college allowed for the active participation of the city's residents but in a

---

[62] Kamran and Talbot, 14.
[63] Ibid.
[64] Glover, 68.
[65] Ibid.
[66] Ibid., 71.
[67] Peter Scriver, "Stones and Texts: The Architectural Historiography of Colonial India and its Colonial-Modern Contexts," in *Colonial Modernities: Building, Dwelling and Architecture in British India and Ceylon*, ed. Peter Scriver and Vikramaditya Prakash (London: Routledge, 2007), 47. Scriver maintains that the term Indo-Saracenic does not reflect a true fusion of European and Indian architecture; for him, one must first consider how authentic cultural intercourse and invention were under colonialism.
[68] Glover, 71.

controlled landscape that manifested colonial influence physically in British and Indian iconography.[69]

Other parts of the civil station expressed an exclusively "Western" feel, resulting in the emergence of new suburbs such as Donald Town. Extending for three miles, this area became the site of prominent buildings like Government House and Montgomery Hall (used as a dance hall and sports club). More importantly, Donald Town featured noticeable examples of the values and ideals that attempted to distinguish the rulers from the ruled. Among them was the single-story house, the main style of residence for British officers in the city, which became a symbolic visual representation of "expatriate domesticity" in Lahore.[70] In fact, houses in Donald Town often reflected neoclassical or Gothic-revival designs that alluded to contemporary trends in Britain during the late nineteenth century.[71] Moreover, they were characterized by details such as gates and walls that sought to isolate them from their Indian surroundings; many were also elevated on a raised foundation as a symbolic gesture of their exclusivity and imperial status.[72] Together, these features were intended to make colonial houses a place of refuge and comfort for the British officials who resided there. However, while they were regularly adopted as a "metonym for empire", these spaces simultaneously undermined the very ideals that they were meant to uphold.[73]

As with the rest of the newly built civil station, colonial homes hinted at the inability of British officials to assert complete authority over the material culture of

---

[69] Ibid., 72-73.
[70] Ibid., 163.
[71] D. J. Huppatz, *Modern Asian Design* (London, New York: Bloomsbury, 2018), 63.
[72] Ibid.
[73] Glover, 163.

Lahore. For one thing, colonial residences were usually built by local landowners and

businessmen who rented them to British officers.[74] Therefore, while the design of these

houses often mirrored those in the metropole, residents had limited control over the basic

features of the domestic space because they hinged on the impulses of the landlord.[75]

This, in turn, raised important questions (and anxieties) about who was more at home in

their surroundings: the colonial officer or the Indian landlord. Even household

furnishings - usually designed according to European tastes - were purchased as inferior

copies from local craftsmen.[76] For example, B. H. Baden Powell, who served as the

Conservator of Forests for the Punjab, stated:

> There being a large European community, the demand for furniture is
> considerable, and for some years past every house almost, has been supplied with
> copies of bad originals, in the shape of folding-chairs, side-tables, what-nots, and
> corner *elageres*. All are exactly alike, except that the work and carving gets worse
> and worse.[77]

Despite attempts to maintain a "proper" English domestic life in Lahore – defined by

principles such as family virtue, cleanliness, and morality – colonial homes could not be

transplanted simply from the metropole to India. Even areas like Donald Town, which

were built with colonial ideals in mind, relied on collaboration and exchange between

British and Indians residents.

 Evidently, the newly constructed civil station and colonial suburbs were never

distinctly British spaces. Each was connected to the old parts of Lahore via bustling,

commercial roads where the social life of the city thrived and where racial separation -

---

[74] Ibid., 165. In these situations, Indian landlords dominated the scene because they already owned the property upon which these houses were constructed and, therefore, they did not have to deal with the added expense of buying land.

[75] Ibid.

[76] Huppatz, 64.

[77] B. H. Baden Powell, "Indian Manufactures from a Practical Point of View," *Journal of the Society of Arts* 34 (1886): 710.

otherwise formalized in the military cantonment at Mian Mir - was overlooked.[78] Along a half-mile stretch of road called the Mall, for example, carefully constructed spaces like Lawrence Gardens were used as a "pleasure ground" for controlled cultural interactions between the races.[79] Here, a bandstand offered a place for the cantonment's military to perform for public entertainment while tennis courts and cricket fields allowed mixed-race teams to participate in recreational sport (although this was more common in the twentieth century).[80] Lawrence Gardens also included a zoo and botanical garden that were frequented by British and Indians alike.[81] This integrated landscape, moreover, relied on contributions from local elites, further reinforcing the role that Indians played in the city's larger development. This way, spaces like Lawrence Gardens, and the civil station more generally, created a new landscape in Lahore that expressed both British and Indian cultural ideals.

Social and Cultural Expressions

By the late nineteenth century, Lahore had become a prominent cultural and social hub in the northwest. Not only was the city the centre of the province's administrative system, it was a place of economic, religious, and educational activity, particularly among the Indian community. In fact, by the 1880s, Lahore's indigenous population became increasingly diverse, with more residents born outside the district than within.[82] One contemporary, for instance, noted: "In the evening a pedestrian finds it rather difficult to make his way through the dense crowd of people of different

---

[78] Latif, 252.
[79] Ibid., 314.
[80] Glover, 68.
[81] Ibid.
[82] Kenneth Jones, *Arya Dharm: Hindu Consciousness in 19th–Century Punjab* (Berkley: University of California Press, 1976), 58.

nationalities."[83] As the city became better connected to other parts of the country via railway lines – train service between Lahore and Amritsar was established in 1862 and between Delhi and Lahore in 1870 - improvements in communication and trade reinforced the movement of goods and people throughout the region.[84] Many Indians were drawn to Lahore in search of better positions within the civil service, leading to key transformations in the city's social and urban landscape.[85] Some of the more important changes in the capital included the development of a new system of schools and colleges that advanced British educational policies in the province. Among them were the Mayo School of Industrial Arts (one of four art schools in India that was sanctioned by the central government), Aitchison College (modeled on the English boarding school system), and Punjab University (established primarily for professional instruction in law and medicine).[86] As well, with over three hundred colonial institutions established in the city by the end of the nineteenth century, educated Indians were needed to fill positions in government offices and institutions.[87] Therefore, officials in Lahore expanded the scope of western education in the city in order to prepare locals for new professional and administrative careers. Lahore, thus, emerged as the principal centre of modern education and intellectual life in North India.[88]

Despite the growing influence of the city's local residents, colonial administrators continued to enlist the services of educated Indians from other parts of the country to promote Lahore's economic and social development. For example, Brahmins and

---

[83] "The Anarkulle Sudder Bazaar," *The Tribune*, April 21, 1883, 3.
[84] Kamran and Talbot, 25-26.
[85] Glover, 79.
[86] Ibid., 68, 80, 85.
[87] Kenneth Jones, *The New Cambridge History of India,* vol. 3, *Socio-religious reform movements in British India* (Cambridge: Cambridge University Press, 1989), 94.
[88] Kamran and Talbot, 28.

Kayasthas were recruited from areas such as Bengal and the North-Western Provinces to fill bureaucratic roles within the colonial administration (largely because they served as scribes and advisors to pre-colonial rulers).[89] Similarly, many middle class Indians who arrived in the city to receive an education ultimately remained in Lahore to pursue profitable careers in the legal, financial, and commercial sectors.[90] The presence of these groups had important implications for the social structure and political future of the city. Indeed, they came to form a new class of Indians that contributed to the economic, social, and cultural revival of Lahore.[91] For example, among the migrants who moved to the city was Dyal Singh Majithia, a prominent industrialist and philanthropist who launched Lahore's *Tribune* newspaper in 1881 and was a founding member of the Punjab National Bank (established in Anarkali Bazaar in 1895).[92] Another leading figure in the city was Lala Harkishen Lal. Born in Layyah near Dera Ghazi Khan, Harkishen Lal was educated at Lahore's Government College before becoming a high-profile entrepreneur with a growing industrial empire.[93] By the early twentieth century, his assets included a number of insurance companies, flour and saw mills, and electricity supply companies that helped secure Lahore's connection to the global economy.[94]

Other groups that played a critical role in the city were newly arrived migrants from Bengal under whose influence Lahore witnessed the formation of Punjab's first branch of the Brahmo Samaj. This Hindu socio-religious reform organization was established in the city in 1863 and called for the eradication of certain practices from the

---

[89] Jones, *The New Cambridge History of India,* 78.
[90] Kamran and Talbot, 29.
[91] Jones, *The New Cambridge History of India,* 78.
[92] Kamran and Talbot, 22-23, 29.
[93] Ibid., 29.
[94] Ibid.

Hindu faith (such as female infanticide, *sati,* untouchability, and polygamy).[95] Triggered

by a larger intellectual movement that broke out in Bengal in the early nineteenth century

- the Bengali Renaissance prompted new ideas about equality, justice, and liberty among

a growing middle class – the Lahore Brahmo Samaj legitimized its own presence in the

city by founding schools, erecting places of worship, and organizing weekly meetings for

members.[96] Moreover, because Bengali was understood very little in the Punjab, the

Brahmo Samaj attempted to bridge the language barrier in Lahore by instituting a society

for translating and publishing Brahmo literature into Hindu, Urdu, and Punjabi; this

helped advance the movement's objectives among the Punjabi community in the city.[97]

However, as Kenneth Jones argues, the work of the organization "was successful enough

to result in both emulation and opposition."[98] By the late 1870s, criticism from orthodox

Hindu leaders, who resented the Brahmo's attack on traditional Hinduism, contributed to

the decline of the movement in Lahore.[99] More importantly, it was the emergence of a

new Punjabi elite and the growth of a rival Hindu organization, the Arya Samaj, which

diminished the Brahmo appeal in the city.

Indeed, a new group of anglicized Punjabis began to engage with questions about

social and religious reform in the province. The Hindus among them, many of who were

students and graduates of Lahore colleges, turned to the Arya Samaj for direction in their

personal and professional lives. Having found a foothold in the city in 1877 (after a visit

from the movement's founder, Swami Dayanand Saraswati), the Arya Samaj established

---

[95] Harish Jain, ed., *The Making of Punjab* (Chandigarh: Unistar Books Pvt. Ltd., 2003), 244.
[96] Kenneth W. Jones, "The Bengali Elite in Post-Annexation Punjab: An Example of Inter-Regional Influence in 19th Century India," *Indian Economic and Social History Review* 3, no. 4 (1996): 379.
[97] Ibid., 379-380.
[98] Ibid., 380.
[99] Kamran and Talbot, 23.

nine chapters in the Punjab by 1878.[100] With this, several members of the Brahmo Samaj gradually drifted away to join the new organization. Brahmo ideology had been too eclectic and tolerant (especially of other religious doctrines such as monotheism) to gain widespread acceptance among Punjabi Hindus in Lahore.[101] For example, a communal feast organized by the group that was intended to unite its members instead alienated the leading Punjabi Brahmos in the city by ignoring caste restrictions.[102] The Arya Samaj, on the other hand, was militant and aggressive in its support of a "purified" Hinduism that was grounded in a deep-seated understanding of the Vedas, the oldest Hindu scriptures.[103] Despite lacking any central organization during its early years, the Arya Samaj gained considerable support in Lahore in the 1880s. Its traditional values - especially its call to return to a golden age of Hinduism - appealed to the elites in the city while its attack on Brahmanical privileges and push for a caste system based on merit rather than birth contributed to its popularity among educated members of the middle class.[104] But, more importantly, the success of the Arya Samaj in Lahore, and the Punjab more generally, was due in large part to the specific social dynamics of the province itself. Punjabi society was less constricted by the control of Brahmin orthodoxy - Brahmins had lost much of their status as highest caste Hindus during the Mughal era when Hinduism was prevented from being practiced openly in the region – and this contributed to a more

---

[100] Jones, *The New Cambridge History of India,* 78.
[101] Jones, "The Bengali Elite in Post-Annexation Punjab," 382.
[102] Ibid.
[103] Kamran and Talbot, 31.
[104] Jones, *The New Cambridge History of India*, 98.

flexible and receptive Hindu religion that was open to the reform-minded ideology of the Arya Samaj.[105]

During the second half of the nineteenth century, Muslim and Sikh migrants also influenced the changing socio-religious environment in colonial Lahore. Like their Hindu counterparts, organizations like the Anjuman-i-Islamia, the Society for the Defence of Islam, and the Singh Sabha were driven by challenges to their community from the activities of proselytizing Christian missionaries.[106] In an attempt to protect their respective religions, members of these movements revitalized the tenets of their faith in ways that transformed the consciousness and responsiveness of their adherents and propagated social changes within the larger community. For instance, the Society for the Defence of Islam (founded by the followers of reformer Syed Ahmad Khan in 1866) promoted Western-style education, especially for girls, and contributed to the establishment of several schools and publishing houses in Lahore.[107] The Anjuman-i-Islamia (1869) focused on reviving the city's Islamic heritage by organizing rebuilding projects that included repairing the Badshahi Mosque and restoring the shops attached to the Golden Mosque.[108] Similarly, the Singh Sabha (1879) - which originated in response to the Arya Samaj and its move to 'reconvert' lower caste Sikhs to Hinduism - took advantage of the burgeoning print culture and literary tradition in the city to revive the teachings of the Guru Granth Sahib in Punjabi.[109] In its move to purify the religion, the group called for the removal of Hindu images from Sikh shrines and sought to establish

---

[105] Dipankar Gupta, "'De-Sanskritization' of Untouchables: Arya Samaj Movement in Punjab," in *Struggle for Status,* ed. P. N. Pimpley and S. K. Sharma (Delhi: B. R. Publishing Corporation, 1985), 91.
[106] Mir, 19.
[107] Jones, *The New Cambridge History of India,* 95.
[108] Kamran and Talbot, 33.
[109] Tony Ballantyne, *Between Colonialism and Diaspora: Sikh Cultural Formations in an Imperial World* (Durham: Duke University Press, 2006), 5.

distinct rites of passage for the community.[110] Unlike its Amritsar branch, which drew members from the Sikh aristocracy, the Lahore Sabha reflected the changing dynamics of the city by highlighting the activities of a growing middle class and its engagement with public culture.[111] Its campaign for increased literacy helped draw these educated classes within its fold.

Lahore also emerged as a major centre of Urdu culture after 1857 when a large number of Muslim literati migrated to the city from Delhi following the Indian Mutiny. In particular, it was the contributions of individuals like Altaf Hussain Hali and Muhammad Husain Azad that helped advance the modern age of Urdu poetry in Punjab's capital.[112] Hali's work, influenced considerably by his experiences in Lahore after being uprooted from Delhi, marked the beginning of a more simplistic style in Urdu poetry that differed from the traditional and elaborate *ghazal* (generally characterized by themes such as loss, pain, and unconditional love).[113] Among his more famous poems is *Madd o Jazr i Islam* ("The Flow and Ebb of Islam") which evoked the ideals of the Aligarh movement, a campaign that called for the education of Muslims in the colony and which led to the preservation and popularization of Urdu in North India.[114] Similarly, Muhammad Husain Azad helped revive the language in Lahore by publishing important texts that gave Urdu a grassroots foundation in the city.[115] Perhaps his best-known work is *Ab-e-Hayat* ("Water of Life") which examined nearly two centuries of Urdu poetry and

---

[110] Ibid., 36.
[111] Kamran and Talbot, 32-33.
[112] Ayesha Jalal, *Self and Sovereignty: Individual and Community in South Asian Islam Since 1850* (New York: Routledge, 2000), 53.
[113] Ibid.
[114] Kamran and Talbot, 32.
[115] K. M. George, ed., *Modern Indian Literature: An Anthology* (New Delhi: Sahitya Akademi, 1994), 3: 717.

prose and became a primary source of information regarding the evolution of the language.[116] The increasing influence of individuals like Hali and Azad allowed Urdu culture to become an important part of Lahore's identity. By the 1880s, in fact, most vernacular publications in the city were in Urdu and this ultimately helped privilege the language over others like Persian and Punjabi (the official language of the Mughal and Sikh eras).[117]

Conclusion

The diverse nature of Lahore's socio-religious movements came to express new social, moral, and religious attitudes in the city, reflecting not only cohesiveness and unity but also divisiveness. It was precisely these changing perspectives among the city's inhabitants that help explain Lahore's cultural and social development in the nineteenth century. While the colonial occupation of the city in 1849 and the subsequent changes to its built environment certainly shaped Lahore's status as a key urban centre in the Punjab, it was the collaborations and exchanges with the city's local residents that really contributed to its emergence as a leading imperial, administrative, and educational hub. Lahore drew Indians from all over India in search of knowledge, better employment, and new social relationships and, together, they transformed the cultural and political atmosphere of the city. As the following chapters will demonstrate, it was the contributions of these diverse groups that would determine the ways in which the colonial administration operated – although not always successfully - in the city.

---

[116] Ibid., 715.
[117] Kamran and Talbot, 35.

Chapter 2 – Public Health, Urban Development, and the Politics of Sanitation

Introduction

One of the greatest concerns that drove, perhaps most emphatically, the colonial urgency for reform in major Indian cities was sanitation. Having encountered similar problems in Britain during the eighteenth century – mass urbanization and increased housing density in urban centres like London had created serious sanitary problems – colonial administrators were convinced that redefining urban spaces would not only make Indian cities more governable but, more importantly, safer for British residents. Scholars like Mark Harrison and David Arnold have argued that colonial cities were rebuilt and transformed to protect the British from the harmful effects of the Indian environment.[1] Indeed, dominant theories in the nineteenth century suggested that disease was linked to two primary sources: tainted water and decaying organic matter.[2] Although these ideas continued to be debated within the larger medical community, most health officials accepted the principles of the miasma theory until the late nineteenth century. This theory posited that hazardous odours and gases rising from the environment were the cause of ill health among people, particularly those residing in urban areas. The emphasis on the relationship between disease and the built environment reinforced a colonial commitment to "fix" India's geography and to replace it with one that would be conducive to the health of the colonizer.[3] Undoubtedly, this mission was grounded in the conviction that British theories about sanitation were superior to indigenous ideas and, as such,

---

[1] Arnold, *Colonizing the Body,* 37; Harrison, *Public Health in British India,* 38.
[2] Tilbury Fox and T. Farquhar, *On Certain Endemic Skin and Other Diseases of India and Hot Generally* (London: J. and A. Churchill, 1876), 12.
[3] Maysoon Sheikh, "They'll be the death of you: Indian prostitutes, colonial anxieties, and the medicalization of space, 1860-1900" (master's thesis, McMaster University, 2010), 26.

indispensable to colonial health. For instance, the transactions of the Sanitary Institute of Great Britain – established in England in 1876 in response to the Public Health Act (1872) - described the movement to reform Indian cities as a "high and noble task", and called on local authorities to "recognize their responsibilities as the guardians of public health."[4] With sweeping changes already taking place at home, officials in India looked to the metropole as the model of civilization and progress they wanted to imitate. But, despite the belief that it was their duty to implement sanitary reform in India, the British realized quickly that this task hinged on several factors, the most important of which was obtaining concrete information about local conditions and customs.

Sanitary Reform in Lahore

In Lahore, the imposition of new sanitary objectives by the municipal government played an increasingly important role in the development of the city's urban landscape. It was evident, in fact, that the campaign to maintain "healthy" conditions in the city had been part of the colonial administration's mandate since the annexation of the Punjab. In 1852, for example, three years after the British takeover, the walls of Old Lahore were reduced "for sanitary reasons" from a height of twenty feet to fourteen feet because, it was argued, the "lofty walls…greatly impeded the free airing of the interior of the city."[5] Even the troops stationed at Anarkali were relocated five miles east of Lahore to a new cantonment, Mian Mir, in response to the city's "unhealthiness". Because the new site was less developed than Lahore, colonial authorities believed they could plan the

---

[4] Sanitary Institute of Great Britain, *Transactions of the Sanitary Institute of Great Britain 1884-1885* (London: Edward Stanford, 1885), 6: 113.
[5] "Lahore," *Encyclopaedia Britannica: Arts, Sciences and General Literature*, 9th ed. (Philadelphia: Maxwell and Sommerville, 1894), 213; David Ross in *The Land of the Five Rivers and Sindh: Sketches Historical and Descriptive* (1883) suggests the walls were reduced from thirty feet to fifteen feet (p. 127).

cantonment according to their own sanitary principles and, in turn, construct a space that would be better suited to British health.[6] Separated from the city's native residents, moreover, the insulated military community at Mian Mir established physical barriers between colonizer and colonized and reinforced British connections between geography, race, and disease. As we will see, these motions stemmed from a growing impression that improved sanitation and segregated landscapes could reduce the virulence of epidemic diseases in Lahore.

The changes that were brought to the built environment of the city were, first and foremost, designed to safeguard the wellbeing of the British and Indian armies. This became relevant in other parts of India as early as the 1780s and 1790s when it was observed that, relative to the ratio of the colony's British inhabitants to its indigenous population, more Europeans died of illness every year than did Indians; this idea was further entrenched after the British began to officially record birth and death rates in the 1830s, extending the collection of statistical evidence used to understand disease.[7] According to the *Annals of Military and Naval Surgery* (1864), for instance, there was a thirty-nine percent mortality rate for Europeans in 1843 compared to eleven percent for Indians.[8] Between 1800 and 1856, the average death rate of European soldiers in India was approximately sixty-nine per thousand; as a comparison, the average mortality rate of military-aged men in England in the mid-nineteenth century was calculated at ten per

[6] Martyn Clark, "Remarks on Malaria and Acclimatisation," *The Scottish Geographical Magazine* 9, no. 6 (1893): 291.

[7] Philip Curtin, *Death by Migration: Europe's Encounter with the Tropical World in the Nineteenth Century* (Cambridge: Cambridge University Press, 1989), 1-2.

[8] *Annals of Military and Naval Surgery and Tropical Medicine and Hygiene: Being an Annual Retrospect Embracing the Experience of the Medical Officers of Her Majesty's Armies and Fleets in in all Parts of the World* (London: John Churchill and Sons, 1864), 254.

thousand.[9] In Lahore, the situation was even more concerning. Between 1846 and 1852, the death rate for European troops was estimated at eighty-four per thousand.[10] These observations led one commentator to remark: "The mortality of the officers who were stationed with the British and native troops…was excessive, and involved great losses of life and property."[11] It must be noted that similar conclusions were being drawn by other colonial governments as well. One army doctor, for example, noted that sixty-four French soldiers per thousand died in Algeria during the 1840s, seven times the mortality rate among military-aged men in France.[12] Such preoccupations with the death of Europeans overseas were partly the result of a larger statistical movement in the West that was drawn to the use of quantitative data to direct public policies in the colonies. Nowhere was this more evident than in writings about sanitation. In India, government accounts and medical journals asserted that the reason for high mortality rates among British soldiers was the filthy and overall insalubrious condition of Indian cities and villages, a state that exacerbated the emergence and transmission of deadly diseases such as cholera and smallpox.

With statistical reports drawing attention to the unusually high death rate of soldiers, colonial authorities in India began prioritizing the move towards improving their living conditions. The focus on sanitation was further underscored by the work of British reformers who pushed for the adoption of "enlightened" values such as hygiene and sanitation within the colony. Most notable among them was Florence Nightingale whose

---

[9] Curtin, 5.

[10] Government of India, *Report of the Commissioners Appointed to Inquire into the Sanitary State of the British Army in India; With Precis of Evidence* (London: Eyre and Spottiswoode, 1863), 7.

[11] Ibid., 27.

[12] Curtin, 5.

investigation into the health of European troops marked a key moment in the development of a public health agenda for India. Using data from military reports, she concluded that environmental factors and lifestyle risks were the main contributors to the increased mortality rate among soldiers in India.[13] As a result, in 1858 she campaigned for the creation of a Royal Commission on Sanitary Reform which would provide an official report on the state of army health in the colony.[14] The details of this two-volume report, published in 1863, outlined the main causes of sickness and death in Indian military stations, recommended "healthy" and "wholesome" sites for new stations, and offered guidance on the best ways to construct barracks, hospitals, and tents.[15] The report was given considerable attention by Nightingale and became one of the key guides for the sanitary reform movement in India.

The Royal Commission's report influenced a shift away from more traditional ideas about health (which attributed sickness to hot climates) by demonstrating that high incidences of disease among soldiers in India were also caused by extreme overcrowding of men in barracks and hospitals.[16] Although this was not a novel concept – overcrowding had been associated with disease since at least the 1830s when England was in the midst of its own sanitary reform movement – it assumed significance in India in the 1860s because of new ideas about the relationship between improved health and

---

[13] Judith C. Hays, "Florence Nightingale and the India Sanitary Reforms," *Public Health Nursing* 6, no. 3 (1989): 153.
[14] Ibid.
[15] Government of Punjab, *The Second and Third Sections of the Report of the Commissioners Appointed to Inquire into the Cholera Epidemic of 1861 in Northern India* (Calcutta: O. T. Cutter Military Orphan Press, 1864), 5.
[16] Ibid.

the modern, progressive state.[17] Many colonial officials, in fact, believed that a healthy

population would contribute to a more stable society and, thus, to a more productive and

successful colonial regime.[18] For this reason, the poor living conditions of European

troops in India became increasingly a cause for concern. In Lahore, for example, the

Report into the Sanitary State of the British Army (1863) revealed that, in 1849, three

hundred sick people were placed in a military hospital that was only intended to

accommodate one hundred and twenty individuals.[19] Therefore, it called for important

changes which included better ventilation in army quarters, more space between soldiers'

beds, the construction of double roofs and broad verandahs (where men would not be

exposed to the sun), and a limit on the number of troops in each barrack.[20] With this new

emphasis on the relationship between sanitation and urban space, local authorities

attempted to isolate British officials and the army by relocating them to newly built

barracks and residences that were far removed from the dangers associated with the dense

areas of the city.[21] However, despite its efforts to counter overcrowding in the city,

Lahore continued to challenge the sanitary goals of the colonial administration. Even in

1873, a decade after the publication of the Royal Commission's sanitary report, one

commentator described the city as "a compact mass of lofty houses, rapidly falling into

decay, and harbouring so much infection that it is in reality an asylum for disease."[22]

---

[17] David Arnold, *The New Cambridge History of India,* vol. 3, *Science, Technology and Medicine in Colonial India* (Cambridge: Cambridge University Press, 2000), 85.
[18] Ibid.
[19] Government of India, *Report of the Commissioners,* 7.
[20] Ibid., 180.
[21] Mark Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine 1859-1914* (Cambridge: Cambridge University Press, 1994), 66.
[22] "Travels in Many Lands: Lahore," *The Guernsey Magazine: A Monthly Illustrated Journal, of Useful Information, Instruction, and Entertainment* 2, no. 5 (1873): 13.

Evidently, changes to Lahore's material environment had been established in theory but, in reality, the city's transformation was still far out of reach.

The individuals who were deemed most vulnerable to the poor environmental conditions of Indian cities like Lahore were newly-arrived British soldiers. According to one commentator, "the soldier on landing in this country [was] placed under entirely new physiological conditions in regard to climate, food, and mode of life."[23] Statistics related to sickness among troops revealed that the first year of service was often marked by increased hospital admissions and higher incidences of disease.[24] Although factors such as a soldier's lifestyle – excessive alcohol consumption was deemed particularly hazardous to health - were known to contribute to these disparate numbers, authorities also suspected the influence of local unsanitary conditions on the overall health of the army.[25] Enteric fever, in particular, was designated as a "filth disease" and was attributed to insalubrious living conditions which included deficient ventilation and "destitution".[26] Even chronic diseases like leprosy and tuberculosis were described as a "great class of degenerations"; in fact, one report suggested that more soldiers died from these disorders than from "acute affections" (like cholera) because factors such as climate, improper personal hygiene, and poor sanitary conditions increased the prevalence of these diseases, particularly among young soldiers.[27] Therefore, officials made every attempt to assign "undeveloped youths" to newly constructed cantonments that took into consideration

---

[23] *Army Medical Report for the Year 1879* (London: Eyre and Spottiswoode, 1881), 243.
[24] Ibid.
[25] Government of India, *Report on Sanitary Measures in India in 1875-76: Together with Miscellaneous Information up to June 1877* (London: Eyre and Spottiswoode, 1877), 76.
[26] C.A. Gordon, "Remarks on Certain Assigned Causes of Fever," in *The Medical Times and Gazette: A Journal of Medical Science, Literature, Criticism, and News* (London: J. & A. Churchill, 1881), 2: 382.
[27] "Tropical Service," *The Lancet,* January 27, 1872, 119.

factors such as location – the "probable salubrity of the spot" – and proximity to proper sources of drainage.[28]

The creation of a sanitary police force under the Military Cantonments Act of 1864 further reinforced the colonial urgency to monitor and improve military hygiene.[29] Created in response to the recommendations of the Royal Commission, it was the responsibility of these sanitary inspectors to "remove, abate, or prevent all nuisances" as a means of keeping military stations in good sanitary order.[30] In this vein, it was advised that an "Inspector of Nuisances" be appointed to see to the execution of sanitary tasks.[31] While these strategies demonstrated an official preoccupation with implementing projects such as sewage removal, subsoil drainage, and improved construction of barracks and hospitals, colonial authorities argued that disease would continue to prevail unless sanitary improvements were also brought to indigenous towns and bazaars in the vicinity of military stations.[32] As a result, the health of the British Army began to dictate the development of Indian cities close to where soldiers were stationed.

Concerns about the role of environmental conditions in propagating disease meant that the British could not envision sanitation as an exclusively colonial project. Scholars like Robert Peckham and David Pomfret have shown that a shift in colonial priorities by the mid to late nineteenth century reflected a move away from an "enclavist" approach –

---

[28] Government of India, *Report on Sanitary Measures in India in 1875-76*, 77.
[29] The office of the provincial sanitary commissioner had been created within each province in India by the 1870s; commissioners were responsible for advising their respective governments on sanitary improvement. Government of India, *Report on Measures Adopted for Sanitary Improvements in India, from June 1869 to June 1870: Together with Abstracts of Sanitary Reports for 1868 Forwarded from Bengal, Madras, and Bombay* (London: Eyre and Spottiswoode, 1870), 43.
[30] *Suggestions in Regard to Sanitary Works Required for Improving Indian Stations* (London: Eyre and Spottiswoode, 1864), 31.
[31] Ibid.
[32] Government of India, *Report on Measures Adopted for Sanitary Improvements in India*, 43.

focused on protecting British residents and the military - to a more extensive public

health program geared towards incorporating the native population within the project for

sanitary reform.[33] Medical officials began to realize that what was really at stake was a

shared environment because the health of the army was inextricably connected to the

health of the Indian people. Moreover, this shared environment would remain hazardous

to all British inhabitants unless a collective effort to promote sanitation that included the

native population was initiated. The belief that diseases were caused by "infection

floating in the air" evoked anxiety among advocates of sanitary reform who urged the

colonial government to expand its regulatory measures beyond army cantonments.[34] One

commentator, for instance, called on the municipality to direct its attention to the state of

Old Lahore: "the filth that is accumulated near the Moree Gate is very offensive and is

per se sufficient to create an epidemic."[35] For this reason, the overcrowded and

unsanitary state of Indian cities, along with the health of native subjects, became the

focus of changing government policies on public health in the mid nineteenth century.

    The first sanitary commissioner in the Punjab was appointed in 1868.[36] Reporting

to the provincial government, Dr. A. C. DeRenzy was charged with recommending ways

to improve the sanitary state of the entire province, and not just the condition of the

---

[33] Robert Peckham and David M. Pomfret, "Introduction: Medicine, Hygiene, and the Re-ordering of Empire," in *Imperial Contagions: Medicine, Hygiene, and Cultures of Planning in Asia,* ed. Robert Peckham and David M. Pomfret (Hong Kong: Hong Kong University Press, 2013), 6. The authors note that the shift away from enclavism should not be viewed in teleological terms; the transition towards public health, after all, was not an unambiguous or direct process. Rather, Peckham and Pomfret argue that the institutionalization of health did not result in the end of enclavist attitudes and that such sentiments continued to exist well into the twentieth century.

[34] Reginald Craufuird Sterndale, *Municipal Work in India; or, Hints on Sanitation - General Conservancy and Improvement in Municipalities, Towns, and Villages* (Calcutta: Thacker, Spink, and Co., 1881), 28.

[35] "The Sanitation of Lahore," *The Tribune,* June 9, 1883, 8.

[36] Saurabh Mishra, *Pilgrimage, Politics, and Pestilence: The Haj from the Indian Subcontinent: The Haj from the Indian Subcontinent, 1860-1920* (Oxford: Oxford University Press, 2011), 71.

British army. As such, DeRenzy's responsibilities included investigating outbreaks of disease in the Punjab, proposing measures to eradicate epidemics, and establishing a system to organize and collect statistics.[37] Among his suggestions was a call to educate the public in matters related to personal hygiene as part of a larger program to improve the general health of India.[38] However, some of DeRenzy's other ideas were less well-received by local officials, such as his proposal to appoint *hakims* – native practitioners of traditional Islamic medicine – to various districts in the province. *Hakims* were to be trained in Lahore on subjects such as epidemic diseases and would report on sanitary conditions throughout the Punjab by diagnosing the source of disease and identifying means to eradicate them.[39] Although the plan was met with indifference from the local government – largely because of racial prejudices against Indians which convinced the British that *hakims* would use their positions as sanitary inspectors for extortion - public administrators allowed the use of a native staff in some rural health programs.[40] This was because they were cheaper to employ than British health officials and they eased the process of implementing sanitary reform in smaller towns where skepticism of Western medicine remained entrenched.[41] Along with newly developing ideas about the origins of disease, DeRenzy's suggestions for reform helped reshape colonial health priorities in the Punjab and, as we will see, prompted important discussions concerning the direction of the province's preventive medical program.

---

[37] Ibid.

[38] John Chandler Hume Jr., "Colonialism and Sanitary Medicine: The Development of Preventive Health Policy in the Punjab, 1860 to 1900," *Modern Asian Studies* 20, no. 4 (1986): 709.

[39] Sheldon J. Watts, *Epidemics and History: Disease, Power and Imperialism* (New Haven and London: Yale University Press, 1999), 208.

[40] Hume, 710.

[41] Ibid., 718.

In Lahore, the transition towards the application of more universal health measures was perhaps most apparent in the British preoccupation with the city's water supply and drainage system during the 1870s and 1880s. Although these infrastructures were eventually considered fundamental for maintaining overall public health in India, the widespread acceptance of this concept only emerged after a grueling intellectual battle between colonial health officials. Ideas about the sanitary importance of urban water systems had already developed decades earlier in England when some medical authorities began to suspect a link between diseases like cholera and impure water.[42] More specifically, the theory was grounded on research conducted in London by men like John Snow and John Simon during the 1840s and 1850s which demonstrated that the city's water supply was responsible for higher rates of cholera in areas where unfiltered water from the Thames was used. Influenced by these studies, DeRenzy became one of the earliest proponents of the "water theory" in India, and in his sanitary report of 1868 he pressured the government to make changes to the water reserves of towns and cantonments throughout the Punjab.[43] Until then, most cities in the province relied on wells for their supply of water, with 1300 set up in Lahore alone.[44] The Ravi River, which flowed north to south along the city, was the primary source of water collected in these wells. Although several were built within private homes, officials like DeRenzy worried that contaminated subsoil, "saturated with the filth of years", made well water

---

[42] Government of Punjab, *Report on the Sanitary Administration of the Punjab, 1869* (Lahore: Lawrence Press, 1870), 27.

[43] Hume, 712-713.

[44] J. B. Scriven, "The Sanitary Condition of Lahore," *The Lancet,* December 10, 1881,1027.

unwholesome and "unfit for human consumption".[45] *The Medical Times and Gazette,* for example, reported in 1870:

> At Mian Mir last September there was a great deal of intermittent fever…In this instance Dr. DeRenzy attributes the disease to the drinking of stagnant water from the wells, "which are, in fact, deep ditches floored with a thick deposit of putrid vegetable and animal matter."[46]

Another report suggested that a large amount of sodium sulphate in Lahore's well water was responsible for "troublesome" ulcers known as "Lahore sores" as well as for "calculine diseases" like kidney stones.[47]

DeRenzy's study - which included an investigation of several cities in the Punjab during the 1860s - determined that there was scarcely any place in the province where the water supply could be used safely for domestic purposes. In Peshawar, water was conveyed through open passages that were exposed to "all kinds of nuisance from the native population" and ultimately turned into "mere foul ditches".[48] For DeRenzy, this was the principal cause of unhealthiness in the city, resulting in 200 European deaths and 1200 native deaths from cholera in 1868.[49] Similarly, he argued that wells constructed near cesspits in Mian Mir increased cholera-related deaths among soldiers in that station from a rate of seventeen percent in 1856 to twenty-five percent in 1861.[50] Here, DeRenzy found two wells situated only a few metres away from a ditch that contained "the accumulated filth of eleven years".[51] In Amritsar, DeRenzy's investigations led him to

---

[45] A. C. DeRenzy in *Report on the Sanitary Administration of the Punjab, 1869*, 27.
[46] "Report on the Sanitary Administration of the Punjab for the Year 1868," *The Medical Times and Gazette* 1 (1870): 451.
[47] Scriven, 1027.
[48] *Abstract of Proceedings of the Sanitary Commissioner with the Government of India* (Calcutta: Office of Superintendent of Government Printing, 1870), 411-412.
[49] Ibid.
[50] Ibid., 412.
[51] Ibid.

conclude that the city derived its water from shallow wells saturated with town sewage.[52]

As such, he stated: "…it is no wonder that the inhabitants have been cruelly scourged

with epidemics of cholera, fever, diarrhoea, and dysentery."[53] Indeed, DeRenzy's report

on the sanitary state of Punjab's water supply system reinforced his belief in the

unmistakable connection between "poisoned" water and the health of the province's

residents. The solution, he argued, was to provide each city with a reliable water supply

and sewage system while also regularly draining houses.

DeRenzy's recommendations, however, met with strong resistance from other

medical officials, many of who continued to argue that disease was caused by miasmas

emanating from rotting filth in overcrowded cities. Although DeRenzy did not disagree

with this view, he maintained that impure water was the more dangerous culprit.[54] In fact,

his report expressed harsh criticism of the theories proposed by Dr. J. L. Bryden, the

statistical officer to the Sanitary Department of India, who had been commissioned by the

government in 1869 to investigate the cause of cholera in the country. Bryden supported

the view that the disease was airborne and that meteorological conditions, along with

India's geography, were key factors determining the intensity and potency of cholera.[55]

DeRenzy, however, persistently denounced Bryden's hypothesis, arguing that it had been

"calculated seriously to retard sanitary progress".[56] This debate, in turn, became a critical

obstacle to British intervention in public health. DeRenzy's attack on Bryden and his call

for more investment in fresh water infrastructures in the Punjab placed him in direct

---

[52] Ibid.
[53] Ibid.
[54] Hume, 713.
[55] Harrison, *Public Health in British India,* 102.
[56] DeRenzy in *Report on the Sanitary Administration of the Punjab, 1869,* 93.

opposition to the official cholera agenda of the colonial government which was influenced by the atmospheric model advanced by J. M. Cuningham, the Sanitary Commissioner of India. Geared towards the improvement of general hygiene so as to prevent the rise of pathogenic miasmas, Cuningham's approach was grounded in the belief that the presence of specific local conditions generated disease.[57] As such, he disagreed firmly with DeRenzy's views and even filed several complaints against the commissioner for his continued opposition to the government's official cholera agenda.[58] The conflict between Cuningham and DeRezny was only laid to rest in 1875 when DeRenzy was transferred to a remote military station in Assam (presumably for failing to refrain from criticizing his superiors).[59] Consequently, Cuningham's official doctrine remained entrenched within the colonial medical community until the late 1870s and continued to undermine efforts to revitalize the water supply system of major cities in the Punjab.

But, DeRenzy's campaign against Bryden and Cuningham was not in vain. In fact, the waterborne theory for disease eventually did gain more converts among health officials. This development was informed in part by British medicine's move away from its enclavist origins.[60] The imposition of a more extensive public health scheme meant that new geographic spaces fell under colonial jurisdiction which, in turn, helped legitimize the government's plan for securing better control over urban centres. Protecting the sanitary state of water in major cities was essential to the regulatory aims

[57] J. M. Cuningham, *Fourteenth Annual Report of the Sanitary Commissioner with the Government of India with Appendices and Returns of Sickness and Mortality Among British Troops, Native Troops and Prisoners, in India, for the Year 1877* (Calcutta: Office of the Superintendent of Government Printing, 1878), 21.
[58] Harrison, *Public Health in British India,* 103.
[59] Ibid.
[60] Here, I refer to British medicine in India and not British medicine more generally.

of the colonial administration, particularly since the disease it was suspected of spreading, cholera, was epidemic.[61] As we will see in more detail in the following chapters, epidemic diseases exposed latent colonial anxieties about disorder because their sporadic nature and ability to defy social and geographic boundaries evoked a sense of turmoil that challenged the functioning of the British administration.[62] As a result, colonial health services drew away from providing only curative measures for disease and shifted towards implementing a preventive system intended to avoid them completely.[63] One commentator writing in *The Tribune,* for example, agreed:

> As the sickly season is drawing nigh and the people owing to fitful changes of weather are apprehensive of coming epidemic, it is proper that the attention of the municipality should be directed to the sanitation of Lahore…As prevention is better than cure, it behooves us now to be on our guard…[64]

Public officials were unwilling to risk the lives of the army or European residents by making them vulnerable to the source of epidemic disease and so the subject of contaminated water, and its seemingly disruptive impact, entered discourses on disease and health.

Growing apprehensions about the state of water in India were evident in several late nineteenth-century accounts. One sanitary report from 1877 stated that pure water was the "most important preservative of health, not only against cholera, but against all diseases."[65] In Lahore, specifically, several reports complained about the dangerously

---

[61] Amna Khalid and Ryan Johnson, introduction to *Public Health in the British Empire: Intermediaries, Subordinates, and the Practice of Public Health, 1850-1960,* ed. Amna Khalid and Ryan Johnson (New York: Routledge, 2011), 7.

[62] Robert Peckham, "Introduction: Panic: Reading the Signs," in *Empires of Panic: Epidemics and Colonial Anxieties*, ed. Robert Peckham (Hong Kong: Hong Kong University Press, 2015), 3.

[63] Fatima da Silva Gracias, *Health and Hygiene in Colonial Goa 1510-1961* (New Delhi: Concept Publishing Company, 1994), 207.

[64] "The Sanitation of Lahore," 7.

[65] Cuningham, 81.

unsanitary state of the city's drains and sewers and expressed concerns that they threatened the health of local residents by tainting the water supply with pestilence.[66] For example, private latrines on the roofs of houses were known to carry waste down the sides of the buildings and into open drains below, a system that was accepted as hazardous to health.[67] Similar inconsistencies in the lack of sewage disposal in Victorian London served as a reminder that such practices heavily impacted a city's water supply. Lahore, however, was considered unique because its natural physical geography was believed to contribute to the unsanitary state of its water; the civil station of Anarkali, in particular, was situated six feet above river level and fifteen feet lower than the rest of the city, making it difficult to drain.[68] Unlike the surrounding mountainous regions of the Punjab, moreover, much of Lahore's topography was flat and this allowed stale water and sewage to remain behind in tight passages.

Because water was an essential commodity, it was imperative for colonial officials to establish a system that would ensure the purity of the entire city's supply. Therefore, in the late 1870s, the local government decided to rebuild Lahore's water system and implement new drains that would discharge the city's waste into the Ravi River.[69] Completed in June 1881, the system brought significant changes to the city's urban environment.[70] Streets were widened to accommodate open side gutters that were coated with cement to prevent the absorption of sewage; clean water was pumped from six wells below a strip of land and distributed along twenty-two miles of pipes to supply

---

[66] *Gazetteer of the Ferozpur District,* 1883, 159.
[67] Ibid.
[68] F. R. Hogg, *Indian Notes* (London: J. and A. Churchill, 1880), 76.
[69] Ibid.
[70] *Gazetteer of the Ferozpur District,* 1883, 154.

the city's residents.[71] A newly-built service reservoir which could contain a supply of one

million gallons of water led the *Gazetteer of the Ferozpur District* to report that pure

water was available to "all" through the city's water-works system.[72] Another

commentator described it as a "great blessing" that had saved people from "poisoning

their blood with the filthy waters of old wells."[73]

The project did face resistance from some high-caste Hindus who refused to drink

water from a communal source. For them, it was unacceptable to use water that had been

contaminated by a member of an inferior caste and, as such, the introduction of pipe

water (which was accessible to large numbers of people) came with certain

reservations.[74] Such antipathy, moreover, existed in other parts of India as well. In Jaipur,

for example, one high-caste Hindu felt compelled to "remove the prejudices of his fellow

religionists…against schemes of water supply" in the city.[75] Similarly, in Madras, official

reports noted that "men of a higher caste [would] not draw water at the same spot as a

low caste one…"[76] Eventually, however, even these classes of Indians came to accept the

new water supply systems in their cities. In Lahore, for example, *The Tribune* explained

that although "some prejudiced persons at first objected to the use of pipe-water," their

concerns abated after they experienced the benefits of the system.[77] Indeed, local attitudes

towards urban reform seemed to be changing. For instance, one commentator writing to

the editor of the *Indian Public Opinion and Panjab Times* observed:

---

[71] Ibid.

[72] Ibid., 159.

[73] "Editorial Notes," *The Tribune,* June 23, 1883, 7.

[74] Hogg, 44-45.

[75] C. E. Shelly, ed. *Transactions of the Seventh International Congress of Hygiene and Demography* (London: Eyre and Spottiswoode, 1892), 11: 106.

