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RESEARCH PAPER

Epidemic of Plague: A Critical Analysis of British Medical Policies in Colonial Punjab (1896–1920)

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ABSTRACT

British Raj established modern health care system in colonial India which was based on hierarchies in which European medicines and doctors held superior positions. Indigenous medicines lost patronage and modern medicines got superiority. Although modern medicines were not sufficient for the large Indian population. The system of modern medicines launches by the colonial rulers created medical authority upon local system which created subornation of system and people. This paper investigates the outbreak of the bubonic plague in colonial Punjab, and it was critically examined the British response from 1896 to 1920. Using rare primary source evidence—especially from the village of Khatkar Kalan in Jullundur district, a significant location due to its early and severe exposure to the plague—it explores the colonial framework of surveillance, evacuation, and disinfection. This paper argues that the British medical policy was effective in reducing the rates of surface-level infection. However, the policy was caste-based and racial. The medical reports and archival materials are evaluated through the analytical research method, which gave results that the colonial rulers used the authoritative ways that disrupted the indigenous life, eroded trust of the people, not only this but also failed to stop the plague's spread to the neighboring villages.

KEYWORDS Colonial Punjab, Bubonic Plague, British Public Health, Khatkar Kalan, Caste, Evacuation Policy, Critique

Introduction

Outbreak of the plague in the Punjab during this time period shows the encounters between British medical policies and the society of indigenous Indians. Moreover, It was present in the districts of *Jullundur* and *Hoshiarpur*. This epidemic brought out a wide ranged administrative response from the British government, which were ranged from medical interventions to public health strategies. The policies British introduced seemed to prevent the plague, however it revealed the intention of British to practice power, control area politically and control over the local population. They did it through the quarantines, cordoning off villages, forced evacuations, cordoning off the villages, and inoculation campaigns. The British authorities didn't only attempt to stop the transmission of the plague. They also deployed the crisis to expand their authority and disrupt traditional sociocultural frameworks.

The following article critically analysis the medical responses of British authorities during the plague outbreak via in-depth examination of the official report of the British era: "*Outbreak of Plague in Jullundur and Hoshiarpur Districts of the Punjab 1897-98.*" it was authored by C.H. James and his fellow officers of the Indian Medical Service. The report

offers an insight which is candid and rare into the logic of the colonial health policies. It is repleted with failures, justifications and the observations from the field. Nonetheless, rather than accepting the report's statement at the face value the following article will situate it within the broader scholarly debates on state authority, colonial medicine and bio political governance.

Eminent scholars such as David Arnold have argued that the colonial medical interventions in British India, were nor neutral or purely scientific. Instead, they served as the instruments of domination and helping to secure the imperial rule under the mask of health and hygiene. Likewise, Michael Foucault's framework of biopolitics provides a valuable lens to interrogate how populations were managed and categorized. How they were disciplined through medical practices (Foucault, 2003).

While the plague report of British period stresses about the administrative competence and British responses along with the logical coordination of these responses. For example, the daily roll calls in the segregation camps, disinfection protocols and evacuations from the infected areas. This study is set to reveal that how these actions disrupted the society as it created caste-based segregations which worsen the existing social inequalities.

By collecting the official British medical accounts with analytical historiography, this article seeks to have insights of public health, colonial British control, and local resistance faced by British. Finally, the study argues that the plague operations in *Jullundur* and *Hoshiarpur* were as much about consolidating the state authority as they were about combating an epidemic. It also contributes to the ongoing discussions about the medical history of the colonial Punjab and the critical legacies of imperial health governance.

Literature Review

The scholars who worked on the British medical policies unites on a central insight, that the epidemic management in the British period was not only the endeavor of biomedical, but its purpose was to reshape the social hierarchies, reshape the governance and everyday life of people was their political project. The foundation work of David Arnold set the terms of this discussion by showing how "state medicine" functioned as an arm of imperial rule, producing knowledge about Indian bodies and spaces while legitimating intrusive interventions under a sanitary rationale (Arnold, Colonizing The Body State Medicine And Epidemic Disease In 19th Century India, 1993). Likewise, Mark Harrison traced the authoritarian turn used by epidemics. They used preventive medicine to exert power, surveillance, movement control and reordering rural and urban places (Harrison, 1994). Both these studies set the ground for entanglement of medicine with state capacity, and disciplinary power, offering a vital backdrop for reading official plague reports from Punjab.