[76] *Abstract of Proceedings of the Sanitary Commissioner,* 82.

[77] *The Lahore Tribune,* April 3, 1886.

> People ignorant of the real motive of Government have generally some misapprehension in the beginning, as was the case when the city ditches were removed…but when the thing is done and they feel the advantages then they begin to appreciate and admire the measure they had in vain tried to oppose.[78]

It appeared, then, that the general consensus was in favour of such urban renewal projects in Lahore. At least, that was the opinion publicly expressed in official colonial reports. After all, the link between environment and disease had convinced officials that refashioning the landscape of Lahore to create carefully controlled spaces of sanitation was imperative if the city was to thrive.

The Development of Ordered Landscapes

Another key outcome of the imposition of British sanitary practices onto native space was that cleanliness came to operate as a defining characteristic of the colonial regime:

> But the great cause which aggravates the severity and fatality of all Indian diseases is simply filth. If every town and village in India were cleansed and kept clean in its open spaces, streets, lanes, and houses…we would hear little of these diseases.[79]

The emphasis on sanitation and cleanliness, moreover, called not only for removing impurities from public settings but also for establishing urban renewal projects that were dedicated to organizing the physical landscape. There was a connection between disease and physical decay that inspired a move towards creating an aesthetically pleasing environment that would be incapable of producing disease. In Lahore, this was evident in the redevelopment of the civil station which, at least on the surface, reflected an urban landscape that was regulated and organized. Colonial officials recognized the importance

---

[78] *Indian Public Opinion and Panjab Times,* April 5, 1870.
[79] House of Commons, *Accounts and Papers: Sanitary Measures* (London: House of Commons, 1883), 15: 207.

of sanitary intervention in a city where the British population was often in close proximity to locals, prompting a spatial organization of Lahore's geography that was grounded in notions of visibility and openness. In the colonial mind, developing order through reduced densities, planned residential areas, and spaces of leisure were strategies intended to foster greater organization and stability:

> The Station of Lahore is to be congratulated…Thousands of young trees have been put out and properly fenced…a lake and a grove have been made in the heart of the Station, the Canal has been conducted into fresh localities, the sides of the roads have been cleared of the wretched jungle which disfigured them, [and] tumbled-down bridges have been suddenly resuscitated…[80]

These were some of the projects that were undertaken by the city's new Assistant Commissioner, Lieutenant Hutchinson, who had been assigned the task of improving and embellishing Lahore. While a focus on structure and order is clearly evident in this news report, the impulse for these changes was rooted in ideas about sanitation. After all, as another commentator remarked, surface changes would "materially add to [the city's] salubrity."[81]

It should be noted that the British preoccupation with organizing and enhancing urban settings was not unique to Lahore. In fact, this mindset was a common feature of colonial planning in other nineteenth-century Indian cities as well. For example, Partho Datta's study of Calcutta in *Planning the City: Urbanization and Reform in Calcutta, c. 1800 – c. 1940* (2012) reveals that ideas about sanitation, health, and urban development dominated discourses about colonial governance, leading to important planning initiatives

---

[80] "Lahore Improvements," *Indian Public Opinion and Panjab Times,* July 16, 1870.
[81] "Lahore Intelligence," *The Lahore Chronicle,* September 23, 1854.

that altered the physical environment of the city.[82] Here, as early as 1852, special

commissioners were appointed to oversee the "cleansing, improving, and embellishing

[of] the town."[83] Similarly, Awadhendra Saran's *In the City, Out of Place: Nuisance,*

Pollution, and Dwelling in Delhi, c. 1850 - 2000 (2014) traces the history of

environmental reform in Delhi to better understand colonial (and postcolonial) practices

and governance.[84] The author demonstrates that several buildings of architectural and

historical significance were repaired as part of the larger spatial planning of the city.[85]

Roads were also widened and paved while large areas of land were planted with trees.[86]

As one contemporary account noted, most of these "useful works of miscellaneous

character" were carried out for sanitary purposes and to promote the "wholesome

growth" of these urban centres.[87]

In Lahore, one of the most visible expressions of the colonial effort to revitalize

the city was Lawrence Gardens. Established in 1862, the garden was designed to serve as

a public space of leisure and recreation, covering approximately 112 acres of previously

"desolate wilderness".[88] Lawrence Gardens featured several attractions including a zoo

and botanical garden, both of which reflected carefully controlled displays of exotic

animal and plant species.[89] The formal design of the public grounds, often referred to as

---

[82] Partho Datta, *Planning the City Urbanization and Reform in Calcutta, c. 1800 - c. 1940* (New Delhi: Tulika Books, 2012), 2-4.
[83] Edward Thornton, *A Gazetteer of the Territories Under the Government of the East-India Company, and of the Native States on the Continent of India* (London: W. H. Allen & Co., 1858), 176.
[84] Awadhendra Saran, *In the City, Out of Place: Nuisance, Pollution, and Dwelling in Delhi, c. 1850 – 2000* (Oxford: Oxford University Press, 2014), 6.
[85] Ibid.
[86] Government of Punjab, *Annual Progress Report of Public Works in Punjab, for the Year 1874-75* (Lahore: Public Works Department Press, 1875), 29.
[87] Government of Punjab, *Annual Progress Report of Public Works in Punjab, for the Year 1872-73* (Lahore: Public Works Department Press, 1873), 5, 7.
[88] Latif, 314.
[89] Glover, 66.

the "Kensington Gardens of Lahore", exhibited elements of order and structure that were apparent in the meticulously tended walkways and lawns.[90] The garden was further regulated by rules that called for a ban on offensive behaviour such as spitting as well as on objectionable activities like dog walking and billposting.[91] Together, the physical and regulatory characteristics of the park cultivated ideas about exemplary urban development by reinforcing the relationship between orderly spaces and public health. The colonial's state's desire to ensure proper sanitation in Lahore depended considerably on the development of purportedly "pure" and "hygienic" spaces that would allow residents much-needed reprieve from the otherwise densely populated city. For example, according to one commentator, "open spaces in towns…contribute[d] to the health and length of life of the citizens."[92] Public parks, in particular, were believed to "provid[e] places for healthy exercise and health-giving recreation" and were considered "an oasis in a wilderness of bricks, and a reservoir of fresh pure air for the crowded habitations round."[93] Lawrence Gardens, moreover, was not exclusively reserved for the British residents of Lahore – domestic servants and Indian students were often found visiting the park – and this reinforced the colonial impulse to construct model environments that would benefit public health.[94] In this regard, it was similar to other public gardens in colonial India, such as Victoria Gardens in Bombay, which were also open to Indian visitors.[95] Ultimately, the planning and landscaping of these gardens was meant to

---

[90] Latif, 314.
[91] Glover, 68.
[92] M. J. Vernon, "On Public Parks and Gardens," in *The Sanitary Record: A Journal of Public Health* ed. Ernest Hart (London: Smith, Elder & Co., 1879), 9: 321.
[93] Ibid.
[94] Glover, 68.
[95] Christopher Hill, "Colonial Gardens and the Validation of Empire in Imperial India," *Journal of South Asian Studies* 1 no. 2 (2013): 141.

highlight the importance of civilized nature for British and Indians alike, especially in terms of their physical and emotional well-being.

The preoccupation with clean and healthy landscapes was also evident in the colonial practice of retreating to hill stations, a custom that dated back to the early nineteenth century. Hill stations came to serve as idyllic spaces where the British could retire and withdraw from daily life in hot and crowded cities. They were closed communities that catered to the needs of the colonial elite and served as a "seasonal site for the recreational activities of a highly transitory expatriate population".[96] Cooler weather in the hills was thought to better suit the British constitution and so these exclusive social spaces became a sanctuary for Europeans who wanted to recover from India's tropical heat.[97] Many official reports perpetuated the idea that the hills were places for curing disease while the "plains" were responsible for ill health among the British. In describing the benefits of hill stations, one commentator reported: "…European officials cannot work in the plains, without endangering their constitution, and more work is done by them on the Hills than in the plains."[98] Although the curative effects of hill stations came into question by the 1860s - once it was apparent that there was no relief from diseases such as malaria and cholera even in these supposedly idyllic spaces – they were nevertheless recognized for their restorative benefits throughout

---

[96] Dane Kennedy, *The Magic Mountains: Hill Stations and the British Raj* (Los Angeles: University of California Press, 1996), 3.
[97] This was particularly true for women and children who were thought to possess a more fragile constitution.
[98] *The Tribune,* July 24, 1886, 7.

70

colonial rule. A *Tribune* article as late as 1886, for example, touted the "cool mountain breezes, and the healthy atmosphere of the sanitaria…"[99]

Perhaps the most important implication of the colonial concern with public health and the orderly arrangement of space was a deep-seated connection between sanitation and Indian social customs. For the British, advances in the material conditions of Lahore depended considerably on the manners and habits of a local population that was often described as being consumed by its caste and religious biases. The civil surgeon of Lahore, J. B. Scriven, noted: "sanitary reform can only be effected by rebuilding the city and by changing the habits and removing the prejudices of the people…"[100] Officials worried that old-established Indian customs bred widespread antipathy towards British innovations which, in turn, encouraged habits of uncleanliness among locals. For example, practices such as smearing cow dung on the walls and floors of native houses – seemingly to keep them cool - and using cow urine to ward off evil spirits were regarded with disdain by British officials seeking sanitary reform.[101] While the cow was revered by Hindus as a sacred animal, British authorities found the use of its excreta in Indian custom objectionable, largely because it was believed to spread vermin and disease.[102] Such practices led Scriven to conclude that "the native [was] so wedded to his prejudices of caste, habit, and religion that only the most gradual improvement [could] be expected from him."[103]

---

[99] Ibid.
[100] Scriven, "The Sanitary Condition of Lahore," 1027.
[101] Edward Balfour, ed. *Cyclopedia of India and of Eastern and Southern Asia, Commercial, Industrial and Scientific: Products of the Mineral, Vegetable and Animal Kingdoms, Useful Arts and Manufactures* (Madras: Scottish, Lawrence and Foster Presses, 1873), 3: 382.
[102] Ibid.
[103] Scriven, 1027.

Consequently, medical professionals and civil officers attempted to extend public health practices not just to material space but also to the daily habits of Indian people.[104] It was believed that a comprehensive program of education regarding matters such as waste disposal techniques, proper nutrition, and shelter would encourage people to take more interest in their own health.[105] However, the general British opinion on the issue, as expressed in several contemporary reports, was that progress in sanitary improvement among locals required careful regard for their customs.[106] In other words, while it was imperative that Indians understood the lessons of sanitary science, the project for public health reform was to reflect a direct interest in the welfare of the local people as well as an awareness of their social and religious traditions. Thus, education was upheld as the primary means of encouraging Indians to accept the doctrines of cleanliness and purity. By the 1870s, vernacular publications on urban sanitation and public health had appeared with the goal of promoting knowledge of "proper" sanitary practices.[107] One pamphlet, which was distributed throughout the Punjab, described the history and the elementary principles of sanitary science and was praised for generating so much interest "that it was necessary to print 22,000 copies of it for circulation among the village population."[108] In 1877, the Sanitary Commissioner of the Punjab, Dr. H. W. Bellew, remarked that public opinion regarding sanitary reform was shifting among a "goodly number of people" and this demonstrated that Indians, too, felt a need to see the filth around them removed.[109] This was particularly true among an emerging class of western-educated Indians in the

---

[104] Glover, 48-49.
[105] Hume, 723.
[106] *Journal of the Society of Arts,* May 11, 1888, 690.
[107] Glover, 132.
[108] Government of India, *Report on Sanitary Measures in India in 1875-76,* 34.
[109] Cuningham, 117.

city. Lalla Mulraj of the Lahore Arya Samaj, for instance, wrote and distributed his own pamphlet on the science of sanitation in 1880 which, he hoped, would be "read and pondered over by every intelligent Native".[110] A similar pamphlet was published in 1882 by Lala Kashi Ram, a clerk with the office of the Sanitary Commissioner of Punjab. It was described as being "very favorably reviewed by both the English and Native press."[111] Evidently, there were a growing number of Indians within the city who pushed forward the larger sanitary reform agenda.

From the lessons prescribed in these pamphlets on sanitation, the one most reiterated was that cleanliness began at home. Indians were encouraged to view themselves as members of a community and, therefore, as responsible for ensuring that their habits and surroundings did not spread disease to themselves or their neighbours.[112] An emphasis on urban design was also evident in some colonial documents; one solution to overcrowding, for example, called for tearing down poorly ventilated, "offending houses" that contributed to existing miasma in the air and replacing them with model huts.[113] These new huts would be built on the outskirts of towns instead of in old, overcrowded localities, a plan that was based primarily on the assumption that good health was more attainable in rural areas where the air was fresh and unsaturated with urban filth.[114] By renting out the houses in these model villages to the urban poor, the proposal reflected a colonial belief that transferring people to new spaces would weaken

---

[110] Henry Steel Olcott, *A Collection of Lectures on Theosophy and Archaic Religions, Delivered in India and Ceylon* (Madras: A. Theyaga Rajier, 1883), 23.
[111] Government of Punjab, *Report on the Sanitary Administration of the Punjab for the Year 1883* (Lahore: Central Jail Press, 1884), 76.
[112] "Means of Improving Sanitation in India," *The Indian Magazine*, October 1889, 497.
[113] Ibid., 499.
[114] Ibid.

the bonds of custom and make locals more amenable to the values of sanitary reform.[115]

Spatial dislocation, in other words, would shape the habits of Indians by providing new opportunities for rebuilding their relationship with the material environment.[116] In reality, however, these projects were too expensive for the local government to fund and the closest the province came to adopting model villages was in the 1850s when reformatory settlements were built in rural areas to regulate criminals (and later in the 1870s with the passing of the Criminal Tribes Act in 1871).[117] Nevertheless, these pamphlets demonstrated the importance of educating Indians about sanitation. More importantly, they revealed that the government's reform-driven agenda was motivated by a commitment to raising virtuous individuals who would contribute to the establishment of a healthy and stable society.[118] After all, the means of improving sanitation in India required local acceptance of sanitary science.

Conclusion

Not long after the British annexation of the Punjab, colonial strategies for sanitary reform became a top priority in urban centres such as Lahore. In fact, sweeping changes to the built environment of the city were deemed the most effective means of preserving and maintaining the health of Lahore's residents. While these reforms were, at first, implemented primarily to protect a particularly vulnerable section of the British population – soldiers were deemed most susceptible to the harmful effects of the Indian climate and environment – sanitary policies were eventually extended to include native

---

[115] Glover, 42.
[116] Ibid., 42, 46.
[117] Imran Ali, *The Punjab Under Imperialism, 1885-1947* (Princeton: Princeton University Press, 1988), 102.
[118] *Journal of the Society of Arts,* February 3, 1888, 263.

74

residents of the city as well. This shift from enclavist strategies towards a more comprehensive public health program brought important changes to the urban landscape of Lahore. As this chapter has demonstrated, colonial sanitary ideals were steeped in larger ideas about the significance of geographic space, resulting in new plans for the city's urban development. From changes to Lahore's water supply and sewage system to the newly constructed civil station, the city was undeniably transformed over the course of a few decades. But, the British realized quickly that physical transformations were not enough to guarantee the health of the city's residents and, as such, public health reforms were extended to the daily activities of the Indian people. Although these policies made sense in theory, they were liable to certain limitations that the British did not anticipate. Besides interfering with the social and religious customs of the local population, colonial attempts to regulate the everyday lives of Lahore's Indian residents also faced financial and administrative challenges. Nevertheless, the preservation of public health remained a key priority for the British in Lahore and, as the next chapter will reveal, it would become a unique platform upon which new relationships between the colonizers and colonized were established.

Chapter 3 - The "Inscrutable" Inner City

<u>Introduction</u>

Although the expansion of the sanitary reform movement in India had brought considerable changes to Lahore's urban landscape, there were some areas where colonial efforts to revitalize old infrastructures in the name of public health proved to be too difficult. In particular, the old inner city and the suburb of Anarkali appear in official records as spaces that evaded regulation and reform despite British attempts to manage them.[1] Writing in 1850, for instance, Brigadier Tennant of the Indian Army remarked: "I am constantly receiving complaints of accumulations of filth and faulty drainage in various parts of…(Anarkullee) which I have no means of rectifying."[2] Similarly, a commentator in *The Lahore Chronicle* (1857) stated*:*

> I believe no disinterested party will deny that Anarkullee is a most unwholesome locality, and though a few who have property there may be content to sniff its dank unwholesome atmosphere, a large majority of the residents will hail with gladness the order to move from such a pestiferous hole.[3]

As for Old Lahore, an 1883 edition of *The Tribune* commented on the "dirt and nauseating smells of the streets of the [Old] City and its choking population".[4] Contemporary reports like these suggest that the old parts of Lahore did not physically conform to the spatial ideals of order that were sought by the colonial administration.

The main concern with the inner city, in particular, was the challenge it presented to what William Glover calls the "colonial spatial imagination", preconceived ideas about

---

[1] Old Lahore and the "inner city" refer to the walled city constructed during the time of the Mughals. Anarkali refers to the suburb south of Old Lahore where the British eventually constructed their civil station; before colonial intervention in the area, Anarkali was considered a dilapidated and neglected space.
[2] Remarks on Lahore sanitation by Brigadier J. Tennant, 1850, IOR/E/4/812, India Office Records, The British Library, London, United Kingdom.
[3] Keranee, "Anarkullee, Its Unhealthiness," *The Lahore Chronicle,* March 18, 1857, 171.
[4] "The Anarkulle Sudder Bazaar," *The Tribune*, April 21, 1883, 3.

the relationship between spatial organization and social and moral reform.[5] According to

him, effective administration of the colony depended on how material phenomena was

understood by the British and then applied to distribute objects into specific spaces.[6] This

process, moreover, was determined by "assessments, judgments, and observations [that

were] rooted in Anglo-European contexts and histories" as well as by the specifically

"colonial" terrain upon which it was transposed.[7] This way, the colonial spatial

imagination - defined by classification, regularity, and uniformity - shaped the way India

was made coherent to her colonizer.[8] For the British, however, the squalid state of

Lahore's inner city defied the patterns, sequences, and hierarchies that steered the

colonial spatial imagination. The persistent materialization of derelict conditions was

thought to add an elusive quality to Lahore's inner core. Its crowded and narrow streets

were believed to create a spatial model that added a new and complicated depth to the

visual and ideological perception of these sectors.[9] Although British attitudes towards

other urban cities (including those in the metropole) reflected similar concerns about their

material and social conditions, Lahore's inner city was deemed unique because it

challenged the spatial paradigms that colonial officials believed were necessary for

generating change. Even other cities in India did not embody the same unyielding

characteristics that had come to define Old Lahore.[10] As Stephen Legg demonstrates, for

example, Delhi reflected an adaptability that allowed for far more intimate interactions

between the old and new parts of the city than did Lahore; this, in turn, meant that

---

[5] Glover, 29.
[6] Ibid.
[7] Ibid., 29-30.
[8] Ibid., 30.
[9] Kamran and Talbot, 43.
[10] Legg, 1.

Delhi's inner core was more open to adopting the rational aesthetics of the colonial

imagination (likely facilitating the transfer of the British capital in India from Calcutta to

Delhi in 1911).[11] Similarly, the old city of Agra witnessed colonial intrusions in the form

of railway lines and newly built roads that marked its otherwise traditional cityscape.[12]

But unlike either Delhi or Agra, planning and development initiatives for Lahore that

were formulated by the British only resulted in minor transformations because the city

was imagined to be "too durable in its inferior condition to be easily reconfigured."[13]

Moreover, as we will see, covert pressure from local residents only added to the

image of Lahore as an incomprehensible and morally degraded city. Even sanitary logic

failed to apply here with nineteenth-century British reports often remarking on the poor

living conditions of the "unknowable" areas of the city. For example, a traveler to Old

Lahore argued that it was "uninhabitable for Europeans" and that "a few hours is as long

as its inconveniences could be endured by English nostrils or lungs".[14] Similarly, one

report describing Anarkali in the early years of British rule in the city stated: "The place

is in such a state of filth, from the gradual accumulation of years, that there can be no

wonder at disease breaking out and continuing steadily as it does."[15] Another

commentator, who sarcastically used the term "Anarkulee malaria", offered a detailed

description in *The Lahore Chronicle*:

> Rich in the causes of fever, highly favorable to the luxuriant development of those
> protuberances termed "boils"…sweetly flavoured with the delightful odours of
> sewers, so happily situated as to defy every effort to carry out an effective system

---

[11] Ibid., 1-2.

[12] Dharma Bhanu Srivastava, *The Province of Agra: Its History and Administration* (New Delhi: Concept Publishing Company, 1979), 226.

[13] Glover, 48.

[14] "Travels in Many Lands: Lahore," 13.

[15] "Summary and Review," *Allen's Indian Mail and Register of Intelligence for British and Foreign India, China, & All Parts of the East* 8, no.163 (1850): 730.

of drainage, remarkable for a dozen other trifles equally attractive, who can be surprised when they find that good and sensible people should be charmed with this little paradise, Anarkulee…[16]

Although the construction of the civil station in Anarkali meant that the area was eventually redeveloped to reflect the spatial ideas of the colonial administration, the inner city exhibited a constant need for reform that went beyond the reaches of government intervention.

Colonial Constructions of Old Lahore

Why, though, was the old city seen as challenging colonial regulations that were otherwise implemented more readily in areas like the civil station and the suburbs? Factors such as the cost of land and the fear of triggering political disorder certainly limited the scope of reconstruction in the inner city. For example, one report in the *Indian Public Opinion and Panjab Times* revealed that householders in the area refused to sell their property to the municipal government, leaving no room to allow improvements to the narrow roads and crowded structures of the old city.[17] Similarly, colonial apprehensions about interfering with local customs and habits further restricted colonial development in Old Lahore. However, for scholars like Tahir Kamran and Ian Talbot, these factors do not completely explain the seemingly incompatible nature of the walled city with the government's reform-driven enterprise.[18] In fact, they argue that representations of the inner city as a neglected and confined space were intentionally advanced by the British to reinforce colonial rule.[19] More specifically, they maintain that

---

[16] Sniggings, "Anarkulee – Its Advantages and Disadvantages," *The Lahore Chronicle,* September 30, 1854, 619.
[17] "Lahore. A Suggestion," *Indian Public Opinion and Panjab Times,* July 16, 1870.
[18] Kamran and Talbot, 44.
[19] Ibid., 44-45.

Old Lahore was often portrayed as a decrepit site of disease and filth in order to justify the need for British intervention in India.[20] This way, colonial ideas about the "disorderly" inner city as fundamentally distinct from the newly built civil station of Lahore have overemphasized the transformative impact of colonialism.[21] Indeed, many novelists as well as some historians have examined the city in these binary terms – studies of other colonial cities by Anthony King, Janet Abu-Lughod, and Gwendolyn Wright also reinforce the concept of "dual cities" - and this risks reproducing discourses that justified the need to "modernize" Lahore and its material environment.[22]

In reality, however, the inner city was never an isolated or inward looking space but, as Kamran and Talbot demonstrate, a place with a rich cultural, social, and political legacy.[23] Moreover, the chaos and discord that characterized Old Lahore in colonial discourses were not indicative of the city's failure to "modernize" or suggestive of its need for reform. Rather, the walled city defined its own logic and experiences – not always as a reaction against colonialism – and found meaning in its own existence. By establishing distinct urban ideals, the old city produced unique spatial, moral, and social measures for "modernization". These, in turn, created spaces that were fluid, adaptable, and limitless in their responses to the colonial presence. Ideas like these have been critical for challenging the orientalist view of Old Lahore as constricted and inscrutable. Nevertheless, even they overlook the important role of the Indian people in shaping British understandings of the inner city. In fact, as this chapter will demonstrate, colonial

---

[20] Ibid.

[21] Ibid., 18.

[22] For more on the "dual" colonial city, see Anthony King, *Colonial Urban Development: Culture, Social Power and Environment* (London: Routledge and Kegan Paul, 1976), Janet Abu-Lughod, *Rabat: Urban Apartheid in Morocco* (Princeton: Princeton University Press, 1980), and Gwendolyn Wright, *The Politics of Design in French Colonial Urbanism* (Chicago: University of Chicago Press, 1991).

[23] Kamran and Talbot, 45.

constructions of the walled city as uninhabitable and unknowable owed much to the existence of everyday resistances by local inhabitants. More specifically, limited British intervention within Old Lahore was often influenced by the activities of a class of "dangerous populations" whose behaviours were characterized by a persistent nonchalance towards – but not necessarily opposition to - colonial "modernity".[24] These individuals, as we will see, endorsed an alternative form of modernity that lent an immutability and resolve to the inner city of Lahore and created a landscape that evaded the colonial aim to construct an architecturally distinct centre. As one contemporary writer suggested, Old Lahore reflected a "sublime disregard of all European principles of sanitation, and ideas of convenience."[25] Here, urban objectives such as planned infrastructure, centralized administration, and sanitation seemed irrelevant. Instead, local culture and agency thrived amidst the dense crowds and rapidly emerging buildings, producing an environment that was quite unlike the (mis)representations in the colonial archive. This is not to say that the sections of Lahore that existed beyond the walls were devoid of culture, tradition, or agency. After all, the city was a social and intellectual hub for northwest India and facilitated interaction and dialogue between the British, Muslims, Hindus, and Sikhs. Nevertheless, nineteenth-century Lahore was a city built on collaboration and compromise, where the success of colonial objectives depended largely on dialogues between the British and Indians. Within the inner walls of the old city, however, there appeared to be an unapologetic indifference to the logic of the colonial spatial imagination.

---

[24] It is important to problematize the concept of modernity so it is not regarded as a fixed ideal that was representative of the West.

[25] Alfred Deakin, *Irrigated India: An Australian View of India and Ceylon, their Irrigation and Agriculture* (London: Thacker and Co., 1893), 106.

By perpetuating its obscurity, moreover, the walled city mediated what Henri Lefebvre calls "representational space" – subconsciously experienced realms that the imagination works to alter and appropriate – and in doing so reflected compelling signs of its spatial complexity.[26] Although representational space is symbolic – Gyan Prakash, for instance, has remarked that "[c]ities live in our imagination"[27] – it nevertheless intersects with built environments to transform landscapes on the ground and in the mind. In this way, representational space is defined as the realm of 'inhabitants' and 'users' who assign symbolic values to lived spaces.[28] Applying Lefebvre's concept to the colonial setting is particularly important for understanding spatial patterns in Indian cities such as Lahore where there was very little separating real and ideal space. More importantly, it demonstrates that the built environment was constantly being transformed through a process of contention and negotiation to reveal "counter-spaces embodying complex symbolisms…"[29] Take, for instance, two contrasting descriptions of Old Lahore. During a visit to Lahore in 1878, Viscount Hinchingbrook described the streets of the inner city as "very torturous, narrow, and crowded."[30] But, for Syed Muhammad Latif, the bustling nature of the same crowded streets and busy markets that were visited by the viscount were a representation of "thriving industries…great prosperity and successful

---

[26] "Representational space" is part of a conceptual triad proposed by Henri Lefebvre to understand space as a social product. The other two elements within this triad are "representations of space" ('conceived space' or material manifestations of ideas and drawings produced by designers) and "spatial practice" ('perceived space' or the ways in which space is used). Henri Lefebvre, *The Production of Space*, trans. Donald Nicholson-Smith (Oxford: Blackwell Publishing, 1991), 14.

[27] Gyan Prakash, *Mumbai Fables* (New Jersey: Princeton University Press, 2010), 3.

[28] Lefebvre, 31.

[29] Ibid., 33.

[30] Edward George Henry Montagu, *Diary in Ceylon and India, 1878-9* (London: W. S. Johnson, Nassau Steam Press, 1879), 129.

progress."[31] Although such wide-ranging observations were also made about nineteenth-century European cities – London, for example, was described as "filthy, dingy, and forbidding in appearance" but also as "the microcosm of civilization and history" [32] – conceptualizing the complex nature of colonial cities demonstrates that space is socially produced and shaped as much by physical elements as by intervention and exchange. In the colonial setting, this becomes an important way to deconstruct the seemingly dominant spaces created by colonialism and, in turn, reveal their fragmented nature.[33] Lahore, in particular, was a city shaped by its long-standing history and by the experiences of its people and this played a key role in determining the way it responded to British ambitions.

Colonial Surveillance and "Dangerous" Populations

Colonial representations of Old Lahore suggest that the city presented a roadblock to one of the most important features of the government's regulatory ambitions: surveillance. In fact, concerns about the limits of colonial supervision in the inner city were evident in many contemporary reports:

> The native city is of immense antiquity…Its two and three-storied brick buildings…present blank wall-faces of yellow and white plaster, to the prying outside world. The Muhammadan anxiety for privacy imparts, even to its dwellings, a sullen air of suspicion and resentment of any attempt to penetrate [its] seclusion...[34]

Indeed, surveillance offered important ways of regulating the daily lives of colonized subjects. The practice, moreover, took several different forms and included systematized

---

[31] Latif, i.

[32] John Garwood, *The Million-Peopled City; or, One-Half of the People of London Made Known to the Other Half* (London: Wertheim and Macintosh, 1853), 37; "Greater London," *The Literary News* 5 (1884): 200.

[33] Libby Porter, *Unlearning the Colonial Cultures of Planning* (New York: Routledge, 2016), 45.

[34] Deakin, 106.

administrative policies such as registration, census taking, road surveys, and the issuing

of travel passes. These, however, were not neutral exercises; colonial bureaucratic and

legal measures that incorporated surveillance were aimed at objectifying the colonized by

defining them in relation to their observer.[35] Ultimately, the goal was to create order in

society by "knowing" the local population and responding to its behaviour. C.A. Bayly,

however, demonstrates that the practice of intelligence gathering had been in place long

before the arrival of the British in India; carried out by local rulers who depended on

informal networks of information, the aim of this pre-colonial system was to uncover

moral transgressions amongst royal agents, prevent the oppression of the weak and,

perhaps most importantly, intercept any challenges to the established authority.[36] The

colonial state subsequently extended these pre-existing techniques and institutions of

surveillance in their quest for "successful" governance.[37] Particularly in the years

following the Indian Mutiny, when colonial anxieties about the threat posed by the

colonized had reached their peak, the practice of surveillance implemented by the British

exposed a distinct racial element that problematized certain individuals and groups as

"dangerous" or "deviant".

In fact, the primary focus of colonial observation and control in Lahore were

Indians who appeared to be a threat to public health and social order. Public health, in

particular, had re-emerged as a key area of concern for state officials in the late

nineteenth century, largely in response to the growing acceptance of germ theory which

regarded infectious diseases as the products of active microorganisms in the body. The

---

[35] Bill Ashcroft, Gareth Griffiths, and Helen Tiffin, *Key Concepts in Post-Colonial Studies,* 2nd ed. (London and New York: Routledge, 2000), 207.
[36] C.A. Bayly, *Empire and Information,* 10.
[37] Ibid.

expansion of scientific fields such as bacteriology and epidemiology informed a growing

consensus among medical professionals that certain microbes caused their own specific

diseases.[38] Although the environment still featured prominently in discussions concerning

the management of health in India, and a conceptual link between local habits and the

outbreak of disease remained embedded within the discourse of colonial knowledge,

germ theory placed a strong emphasis on the biological body as the source of disease.[39]

By locating contagion within the individual, this new concept separated disease from its

social ties and imagined it, instead, as the product of impersonal natural laws.[40] As such,

authority and legitimacy were given to Western scientific methods that called for an

impartial, empirical approach to studying the outbreak of disease.

The government's objective in terms of public health during this period continued

to focus on the regulation and containment of epidemic diseases such as the plague,

cholera, and smallpox. But state medicine now became fixed on the body - more

specifically, the Indian body – prompting colonial officials to find new sites upon which

to express their political concerns and cultural preoccupations. The immediate effect of

this shift in understanding the etiology of disease was the way Indian bodies were

interpreted as objects over which medical monopoly could be established.[41] The medical

body, in other words, was made passive in an attempt to secure it as "normal" and

"healthy". This was especially important for Indian bodies that were considered a danger

to the political and material interests of the colonial government, largely because of their

---

[38] Stephen Halliday, *The Great Filth: Disease, Death and the Victorian City* (New York: The History Press, 2003), 34.
[39] Glover, 48-49.
[40] Jayanta Bhattacharya, "The Body: Epistemological Encounters in Colonial India," in *Making Sense of Health, Illness and Disease,* ed. Peter L. Twohig and Vera Kalitzkus (New York: Rodopi, 2004), 40.
[41] Alexandra Howson, *The Body in Society: An Introduction,* 2nd ed. (Cambridge: Polity Press, 2013), 114.

"natural" inclination towards undesirable activities.[42] In fact, they were defined by

impulses that otherwise violated British social norms and, therefore, it was deemed

imperative to oversee their activities through specific measures such as surveillance. The

colonial objective was to create order in society by distributing individuals into particular

spaces that could be organized and policed more easily. Managing the urban landscape,

in turn, meant that the people who inhabited them could be more efficiently classified and

controlled.[43] As such, Indians who were considered "dangerous" to public health were

more likely to fall under the scrutinizing gaze of colonial officials.

Prostitution and Venereal Disease

Perhaps the most closely inspected class of "dangerous populations" in urban

areas throughout British India was prostitutes. Before the nineteenth century, however,

many of the women who were ultimately confined to this category would not have been

labeled as sex workers. Rather, their identity as prostitutes was the product of

historically-contingent gender roles in India that had been shaped by the beliefs and

practices of various groups and professionals.[44] Although the British were among those

who informed changing ideas about prostitution, the process was never only a product of

colonialism. Evolving social, economic, and political impulses across the country

challenged and redefined concepts such as morality and femininity, and broadened the

category of 'prostitute' to ultimately incorporate several groups of women within its fold.

As a result, the sex trade was no longer represented exclusively by stereotypical women

---

[42] Julius Bautista and Mercedes Planta, "The Sacred and the Sanitary: The Colonial 'Medicalization' of the Filipino Body," in *The Body in Asia,* ed. Bryan S. Turner and Zheng Yangwen (New York, Oxford: Berghahn Books, 2009), 149.
[43] Foucault, 184.
[44] Erica Wald, "Defining Prostitution and Redefining Women's Roles: The Colonial State and Society in Early 19th Century India," *History Compass* 7, no. 6 (2009): 1471.

of ill repute who worked in brothels and the streets of the bazaar. Instead, other classes of native women, including some household servants and domestic slaves who had never before been associated with the sex trade, became categorized as prostitutes.[45] One of the reasons why prostitution was reinterpreted this way in the nineteenth century was the growing concern among colonial officials and social reformers that unregulated sexual activity propagated venereal disease. If left unchecked, it was believed that prostitution would pose a serious threat to the health of the public in India.

The growing number of brothels in the colony elicited urgent British anxieties about the high incidences of sexually transmitted diseases, particularly among European troops. In 1863, the *British Medical Journal* estimated that the prostitute population in India was approximately 30,000, a number that increased to nearly 123,000 by 1881.[46] Increasing rates of infection among British soldiers meant that troop strength was weakened by approximately one quarter to one third at any given time; the issue was made more unfavorable by the twenty-two day treatment period that was required to manage each case of venereal infection (which was also not always successful).[47] In fact, as the largest group of prostitute clients, soldiers made up nearly 37% of all hospital admissions in 1881.[48] By 1896, the number had risen to 55.5% and in the late 1890s, nearly 2000 soldiers died annually of venereal disease in India.[49] Moreover, growing

---

[45] Ibid.

[46] Parliamentary Bills Committee, "Memorandum on Venereal Diseases in India," *British Medical Journal,* March 20, 1897, 733.

[47] Judith Walkowitz, *Prostitution and Victorian Society: Women, Class, and the State* (Cambridge: Cambridge University Press, 1980), 75.

[48] Ashwini Tambe, *Codes of Misconduct: Regulating Prostitution in Late Colonial Bombay* (Minneapolis: University of Minnesota Press, 2009), 21.

[49] According to Douglas Peers, Indian soldiers did not appear to be affected at the same rate as British soldiers presumably because they were more likely to be married and more reluctant to rely on Western

military costs – in 1868, it was estimated that the government spent an average of one

hundred pounds a year to train, clothe, and feed each soldier which was twice the cost of

equipping native troops – meant that the colonial state could not afford to overlook any

risks to the health of its army.[50]

With no effective cure for venereal disease, the British turned to alternate ways of

containing the spread of infection among soldiers. Interestingly, though, a ban on public

solicitation remained absent from military discourses regarding prostitution, largely

because the trade was believed to satisfy a deep-seated biological need within men which

if left unfulfilled could push soldiers to engage in sodomy. In an August 1870 edition of

the *British Medical Journal*, Dr. W.T. Greene even described prostitution as a

"safeguard" for society:

> I cannot look upon the existence in our midst of a class of professional
> prostitutes as altogether an unmixed evil; for I believe that were such a means –
> deplorable as the necessity for it must ever remain – of gratifying their passions
> unattainable by the rising generation far greater evils than those we deprecate at
> present would result.[51]

Greene continues by suggesting that without an outlet such as prostitution, soldiers could

turn to far more objectionable activities like onanism, incest, and other "crimes against

nature".[52] The colonial response to containing venereal disease in India was to impose

restrictions on the women who offered sexual services to soldiers in the British Army. In

focusing on Indian prostitutes who lived and worked near cantonments, colonial

medicine for treatment. Douglas Peers, "Soldiers, Surgeons and the Campaigns to Combat Sexually
Transmitted Diseases in Colonial India, 1805-1860," *Medical History* 42 (1998): 142.
[50] Wald, 1476.
[51] W.T. Greene, "The Remedy for Prostitution," *British Medical Journal*, August 13, 1870, 181.
[52] Ibid.

administrators created a rigorous system of treatment and surveillance that regulated not just the activities of these women but also the spaces they frequented.

For colonial administrators, restructuring the geography of commercial activity became essential for managing problems associated with prostitution (such as disease, "deviant" sexuality, and immorality). This type of regulation, while accepting the inevitability of the sex trade, attempted to minimize its most harmful effects by creating spatial patterns that both marginalized and made visible the Indian prostitute.[53] Perhaps the most infamous tool of the colonial state was the Contagious Diseases (CD) Act of 1868.[54] The CD laws in India employed the medical profession to define sexual deviance and assert control over the bodies of Indian women. Modeled on the CD Act passed by the British Parliament in 1864, the regulations empowered colonial authorities to regulate the activities of any local woman who was suspected of consorting with members of the British military.[55] These women were taken into custody and ordered to register before a magistrate before submitting to a compulsory medical examination that would determine if they suffered from venereal disease.[56] Those deemed "infected" were sent to specialized hospitals for sexually transmitted diseases, known as "lock hospitals", where they were treated and detained at the discretion of the physician in charge; if lock hospitals were not available in a municipality, colonial officials had the authority to

---

[53] Philip Howell, "Prostitutional Space in the Nineteenth-Century European City," in *Place, Culture, and Identity: Essays in Historical Geography in Honour of Alan R.H. Baker,* ed. Iain S. Black and Robin Alan Butlin (Laval: Le Presses de l'Universite Laval, 2001), 183.

[54] The Contagious Diseases Act of 1868 applied to modern day India, Pakistan, and Bangladesh.

[55] Philippa Levine, *Prostitution, Race, and Politics: Policing Venereal Disease in the British Empire* (New York: Routledge, 2003), 40.

[56] Wald, 1471-1472.

"provide any building or parts of buildings as hospitals for the purposes of this Act".[57] Women who refused to act in accordance with these policies faced imprisonment for a period up to one month as well as an extravagant 100 rupee fine.[58]

Although the Contagious Diseases Act of India had not been officially implemented in the Punjab – they were repealed in 1888 before they could be extended to the province - regulations for inspecting and containing brothels and other often ad hoc measures for curbing the spread of venereal disease were employed at most cantonments in the Punjab where British soldiers resided.[59] The transfer of Lahore's troops to Mian Mir in 1852 meant that rules calling for the registration of brothels and the examination of public prostitutes were imposed here instead. However, the absence of formal legislation in the province did not mean that the colonial government overlooked the management of prostitutes in Lahore. After all, a small group of soldiers remained stationed in the city even after the relocation of the rest of the army. Therefore, as part of its protective measures, the government called for the establishment of a lock hospital in Anarkali in 1879 which continued to operate until October 1882.[60] This was followed by the appointment of a local attendant who assumed the responsibility of performing routine inspections on Indian women.[61] Despite never formally extending the Contagious

---

[57] George Smoult Fagan, *The Unrepealed and Unexpired Acts of the Legislative Council of India, From 1834 to 1870 inclusive, with Abstracts, Marginal and Foot Notes, an Elaborate Index, a Chronological Table and, a Table of All Acts Repealed* (Calcutta: Calcutta Central Press, 1871), 3: 1845.

[58] In fact, two years after the enforcement of the law, 2,359 prostitutes had already been arrested for failing to register with the government in Bengal. Harrison, *Public Health in British India,* 73.

[59] The abolition of the CD Act in India came in response to pressure from Christian missionaries in the colony and their allies in Britain who called on the House of Commons to condemn the compulsory examination of women and to end their confinement in lock hospitals.

[60] *Gazetteer of the Ferozpur District,* 1883, 112.

[61] W. M. Young, *Reports of Lock Hospitals in the Punjab 1882-1883*, 3.

Diseases Act to Lahore, the city nevertheless carried out the registration of prostitutes and the inspection of brothels in keeping with section nineteen of the legislation.

Especially within the dense inner city, there remained a constant awareness of the presence and movement of local prostitutes who served the British army. Perhaps most disconcerting for the British was the limited number of women who came forward to register with the local government. In 1867, for instance, it was estimated that there were approximately 8000 prostitutes residing in Lahore; this was significantly higher than the number of registered prostitutes that was calculated by officials in subsequent years (estimated at only 97 in 1870 and 240 in 1881).[62] Such discrepancies pushed authorities to advance the systematic and regular collection of information concerning prostitute activities. More specifically, the colonial state was interested in statistical data to help regulate the trade because it allowed populations to be categorized in terms of trends, patterns, and densities. The classification of prostitute women, in particular, was informed by an imperial impulse to "rule by records" and this had serious implications for the sex trade in India.[63] Oftentimes, no distinction was made between different classes of women who performed sexual services such as *nautch* girls and *devadasis*. The latter two can be described loosely as dance girls: *devadasis* were temple dancers who dedicated their lives in service of a deity or temple while *nautch* girls were secular performers whose musical distinctions could be traced back to the Mughal courts.[64] The compulsory registration of women collapsed these figures into the general term

---

[62] Government of Punjab, *Report on the Administration of Criminal Justice in the Punjab and its Dependencies During the Year 1881-1882* (Lahore: Central Jail Press, 1882), 183-184.
[63] Richard Suamarez Smith, *Rule by Records: Land Registration and Village Custom in Early British Panjab* (Oxford: Oxford University Press, 1996), 4.
[64] Young, 5-7.

"prostitute" and located them in a binary system of meaning that categorized them as either "respectable" or "immoral". With no such comparable classes recognized in Britain, these other groups of women came to be identified as prostitutes and denounced for engaging in activities that were beyond the limits of "acceptable" sexuality.[65]

Therefore, information gathered through registration became a surveillance tactic that established a measure for the spread of venereal disease. After all, statistics concerning the number of prostitutes in these registers helped determine the efficiency and relevancy of state tactics to manage disease, reinforcing the social ordering that determined which element of prostitution required the most governmental control. Municipal proceedings for the Punjab, for instance, reported that ninety-eight brothels were investigated in Lahore in 1859; by 1873, registered women were required to obtain permission before leaving the civil station.[66] The restriction on their mobility, in particular, was suggestive of the different ways that knowledge about prostitutes was gathered and produced. Ultimately, the aim of such measures was to provide British soldiers with a pool of "healthy" women with whom they could consort.[67] Despite such policies, however, one commentator reported that Indian prostitutes in Old Lahore practiced their trade with great success and established their businesses in houses for which they paid "unreasonably" expensive rent.[68]

The colonial preoccupation with sexual activity in Lahore, although formulated around issues of public health and disease, also led to the practical management of

---

[65] Wald, 1478-1479.
[66] *Abstract of the Proceedings of the Sanitary Commissioner with the Government of India During the Year 1872* (Calcutta: Office of the Superintendent of Government Printing, 1873), 257.
[67] Wald, 1476.
[68] "The Anarkulle Sudder Bazaar," *The Lahore Tribune,* April 21, 1883, 3.

prostitute spaces. The regulations imposed in the city, for example, required that

registered prostitutes be issued tickets so they could appear regularly at the lock hospital

in Mian Mir for inspection (one of the first to open in India in 1859).[69] While this policy

necessitated a certain degree of movement, registered women were typically expected to

remain confined within specific areas of limited toleration. A report on cantonment

regulations from 1893-1894 remarked on this arrangement:

> The Indian harlots…affect certain special quarters of the town in which they
> reside, such as the Anarkali Bazaar at Lahore…There they generally occupy
> the upper storeys of the shops, and sitting at their open windows, expose their
> charms to the passers by.[70]

Thus, regulations governing spaces of prostitution produced a geopolitical map of the

trade in Lahore that determined where the sexual encounters of Indian women would

have the least repercussions for British public health and the sanitary reform movement.

It was for this reason that the presence of prostitutes was unwelcome beyond the brothels

in the old city; in fact, any sexual encounter outside these spaces was often the subject of

complaint. One resident, for example, commented in a local newspaper:

> Allow me through the medium of your widely-circulated paper to bring to the
> notice of the public the disgraceful manner in which women and girls of loose
> character are permitted to stroll about the Anarkali Gardens at all hours of the
> night. Respectable ladies can on no account be prevailed upon to enter the said
> Gardens after dusk, for fear of gaining a name for themselves.[71]

---

[69] *Gazetteer of the Ferozpur District,* 1883, 112.
[70] Government of India, *Report of the Special Commission to Inquire into the Working of the Cantonment Regulations regarding Infectious and Contagious Disorders* (London: Eyre and Spottiswoode, 1893), 232-233.
[71] "Public Morality in the Anarkali Gardens," *The Tribune*, July 23, 1881, 10.

While colonial administrators reluctantly accepted that "women of bad repute" would ply their "dirty trade openly in [Anarkali] Bazaar", there was an expectation that these illicit transactions would remain confined to designated areas of sexual activity.[72]

The emphasis on the segregation of Indian prostitutes in Lahore stigmatized certain spaces as sites of disease and contagion. Although the practice in Lahore was unofficial - in some cities such as Bombay, public campaigns resulted in the enforcement of formal segregation rules that created identifiable spaces of prostitution – the isolation of Indian sex workers was nevertheless an important concern for British residents living in the city.[73] By imagining these women's bodies as best-suited to specific geographic spaces, particularly those established as separate or distinct from areas inhabited by "healthy" society, British officials declared that prostitution was a danger to the public. The importance of spatial organization was evident even beyond the inner city, at the lock hospital situated in Mian Mir. Here, the regulations imposed on local women continued to prevail even after the abolition of the CD Act in the rest of India. In fact, by 1888, the Government of India no longer issued tickets or kept registers of public prostitutes in urban centres; furthermore, it had ended compulsory medical examinations and maintained lock hospitals as purely voluntary institutions.[74] However, throughout the 1890s, prostitutes who served British soldiers in Mian Mir were still subject to these rules under the provisions of a new legislation. The Cantonment Act, instituted in 1889 to regulate all military cantonments in British India, incorporated an intentionally sweeping policy that allowed officials to use draconian means to prevent the spread of infectious

[72] "The Anarkulle Sudder Bazaar," 3.
[73] Tambe, 125.
[74] Jane Jordan and Ingrid Sharp, eds., *Josephine Butler and the Prostitution Campaigns: Diseases of the Body Politic* (London: Routledge, 2003), 5: 370.

Figure 3.1 Registration Ticket for Prostitute, Mean Meer, 1890.
Source: Elizabeth W. Andrew and Katherine C. Bushnell. *The Queen's Daughters in India.* London: Morgan and Scott, 1899.

diseases in cantonments.[75] The Act was often interpreted in ways that permitted the continued inspection and compulsory treatment of Indian prostitutes.[76] For example, in Mian Mir, if sex workers were found to be diseased, they were either fined and expelled from the cantonment or separated from the rest of the community in the local lock hospital.[77] Moreover, when the hospital building was eventually renovated in the 1880s, its walls were raised and its doors completely boarded to prevent women from escaping

---

[75] Harrison, *Public Health in British India,* 75.
[76] Ibid.
[77] Government of Punjab, *Report on the Lock Hospitals in the Punjab for the Year 1887* (Lahore: Punjab Government Press, 1888), 59.

before their treatment was complete.[78] Because prostitutes were considered a critical threat to public health, they were managed on an inpatient basis so they could be exposed to the discipline of a hospital regimen as well as to medical treatment.[79] Ultimately, British commentators who were concerned with the issue of prostitution believed that the unhealthy nature of the trade would be "systematically palliated by lock hospitals".[80] For them, the management of venereal disease required not only the spatial segregation of native prostitutes but, simultaneously, closer access to their bodies by placing them under medical jurisdiction.

Indian prostitutes were situated clearly within official colonial records as belonging to a class of "dangerous populations". While measures governing the sex trade were constantly redefined to allow a closer surveillance of these women's activities, evidence suggests that prohibitionist laws were, in reality, responding to colonial anxieties about their failure to maintain public order. As Janaki Bakhle argues, the risk these "dangerous" individuals posed to British society was "far more rhetorical and symbolic than physical, for what was really at stake was the fundamental legitimacy of colonial rule."[81] More specifically, over the course of the nineteenth century, it became notably apparent that law enforcement policies concerning prostitution were limited in their ambitions. The language of administrative strategies such as compulsory examinations and registration often differed from the way these practices were ultimately

---

[78] Ibid.
[79] Jordan and Sharp, 314.
[80] Florence Nightingale, *Observations on the Evidence Contained in the Stational Reports Submitted to her by the Royal Commission on the Sanitary State of the Army in India* (London: Edward Stanford, 1863), 88.
[81] Janaki Bakhle, "Savarkar (1883–1966), Sedition and Surveillance: the rule of law in a colonial situation," *Social History* 35, no. 1 (2010), 51.

enforced on the ground, challenging the government's linear reading of the law as ensuring its intended outcome.[82]

Several reports, for instance, reveal the extent to which prostitutes intentionally evaded surveillance. One lock hospital report for the Punjab indicates that some women used astringent injections before being examined to prevent the detection of disease; others simply avoided appearing for regular inspections.[83] This led one medical official to assert: "…it is now a general complaint that the women are most unwilling to attend the appointed places for undergoing the required examinations."[84] Similarly, another commentator suggested that "there [were] large classes of women over which police supervision could not be extended, for political, religious, and local social reasons".[85] Moreover, prostitutes' ability to cross the contained and segregated spaces of the military cantonment only reinforced colonial misgivings about the trade and these women's place in society.[86] One health official even believed that they deliberately spread disease among soldiers because the imposition of regulatory measures against them had deprived them of the self-respect and pride their position once granted them.[87] While there is little evidence to uphold this allegation, it nevertheless expresses the urgency of colonial apprehensions regarding the trade.

---

[82] Tambe, xiii.

[83] Government of Punjab, *Report on the Lock Hospitals in the Punjab for the Year 1888* (Lahore: Punjab Government Press, 1889), 3.

[84] *Abstract of Proceedings of the Sanitary Commissioner with the Government of India During the Year 1871* (Calcutta: Office of the Superintendent of Government Printing, 1872), 127.

[85] *Extracts from, Correspondence between the Government of India and the Secretary of State in Council upon the subject of the Contagious Diseases Acts and their Repeal* (London: Henry Hansard and Son, 1883), 76.

[86] In her discussion of prostitution in colonial Madras, Sarah Hodges points out other strategies that were employed by these women in order to survive. For example, she demonstrates that destitute prostitutes often transformed lock hospitals into sites of refuge, particularly during hard times (such as the Madras famine crisis of the 1870s). Sarah Hodges, "'Looting' the Lock Hospital in Colonial Madras during the Famine Years of the 1870s," *Social History of Medicine* 18 no. 3 (2005): 396.

[87] Ibid., 75.

Another concern for British authorities was that prostitutes frequently bribed *dhais,* the native birth attendants who assisted in brothels and lock hospitals. These local agents were placed firmly within a chain of command that reported the activities of prostitutes to colonial administrators and, as a result, their double-dealing was cause for serious concern. Surgeon-Major Shirley Deakin of the Indian Medical Services argued that the *dhais* at the Mian Mir lock hospital were "useless" and that they rarely reported their women as being diseased:

> They appear to live upon the women, waxing fat on the spoils and taking half an anna *dasturi* in every rupee from the women. They should be abolished; they hold an objectionable monopoly.[88]

Clearly, there existed a hierarchical system of surveillance that was intended to regulate prostitution; however, the realization that it struggled to meet the managerial demands of the colonial state only reinforced the anxiety that already surrounded the sex trade.

Perhaps most importantly, the link between prostitution and disease was grounded in ideas about the trade disrupting the Western boundary between public and private. In Britain, especially, a common nineteenth-century middle class view upheld the private sphere as a familial space that was meant to celebrate a life removed from the busy (and public) city. Therefore, the home - alongside women who were regarded as the traditional guardians of domesticity - became a quintessential symbol of private living. Although scholars like Robert Shoemaker and Amanda Vickery have demonstrated that nineteenth-century ideologies about separate spheres established binary distinctions that did not always translate into reality, the notion of private and public spaces nevertheless shaped the idealized and discursive division of responsibilities between men and women at the

---

[88] Government of Punjab, *Report on the Lock Hospitals in the Punjab for the Year 1887,* 60.

time.[89] This was particularly apparent with prostitutes who were believed to violate the

mental and physical maps of colonial India by blurring the distinctions between business

and pleasure, home and work, and health and disease.[90] Sexual commerce, in other

words, undermined a growing association between femininity and sanitation by mocking

the idea of women as the protectors of a sanitized and sanctified home. As a result,

prostitutes were believed to "improperly" fuse together the public and private spheres in

the colony's urban centres, a sentiment that is evident in the following excerpt from the

Sanitary Commissioner's 1872 report:

> To prevent access of strolling women into Cantonments…any women
> detected in the society of one or more Europeans under circumstances
> sufficiently suspicious to lead to the conviction that the meeting could only
> have taken place for the purposes of prostitution…she should at once be
> registered as a public woman. [91]

As women whose occupation drove them into urban spaces of visibility, native sex

workers were represented as "public" figures that were sexually available and morally

licentious. It was the very nature of their "publicness", in fact, that presented them as a

risk to the precarious balance the British attempted to maintain between order and

discord.

The Urban Poor

Colonial anxieties about unchecked disturbances within certain areas of Lahore

were also exacerbated by another class of "dangerous" Indians that had come under

colonial scrutiny. Indeed, a late nineteenth-century link between poverty and disease

---

[89] Robert Shoemaker, *Gender in English Society 1650-1850: The Emergence of Separate Spheres?* (New York: Routledge, 2013), 7; Amanda Vickery, *Behind Closed Doors: At Home in Georgian England* (New Haven: Yale University Press, 2009), 25.
[90] Walkowitz, 178.
[91] Government of India, *Proceedings of Sanitary Commissioner with the Government of India* (Calcutta: Office of Superintendent of Government Printing, 1872), 226.

meant that the urban poor were declared to be another threat to social order in the colony.

This growing concern with the lower classes was prompted by the emergence of a

"localist" framework for disease that viewed specific conditions of poverty, like filth and

squalor, as the primary causes of epidemic outbreaks.[92] Although these issues were also

the subject of debate among social reformers and government officials in England, there

was a distinct racial element to the colonial understanding of the relationship between

poverty and disease in India. In Lahore, for example, Dr. H. W. Bellew, suggested that

the inferior living conditions of the Indian poor and labouring classes made this group the

"chief victims" of cholera in the city.[93] This led one commentator to argue that the lower

classes "require[d] more looking after than people of the higher orders."[94] Beyond

Lahore, Bellew blamed the unhealthy living practices of Kashmiri shawl weavers for the

spread of cholera in Amritsar in 1881.[95] They were among the first to contract the disease

after using water from a well that had been poisoned by the discharges of a sick traveler

to the city. But, according to Bellew, the shawl weavers were predisposed to higher rates

of mortality because of their "impoverished condition"; it was the "deficient and

unsuitable clothing of the people", who were known to sleep on the ground with "only a

thin cotton sheet pulled over them", that left them susceptible to the "greatest ravages" of

cholera when it first arrived in Amritsar.[96] Similarly, Indian barbers were held

responsible for the spread of plague in the Hoshiarpur district because they were believed

---

[92] Kidambi, 52.
[93] Walter H. Bellew, *The History of Cholera in India from 1862-1881* (London: Trubner & Co., 1885), 643.
[94]*The Tribune,* June 9, 1883, 8.
[95] Bellew, 653.
[96] Ibid., 652, 654.

to be in the habit of collecting and transferring the clothes of the dead between villages.[97]

Consequently, policies related to health and disease were often directed towards the

Indian poor and the slums they inhabited; in Bombay, for example, the colonial anti-

plague campaign called for regular house inspections in poor localities which sometimes

resulted in the demolition of lower class homes that were deemed unsanitary.[98]

Ideas about the threat of the urban poor, however, went beyond the risk they

posed to public health. Colonial officials were just as apprehensive about the

unmistakable visibility and widespread existence of the poor in "unsettled landscapes" as

they were about their seemingly disease-ridden bodies.[99] A nineteenth-century

intellectual and ideological shift in Europe had identified poverty as a social problem that

could only be remedied through philanthropic campaigns, education, mutualism, and

behavioural reform.[100] But in India, the discourse and practice of these "social services"

were not established until the late nineteenth and early twentieth centuries and, until then,

the management of the Indian poor remained largely neglected.[101] This is not to say that

strategies for social reform were nonexistent in the colony; rather, there was a growing

interest among English-educated Indians to counter specific cultural practices that were

perceived as irrational, barbaric, and ignorant (like *sati, purdah,* and child marriage).

However, these initiatives were directed towards educating those castes and communities

that were engaged in such "outmoded" practices, and wider debates concerning the

---

[97] Sasha Tandon, "Epidemics in Colonial Punjab," *Journal of Punjab Studies* 20, nos. 1 & 2 (2013): 221.
[98] Kidambi, 64.
[99] Satarupa Sinha Roy, "Unsettling Landscapes: Landscape and the Entelechies of the Alienating Gaze in Kipling's The City of Dreadful Night," *Rupkatha Journal on Interdisciplinary Studies in Humanities* 7, no. 2 (2015): 162.
[100] Nandini Gooptu, *The Politics of the Urban Poor in Early Twentieth-Century India* (Cambridge: Cambridge University Press, 2001), 12.
[101] Kidambi, 204.

condition of the lower classes were generally absent from nineteenth-century narratives on reform. Indeed, no poor law existed in India to regulate and relieve poverty; while certain measures were adopted following intense famines, these programs were overseen predominantly by Indian philanthropists rather than by colonial administrators.[102] Even the Vagrancy Acts of 1869, 1871, and 1874, which attempted to combat the issue of poverty in the colony, applied only to destitute Europeans who threatened to undermine the illusion of a healthy, purposeful, and powerful white ruling race.[103]

Part of the reason the colonial government did not take a direct interest in regulating the poor population was the conviction that there were too many impoverished Indians for a systematic program of relief to operate effectively in the colony.[104] This view developed alongside the idea that poverty was natural in India and that the local poor required less than Europeans in order to survive: "…from the nature of the climate and by immemorial custom, the poorer classes have fewer wants, and can satisfy them more cheaply than in Europe."[105] Such claims ultimately absolved the British from intervening in the affairs of the lower classes and, as a result, colonial strategies regarding poverty in India remained limited. In fact, the move towards state-sponsored relief for the poor only emerged in the colony after the First World War with the development of local government institutions focused on public welfare.[106] It would be misleading, however, to

---

[102] David Arnold, "Vagrant India: Famine, Poverty and Welfare Under Colonial Rule," in *Cast Out: Vagrancy and Homelessness in Global and Historical Perspective,* ed. A. L. Beier and Paul Ocobock (Athens: Ohio University Press, 2008), 118.
[103] Jane Buckingham, *Leprosy in Colonial South India: Medicine and Confinement* (New York: Palgrave, 2002), 160.
[104] David Arnold, "The medicalization of poverty in colonial India," *Historical Research* 85, no. 229 (2012): 492.
[105] *Memorandum on Some of the Results of Indian Administration During the Past Thirty Years of British Rule in India* (London: Eyre and Spottiswoode, 1889), 27.
[106] Arnold, "The medicalization of poverty," 499.

suggest that the lack of a standard system for poverty relief until then was solely the result of colonial indifference and neglect. Rather, certain aspects of India's impoverished population placed them beyond the reach of colonial control and, as we will see, this generated certain apprehensions within a government that was otherwise fixated on containing and regulating its subject population.[107]

As with the rest of India, there were no formal measures in Lahore to monitor the activities of the poor and this presented immediate problems for the local government. More specifically, it was the public exhibition of poverty, as well as the seemingly unrestricted mobility of the poor, which prompted the most concern among city officials. Although some impoverished Indians earned regular incomes as labourers, street vendors, and entertainers, many turned to begging. As a result, they came to be seen within the colonial imagination as monopolizing public spaces. The following description of Lahore from 1873, for example, captures the pervading presence of the lower classes within the walled city:

> …there are hideous eunuchs; fakirs with their faces grotesquely painted, and their bodies swathed in the skins of wild beasts; there are merchants of all sorts, and in all descriptions of costume, and there are scores of people in no costume at all. The streets are crowded to an extent unequalled in any other Indian city.[108]

Visual appearances of the poor confronted colonial conceptions of how public spaces were to be utilized because they reconstituted the inner city as a marginal space.[109] These landscapes proved to be particularly problematic for British authorities because they

---

[107] Ibid., 493.
[108] "Travels in Many Lands: Lahore," 13.
[109] Pamela Shaw, "The Qualities of Informal Space: (Re)appropriation within the informal, interstitial spaces of the city," (presentation, Conference of the School of Architecture and Design: Interior Architecture and Urban Studies Programme, University of Brighton, 2nd to 4th July 2009), 1.

interfered with the construction of a "homogenous, staged, controlled, [and] 'official'

public space" where the logic and aesthetics of the colonial spatial imagination could be

legitimized.[110] Therefore, the appropriation of these spaces by specific groups like the

poor made it increasingly difficult for state power to function effectively within the old

city. By accommodating individuals whose activities and behaviours otherwise diverged

from colonial standards of respectability and order, marginal spaces such as the public

walks and bazaars of Old Lahore became established sites of poverty where the lower

classes could reclaim some aspects of their existence. One correspondent writing for *The

Tribune* in 1881 stated:

> There is no denying the fact that, beggars…are very numerous in our city, and
> that one's walk of an evening is robbed of half its   pleasure and enjoyment
> owing to their clamorous and importunate begging, and more so because of
> the "unsightly and indecent exposure" of their persons…[111]

Here, it can be argued that an undisclosed battle for ownership of the city is taking place;

the correspondent who describes the city as "ours" recognizes that Lahore has been lost

to the sheer number of beggars who dominate its streets. The fact that residents are

"robbed" of the pleasure of walking in their city further suggests that Lahore has, in a

way, been surrendered to this class of impoverished individuals. Moreover, the reference

to "indecent exposure" is also noteworthy because it reinforces ideas about the visibility

of the poor in the public setting. Their uncovered bodies signal notions of social unrest by

representing the failure of colonial power to produce respectable subjects. Indeed, the

overwhelming presence of the poor can be regarded as an expression of "everyday

---

[110] Ibid.

[111] *The Tribune,* February 9, 1881, 7.

resistance" where the most commonplace actions and circumstances of the lower classes generated significant concerns about their resilience.

Clearly, then, marginal landscapes like the walled city of Lahore transcended the limits of colonial spatial logic. As Glover argues, the modes of inquiry that were used to make the rest of Lahore knowable (such as surveillance, classification, and registration) seemed insufficient for regulating informal spaces of poverty in the city.[112] Poverty, in fact, had become a manifestation of excessiveness – excessive waste, excessive misery, excessive idleness – and this challenged the scope of colonial intervention in the old city.[113] Nevertheless, some local residents did appeal to the municipal government to manage the issue of the poor in Lahore. The above-mentioned correspondent for *The Tribune*, for instance, suggested that "the enlightened principles of charity" be used to "house and feed [the poor] at the public expense" and for the able-bodied among them to be assigned work.[114] However, the inability of state power to filter through the disordered spaces of the inner city and the propensity of the poor to thrive in such areas meant that poverty remained a critical problem for officials throughout the nineteenth century.[115]

With no distinct colonial strategy to manage lower class and economically marginalized individuals, poverty in Lahore, as well as in the rest of India, often came to be criminalized. The poor, classified as "the repository of a deviant culture", became affiliated with a class of reputed criminal offenders that British authorities had attempted

---

[112] Glover, 52.
[113] Ibid.
[114] *The Tribune,* February 9, 1881, 7.
[115] Colin McFarlane and Michael Waibel, "Introduction: The Informal-formal Divide in Context," in *Urban Informalities: Reflections on the Formal and the Informal,* ed. Colin McFarlane and Michael Waibel (New York: Routledge, 2012), 2.

to reform and punish since the beginning of the nineteenth century.[116] Colonial officers

first encountered these "criminal tribes" in northern India and identified them as low

caste or outcaste groups whose criminal behaviour was "inherited by descent".[117] This

conclusion was the result of a largely mistaken British belief that criminal tribes were

directly linked to specific castes such as the Pindaris (primarily Muslim bandits that

accompanied the Maratha armies), Thugs (thieves and murderers), and Brinjaras

(wandering grain and livestock dealers).[118] Colonial authorities maintained that crime

was the traditional livelihood of the criminal classes and that these individuals did not

adhere to any moral code beyond those outlined by their caste.[119] British officials

perceived such habitual crime and inherent criminality as particularly dangerous because

they were deemed pervasive and irreversible. This way, criminal tribes posed a collective

risk to colonial order by threatening to transfer deviant behaviour down through

generations; it was imperative, therefore, that they were contained and controlled before

they could "pollute" others with their delinquent tendencies.[120] This colonial

understanding of criminal tribes would in turn shape the experiences of Lahore's urban

poor through a new criminal legislation that had significant ramifications for

economically marginalized groups in the city.

  In 1871, the class of "dangerous" offenders was brought under the provisions of

the Criminal Tribes Act which allowed officials to register, resettle, and punish any

---

[116] "Travels in Many Lands: Lahore," 13.

[117] *The Friend of India* (Calcutta: Statesman and Friend of India Office, 1869).

[118] Andrew J. Major, "State and Criminal Tribes in Colonial Punjab: Surveillance, Control and Reclamation of the 'Dangerous Classes,'" *Modern Asian Studies* 33, no. 3 (1999): 658.

[119] Ibid.

[120] Preeti Nijhar, *Law and Imperialism: Criminality and Constitution in Colonial India and Victorian England* (London: Routledge, 2009), 119-120.

member of a criminal tribe.[121] However, there were no specific details in the legislation

outlining which actions resulted in labeling a group as a criminal tribe.[122] Instead, a

preconceived set of characteristics – these were partly developed in the 1830s and 1840s

as part of the Thuggee and Dacoity Suppression Acts - were applied to any class of

persons or groups *believed* to earn their living by committing offences. That is, proof for

the actual commission of a crime was not necessary to label criminal tribes as such as

long as ideas about their inherent criminality were believed.[123] Indeed, several diverse

groups of Indians were targeted under the legislation, from displaced pastoralists and

gypsies to beggars and thieves; menial castes such as *chuhras* (scavengers/sweepers) and

bazigar (entertainers) were also included within the category because they were virtually

undistinguishable from the itinerant criminals.[124] One contemporary journal, for example,

noted that "prisoners in India generally belonged to the poor and agricultural classes."[125]

Similarly, another report revealed: "For the purposes of counterfeiting good coin and

passing it in large quantities, there is a class of Mohammadens who go about in the

character of fakirs, or pious ascetics, and are masters of their nefarious craft."[126]

Observations like these extended the scope of colonial surveillance over criminal tribes,

allowing more low class Indians to be stigmatized as criminals by birth.

  In Lahore, the establishment of the Criminal Tribes Act meant that criminal

---

[121] The Act was initially only enacted in the Punjab, North-Western Provinces, and Oudh but was extended to Madras and Bombay in 1911.

[122] Sanjay Nigam, "Disciplining and policing the 'criminals by birth', Part 2: The development of a disciplinary system, 1871-1900," *The Indian Economic and Social Review* 27, no. 3 (1990): 257.

[123] Henry Schwarz, *Constructing the Criminal Tribe in Colonial India: Acting Like a Thief* (Oxford: Wiley-Blackwell, 2010), 3.

[124] Major, 661.

[125] *Journal of the Society of Arts,* February 23, 1872, 277.

[126] Robert Brown, *The Peoples of the World: Being a Popular Description of the Characteristics, Condition, and Custom of the Human Family* (London: Cassell & Company, Ltd., 1892), 27.

activity was seen as coinciding with the presence of "depressed" and "deviant" classes. One report even suggested that the increase of non-bailable offences in the city was the result of economically marginalized individuals who had turned to crime.[127] The old city, in particular, was regarded as a refuge for beggars, fakirs, and "notorious bad characters" who came under colonial surveillance not on the basis of their impoverished circumstances but as a result of official measures that sought to regulate their criminal behaviour.[128] Many, in fact, were rounded up by the police, convicted for petty crimes, and sent to jail.[129] A census from the Lahore Central Jail from 1871-1872 (after the enforcement of the Criminal Tribes Act) reveals that lower class individuals such as beggars, sweepers, and scavengers continued to make up a large percentage of the prison's inmates.[130] Relegating Lahore's poor to a class of hereditary criminals was a testament to the colonial anxiety concerning the city's destitute population; after all, by imprisoning them under the measures outlined by the Criminal Tribes Act, the local government attempted to reconcile their presence and visibility in the city. Despite this, however, these individuals could be commonly found within the walled inner city. One contemporary writer, for example, described Old Lahore as a place "where indeed the poorer classes of both sexes spend most of their lives, retaining one or two small cells in a dark dwelling, up an undrained right of way, where they can eat, sleep, and multiply."[131]

---

[127] Government of Punjab, *Report on the Administration of Criminal Justice in the Punjab and its Dependencies During the Year 1878* (Lahore: Central Jail Press, 1879), 3.
[128] Ibid.
[129] Arnold, "Vagrant in India," 119.
[130] George Smith, ed., *Annals of Indian Administration in the Year 1871-1872* (Serampore: Gopal Chundra Gungopadhya, 1873), 290.
[131] Deakin, 107.

British attempts to order public space through the Criminal Tribes Act not only expressed a colonial fixation with surveillance but also reinforced the urgency to discipline any activity that was deemed unnatural or deviant. For this reason, a second section of the Act imposed regulatory measures upon a group that persistently challenged colonial discourses of masculinity and sexuality: *hijras,* or eunuchs.[132] Described in the legislation as "all persons of the male sex who admit themselves, or on medical inspection clearly appear, to be impotent", eunuchs were often recognized as emasculated persons.[133] As individuals who did not identify as either male or female, eunuchs were featured within the Criminal Tribes Act because they occupied an ambivalent space within colonial understandings about gender and challenged the binary division of the sexes to which the British state subscribed. Known for dressing like women and adopting feminine names, eunuchs violated normative colonial masculine ideals (exemplified by qualities such as discipline, virility, and authority). Consequently, eunuchs were regarded as markers of failed manhood and their criminality came to be defined in gendered and sexual terms with the Criminal Tribes Act serving as a means of policing and regulating their conflicting identity. For instance, the legislation compelled eunuchs to register with the districts they resided in and punished those who appeared "dressed or ornamented like a woman, in a public street or place, with the intention of being seen from a public street or place".[134] More importantly, effeminate behaviour and appearance became

---

[132] *Hijra* was the term used to refer to castrated men who dressed like women.
[133] Government of India, "The Criminal Tribes Act," in *The Punjab Code: Consisting of the Unrepealed Bengal Regulations, Local Acts of the Governor General in Council, and Regulations made under the Statute 33 Victoria, Cap. 3 in Force in the Punjab* (Calcutta: Superintendent of Government Printing), 62.
[134] Ibid.

grounds for criminality because they were associated with more dangerous offences such as sodomy. One report from 1884 draws attention to this connection:

> Sodomites are persons of all ages, but they usually present a somewhat feminine appearance, or strive to appear like women. To this end they commonly conceal or destroy, as far as practicable, such virile appendages as beard, whiskers, or moustache, wearing a profusion of jewelry, paint, and padding.[135]

British authorities also employed other strategies to minimize the danger that eunuchs presented. For example, in an effort to restore balance to their binary conception of gender, official reports almost always labeled eunuchs as "men"; this was a linguistic strategy that attempted to discredit and abolish the notion of a third gender.[136] Despite this, however, imperial masculinity was unable to locate eunuchs within traditional (read: Western) interpretations of gender and this contributed to their marginalization under the Criminal Tribes Act.

Perhaps even more alarming for colonial officials, however, was the threat that eunuchs posed to public space. Eunuchs had an established position within Indian tradition even before the arrival of the British in India. Many took part in public performances as singers and dancers during weddings and celebrations; in Hindu mythology, they were believed to have the power to bless or curse the fertility of others and, as such, they often received charity from people who wished to ward off bad spells.[137] For the British, however, the public presence of eunuchs evoked anxieties about social and moral contagion, not only because they violated gender norms but because

---

[135] Charles Meymott Tidy, *Legal Medicine* (New York: William Wood & Company, 1884), 3: 140.
[136] Jessica Hinchy, "Troubling bodies: 'eunuchs,' masculinity and impotence in colonial North India," *South Asian History and Culture* 4, no. 2 (2013): 202.
[137] Ibid.

they also defiled public space.[138] One traveler passing through the inner city of Lahore, for example, described eunuchs as "hideous" and as "suggestive of the witches who met Macbeth".[139] At a time when British authorities were fixated on the purity and order of public space, eunuch performances were seen as contaminating and polluting; their public singing and dancing was often interpreted as an invitation to unnatural sexual activities that unsettled colonial ideas about proper public and moral conduct. Moreover, their visibility in public places gave obscenity and perversion a public platform. In Lahore, *The Tribune* recounted an incident during the Indian festival of Holi which expressed concerns about such public displays: "We saw the other day at Anarkali a really fine tamasha – a man dressed like an English lady was going from one shop to another making purchases (of course only pretending to do so) after English fashion!"[140] Although the man is not explicitly described as a eunuch, there is an uneasiness about his presence which is apparent in the narrator's description of his actions as a *tamasha*, or disturbance. Here, the cross-dressing man not only transgresses gender binaries, he also inverts the existing boundaries between colonizer and colonized, reinforcing concerns about effective social and government control over deviant bodies.

The City of Dreadful Night

It is evident that a deep-seated colonial preoccupation with the activities of dangerous populations featured prominently in official colonial records. But, there were also more subtle references to their existence in the archive. In fact, one description of the dangerous classes that resided within the walled city of Lahore is by Rudyard Kipling in

---

[138] Ibid., 203.
[139] "Travels in Many Lands: Lahore," 13.
[140] *The Tribune,* November 8, 1884, 6.

"The City of Dreadful Night" (1885).[141] His rendering of the colonial city introduces, albeit briefly, several members of this group - coolies, servants, drivers, shop keeps, entertainers, and fakirs – and exposes an otherwise overlooked side to their lives. Kipling's narrative is unique because it appears to acknowledge the "everyday resistances" of the individuals who inhabited the old city and suggests that they did so with an awareness and understanding that was inaccessible to outsiders. Moreover, despite the seemingly Orientalist framework of his narrative (one that reinforces colonial stereotypes of Old Lahore as squalid and suffocating), Kipling nevertheless reveals an awareness of the constantly shifting and permeable nature of the walled city and its occupants. A close reading of "The City of Dreadful Night" suggests that he sensed the working of Indian agency in ways that colonial officials did not.

Kipling's story follows the narrator on a sleepless night in Lahore where he encounters a diverse community of marginalized individuals that attempts to brave the "dense wet heat" of the summer night.[142] These people made their homes in the unwholesome and bleak inner city where the walled houses "radiat[ed] heat savagely" and the "obscure side gullies" propelled "fetid breezes".[143] On his journey, the narrator

---

[141] There has been some debate about whether the city in this short story refers to Calcutta or Lahore. David Gilmour maintains that the city in question is, in fact, the latter. He explains that the title, "The City of Dreadful Night" was taken from James Thompson's 1874 poem of the same name. Kipling first used the title for his short story on Lahore which was printed in the *Civil and Military Gazette* in 1885. However, he also used the title for a collection of articles about Calcutta that was published in 1888. Both works reflect a preoccupation with death and decay in the old cities of Lahore and Calcutta. The similarities between the two have added to questions about the true subject of the stories. David Gilmour, *The Long Recessional: The Imperial Life of Rudyard Kipling* (New York: Farrar, Straus and Giroux, 2002), 56. For more on Lahore as the subject of "The City of Dreadful Night", see Charles Allen, *Kipling Sahib: India and the Making of Rudyard Kipling 1865-1900* (London: Abacus, 2007), Krishna Dutta, *Calcutta: A Cultural and Literary History* (Oxford: Signal Books, 2003), and Zohreh Sullivan, *Narratives of Empire: The Fictions of Rudyard Kipling* (Cambridge: Cambridge University Press, 1993).

[142] Rudyard Kipling, *Life's Handicap: Being Stories of Mine Own People* (London: Macmillon and Co., 1899), 52.

[143] Ibid., 54.

describes streets littered with "sleeping men who lay like sheeted corpses" and "roof-

tops crammed with men, women, and children."[144] Despite the illusion of peace and

slumber, the "witchery of the moonlight" reveals that the city is restless with people

stirring wearily in the overwhelming heat.[145] He writes:

> Overhead blazed the unwinking eye of the Moon. Darkness gives at least a
> false impression of coolness. It was hard not to believe that the flood of light
> from above was warm. Not so hot as the Sun, but still sickly warm, and heating
> the heavy air beyond what was our due.[146]

Kipling's Lahore expresses an intimate familiarity with suffering and struggle. The

people within the walls seem defenseless against the dirty and heat-tortured city; the

fevered bodies lying exposed in the darkness become a testament to their vulnerability.

The narrator's nighttime journey features a nihilistic vision of Lahore where the boundary

between nightmare and reality has become blurred.[147] The sleeping bodies are likened to

cadavers, neither alive nor dead, while the city itself is imagined as a ravaged space that

cradles the "wreckage of humanity" as it lies exhausted in the night.[148] Lahore is a

wasteland where ruin and destruction thrive and where the people seek in vain for rest. "It

is a compound of all evil savours, animal and vegetable, that a walled city can brew in a

day and a night," writes Kipling.[149] His story, in fact, reports that the relentless and

oppressive environment claims the life of one woman who fails to survive the sweltering

---

[144] Ibid., 52.
[145] Ibid., 53.
[146] Ibid., 52.
[147] Lizzy Welby, "Solar Midnight: Traversing the Abject Borderline State in Rudyard Kipling's 'The City of Dreadful Night'," in *The Domination of Fear: Probing the Boundaries,* ed. Mikko Canini (New York: Rodopi Press, 2010), 150.
[148] Ibid., 156.
[149] Kipling, 54.

heat and noxious air, making it a "city of Death as well as Night".[150] The reality within

the old city, moreover, is much different from what lies beyond the walls:

> A stifling hot blast from the mouth of the Delhi Gate nearly ends my
> resolution of entering the City of Dreadful Night at this hour…The
> temperature within the motionless groves of plantain and orange-trees outside the
> city walls seems chilly by comparison.[151]

Here, the troubled inner city contrasts sharply from the rest of Lahore, reinforcing

the impression that disrepair and desolation belong exclusively to the old city.

But, what is often overlooked is that Kipling's Lahore is also an ambivalent

space. The city of dreadful night - and the people who occupy it – signals a contest

between decline and renewal. Despite the illusion of decay in this "unsettled landscape",

the people of the old city belong there and are part of its natural order.[152] Even in its

darkest depths, where the "heat of a decade of fierce Indian summers is stored", life

continues to move on.[153] On one of the roofs, men speak softly around a guttering hookah

in full blast. Inside a shop, a "stubble-bearded, weary-eyed trader" balances his accounts

while three "sheeted figures" give him company; although the heat inside is almost

unendurable, "work goes on steadily…with the precision of clock-work."[154] Perhaps most

important is the call of the *muezzin,* the minister who summons the faithful to prayer;

although an hour late, he nevertheless arrives at the mosque and proclaims "the creed that

brings men out of their beds at midnight".[155] His "bull-like roar" provides momentary

reprieve from the horrors of the city and defies the landscape of decay; the dawn wind,

---

[150] Ibid., 59.
[151] Ibid., 54.
[152] Roy, 162.
[153] Kipling, 56.
[154] Ibid., 55.
[155] Ibid., 58.

which brings a slight coolness to the atmosphere, "comes up as though the Muezzin summoned it."[156] Finally, there is the narrator himself who, upon reaching the top of a minaret, looks down onto the slumbering city and asks himself: "How do they live down there? What do they think of? When will they awake?"[157] The questions themselves allude to the resilience of the residents and demonstrate that the city will ultimately rouse itself from its delirious and heat-encumbered state. Dawn finally brings an end to the "several weeks of darkness" that envelop the walled city and, with it, comes the "return of life".[158] Indeed, Kipling's narrative reveals that Old Lahore was not a city defined by narrow alleyways, closed gates, or confining walls. Rather, it was a place where people and ideas were constantly in flux and where local identities were shaped in response to cultural, political, and social experiences.

It is important to note that any examination of Kipling must bear in mind his overall ambivalent attitude towards India. Having spent much of his life in the colony, he was simultaneously repelled by and drawn to Indian society, expressing both a fascination with Eastern cultures and peoples as well as a prejudiced and pro-imperial attitude towards the superiority of the white race. B. J. Moore-Gilbert argues that such complicated perceptions were common among the small community of Indian-born British residents that had developed its own distinct identity in India.[159] In confronting the reality of life in the colony, this growing Anglo-Indian group asserted a unique version of 'Orientalism' that struggled with ideas about the ideological, cultural, and

---

[156] Ibid., 59.
[157] Ibid., 58.
[158] Ibid. 59.
[159] B. J. Moore-Gilbert, *Kipling and 'Orientalism'* (New York: St. Martin's, 1986), 5. The term "Anglo-Indian" was generally used in 1840 to refer to the community of British expatriates who worked and lived in India. After the census of 1911, it was used as a category to distinguish individuals of mixed ethnicity (Indian and British) who had hitherto been called half-castes or Eurasians.

social autonomy of its members.[160] After all, as British residents in a country that was, ultimately, an imperial possession, Anglo-Indians often found themselves perceived as neither colonizers nor colonized. It was precisely this conflicting understanding of the Anglo-Indian self that molded Kipling's writings about India. Despite his familiarity with local cultures and languages, his stories convey a sense of him as an outsider and emphasize his existence in a liminal space between Indian and British life.[161] In fact, it was this desire to know India that resonated in works like "The City of Dreadful Night" where a lone man wanders through the streets of Old Lahore at night. Like Kipling, however, this man was an outsider and despite finding himself within the deepest recesses of Indian life, he could never quite comprehend the true nature of his adopted country. It is for this reason that he fails to understand how the urban poor persevered within the dismal space of the inner city, a space that otherwise challenged the logic of the colonial spatial imagination. For although Kipling's protagonist was prone to "forgetting his white blood", the old city did not.[162]

Conclusion

Growing British concerns about public health in the mid to late nineteenth century resulted in the construction of a wholly new landscape for colonial Lahore. Discourses on science and sanitation, in particular, drew attention to the importance of reconstituting the city's geography in order to maintain the health of British troops in the area. However, what began as a solely enclavist project concerned with the maintenance of European health was eventually replaced by a larger sanitary reform movement that focused on the

---

[160] Ibid.
[161] Ahmad M. S. Abu Bakr, "Identity Crisis: Rudyard Kipling's Kim – A Postcolonial Perspective," *Epiphany* no. 3 (2009): 84.
[162] Rudyard Kipling, *Kim* (Toronto and New York: Doubleday, Page & Company, 1922), 308.

well-being of the entire city. By the late nineteenth century, much of Lahore and its inhabitants fell under the regulatory aims of the local government. But, as we have seen, certain areas within the city evaded these measures and, instead, came to challenge the spatial logic of the colonial spatial imagination. The old city, especially, harboured a unique Indian agency with distinct moral, social, and spatial ideals that limited the scope of British intervention in the area. Combined with the everyday resistances of the dangerous populations that inhabited Old Lahore, the dense inner city reflected a resilience that defied colonial attempts at surveillance and regulation.

Chapter 4 – Cholera and the Grotesque Body

<u>Introduction</u>

Punjab was subject to the outbreak of several deadly and recurring epidemics throughout the nineteenth and early twentieth centuries. Between 1875 and 1919, nine major outbreaks of smallpox ravaged twenty-seven districts in the region while cholera accounted for the deaths of nearly 250,000 people between 1866 and 1921.[1] Colonial medical opinion continued to attribute the outbreak of these diseases to the habits and customs of the local people, which often resulted in the adoption of haphazard health measures to suppress the epidemics. In most cases, relief efforts prioritized the material and political interests of the colonial state and its officials and, as we have seen in previous chapters, when information regarding the cause of disease was unclear, public health policies were usually directed against Indians themselves. But new interpretations about health and illness in the late nineteenth century would reshape the way the colonial administration operated in India. In particular, changing ideas about the body produced a unique system of knowledge that redefined the relationship between the British and Indians.

Epidemics often provided a context within which colonizers could assert their authority over the colonized by legitimizing social control over various aspects of native life. While this was certainly true in some respects – Margaret Lock and Vinh-Kim Nguyen, for instance, argue that the reasonable success of biomedical approaches to epidemics in the colonies allowed state officials to claim jurisdiction over individual experiences such as childbirth and fertility – large-scale outbreaks of disease were not

---

[1] Tandon, 218.

always part of a triumphant narrative for colonialism.[2] Epidemics, after all, also disrupted the precarious balance between order and chaos by exposing healthy bodies to diseased space. A closer examination of the colonial archive demonstrates that, at an intellectual level, epidemics roused uncertainty among colonial officials by testing and reshaping social, political, and medical assumptions about the way disease could be suppressed. In fact, discourses of panic and anxiety played an important role in producing colonial knowledge about health in India; epidemics, especially, acted as a reminder that certain factors, external and environmental, were beyond the control of the colonial state. The fact that there was no general medical consensus until much later regarding the origins of disease – this was especially glaring in the debates surrounding miasma and germ theories – only heightened the uncertainty that surrounded epidemics. As we will see, these anxieties often resulted in the imposition of rigid colonial policies that attempted to contain and restrict the bodies of the sick.

With this in mind, it is perhaps valuable to examine the outbreak of epidemics in terms of colonial perceptions of *risk*. Sandhya Polu's study of infectious diseases in colonial India defines the concept as "the potential for suffering harm or incurring unwanted, negative consequences from a hazard, which could be substance, action, or event."[3] Applied to the colonial setting, risk highlights the ways in which certain diseases such as cholera and smallpox shaped government policies in the country. More specifically, it can be argued that public health priorities depended largely on the calculation of risk that particular virulent diseases posed to India's economy, security,

[2] Margaret Lock and Vinh-Kim Nguyen, *An Anthropology of Biomedicine* (Chichester: John Wiley & Sons Ltd., 2010), 146.
[3] Sandhya Polu, *Infectious Disease in India, 1892-1940: Policy-Making and the Perception of Risk* (New York: Palgrave MacMillan, 2012), 6.

and social stability.[4] The British regarded epidemics as disruptive and problematic

events, a view that was reinforced in the late nineteenth century when medical officials

and statisticians began assessing the value of human life in order to calculate losses that

resulted from disease.[5] Ultimately, the objective was to understand the administrative,

institutional, political, and social implications of these losses to the state. In fact, many

official accounts reflected a preoccupation with the damages and deficits incurred by

India's political economy as a result of disease. One government report from 1872 stated:

> …when an epidemic of disease occurs and last for 4, 5 or 6 years and large
> numbers die, the whole conditions of labor in that district become altered by
> the calamity…either labor has to be imported into the villages from a
> neighbouring district and, of course, at an enhanced rate, or those who have
> survived the epidemic obtain the benefit of higher wages…[6]

Similarly, maintaining the health of British troops remained a top priority for colonial

administrators who believed that keeping soldiers in a "more efficient condition" was

vital for saving the state "enormous expense."[7] Thus, government interest in the

consequences of epidemic diseases was important for determining what course of action

would be taken to minimize or remove risk.

    This epidemiological understanding of disease created a deep-seated colonial

urgency to assert control over epidemic outbreaks before they threatened British

investments in India. An emphasis on statistical evidence, in particular, had been gaining

ground in the metropole since the 1840s, producing calls for a more systematic collection

---

[4] Ibid., 3.
[5] Ibid., 8.
[6] G. Saunders, "Extract from a Report by Deputy Inspector-General G. Saunders - May 1872," in *Selections from the Records of the Bengal Government irrigation Department: Papers from 1865 to 1893 Regarding the Eden Canal* (Calcutta: Bengal Secretariat Press, 1893), 85.
[7] Government of India, *Report on Measures Adopted for Sanitary Improvements in India,* 220.

of information that could be used to improve and reform society.[8] Statistics offered the

kind of data that officials relied on to legitimize and consolidate their decisions,

especially because they offered a seemingly objective means of accumulating

knowledge.[9] As such, it was no surprise that epidemiology and colonial health policies

were shaped heavily by such methodologies; statistical data related to disease and

mortality became instrumental in justifying state intervention into public health.

However, the colonial approach towards subduing epidemics was never consistent or

fixed. In fact, different diseases were subject to various levels of scrutiny and interest,

demonstrating that the British management of outbreaks was motivated by specific

concerns. As the following discussion of cholera will illustrate, colonial motivations for

regulating epidemics in India depended largely on the uncertainty and alarm the disease

provoked among medical professionals and the general public (both Indian and British).[10]

Cholera, specifically, was a disease that was defined by its dramatic intensity as well as

by its seemingly arbitrary and random nature. Its visible assault on the body spurred

changing interpretations of and responses to outbreaks of the disease. It was unique,

therefore, because it reshaped medical readings of human ecology by rousing concerns

about the vulnerability of the body. This way, a study of cholera offers critical insight

into the way the disease came to redefine colonial perceptions of public health

management in the Punjab.

---

[8] U. Kalpagam, *Rule by Numbers: Governmentality in Colonial India* (New York and London: Lexington Books, 2014), 20.
[9] Ibid., 16-17.
[10] Charles Rosenberg, *Explaining Epidemics and Other Studies in the History of Medicine* (Cambridge: Cambridge University Press, 1992), 279.