A second, more plague-specific strand interrogates the technologies, controversies, and on-the-ground frictions of anti-plague campaigns. Historians have examined cordons sanitaires, house-to-house inspections, forced evacuations, and the legal scaffolding of the Epidemic Diseases Act (1897) as instruments that blurred medical precaution with coercive rule (Arnold, Colonizing The Body State Medicine And Epidemic Disease In 19th Century India, 1993). The Bombay presidency has drawn particular attention because of dramatic urban interventions and working-class resistance; yet this urban focus has sometimes obscured rural dynamics. Because labor rhythms, kinship mobility, and dispersed settlement patterns shaped transmission differently in rural settings (Arnold, Cholera and Colonialism in British India (Past & Present), 1986). Studies that do attend to rural settings

underscore how agricultural imperatives regularly collided with quarantine logics, forcing administrators to improvise "porous" cordons that permitted fieldwork while restricting markets and inter-village travel (Hardiman, 2006). And these articles focus on stats of Jullundur and Hoshiarpur will extend the line of inquiry by analyzing that how many compromises were actually made in practice. It will try to discuss about the limits of colonial command over space and movement.

Work on colonial biopolitics provides the theoretical spine for much recent writing. Following Michel Foucault, historians read epidemic policy as a set of techniques for managing populations i.e. counting, classifying, segregating, and disciplining. Rather than simply curing individuals. This perspective draws attention to how epidemic policy created new categories like "infected houses," "suspect contacts," and "dangerous neighborhoods."

These categories were not neutral as they mapped risk onto caste, occupation, and what British officials saw as "dirty" habits. In Punjab, this played out very clearly and official reports praised their "efficiency" and their "vigilance." However, at the same time normalized caste-segregated camps, unequal policing, and the constant suspicion of low-caste or the mobile groups. Reading the *Jullundur–Hoshiarpur* report alongside these texts of scholars shows how these biopolitical ideas were applied in actual practice.

A body of work looks at the bacteriology, vaccination, and the role of Waldemar Haffkine (Haffkine, 1899). Studies of early anti-plague prevention measures shows both promise and the problems, when the laboratory methods were moved into contested field settings. Scholars noted there were three recurring issues. First one was the evidence was unstable and the data on efficacy was partial, the doses were inconsistent, and follow-up was mostly weak. Secondly, rumors shaped the response of the public and people feared poisoning, infertility, or some religious defilement. Thirdly, the uptake was not even, gender and the caste system played a key role in who accepted or rejected the inoculation (Arnold, Colonizing The Body State Medicine And Epidemic Disease In 19th Century India, 1993).

These three themes fit closely with the Punjab report in discussion, The officials have made some enthusiastic claims about inoculation. Yet they admitted that there was reluctance, especially among the women, people missed second doses, and they saw inoculation as useful for displaying power of the state. Furthermore, this study adds to this by showing how success was often measured only numerically, such as counting the doses or days since the last case was emerged. These numbers only created a visibility for the administrators, but it did not guarantee real clinical outcomes in the people.

Scholarly works on caste and sanitation also helps frame this history, as historians and anthropologists argue that the colonial health regimes mapped hygiene onto the society. The reforms of latrines introduced by the British along with the inspections of the houses and the cleaning rituals made people more uncomfortable who were already labeled as "unclean". The case studies of different villages also prove these claims. These show how the sanitation categories were made along with caste categories. This claim also supports the narrative that British health system strengthens the social divisions.

This literature, has three gaps the first one is Punjab's rural experience in the first plague wave has received less attention than Bombay's urban crises. This study's focus on various villages will help balance the first gap. Second gap shows that the readings and data of biopolitical are strong in theory. But less connected to administrative detail, and this study will try to link the theory to the logistics. Lastly, the third gap shows the histories

of the vaccination operations and how they often focus on metropolitan debates and laboratory practices, this study will reflect upon the vaccine operations and how these operations were carried out in police supervision in caste segregated camps.