<u>The Outbreak of Cholera</u>

India witnessed its first cholera epidemic of the nineteenth century in 1817. Although this round of the disease lasted four years, the colonial archive offers few reliable statistics to confirm the number of deaths from the epidemic.[11] One estimate was provided in 1831 by a French doctor, Moreau de Jonnes, who reported that one sixteenth of the population of British India was killed by cholera in the early nineteenth century (this averaged to 1,125,000 deaths a year).[12] However, David Arnold argues that this number was likely inflated by the alarm the disease generated in Europe at the time.[13] Christopher Hamlin, for instance, suggests that the average annual mortality rate was likely closer to a few hundred thousand; later in the century, between 1887 and 1896, he estimates that close to 429,000 people died of cholera each year in India.[14] In Lahore, the first cholera epidemic was recorded in 1831 and was followed by violent flare-ups every five to ten years throughout the nineteenth century.[15] On August 6, 1861, for example, an outbreak in Lahore and Mian Mir killed more than half the soldiers from the cantonment who were struck by the disease (261 out of 457).[16] One report detailed the dismal state of the city during the height of this epidemic, describing soldiers as "panic-stricken" and "hopeless" while their comrades succumbed to the disease.[17] Another report recounting an outbreak in 1881 revealed that 772 cases of cholera occurred in Lahore in that year

---

[11] This was likely because of large-scale disturbances in India such as the Pindari War between the British East India Company and the Maratha Empire.

[12] David Arnold, "Cholera and Colonialism in British India," *Past & Present* no. 113 (1986): 120.

[13] Ibid.

[14] Christopher Hamlin, *Cholera: The Biography* (Oxford: Oxford University Press, 2009), 3.

[15] *Cholera Epidemic of 1861 in Northern India,* 21.

[16] Ibid.

[17] Ibid., 19.

alone.[18] Over the next several decades, Lahore and Mian Mir were continually subjected to the disease, and over the course of thirty years, 2,638 cases of cholera were reported in official government records.[19] During this time, however, authorities noted that mortality rates varied throughout different times of the year. One medical journal from 1887, for instance, reported that "the period of maximum intensity of cholera in Lahore is said to be the month of August, and the minimum in the month of April."[20] Similar observations were also made in other parts of India such as the Central Provinces, Berar, and Bengal where the highest incidences of cholera (usually in July and August) corresponded with the heaviest rainfall of the year.[21] This knowledge reinforced the idea that local and seasonal conditions shaped mortality statistics for cholera in the country. Nevertheless, there was no certainty about when and how the disease would strike.

Despite the overwhelming number of deaths related to the disease, cholera "was not an immoderate killer", especially when measured against other diseases.[22] In fact, between 1890 and 1921, malaria claimed nearly 20 million lives in India and, during particularly bad epidemics, caused an average of 1 million deaths a year.[23] On the contrary, cholera was responsible for 365,000 deaths between 1875 and 1877 and 580,000 people died from the disease during a particularly virulent season in 1891; only in 1900, during its worst year on record, did cholera claim nearly as many lives (800,000)

---

[18] Government of Punjab, *Gazetteer of the Lahore District 1883-4* (Lahore: Sang-e-Meel Publications, 1989), 9.

[19] William Aitkin, A. E. Brown, and G. E. Dobson, ed., *Physiological and Pathological Researches; Being a Reprint of the Principal Scientific Writings of the Late T. R. Lewis* (London: Lewis Memorial Committee, 1888), 282.

[20] "On Cholera," *The British Medical Journal,* October 8, 1887.

[21] Andrew Davidson, *Geographical Pathology: An Inquiry into the Geographical Distribution of Infective and Climatic Disease* (New York: D. Appleton & Co., 1892), 437-438.

[22] Arnold, "Cholera and Colonialism", 123.

[23] Nandini Bhattacharya, "The Logic of Location: Malaria Research in Colonial India, Darjeeling and Duars, 1900–30," *Medical History* 55, no. 2 (2011): 186.

as malaria in one year.[24] Despite this, official colonial records reveal a persistent preoccupation with the examination of cholera outbreaks in India.[25] One commentator described the disease:

> [C]holera is the most terrible scourge of India…[it] is a demon that walks in silence and darkness, and that spares no rank or age. Its doomed victims, although dreading, are unconscious of its approach, till it lays its hand on them and strikes them down."[26]

Other reports in the colonial archive expressed regular concerns with the nature, origins, and potency of the disease with public health policies calling for quick and efficient measures to combat cholera through sanitary reform. Special inquiries into the disease were made in 1861, 1867, 1875, 1885 and 1890 – these were among a few - and offered careful observations into the movement and prevalence of cholera epidemics.

Why, though, did the disease garner so much public attention despite the incidence of other epidemic outbreaks? For one thing, cholera was associated almost inextricably with death. Unlike other diseases, such as smallpox from which individuals could potentially recover and develop immunity, cholera killed at least fifty percent of the time.[27] The disease was deemed so virulent that many contemporary health officials observed that it could cause death "within a few hours after seizure".[28] But another reason for the colonial preoccupation with the disease was that India came to be widely accepted and recognized by many contemporary medical professionals as the home of malignant cholera. This idea was influenced largely by the work of two high-ranking

---

[24] George Childs Kohn, ed. *Encyclopedia of Plague and Pestilence From Ancient Times to the Present,* 3rd ed. (New York: Facts on File Inc., 2008), 173-174.

[25] Polu, 12.

[26] *Everyday Life in South India* (Piccadilly: The Religious Tract Society, 1885), 42.

[27] Alfred Stille, *Cholera: Its Origin, History, Causation, Symptoms, Lesions, Prevention, and Treatment* (Philadelphia: Lea Brothers and Co., 1885), 64-65.

[28] Sir Joseph Fayrer, "Croonian Lectures on Climate and Fevers of India," *The British Medical Journal,* April 22, 1882, 490.

contemporary physicians, John Macpherson and N. Charles Macnamara.[29] While they

admitted that a cholera-like disease had existed in Europe for centuries, they attributed

these outbreaks to a benign illness known as 'cholera nostras' (described as simple

diarrhea).[30] By distinguishing this form of the disease from the deadly Asiatic cholera

that ravaged British India, Macpherson and Macnamara persuasively established the

latter as endemic to India.[31] Officials now worried that the disease would never die out

and could appear in its epidemic form at any given time, during any season, and without

warning. Asiatic cholera, therefore, was identified as a disease that followed little logic or

coherent patterns and became recognized for requiring continued government attention.

Many contemporaries even alluded to the "veil of mystery" that enshrouded the disease

and called for more systematic studies into understanding its behaviour.[32] The elusive and

inconsistent nature of cholera meant that Indians and British alike were susceptible to its

effects. Although the poor sometimes appeared more likely to contract the disease

because of their unhealthy living conditions, the death of high profile figures such as Sir

Thomas Munro, the governor of Madras, served as a reminder that the disease did not

discriminate in selecting its victims.[33]

The quick and violent nature of cholera also raised questions about the

epidemiological security of the colony. The fact that the disease seemed to attack most

violently at times when famine was rife and resistance was low – this was the case in

---

[29] Hamlin, 45-48.
[30] Ibid., 48.
[31] Even today, many historians remain uncertain about where cholera originated. Hamlin himself proposes several possibilities: 1) cholera was indigenous to India and spread to the rest of the world through commerce and colonialism 2) a new strain of the disease originated in India, specifically Bengal, in the eighteenth century 3) Europeans brought cholera to Asia. Hamlin, 46-51.
[32] Bellew, *The History of Cholera in India from 1862 to 1881,* 589.
[33] David Arnold, "Cholera and Colonialism," 123.

Madras and Bombay in 1877, for example – only reinforced colonial anxieties about the devastating effects of cholera.[34] After all, the simultaneous occurrence of two highly destructive events – famine, for example, claimed the lives of 800,000 people in north and west India between 1876 and 1878 - resulted in excess mortality and compelled colonial authorities to fight the battle against death on two different fronts.[35] However, uncertainty about the way the disease was transmitted meant that the colonial state's policies regarding cholera remained ambivalent (at least until Robert Koch's discovery of the cholera vibrio in 1883). The skepticism about the origins of the disease, moreover, existed despite the connection between cholera and impure water that had already been drawn by John Snow and John Simon in the mid nineteenth century. After all, as we saw earlier, debates between colonial officials like J. M. Cuningham (who advanced an atmospheric model for the disease) and A. C. DeRenzy (who supported the waterborne theory for cholera) prevented the administration from reaching a general consensus about managing the disease. Even the report of an international sanitary conference in 1866, which stressed the role of human agency in the propagation of cholera, did not convince medical professionals about the contagious nature of the disease.[36] At the time, perhaps the closest to recognizing the infectious nature of cholera was John Murray who published a report on the disease in 1869. However, even his work remained markedly ambivalent:

> There is abundant concurrent evidence that contact with the evacuations from cholera patients…have been followed by attacks of the disease…In some instances the poison appears to have been inhaled from the atmosphere into

---

[34] Ibid., 125.
[35] Dharma Kumar, ed. *The Cambridge Economic History of India, 1757-1970,* vol. 2 (Cambridge: Cambridge University Press, 1983), 492-493.
[36] David Arnold, "Cholera and Colonialism," 143-144.

the lungs...[37]

The general consensus, it appeared, overwhelmingly favoured factors like geography and

climate as the leading cause of the disease. In fact, as late as 1885, Henry Walter

Bellew's *History of Cholera in India* reported:

> …we have no evidence of a conclusive kind that cholera spreads by
> contagion. On the contrary, the tendency of all the evidence furnished by the
> deportment of the disease in India…is most clearly to negative this
> idea...[38]

This widespread anti-contagionist outlook contributed to the colonial government's

fragmented intervention of the spread of disease in India. After all, for the proponents of

this view (shaped invariably by Macpherson and Macnamara), cholera was a distinctly

Indian disease that originated in the country as a result of its peculiar climate and

required specific measures to eradicate completely.

Cholera as Ideological Disorder: The Chaotic and Grotesque Body

For many scholars of colonial public health, diseases like cholera evoked colonial

anxieties about how health-related policies impacted the general running of the colonial

administrative and military structures. As such, they highlight the importance of

examining epidemic diseases as a crisis of colonial political rule and economic and social

stability. Like Sandhya Polu's study on infectious diseases and the colonial perception of

risk, Nandini Bhattacharya, Prashant Kidambi, and Mridula Ramanna have all addressed

the role of disease in shaping colonial policies, urban municipal concerns, and military

---

[37] John Murray, *The Treatment of Epidemic Cholera* (Calcutta: Office of Superintendent of Government Printing, 1869), 4.
[38] Bellew, 828.

priorities in the country.[39] For them, cholera was a highly politicized disease that had the potential to threaten Britain's colonial hold in India, particularly because it emerged at a time when medicine and epidemiology intersected with the objectives of the Empire.[40] Similarly, David Arnold's seminal work on cholera has examined the cultural implications of the disease in colonial India.[41] Here, he has uncovered a widespread Hindu belief that suggested the British were in some way responsible for cholera outbreaks in India because they violated moral and religious laws; the slaughter of cows to feed British soldiers and the pollution of sacred tanks in villages occupied by low caste soldiers were thought to evoke divine displeasure.[42] At least for some Indians, then, the origins of the disease could be traced to the British disregard for local religious taboos, leading state officials to worry that the alarm generated by virulent outbreaks of the disease would incite Indian resistance to foreign rule.

But moving beyond these studies allows us to consider another factor that has been less explored in the field of colonial medical history: the diseased body as a symbol of disorder. Particularly with the pioneering work of Louis Pasteur and Robert Koch who identified microbes as the leading cause of disease, a newfound suspicion of the body of the sick began to develop within contemporary medical discourses.[43] Unlike malaria, for instance, which was recognized as being spread by the anopheles mosquito under specific climatic conditions, bacteria that caused diseases such as cholera and smallpox were

---

[39] Nandini Bhattacharya, *Contagion and Enclaves: Tropical Medicine in Colonial India* (Liverpool: Liverpool University Press, 2012), 5; Kidambi, 32; Ramanna, 4.
[40] Kidambi, 9.
[41] Arnold, *Colonizing the Body,* 171-172.
[42] Ibid.
[43] Tony Ballantyne and Antoinette Burton, "Introduction: Bodies, Empires, and World," in *Bodies in Contact: Rethinking Colonial Encounters in World History,* ed. Tony Ballantyne and Antoinette Burton (Durham and London: Duke University Press, 2005), 7.

eventually accepted as living inside the body. As a result, illness was suddenly recognized, in some cases, as being transmitted between individuals without the influence of external factors like the environment.[44] The greatest implication of this development in the field of biomedical science was that the study of disease prevention and control expanded beyond an examination of India's climate and environment. Now, new ideas about a "grotesque" and diseased body that threatened to create disorder in society through contamination became part of public health discourses.

More specifically, it was the institutionalization of bacteriology in India by the 1890s – prompted by the establishment of several research laboratories in the colony – that led the body to be imagined as intrinsically inclined towards producing disease. With the concept of "germs" came the realization that the body was always in imminent danger of playing host to these dangerous agents; after all, medicine had redefined the functioning of the human body in ways that reinforced its fragility and mortality. These developments, in turn, saw the emergence of a new relationship between the body, disease, and filth that was fixated on the act of cleaning and sanitizing the self in order to protect against disease. However, as we will see, ideas about what constituted a healthy body had already shifted, and with this came new expectations for the field of medicine that could not always be fulfilled. Cholera, in particular, cultivated a unique understanding of the diseased body as well as the experience of illness that played a critical role in determining the way health professionals conceptualized the outbreak of epidemics.

---

[44] Polu, 12-13.

To understand this nineteenth-century re-imagination of the human body, it is useful to consider Mikhail Bakhtin's conceptualization of the "grotesque body".[45] In his study of Francois Rabelais' work, Bakhtin used the grotesque body as a literary trope to represent the cycle of life, placing particular emphasis on a transformative body that was simultaneously connected to birth and renewal as well as to death and decay.[46] More specifically, Bakhtin defined the grotesque body as visible, penetrative, and permeable, and as allowing potentially dangerous and impure substances to enter within; an emphasis was also placed on the body's ability to produce degrading material (urine, feces, semen) through its openings, particularly from its lower stratum.[47] This way, the grotesque body - associated with abhorrent bodily fluids and the failure to contain them within – can be intimately connected to what Julia Kristeva has referred to as "abjection".[48] Described as a process by which individuals dissociate themselves from things they deem repulsive or which otherwise undermine their sense of certainty, abjection alludes to a violation of the boundaries and limitations of one's selfhood.[49] Kristeva, therefore, contends that it is not a "lack of cleanliness or health that causes abjection but what disturbs identity, system, order."[50] With this in mind, the choleric body can be regarded as both grotesque and abject because its ambiguous limits (i.e. its excretion of waste and fluid from multiple orifices) repeatedly disrupted the borders of the physical body.[51] Indeed, as a product of

---

[45] Mikhail Bakhtin, *Rabelais and His World*, trans. Helene Iswolsky (Bloomington: Indiana University Press, 1984), 317-318.
[46] Ibid.
[47] Ibid., 309.
[48] Julia Kristeva, *Powers of Horror: An Essay on Abjection,* trans. Leon S. Roudiez (New York: Columbia University Press, 1982), 2-3.
[49] Ibid.
[50] Ibid., 4.
[51] Ibid.

distorted and exaggerated parts, the body of the cholera patient transgressed its own

natural limits to create disorder and imbalance [read: disease] within itself.[52]

The establishment of cholera as a grotesque disease was shaped primarily by the

way its symptoms presented.[53] Even when the disease first appeared in colonial medical

records in 1819, it was considered particularly destructive because of how quickly and

unpredictably it struck its victims.[54] Although similar apprehensions about cholera

existed in Europe as well, the fear evoked by the disease in the colony was bolstered by

the continued belief that cholera was endemic to India. Even with the establishment of

germ theory, medical officials asserted that the cholera bacterium relied on distinct

atmospheric and environmental conditions (such as tropical climates and stagnant water)

to become contagious.[55] Once infected, an otherwise healthy individual was taken

suddenly by uncontrollable vomiting and diarrhea that, in turn, produced other alarming

side effects such as painful muscle cramps, cold, clammy skin and insatiable thirst. One

report on cholera from 1885 described the intense symptoms of the disease:

> …usually the attack begins with diarrhea and vomiting…which then assume,
> more or less rapidly, a high degree of violence, expressed by their frequency
> and excess…[liquid] is poured forth less by an ordinary act of vomiting than
> by gushes, as if it overflowed from the throat and mouth; and it often escapes
> from the stomach and the bowels at the same instant…Sometimes a
> distressing hiccough accompanies these symptoms. It is indeed only one of
> many spasms which may affect the muscular system…The pain they produce
> is extremely severe…As the attack advances the patient falls into a dull, listless,
> and motionless state, which may be mistaken for insensibility or even
> unconsciousness, but is really due to exhaustion of all the faculties of mind

---

[52] Bakhtin, 320.

[53] Similar observations were also made about yellow fever which the Spanish referred to as *vomito negro* for the large quantities of black vomit (digested blood) that patients expelled in the last stages of the disease. Rodrigo Fernos, *Medicine and International Relations in the Caribbean: Some Historical Variants* (New York: iUniverse, Inc., 2006), 72.

[54] David Arnold, *Colonizing the Body,* 159.

[55] Pratik Chakrabarti, "Curing Cholera: Pathogens, Places and Poverty in South Asia," *International Journal of South Asian Studies* 3 (2010): 155.

and body.[56]

Death often occurred within hours of the first bout of sickness, leaving health officials baffled by the randomness and irregularity of the disease.[57] This was unlike other diseases such as malaria and smallpox which could take several weeks, or even months, before claiming the life of the sick. Malaria, especially, often caused lasting debility as a result of increased susceptibility to acute infections like diarrhea, anemia, or pneumonia before resulting in death. As such, compared to other diseases, the rapid decline that characterized cholera drew considerable attention from medical officials.

In particular, it was the uncontrollable and frequent emptying of the body's digestive contents that made cholera such a dramatic disease. Most nineteenth-century commentators, in fact, were shocked by the sheer amount of bodily fluid that was expelled during the course of the illness. Many medical professionals described the "excessive purging" and "copious discharges" as exhausting the patient to the point of collapse.[58] It was this association with the body's orifices (and what was emitted from them) that was critical to the identity of the grotesque body. The uncontained bodily fluids represented an internal chaos that disrupted the boundary between the internal and the external and, thereby, framed the choleric body as a grotesque site.[59] The disease pushed forth excess matter that was, by nature, supposed to remain within but was, instead, expelled outside the body as impurity. One article in the *Indian Medical Gazette* (1873) reported: "It is astonishing the quantity of fluid that passes from the patient…You

---

[56] Stille, 64-65.

[57] Chakrabarti, 160.

[58] Norman Chevers, "Practical Notes on the Ordinary Diseases of India, Especially Those Prevalent in Bengal," *The Medical Times and Gazette* (London: J. & A. Churchill, 1883): 208.

[59] Francette Pacteau, "Dark Continent" in *With Other Eyes: Looking at Race and Gender in Visual Culture,* ed. Lisa Bloom (Minneapolis: University of Minnesota Press, 1999), 92.

cannot collect vessels enough together at the moment (even if plentifully provided) to

contain the evacuations."[60] By externalizing itself, the body's inner turmoil became a

form of "contagious symbolic disorder" that threatened to pollute the sanitized space of

the colonial imagination.[61] After all, the grotesque body's lack of control over the abject

made it impossible for any space it occupied to remain uncontaminated and, therefore,

prevented clear boundaries from existing between clean and unclean, proper and

improper.[62]

Cholera, moreover, reproduced anxieties about bodily control by eliminating the

patient's ability to participate in civilized culture. The "dirty and disgusting" evacuations

of a person stricken with the disease were an affront to the characteristics of the model

body that dominated colonial discourses at the time: restraint, control, and balance.[63]

Influenced considerably by Victorian notions of discipline and cleanliness, this ideal

body represented one's social and moral status in the community. As one contemporary

writer maintained, "bodily and social cleanliness [were] an essential mark of

civilization."[64] Cholera, however, denied individuals their place in civilized society by

condemning the body to a state of fragility and by inflicting a violence upon it that forced

it to transgress its natural limits. In expelling waste from within, the disease emptied the

body of contents that were considered unpleasant and even shameful, allowing filth that

---

[60] L. Boehm, "Cholera," *Indian Medical Gazette,* ed. C. Macnamara & K. McLeod (Calcutta: Wyman and Co., 1873), 220.

[61] Pacteau, 92.

[62] Ibid., 92-93.

[63] "Conveyance of Contagion by Flies," *The Medical Press and Circular*, September 8, 1875, 188.

[64] Jan Helenus Ferguson, *The Philosophy of Civilization: A Sociological Study* (London: W. B. Whittingham & Co., 1889), 232.

was meant to be concealed within the body to expose itself on the outside.[65] This way, cholera broke through the barriers of privacy and discretion and made illness a public event. In particular, the profuse voiding of the bowels, oftentimes directly onto the bedding, marked a departure from "civilized" bodies that were characterized by discipline and restraint. Edward Shakespeare, for example, reported that "cholera patients are constantly soiling the floor and beds with their evacuations..."[66] Here, the stained linen of the patient became a visible sign of their internal filth, blatantly exposed in the presence of respectable people.

The discharge of bodily waste meant that individuals also expelled a part of themselves and, consequently, distorted their social, physical, and emotional identities. It was precisely this alteration of the self and the lack of respect for limits, rules, and order that made the diseased body so abject.[67] Sapped of its virility, the choleric body was a figment of its former self; the coherence and unity that normally existed between the individual and their body became fractured by the disease. This presented a real threat to the illusion of stability that was otherwise exhibited by a healthy body.[68] *A Treatise on Asiatic Cholera* (1885), for example, described the patient's countenance as "frightfully distorted" and reported that the individual became "so wasted and shrunken that all identity of person [was] obscured or obliterated."[69] Similarly, a medical journal describing the disease maintained that the "frequent, profuse, watery discharges" that

---

[65] Pamela K. Gilbert, *Cholera and Nation: Doctoring the Social Body in Victorian England* (New York: State University of New York Press, 2008), 93.

[66] Edward Shakespeare, *Report on Cholera in Europe and India* (Washington: Government Printing Office, 1890), 508.

[67] Kristeva, 4.

[68] Laura E. Tanner, *Lost Bodies: Inhabiting the Borders of Life and Death* (Ithaca and London: Cornell University Press, 2006), 30.

[69] Edmund Charles Wendt, ed., *A Treatise on Asiatic Cholera* (New York: William Wood and Company, 1885), 225, 226.

characterized Asiatic cholera "so change[d] the patient, by shriveling and shrinking of the cutaneous surface, as to render it almost unrecognizable."[70] Also alarming was that "[u]nder all these bodily sufferings the mind remain[ed] collected and sensible to the last."[71] As such, the individual's awareness of their ordeal ultimately dislocated them from their subjective self by making their own body repulsive. This way, cholera reduced human existence to body materiality and, more specifically, to the excretions produced by the body.

Although the violence with which cholera inflicted itself on the individual while they were alive was certainly shocking, the body on the verge of death was another visibly disturbing event. Here, the victim was positioned on a boundary between life and death, reflecting perhaps the most marked characteristic of the grotesque body: its limitlessness. That is, even on the brink of death, the grotesque body brandished its deformities and displayed no bounds.[72] Severe dehydration shriveled the skin and turned it to a dark blue colour while the eyes sunk into the face and the teeth protruded outside the mouth.[73] The pale, cold body and shriveled facial features mimicked death while the victim was still alive and, thereby, upset the boundaries that distinguished the living from the dead.[74] The corpse-like condition of the body even led to hasty burials despite signs of life, a practice that stemmed from the widespread belief that the decomposing body

---

[70] M. H. Jordan, "Infantile Diarrhea," *Transactions of the Medical Association of the State of Alabama* (Montgomery: Barrett & Brown, 1877), 169.
[71] Whitelaw Ainslie et al., *Historical and Descriptive Account of British India, From the Most Remote Period to the Present Time* (New York: J. & J. Harper, 1832), 3: 274.
[72] Gilbert, 104.
[73] Ibid.
[74] Ibid.

was a danger to public health.[75] In fact, contemporary reporters often commented on the fickle nature of the disease because there was no guarantee that a victim close to death would die or that a patient on the path to recovery would live. One treatise on cholera, for instance, stated:

> …even when the patient seems already quite out of danger, the confident promise of his recovery may be turned to utter hopelessness by a speedy return of former symptoms. Once more the fickleness of the disease, as we feel tempted to call this characteristic of cholera, appears in all its delusive uncertainty.[76]

Thus, the unpredictability that characterized cholera evoked ideas about the destruction and deterioration of not just the material body but also individual identity.

In death, the body was subjected to even more physical degradation. In some cases, muscle convulsions forced the arms and legs of the corpse to jerk sharply for up to an hour after the victim succumbed to the disease, leading those standing nearby to believe they were still alive.[77] In his *Manual of the Diseases of India* (1886), William James Moore described this unnerving phenomenon:

> After death a remarkable contraction of voluntary muscles sometimes occurs, which has led to stories of persons being removed to the dead-house while yet alive. These spasmodic contractions are due to post-mortem relaxation of arteries and flow of blood.[78]

Muscle movements varied from "flickering and tremulous undulations…to contractions sufficiently powerful to move the limbs from their position, or even to displace the body itself."[79] While such spontaneous spasms after death were not uncommon – they were reported in cases of other diseases such as tetanus – the suddenness with which cholera

---

[75] Alexander Charles MacLeod, *Alcoholic Diseases; Comprising Jaundice, Diarrhoea, Dysentery, and Cholera* (London: John Churchill and Sons, 1866), 204-205.
[76] Wendt, 226.
[77] Watts, 173.
[78] Moore, *Manual of the Diseases of India*, 120.
[79] John Chapman, *Diarrhea and Cholera: Their Nature, Origin and Treatment through the Agency of the Nervous System* (London: Turner & Co., 1866), 76.

patients transitioned from healthy to sick and, in most cases, to death added an element of

shock to the disease. It was precisely this rapid decline of the body that made it difficult

to believe that the patient was in fact dead; their fits of convulsion often convinced

witnesses that the individual was still alive. Moreover, cholera corpses retained heat after

death, adding to the illusion of life despite all other signs of death.[80] In one reported case,

the body's temperature rose to 113° F fifteen minutes after the individual reportedly

died.[81] Similarly, a medical treatise on cholera noted:

> The temperature of the body rises immediately after death, and continues to rise
> for a considerable time; or if it does not rise the body retains its heat an unusually
> long time.[82]

Evidently, the grotesque body embraced its demise, rendering it more dangerous than

other unhealthy bodies. In accepting death, bodies impacted by cholera became a symbol

of pollution, both physical (through fear of contamination by the diseased body) and

symbolic (from fear of bodily decay).[83] These corpses, with their unstable boundaries and

ambivalent nature, had no place within dominant medical models of the body.[84]

The figure of the grotesque and abject body demonstrates why cholera was

particularly alarming for colonial officials. Its striking assault on the individual

undermined the notions of order and regularity that colonial health discourses attempted

to uphold. As such, cholera was defined as a disease of disorder. It not only signaled fears

about social and political dissolution – as David Arnold asserts, Indians often associated

the disease with foreign rule and conquest – it also altered perceptions of the human body

---

[80] Watts, 173.

[81] L. Salzer, *Lectures on Cholera and Its Homeopathic Treatment* (Calcutta: Berigny & Co., 1883), 26.

[82] Chapman, 75.

[83] Elizabeth Hallam, Jenny Hockey, and Glennys Howart, *Beyond the Body: Death and Social Identity* (London and New York: Routledge, 1999), 127, 128.

[84] Ibid., 128.

in ways that revealed its limitations.[85] Any visible sign of cholera aroused concerns about

the body's capacity to spread infection as well as its susceptibility to physical

disintegration. Therefore, the urgency that surrounded the disease reinforced anxieties

about the fragile nature of the human body. In fact, contemporary reports about cholera

often expressed these apprehensions in a language that emphasized the vulnerability of

the body in the face of disease. For instance, one account by a former surgeon to the East

India Company stated: "Every time [the patient] was purged his pulse would sink, and he

would have a spell of cramps in his feet and legs, and get bewildered, and stagger like a

drunken man, or fall down like a helpless child."[86] Similarly, another report described a

patient "[lying] in a state of helpless exhaustion" as he struggled in vain to combat the

disease.[87] This awareness of the limits of the human body convinced many officials that it

was only through legislative control and regulation – particularly those focused on

overseeing and containing the body - that the disruptive nature of the grotesque body

could be reconciled.

Colonial Policies – Regulating the Choleric Body

      The colonial belief that cholera was endemic to India convinced officials that

persistent outbreaks of the disease required their constant and urgent attention. After all,

the preservation of public health had been deemed a fundamental responsibility of the

state and, as such, the implementation of large-scale strategies to combat the disease was

---

[85] David Arnold, "Cholera and Colonialism," 134.

[86] *Epidemic Cholera: Its Mission and Mystery, Haunts and Havocs, Pathology and Treatment* (New York: Carleton, 1866), 23.

[87] Ainslie, 274.

not unexpected.[88] But, despite the seemingly organized efforts of administrators to mobilize against epidemic cholera, colonial regulations concerning the disease were neither uniform nor consistent. As with the regulation of other virulent diseases, disagreements among officials at different levels of government limited the scope of cholera policies in India. These measures were further complicated by changing ideas within the medical field which dictated the way officials responded to outbreaks. Early cholera efforts, for instance, were largely preoccupied with the significance of urban infrastructures and geographic space. In Lahore, as we saw earlier, this was evident in the establishment of a new public works system that became the first tangible means for checking the spread of the disease in the city. Here, the waterborne theory for cholera (backed by officials such as DeRenzy) resulted in key changes to the city's urban landscape in order to ensure clean drinking water for its residents. The development of the sanitary reform movement in Lahore further reinforced the importance of an efficient drainage and sewage system for the city, especially one that would withstand the "horribly filthy" habits of the Indian people.[89]

But, while ideas about urban reform were the foundation for cholera policies in Lahore (at least until the late 1870s), officials in the city did not always present a unified front in the overall management of the disease. In fact, more often than not, the local government betrayed its apprehensions about epidemic cholera by demonstrating that there was very little consensus on what specific measures would be most successful in eradicating the disease. Before the widespread acceptance of germ theory in the 1880s,

---

[88] Paul Slack, introduction to *Epidemics and Ideas: Essays on the Historical Perception of Pestilence,* ed. Terence Ranger and Paul Slack (Cambridge: Cambridge University Press, 1992), 12.
[89] James G. Wakley, ed., *The Lancet,* vol. 3 (London: John James Croft, 1876), 64.

for instance, general observations on cholera convinced some medical authorities that

isolating the sick – whose bodies supposedly emitted the cholera "poison" into the

atmosphere – was the most effective way of preventing the disease from spreading. The

move towards the creation of these *cordons sanitaires* to separate the sick from the

healthy was shaped in part by the British effort to contain epidemic outbreaks within

specific spaces. One supporter of isolation, for instance, stated:

> Whether the germs of cholera are in the air, in the water, or in food, or in all,
> it is now sufficiently proved that isolation…is the one great means of
> arresting the disease.[90]

For this reason, during an outbreak in Lahore in 1867, those infected with the disease

were confined to camps outside the city.[91] Authorities also called for the construction of

enclosure walls around specific sites where cholera victims were buried and warned the

public against visiting places that had recently been occupied by patients.[92] Officials

maintained that such "buildings and camping grounds [were] in many instances followed

by attacks of the disease."[93] However, the belief in isolating the sick and the dead was not

shared by everyone; Cuningham, who espoused traditional sanitarian ideals, argued that

quarantine and isolation were "costly", "inefficient", "productive of much social misery",

and "powerless to effect any good".[94] For him, cholera poison did not emanate from

within the individual but originated as a result of filth which then gave rise to miasmas.[95]

In his reports, he warned that isolating and removing the sick excited alarm among the

public – a cause of cholera in and of itself – and exposed troops and others on cordon

---

[90] Iltudus Thomas Prichard, *The Administration of India From 1859-1868: The First Ten Years of Administration Under the Crown* (London: MacMillan and Co., 1869), 2: 284-285.
[91] Tandon, 91, 97.
[92] Murray, 7.
[93] Henry Blanc, *Cholera: How to Avoid and Treat it* (London: Henry S. King & Co., 1873), 27.
[94] Cuningham, 82.
[95] Ibid.

duty to exhaustion.[96] Worst of all, he maintained, isolation lulled people into a false and fatal sense of security by making them believe that the disease was static and could be contained within remote spaces.[97]

Other disagreements between officials concerning the management of cholera became apparent once connections between the disease and religious pilgrimages were suspected. In 1867, medical authorities noted a significant spike in the outbreak of disease along the pilgrim routes of northern India following the Hardwar *kumbh mela,* a mass Hindu pilgrimage held every twelve years.[98] While the source of the epidemic was debated, officials worried that human agency was a determining factor. More specifically, the British suspected that pilgrims had facilitated the spread of the disease by bringing back cholera-infected water for relatives to drink from the sacred Ganges River.[99] Although the waterborne theory for cholera was only just beginning to establish itself within mainstream medical discourses, colonial suspicions about the role of unsanitary water in generating disease nevertheless drew their attention towards Indian religious culture. To combat the ensuing epidemic, marriage processions and fairs in the Punjab were prohibited while customary feasts were banned altogether.[100] As well, pilgrims returning from the *kumbh mela* were detained in quarantine camps for up to five days where they were compelled to bathe and have their clothes fumigated before being allowed back into their villages and towns.[101] Once again, however, the reality of these measures on the ground resulted in fierce debates among contemporaries about the merits

---

[96] Government of India, *Report on Sanitary Measures in India in 1875-76,* 175.
[97] Ibid.
[98] Gyan Prakash, "Body Politic in Colonial India," in *Questions of Modernity,* ed. Timothy Mitchell (London and Minneapolis: University of Minnesota Press, 2000), 200-201.
[99] Ibid.
[100] Tandon, 97-98.
[101] Gyan Prakash, "Body Politic in Colonial India," 201.

of limiting the free movement of people. One commentator writing in response to the Hardwar epidemic argued: "A quarantine which is ineffective is a mere irrational derangement of commerce; and a quarantine of the kind which ensures success is more easily imagined than realized."[102] Others contended that quarantine camps became an obstacle in the free communication between different districts and were ultimately powerless to arrest the spread of epidemic cholera.[103]

The limited success of measures such as isolation and the restriction of individuals to quarantine camps served as a reminder that it was impossible to control the spread of epidemic disease by withdrawing the sick from contact with the outside world; the operation of the colonial state rested on the functioning of both, the healthy and the unhealthy, and this required space to be shared in ways that allowed people and commodities to circulate.[104] Exposure to disease, then, could not be avoided despite the attempts of some medical officials to push for isolationist measures. Perhaps more importantly, debates over the proper management of epidemic cholera challenged the British commitment to maintaining order and structure during times of unrest by exposing the reality of the colonial power's own lack of solutions for combating the disease. These concerns were further fueled by the knowledge that, even with the growing influence of biomedicine in India, Western remedies had failed to establish a cure for symptoms of the disease.[105] Whereas other epidemics such as smallpox and plague (as we will see in the next chapter) responded, to a certain extent, to the use of

---

[102] Government of Punjab, *Report on the Cholera Epidemic of 1867 in Northern India* (Calcutta: Office of the Superintendent of Government Printing, 1868), 137.
[103] Government of Punjab, *Report on the Sanitary Administration of the Punjab, 1869,* 116.
[104] Gilbert, 92-93.
[105] Dhrub Kumar Singh, "Cholera in Two Contrasting Pathies in Nineteenth Century India," *Disquisitions on the Past and Present* no. 13 (2005): 110.

curative medicine in managing illness, cholera's resistance to the basic mode of treatment – which entailed using opiates as well as more aggressive approaches like bleeding - raised new questions about biomedicine's aim to "oppose, dominate and tame diseases."[106] John Murray's report on the treatment of cholera from 1869 pointed to this challenge: "Powerful remedies are recommended which are applicable to similar symptoms in other diseases; but in the collapse of cholera they are powerless."[107] Seen in this light, British interventionist measures related to the management of cholera in the Punjab were often limited and ineffective. But, official responses to the disease were about to change, becoming motivated more by the need to restore normalcy and order than by a desire to relieve suffering among individuals.[108]

This impulse was perhaps most evident in official records during the late nineteenth century when anxieties about the choleric body became a driving force behind British policies towards cholera. As noted earlier, the transition to an epidemiological understanding of disease had redefined the place of the body in colonial medical discourses. This, in turn, reinforced British ideas about cholera as a disease of disorder, prompting the enforcement of distinct policies that were not only practically driven but also ideologically motivated. Indeed, diseases like cholera were deemed particularly alarming and dangerous because they inflicted a type of suffering on the material body that was disconcerting and unacceptable. As such, one of the approaches adopted by colonial medicine in the management of the disease was the construction of normalized

---

[106] Ibid., 104.
[107] Slack, 11.
[108] Ibid., 16.

bodies. This new development gave the illusion of reconciling the impact of cholera on the body by facilitating standardized interventions and treatments for the disease.

Colonial interest in normalized bodies developed during a time when Western biomedicine was adopting a more clinical and experimental understanding of disease that called for an emphasis on standardizing the internal workings of the body. Here, the internalizing approach of the biomedical model assessed the human body in terms of set measures and universal processes.[109] These new criteria helped redefine the properties of not just the healthy body but also the unhealthy body. The diseased body, in particular, came to be recognized primarily as infectious and deformed and was understood as being subjected to biological events that resulted from complications within natural laws.[110] This empirical reading of the body, moreover, authorized certain truths about the way disease functioned within the individual. Perhaps most significant among them was that the social person was separate from their illness. By locating disease within the individual and by omitting experiential knowledge from the larger narrative regarding health, Western medicine established the body as an object that existed primarily in relation to the facts and symptoms that defined it.[111] This development prompted the British to think of the body as an independent, physical entity upon which the laws of biological science could be directed.[112] Disease, thus, became de-socialized. This is not to say that factors such as race, culture, and religion did not inform British attitudes towards disease. Concerns about Indian resistance during outbreaks of cholera demonstrate that the

---

[109] Bhattacharya, "The Body", 35.
[110] Ibid., 35, 40.
[111] Jeffrey Jentzen, "Death and Empire: Legal Medicine in the Colonization of India and Africa," in *Medicine and Colonialism,* ed. Poonam Bala (London and New York: Routledge, 2014), 161.
[112] Ibid.

colonial administration certainly recognized the influence of Indian social ties on public health. Nevertheless, changing ideas about the body in the late nineteenth century meant that disease was seemingly better understood through disciplines such as physiology and pathology that detached illnesses from everyday life.

Colonial medical discourses, then, came to define health by the material characteristics of individual bodies that could be quantified and assessed against "normal" values.[113] New advances in surgery and dissection had contributed to the production of a universal somatic body from which any deviation was inherently linked to the pathological. This normal and standardized body, moreover, was believed to exist in spite of cultural changes and as responding, above all, to immutable inner needs.[114] Within this framework, diseases like cholera were regarded not just as real events with material consequences but also as metaphorical attacks on normalcy. For example, according to one contemporary medical report: "…the reproduction [of disease] cannot be prolonged, and the outbreak of a body has a normal limit in time which is only exceptionally prolonged."[115] A disease defined by excess, cholera evidently pushed past the colonial acceptance of what constituted the healthy and "normal" body; after all, it had the capacity to drive an individual to a point beyond recognition and was, therefore, an illness that lacked boundaries and order.[116]

The emergence of this new understanding of the body and its relationship to disease privileged scientific knowledge as the most effective measure for gauging

---

[113] Lock and Nguyen, 32.
[114] Ibid., 35-36.
[115] James Bryden, *A Report on the Cholera of 1866-1868, and its Relations to the Cholera of Previous Epidemics* (Calcutta: Office of the Superintendent of Government Printing, 1869), 226.
[116] "Conveyance of Contagion by Flies," 188.

progress in the field of public health in India. Although a "science-civilization-progress" framework had shaped colonial rule in India for decades, the emphasis now was on applying medicine to normalize the body by using fixed treatments and established cures.[117] In particular, biomedicine's more mechanistic understanding of human anatomy – which conceptualized the body as a sum of its parts and as predisposed to recurring malfunctions within these components – encouraged therapeutic intervention to target each constituent part independently and treat specific symptoms individually.[118] In the treatment of cholera, for instance, calomel (a form of mercury) was often used as a purgative to cleanse the bowels while opium was administered to suppress vomiting and spasms in the body; any side effects from the use of these remedies were targeted independently with more drugs.[119] This systematic understanding of the body's response to various therapies was different from earlier conceptions of the role of medicine. As we have seen, particularly during the predominance of the miasma theory, scientific observations about the body were preoccupied with the continuous exchange between the individual and their social and physical environment; therefore, treatments for disease required not only rendering the environment suitable for the patient but also creating a regimen that was appropriate to their ecological condition.[120] However, with the construction of an abstract and decontextualized body, the focus of therapeutics shifted towards the management of the various symptoms that made up the medical body.[121]

---

[117] Bhattacharya, "The Body", 36.
[118] Singh, 111.
[119] Ibid., 106-107.
[120] Bhattacharya, "The Body", 37.
[121] Ibid., 38.

Discourses concerning cholera's uncompromising attack on "normal" bodily practices convinced colonial administrators that careful control and management of the choleric body was critical.[122] As such, one of the key concerns for medical officials became the management of the discharges that were produced by the bodies of the sick. Especially now that the individual was regarded as the "chief medium of reproduction, or multiplication and dissemination of the [cholera] poison", most contemporaries agreed that cholera evacuations constituted "the principal, if not the only channel of contagion".[123] Therefore, in Lahore, medical discourses called for the immediate removal of the patient's discharges into "filth pits" or earthen vessels which were then instructed to be destroyed over a "brisk fire".[124] The Government of Punjab also pushed all hospitals to treat any pans used by cholera patients with a disinfecting solution of carbolic acid and ordered the evacuations to be mixed with straw or resin before their removal and burial.[125] Even spots "where cholera discharges [had] fallen" were to be dug up and burnt while the bodies of the victims themselves were to be "buried or burned speedily in the clothes in which they died".[126] In all these cases, there existed a fear that noxious secretions from diseased bodies would contaminate not only surrounding spaces but also any individual in close proximity, driving the push for the proper management of cholera patients.

While similar strategies to combat epidemics had also been adopted in Europe (such as during the mid-nineteenth century when cholera swept the continent), policies

---

[122] Julie Christine Nack Ngue, "Critical Conditions: Refiguring Bodies of Illness and Disability in Francophone African and Caribbean Women's Writing" (PhD diss., University of California Los Angeles, 2008), 14.

[123] Murray, 7; William Moore, "Memo on Cholera,' *The Asiatic Quarterly Review* 3 (1892): 419.

[124] Lala Kashi Ram, *Notes and Suggestions on Sanitation in the Punjab* (Calcutta: Bidhan Press, 1884), 20.

[125] *The Punjab Record* (Lahore: W. Ball & Co., 1890), 25: 6.

[126] *The Punjab Record* (Lahore: W. Ball & Co., 1901), 35: 8.

related to diseases in the colony were driven by distinct racial ideas that shaped the dynamics of decision-making. The grotesque body of the diseased Indian elicited feelings that were different from those evoked by the body of diseased Europeans. This was largely due to nineteenth-century colonial representations of the native body as manifestly diseased, even when apparently healthy. Particularly within the context of colonial epidemiological advancements, colonized bodies were seen as the carriers of pathogens and germs and, as such, were considered infected or contagious even when they did not display outward signs of illness.[127] This view, in fact, replaced older ideas about native immunity to tropical diseases - Philip Curtin argues that in the eighteenth and early nineteenth centuries, colonized bodies were seen as resistant to tropical diseases because of a long-established immunity to the pathogens in their environment – and, instead, gave rise to new fears about racial bodies being complicit in the transmission of local pathogens.[128] As a result, the existence of cholera germs in native bodies created a different sense of urgency among officials, especially since their bodies were deemed "careless of personal cleanliness".[129]

But, despite the anxieties produced by indigenous bodies, medical discourses concerning cholera in the nineteenth century remained preoccupied with the health of both the colonizer and the colonized. On the ground in Lahore, a growing initiative in the field of public health came to advance the importance of self-care for the general public. Cholera, after all, had redefined the physical limits of the human body thereby prompting medical professionals to draw attention to the need for better awareness of individual

---

[127] Warwick Anderson, "The Third-World Body," in *Companion to Medicine in the Twentieth Century,* ed. Roger Cooter and John Pickstone (London, New York: Routledge, 2003), 241.
[128] Curtin, 108.
[129] Ram, *Notes and Suggestions,* 18.

needs. Although they did not undervalue the importance of sanitary improvement,

officials nevertheless called for vigilance in keeping the body in a state of health and

strength. An examination of cholera in Lahore by H. W. Bellew, the Sanitary

Commissioner of the Punjab, perhaps best illustrates this objective:

> To avert cholera, therefore, we should not content ourselves by reliance solely on attention to the measures required for maintaining our centres of habitation and our dwellings in the most perfect sanitary condition attainable…but we must also personally and individually aid the good effect of these measures by the exercise of judgment and discretion; by, at least fair treatment of our own bodies and persons, and not, as is too often the case, thwart and counteract them by direct acts of indiscretion, by injudicious and careless conduct.[130]

Indeed, Bellew maintained that individuals whose health had been impaired by

"ascertained conditions" – excessive eating or drinking, careless exposure to the weather,

exhausting exercise - were more likely to contract cholera.[131] Similarly, in his letter to the

Temperance Society of Lahore, the city's Assistant Surgeon discussed the consequences

of indulging in spirits, even in minute doses.[132] For him, the consumption of liquor made

individuals more liable to certain diseases by poisoning vital organs in the body such as

the liver, kidneys, stomach, and brain.[133] Because excessive drinking was common

among British soldiers, it was even more important to draw attention to the dangers of

poor health choices. This focus on self-care, moreover, differed from earlier calls to

cultivate sanitary habits because it was entrenched in developing ideas about the

mechanical workings of the body. As we have seen, many medical authorities now

regarded the body as a sensitive machine that was susceptible to various changes;

---

[130] Bellew, 638.
[131] Ibid., 639.
[132] "The Evils of Drinking," *The Tribune,* June 21, 1884, 6.
[133] Ibid., 6-7.

exposure to harmful stimulants was believed to throw the body into disorder and, consequently, result in disease.[134]

With officials in Lahore focused on detailing the means to a "healthy" body, medical discourses in the city also became more engaged with issues related to personal nutrition and diet. For example, an article in *The Tribune* argued that consuming watermelons and cucumbers on an empty stomach was "a pregnant cause of cholera"; therefore, the author called for restricting the sale of both items in local bazaars.[135] Another report in the newspaper advocated the benefits of vegetarianism, criticizing "animal food" for being injurious to the human body by "generating some of the most loathsome forms of diseases."[136] Local responses to the movement, moreover, were evident in the establishment of Lahore's own vegetarian journal, the *Harbinger*. First published in 1889, it advocated vegetarian principles while also denouncing the use of tobacco and liquor.[137] While the *Harbinger* mostly promoted vegetarianism from a Hindu standpoint, many of its arguments were taken from literature published in *The Vegetarian Messenger* (a Manchester-based journal) as well as from the writings of eminent physicians such as Benjamin Ward Richardson.[138] In particular, it was the movement's affiliation with the British-based campaign that reinforced contemporary connections between health and nutrition. Vegetarianism in the metropole, after all, had been shaped by larger Victorian ideas about abstinence and self-restraint. Within this framework, the move to eliminate meat from one's diet was deemed an essential part of the individual's

---

[134] "On the Health of the Troops Serving in India," *Army Medical Department Report for the Year 1893* (London: Harrison and Sons, 1895), 35: 107.
[135] "The Sanitation of Lahore," *The Tribune,* September 3, 1881, 5.
[136] "Vegetarianism," *The Tribune,* January 6, 1883, 8.
[137] "Literary Notices," *Good Health,* ed. J. H. Kellogg (London: Good Health Publishing Company, 1895), 72.
[138] Ibid., 63. The first British vegetarian society was established in Ramsgate in 1847.

social and physical well-being. For example, in *A Vindication of Natural Diet* (1884)*,*

Percy Bysshe Shelley argued that it was "only among the enlightened and benevolent that

so great a sacrifice of appetite and prejudice can be expected…"[139] Although a marginal

phenomenon in the colony (and Britain) - it was often identified as a form of quackery by

its opponents - vegetarianism nevertheless became a vocal movement that attracted the

attention of diverse groups ranging from scientific men to those motivated by religious

beliefs.[140] The influence of the movement in Lahore, for instance, was recorded in an

1891 edition of *The Tribune*:

> On the 13th September, 1891, a Vegetarian procession walked throughout the city
> of Lahore, singing Vegetarian songs in the vernacular, and making short speeches
> at the principal squares. Hundreds of people followed us, and came to hear our
> lectures at the place of our ordinary meeting. About thirty new members joined us
> at the conclusion.[141]

The development of vegetarianism in Lahore, then, suggests that the maintenance of

personal health was intimately connected to larger ideas about nutrition and its role in

combating disease.

Conclusion

Changing ideas about what defined a healthy body played a critical role in

shaping British strategies towards the management of cholera in India. Whereas earlier

methods had focused on rebuilding infrastructure in urban centres and isolating the sick

from the healthy, late nineteenth-century policies related to cholera became preoccupied

with new perceptions of privacy, restraint, and the abject. This was especially relevant in

---

[139] Percy Bysshe Shelley, *A Vindication of Natural Diet* (London: F. Pitman, 1884), 18. Shelley's original pamphlet, published in 1814 is exceedingly rare. However, reprinted versions were published in 1835 and 1884. The above quote is from the later edition.
[140] James Gregory, *Of Victorians and Vegetarians: The Vegetarian Movement in Victorian Britain* (London, New York: Tauris Academic Studies, 2007), 1.
[141] Durga Prasad, excerpt from the *Harbinger* in *The Vegetarian Messenger*, December 1891, 375.

the wake of growing concerns about the human body's vulnerability to disease which led to an emerging interest in "normalized" bodies and bodily practices. These ideological motivations for managing cholera helped reconcile some of the anxieties about the choleric body by reinforcing the importance of individual health and self-care. In Lahore, this led to a growing awareness of the need to maintain a proper diet and to participate in activities that would ensure the fair treatment of one's body. Despite this, however, cholera continued to plague the province over the next several years – close to two thousand deaths from the disease were reported in the year 1899 – which suggests that the theoretical understanding of the body simply served as a means of alleviating colonial anxieties regarding cholera.[142]

---

[142] Tandon, 70.

Chapter 5 – Disease and the Construction of Imagined Order: Smallpox and Plague

<u>Introduction</u>

During the latter half of the nineteenth century, Lahore witnessed persistent outbreaks of two other devastating diseases: smallpox and plague. The severity with which the diseases attacked the city led the British to adopt particularly stringent and comprehensive measures to combat the epidemics. However, the "success" of colonial intervention in the management of the plague and smallpox depended considerably on the actions and sentiments of Lahore's Indian residents. Indeed, the cultural, social, and political heritage of the city helped inform contemporary Indian responses to British public health strategies. More specifically, the growing influx of migrants to Lahore had established a new identity for the city that was grounded in notions of diversity and exchange and this played a key role in the development of local understandings about disease.

As such, the history of smallpox and plague in Lahore cannot be simplified into a narrative of colonial intervention versus Indian resistance. Public health policies related to the epidemics were more complex than this and the implementation of preventative measures to manage the diseases were a testament to the multifaceted nature of changing medical strategies in the Punjab. In fact, an examination of the outbreaks of smallpox and plague in Lahore reveals that the city faced several complications in its attempts to combat the diseases. These issues, moreover, were determined primarily by two things. First, colonial public health management in the province (and many other parts of India) was fragmented at best and this had important implications for the treatment of disease in Lahore. As we will see, British efforts to eradicate smallpox and plague were influenced

153

largely by bureaucratic strategies that sought to reinforce colonial rule. But, despite the illusion of efficiency and structure, British medical establishments and institutions were quite often riddled with inconsistencies that resulted in the failure to contain epidemic outbreaks in the city. Second, local reactions to public health policies further challenged the working of colonial public health initiatives in Lahore. These responses, moreover, were informed as much by opposition to British interventionist measures as they were by unique social, economic, and political factors that reflected the agency of the city's Indian residents. As this chapter will demonstrate, the complicated nature of local reactions to colonial smallpox and plague measures only disrupted the already disjointed public health agenda that the British attempted to implement in Lahore.

The Outbreak of Smallpox

In its epidemic form, smallpox was responsible for the deaths of over 850,000 people in the Punjab between 1868 and 1947, making it fatal in approximately one third of all cases.[1] In Lahore, during a particularly severe outbreak in 1865, the disease claimed the lives of 7000 people in just two months.[2] These statistics, however, must be considered with caution especially because estimates for the disease were sometimes exaggerated in official records. This happened when death rates from other, less familiar, illnesses were mistakenly attributed to smallpox, thereby inflating mortality statistics for the disease.[3] Nevertheless, colonial records reveal a deep-seated anxiety about smallpox, not only because of its seemingly high death rate but also because the disease often caused permanent disability and disfigurement in those who survived. Therefore,

---

[1] Tandon, 218; David Arnold, "Smallpox and colonial medicine in nineteenth-century India," in *Imperial Medicine and Indigenous Societies* ed. David Arnold (Manchester: Manchester University Press, 1988), 45.
[2] *The Medical News,* vol. 23 (Philadelphia: Henry C. Lea, 1865), 63.
[3] Arnold, "Smallpox and colonial medicine," 47.

throughout the nineteenth century, it was deemed a disease of "exceptional

significance".[4] Perhaps its most characteristic symptom was the deep, pitted scars left

behind from oozing pustules that erupted over the face, arms, and legs of the patient; the

more virulent strain of the disease, variola major, resulted in extreme internal or external

bleeding which almost always guaranteed a quick death.[5] John Murdoch's *Papers on

Indian Reform* (1889) described the debilitating nature of the disease:

> To see a bad case of smallpox; the thick crust of eruption masking the entire
> face and head; the swollen distorted features which make the person
> unrecognizable: the closed eyes, half-glued together by matter; the swollen,
> open, dribbling mouth; the swollen, nerveless, shaking hand, all form a sight
> never to be forgotten.[6]

The severity of the disease's impact on the individual meant that epidemics of smallpox

were often regarded with fear and anxiety. For British officials, even the outbreak of a

few cases could prompt the declaration of a public health emergency. Similarly, among

the local population, smallpox was deemed so pervasive that many regarded it as a rite of

passage for children with recovery from the disease considered a second birth.[7] As one

commentator observed: "It touches the keenest of human susceptibilities; for there are

thousands in this country who, spared by it from death, still have traces of its violence in

the deep marks on the face or the loss of an eye."[8]

---

[4] Ibid.

[5] Sanjoy Bhattacharya, Mark Harrison, and Michael Worboys, *Fractured States: Smallpox, Public Health and Vaccination Policy in British India, 1800-1947* (New Delhi: Orient Longman Private Limited, 2005), 2.

[6] John Murdoch, *Papers on Indian Reform: Sanitary, Material, Social, Moral and Religious* (Madras: S. P. C. K. Press, 1889), 6-7.

[7] Syed Ahmad Khan in *Abstract of the Proceedings of the Council of the Governor General of India Assembled for the Purpose of Making Laws and Regulations* (Calcutta: Office of the Superintendent of Government Printing, 1880), 18: 233.

[8] Ibid.

The management of smallpox in colonial India was different from the way other epidemic diseases were regulated and contained by the state. Unlike cholera, for instance, smallpox had been regarded as a preventable disease since the early nineteenth century, an idea that was shaped largely by the introduction of the Jennerian vaccination in the colony in 1802.[9] Edward Jenner, the English doctor who pioneered the vaccine in 1796, had discovered that preparations composed of cowpox matter built human resistance against smallpox when used in mild doses. The procedure required making abrasions in the skin with a sharp lancet that was then rubbed with dried cowpox matter mixed in a few drops of cold water. Immunity to the disease was marked by the appearance of a pustule on the skin where the vaccination was administered (usually within two to five days) with more blisters signifying greater resistance to smallpox.[10] Another technique, known as the arm-to-arm method, transferred matter from the cowpox pustule of a vaccinated individual to other recipients.[11] This method attempted to keep vaccine matter "alive" by relying on human lymph (the clear fluid that circulates within the body's vessels).[12] However, despite the growing importance of vaccination among colonial medical officials, other means of protection against smallpox were also consistently practiced in the colony, including disinfection, isolation, and the practice of inoculation (*chhopa*). Inoculation (or variolation), in particular, remained the leading form of treatment among the Indian population and had been carried out in the subcontinent since at least the seventeenth century. Unlike vaccination, which relied on the prophylactic

---

[9] Arnold, "Smallpox and colonial medicine," 45.

[10] Frederick A. P. Barnard and Arnold Guyot, eds., *Johnson's New Universal Cyclopaedia: A Scientific and Popular Treasury of Useful Knowledge* (New York: A. J. Johnson & Co., 1883), 4: 1081.

[11] Jonathan B. Tucker, *Scourge: The Once and Future Threat of Smallpox* (New York: Grove Press, 2001), 29.

[12] Ibid.

effects of cowpox, inoculation used pustular matter from smallpox patients to produce a mild case of the disease in the individual who, upon recovery, was afforded lifelong resistance to smallpox.[13]

Although outbreaks of smallpox were attributed to environmental factors and unsanitary conditions, more people were also willing to acknowledge the role of the individual as an active agent in the transmission of disease.[14] As early as 1832, four decades before Louis Pasteur and Robert Koch's work helped crystallize what would become the germ theory, one report argued: "nearly all the physicians of Great Britain believe [smallpox] is contagious…Dr. Lowrie, who had seen the disease in India without suspecting it contagious, is convinced that it is so at present."[15] Other reports pointed to the double origins of the disease; in 1846, for example, the *Calcutta Journal of Natural History* described smallpox as "miasmatico-contagious", i.e. a disease that arose from something injurious in the air as well as from the body of the sick.[16] Despite this multifaceted, and contentious, explanation for the outbreak of smallpox, most colonial officials agreed that the best recourse for the management and prevention of the disease was a comprehensive and systematic vaccination campaign throughout India.[17] Ultimately, a growing conviction of the contagious nature of smallpox drew medical authorities away from alternate means of combating the disease (such as establishing large hospitals or camps as was the case in other epidemic diseases such as cholera) and pushed them towards prophylactic treatment.

---

[13] Bhattacharya et al., *Fractured States,* 53.
[14] Ibid., 17.
[15] Lunsford P. Yandell, ed., *The Transylvania Journal of Medicine and the Associate Sciences* (Lexington: Savary and Co., 1832), 5: 84.
[16] John McLelland, ed., *Calcutta Journal of Natural History and Miscellany of the Arts and Sciences in India* (Calcutta: Bishop's College Press, 1846), 6: 237.
[17] Bhattacharya et al., *Fractured States*, 19.

Vaccination against smallpox represented one of the first large-scale attempts by the colonial administration to make medicine accessible to the masses. Several studies concerning the subject recognize the extensive nature of this colonial public health program in the colony during the nineteenth century. Many of these works focus on the way vaccination campaigns influenced the relationship between colonizer and colonized by re-defining ideas about pollution, contamination, and impurity. One such analysis is offered by Alison Bashford's chapter in *Contagion: Epidemics, History and Culture from Small Pox to Anthrax* which focuses on the movement of infected bodies and the establishment of epidemiological connections between people in the British Empire. According to Bashford, vaccination was a process that was distinct from other measures taken to combat epidemics in British colonies because it did not break the cycle of transmission that inhibited contagious matter; rather, vaccination consciously introduced infection into the individual and thereby crossed the boundary between clean and unclean, healthy and unhealthy.[18] Bashford's work has been critical for drawing attention to the concept of the porous body as well as for stressing the importance of ideas such as movement and contact in relation to vaccination.[19] In particular, her emphasis on the cultural meaning of contagion and its use in the development of strategies like isolation and containment has set her analysis apart from earlier positivist works in the field.[20] Nevertheless, studies like Bashford's do not consider more nuanced arguments about the impact of technologies such as vaccination on the logic of colonial rule. Moreover, they

---

[18] Alison Bashford, "Vaccination: Foreign Bodies, Contagion and Colonialism," in *Contagion: Epidemics, History and Culture from Small Pox to Anthrax*, ed. Alison Bashford and Claire Hooker (Annandale: Pluto Press, 2002), 15, 16.
[19] Ibid., 23.
[20] Ibid., 9.

overlook the role that vaccination played in the rise of local activities and behaviours that challenged the demands of the colonial state. Indeed, the British regarded the practice as the most reliable and effective solution to the problem of epidemic smallpox; however, the reality of containing the disease through vaccination required more insight and preparation than the British anticipated.

The Limits of British Intervention I

According to a report in *The Lancet*, British officials aspired to implement a system of vaccination so universal that every newborn in India would have been given the prophylactic until eventually there was no longer any need for it.[21] The introduction of vaccination in the country, moreover, was prompted by the belief that the procedure would prove more successful in saving lives and containing epidemics than any other sanitary or medical measure.[22] As early as 1849, for instance, Dr. William Campbell Maclean's treatise on smallpox affirmed: "…the benefit of Vaccination to mankind is very great, and this is a news in which the high as well as the low benefit."[23] Decades later, in 1891, William Moore's observations on smallpox in India reiterated a similar sentiment; commenting on the "protective power of vaccination", Moore argued that increased immunity from the disease had contributed to a decline of epidemic outbreaks

---

[21] Robert Pringle, "Smallpox Hospitals and Camps," *The Lancet,* ed. James Wakley (London: John James Croft, 1885), 196.

[22] Nigel Chancellor's examination of vaccination in Mysore reveals that the British often enlisted the help of Indian elites to promote the operation among Indians. He demonstrates, for instance, that the introduction of vaccination in the region coincided with the marriage of the young maharaja of Mysore whose future bride agreed to be vaccinated against smallpox. The announcement was made public in 1805 to advance the benefits of vaccination among the indigenous population. Nigel Chancellor, "A Picture of Health: The Dilemma of Gender and Status in the Iconography of Empire, India c. 1805," *Modern Asian Studies* 35 no. 4 (2001): 775.

[23] William Campbell Maclean, *A Treatise on the Small Pox, 1849* (Madras: Fort St. George Gazette Press, 1858), 16.

and a diminution in the death rate from smallpox in the country.[24] Much of the support

for vaccination among the European community in India was grounded in the success of

the smallpox vaccine in England (this was despite considerable opposition to the practice

even in the metropole). Vaccine crusts from inoculated children along with tubes of

preserved humanized lymph from the National Vaccine Establishment in London were

transported to India throughout the nineteenth century.[25] However, delays along the mail

route meant that the potency of the vaccine matter was often compromised by the time it

reached the colony. As a result, by the 1860s, public health officials were forced to

supplement the supplies from Europe with locally harvested lymph that was overseen and

distributed by the newly established Sanitary Commissions of Bengal, Bombay, and

Madras.[26]

Relying on locally sourced lymph for smallpox vaccinations, however, was only

part of the problem for colonial officials. Several other factors exacerbated the fractured

nature of smallpox regulation in the province. Among them were the inconsistencies and

disparities within the colonial medical establishment itself which led to disagreements on

policy implementation. The involvement of several individuals at different levels of

authority – not just state officials but also doctors and scientists – made it difficult to

establish consistent public health programs to combat the disease.[27] Despite a semblance

of order and efficacy, there was hardly ever a unified vision or purpose within the

colonial administration when it came to implementing smallpox policies. Even if

---

[24] William Moore, "Vaccination in India," *The Sanitary Record and Journal of Municipal Engineering* (London: The Sanitary Publishing Company Ltd., 1891), 148.
[25] Sanjoy Bhattacharya, "Re-devising Jennerian Vaccines? European Technologies, Indian Innovation and the Control of Smallpox in South Asia, 1850-1950," *Social Scientist* 26, nos. 11/12 (1998): 28.
[26] Ibid., 28-28.
[27] Harrison, *Public Health in British India,* 11.

authorities agreed on specific strategies at the state or provincial levels, imposing them on British and Indian junior officials within the districts presented its own challenges.[28] This was especially true in the late nineteenth century when increased intervention from the provinces regarding the management of vaccination created new tensions between the different levels of government. As we will see, some local administrators adapted or discontinued certain practices at their own discretion even when they were approved by senior officials and scientific "experts". Similarly, disagreements within the medical establishment regarding the best methods for producing and deploying the smallpox vaccine made it difficult to advance consistent strategies.[29] These discrepancies along with the indifference, and sometimes active opposition, of some officials played a critical role in weakening public health policies concerning the disease.

In 1868, the Sanitary Commissioner of the Punjab was given charge of the province's vaccine department. His responsibilities included overseeing the work of district medical officers who, in turn, directed and supervised vaccinators.[30] Dispensaries, which acted as stores for vaccine lymph, were also established in urban centres and used as sites for the administration of the prophylactic among the Punjab's residents.[31] Even with this elaborate framework for vaccination, the conflicting priorities of the municipal and provincial governments meant that efforts to implement a widespread vaccination program in the Punjab faced certain challenges. For instance, in Lahore, one report from 1871 revealed that there were no municipal funds available to compensate vaccinators in

---

[28] Ibid.
[29] Ibid., 12.
[30] Tandon, 92.
[31] Ibid.

the city that year.[32] As a result, provincial medical authorities supplied three vaccinators from the province's vaccine establishment to help conduct local operations.[33] Despite this, the Superintendent General of Vaccination for the Punjab complained that Lahore's municipal committee offered very little efficient support in the vaccination campaign, "taking no interest whatever in the work."[34] Similarly, ten years later in 1881, an official complained of a significant decrease in the number of vaccinations in the Punjab that year, attributing the problem to a vacancy in the office of the Superintendent of Vaccination that remained unfilled the entire year.[35] Evidently, a lack of interest and resources at local levels of government made systematic vaccination a persistent challenge for the province. To counter such problems, the existing staffs of the provincial and municipal vaccine establishments were amalgamated into the Punjab Vaccination Department in October 1881.[36] But despite the move to simplify and consolidate vaccination programs in the province, administrative and financial issues continued to plague larger efforts to implement smallpox-related policies.

British official, then, were often left to rely on Indian assistants to function on their behalf.[37] For example, in 1885, a shortage of funds made it increasingly difficult to compensate trained vaccinators for their service. Therefore, attempts were made by Lahore's municipal committee to invite two well-known *hakims* to introduce the practice

---

[32] Isaac Newton, *Report on Vaccine Operations in the Panjab, During the Season 1871-72* (Lahore: Central Jail Press, 1872), 21.
[33] Ibid.
[34] Ibid.
[35] J. M. Cuningham, *Sixteenth Annual Report of the Sanitary Commissioner,* 81.
[36] Government of India, *Report on Sanitary Measures in India in 1881-2: Together With Miscellaneous Information Up to June 1883* (London: Eyre and Spottiswoode), 15: 94.
[37] Bhattacharya et al., *Fractured States,* 7.

of vaccination among the local residents.[38] Colonial officials also struggled with extending vaccination to Indian women of higher classes who were kept in *purdah* (segregation from unrelated males). In cases like these, they depended on the assistance of female vaccinators, usually selected from among a group of *dhais* (Indian birth attendants), to gain admission to *purdah* families. Here, despite the efforts of the Civil Surgeon to supervise the operations, the management of patients was entirely at the discretion of the *dhais* because male vaccinators were never permitted access to these segregated spaces.[39] Clearly, the expansion and administration of vaccination policy - and smallpox control measures more generally - were contingent upon the assistance of several different groups throughout the province. As one report for the Punjab admitted, there was "no systematic method of carrying on vaccination" in the province, a fact that resulted largely from "grave irregularities in the work of the Vaccination staff."[40]

Another factor that prompted variations within the system was vaccination technology itself. The prophylactic treatment was in no way a static or unchanging procedure; rather, medical professionals were often found contemplating ways to make the vaccine more effective and, in turn, better established among the Indian population. For example, one of the leading discussions in the Punjab focused on the benefits of smallpox crusts versus fresh lymph. By the 1870s, officials began to turn away from using the former because of concerns that they were only successful fifty percent of the

---

[38] Government of Punjab, *Report on Vaccination in the Punjab for the Year 1885-86* (Lahore: Punjab Government Press, 1886), 7.

[39] Government of Punjab, *Report on Vaccination in the Punjab for the Year 1870-71* (Lahore: Punjab Government Press, 1871), 18.

[40] Government of Punjab, *Report on Vaccination in the Punjab for the Year 1896-96* (Lahore: Civil and Military Gazette Press, 1896), 2-3.

time.[41] In an 1885 report of *The Lancet,* Dr. Robert Pringle argued that he "would never think of using the virus in a crust when that from a good vesicle [lymph] was obtainable."[42] The potency of crusts depended on several factors including their size and age; the latter was particularly important because the length of time before attenuated crusts could be collected from an infected individual was critical.[43] Therefore, with no consistent means of guaranteeing the quality of the source, medical authorities became increasingly wary of using crusts as a prophylaxis. Dr. Isaac Newton, the Punjab's superintendent-general for vaccination, even argued that vaccinators should be removed from districts in which the arm-to-arm technique or the use of fresh lymph were not carried out; any other method was seen as doing "more harm than good."[44] Among the Indian population, however, strong objections to the extraction of lymph from children meant that crusts remained the more popular method of performing vaccinations. As a result, despite the theoretical move away from this approach in the larger scientific community, public health officials on the ground were often left with little choice but to carry out vaccinations using smallpox crusts in order to appease local sentiments. Dr. Newton, in fact, worried that the continued use of crusts – which, according to him, increased the failure rate of vaccination - would damage the overall legitimacy of the smallpox prevention campaign in the Punjab: "…in this way, much injury is done to the

---

[41] Government of Punjab, *Report on Vaccination in the Punjab for the Year 1870-71,* 16.
[42] Pringle, "Smallpox Hospitals and Camps," 196.
[43] Lauren Minsky, "Pursuing Protection from Disease: The Making of Smallpox Prophylactic Practice in Colonial Punjab," *Bulletin of the History of Medicine* 83, no. 1 (2009): 176.
[44] Government of Punjab, *Report on Vaccination in the Punjab for the Year 1870-71*, 16.

cause of vaccination, ignorant people being led to place little faith in its prophylactic value against small pox."[45]

Even vaccine lymph presented its own challenges. For one thing, medical officials were uncertain whether wet lymph was more potent than dry lymph in establishing immunity against the disease. An even greater issue was that local lymph collected in the colony was difficult to store.[46] Dr. Pringle, for example, argued that the Indian heat made it impossible to sustain a fresh supply of humanized lymph in the region.[47] Unless kept above an altitude of 6000 feet, he maintained that the vaccine matter would deteriorate and become useless.[48] In response to these concerns, the medical community experimented with several storage techniques, including the use of lead and glass tubes; during the warmer months, officials also attempted to use capillary tubes that could be more easily transported to the Himalayas (where the vaccine was believed to have a better chance of remaining in an active condition).[49] However, the success of these methods was complicated by the absence of a sufficient preservative that could ensure the potency of humanized lymph while it was being stored. Despite experiments with several substances such as vaseline, lanolin, and glycerin – vaseline was particularly popular in the Punjab – there was little agreement among scientists about the best strategy for mixing and preserving vaccine matter.[50] The biggest problem, in fact, was bacterial contamination which resulted from mixing fresh lymph into the various preservatives; many of these solutions caused severe ulcerations and infections which, for obvious

---

[45] Newton, 22.
[46] Bhattacharya, "Re-devising Jennerian Vaccines," 30.
[47] Pringle, "Smallpox Hospitals and Camps," 195.
[48] Ibid.
[49] Ibid.
[50] Bhattacharya et al., *Fractured States,* 49.

reasons, made them widely unpopular.[51] It was not until 1905, after extensive experimentation, that the sanitary commissioner of the Punjab, W. H. Harvey, acknowledged chloroformed glycerine lymph as the best form of preservative in the region.[52] Until then, most provinces faced chronic lymph shortages that were only made worse during severe smallpox epidemics.

For some medical professionals, however, concerns about storage and preservation were irrelevant until other, more important, issues were first resolved. Among them was that rural areas often received inadequate and less potent supplies of vaccine matter because more reliable sources of lymph were reserved for urban towns and cities with larger populations (and, therefore, greater susceptibility to epidemic outbreaks).[53] In turn, the use of weak lymph made the vaccination procedure more painful because it required making deeper cuts to introduce the prophylactic into the individual.[54] Even more problematic was that treatment with less potent human lymph resulted in a significant percentage of unsuccessful vaccinations. This forced medical officials to launch largely unpopular revaccination drives that contributed to local anxieties about the procedure.[55] As we will see, many parents already objected to their children being vaccinated once and so the thought of revaccination was even more

---

[51] Robert Harvey, "On the Dilution of Vaccine Lymph with Glycerine and the Multiplication and Preservation of the Virus Thereby," *The Indian Medical Gazette*, March 2, 1868, 57.
[52] Minsky, 183.
[53] Bhattacharya et al., *Fractured States*, 58.
[54] Ibid.
[55] Re-vaccination here refers to a second or third operation performed after an unsuccessful attempt (often described as the "primary vaccination"). After 1910, the term was used to denote a booster vaccination to guarantee immunity to smallpox; analysis of data between 1900-1910 led public health officials to realize that lifelong protection against the disease would only be successful if the vaccination was performed twice in an individual's lifetime, once in infancy and then again during adolescence. As such, the meaning of "re-vaccination" shifted considerably throughout the early twentieth century. Bhattacharya et al., *Fractured States,* 160.

disagreeable.[56] Official reports indicate that many Indians were reluctant to volunteer their children a second, or sometimes third, time when approached by traveling vaccinators in the province. As one commentator remarked, "…those badly vaccinated cannot be made to take it properly afterwards…"[57]

Revaccination was particularly contentious because vaccinators were in the habit of performing the operation on children who had only been vaccinated a year or two earlier.[58] The Lieutenant-Governor of Punjab argued that this practice was common among Indian vaccinators who sought to "increas[e] the tale of their work".[59] Other discrepancies in provincial statistics were also acknowledged:

> The vaccinators hunts up children of between five and ten years of age, and if they have no marks of vaccination and the parents say they have been vaccinated, the vaccinators operate upon them and enter the operation as a re-vaccination.[60]

By inflating the number of successful revaccinations in the province, officials feared that the legitimacy of the campaign would be at stake.[61] In fact, some colonial administrators argued that the adoption of revaccination was not the result of the "imaginary deterioration in the vaccine virus", but of the inefficacy and carelessness of health officials in managing their staff.[62] Dr. Pringle, for instance, described revaccination as compromising the quality of the prophylactic for the "wholesale fabrication of returns", leading him to push for the careful supervision of vaccine operations throughout the

---

[56] Minsky, 175.
[57] Punjab Public Health Department, *Report on Vaccination* (Lahore: Central Jail Press, 1868), 54.
[58] Government of Punjab, *Report on Vaccination in the Punjab for the Year 1891-92* (Lahore: Civil and Military Gazette Press, 1892), 1.
[59] Ibid.
[60] Government of Punjab, *Report on Vaccination in the Punjab for the Year 1870-71*, 40.
[61] Government of Punjab, *Report on Vaccination in the Punjab for the Year 1891-92*, 1.
[62] Robert Pringle, "Ancient and Modern Methods of Treating Small-Pox Epidemics in India," *The Medical Times and Gazette* (London: J. & A. Churchill, 1885), 1: 637.

country.[63] Orders were also issued by the Sanitary Commissioner to only allow

revaccination after seven years had elapsed from the last successful operation.[64]

Moreover, Indian superintendents and vaccinators were warned that they would be

dismissed if they continued to submit untruthful returns.[65] Despite such precautions, the

colonial administration continued to be plagued with inefficiencies, leading one

contemporary commentator to remark: "The opposition to vaccination, wherever it exists,

is due either to the manner in which some of the underlings of the department conduct

themselves, or to defects of system."[66]

But there was more to the irregular enforcement of smallpox policies than just the

disorganized activities or self-interest of officials at lower levels of the public health

system. Despite persistent reports criticizing the apathy of local authorities and the

deception of Indians vaccinators, inconsistencies within the senior levels of the

administration also affected the success of vaccine establishments in the province. For

example, the Lieutenant Governor of Punjab pushed to implement new policies related to

vaccination in 1880, particularly those that would prioritize the needs of the various

districts in the province. For him, the formation of a purely district staff under the control

of medical and civil officers, along with the increased involvement of civil surgeons in

their respective sectors, would be the "chief guarantee of success" for the new scheme.[67]

This model was meant to ensure that each locality would have within itself a "perfect and

---

[63] Ibid.
[64] Government of Punjab, *Report on Vaccination in the Punjab for the Year 1891-92*, 1.
[65] Newton, 1.
[66] Syed Ahmad Khan, in *The Life and Work of Syed Ahmad Khan*, ed. George Farquhar I. Graham (Edinburgh and London: William Blackwood and Sons, 1888), 303.
[67] W. M. Young, in *Report on Vaccine Operations in the Punjab During the Year 1879-1880,* ed. J. Bennett (Lahore: Central Jail Press, 1880), 5.

complete organization" that would meet the vaccination requirements of the province.[68]

Although vaccination was carried out by these district operators by 1883, the success of

the program was impeded by administrative and financial issues which disrupted the

smooth functioning of the provincial and municipal arms of the colonial public health

system.[69] For instance, there were no clear rules outlining the jurisdiction of civil

surgeons in the Punjab. As officials who were responsible for inspecting the quality of

vaccinations that were administered by subordinate staff in their respective districts, civil

surgeons were deemed essential for ensuring the success of the district plan. While some

were charged with supervising the vaccinations of either the civil or military populations,

limited funds in other districts required them to oversee vaccinations within both

groups.[70] In areas where the latter model was enforced, government administrators noted

that civil surgeons could not direct enough attention to securing accurate returns. In fact,

one contemporary vaccination report suggested that this discrepancy was the cause of

decreased vaccinations in several districts throughout the province:

> It is hopeless to expect any system of vaccination, however elaborately
> developed, to succeed, unless the subordinate agency is thoroughly
> supervised, and Civil Surgeons, who most carefully watch the work in their
> districts, bear the strongest testimony to this. The importance of Civil
> Surgeons personally inspecting the working of the vaccinators in their
> districts cannot be too strongly urged, and it is to be hoped similar complaints of
> neglect will not appear in future Reports.[71]

Clearly, the move to employ a district staff in the Punjab was hampered by practical

issues that made it impossible for civil surgeons to supervise entire districts on their own.

---

[68] Ibid., 4-5.
[69] Bhattacharya et al., *Fractured States,* 33.
[70] Center, quoted in H. W. Bellew, *Report on Vaccination in the Punjab for the Year 1885-86* (Lahore: Punjab Government Press, 1886), 6.
[71] Young, in *Report on Vaccination in the Punjab for the Year 1885-86,* 2.

For example, of the total vaccinations performed in the districts of Lahore, Hoshiarpur, Shalpur, and Bannu – totaling 550,806 - only 62,201 were inspected by civil surgeons. This demonstrates that there existed serious defects even within the senior levels of the health system that jeopardized the vaccination program in the province.

Local Responses to Colonial Regulatory Objectives I

While discrepancies within the colonial administration certainly limited the proper functioning of smallpox measures in the Punjab, British officials were to face even greater challenges to their public health agenda from local residents. Indeed, native responses to smallpox policies significantly impeded a large-scale vaccination program from being implemented consistently in the province. The primary cause of this disruption was the local practice of inoculation which presented perhaps the biggest challenge to the colonial administration's management of the disease. Because inoculation relied on the use of live smallpox virus to trigger immunity (instead of the more subdued cowpox strain used in vaccines), it came under intense criticism in the mid-nineteenth century by colonial medical officials who argued that the procedure risked exposing patients to severe, even fatal, attacks of the disease. For them, inoculation allowed the transmission of virulent strains that could result in epidemic outbreaks of smallpox. Dr. Pringle, for instance, observed:

> I am not likely to practice inoculation, or recommend it…after inoculation smallpox appeared in many cases, and some of them were very serious ones; with vaccination this never happened…[72]

---

[72] Robert Pringle, "On Vaccination versus Isolation, as a preventive against outbreaks of Smallpox," *Transactions of the Sanitary Institute of Great Britain* (London: Offices of the Sanitary Institute, 1886), 7: 110.

The skepticism regarding inoculation, however, only really surfaced with the introduction

of vaccination in India after 1802. Before this, even colonial descriptions of inoculation

suggest that it was widely accepted in many parts of the country by the European

community.[73] For instance, J. Z. Holwell's report from 1767 was based on his

observations of the effectiveness of inoculation as practiced by the Brahmins in India to

combat smallpox. Presented to the College of Physicians in London, Holwell's account

revealed that the inoculators belonged to a "particular tribe of Bramins" who travelled

annually to the different provinces and "arrive[d] at the places of their respective

destination some weeks before the usual return of the disease."[74] Holwell also detailed

the success of this "Eastern practice", leading him to conclude that it "must have been

originally founded on the basis of rational principles and experiment."[75] After Jenner's

discovery, however, colonial administrators attempted to replace inoculation with

vaccination, an agenda that proved far more difficult than the British initially believed. In

fact, David Arnold estimates that even by 1871, there were twenty times more inoculators

than vaccinators in the country.[76]

Part of the reason for the prevalence of inoculation among Indians was that the

practice featured prominently within local religious traditions and customs. Especially in

Bengal, Hindus (and to a lesser extent Muslims) associated smallpox with the goddess

Sitala whose powers were expressed in the form of fever and eruptions.[77] As such, songs

and devotional offerings played a key role during rituals to placate the goddess and seek

---

[73] Arnold, "Smallpox and colonial medicine," 47.
[74] J. Z. Holwell, *An Account of the Manner of Inoculating for the Small Pox in the East Indies With Some observations on the Practice and Mode of Treating the Disease in Those Parts* (London: T. Becket and P. A. De Hondt, 1767), 8.
[75] Ibid., 20.
[76] Arnold, "Smallpox and colonial medicine," 50.
[77] Arnold, *Science, Technology and Medicine in Colonial India,* 73.

her pleasure.[78] One contemporary medical report even cynically suggested that *tikadaars* (inoculators) consistently promoted inoculation as a religious rite in order to legitimize their work among the local population.[79] Vaccination, on the other hand, was regarded by Indians with suspicion. Not only was the use of lymph from members of lower castes thought to be offensive and polluting, the critical link between religion and disease meant that the practice was seen as offending and defiling the goddess, Sitala.[80] Moreover, among the larger Muslim community in the Punjab (and elsewhere in India), vaccination was rumoured to be a way for the British to discover and kill the long awaited redeemer of the faith, the Mahdi.[81] In an 1884 edition of *Punjab Notes and Queries,* for example, one contemporary observer stated:

> One of the reasons natives have against their children being vaccinated is, that a child, with milk in its veins instead of blood, is to be born, which is to raise the country against the English and dispossess them. Government is naturally on the look-out for this child and anxious to destroy it, so it carefully punctures the arms of all the babies that can be got hold of by its emissaries and examines their blood.[82]

The influence of religion on local understandings of smallpox meant that vaccination became "an important site of cultural resistance to colonial medical intervention."[83] In this regard, the practice was much like other colonial projects – such as the water supply and drainage system introduced in Lahore - that heightened religious and social tensions in the province.

---

[78] Ibid.
[79] "The Report of the Indian Smallpox Commissioners," *The Lancet* (London: George Churchill, 1851), 278.
[80] Arnold, *Science, Technology and Medicine in Colonial India*, 73.
[81] Lala Kashi Ram, *The Tribune,* June 20, 1885, 8.
[82] R. C. Temple, ed., *Punjab Notes and Queries, a Monthly Periodical, Devoted to the Systematic Collection of Authentic Notes and Scraps of Information Regarding the Country and the People* (Allahabad: The Pioneer Press, 1884), 136.
[83] Arnold, *Science, Technology and Medicine in Colonial India*, 74.

Colonial experimentation with animal lymph further problematized the practice of vaccination among Indians. Difficulties with collecting and preserving humanized lymph eventually led to the development of animal lymph which secured better availability of fresh vaccine matter as it was needed. There was much optimism among medical officials with the introduction of this new technique because it involved collecting lymph directly from an inoculated animal rather than harvesting pustular matter from infected humans.[84] Perhaps the greatest advantage of this method was that it limited the transmission of diseases such as syphilis and tuberculosis which were otherwise prevalent with the arm-to-arm system.[85] The first experiments with animal vaccination – or "retrovaccination" – took place in Bombay and Calcutta as early as 1832 with more successful methods introduced throughout the rest of India after 1850.[86] However, ideas about the "success" of animal vaccination remained largely limited to the medical establishment, at least until the late nineteenth century. On the ground, there existed considerable resistance to the use of animal lymph among Indians. High caste Hindus, in particular, objected to the use of cows - considered sacred animals - in the vaccination procedure.[87] This prompted the employment of donkey lymph in 1890, although even this was eventually abandoned because of a belief among Indians that donkeys were unclean animals.[88] Evidently, colonial bids to equip the Punjab with a supply of animal lymph remained mostly

---

[84] S. P. James, *Smallpox and Vaccination in British India* (Calcutta: Thacker, Spink & Co., 1901), 37.
[85] Bhattacharya et al., *Fractured States,* 41.
[86] Ibid.*,* 40.
[87] James, 38. It was only by the 1890s that animal vaccination became more readily accepted among residents in the province. By this time, ninety-three percent of total operations in the Punjab were performed using animal lymph.
[88] Ibid.

unsuccessful in the nineteenth century, leaving officials to continue supplementing their

reserve with human lymph.[89]

According to scholars like Mark Harrison, however, native opinions about

vaccination and smallpox were not always determined by religion and nor were local

attitudes towards the disease monolithic.[90] In fact, focusing specifically on local religion

risks representing Indian responses and opposition to colonial medicine as essentialist

and reinforces binary constructions of the British as 'scientific' and Indians as 'culturally

informed'.[91] Moreover, it prioritizes linear cultural change – the orientalist idea that

Western culture was the pinnacle of social evolution and that culturally underdeveloped

societies such as India had yet to reach their peak - as the basis of India's experiences

with vaccination. This, in turn, risks overlooking the nuances that comprise the more

complex stories of smallpox and disease prevention in the country during the nineteenth

century. It is imperative, therefore, that local attitudes towards smallpox not be identified

as culturally distinct or represented solely as resistance to British medical intervention.

This latter point, in particular, is critical because local attitudes towards colonial health

measures were not always combative and were, in fact, shaped by several different

factors. An analysis of the reality on the ground demonstrates that the individual interests

of different social groups helped shape the scope of official smallpox policies in the

colony.

The local response to smallpox in Lahore is a case in point. Here, the government

policy to eradicate the disease through vaccination met with more criticism than in many

---

[89] Ibid.
[90] Harrison, *Public Health in British India,* 40.
[91] Bhattacharya et al., *Fractured States*, 9.

other parts of the country. Before the establishment of the Punjab Vaccine Institution in

Lahore in 1881 (which manufactured and supplied vaccine lymph), provincial staff

travelled to the region every three or four years to administer vaccines that had been

sourced from Europe.[92] However, contemporary accounts note a strong opposition to the

treatment of smallpox that had been implemented by the colonial government. The

Report on the Sanitary Administration of the Punjab from 1873 revealed: "It was not

better vaccination that saved Lahore, for there are few large towns in which the

inhabitants have shown themselves more averse to vaccination."[93] Similarly, the

Gazetteer of the Ferozpur District reported:

> The attitude of the people of the Lahore district towards vaccination is most
> favourable, much more so than it is in the city of Lahore…No caste or other
> prejudice appears to stand in the way, but the people generally, and the Hindus in
> particular, object emphatically to the transfer of lymph from their children to
> others, So much are they opposed to this that when the vesicles are ripe and the
> time comes for inspecting their children, they carry them off and lock their
> doors.[94]

Evidently, the opposition to vaccination in Lahore existed largely as a result of parents'

misgivings about the consequences of smallpox treatment on their families. After all, the

production of new vaccines depended on human sources of the virus to sustain the

antidote to the disease; these individuals, often children, were either operated on for

pustular matter caused by the cowpox virus (to be stored and used on others later) or were

required to travel with vaccinators as sources of fresh lymph.[95] According to *The*

Tribune, the primary objection to vaccination in the city was not the practice itself but,

---

[92] Government of Punjab, *Report on the Sanitary Administration of the Punjab for the Year 1873* (Lahore:
Mayo Press, 1874), 31.
[93] Ibid., 32.
[94] *Gazetteer of the Ferozpur District,* 1883, 10.
[95] Bhattacharya et al., *Fractured States,* 37. In some rural areas, children were vaccinated and taken
between villages without the consent of the parents. Dr. A. M. Garden, *Annual Report on Vaccine
Operations in the Punjab for the Year 1867* (Lahore: 1868), 10.

rather, to the process of taking lymph from children.[96] The annual vaccine report for the

Punjab from 1885-86 revealed that parents often disregarded official notices outlining the

time and place of vaccinations in the city.[97] In his observations on Lahore, the Civil

Surgeon for the city, Dr. Center, wrote: "The people were willing to have their children

vaccinated, but there is a strong prejudice against having their lymph taken."[98] Such

resistance, in fact, existed despite colonial efforts to appease the city's Indian residents.

Parents, for example, were often compensated for having their child taken between

villages while children themselves were offered sweets for their compliance.[99] The

monetary reward extended to parents - usually two *annas* (equivalent to one eighth of a

rupee) – was comparable to the average daily earnings of the city's lower classes.[100]

Nevertheless, opposition to the extraction procedure remained entrenched in the city.

According to *The Tribune,* moreover, resistance to the efforts of vaccinators was not

grounded in "religious scruple or prejudice" but to the feeling that the operation inflicted

pain on children without any benefit.[101] Ultimately, the lack of contributors meant that

the city's supply of fresh lymph was often in jeopardy, leading many officials to conclude

that the practice of smallpox vaccination in Lahore was a decided failure.