Material and Methods

The approach used in this study is analytical and historical in nature. Primary evidence to support the article comes from the report of British period which is *Outbreak of Plague in Jullundur and Hoshiarpur Districts, 1897–98*, compiled by Captain C. H. James and other officers of the Indian Medical Service. The report elaborates data of different villages, recorded cases of plague and administrative notes. This data not only provided general numbers of plague patients, but also detailed information of the British interventions. This very important official report is critically analyzed alongside other important secondary sources on colonial medicine. These secondary sources talk about the social hierarchies and biopolitics used in the management of the epidemic. The quantitative details given in the report like number of vaccinations and mortality will help understand qualitative steps of the governance, local resistance and segregation of the caste. Historical framing along with the analysis of archival material will allow the article to assess the effectiveness of British measures for the plague management. Not just this but it will help understand the broader political and social implications.

Context

Bubonic plague when first reached the Bombay Presidency in 1896, it was met with a combination of alarm and denial by the people. The colonial state though initially hesitant to disrupt the trade and urban order, soon embarked on a campaign of strict plague regulations under the Epidemic Diseases Act of 1897. By the following year, the disease had traveled northwards as it entered the Punjab province. It reached through commercial and migratory routes that connected the province with Bombay, the United Provinces, and even beyond that. The districts of *Jullundur* and *Hoshiarpur* being situated in the fertile *Doaba* region became among the earliest rural flashpoints for plague epidemic, as they lay between the *Beas* and *Sutlej* rivers.

The spread of this disease into the Punjab marked an important shift from the urban and rural epidemic management. And it exposes the unreadiness of colonial administration for dealing with the disease in the village settings. It was unlike the cities with ports where infrastructure was already present, rural Punjab lacked these and manpower. The British authorities responded by expansion of coercive urban measures. These measures clashed with the local people, their ideologies and daily life. Consequently, the plague did not only challenge the British authorities but also the agrarian rural population. it intensified tensions between the state authorities and community.

The *Outbreak of Plague in Jullundur and Hoshiarpur Districts of the Punjab, 1897–98:* The central primary source for this study documents the unfolding crisis of plague in unusually coarse detail. Authored by Captain C. H. James, Deputy Sanitary Commissioner of Punjab, alongside other Indian Medical Service officers. The report in discussion elaborates extensive details on the quantitative records such as infection counts and mortality rates. And qualitative observations like the responses of the people of the villages and logistical challenges. The official report opens with a plain timeline, for example it states about first case which appeared in the October pf 1897 and peaked in March and April of 1898. Followed by a quick decline in the incidences by mid-May of the same year. This illustrates the general pattern of the disease spread in the subcontinent.

Two challenges were faced by the British administration, first was to stop the deadly spread of the plague which killed around 20% population of some of the villages. Secondly, their need to show their control and they could tackle the crises. Specifically at a time when people's trust in the British govenement was not high because of the years of famines and economic exploitations. As David Arnold writes that colonial epidemic policy in India often attached medical reasoning with political symbolism and making public health a theatre for the imperial legitimacy (Arnold, Colonizing The Body State Medicine And Epidemic Disease In 19th Century India, 1993).

The Punjab presented a distinctive epidemiological landscape and it was unlike Bombay. There were dense urban quarters in Bombay, which facilitated rapid human-to-human and rat-flea transmissions. Meanwhile, the plague in Punjab spread through dispersed rural settlements, mainly the mobility between villages driven by kinship, commerce, and agricultural labor. Which means that infection could jump across the countryside. The report features 67 cases of village-to-village infection directly due to human movement, with at least 45 incidences, where people broke through police cordons (James, 1898). Not as per APA Such breaches show the limitations of colonial containment measures, and the persistent efforts of local people in navigating, resisting, and evading, the restrictions of the state.

Moreover, the colonial administration's approach was shaped by examples in handling the diseases of cholera and smallpox in the region. Since the mid-nineteenth century Punjab's sanitary policy had relied on an amalgamation of district-level sanitary commissioners, military medical expertise, and a growing apparatus of statistical record-keeping. The Plague presented an unfamiliar challenge, unlike cholera, whose waterborne nature had been understood since the 1860s. Plague's transmission through rats and fleas was still contested among British medical circles in India in the late 1890s. The unpredictability at the time explains why the report focused a lot on the recordings of the deaths, even when there was not any clear bacteriological proof of the disease in the province.