Other concerns also shaped local ideas about vaccination in the city. Among them

was the notion that the procedure risked exposing individuals to other, equally

---

[96] *The Tribune,* March 28, 1885, 6.
[97] Government of Punjab, *Report on Vaccination in the Punjab for the Year 1885-86,* 2.
[98] Center, 7.
[99] Newton, 13.
[100] Government of India, *Prices and Wages in India* (Calcutta: Office of the Superintendent of Government Printing, 1895), 301. An unskilled labourer working in Lahore during the 1880s earned nearly five *annas* per day (approximately one fifth of a rupee) while an agricultural labourer earned close to four *annas* per day. For more, see Paramjit S. Judge, *Insurrection to Agitation: The Naxalite Movement in Punjab* (Mumbai: Popular Prakashan, 1992).
[101] *The Tribune,* March 28, 1885, 6.

debilitating diseases like cancer and blood poisoning.[102] Therefore, a proposal by the

municipal committee of Lahore in 1885 to extend the Government of India's Vaccination

Act to the city met with strong resistance from residents. First enacted in India in 1880,

the legislation authorized certain municipalities and towns in urban areas – specifically

those that had local committees to carry out the provisions of the Act - to enforce the

compulsory vaccination of children within their respective jurisdictions.[103]

Noncompliance with the provisions of the Act was met with harsh punishments.[104]

Penalties ranged from a fine of fifty rupees to imprisonment up to six months together

with a one thousand rupee fine.[105] The Act also expected vaccinated individuals to remain

quarantined for forty days after the procedure unless otherwise indicated by a doctor;

those who chose to travel without clearance or a medical certificate were subjected to

three - some reports suggest six - months imprisonment and/or a three hundred rupee

fine.[106] The fines, in particular, were considerable by anyone's standards, especially

given the modest earnings of the working classes at the time (many labourers earned an

average of three to four rupees a month).[107] The harsh penalties imposed by the

Vaccination Act convinced Robert Egerton, the Lieutenant Governor of the Punjab, that

the legislation would have the opposite effect than that which it intended to produce.

Furthermore, he maintained that the "prejudices of the people" had made them averse to

vaccination and that their objections would continue to challenge the implementation of

---

[102] Ibid.
[103] Bhattacharya et al., *Fractured States,* 114. A compulsory system of vaccination that had first been implemented in Bombay (1877) and then Karachi (1879) became the basis for the Vaccination Act of India (1880).
[104] Syed Ahmad Khan in *The Life and Work of Syed Ahmad Khan*, 301.
[105] Ibid.
[106] *Delhi Punch,* June 3, 1885.
[107] Government of India, *Prices and Wages in India,* 301.

the Act in Lahore.[108] Although the legislation was eventually extended to the city in

1894, few Indians were seen adhering to its principles even after the First World War.[109]

According to one report from 1921, the municipality of Lahore filed 10,500 notices

against parents who had failed to vaccinate their children; from among them, 49 were

taken to court and only 18 ultimately agreed to the procedure.[110] Although there were

certainly some Indians in the city who believed in the value of vaccination, the general

consensus appeared to be an unwillingness to accept the extension of the legislation in

Lahore. As one contemporary account suggested, "gentle persuasion" rather than

compulsion was a more acceptable means of popularizing vaccination in Lahore.[111]

Indeed, many colonial officials were unwilling to raise "hostility and opposition [against]

the most beneficent of all advantages bestowed by England upon India".[112]

Lahore was a unique arena within which debates about the Vaccination Act took

place. As the capital of the province, the city's population consisted of what one

contemporary described as a heterogeneous mass of "educated, half-educated, ignorant

[and] superstitious" people.[113] Lahore's noticeably eclectic population meant that Indian

public opinion in the city was not only diverse but also influential; after all, Lahore drew

people from all over India, many of who played an active role in the city's social and

political development. The beliefs and perspectives of the educated among them were

particularly critical for shaping the implementation of British vaccination strategies in the

---

[108] *The Tribune,* March 28, 1885, 6.

[109] Government of Punjab, *Report on Vaccination in the Punjab for the Year 1899-1900* (Lahore: Civil and Military Gazette Press, 1900), 11.

[110] Bhattacharya et al., *Fractured States*, 77.

[111] *The Tribune,* May 30, 1885, 7.

[112] Government of Punjab, *Report on the Administration of the Punjab and its Dependencies for the Year 1878-79* (Lahore: Punjab Government Civil Secretariat Press, 1879), 46.

[113] Lala Kashi Ram, *The Tribune,* 8.

city. This was because many among the English-educated classes had acquired positions within the colonial bureaucratic system and drew on their knowledge and experiences to relate to British officials on their own terms. Others were part of voluntary organizations, literary associations, and educational societies that became important platforms from which they could lobby the colonial government.[114] Anxieties about large-scale resistance to colonial rule, moreover, meant that the sentiments of the uneducated masses were taken more seriously by the colonizers. These dynamics, in turn, played a decisive role in the varying, and often conflicting, responses to vaccination in the city.

Interestingly, the grounds for discussions among the educated classes in Lahore often appeared to be rooted less in medical debates surrounding the merits of vaccination and more in concerns that the Act would violate the personal liberty of residents. For instance, the most vehement opposition to the extension of the Vaccination Act in Lahore came from members of the local Indian Association whose influence in the city prompted many locals to oppose vaccination against smallpox throughout the late nineteenth century. Established in 1877, the Indian Association was a nationalist group founded by political leader Surendranath Banerjee that sought to represent the civic, intellectual and material interests of Indians to the government.[115] In response to debates surrounding the implementation of the Vaccination Act in Lahore, local members argued that the legislation would expose the city's residents to the "tyranny and malpractices of the Police and the vaccinators" and that enforcing it would be a "gross misrepresentation" of

---

[114] Douglas E. Haynes, *Rhetoric and Ritual in Colonial India: The Shaping of a Public Culture in Surat City* (Berkeley: University of California Press, 1991), 145.
[115] Kamran and Talbot, 23.

179

the actual sentiments of the citizens.[116] A *jalsa* (meeting) held in Lahore by the group in June 1885 called on the municipal committee to respect the views of the general public and to take into consideration the opinions of the uneducated classes whose voices were not part of the larger discussion on the enforcement of the Vaccination Act in the city.[117] Members, it seemed, were more troubled by the exclusion of the masses from the debate than by any particular prejudice against the smallpox vaccine itself. A similar observation was made in a local Urdu newspaper, the *Kohinoor*: "…the Act also applies to the ninety-five percent of the population that is uneducated…it is important to get the opinions of these individuals as well…Without acknowledging these opinions, a law that fines 300 rupees and six months imprisonment for disobeying it is too much to ask of the poor population."[118] Evidently, the issue with compulsory vaccination lay in the fact that it infringed upon the personal liberties of the people and that discussions surrounding its implementation in Lahore excluded the sentiments of the majority of the city's residents.

Indians who supported vaccination in the city also established their arguments along similar lines. Among them was Lala Kashi Ram, the secretary of the sanitary committee of the Anjuman-i-Punjab, a voluntary society established in Lahore in 1865 to advance vernacular literature related to a wide range of social and scientific issues. Ram contended that vaccination offered the best means of protection against smallpox.[119] He stated: "…if the operation be performed on all the children left unvaccinated in previous years in this province, and upon all those that are born in future, the disease will soon be

---

[116] *The Tribune,* June 13, 1885, 8.
[117] *Kohinoor,* June 3, 1885.
[118] *Kohinoor,* June 6, 1885.
[119] Founded in Lahore in 1865, the Anjuman-i-Punjab called for the propagation of popular knowledge and the advancement of vernacular literature in the city.

a thing of the past."[120] Local resistance to vaccination in Lahore had convinced Ram that

the only way to ensure the practice was carried out efficiently was through compulsion.

Moreover, in response to those who considered the Vaccination Act a violation of

individual freedom, Ram maintained that the legislation only interfered with "false

notions of liberty"; for him, the aim and object of any law was to benefit the individual

and, as such, it was only by submitting to it that one became truly free.[121] He stated, for

instance: "The history of man from primitive barbarism to his present stage of civilization

shows that his highest freedom has been the natural growth of the spirit of obedience to

law."[122] Clearly, Ram's support for the Vaccination Act was grounded in ideas about the

rights and responsibilities of the individual. He argued that it was the duty of every

"enlightened member" of the community to remove the false notions of the "superstitious

and bigoted" classes by explaining to them the value of vaccination.[123] While he agreed

that public sympathy for the practice could be better secured through education and

influence, in reality, "mere ideas" would not protect the city against smallpox.[124] He

asserted that by protesting against compulsory vaccination in terms of personal liberty,

opponents of the Act were shirking another serious responsibility, the welfare of the

city's residents. According to him, the blood of the innocent would be on the hands of all

those who continued to resist the imposition of the Vaccination Act in the city.[125]

     This emphasis on civic duty was also upheld by Sir Syed Ahmad Khan, a leading

Indian reformer who was the first to introduce the Vaccination Bill to Lahore's legislative

---

[120] Lala Kashi Ram, *The Tribune,* 8.
[121] Ibid.
[122] Ibid.
[123] Ibid.
[124] Ibid.
[125] Ibid.

council. He called on the public to accept smallpox vaccination as a "safe and salutary practice", arguing that there existed "sufficient reasons" to justify making the custom compulsory by law throughout India.[126] The most important of these was the fact that smallpox could not be confined to individuals or localities. As Khan argued, "…it attacks persons of all classes…The infection carries [the disease] from neighbour to neighbour, and those who suffer from the calamity may be said to be instrumental in inflicting it upon others."[127] He believed that the preservation of human life was far more important than the defense of personal liberty. He maintained, for example: "Even if it be granted that a man has a right, if he chooses, to die of small-pox, no respect for personal liberty would justify the harm which he does to his neighbours by conveying infection."[128] Compulsory vaccination was, therefore, deemed critical for protecting residents from the "ignorance or apathy of their neighbours."[129] In this regard, Khan argued that by accepting the "indifference or opposition of a part of the community", the entire country was deprived of the "advantages which the truths of science and the conclusions of actual experience have made undeniable."[130] Indeed, Khan saw himself as an advocate for the cause of humanity against the disregard and negligence of those who opposed the "undeniable results of science".[131]

Evidently, the intellectual battle between Indian supporters and opponents of the Vaccination Act in Lahore was reflective of a growing exchange between different reformist groups in the city. Although there can be no doubt that outbreaks of the disease

---

[126] Syed Ahmad Khan in *Abstract of the Proceedings,* 231.
[127] Ibid., 232.
[128] Ibid.
[129] Ibid.
[130] Syed Ahmad Khan in *The Life and Work of Syed Ahmad Khan,* 302.
[131] Syed Ahmad Khan in *Abstract of the Proceedings,* 232.

continued to provoke widespread anxiety among the public, the presence of these diverse and, sometimes, competing ideas and objectives resulted in new ways to understand not just health but also the place of Indians in colonial society. The vaccination debate became a means through which these groups identified and advanced specific agendas. For instance, it increased the tendency among the educated classes to call for better security for Indian rights. Whether they supported government interference in the regulation of smallpox or opposed the implementation of compulsory vaccination, debates surrounding the management of smallpox generated a consciousness among Indians that nurtured and encouraged the expression of Indian opinion. This search for autonomy, moreover, strained the already troubled future of vaccination in India and was part of the reason that the practice could not be implemented evenly in the country.

In fact, the issues surrounding the vaccination debate, and smallpox more generally, were so pervasive that only 441 towns and cantonments in India had introduced compulsory vaccination by 1906, representing just seven percent of the entire population of the colony.[132] As such, it is important to acknowledge that colonial health policies were never established consistently in India and that this contributed significantly to the issues that plagued the early years of the vaccination program. Moreover, Indian agency in the development and implementation of smallpox control strategies cannot be regarded as being grounded exclusively in discourses of resistance or passive acceptance. Rather, as we have seen, local attitudes towards British health infrastructures were shaped as much by cultural sentiments as they were by social motivations or even by the very human impulse to protect people (mainly children) from

---

[132] Harrison, *Public Health in British India,* 85.

the pain and discomfort associated with vaccination. There was, in other words, no uniform or homogeneous Indian response to smallpox. While these factors played a critical role in challenging the development of British smallpox policies in the Punjab, their influence in the province's larger public health narrative was not limited to the regulation of that disease alone. Tensions and antagonisms between health officials remained prevalent even during the outbreak of another even more deadly disease at the end of the nineteenth century: the plague. Combined with evolving Indian ideas and discourses, these colonial inconsistencies resulted in conflicting ideas about the disease that jeopardized the way it was confronted and regulated by colonial authorities.

<u>The Plague Epidemic</u>

The outbreak of plague in India in 1896 ushered in a sense of political and social anxiety that had not been felt in the country since the Indian Mutiny of 1857. The intensity with which the disease spread throughout the country incited ideas that the plague would have serious repercussions not just for India but also for Europe. Even though the epidemiology of the disease was still poorly understood – medical officials continued to debate the miasmatic and contagious properties of the plague into the twentieth century - public health officials recognized that infection spread very quickly. Therefore, colonial authorities worried that the plague would eventually transcend national borders and jeopardize the health and security of populations beyond Asia. This was especially true towards the end of the nineteenth century when global connections through international trade meant that the world was more deeply connected than ever before. In this regard, the plague was a worldwide problem that moved beyond national politics and institutions and required international collaboration to be successfully

184

eradicated.[133] The recognition of the disease's global nature was perhaps most apparent in

1897 when an international sanitary conference in Venice threatened to impose an

embargo on all goods imported from India as a precaution against the transmission of

plague to Europe.[134] Afraid that such restrictions would endanger trade with the colony,

the Government of India recognized the need for drastic state action to mollify

international fears and protect India's economic interests.

The Punjab was one of the hardest hit provinces in the country, with an estimated

two million plague-related deaths during the disease's peak period between 1903 and

1907.[135] In the Lahore district, there were over twenty thousand cases of plague reported

in 1902, fifty percent of which resulted in death.[136] This prompted the government of

Punjab to draft a resolution in 1898 that sought to extend a rigorous platform of plague

policies in the province. Modeled on the directives enforced in Bengal during its own

plague outbreak, the January Resolution stressed the early detection of disease, the

quarantine of sick individuals, the evacuation of infected buildings, and the chemical

disinfection of disease-ridden objects and spaces.[137] However, unlike previous epidemics,

when similar strategies were employed to curb the spread of disease, plague measures

were carried out to an extreme. For example, in some regions, isolation was enforced

under armed military guard while disinfection consisted of flooding entire towns with a

---

[133] Polu, 27.

[134] Robert Peckham, "Panic Encabled: Epidemics and the Telegraphic World," in *Empires of Panic*, 113.

[135] Kavita Sivaramakrishnan, "Recasting Disease and Its Environment: Medical Practitioners, the Plague, and Politics in Colonial India," in *Cultivating the Colonies: Colonial States and their Environmental Legacies,* ed. Christina Folke Ax, Niels Brimnes, Niklas Thode Jensen, Karen Oslund (Athens: Ohio University Press, 2011), 191.

[136] E. Wilkinson, *Report on Plague in the Punjab From October 1st 1901, to September 30th 1902, Being the Fifth Season of Plague in the Province* (Lahore: Punjab Government Press, 1904), 12.

[137] Tandon, 226.

harsh solution of mercuric chloride.[138] The extremely intrusive nature of these policies

prompted colonial administrators to anticipate resistance from the local population in the

province. As such, the January Resolution placed some authority for medical intervention

into the hands of local urban leaders and indigenous practitioners who were expected to

function as mediators between the public and government officials.[139] This strategy was

guided by the idea that local notables would be more likely to gain the trust and

cooperation of their respective Indian communities. Therefore, the Resolution

acknowledged the importance of transferring epidemic relief to the level of the *mohalla,*

or neighbourhood, and expected municipal committee members and local leaders to

organize together and embark on plague-related operations.[140] While similar policies had

been implemented during previous epidemics – subordinate staff, as we saw earlier,

assisted in smallpox vaccination drives in urban centres – plague measures established

stronger ties with representatives of local communities as well as Indian medical

practitioners.[141] For instance, colonial plague policies enlisted prominent individuals

from small towns throughout the Punjab to conduct inspections and coordinate

evacuations in their respective districts; they also mobilized Indian physicians to

participate in relief processes by overseeing the implementation of sanitary measures in

urban centres.[142] This way, the outbreak of plague in the Punjab highlighted a new

relationship between colonial authority and urban leadership, one that was reformulated

to reflect the importance of Indian and colonial interactions.

---

[138] Rajnarayan Chandavarkar, *Imperial Power and Popular Politics: Class, Resistance and the State, c. 1850-1950* (Cambridge: Cambridge University Press, 1998), 245.
[139] Tandon, 226.
[140] Sivaramakrishnan, "Recasting Disease and Its Environment", 197.
[141] Ibid., 196.
[142] Harrison, *Public Health in British India,* 144-146.

Despite the impression of compliance and compromise between British and Indian agents, however, many of the measures enforced by the administration in the January Resolution remained ineffectual. In this regard, colonial strategies to combat the disease reflected similar inconsistencies as the British smallpox agenda. Indeed, one of the greatest challenges to the government's plague initiatives existed in the diluted adaptation of plague policies, particularly in those cases where officials relied on local mediation. Here, Indian public figures (mostly reformers and newspaper editors) as well as medical men took advantage of their provisional authority to reconstitute local spaces and increase their engagement with and access to discourses on the plague.[143] In the spring of 1898, for example, Munshi Muharram Ali (the editor of the *Rafiq-i-Hind*) held a meeting of Indian medical practitioners in Lahore to discuss the implications of the city's plague rules.[144] The group concluded that measures such as segregation and quarantine should be tempered and replaced with less intrusive methods to combat the disease.[145] One proposal put forward by Vaid Thakur Dutt Sharma, a renowned local practitioner, suggested that cleansing the environment by lighting fires to purify the air was a much better preventive strategy than forcible evacuation and segregation.[146] However, if policies like quarantine had to be enforced, many Indian physicians recommended securing the cooperation of the public by appealing to local leaders and *mohalladars*.[147] This way, local practitioners served a distinct role as mediators for the government during

---

[143] Ibid.*,* 146.
[144] Sivaramakrishnan, "Recasting Disease and Its Environment", 200-201.
[145] Ibid.
[146] Ibid., 203.
[147] Harrison, *Public Health in British India,* 146.

the plague epidemic in the Punjab and demonstrated, more significantly, that Indian interpretations of the disease had important ramifications for the colonial plague agenda.

While these factors played an important part in interfering with the epidemiological priorities of the colonial administration during the plague years, one issue that further complicated the government's formulation of effective plague policies was a limited knowledge of the causes and transmission of the disease itself. When the plague first hit the Punjab in 1896, medical and sanitary officials emphasized a localist theory which assumed that factors such as poorly built houses, crowded spaces, and the presence of disease-carrying rats facilitated the spread of the disease.[148] Others proposed a "miasmatico-contagious" theory for the plague which asserted the probability of infection through contact as well as localized miasmas.[149] Even after the discovery of the plague bacillus by Alexandre Yersin in 1894, a number of epidemiologists continued to challenge the role of the microbe in the causation of disease because they believed the bacterium was a consequence of the plague.[150] It was in response to this uncertainty that the Government of India established the Indian Plague Commission in 1898 to inquire into the aetiology of the disease. Led by Dr. T. R. Fraser, its primary role was to understand the conditions that contributed to the spread of the plague and to consider the most effective sanitary approaches for managing the epidemic in India. After deliberating for seventy-two days, the Commission leaned more favourably towards human agency as a cause for disease transmission.[151] Furthermore, it published several volumes detailing its analysis of the plague and suggested that the best strategy for its management was to

---

[148] As such, early anti-plague regulations encouraged policies like disinfection.
[149] Chandavarkar, 243.
[150] Ibid.
[151] Kalpagam, 248.

188

administer an anti-plague vaccine throughout India; this approach, in fact, eventually became the central and provincial governments' policy of choice.[152]

The vaccine, developed by Waldemar Haffkine in 1897, was intended to work like the smallpox vaccination by producing an immune reaction in the body that would protect it against the disease. However, unlike the smallpox vaccine, which used cowpox matter to trigger immunity, Haffkine's prophylactic relied on attenuated plague bacteria to engender a reaction in the body. As such, it was similar to the Indian practice of inoculation (i.e. treating like with like), leading many officials to use the term synonymously with "vaccination" to describe the anti-plague procedure. Some colonial authorities did object to expanding the use of Haffkine's vaccine in India because of a lack of standardization with the early doses of the prophylactic. Most, however, agreed that it significantly diminished mortality rates among those who were vaccinated.[153] In the Punjab, one report by Major E. Wilkinson, the Chief Plague Medical Officer for the province, stated: "Opinions regarding the value of inoculation as a means of dealing with outbreak of plague are unanimous – many regarding it as the most valuable of all such measures…"[154] Vaccination was also preferred because it was a cheaper alternative to other anti-plague measures such as disinfection; in the Punjab, the cost of the former was calculated at 33,276 rupees for the year 1902 whereas disinfection was estimated at over 80,000 rupees.[155] The latter was also carried out sparingly in the Punjab because it involved interfering with the domestic privacy of the people and, more importantly, required resources the municipal government often lacked. By the beginning of the

---

[152] Polu, 71.
[153] Kalpagam, 242.
[154] Wilkinson, *Report on Plague in the Punjab From October 1st 1901, to September 30th 1902,* 17.
[155] Ibid., 17-18.

twentieth century, moreover, the government's bacteriologist, Edward Hankin, concluded that disinfection provided only limited protection because the plague bacillus was resistant to certain chemical disinfectants such as carbolic acid.[156]

Vaccination, therefore, was the preferred option. Colonial officials believed that educated members of the Indian population would voluntarily accept the prophylactic, especially if the government advised them of its benefits and provided adequate facilities for administering the vaccine. However, having learned from the smallpox vaccination campaigns, authorities were wary of enforcing the practice on the people through legislation. For example, one contemporary report stated: "The cast or sect prejudices of the people of India are well-known, and the most scrupulous care is always taken by the Government to avoid encroaching upon them in the slightest degree in any movement for the public good."[157] This led Wilkinson to argue that the only way to ensure that there was no discontent or disturbance in the province during plague outbreaks was by avoiding compulsory measures to restrain the spread of the disease.[158] Rather, he suggested that groups of select officials be sent to infected districts in order to "preach on the good effects of inoculation" and "do all in their power to persuade the people to accept it."[159] Nevertheless, the ambitions and agendas of certain members of the local community made it difficult to enforce the preventive measure without stirring local resistance.

---

[156] Harrison, *Public Health in British India,* 153-156.
[157] Howard Vincent, *Russia and India in 1903* (London: P. S. King & Son, 1903), 54.
[158] Wilkinson, *Report on Plague in the Punjab From October 1st 1901, to September 30th 1902,* 4.
[159] Ibid., 39.

Local Responses to Colonial Regulatory Objectives II

Indian responses to plague measures in Lahore suggest that locals were influenced by several factors. For example, communities often resisted segregation and evacuation on practical grounds, such as the inconveniences that came with displacement. This was evident in the report of the Plague Medical Officer: "Except in the case of a few [residents] who voluntarily left their infected houses and went to live near their wells on the river bank, no evacuation was practiced in Lahore."[160] Moreover, attempts to eradicate rats – while they were known to contribute to the spread of disease, there was little agreement on how they spread infection to humans - were opposed by residents, particularly Hindus, who objected to killing the animals on religious grounds. One plague report from the Punjab revealed that notices issued in several districts ordering people to burn dead rats when found went largely ignored.[161] As a result, some officials argued that Indians were less likely than Europeans to survive the plague because they resisted preventive measures and seldom sought medical attention in the early stages of the disease when it was easiest to treat.[162]

Local reactions to the plague vaccination were similarly adverse. Although some Indians came willingly to be vaccinated, the alarm and uncertainty that surrounded the disease meant that the general sentiment towards the prophylactic was opposition. In fact, according to a report in *The British Medical Journal* from 1899, the progress of vaccination in the Punjab at the end of the century was considered "unfavourable"; from a population of nearly 21 million people in the province, only 596,391 had been

---

[160] Ibid., 77.
[161] Ibid., 11.
[162] R. Nathan, comp., *The Plague in India 1896-1897* (Simla: Government Central Printing, 1898), 23.

successfully vaccinated between 1897 and 1898.[163] Indian resistance to the procedure, moreover, took several different forms but perhaps the most compelling factor that informed local reactions was, as David Arnold argues, plague rumours. Rumours heightened the feelings of anxiety and panic that were already evoked by epidemic outbreaks.[164] They often appeared in vernacular newspapers and, because they were facilitated by and circulated within print media, rumours gained a higher degree of legitimacy. Indeed, for many Indian critics of plague vaccination, disseminating rumours in local newspapers became a means of discrediting the colonial administration by fueling middle-class resentment towards government intervention.[165] According to Arnold, such unfavourable reports were likely incited by *hakims* and *vaids* who galvanized the public to oppose Western medicine in an effort to serve their own interests.[166] This way, rumours offered not only an accessible and tangible way to articulate local fears and anxieties, they also exposed British officials' incomplete knowledge of and vulnerability to Indian society. After all, their appearance in official and vernacular reports had the power to spread discontent among locals and, in turn, disrupted plague-related colonial endeavours.[167]

Of all the anti-plague measures that were enforced by health officials in the Punjab, vaccination featured most prominently in local rumours and reinforced concerns that the practice caused more harm than good. One report, for example, stated: "People

---

[163] "Vaccination in India," *The British Medical Journal,* June 3, 1899, 1341.

[164] Arnold, "Disease Rumour, and Panic in India's Plague and Influenza Epidemics, 1896-1919," in *Empires of Panic,* 116.

[165] Ibid.

[166] Ibid*.,* 117.

[167] Rumours must not be viewed as an exclusively Indian means of expression. Colonial officials often used the same medium to expose accusations against themselves as irrational and superstitious as well as to demonstrate the "absurdity and naïve credulity of the masses". Arnold, *Colonizing the Body*, 218.

were at first greatly frightened of and opposed to inoculation. All sorts of rumours were started about it."[168] The rumours included claims that the plague vaccine caused impotence and blindness and spread "other ills" such as leprosy.[169] They even suggested that some individuals had died after receiving the vaccine, which no doubt deterred many Indians from volunteering to be vaccinated.[170] Although the report was ultimately found to be fabricated, colonial officials argued that the damage had already been done and no amount of publicity in favour of inoculation would convince locals to come forward and accept the prophylactic.[171] Other rumours suggested that vaccination was a means of spreading plague in the Government's attempt to "get rid of the surplus population".[172] A widespread impression among the residents of the Lahore district suggested that this scheme was accompanied by a plan to poison wells in some villages; locals, in fact, believed that doctors had been contracted by the government to kill thousands of Indians this way, prompting them to place guards near drinking wells to keep watch throughout the day and night.[173] Many Indians were also mistrustful of colonial authorities when plague measures with the least amount of interference were adopted. One Indian in Lahore, for instance, was prosecuted for refusing to have his house disinfected.[174] For people like him, objections to the practice were grounded in rumours about the content of the disinfecting solution. It was believed that the green aniline dye, which stained the acidulated mercury solution, was used to spread the plague infection by killing healthy

---

[168] Wilkinson, *Report on Plague in the Punjab From October 1ˢᵗ 1901, to September 30ᵗʰ 1902*, 73.
[169] Ibid.
[170] Ibid., 77
[171] Ibid.
[172] Ibid., 6.
[173] Ibid., 71.
[174] Ibid., 77.

rats.[175] Rumours like these suggest that there existed a deeply ingrained suspicion of the purpose of colonial medicine in the Punjab. While this was not a new sentiment among Indians, it nevertheless reveals how extensively the subject of plague, and the policies established to protect against the disease, were part of the popular discourse at the time.

Other reactions to the plague and to colonial regulations for containing the disease came from a large number of indigenous medical practitioners whose views were often featured in local medical writings. Particularly in the early twentieth century, pamphlets and notices began to circulate among a growing urban population that stressed the relevance and importance of Indian knowledge in the fight against the plague. Like rumours, these writings functioned as an important medium through which local medical advice about the disease could be expressed. But, even more importantly, they became a space that was often manipulated to advance unique Indian agendas. For some, as we will see, local writings on the plague legitimized and strengthened a public role for indigenous medical systems such as Ayurveda and Unani. Particularly in light of the inability of state sponsored medicine to defeat the plague, Indian practitioners were given more opportunities to introduce into the public consciousness their own understanding of the disease. Public skepticism of and resistance to colonial medicine had already informed a shift in colonial plague measures which replaced offensive policies (meant to eliminate the source of plague such as disinfection and quarantine) with more defensive tactics that would decrease human susceptibility to the disease (i.e. vaccination).[176] With British administrators relying more consistently on Indian mediators to promote the

---

[175] Ibid., 27, 124.
[176] Sivaramakrishnan, "Recasting Disease and Its Environment", 194.

government's medical policies, Indian physicians used this opportunity to address the emerging market of literate readers in major cities.

Indigenous medical writings established important dialogues between Indian physicians, colonial authorities, and the public. In addition to enabling local engagement and participation in public issues, these writings helped promote the authority and value of Indian medical knowledge in matters related to health. Plague tracts, in particular, became a new forum for debates concerning the disease and were used by Indian practitioners to redefine and reformulate their position in the medical arena.[177] In Lahore, they were often aimed at a largely literate and educated public and helped shape the opinions of influential groups in the city by making the disease intelligible in social and medical terms; the authority and resources of these patrons, in turn, widened the scope of indigenous medicine by negotiating a public space for its operation in urban centres.[178] The dissemination of these writings on the plague, however, came with its own challenges. Perhaps the most significant for Indian physicians was the growing competition of rival "quack" medicine which was mediating its own place within plague discourses.[179] A new group of chemists and druggists was venturing into the medical arena and appropriating the identity of physicians by preparing drugs and offering diagnoses to the sick.[180] Statistics from the province during the late nineteenth century reveal that no distinctions were made between these chemists and various classes of traditional grocers.[181] As such, despite their affiliation with established Indian medical

---

[177] Ibid., 197.
[178] Ibid., 195.
[179] Ibid.
[180] Sivaramakrishnan, *Old Potions, New Bottles,* 102.
[181] Ibid.

systems, local practitioners found themselves on a quest for "alternative social legitimacy" in order to create a public profile that differed from these peripheral practices.[182]

One of the ways that Indian writers of plague tracts distinguished their work from the commercial interests of "quacks" was by offering their audience a "service-oriented" strategy towards the disease.[183] More specifically, this meant stressing their involvement in philanthropic acts, expressing their commitment to healing the sick, and relating the success of traditional indigenous medicine during specific incidents.[184] As well, plague tracts often featured remedies for treating the disease at home, a factor that helped extend the practitioner's influence beyond the public domain and into the private sphere. Using their skills as publicists as well as medical men, these Indian physicians propagated ideas about their charity and service to the people and, in doing so, reinforced their presence in the medical field.[185] Among those popular in Lahore was the previously mentioned Thakur Dutt Sharma, an Ayurvedic practitioner who upheld the authority of Vedic treatises in understanding and treating disease. His knowledge of the plague was derived from classical medical texts as well as from local practices which he believed were better suited to the habits and customs of the Indian people (unlike Western remedies which he deemed foreign).[186] By situating a disease like the plague within an intellectual and rational scriptural tradition, practitioners like Thakur Dutt Sharma maintained that the successful treatment of the disease was anchored in the knowledge and experiences of

---

[182] Sivaramakrishnan, "Recasting Disease and Its Environment", 198.
[183] Myron Echenberg, *Plague Ports: The Global Urban Impact of Bubonic Plague, 1894-1901* (New York: New York University Press, 2007), 51-52.
[184] Ibid., 52.
[185] Ibid.
[186] Sivaramakrishnan, *Old Potions, New Bottles*, 110.

those who practiced and applied Vedic learning.[187] This emphasis on ancient texts was shaped, in large part, by a need to define indigenous medicine as an authentic source of medical knowledge. Therefore, many local physicians who were trained in classical medicine often stressed the differences between their field and what they considered "quack" medicine. For them, the rightful treatment of the plague belonged to the formal practices of Vedic medicine. One physician, for example, argued that turning to remedies such as exorcism, divination, and charm-based healing only interfered with legitimate medical relief by spreading false knowledge about the disease.[188] Instead, Indian practitioners like Thakur Sharma Dutt used plague tracts to endorse Ayurvedic medicines and locally made drugs whose formulas were derived from Vedic knowledge. In his *Plague Pratibandhak,* for example, he campaigned against the use of foreign preparations, such as beet sugar, in treating the disease.[189] Ultimately, in highlighting the importance of classical knowledge, the aim of these indigenous physicians was to establish a more extensive public role for Indian medicine.

Although plague tracts certainly reflected distinct Indian influences, this did not mean that indigenous perceptions of the disease were naturally opposed to western medicine. Indian ideas about the plague reflected a fluid understanding of the disease which often employed, without contradiction (and in some ways similar to British thinking), a miasmatic and contagionist theory for its transmission. As such, it was not uncommon to find Indian practitioners mobilizing public support for colonial plague operations in their writings; vaccination, in particular, was one subject that was taken up

---

[187] Echenberg, 53.
[188] Sivaramakrishnan, *Old Potions, New Bottles*, 112-113.
[189] Ibid., 80.

by several local physicians who attempted to make the practice more agreeable to the masses by publicizing its benefits in their writings. Ghulam Nabi, a well-known hakim from Lahore, for instance, encouraged the residents of the city to volunteer themselves for vaccination and to support the government's sanitation campaigns.[190] For him, the prophylactic was the only reliable "body guard" against the plague and, therefore, he spent much time actively promoting the effectiveness of vaccination during public meetings in the city.[191]

Some vernacular writings on the plague, however, masked more self-interested agendas that were not always informed by resistance to or support for British interventionist measures. In fact, one of the most interesting impulses behind the distribution of a plague tract in Lahore came from the founder of the Ahmadiyya movement, Mirza Ghulam Ahmad. Believed by his followers to be the promised messiah and redeemer of Islam, his tract entitled "A Revealed Cure for the Bubonic Plague" (1898) was meant to be a testament to his divine assertions. Here, Mirza Ghulam Ahmad offered an antidote to the plague that found its roots in the salve used on Jesus' wounds after his crucifixion. He wrote:

> …God reveals by direct Inspiration the specific remedy of the evil to some His chosen people, whose connections with Him are most sincere. In this age Almighty God has been pleased to choose *me* to perform this function. The cure which I proclaim for the plague consists of two different medicines. One of them called the Tiryaq-i-Ilahi or the Divine treacle has been prepared solely by me, and it is to be taken as hereafter suggested. The other which is to be applied externally to the glands is an ointment called Marham-i-Isa or the ointment of Jesus.[192]

---

[190] Ghulam Nabi, *Chuha aur Plague. Billi aur Chuha aur Muhafaze Jaan Tikka* [Rat and Plague. Cat and Plague and Vaccination] (Lahore: n.d.).
[191] Ibid.
[192] Mirza Ghulam Ahmad, *A Revealed Cure for the Bubonic Plague* (Lahore: Victoria Press, 1898), 2.

In offering a divinely inspired remedy for the plague, Mirza Ghulam Ahmad's tract reflects his efforts to substantiate his position as the promised disciple. His claim to be the spiritual second coming of Jesus set him apart from mainstream Islam which held that the Mahdi was yet to come. Also, unlike established Islamic convictions, Mirza Ghulam Ahmad claimed that Jesus did not die on the cross but came down alive from it, only to die a natural death in Kashmir at the age of 120.[193] According to him, it was the ointment that helped restore Jesus to full health, making it critical for "falsif[ying] the popular supposition that Christ died on the cross…" Prepared by his apostles, the salve was "wonderfully efficacious in curing [his] wounds within forty days."[194] The plague remedy described in the tract was directly linked to the *Marham-i-Isa* (ointment of Jesus) which not only helped legitimize the potency of the cure but also sought to validate Mirza Ghulam Ahmad's claim to be the promised Mahdi.[195]

The followers of Mirza Ghulam Ahmad allegedly contributed 2,500 rupees towards the preparation of the medicine.[196] Although it was marketed and sold in Lahore for a year, the Deputy Commissioner of the city labeled the remedy a fraudulent product in 1899 and ordered its sale be discontinued.[197] Mirza Ghulam Ahmad appealed the ruling but the Chief Court of Punjab upheld the decision in the summer of 1900.[198] Two years later, Mirza Ghulam Ahmad published a book in response to the backlash he faced regarding his claims to be divinely appointed; here, he argued that the plague continued to ravish the Punjab and the rest of India only because the promised messiah of God had

---

[193] Ibid., 3.
[194] Ibid.
[195] Ibid., 2.
[196] Eric Pement, "The Ahmadiyya Movement in Islam," *Watchman Fellowship,* 2010, http://www.watchman.org/profiles/pdf/ahmadiyyaprofile.pdf. Accessed November 16, 2016.
[197] Ibid.
[198] Ibid.

been denied and made to suffer at the hands of disbelievers who plotted to kill him.[199] He

also reiterated a prophecy made four years earlier in which he maintained that a severe

outbreak of plague would devastate the Punjab because the people had rejected God's

will.[200] Thus, for Mirza Ghulam Ahmad, the plague was inevitable and the only way it

would be eradicated in the province was if the people recognized him as the redeemer of

mankind. He wrote: "The message that God revealed to me for removing this disease is

that people should wholeheartedly accept me as the Promised Messiah."[201] Despite being

called a disbeliever by the majority of Muslims in the province, Mirza Ghulam Ahmad

nevertheless found a following that eventually broke away from mainstream Islam. A

large part of his success was due to the fact that he owned a printing press that allowed

him to publish a large number of books and pamphlets to promote his ideas. But, even

more importantly, it was his revelations about the spread of plague in the province that

encouraged many to accept his message. In fact, one contemporary report suggested he

had over ten thousand followers in India by 1905.[202]

Conclusion

The outbreak of smallpox and plague in Lahore had important ramifications for

the colonial government and its enforcement of public health measures in the city. While

medical officials spent much of the late nineteenth and early twentieth centuries debating

and testing various methods to restrain the spread of disease, inconsistencies within the

administration and resistance from Indians made the imposition of an all-encompassing

---

[199] Mirza Ghulam Ahmad, *Defence Against the Plague & Criterion for the Elect of God* (Qadian: Diya-ul Islam Press, 1902), 16.
[200] Ibid.
[201] Mirza Ghulam Ahmad, "The Plague," in *The Essence of Islam Vol. 5: Extracts from the Writings, Speeches, Announcements and Discourses of The Promised Messiah and Mahdi Hazrat Mirza Ghulam Ahmad of Qadian,* trans. Saleem-ur-Rehman (Tilford: Islam International Publications, Ltd., 2007), 95.
[202] H. D. Griswold, *The Messiah of Qadian* (London: Harrison and Sons, 1905), 12.

colonial medical agenda nearly impossible. As this chapter has demonstrated, disagreements and divisions at different levels of government highlighted the fragmented nature of colonial rule as well as the government's dependence on local mediators to carry out its policies. Moreover, indigenous responses to these measures further limited the scope of public health regulations in the Punjab. But, as we have seen, Indian resistance to colonial measures such as vaccination should not be regarded solely as culturally-informed opposition to government intervention. Rather, Indian experiences of diseases like the plague and smallpox allowed the educated classes to advance their own unique agendas. For many, epidemic outbreaks presented an opportunity to gain social prominence in their community while for others they served as a space for promoting indigenous knowledge. Lahore's cosmopolitan culture ensured the advancement and legitimization of these diverse medical ideas, many of which came to challenge colonial endeavours in the city. As such, diseases like the plague and smallpox must be recognized not only for highlighting the fragmented nature of the colonial administration but also for drawing attention to the perseverance of Indian agency.

Chapter 6 – Opium Consumption as Subversion

<u>Introduction</u>

The limits of colonial intervention in Lahore were evident in other, more marginal, areas of public health too. In particular, the consumption and sale of drugs like opium created new issues for the British administration, especially when carried out illicitly. Indeed, the opium trade in the colony had a long and complex history. The drug was produced largely in northern and western India since at least the seventeenth century and became an important commodity in British intra-Asian trade by the 1820s.[1] Despite efforts by Qing Emperors to abolish its consumption in China, British and Indian traders continued to sell contraband opium in the region, making it a key element of colonial trade in the nineteenth century.[2] Most scholars of South Asia agree that opium had widespread benefits for the Indian economy and, as one of the colony's top export products, the drug helped offset the cost of imperialism by creating substantial revenues for Britain.[3] In fact, by the mid-nineteenth century, the success of the opium trade and the revenues it generated for the British Empire were undeniable. In the 1870s, for example, the drug was the single largest product to be exported from India to Southeast Asia by the British with approximately 90,000 chests of opium transported annually.[4] This amounted to an average of 93 million rupees a year (16% of the state's total revenue) for the

---

[1] Amar Farooqui, "Opium as a household remedy in nineteenth-century western India?" in *The Social History of Health and Medicine in Colonial India,* ed. Mark Harrison and Biswamoy Pati (London: Routledge, 2009), 229.

[2] Frank Dikötter, Lars Laamann, and Zhou Xun, *Narcotic Culture: A History of Drugs in China* (Hong Kong: Hong Kong University Press, 2004), 41.

[3] John F. Richards, "Opium and the British Indian Empire: The Royal Commission of 1895," *Modern Asian Studies* 36, no. 2 (2002): 377.

[4] Ibid., 365.

Government of India.[5] These returns played a critical role in reducing Britain's trade deficits with China and became a key incentive for keeping the opium trade alive. After all, the growing enterprise allowed the government to pay for Chinese goods in a currency other than silver. The success of the trade with China, moreover, informed a British reluctance to develop a domestic Indian market for the drug. Colonial authorities realized quickly that they could achieve the same returns by selling opium in either India or China; in order to balance their trade with the latter, the government determined it would better serve their economic interests to export the drug to Southeast Asia.[6] These calculated moves reinforced the growing importance and value of opium during the nineteenth century and helped shape its development into an essential commodity that influenced larger colonial objectives in India.

As a subject of academic scholarship, the opium trade has been examined extensively by historians of Asia. During the late 1990s, some scholars were of the opinion that British imperialists exploited colonized populations by compelling them to produce large amounts of the drug – to which they also became highly addicted – as a means of sustaining the Empire's economic growth.[7] However, the problem with this view, according to influential studies on the subject by Richard Newman and John F. Richards, was that it depicted the indigenous population as the victims of imperial power and minimized the social and cultural value of opium in Asia.[8] Uneasy with this

---

[5] Ibid.
[6] Ibid., 377-378.
[7] Among them were M. Emdad-ul Haq, *Drugs in South Asia* (New York: Palgrave, 2000) and Carl Trocki, *Opium, Empire and the Global Political Economy: A Study of the Asian Opium Trade 1790-1950* (London: Routledge, 1999).
[8] John F. Richards, "The Opium Industry in British India," *The Indian Economic and Social History Review* 39, no. 2-3 (2002): 152; Richard Newman, "Opium Smoking in late imperial China: A reconsideration," *Modern Asian Studies* 29 no. 4 (1995): 767-769.

interpretation, Newman and Richards set out to demonstrate that the production of the drug in India was viewed with as much logic and reasoning by the colonized as it was by the colonizers and that the local people, like the British, recognized the lucrative nature of the trade.[9] As such, they argued that Indians often took advantage of the favourable conditions of the market to serve their own interests. As we will see, for example, the high demand for opium in India indirectly encouraged activities such as smuggling and the establishment of opium dens which, by the end of the nineteenth century, had become well-organized and large-scale enterprises. In fact, a closer look at opium-related activities in the colony suggests that Indians were able to circumvent the imperial stranglehold on the production and trade of the drug and made personal profits by illegally retaining and selling portions of opium from cultivators.[10] Using the Punjab and Lahore as a case study, this chapter will demonstrate not only that the government was unable to minimize the sale of illegal opium but that Indians were far from being pawns in a colonial game designed to "poison" and overpower them for economic gain. Rather, locals participated in the workings of the opium market by establishing themselves as skilled and competent rivals of British capital.[11]

Opium in the Punjab

Before the British annexation of the Punjab, opium consumption and poppy cultivation had already been prevalent in the region, particularly under Sikh rule. During this time, there were no regulations on the production or sale of the commodity which

---

[9] Richards, "Opium and the British Indian Empire," 381.
[10] Farooqui, *Smuggling as Subversion* (New Delhi: New Age International, 1998), 12.
[11] Ibid.

allowed opium to be freely available on the market.[12] The establishment of colonial rule,
however, signaled new changes for the way the drug was to be manufactured and
consumed in the province (and the colony in general). The British urgency to protect its
interests in the opium trade along with pressures from anti-opium lobby groups in the
metropole - the demands from reformers were particularly influential in forcing officials
to consider the moral aspects of the trade as well as the detrimental effects of opium on
Indian society - pushed the government to impose strict regulations on the drug. In light
of these mounting pressures, the key objective of the colonial government became the
establishment of a system that would control the production and movement of opium
without jeopardizing the revenue it generated.[13]

Perhaps the most important measure that came to regulate the drug in the province
was the Opium Act (1878) which established complete state monopoly over the
commodity. The Act, implemented across British India and Burma, expressly prohibited
any cultivation, possession, or trade of opium that was not sanctioned by the government
and granted complete authority of all matters related to the manufacturing, sale, and
possession of the drug to the Governor General in Council.[14] Among the key changes
introduced by the legislation was the regulation of poppy cultivation. In the Punjab, for
example, opium could only be produced under special license in the districts of Ambalah,
Ludianah, Ferozpur, Jalandhar, Lahore, and Gujranwala.[15] Here, poppy cultivators were

---

[12] Richards, "Opium and the British Indian Empire," 412.
[13] Ibid., 409.
[14] Anirudh Deshpande, "An Historical Overview of Opium Cultivation and Changing State Attitudes
towards the Crop in India, 1878–2000 A.D.," *Studies in History* 25, no. 1 (2005): 114; Government of
India, "The Opium Act, 1878," in *Acts of the Legislature in Force in the Presidency of Bombay,* ed. H. M.
Birdwood and H. J. Parsons (Bombay: Education Society's Press, 1881), 1-2. The only places where the
Act was not extended were the Andaman and Nicobar Islands and the Pargana of Manipur.
[15] G. H. M. Batten, "The Opium Question," *Journal of the Society of Arts* 40, no. 2035 (1891): 448.

also required to pay a per-acre fee - two rupees in 1871 which increased to eight rupees in 1889 - for any land that was used in the production of the plant.[16] Under the regulation, moreover, poppy grown outside these districts was illegal and subject to confiscation by police, custom, or revenue officials who had been authorized to monitor and supervise the crops.[17] Opium could also only be purchased from licensed vendors who were charged a fixed fee to sell the drug; there were close to 1,900 such retailers operating in the Punjab by the 1880s.[18] These opium shops received their supply directly from poppy cultivators or through wholesale dealers that were licensed specifically for that purpose.[19] Opium that was imported from outside the province was regulated by a government-imposed tax whereas homegrown opium was moderated by a system of passes that authorized its transportation from the district of purchase to the district of sale.[20]

The Opium Act allowed provinces to establish their own system of regulation to manage the drug for domestic use. Provincial officials, for example, authorized the number of vendor licenses that could be granted in each city and district under their jurisdiction.[21] Provinces also determined fixed limits for the individual possession of the drug which could range anywhere between 300 to 900 grains (20 to 60 grams) of crude opium per person at a time; in the Punjab, the maximum amount saleable by retail was set to 540 grains (35 grams) per person.[22] Anyone in possession of more than this amount

---

[16] Government of Punjab, *Report on the Administration of the Punjab and its Dependencies for the Year 1871-1872* (Lahore: Government Civil Secretariat Press, 1872), 97.
[17] Richards, "Opium and the British Indian Empire," 410.
[18] *Statement Exhibiting the Moral and Material Progress and Condition of India During the Year 1891-92 and the Nine Preceding Years* (London: Eyre and Spottiswoode, 1894), 54.
[19] *First Report of the Royal Commission on Opium* (London: Eyre and Spottiswoode, 1895), 110.
[20] Richards, "Opium and the British Indian Empire," 410.
[21] Ibid., 412.
[22] Sandeep Chawla, ed. *Bulletin on Narcotics: A Century of International Drug Control* (Herndon: United Nations Publications, 2007), 59: 29; *First Report of the Royal Commission on Opium,* 8.

was subject to punishment under the Opium Act which also detailed penalties - fines, confiscation, and prison sentences - for the illicit purchase, storage, and trade of the drug.[23] Despite regional differences in some parts of the Act, most of the penalties outlined in the legislation remained consistent throughout British India. Section nine, for example, called for imprisoning anyone in contravention of the Act for up to one year; it also authorized the imposition of a fine of one thousand rupees on the transgressor.[24] These penalties, furthermore, were to be charged for *each* action that violated the provisions of the Act.[25] Evidently, the overall aim of the restrictive regulation was to produce maximum revenues for the government while limiting domestic consumption.

Even with the imposition of the Opium Act, however, production and use of the drug in the Punjab remained widespread well throughout the nineteenth century. According to one report, 550 chests of opium – one chest contained approximately 140 pounds of the drug - were imported into the Punjab between 1893 and 1894, 150 of which were reserved for use within the province itself.[26] The drug, moreover, was also reported to be "found in the bazars of the Punjab cities", making it increasingly accessible to the local public.[27] Among the indigenous population, consumption of opium was influenced considerably by the powerful social and cultural overtones of the drug. Indeed, opium was believed to possess medical properties which, when taken in

---

[23] Deshpande, 114.
[24] Government of India, "The Opium Act, 1878," 6.
[25] Ibid.
[26] "Excise Departmental Orders," *The Punjab Record, or Reference Book for Civil Officers* 28 (1895): 29; Farooqui, *Smuggling as Subversion*, 30.
[27] Baden H. Powell, ed. *Hand-book of the Economic Products of the Punjab: With a Combined Index and Glossary of Technical Vernacular Words* (Roorkee: Thomason Civil Engineering College Press, 1868), 1: 294.

moderation, was meant to benefit personal health.[28] It was also consumed recreationally

by younger men on social occasions such as weddings as well as by older men and

women who used the drug more habitually; average dosages ranged from a low of 2 to 5

grains of opium (0.13 to 0.32 grams) a day to a high of 40 grains (2.6 grams) a day.[29] A

report on opium by the Assistant-Surgeon of the Punjab, Mul Chand, commented on the

extensive use of the drug:

> …opium is largely taken by Jat Sikhs…On inquiry I was informed that the use
> of opium keeps them free from fever, cold, and other effects of moisture…
> moreover, for the sake of formality, it is presented to friends and other
> gentlemen who come for interviews…[30]

Another contemporary account suggested that those who consumed opium were not only

more "active, energetic being[s], capable of going through any amount of physical or

mental labour" but also better fathers and husbands because of the "domesticating

tendency" of the drug.[31] Even children received opium at a young age in order to comfort

them while their mothers and nurses carried out household chores.[32]

Generally speaking, popular Indian discourses about opium consumption

represented the drug as a safe and reliable health remedy. Mul Chand's own report

concluded that "opium-eaters enjoy[ed] immunity from sickness in a remarkable degree

when compared with others."[33] Other medical authorities also authorized it as a safe and

acceptable household drug. For instance, according to Rahim Khan, a lecturer at the

---

[28] Farooqui, "Opium as a household remedy," 232
[29] One kilogram = 15,432 grains. Richards, "Opium and the British Indian Empire," 402; Richards, "The Opium Industry in British India," 163.
[30] Mul Chand, "Evidence Regarding Opium Given Before the Royal Commission," in *The Medical Reporter, A Record of Medicine, Surgery, Public Health, and of General Medical Intelligence* ed. Lawrence Fernandez (Calcutta: Medical Publishing Press, 1894), 97.
[31] Patrick Hehir, "The Opium Question," *The Indian Medical Gazette*, May 1894, 216.
[32] Farooqui, "Opium as a household remedy," 233.
[33] Mul Chand, 98.

Lahore Medical College, opium was consumed primarily to obtain relief from bodily

ailments as well as in cases of fatigue.[34] Similarly, Dr. Elizabeth Bielby, the first female

doctor in the Punjab and the director of Lady Aitchison Hospital in Lahore, stated that it

was general practice among women in the Punjab to consume a small dose of the drug

(about one grain) before their midday meal to aid with digestion.[35] Another commentator

maintained that opium users were "protected by the habit against the inroads of diarrhoea,

dysentery, ague, and other maladies incidental to damp and malarious climates" such as

India's.[36] Evidently, many locals regarded opium as an invaluable therapeutic that served

both recreational and medicinal purposes, allowing it to become easily established as a

domesticated drug.

The Colonial Construction of Opium

Amar Farooqui, however, argues that ideas about the relative harmlessness of

opium were shaped by colonial constructions of the drug as a respectable commodity, a

strategy, he maintains, that was used to legitimize the opium industry in India.[37] Although

its pervasive use within many sections of Indian society certainly suggests that the drug

did not signal any moral or social dilemmas for the native population, this sentiment was

more likely the outcome of the "legitimizing processes of the colonial state."[38] Farooqui,

in fact, suggests that ideas about the seemingly benign nature of opium were shaped

ostensibly by the report of a royal commission that was appointed in 1893 to determine

whether the opium trade should be abolished and whether local consumption of the drug

---

[34] Lepel Griffin, "The Lotos Eaters," in *The Nineteenth Century: A Monthly Review,* ed. James Knowles (London: Sampson Low, Marston, and Company, 1894), 519.
[35] *First Report of the Royal Commission on Opium,* 105.
[36] Ibid.
[37] Farooqui, "Opium as a household remedy," 229-230.
[38] Ibid., 230.

be prohibited (except for medical purposes).[39] More specifically, the Royal Commission on Opium was responsible for determining three things: the cost of outlawing opium in India, the views of the local population regarding the prohibition of the drug, and the effect of opium use on the moral and physical health of Indians.[40] The Commission itself was established largely in response to objections from reformers in Britain - led by Evangelicals and Quakers - who sought to end Indian exports of opium throughout Asia.[41] For many of these critics, the drug was an "unmitigated evil" that produced destructive effects in consumers, making them more inclined towards criminal and immoral behaviour.[42] Despite pressure from these groups in Parliament, however, the results of the Royal Commission struck a decisive blow to the reform movement. The report, published in 1895, concluded the following:

> As the result of a searching inquiry, and upon a deliberate review of the copious evidence submitted to us, we feel bound to express our conviction that the movement in England in favour of active interference on the part of the Imperial Parliament for the suppression of the opium habit in India, has proceeded from an exaggerated impression as to the nature and extent of the evil to be controlled. The gloomy descriptions presented to British audiences of extensive moral and physical degradation by opium, have not been accepted by the witnesses representing the people of India, nor by those most responsible for the government of the country.[43]

These findings not only firmly rejected the concerns of anti-opiumists, they also dismissed any criticism of the morality of the government's endorsement of opium consumption. According to the Commission's findings, suppressing the use of the drug in India would destroy one of the colony's most valuable exports and, more importantly,

---

[39] Ibid.
[40] *First Report of the Royal Commission on Opium,* 1.
[41] Richards, "Opium and the British Indian Empire," 378.
[42] "A few words about the opium commission," *The Liberal and the New Dispensation* 12, no. 3 (1893): 5.
[43] *First Report of the Royal Commission on Opium,* 94.

risked creating widespread dissatisfaction among locals by disregarding popular

sentiments.[44] The Commission, for instance, argued that any attempt to restrict the sale of

opium in India would be "in complete opposition to the wishes of the mass of the

people…" for whom the drug was neither dangerous nor culturally unacceptable.[45] This

logic, in turn, was used to justify British officials' continued support of the drug and its

use in the colony.

But, despite the report of the Royal Commission, critics continued to challenge

the production and consumption of opium in India and denounced the findings of the

Commission as a well-crafted scheme to promote the interests of the Government of

India.[46] Arthur E. Moule, writing for *The Church Missionary Review,* for instance, argued

that the report "traverse[d] the whole case of the anti-opium party" by clearing the trade

"from the charge of an offence against international morality" and allowing the

government to "pocket its revenue with complacency."[47] Others accused the report of

deliberately misleading the public into believing in the merits of opium by presenting

contradictory medical evidence.[48] For example, one medical doctor stated:

> Government Surgeons and opium officials tried to prove that the people could not
> get along without [opium]. I will say here, in justice to some of the Government
> Surgeons, that they had the courage to oppose its use, but unfortunately their
> evidence was suppressed.[49]

Several witnesses interviewed by the Royal Commission also perpetuated ideas about

opium as a cure for malaria and stressed that its medical value far outweighed any

---

[44] Ibid., 93-94.
[45] Ibid., 47.
[46] Richards, "Opium and the British Indian Empire," 378.
[47] Arthur E. Moule, "The Report of the Royal Commission on Opium: A Few Words in Anticipation," in
The Church Missionary Review (London: Church Missionary Society, 1895), 336.
[48] Joshua Rowntree, *Opium habit in the East: A study of the evidence given to the Royal Commission on
Opium, 1893–94* (London: P. S. King & Son, 1895), 16.
[49] A. W. Hitt, "The Opium Plague in India," *The Journal of Materia Medica* 32, no. 2 (1894): 161.

negative effects (such as addiction).[50] While there was certainly some truth to the concerns voiced by anti-opiumists – of the nine members that led the Commission, for example, only two (Arthur Pease and Henry Wilson) were anti-opium reformers – the Royal Commission cannot be regarded as a deceptive scheme that exploited a vulnerable local population into legitimizing the harmlessness of opium.[51] In other words, British constructions of the drug may have been used to validate the opium industry in India but this strategy did not define local relationships with the commodity. As we will see, the opium debate was formulated within a much more nuanced context than is often credited.

Opium Consumption as Subversion

The production and sale of opium in India was never a success story for the British Empire. In fact, the idea that the colonial state established a comprehensive monopoly over the drug by legitimizing its consumption for profit overlooks the critical role that the local population played in shaping the larger narrative. A closer examination of the evidence suggests that Indians often complicated the systems and strategies that regulated opium in the colony. After all, despite measures such as the enforcement of the Opium Act and the formation of the Royal Commission, many locals were able to take advantage of the system to serve their own personal interests. This was, in part, possible because of the contradictory nature of the British government's policies on opium. On the one hand, for instance, stringent regulations were put in place to curb illicit activities involving the drug. On the other, the opium habit itself was indirectly encouraged among Indians – if we recall, the general population was allowed to possess a specific amount of

---

[50] *First Report of the Royal Commission on Opium,* 272.
[51] Gregory Blue, "Opium for China: The British Connection," in *Opium Regimes: China, Britain, and Japan, 1839-1952,* ed. Timothy Brook and Bob Tadashi Wakabayashi (Berkeley: University of California Press, 2000), 39.

the drug for personal use - making it easy for them to (knowingly and unknowingly)

violate the state's opium laws.

Perhaps one of the most problematic issues for colonial officials was native

involvement in illicit activities such as smuggling. It was no secret that "enormous

quantities" of opium were trafficked into parts of the Punjab from Malwa where the drug

was largely produced.[52] According to an official report for the province, "there [was]

much liability to smuggling from the many Native States in the Punjab," especially

because it compromised the government's annual returns from the commodity.[53]

Smuggling, moreover, did not always occur on a large scale. For example, one

commentator's observations on opium transactions in northern India reveal the following:

> There is something facetious about the method of illicit sale as described to me.
> The licensed opium-vendor places before him at his shop a small pile of
> Government opium which he calls 'sirkari mahadeo'. A purchaser comes up and
> takes his seat. The vendor seeing he has before him a hardened opium consumer
> asks 'Do you not prefer the *dudhi afiun.*' This term is that given to the smuggled
> opium which inveterate opium eaters much prefer to the standard article. The
> purchaser remarks it is hard to get *dudhi afiun* and the vendor says he has a very
> little which he has with much difficulty stored, and after much feigned reluctance
> he slips inside and produces a little which he sells. The sale will of course not
> appear in the shop register…[54]

But for many locals, organized crime was necessary. For one thing, the number of

licensed opium vendors in the province was significantly limited. Based on calculations

from the report of the Royal Commission, there was one such shop for every 12,000

---

[52] H. H. T. Cleife, *England's Greatest National Sin: Being Selections and Reflections on Our Asiatic Opium Policy and Traffic* (London: Elliot Stock, 1892), 19.

[53] *Explanatory Memorandum by the Under Secretary of State for India* (London: Eyre and Spottiswoode, 1890), 78.

[54] William Hoey, *A Monograph on Trade and Manufactures in Northern India* (Lucknow: American Methodist Mission Press, 1880), 52.

people in the Punjab during the 1880s.[55] As well, contraband opium was cheaper than the heavily taxed opium that was imported into the province from other parts of India. For instance, in 1892, excise opium that was issued to licensed vendors in the Punjab by government depots cost 10 rupees per pound.[56] Considering the fact that the average consumption rate of the province during the same year was approximately 130,000 pounds, acquiring opium could be very expensive for the limited number of merchants who were authorized to sell the drug.[57] One official nevertheless suggested that the sale of licensed opium allowed a "sure profit of 25 per cent"; but even he admitted that illicit dealings in contraband opium were much more profitable because they were "limited only by the risk of detection."[58] Unfortunately, a lack of evidence makes it difficult to determine the exact cost of contraband opium in the Punjab; despite this, the high price of excise opium can explain why some locals turned to smuggling in order to satisfy the demand for the drug in the province.

Illicit activities were not only limited to smuggling and often occurred on more subtle terms. For example, local farmers with licenses to cultivate poppy in exchange for compensation from the government sometimes planted the crop in areas that were larger than those covered by their official license; this ultimately allowed them to sell opium discreetly for a profit.[59] As one contemporary commentator explained:

> …a man might so craftily amplify his boundaries that he might be cultivating a quarter of an acre more than he was licensed to cultivate…the produce of

---

[55] The proportion for the colony during the same time was one shop to 22,000 people. *First Report of the Royal Commission on Opium,* 10.
[56] *Statement Exhibiting the Moral and Material Progress and Condition of India,* 247.
[57] Hitt, 162.
[58] Hoey, 53.
[59] Richards, "Opium and the British Indian Empire," 376.

that extra quarter of an acre would become his own property, and he would
be able to dispose of it by selling it to the professional smuggler.[60]

Other unlawful activities included a process known as "paper cultivation" whereby native
accountants employed by the government claimed advances in money that were not
intended for them.[61] This was accomplished by adding fictitious names to an official list
of village cultivators (who were paid for devoting a portion of their land to the production
of poppy) and then drawing money on their behalf.[62] Despite implementing several
strategies to counter these unauthorized opium transactions – other than the Opium Act,
colonial officials also employed informers and spies to report offenders and kept special
registers in opium producing districts – opium smuggling remained prevalent in India
well into the twentieth century.[63] In fact, observations in the report of the Punjab Revenue
Department from 1914 suggests this was an ongoing problem for the British:

> Two notorious smugglers were convicted in Attock, another in Montgomery, and
> other important captures were made in Lahore, Amritsar, Sialkot and Ferozepore.
> The trade is a lucrative one and demands incessant vigilance on the part of the
> Excise Staff…[64]

Clearly, the opium industry, while profitable for the British, was certainly not flawless.

It is important to note here that illicit activities by Indians regarding opium cannot
be represented explicitly as political efforts to challenge the colonial government.
Although the evidence suggests that such behaviour did, to a certain extent, undermine
the British monopoly on opium in India, it was more often the result of opportunism than

---

[60] "Opium Smuggling in India," *Blackwood's Edinburgh Magazine* 151 (1892): 671.
[61] Ibid., 670.
[62] Ibid.
[63] Deshpande, 117; *The Punjab Record,* 8.
[64] Government of Punjab, *Report on the Excise Administration in the Punjab During the Year 1913-1914*
(Lahore: Civil Secretariat Press**,** 1914), 12.

a systematic attack on colonial rule.[65] Among those who support this view is Claude

Markovits who maintains that the diverse range of illicit activities involving opium in the

colony were rarely motivated by a conscious native desire to subvert British authority.[66]

The problem with this argument, however, is the implication that subversive actions

required conscious thought. This, in turn, overlooks the critical role of everyday forms of

local resistance which, though not intentional, were nevertheless subversive in nature.[67]

In light of this view, indigenous participation in activities like smuggling cannot be

dismissed as meaningless acts, especially because they played a part in impeding colonial

political and economic objectives in India. More specifically, as Kate Boehme asserts,

these illicit practices highlight the often ineffective nature of "enforcement processes"

that had been established by the British to extend their control over commodities like

opium.[68] But, even more significantly, as the following section will demonstrate, native

interactions with the drug often evoked feelings of anxiety among colonial authorities

that were shaped more by imagined concerns than by reality.

The Geography of Opium Consumption

Like many other colonial regulatory practices, the management of opium in the

Punjab was also informed considerably by the significance of geographic space. In fact, a

critical part of the British management of opium in the province depended not just on

how much of the drug was consumed domestically but also *where* it was being used.

Indeed, one of the most contested sites of opium consumption in the late nineteenth

---

[65] Claude Markovits, "The Political Economy of Opium Smuggling in Early Nineteenth Century India: Leakage or Resistance?" *Modern Asian Studies* 43, no. 1 (2009): 89.
[66] Ibid., 101.
[67] James Scott, xvi.
[68] Kate Boehme, "Smuggling India: Deconstructing Western India's Illicit Export Trade, 1818-1870," *Journal of the Royal Asiatic Society* 25, no. 4 (2015): 703.

century was the Indian opium den, a private establishment where locals could buy, sell, and smoke opium. These spaces emerged largely as fallout from pressures imposed on the colonial government by organizations like the Society for the Suppression of the Opium Trade (a London based anti-opium movement). In 1891, the administration's attempt to appease these groups led to the abolition of opium smoking in the licensed shops where the drug was sold lawfully; the regulation, however, did not restrict consumption in private saloons (specifically in the Punjab, Northwestern Provinces, and Bombay), resulting in the increasing popularity of opium dens and clubs in the colony.[69] In Lahore, there were believed to be thirty such spaces (eight of which were located in the old city) that were established after 1891.[70] The report of the Royal Commission suggested that the consumption of opium was "as great as ever" with men who formerly frequented public shops "simply smoking at home".[71] A similar observation was made by the secretary to the Financial Commissioner of the Punjab who maintained that the regulation to close opium shops in Lahore was never completely successful because regular patrons tactfully relocated to new, albeit private, clubs in order to continue their opium habit.[72] As one resident of the city asserted:

> Formerly they kept shops for opium-consumers, but those have been closed. People now, however, have clubbed together and have different shops in different parts of the city. They are regular dens; 10 or 12 persons clubbing together…[73]

These concerns played an important role in the way colonial authorities conceptualized the relationship between space and the successful regulation of opium.

---

[69] Ashley Wright, "Not Just a "Place for the Smoking of Opium": The Indian opium den and imperial anxieties in the 1890s," *Journal of Colonialism and Colonial History* 18, no. 2 (2017).
[70] *First Report of the Royal Commission on Opium,* 228.
[71] Ibid*.,* 35.
[72] D. C. Johnstone in *England's Greatest National Sin,* 142-143.
[73] Abinash Chandra Mazumdar in *First Report of the Royal Commission on Opium,* 228.

Despite the drug's position within a government-regulated industry and the colonial administration's seemingly unproblematic view of opium, private dens evoked feelings of anxiety among British officials that seemed to contradict their otherwise nonchalant attitude towards the drug. Opium clubs, in fact, held an ambivalent place in colonial discourses and unveiled a latent British uneasiness with the activities that were believed to transpire within such spaces. Opium dens in England had already been criticized by social reformers as sites of debauchery, vice, and depravity. One contemporary report in *The Gospel in All Lands* (1883), for example, described London's opium dens as a "fearful curse" that yielded to a "seductive and deadly vice".[74] Another account detailed one Londoner's visit to a local opium den:

> The smell was something frightening, as the room was only twelve feet by eight, and both door and window were closed. The utter squalor of the scene, the dirt of the room, the dirt of the mattress, and O, the still more terrible dirt of the smokers themselves, are more easily imagined than described.[75]

The concern with opium dens in England corresponded with British anxieties about race which stemmed from the presence of mysterious and foreign "Eastern" vices at home (especially since most of these dens were operated by Chinese proprietors).[76] But, the fact that similar sentiments existed in India, where opium smoking and consumption were largely accepted and even encouraged, requires further examination.

Unsurprisingly, opium dens in India were primarily targeted by social purity and temperance movements – both British and Indian - which criticized them as spaces of transgressive behaviour and immoral activities. In Lahore, for instance, one description of

---

[74] "Evil Results in India," *The Gospel in All Lands* 7 (1883): 15.
[75] J. Randal, "A Chinese Opium Den in East London," *London Society: An Illustrated Magazine of Light and Amusing Literature for the Hours of Relaxation* (London: Robson and Sons, 1884), 45: 543-544.
[76] Wright, "Not Just a "Place for the Smoking of Opium".

a local opium den by the president of the Punjab Purity Association sheds light on this view:

> Only recently I visited an opium den accompanied by a friend. The very sight was sickening and painful to the extreme...There were nine men at that time all smoking in a lying-down posture. Their faces indicated misery, poverty, and helplessness. They all told with one voice that bad society and lustful desire…created this habit in them and it was now impossible for them to give it up.[77]

Observations like these were expected. Social reformers in both England and India formulated their criticism of opium and opium dens on the same grounds: morality. What seems unusual though is the uncertainty and apprehension of colonial officials in regards to these spaces, particularly since the sale and consumption of opium produced substantial revenues for the British Empire. The criticism, moreover, came from many different groups. For example, one army officer argued that men who paid "even a few visits" to an opium den were more likely to become addicts than men who frequented liquor shops.[78] Similarly, Surgeon-General William Moore, who otherwise accepted the harmless nature of opium – "the total benefits derived from opium far counterbalances the occasional injury", he wrote – described the den as a space of "unsanitary surroundings, want and disease" as well as a site where the "worst effects" of the drug were experienced.[79] Another contemporary wrote that the opium den was a "hideous" and "poison-laden" place where "the stench [was] sickening, the swarms of flies intolerable," and the customers "in various stages of opium stupor."[80] Why, though, did this

---

[77] Mazumdar, 228.

[78] "India and the Opium Trade," *India* (London: British Committee of the Indian National Congress, 1893), 4: 91.

[79] William Moore, "Opium," in *The Medical Reporter, A Record of Medicine, Surgery, Public Health, and of General Medical Intelligence* ed. Lawrence Fernandez (Calcutta: The Medical Publishing Press, 1984), 93, 94.

[80] Cleife, 8.

conception of the opium den remain so firmly entrenched within official colonial discourses?

One reason for colonial authorities' aversion to opium dens was the prevalence of smoking in these spaces. While eating and drinking opium had been common in India (and Britain) for centuries, smoking the drug was a relatively new phenomenon. Without an established social context for the practice, colonial authorities (and to a certain extent, the Indian elite) deemed opium smoking far more contemptible and disreputable than other means of consumption.[81] One contemporary account, for example, stated: "the existence of [opium] houses tends to spread the vice of opium smoking, which is of recent origin in most parts of the Punjab."[82] As well, in his interview with the Royal Commission, Surgeon-Major T. R. Mulroney from the Lahore Medical College attributed the practice to a "disreputable, debauched and depraved lot."[83] It was also deemed "the vice of the vicious" and was believed to be an "incentive to licentiousness."[84] Other accounts commented on the detrimental effects of opium smoking on health. The *British Medical Journal* maintained that many of its correspondents regarded the habit as "the most injurious way of using the drug."[85] Similarly, Mr. C. E. Schwann's "Impressions of Travel in India" noted that opium smoking triggered "a deeper degeneration of mind and body" and was the "immediate cause of madness and…[the] distortion of the limbs and countenance."[86]

---

[81] Wright, "Not Just a "Place for the Smoking of Opium".
[82] "The Opium Trade," *The Friend of China* 12, no. 5 (1891): 226.
[83] *First Report of the Royal Commission on Opium*, 162.
[84] C. E. Schwann, "Impressions of Travel in India," *The Journal of the Manchester Geographical Society* 7 (1891): 186.
[85] "Analysis and Report on Original Documentary Evidence Concerning the use of Opium in India," *The British Medical Journal,* December 23, 1893, 1399.
[86] Schwann, 186.

But even more concerning than its impact on health was the idea that smoking

obscured the activities of those who frequented opium dens and this reinforced British

apprehensions about such spaces.[87] The smoke from opium pipes, in particular, created

an air of mystery that troubled administrators, especially since it signaled ideas about the

limits of colonial regulation. These anxieties, moreover, were reflected in several

contemporary accounts that detailed the inscrutable nature of the opium den. One report,

for example, stated:

> There is a certain secrecy and mystery about [the den]. It is like the desire of
> the school-boy to smoke tobacco in spite of his master. Men will go and smoke in
> these "clubs" with the idea that they are doing something which the Government
> will not approve of and possibly it may be illegal. It has a savour of crime about
> it…[88]

This reference to the opium den as an enigmatic space highlights the author's misgivings

about the practice of smoking in these clubs. It also suggests that locals were drawn to

such places by a desire to disobey the law (and, in turn, the government) which only

added to growing apprehensions about the opium den in colonial discourses. In the

example above, it is not just the deliberateness of the prohibited activities that provokes

the colonial official's inability to "know" the space; it is also the idea that those who

participated in the illicit practices did so with an enthusiasm and willingness that

reinforced their defiance. As another contemporary account stated: "The fact that these

clubs do exist – that is to say, that the orders of the Indian Government are openly defied

– was not denied, but rather gloried in…"[89]

---

[87] Ibid.
[88] T. D. Mackenzie in *First Report of the Royal Commission on Opium,* 284.
[89] "The Bombay Trials," *The Friend of China* 15, no. 1 (1894): 11.

In response to such concerns, one of the few changes proposed by the Royal Commission in its report was a ban on the sale and consumption of *chandu* (a concentrated form of opium) and *madak* (a blend of tobacco and opium), which were prepared specifically for smoking.[90] The Commission, however, did not suggest prohibiting individuals from possessing the limited amount of opium that was made permissible by the Opium Act as long as it was for personal use (eating or drinking) and had been purchased lawfully (i.e. all duties and taxes had been paid on it); in 1892, this limit was set to a maximum of 2 *tolas* (approximately 22 grams).[91] In reality, these contradictions made it exceedingly difficult to detect and convict individuals who purchased the drug for the purposes of smoking. After all, there was no way to determine *how* a person intended to use their supply of opium. In Lahore, moreover, arguments were made to place opium dens under police surveillance in order to restrict individuals from meeting in these establishments and continuing their opium smoking habit.[92] However, because they congregated in private spaces, it was almost impossible to prove that an assembly of locals was, in fact, an opium club (with all its illicit associations) or simply a social gathering where the guests were consuming legal amounts of the drug recreationally.[93] One case described in the report of the Royal Commission even revealed that members of a particular club enlisted the services of the opium department police to prevent colonial authorities from interfering with their activities.[94] Here, open defiance from within the system impeded the authority of the Indian government in exercising

---

[90] *First Report of the Royal Commission on Opium,* 72.
[91] Ibid., 221.
[92] Ibid., 229.
[93] Ibid., 220.
[94] Ibid., 295.

control and supervision over illegal smoking dens. This inability to monitor opium clubs

was perhaps the most alarming consequence of the 1891 ban on licensed shops. Many of

the witnesses interviewed by the Royal Commission argued that private clubs were more

independent than ever before because they were no longer hampered by regulations.[95]

Before 1891, stated hours of operation were enforced for all smoking houses and the

activities of patrons were under constant surveillance by government officials; with the

closing of licensed shops, however, opium officials no longer had the authority to go into

any of these private dens unless they suspected that illicit opium was being sold, a feat

they themselves admitted was impossible to substantiate.[96]

The often obscure location of these private establishments and the evasive attitude

of the people who frequented them further exacerbated the problem of regulation posed

by opium dens. These concerns, in fact, are highlighted in an account that describes a

secluded club that was established after the ban on public smoking houses was enforced.

Although this particular example describes a den that was located in Bombay, it helps

shed light on the types of illicit spaces that emerged in urban centres throughout India

towards the end of the nineteenth century (especially since policies concerning the

regulation of opium dens were applied to establishments across the colony). In this

specific account, the club in question is described as being tucked away on the upper

level of a previously licensed opium den, located in a room "so small that one had to

---

[95] Ibid.
[96] Ibid.

stoop almost double" to stand inside.[97] Here, a conversation between the local patrons

and British missionaries who were visiting the den is even more revealing:

> "What place is this?"
> "(Chorus of voices) 'A *kalab,* sahib.'
> "'What kind of club?'
> "'Oh, like the Byculla club that the *sahibs* use.'
> [The Byculla Club is one of the most fashionable European clubs in Bombay, patronized largely by Government officials.]
> "'What is the subscription rate and what are the rules then?'
> "'Whatever one likes…There is no rule for membership, and you only pay for what you get.'
> "'Then can anybody come here and smoke opium?'
> "'Oh yes, of course. If he pay for his smoke.'
> "'Then what is the difference between this place and the former dens?'
> "'*Kuch nahin'* (nothing at all).
> "We were then interrupted by the owner of the place, who was uneasy. He extinguished two of the lamps and told the men to *chup karo, i.e.,* 'shut up.'"[98]

The description of this exchange is particularly interesting because it draws attention to

the mysterious setting of the den as well as to the wariness of the establishment's owner.

His move to extinguish the two lamps in the den not only throws the space into literal

darkness but is also a means of concealing the true purpose of the club: to provide a

haven for the use of *chandu* and *madak*. The opium smokers, on the other hand, appear to

be much less reluctant about conversing with the missionaries (who, according to the

account, were paying "test-visits" to various dens in the city).[99] However, even their

remarks disguise a more ambiguous attitude. More specifically, their comparison of the

opium den with the prestigious Byculla Club of Bombay exposes an irreverence and

---

[97] "The Crusade Against Opium," in *The Literary Digest: A Repository of Contemporaneous Thought and Research,* ed. Edward Jewitt Wheeler and Isaac Haufman (London: Funk and Wagnalls, 1894), 23.
[98] Ibid.
[99] Ibid.

impertinence that mocks the ideals and principles of India's colonial rulers.[100] After all, by associating the two clubs together, the locals seek to legitimize their own opium retreat as an accepted social space that was as "respectable" and exclusive as any English club. This way, private smoking establishments in urban cities evoked feelings of unease among officials. In particular, it was the inability to regulate and monitor such spaces combined with the Indian construction of opium dens as acceptable and legitimate social spaces that reinforced the anxiety they created for colonial authorities.

As Ashley Wright argues, moreover, it is important to note that there was a gendered element to the colonial unease with opium dens.[101] In fact, these private establishments were often associated with prostitutes and other disreputable women whose presence underscored the link between opium consumption and immorality. As we saw in chapter three, colonial apprehensions about Indian prostitutes already played a critical role in shaping the British administration's approach to public health in the colony. A similar narrative existed for opium dens where the presence of such women prompted concerns about the moral health of the colony and its subjects. The report of the Royal Commission, for example, explained that "prostitutes [were] always found in opium dens" while another contemporary account suggested that "the brothel and opium den [were] almost invariably associated."[102] Similarly, in the Punjab, an official report highlighted the close connection between "disreputable" women and the drug by suggesting that prostitutes in the province were often found in possession of "small

---

[100] The Byculla Club was a residential club open to the British residents of Byculla, a prestigious and prosperous suburb in Bombay.
[101] Wright, "Not Just a "Place for the Smoking of Opium".
[102] *First Report of the Royal Commission on Opium,* 251; "Opium Smoking," *Friend of China* 15, no. 4 (1895): 137.

luxuries" like tobacco and opium.[103] In Lahore, it was reported that at least two opium

dens were kept by women, presumably for "immoral" purposes.[104] As such, prostitutes

were almost always held responsible for men's addiction to *chandu* and *madak*.[105]

Several witnesses interviewed by the Commission even claimed that they were often the

first to expose men to the habit.[106] Thus, for British officials, the opium den was a site of

illicit interactions and a place where appropriate boundaries between men and women

disappeared.[107] Indeed, many reports of prostitutes in these private clubs suggest close

contact between the sexes. According to one account, for instance, a group of young

women lay "sprawling on the senseless bodies of men" while another observer described

"137 men and women lying drunk like hogs in a stye, poisoned with Government

opium."[108] The latter commentator continued:

> Men and women together smoking opium, and as they came slowly under the
> influence of the drug, having lewd and horrid songs sung to them by degraded
> women…[109]

For most critics, it did not matter that prostitutes engaged primarily with Indian men in

opium dens. The issue for British authorities remained one of continued intervention and

the presence of disreputable women in these establishments reasserted the need for

surveillance and regulation in opium clubs. After all, prostitutes had long been associated

---

[103] Government of India, "Statements and Notes," in *Report of the Committee Appointed by the Secretary of State for India to Inquire into the Rules, Regulations, and Practice in the Indian Cantonments and Elsewhere in India, with Regard to Prostitution and to the Treatment of Venereal Disease; Together with Minutes of Evidence and Appendices* (London: Eyre and Spottiswoode, 1893), 323.
[104] *First Report of the Royal Commission on Opium,* 268.
[105] Ibid., 251.
[106] Surgeon-Lieutenant-Colonel Moriarty in *First Report of the Royal Commission on Opium,* 271.
[107] Wright, "Not Just a "Place for the Smoking of Opium".
[108] W. S. Caine, "The Drink and Opium Curse in India," *The Friend of China* 11, no. 2 (1889), 32; "Government Opium Dens," *The Friend of China* 14, no. 2 (1893): 67.
[109] "Government Opium Dens," 67.

with illicit behaviour and criminal activity and this justified the importance of curbing the moral and physical degeneration that allegedly occurred in private opium clubs.

The consumption of opium for "aphrodisiacal purposes" was another cause for alarm among colonial authorities.[110] Some regarded the drug as a physical stimulant that had the means to empower women of ill repute. One British official, for example, argued that prostitutes used opium to renew their energy and enervate their "vital forces" in order to incite men to lust.[111] Another source explained that "potent" preparations (also referred to as "philtres") were widely used by "jealous women, or desperate lovers…for the purpose of captivating affection, or of infatuating or enthralling the object of desire."[112] Its use among Indian men was even more disconcerting. According to several doctors interviewed by the Royal Commission, many native men used opium because they believed it reinforced their virility by enabling "the sexual act to be prolonged".[113] Other medical authorities maintained that Indians credited opium with invigorating the sperm cells, aiding procreation, and curing disorders such as impotency and infertility.[114] This led one British official to state: "Rightly or wrongly, the people of India have implicit faith in opium as an aphrodisiac."[115] Similar observations were made by the previously mentioned president of the Punjab Purity Association who asserted: "youths frequenting houses of ill-fame and addicted to immoral habits resort to opium-smoking for lustful purposes."[116] Therefore, it is not surprising that opium featured as an essential ingredient in contemporary "love potions" that were advertised for sale in local and vernacular

---

[110] *First Report of the Royal Commission on Opium,* 260.
[111] Major W. B. Ferris in *First Report of the Royal Commission on Opium,* 129.
[112] P. A. Simpson, "Native Poisons of India," *The Pharmaceutical Journal and Transactions* 2 (1872): 605.
[113] "Government Opium Dens," 65.
[114] Ferris, 129.
[115] Vincent, 41.
[116] Mazumdar, 228.

newspapers. A notice in *The Tribune*, for instance, promoted impotency charms and debility powders which were said to "impart all sort[s] of vigour and keep a man constantly healthy."[117] Another ad for virility oil claimed to make "an impotent man perfect without pain or blister."[118] Most of these remedies, according to an encyclopedia on Indian drugs, were prepared with a combination of ingredients that included opium, cinnamon, aniseed, and cardamom.[119] Some British authorities, however, remained unconvinced of the stimulating properties of opium. For example, Sir George Birdwood, a British naturalist, discredited the "alleged special aphrodisiac properties" of the drug while Dr. D. R. Francis of the Calcutta Medical College doubted its role in "creat[ing] or increas[ing] the venereal *appetite*."[120] But, despite their skepticism, most colonial officials admitted that opium "excited" the mind and the imagination and that this helped maintain its popularity as an aphrodisiac among Indians.[121]

Perhaps most importantly, the underlying issue for British authorities concerning the relationship between opium and sexuality was one of display. With advertisements for aphrodisiacs printed more regularly in "respectable" newspapers and magazines, the otherwise private and intimate act of sex was transformed into a public spectacle.[122] The proliferation of these ads, moreover, was part of a larger movement that saw the growing commercialization of medicine in India. Particularly by the mid-nineteenth century, print

---

[117] *The Tribune,* May 13, 1884, 8.
[118] *The Tribune,* November 8, 1884, 11.
[119] Balfour, 799.
[120] George Birdwood in *All About Opium* ed. Hartmann Henry Sultzberger (London: Wertheimer Lea, and Co., 1884), 84; C. R. Francis, "The Value and Use of Opium," in *Half-Yearly Compendium of Medical Science: Synopsis of the American and Foreign Literature of Medicine, Surgery, and Collateral Sciences for Six Months,* ed. D. G. Brinton (Philadelphia: Medical Publication Office, 1882), 179.
[121] A. T. Bocarro in *First Report of the Royal Commission on Opium,* 270.
[122] Charu Gupta, *Sexuality, Obscenity and Community: Women, Muslims, and the Hindu Public in Colonial India* (New York: Palgrave, 2002), 79.

media was an important means through which new information about medical treatments and cures could be disseminated to the public. As such, they frequently conveyed details that would attract new consumers and, in turn, expand the market for health-related products. In the case of aphrodisiacs, it was their accessibility to people of all social

Figure 5.1 - Advertisement for Virility Oil, Lahore.
Source: *The Tribune*, November 8, 1884.

classes that helped establish sex as a profitable commodity.[123] Catering primarily to male consumers, ads for love potions acknowledged the real and imagined anxieties of Indian men by promising to restore vigour and prevent problems such as impotency and

---

[123] David Arnold, *Toxic Histories: Poison and Pollution in Modern India* (Cambridge: Cambridge University Press, 2016), 32.

premature ejaculation.[124] This way, they created a new public space for discourses on sex which normalized discussions on intercourse and sexual health.

But, the popularity of opium-laden aphrodisiacs among the local population and their visibility in public forums not only challenged the moral convictions of social reformers (who warned against the dangers of overindulging in physical pleasures) but also reinforced colonial apprehensions about the limits of sexual discipline. By venerating sex in such a public way, British officials worried that the widespread use of these love potions would encourage deviant sexual behaviour. In particular, it was the idea that aphrodisiacs encouraged excessive sexual indulgence that heightened anxieties about the loss of order and control. One medical official, for instance, argued that "irrepressible sexual passion" was the leading cause of "unnatural crimes" among Indian men.[125] Similarly, when interviewed by the Royal Commission, the editor for the *Banner of Asia* related the story of a man who had "abandoned himself to the most horrible debauchery for a month" after taking opium "for the power and pleasure of sexual indulgence."[126] Thus, the relationship between criminal and deviant behaviour was intimately connected to the use of stimulating drugs that were intended to heighten sexual passions.

Opium was also a deeply paradoxical drug. While it was renowned for its powers as a restorative and a stimulant, officials in India simultaneously warned against its role

---

[124] Ibid.
[125] Norman Chevers, *A Manual of Medical Jurisprudence for India, including the outline of a history of crime against the person in India* (Calcutta: Thacker, Spink & Co., 1870), 23.
[126] Mansukh Lal in *First Report of the Royal Commission on Opium,* 301.

as a depressant and a poison.[127] In fact, it was often discovered that opium had been used

in cases of suicide, abortion, and even murder.[128] One book on medical jurisprudence in

India suggested that the drug accounted for forty percent of poison-related deaths in the

country (both deliberate and accidental).[129] In the Punjab, specifically, the *British*

Medical Journal reported that opium was the second most common poison used in cases

of suicide (after arsenic) and that there was a steady increase in the number of deaths by

opium overdose towards the end of the nineteenth century.[130] Another medical official,

moreover, attributed "its rather frequent use, as a poison, to the people of Lahore."[131]

This led the principal of the Lahore Medical College to conclude that between 1886 and

1888, twenty-five percent of poison-related deaths in the city were caused by opium.[132]

For many colonial authorities, the connection between the drug and suicide was

particularly alarming because of the ready availability of opium. One witness interviewed

by the Royal Commission, for example, contended:

> …opium is of all poisons the one which must be most attractive to a suicide. It
> presents death in its easiest and most delightful form to one who has
> reached that state of mind. I believe that its free sale does greatly encourage
> suicide.[133]

As a common household remedy and a popular drug in the Indian pharmacopeia, opium

was also more likely to be used as a poison by women than men (although this was also

---

[127] Although individuals responded differently to opium (depending on whether they were already heavy consumers of the drug or not), most medical authorities agreed that anything over 25 grains was considered excessive. *First Report of the Royal Commission on Opium*, 271.
[128] Arnold, *Toxic Histories,* 30.
[129] I. B. Lyon, *A Text Book of Medical Jurisprudence for India* (Calcutta: Thacker, Spink, and Co., 1889), 253.
[130] "Poisoning in India," *The British Medical Journal,* September 17, 1892, 642.
[131] Chevers, 142.
[132] T. E. B. Brown, *Punjab Poisons: Being a Description of the Poisons Principally Used in the Punjab* (Lahore: Civil and Military Gazette Press, 1888), iii.
[133] *First Report of the Royal Commission on Opium,* 106.

largely influenced by the fact that suicide by opium required less preparation than other means of suicide such as hanging or drowning).[134] Clearly, there was a fine line between opium as an empowering substance and opium as a life-ending force, and it was the ambiguous nature of the drug that reinforced colonial uneasiness about its use in the colony.

Conclusion

The manufacture, trade, and consumption of opium in the Punjab were shaped considerably by colonial and indigenous perceptions of the drug in the province. For the British, opium was a lucrative commodity that helped balance the colonial government's trade deficits with China. As such, one of the key objectives for officials was to regulate the use of the drug in India while simultaneously reinforcing its production via indigenous cultivators. Among the strategies employed by the British to oversee this goal were the enforcement of the Opium Act in 1878 and the establishment of the Royal Commission on Opium in 1893. According to some scholars, the Commission, in particular, helped bolster colonial constructions of opium as a harmless drug which, when used in moderation, had several health benefits. While its pervasive use among the local population suggests that the British were successful in according certain legitimacy to opium, this cannot be regarded as evidence for the colonial exploitation of indigenous society. Rather, Indian experiences of the drug often undermined colonial objectives concerning its production and consumption in the province. More specifically, native participation in illicit activities such as opium smuggling and opium smoking demonstrates that Indians established their own discourses about the drug that

---

[134] Government of Punjab, *Report on the Sanitary Administration of the Punjab for the year 1883,* 29.

complicated the colonial monopoly over opium. As the evidence has revealed, Indians

were never disconnected from the British opium industry, even when officials attempted

to limit local interactions with the drug.