The outbreak of the disease also caused tensions both political and social beyond the medical crises. Rumors were spreading widely for example some people feared that it was the doing of the British, and they were being poisoned by them. The real intention of the vaccination was doubted by the native population. There were harsh measures taken by the British increased mistrust among the people such as forced evacuations, caste-based camps and strict quarantines. Although a British officer James described these actions as public health steps, they often involved disruption in the daily life of the people, police force, interference of the authorities in religious customs and funerals of the locals. The panic in result was therefore not about the plague itself. It was also about politics and deep mistrust between the local people and the colonizers.

British Medical Measures and Implementation in *Jullundur* and *Hoshiarpur*:

During the period of 1897-1898 plague outbreak in the districts of Hoshiarpur *and Jullundur* of the Punjab, British government used a wide ranged strategical control of the disease. The measures included restricting people's movements through evacuations and cordons. Medical actions, vaccinations, hospital treatments and disinfections were also restricting the people. The official British reports explained these efforts as humanitarian and scientific, but in reality, and practice, they mixed public health with coercive and strict enforcement.

One of the central strategies adopted was the imposition of inner and outer police cordons around the infected villages. The outer barrier was typically set along the agricultural boundaries and it restricted outward movement. While it allowed limited access to fields, as a concession to the agrarian livelihoods, of over three-quarters of the rural population. The inner barrier, placed close to the village entrances, was designed to stop evacuees in camps from re-entering the still-infected settlements until disinfection was completed. While colonial reports praised these measures as most essential for preventing intervillage spread. They also admitted frequent breaches due to insufficient workforce and possible corruption among low-paid patrols. Official data conceded that in at least forty-five recorded instances, infection spread because the cordon failed, either from careless enforcement or deliberate evasion. This shows the effectiveness of the barrier system was only in theory, and it did not work well practically.

Another British response was to swiftly empty the villages which were infected. People were moved to the camps which were temporary, and sometimes the evacuation to the camp was within one day of the first reported case. The Village of *Khatar Khurd* was cleared in only thirty hours. People were separated on the base of caste and not only for the health reasons. The segregation was made between *Chamars,* sweepers and high-caste groups and it strengthened the old social divisions. The life of people in these quarantine camps was really hard. Poor shelters, heavy rains and not enough medical supplies made it worst for the people living in these camps. Some people even hid the cases of the plague just because of the fear and lack of trust on the British. As people buried bodies secretly in these camps, found by the officials.

Temporary hospitals were built by the British and were often dismantled to move these hospitals from one place to another. The large *Chappar* hospital was moved from *Khankhanan* to *Sirhal Qazian*. These hospitals treated confirmed cases of the plague, and those who were suspected to have plague were kept in the separate huts. The hospitals didn't provide any specific treatment as there was no special treatment was introduced. They only provided general care. The rates of death were high in the village *Sirhal Qazian,* where 63 patients died out of 82. More than 76% of the people did not survive who were infected, and it shows how deadly was the disease. And also shows how limited were British medicals in controlling it.

Disinfection operations, typically involving washing with phenyl and whitewashing of infected dwellings and these were initiated within days of evacuation. These were often carried out by specially trained crews from unaffected areas. Instead of villagers themselves, to limit the risk of further infection. While colonial officers highlighted the thoroughness of these efforts there were delays due to weather conditions and material shortage. Such as those experienced in Mallupota, reduced the immediate impact. Of these measures. Moreover, the stress on disinfection as a visible activity also served to demonstrate governmental actions and the reinforcement of colonial authority in the public sphere.

Possibly the most scientifically ambitious measure was the introduction of Haffkine's anti-plague vaccinations. It was a killed-culture vaccine developed in Bombay in 1897. The *Jullundur* and *Hoshiarpur* vaccination campaigns were among the earliest large-scale applications of the serum in the northern India. The doses were administered at first in the evacuation camps and some selected towns. Where *Banga* served as a major vaccination center, and official reports claimed promising results. Furthermore, in some inoculated populations, no plague cases occurred. Nevertheless, the campaigns were hampered by public suspicion and gendered resistance, as women were particularly reluctant to be inoculated. They were inconsistent in following-up for second doses. The

case of *Khemi*, a woman from *Karnana* who received only half the standard dose and later died of plague, was cited in official records as well. But the British said that their plague measures were effective as well as scientific, but they basically showed their need to impose control.