Conclusion

By the mid-nineteenth century, Lahore had become a key urban centre with important ideological, political, and cultural connections that reflected its status as the provincial capital of the Punjab. The arrival of the British in 1849 signaled a new beginning for Lahore, one that shaped its development into a "modern" colonial city. Characterized by urbanization, industrialization, increased commercial activity, and a centralized administration, the city's transformation owed much to the decisions of its new colonial rulers. Despite what this suggests, however, the changes in Lahore were never the result of a monolithic process. They were shaped as much by the city's "preexisting peculiarities" as they were by the impact of colonial rule in India itself.[1] In this regard, Lahore was quite unique. Whereas other colonial cities – such as Bombay which, Gyan Prakash argues, barely displayed signs of its ancient past after British settlement or Old Delhi which was subject to punitive demolitions after the Mutiny in 1857 – Lahore displayed a history and culture that continued to persevere even after the establishment of colonial rule.[2] As one local official remarked:

> Lahore is one of the very few places in India in which any permanent trace of our occupancy would remain fifty years hence…[the Lahore Cathedral] will decide the interest of future visitors with the old fort in the city, though I fear our western architecture cannot vie in beauty of conception or magnificence of material with the shrines enclosed in those battlemented walls.[3]

From monuments like the Old Fort and the Tomb of Anarkali to sites of cultural interaction like the Sudder Bazaar and the walled city, Lahore articulated an identity that was informed by the legacy of its past.

---

[1] Glover, xiv.
[2] Gyan Prakash, *Mumbai Fables* (New Jersey: Princeton University Press, 2010), 27.
[3] R. R. Mitford, "Orient and Occident: Notes of a Journey from Lahore to Liverpool via China, Japan and America," in *The Illustrated Naval and Military Magazine* (London: W. H. Allen & Co., 1887), 57.

This had important implications for British officials who sought to rebuild Lahore according to the principles and logic of colonial urban governance. After all, spatial ordering and territorial appropriation in the city remained largely incomplete and when attempts were made to conform Lahore to an Anglo-European urban ideal in the mid-nineteenth century – as evidenced by the organization of the civil station and the development of buildings such as Lawrence Hall – the results were only ever an approximation.[4] As we have seen, moreover, colonial rule in the city was preoccupied with more than just the physical transformation of Lahore's landscape. The British presence in the city, especially after the Mutiny, was also informed by moral, social, and political objectives that, at times, recast the relationship between the colonizers and colonized. More specifically, in their attempt to establish an effective administrative system in the city, British authorities realized that they would need to rely on more than just their observations and analysis of the material environment. Knowledge about Indian culture and religion would also be necessary for implementing the government's reform-driven agenda. This, in turn, meant that the cooperation of the local inhabitants themselves would have to be a part of the British plan. Indeed, the involvement of Indians has been an important feature of this study, largely because it problematizes other, more simplistic, narratives about the "success" of British rule in colonial cities such as Lahore. After all, indigenous agency played a critical role in the social and physical development of the city and this often complicated colonial initiatives and power structures in the region. As several chapters in this work have demonstrated, Indians were

---

[4] Glover, 29.

consistently involved in shaping British policies and, in doing so, highlighted the noticeably limited scope of colonial intervention in Lahore.

For officials in the city, one of the most important sites of reform was health and sanitation. In fact, colonial plans for urban change in Lahore were shaped considerably by outbreaks of virulent diseases that drew attention to the vulnerability of the European population in India. Particularly during the mid nineteenth century, when colonial medical discourses conceptualized disease as being inextricably linked to unsanitary spaces, the need to produce healthy landscapes for the colony's British inhabitants became a key priority. However, despite changes to the city's physical environment – such as the construction of a new water supply and drainage system – epidemic outbreaks continued to persist in Lahore, prompting British authorities to recognize the need to extend their regulatory strategies to the general public. The alarmist rhetoric that regularly followed epidemics was a testament to the growing colonial concern with ensuring good health among Indians as well as the British. This was especially relevant in the late nineteenth century when new developments in biomedicine began to stress the role of contagion in the production of disease, convincing medical authorities that managing the body of the sick was just as critical as regulating the environment. Particularly in the case of cholera, officials became increasingly concerned with the dangers of the body in transmitting disease, leading to an emerging colonial interest in "normalizing" the body and bodily practices through medical science. Similar observations regarding smallpox and the plague reinforced British confidence in Western medicine and prompted the production of new technologies, such as vaccination, to combat epidemic diseases. Based on these developments, it appeared that the colonial

public health agenda in Lahore was influenced overwhelmingly by a British desire to impose a comprehensive (and oftentimes intrusive) regulatory system in the city.

This, however, was only part of the narrative. As my examination of health and medicine in Lahore has demonstrated, indigenous responses to disease in the city frequently exposed the more fragmented nature of colonial rule. Whether it was through conscious acts of resistance – avoiding surveillance, spreading rumours, or participating in illicit activities – or through more harmless behaviours like the seemingly unsanitary habits and customs of the local population, native reactions to colonial health initiatives in Lahore highlighted the inconsistencies of the British administration. Such an analysis is not only critical for dispelling the myth of an all-encompassing and omnipotent colonial regime, it is also valuable for drawing attention to the diverse range of non-European agents whose actions and attitudes helped shape the functioning of British rule in India. By the same token, local contributions to discourses on public health should not be regarded as responding exclusively to colonial power. In fact, as we have seen, Indians often took advantage of the colonial bureaucracy to serve their own personal interests and, in doing so, disrupted the efficiency of British operations in Lahore. This, in turn, advances the argument that interactions between colonizer and colonized were not the only factors influencing the moral, social, and physical transformation of the city. Rather, indigenous responses that reacted to local conditions also helped influence the public health history of Lahore.

Using these arguments as a guide, my dissertation has offered a postcolonial critique of colonial rule in Lahore during the latter half of the nineteenth century. More specifically, by drawing on issues related to health and medicine, I have demonstrated

that the British government's objectives for the city often failed because they depended considerably on specific colonial representations of Lahore and its inhabitants. Such knowledge influenced the trajectory of British rule by prompting colonial authorities to adopt strategies and establish agendas that, in reality, did not always correspond with the needs or ambitions of Lahore's Indian population. This, in turn, not only highlighted moments of British dependence on local residents but also stressed the role that these individuals played in mediating colonial power through intervention.

Bibliography

India Office Records, British Library, United Kingdom

Accountant General's Records, IOR/L/AG.
Committee and Commission Reports, IOR/V/26.
Correspondence with India, IOR/E/4.
Departmental Annual Reports, IOR/V/24.
Indian Serials, IOR/V/25.
Military Department Library, IOR/L/MIL/17.
Monographs, IOR/V/27.
Parliamentary Collections, IOR/L/PARL.
Proceedings and Consultations of the Government of India and of its Presidencies and Provinces, IOR/P/434-2180.
Public and Judicial Department, IOR/L/PJ/6.
Selections from the Records of the Government of India, IOR/V/23.
Statistical Serials, IOR/V/14.

Punjab Archives, Lahore, Pakistan

Proceedings of the Government of the Punjab in the Home Department.
Report of the Committee for the Inspection of Villages.

Newspapers and Periodicals

Allen's Indian Mail
The Asiatic Quarterly Review
Blackwood's Edinburgh Magazine
The British Medical Journal
Calcutta Journal of Natural History and Miscellany of the Arts and Sciences in India
The Calcutta Review
The Church Missionary Review
Delhi Punch
The Friend of China
The Friend of India
Gazetteer of the Ferozpur District
Gazetteer of the Lahore District
A Gazetteer of the Territories Under the Government of the East-India Company, and of the Native States on the Continent of India
Good Health
The Gospel in All Lands
The Guernsey Magazine
Half-Yearly Compendium of Medical Science
Harbinger
Harper's New Monthly Magazine
The Illustrated Naval and Military Magazine

India
The Indian Magazine
The Indian Medical Gazette
Indian Notes
Indian Public Opinion and Panjab Times
The Journal of the Manchester Geographical Society
The Journal of Materia Medica
Journal of the Society of Arts
Kohinoor
The Lahore Chronicle
The Lancet
Legal Medicine
The Liberal and the New Dispensation
The Literary Digest
The Literary News
London Society
The Medical News
The Medical Press and Circular
The Medical Reporter
The Medical Times and Gazette
The Nineteenth Century: A Monthly Review
The Pharmaceutical Journal and Transactions
Punjab Notes and Queries
The Punjab Record
The Sanitary Record
The Scottish Geographical Magazine
The Transylvania Journal of Medicine and the Associate Sciences
The Tribune

Published Primary Sources

Ahmad, Mirza Ghulam. *Defence Against the Plague & Criterion for the Elect of God.*
    Qadian: Diya-ul Islam Press, 1902.
———. "The Plague." In *Extracts from the Writings, Speeches, Announcements and
    Discourses of The Promised Messiah and Mahdi Hazrat Mirza Ghulam Ahmad of
    Qadian*. Vol. 5 of *The Essence of Islam*. Translated by Saleem-ur-Rehamn.
    Tilford: Islam International Publications, Ltd., 2007.
———. *A Revealed Cure for the Bubonic Plague.* Lahore: Victoria Press, 1898.
Ainslie, Whitelaw, Clarence Dalrymple, R. K. Greville, Hugh Murray, William Rhind,
    and James Wilson. *Historical and Descriptive Account of British India, From the
    Most Remote Period to the Present Time.* Vol. 3. New York: J. & J. Harper, 1832.
Aitkin, William, A. E. Brown, and G. E. Dobson, eds. *Physiological and Pathological
    Researches; Being a Reprint of the Principal Scientific Writings of the Late T. R.
    Lewis.* London: Lewis Memorial Committee, 1888.
*Annals of Military and Naval Surgery and Tropical Medicine and Hygiene: Being an
    Annual Retrospect Embracing the Experience of the Medical Officers of Her*

Majesty's Armies and Fleets in in all Parts of the World. London: John Churchill and Sons, 1864.

Baden Powell, B. H., ed. *Hand-book of the Economic Products of the Punjab: With a Combined Index and Glossary of Technical Vernacular Words*. Vol. 1. Roorkee: Thomason Civil Engineering College Press, 1868.

Barnard, Frederick A. P. and Arnold Guyot, eds. *Johnson's New Universal Cyclopaedia: A Scientific and Popular Treasury of Useful Knowledge.* Vol. 4. New York: A. J. Johnson & Co., 1883.

Birdwood, George. In *All About Opium,* edited by Hartmann Henry Sultzberger, 80-85. London: Wertheimer Lea, and Co., 1884.

Blanc, Henry. *Cholera: How to Avoid and Treat it.* London: Henry S. King & Co., 1873.

Brown, Robert. *The Peoples of the World: Being a Popular Description of the Characteristics, Condition, and Custom of the Human Family.* London: Cassell & Company, Ltd., 1892.

Brown, T. E. B. *Punjab Poisons: Being a Description of the Poisons Principally Used in the Punjab*/ Lahore: Civil and Military Gazette Press, 1888.

Bryden, James. *A Report on the Cholera of 1866-1868, and its Relations to the Cholera of Previous Epidemics.* Calcutta: Office of the Superintendent of Government Printing, 1869.

Chapman, John. *Diarrhea and Cholera: Their Nature, Origin and Treatment through the Agency of the Nervous System.* London: Turner & Co., 1866.

Chevers, Norman. *A Manual of Medical Jurisprudence for India, including the outline of a history of crime against the person in India.* Calcutta: Thacker, Spink & Co., 1870.

Cleife, H. H. T. *England's Greatest National Sin: Being Selections and Reflections on Our Asiatic Opium Policy and Traffic.* London: Elliot Stock, 1892.

Davidson, Andrew. *Geographical Pathology: An Inquiry into the Geographical Distribution of Infective and Climatic Disease.* New York: D. Appleton & Co., 1892.

Deakin, Alfred. *Irrigated India: An Australian View of India and Ceylon, their Irrigation and Agriculture.* London: Thacker and Co., 1893.

Epidemic Cholera: Its Mission and Mystery, Haunts and Havocs, Pathology and Treatment. New York: Carleton, 1866.

Everyday Life in South India. Piccadilly: The Religious Tract Society, 1885.

Explanatory Memorandum by the Under Secretary of State for India. London: Eyre and Spottiswoode, 1890.

Ferguson, Jan Helenus. *The Philosophy of Civilization: A Sociological Study.* London: W. B. Whittingham & Co., 1889.

Garwood, John. *The Million-Peopled City; or, One-Half of the People of London Made Known to the Other Half.* London: Wertheim and Macintosh, 1853.

Goulding, H.R. *Old Lahore: Reminiscences of a Resident.* Lahore: Universal Books, 1924.

Griswold, H. D. *The Messiah of Qadian.* London: Harrison and Sons, 1905.

Hoey, William. *A Monograph on Trade and Manufactures in Northern India*. Lucknow: American Methodist Mission Press, 1880.

Holwell, J. Z. *An Account of the Manner of Inoculating for the Small Pox in the East Indies With Some observations on the Practice and Mode of Treating the Disease in Those Parts.* London: T. Becket and P. A. De Hondt, 1767.

James, S. P. *Smallpox and Vaccination in British India.* Calcutta: Thacker, Spink & Co., 1901.

Jordan, M. H. "Infantile Diarrhea." In *Transactions of the Medical Association of the State of Alabama,* 169-179. Montgomery: Barrett & Brown, 1877.

Khan, Syed Ahmad. In *The Life and Work of Syed Ahmad Khan,* edited by George Farquhar I. Graham. Edinburgh and London: William Blackwood and Sons, 1888.

Kipling, Rudyard. *Kim.* Toronto and New York: Doubleday, Page & Company, 1922.

———. *Life's Handicap: Being Stories of Mine Own People*. London: Macmillon and Co., 1899.

"Lahore." *Encyclopaedia Britannica: Arts, Sciences and General Literature*, 9th ed. Philadelphia: Maxwell and Sommerville, 1894.

Latif, Syad Muhammad. *Lahore: Its History, Architectural Remains, and Antiquities, with an Account of Its Modern Institutions, Inhabitants, Their Trade, Custom, etc.* Lahore: New Imperial Press, 1892.

Lyon, I. B. *A Text Book of Medical Jurisprudence for India.* Calcutta: Thacker, Spink, and Co., 1889.

Maclean, William Campbell. *A Treatise on the Small Pox, 1849.* Madras: Fort St. George Gazette Press, 1858.

MacLeod, Alexander Charles. *Alcoholic Diseases; Comprising Jaundice, Diarrhoea, Dysentery, and Cholera*. London: John Churchill and Sons, 1866.

Memorandum on Some of the Results of Indian Administration During the Past Thirty Years of British Rule in India, London: Eyre and Spottiswoode, 1889.

Montagu, Edward George Henry. *Diary in Ceylon and India, 1878-9.* London: W. S. Johnson, Nassau Steam Press, 1879.

Moore, William James. *A Manual of the Diseases of India With a Compendium of Diseases Generally.* London: J. and A. Churchill 1886.

Murdoch, John. *Papers on Indian Reform: Sanitary, Material, Social, Moral and Religious.* Madras: S. P. C. K. Press, 1889.

Murray, Hugh. *Historical and Descriptive Account of British India.* Vol. 3. New York: Harper & Brothers, 1853.

Nabi, Ghulam. *Chuha aur Plague. Billi aur Chuha aur Muhafaze Jaan Tikka* [Rat and Plague. Cat and Plague and Vaccination]. Lahore: n.d.

Nightingale, Florence. *Observations on the Evidence Contained in the Stational Reports Submitted to her by the Royal Commission on the Sanitary State of the Army in India.* London: Edward Stanford, 1863.

Olcott, Henry Steel. *A Collection of Lectures on Theosophy and Archaic Religions, Delivered in India and Ceylon*. Madras: A. Theyaga Rajier, 1883.

Prichard, Iltudus Thomas. *The Administration of India From 1859-1868: The First Ten Years of Administration Under the Crown.* Vol. 2. London: MacMillan and Co., 1869.

Pringle, Robert. "On Vaccination versus Isolation, as a preventive against outbreaks of Smallpox." In *Transactions of the Sanitary Institute of Great Britain*, 99-116. London: Offices of the Sanitary Institute, 1886.

Ram, Lala Kashi. *Notes and Suggestions on Sanitation in the Punjab.* Calcutta: Bidhan Press, 1884.

Ross, David. *The Land of the Five Rivers and Sindh: Sketches Historical and Descriptive.* London: Chapman and Hall, 1883.

Rowntree, Joshua. *Opium habit in the East: A study of the evidence given to the Royal Commission on Opium, 1893–94.* London: P. S. King & Son, 1895.

Salzer, L. *Lectures on Cholera and Its Homeopathic Treatment.* Calcutta: Berigny & Co., 1883.

Shakespeare, Edward. *Report on Cholera in Europe and India.* Washington: Government Printing Office, 1890.

Shelley, Percy Bysshe. *A Vindication of Natural Diet.* London: F. Pitman, 1884.

Shelly, C. E. ed. *Transactions of the Seventh International Congress of Hygiene and Demography.* Vol. 11. London: Eyre and Spottiswoode, 1892.

Sterndale, Reginald Craufuird. *Municipal Work in India; or, Hints on Sanitation - General Conservancy and Improvement in Municipalities, Towns, and Villages.* Calcutta: Thacker, Spink, and Co., 1881.

Stille, Alfred. *Cholera: Its Origin, History, Causation, Symptoms, Lesions, Prevention, and Treatment.* Philadelphia: Lea Brothers and Co., 1885.

Suggestions in Regard to Sanitary Works Required for Improving Indian Stations. London: Eyre and Spottiswoode, 1864.

Thornton, T. H. *A Brief Account of the History and Antiquities of Lahore.* Lahore: Civil Secretariat Press, 1873.

Vincent, Howard. *Russia and India in 1903.* London: P. S. King & Son, 1903.

Wendt, Edmund Charles, ed. *A Treatise on Asiatic Cholera.* New York: William Wood and Company, 1885.

Secondary Sources

Aata-Ullah, Naazish. "Stylistic hybridity and colonial art and design education." In *Colonialism and the Object: Empire, Material Culture and the Museum,* edited by Tim Barringer and Tom Flynn, 68-82. London and New York: Routledge, 1998.

Abu Bakr, Ahmad M. S. "Identity Crisis: Rudyard Kipling's Kim – A Postcolonial Perspective." *Epiphany* no. 3 (2009): 81-104.

Abu-Lughod, Janet. *Rabat: Urban Apartheid in Morocco.* Princeton: Princeton University Press, 1980.

Aijazuddin, F. S. *Lahore Recollected: An Album.* Lahore: Sang-e-Meel, 2004.

Ali, Daud and Indra Sengupta, eds. *Knowledge Production, Pedagogy, and Institutions in Colonial India.* New York: Palgrave Macmillan, 2011.

Ali, Imran. *The Punjab Under Imperialism, 1885-1947.* Princeton: Princeton University Press, 1988.

Allen, Charles. *Kipling Sahib: India and the Making of Rudyard Kipling 1865-1900.* London: Abacus, 2007.

Anderson, Warwick. "The Third-World Body." In *Companion to Medicine in the Twentieth Century,* edited by Roger Cooter and John Pickstone, 235-246. London, New York: Routledge, 2003.

Arnold, David. "Cholera and Colonialism in British India." *Past & Present* no. 113 (1986): 118-151.

———. *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century Indian.* Berkley: University of California Press, 1993.

———. "The medicalization of poverty in colonial India." *Historical Research* 85, no. 229 (2012): 487-504.

———. *Science, Technology and Medicine in Colonial India.* Vol. 3 of *The New Cambridge History of India.* Cambridge: Cambridge University Press, 2000.

———. "Smallpox and colonial medicine in nineteenth-century India." In *Imperial Medicine and Indigenous Societies,* edited by David Arnold, 44-65. Manchester: Manchester University Press, 1988.

———. *Toxic Histories: Poison and Pollution in Modern India.* Cambridge: Cambridge University Press, 2016.

———. "Vagrant India: Famine, Poverty and Welfare Under Colonial Rule." In *Cast Out: Vagrancy and Homelessness in Global and Historical Perspective,* edited by A. L. Beier and Paul Ocobock, 117-139. Athens: Ohio University Press, 2008.

Ashcroft, Bill, Gareth Griffiths, and Helen Tiffin, *Key Concepts in Post-Colonial Studies,* 2nd ed. London and New York: Routledge, 2000.

Bakhle, Janaki. "Savarkar (1883–1966), Sedition and Surveillance: the rule of law in a colonial situation." *Social History* 35, issue 1 (2010): 51-75.

Bakhtin, Mikhail. *Rabelais and His World*. Translated by Helene Iswolsky. Bloomington: Indiana University Press, 1984.

Bala, Poonam. *Medicine and Medical Policies in India: Social and Historical Perspectives.* New York: Lexington Books, 2007.

Ballantyne, Tony. *Between Colonialism and Diaspora: Sikh Cultural Formations in an Imperial World.* Durham and London: Duke University Press, 2006.

——— and Antoinette Burton. "Introduction: Bodies, Empires, and World." In *Bodies in Contact: Rethinking Colonial Encounters in World History,* edited by Tony Ballantyne and Antoinette Burton, 1-18. Durham and London: Duke University Press, 2005.

Bashford, Alison. "Vaccination: Foreign Bodies, Contagion and Colonialism." In *Contagion: Epidemics, History and Culture from Small Pox to Anthrax,* edited by Alison Bashford and Claire Hooker, 14-38. Annandale: Pluto Press, 2002.

Bautista, Julius and Mercedes Planta. "The Sacred and the Sanitary: The Colonial 'Medicalization' of the Filipino Body." In *The Body in Asia,* edited by Bryan S. Turner and Zheng Yangwen, 76-102. New York, Oxford: Berghahn Books, 2009.

Bayly, C. A. *The Birth of the Modern World, 1780-1914: Global Connections and Comparisons*. Oxford: Blackwell Publishing, 2004.

———. *Empire and Information: Intelligence Gathering and Social Communication in India 1780–1870.* Cambridge: Cambridge University Press, 1996.

Bhattacharya, Jayanta. "The Body: Epistemological Encounters in Colonial India." In *Making Sense of Health, Illness and Disease,* edited by Peter L. Twohig and Vera Kalitzkus, 31-54. New York: Rodopi, 2004.

Bhattacharya, Nandini. *Contagion and Enclaves: Tropical Medicine in Colonial India.* Liverpool: Liverpool University Press, 2012.

———. "The Logic of Location: Malaria Research in Colonial India, Darjeeling and Duars, 1900–30." *Medical History* 55, no. 2 (2011): 183-202.

Bhattacharya, Sanjoy. "Re-devising Jennerian Vaccines? European Technologies, Indian Innovation and the Control of Smallpox in South Asia, 1850-1950." *Social Scientist* 26, nos. 11/12 (1998): 27-66.

———, Mark Harrison, and Michael Worboys. *Fractured States: Smallpox, Public Health and Vaccination Policy in British India, 1800-1947*. New Delhi: Orient Longman Private Limited, 2005.

Bissell, William Cunningham. *Urban Design, Chaos, and Colonial Power in Zanzibar*. Bloomington and Indianapolis: Indiana University Press, 2011.

Blue, Gregory. "Opium for China: The British Connection." In *Opium Regimes: China, Britain, and Japan, 1839-1952,* edited by Timothy Brook and Bob Tadashi Wakabayashi, 31-54. Berkeley: University of California Press, 2000.

Boehme, Kate. "Smuggling India: Deconstructing Western India's Illicit Export Trade, 1818-1870." *Journal of the Royal Asiatic Society* 25, no. 4 (2015): 685-704.

Cell, John W. *Hailey: A Study in British Imperialism, 1872-1969*. Cambridge: Cambridge University Press, 1992.

Chakrabarti, Pratik. "Curing Cholera: Pathogens, Places and Poverty in South Asia." *International Journal of South Asian Studies* 3 (2010): 153-168.

Chakrabarty, Dipesh. "Subaltern Studies and Postcolonial Historiography." *Nepantla: Views from South* 1, no. 1 (2000): 9-32.

Chancellor, Nigel. "A Picture of Health: The Dilemma of Gender and Status in the Iconography of Empire, India c. 1805." *Modern Asian Studies* 35 no. 4 (2001): 769-782.

Chandavarkar, Rajnarayan. *Imperial Power and Popular Politics: Class, Resistance and the State, c. 1850-1950*. Cambridge: Cambridge University Press, 1998.

Chawla, Sandeep, ed. *A Century of International Drug Control*. Vol. 59 of *Bulletin on Narcotics*. Herndon: United Nations Publications, 2007.

Cohn, Bernard. *Colonialism and Its Forms of Knowledge: The British in India*. New Jersey: Princeton University Press, 1996.

Condos, Mark. *The Insecurity State: Punjab and the Making of Colonial Power in British India*. Cambridge: Cambridge University Press, 2017.

Cunningham, Andrew and Bridie Andrews, eds. *Western Medicine As Contested Knowledge*. Manchester: Manchester University Press, 1997.

Curtin, Philip. *Death by Migration: Europe's Encounter with the Tropical World in the Nineteenth Century*. Cambridge: Cambridge University Press, 1989.

Datta, Partho. *Planning the City Urbanization and Reform in Calcutta, c. 1800 - c. 1940*. New Delhi: Tulika Books, 2012.

Deshpande, Anirudh. "An Historical Overview of Opium Cultivation and Changing State Attitudes towards the Crop in India, 1878–2000 A.D." *Studies in History* 25, no. 1 (2005): 109-143.

Dikötter, Frank, Lars Laamann, and Zhou Xun. *Narcotic Culture: A History of Drugs in China*. Hong Kong: Hong Kong University Press, 2004.

Dirks, Nicholas. *Castes of Mind: Colonialism and the Making of Modern India*. New Jersey: Princeton University Press, 2001.

Dutta, Krishna. *Calcutta: A Cultural and Literary History*. Oxford: Signal Books, 2003.

Dwyer, Rachel, Gita Dharampal-Frick, Jahnavi Phalkey, and Monika Kirloskar
Steinbach, eds. *Key Concepts in Modern Indian Studies.* New York: New York
University Press, 2015.

Echenberg, Myron. *Plague Ports: The Global Urban Impact of Bubonic Plague, 1894-
1901.* New York: New York University Press, 2007.

Farooqui, Amar. "Opium as a household remedy in nineteenth-century western India?" In
The Social History of Health and Medicine in Colonial India, edited by Mark
Harrison and Biswamoy Pati, 229-237. London: Routledge, 2009.

———. *Smuggling as Subversion: Colonialism, Indian Merchants and thePolitics of
Opium.* New Delhi: New Age International, 1998.

Fernos, Rodrigo. *Medicine and International Relations in the Caribbean: Some
Historical Variants.* New York: iUniverse, Inc., 2006.

Fields, Gary. "Enclosure Landscapes: Historical Reflections on Palestinian Geography."
Historical Geography 39, no. 1 (2011): 189-207.

Foucault, Michel. *Discipline and Punish: The Birth of the Prison.* Translated by Alan
Sheridan. London: Penguin Books, 1979.

Gaonkar, Dilip. "On Alternative Modernities." In *Alternative Modernities,* edited by
Dilip Gaonkar, 1-23. Durham and London: Duke University Press, 2001.

George, K. M., ed. *Modern Indian Literature: An Anthology.* Vol. 3. New Delhi: Sahitya
Akademi, 1994.

Gilbert, Pamela K. *Cholera and Nation: Doctoring the Social Body in Victorian England.*
New York: State University of New York Press, 2008.

Gilmour, David. *The Long Recessional: The Imperial Life of Rudyard Kipling.* New
York: Farrar, Straus and Giroux, 2002.

Glover, William. *Making Lahore Modern: Constructing and Imagining a Colonial City.*
Minneapolis: University of Minnesota Press, 2008.

Gooptu, Nandini. *The Politics of the Urban Poor in Early Twentieth-Century India.*
Cambridge: Cambridge University Press, 2001.

——— and Douglas Peers, eds. *India and the British Empire.* Oxford: Oxford
University Press, 2012.

Gracias, Fatima da Silva. *Health and Hygiene in Colonial Goa 1510-1961.* New Delhi:
Concept Publishing Company, 1994.

Gregory, James. *Of Victorians and Vegetarians: The Vegetarian Movement in Victorian
Britain.* London, New York: Tauris Academic Studies, 2007.

Gupta, Charu. *Sexuality, Obscenity and Community: Women, Muslims, and the Hindu
Public in Colonial India.* New York: Palgrave, 2002.

Gupta, Dipankar. "'De-Sanskritization' of Untouchables: Arya Samaj Movement in
Punjab." In *Struggle for Status,* edited by P. N. Pimpley and S. K. Sharma, 86-
101. Delhi: B. R. Publishing Corporation, 1985.

Gupta, Naryani. *Delhi Between Two Empires, 1803-1931: Society, Government and
Urban Growth.* Oxford: Oxford University Press, 1997.

Hallam, Elizabeth, Jenny Hockey, and Glennys Howart. *Beyond the Body: Death and
Social Identity.* London and New York: Routledge, 1999.

Halliday, Stephen. *The Great Filth: Disease, Death and the Victorian City.* New York:
The History Press, 2003.

Hamlin, Christopher. *Cholera: The Biography.* Oxford: Oxford University Press, 2009.

Haq, M. Emdad-ul. *Drugs in South Asia.* New York: Palgrave, 2000.

Harrison, Mark. *Public Health in British India: Anglo-Indian Preventive Medicine 1859-1914.* Cambridge: Cambridge University Press, 1994.

Harriss, John and Craig Jeffrey. *Keywords for Modern India.* Oxford: Oxford University Press, 2014.

Haynes, Douglas. *Rhetoric and Ritual in Colonial India: The Shaping of a Public Culture in Surat City*. Berkeley: University of California Press, 1991.

———. "Victorian Imperialism in the Making of the Medical Profession: An Argument." In *Decentering Empire: Britain, India and the Transcolonial World,* edited by Durba Ghosh and Dane Kennedy, 130-156. Himayatnagar: Orient Longman, 2006.

——— and Gyan Prakash, eds. *Contesting Power: Resistance and Everyday Social Relations in South Asia.* Los Angeles: University of California Press, 1991.

Hays, C. Judith. "Florence Nightingale and the India Sanitary Reforms." *Public Health Nursing* 6 no. 3 (1989): 152-154.

Headrick, Daniel. *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century.* Oxford: Oxford University Press, 1981.

Hill, Christopher. "Colonial Gardens and the Validation of Empire in Imperial India." *Journal of South Asian Studies* 1 no. 2 (2013): 139-145.

Hinchy, Jessica. "Troubling bodies: 'eunuchs,' masculinity and impotence in colonial North India." *South Asian History and Culture* 4, no. 2 (2013): 196-212.

Hodges, Sarah. *Contraception, Colonialism and Commerce: Birth Control in South India, 1920-1940*. Burlington: Ashgate, 2008.

———. "'Looting' the Lock Hospital in Colonial Madras during the Famine Years of the 1870s." *Social History of Medicine* 18 no. 3 (2005): 379-398.

Howell, Philip. "Prostitutional Space in the Nineteenth-Century European City." In *Place, Culture, and Identity: Essays in Historical Geography in Honour of Alan R.H. Baker,* edited by Iain S. Black and Robin Alan Butlin, 181-202. Laval: Le Presses de l'Universite Laval, 2001.

Howson, Alexandra. *The Body in Society: An Introduction,* 2nd ed. Cambridge: Polity Press, 2013.

Hume Jr., John Chandler. "Colonialism and Sanitary Medicine: The Development of Preventive Health Policy in the Punjab, 1860 to 1900." *Modern Asian Studies* 20, no. 4 (1986): 703-724.

Huppatz, D. J. *Modern Asian Design.* London, New York: Bloomsbury, 2018.

Irschick, Eugene. *Dialogue and History: Constructing South India, 1795-1895.* Los Angeles: University of California Press, 1994.

Jain, Harish, ed. *The Making of Punjab*. Chandigarh: Unistar Books Pvt. Ltd., 2003.

Jalal, Ayesha. *Self and Sovereignty: Individual and Community in South Asian Islam Since 1850.* New York: Routledge, 2000.

Jeffress, David. *Postcolonial Resistance: Culture, Liberation, and Transformation*. Toronto: University of Toronto Press, 2008.

Jentzen, Jeffrey. "Death and Empire: Legal Medicine in the Colonization of India and Africa." In *Medicine and Colonialism,* edited by Poonam Bala, 159-176. London and New York: Routledge, 2014.

Jones, Kenneth W. *Arya Dharm: Hindu Consciousness in 19th-Century Punjab.* Berkley: University of California Press, 1976.

———. "The Bengali Elite in Post-Annexation Punjab: An Example of Inter-Regional Influence in 19th Century India." *Indian Economic and Social History Review* 3, no. 4 (1996): 376-395.

———. *Socio-religious reform movements in British India.* Vol. 3 of *The New Cambridge History of India.* Cambridge: Cambridge University Press, 1989.

Jordan, Jane and Ingrid Sharp, eds. *Josephine Butler and the Prostitution Campaigns: Diseases of the Body Politic.* Vol. 5. London: Routledge, 2003.

Joukhi, Jukku. "Orientalism and India." *J@rgonia* 4, no. 8 (2006): 1-20.

Judge, Paramjit S. *Insurrection to Agitation: The Naxalite Movement in Punjab.* Mumbai: Popular Prakashan, 1992.

Kalpagam, U. *Rule by Numbers: Governmentality in Colonial India.* New York and London: Lexington Books, 2014.

Kamran, Tahir and Ian Talbot. *Colonial Lahore: A History of the City and Beyond.* Oxford: Oxford University Press, 2016.

Kennedy, Dane. *The Magic Mountains: Hill Stations and the British Raj.* Los Angeles: University of California Press, 1996.

Khalid, Amna and Ryan Johnson, eds. *Public Health in the British Empire: Intermediaries, Subordinates, and the Practice of Public Health, 1850-1960.* New York: Routledge, 2011.

Kidambi, Prashant. *The Making of an Indian Metropolis: Colonial Governance and Public Culture in Bombay, 1890-1920.* Burlington: Ashgate, 2007.

King, Anthony. *Colonial Urban Development: Culture, Social Power and Environment.* London: Routledge and Kegan Paul, 1976.

Kohn, George Childs, ed. *Encyclopedia of Plague and Pestilence From Ancient Times to the Present,* 3rd ed. New York: Facts on File Inc., 2008.

Kristeva, Julia. *Powers of Horror: An Essay on Abjection.* Translated by Leon S. Roudiez. New York: Columbia University Press, 1982.

Kumar, Dharma, ed. *The Cambridge Economic History of India, 1757-1970.* Vol. 2. Cambridge: Cambridge University Press, 1983.

Lefebvre, Henri. *The Production of Space.* Translated by Donald Nicholson-Smith. Oxford: Blackwell Publishing, 1991.

Legg, Stephen. *Spaces of Colonialism: Delhi's Urban Governmentalities.* Oxford: Blackwell Publishing, 2007.

Levine, Philippa. *Prostitution, Race, and Politics: Policing Venereal Disease in the British Empire.* New York: Routledge, 2003.

Lock, Margaret and Vinh-Kim Nguyen. *An Anthropology of Biomedicine.* Chichester: John Wiley & Sons Ltd., 2010.

Major, Andrew J. "State and Criminal Tribes in Colonial Punjab: Surveillance, Control and Reclamation of the 'Dangerous Classes.'" *Modern Asian Studies* 33, no. 3 (1999): 657-688

Makdisi, Saree. *Romantic Imperialism: Universal Empire and the Culture of Modernity.* Cambridge: Cambridge University Press, 1998.

Markovits, Claude. "The Political Economy of Opium Smuggling in Early Nineteenth Century India: Leakage or Resistance?" *Modern Asian Studies* 43, no. 1 (2009): 89-111.

McFarlane, Colin and Michael Waibel. "Introduction: The Informal-formal Divide in Context." In *Urban Informalities: Reflections on the Formal and the Informal,* edited by Colin McFarlane and Michael Waibel, 1-12. New York: Routledge, 2012.

Metcalfe, Thomas. *An Imperial Vision: Indian Architecture and Britain's Raj.* London: Faber & Faber, 1989.

Minsky, Lauren. "Pursuing Protection from Disease: The Making of Smallpox Prophylactic Practice in Colonial Punjab." *Bulletin of the History of Medicine* 83, no. 1 (2009): 164-190.

Mir, Farina. *The Social Space of Language: Vernacular Culture in British Colonial Punjab.* Los Angeles: University of California Press, 2010.

Mishra, Saurabh. *Pilgrimage, Politics, and Pestilence: The Haj from the Indian Subcontinent: The Haj from the Indian Subcontinent, 1860-1920.* Oxford: Oxford University Press, 2011.

Moore-Gilbert, B. J. *Kipling and 'Orientalism'.* New York: St. Martin's, 1986.

Mukharji, Projit. *Nationalizing the Body: The Medical Market, Print and Daktari Medicine.* London: Anthem Press, 2011.

Newman, Richard. "Opium Smoking in late imperial China: A reconsideration." *Modern Asian Studies* 29 no. 4 (1995): 765-794.

Ngue, Julie Christine Nack. "Critical Conditions: Refiguring Bodies of Illness and Disability in Francophone African and Caribbean Women's Writing." PhD dissertation, University of California Los Angeles, 2008.

Nigam, Sanjay. "Disciplining and policing the 'criminals by birth', Part 2: The development of a disciplinary system, 1871-1900." *The Indian Economic and Social Review* 27, no. 3 (1990): 257-287.

Nijhar, Preeti. *Law and Imperialism: Criminality and Constitution in Colonial India and Victorian England.* London: Routledge, 2009.

Oldenburg, Veena. *The Making of Colonial Lucknow, 1856-1877.* Princeton: Princeton University Press, 2014.

Pacteau, Francette. "Dark Continent." In *With Other Eyes: Looking at Race and Gender in Visual Culture,* edited by Lisa Bloom, 88-104. Minneapolis: University of Minnesota Press, 1999.

Pande, Ishita. *Medicine, Race and Liberalism in British Bengal: Symptoms of Empire.* London: Routledge, 2010.

Peckham, Robert, ed. *Empires of Panic: Epidemics and Colonial Anxieties.* Hong Kong: Jong Kong University Press, 2015.

——— and David Pomfret, eds. *Imperial Contagions: Medicine, Hygiene, and Cultures of Planning in Asia.* Hong Kong: Hong Kong University Press, 2013.

Peers, Douglas. "Soldiers, Surgeons and the Campaigns to Combat Sexually Transmitted Diseases in Colonial India, 1805-1860." *Medical History* 42, no. 2 (1998): 137 160.

Pement, Eric. "The Ahmadiyya Movement in Islam." *Watchman Fellowship.* 2010 http://www.watchman.org/profiles/pdf/ahmadiyyaprofile.pdf. Accessed November 16, 2016.

Polu, Sandhya. *Infectious Disease in India, 1892-1940: Policy-Making and the Perception of Risk.* New York: Palgrave MacMillan, 2012.

Porter, Libby. *Unlearning the Colonial Cultures of Planning.* New York: Routledge, 2016.

Prakash, Gyan. "Body Politic in Colonial India." In *Questions of Modernity,* edited by Timothy Mitchell, 189-222. London and Minneapolis: University of Minnesota Press, 2000.

———. *Mumbai Fables.* New Jersey: Princeton University Press, 2010.

Ramanna, Mridula. *Western Medicine and Public Health in Colonial Bombay, 1845 1895.* Himayatnagar: Orient Longman, 2002.

Ramasubban, Radhika. *Public Health and Medical Research in India: Their Origins under the Impact of British Colonial Policy.* Stockholm: SAREC, 1982.

Ranger, Terence and Paul Slack, eds. *Epidemics and Ideas: Essays on the Historical Perception of Pestilence.* Cambridge: Cambridge University Press, 1992.

Rehman, Abdul. *Mapping Lahore: Tracing Historical Geography of a City Through Maps.* Lahore: Al-Mezaan, 2013.

———, M. Mushtaq, A. Khan, and S. R. Ahmed. "Stones of British Colonial Lahore: A Study of Two Remarkable Buildings of Earlier Period of British Architecture." *Pakistan Journal of Science* 65, no. 2 (2013): 303-309.

Richards, John F. "Opium and the British Indian Empire: The Royal Commission of 1895." *Modern Asian Studies* 36, no. 2 (2002): 375-420.

———. "The Opium Industry in British India." *The Indian Economic and Social History Review* 39, no. 2-3 (2002): 149-180.

Rosenberg, Charles. *Explaining Epidemics and Other Studies in the History of Medicine.* Cambridge: Cambridge University Press, 1992.

Roy, Satarupa Sinha. "Unsettling Landscapes: Landscape and the Entelechies of the Alienating Gaze in Kipling's The City of Dreadful Night." *Rupkatha Journal on Interdisciplinary Studies in Humanities* 7, no. 2 (2015): 162-168.

Said, Edward. *Orientalism*. New York: Pantheon Books, 1978.

Saran, Awadhendra. *In the City, Out of Place: Nuisance, Pollution, and Dwelling in Delhi, c. 1850 – 2000.* Oxford: Oxford University Press, 2014.

Sayid, Aizad. "A Short Biography of Syed Muhammad Latif." *Scribd*. Accessed May 1. 2018, https://www.scribd.com/doc/72430816/A-Short-Biography-of-Syed-Muhammad-Latif.

Schwarz, Henry. *Constructing the Criminal Tribe in Colonial India: Acting Like a Thief.* Oxford: Wiley-Blackwell, 2010.

Scott, James C. *Weapons of the Weak: Everyday Forms of Peasant Resistance.* New Haven: Yale University Press, 1985.

Scriver, Peter. "Stones and Texts: The Architectural Historiography of Colonial India and its Colonial-Modern Contexts." In *Colonial Modernities: Building, Dwelling and Architecture in British India and Ceylon,* edited by Peter Scriver and Vikramaditya Prakash, 27-50. London: Routledge, 2007.

Shaw, Pamela. "The Qualities of Informal Space: (Re)appropriation within the informal, interstitial spaces of the city." Presentation at the Conference of the School of Architecture and Design: Interior Architecture and Urban Studies Programme, University of Brighton, 2nd to 4th July 2009.

Sheikh, Maysoon. "They'll be the death of you: Indian prostitutes, colonial anxieties, and the medicalization of space, 1860-1900." Master's thesis, McMaster University, 2010.

Shoemaker, Robert. *Gender in English Society 1650-1850: The Emergence of Separate Spheres?* New York: Routledge, 2013.

Shorto, Sylvia. "A Tomb of One's Own: The Governor's House, Lahore." In *Colonial Modernities: Building, Dwelling and Architecture in British India and Ceylon,* edited by P. Scriver and V. Prakash, 151-168. London and New York: Routledge, 2007.

Singh, Dhrub Kumar "Cholera in Two Contrasting Pathies in Nineteenth Century India." *Disquisitions on the Past and Present* no. 13 (2005): 103-126.

Sivaramakrishnan, Kavita. *Old Potions, New Bottles: Recasting Indigenous Medicine in Colonial Punjab, 1850-1945.* New Delhi: Orient Blackswan Private Ltd., 2005.

———. "Recasting Disease and Its Environment: Medical Practitioners, the Plague, and Politics in Colonial India." In *Cultivating the Colonies: Colonial States and their Environmental Legacies,* edited by Christina Folke Ax, Niels Brimnes, Niklas Thode Jensen, Karen Oslund, 191-213. Athens: Ohio University Press, 2011.

Smith, Richard Suamarez. *Rule by Records: Land Registration and Village Custom in Early British Panjab.* Oxford: Oxford University Press, 1996.

Srivastava, Dharma Bhanu. *The Province of Agra: Its History and Administration.* New Delhi: Concept Publishing Company, 1979.

Stoler, Ann Laura. *Alongside the Archival Grain: Epistemic Anxieties and Colonial Common Sense.* Princeton: Princeton University Press, 2009.

Sullivan, Zohreh. *Narratives of Empire: The Fictions of Rudyard Kipling.* Cambridge: Cambridge University Press, 1993.

Tambe, Ashwini. *Codes of Misconduct: Regulating Prostitution in Late Colonial Bombay.* Minneapolis: University of Minnesota Press, 2009.

Tandon, Sasha. "Epidemics in Colonial Punjab." *Journal of Punjab Studies* 20, nos. 1 & 2 (2013): 217-243.

Tanner, Laura E. *Lost Bodies: Inhabiting the Borders of Life and Death.* Ithaca and London: Cornell University Press, 2006.

Trocki, Carl. *Opium, Empire and the Global Political Economy: A Study of the Asian Opium Trade 1790-1950.* London: Routledge, 1999.

Turner, Bryan S. and Zheng Yangwen, eds. *The Body in Asia.* New York, Oxford: Berghahn Books, 2009.

Upstone, Sara. *Spatial Politics in the Postcolonial Novel.* Burlington: Ashgate Publishing Company, 2009.

Vickery, Amanda. *Behind Closed Doors: At Home in Georgian England.* New Haven: Yale University Press, 2009.

Wald, Erica. "Defining Prostitution and Redefining Women's Roles: The Colonial State and Society in Early 19th Century India." *History Compass* 7, no. 6 (2009): 1470-1483.

Walkowitz, Judith. *Prostitution and Victorian Society: Women, Class, and the State.* Cambridge: Cambridge University Press, 1980.

Watts, Sheldon J. *Epidemics and History: Disease, Power and Imperialism.* New Haven and London: Yale University Press, 1999.

Welby, Lizzy. "Solar Midnight: Traversing the Abject Borderline State in Rudyard Kipling's 'The City of Dreadful Night'." In *The Domination of Fear: Probing the Boundaries,* edited by Mikko Canini, 147-171. New York: Rodopi Press, 2010.

Wright, Ashley. "Not Just a "Place for the Smoking of Opium": The Indian opium den and imperial anxieties in the 1890s." *Journal of Colonialism and Colonial History* 18 no. 2 (2017).

Wright, Gwendolyn. *The Politics of Design in French Colonial Urbanism.* Chicago: University of Chicago Press, 1991.