The British often stressed on practicing control than on taking care of the patient, and they used police cordons as well as forced evacuations to show their authority on masses rather meeting their medical requirements. The inoculation campaigns are considered an important and modern step in medical history of India, but they were not generally and widely accepted by the local populations. It was fear and mistrust of people in colonial policies that they avoided being vaccinated.

While these actions of inoculations and hygiene were defended in official discourse as evidence of a scientific and forceful plague response, their implementation reflected underlying colonial priorities. The stress on police cordons and rapid evacuations often prioritized control over patient care. The success of the cordons depended as much on administrative discipline, as on medical necessity. Suggesting that the policy's utility lay partly in the visibility of the state authority. Similarly, while inoculation campaigns marked an important moment in the history of biomedical intervention in India. its limited acceptance and uneven implementation reveal the restraints of imposing novel medical technologies in contexts shaped by deep social mistrust. Overall, the measures taken by the British in *Jullundur* and *Hoshiarpur* (1897-1898) combined their genuine efforts to contain the plague with actions that actually strengthened their power. The following section discusses different case studies of some villages.

Case Studies of Selected Villages

The outbreak of the plague in *Hoshiarpur and Jullundur*, helps us see the clear picture of how British applied the medical measures in the rural area. The following cases gives an insight to the weaknesses and strengths of British policies.

***Khatkar Khurd:* Rapid Evacuation and Caste Segregation**

Khatkar Khurd which was a village of about 1100 people, reported its first plague infected case on 29th of April 1897. The village was declared to be infected and people were evacuated the same day. Camps were set up and were based on caste and occupation of the people. Categories included high caste Hindus, Muslim groups like *Baharis* and *Rawals* and sweepers. In the report the officials applauded the evacuations because the disease stopped in *Chamars* and sweeper areas. Although, the report states that new cases also emerged in some of the camps within days as people went back to villages to disinfect their houses. This shows the failure of the plan to keep camps and villages separate. It only strengthened the old social hierarchies of division in the society. Moreover, the evacuation of *Khatkar Khurd* reveals how the colonial health interventions often based on pre-existing social structures to enforce compliance. By the organization of the relief along the caste and occupational lines the British power shifted the medical emergency into a experiment of social control. Where the segregation of people based on caste and occupation was justified as a sanitation hierarchy under the mask of hygiene.

***Sirhal Qazian*: Mobility of Medical Infrastructure**

Sirhal Qazian demonstrates both the weaknesses and strengths of the British medical practices. When the plague worsened British moved large *Chapar* hospitals to these areas and the process of moving delayed the treatments among the people. British officers

in the report praised the hospital for giving vaccinations to the isolated patients, but in reality, the steps were not carried out thoroughly. Many native people had no trust in the British policies because they feared dying away from their houses. This was the reason that many people were not treated at all. This also made it difficult to keep the accurate records, so the numbers in the report may not have been completely trustworthy.

Mallupota: Disinfection Delays and Reinfection

The experience of *Mallupota* shows another problem which was disinfecting the villages and delay in cleaning. It was declared infected in the early 1898 and people were forced to evacuate their houses. Although, there were heavy rains and it caused a shortage of the cleaning supplies like phenyl and lime. This shortage slowed down the disinfection of the village for weeks. The British did their best to address the issue by increasing the disinfection. But it was too late to stop a second outbreak. This however shows the weak control measures of the British as their resources ran low, and it ruined the whole plan.

The case of *Mallupota* also highlights the wide operational weaknesses of colonial rural health administration. Delays in the disinfection drives showed a deeper level of lack of preparedness for the management of epidemics outside their urban centers. In addition to this the evacuee's temporary displacement messed up the agriculture activities and daily life. It only fueled the resistance. Overall, this village shows that without adequate resources and locals corporation along with doable policies it is not easy to contain the epidemic.

Looking closely to the management of British in the above discussed villages it shows three basic problems. Caste segregation, public mistrust and operational problems can be observed clearly. The health policies reinforced the social divisions instead of being fair to all population. Lack of workers, moving of hospitals and lack of supplies showed the less effective plans. Many villagers resisted vaccinations and hospitals as they did not trust the British, hard enforcements only worsen the things. This shows that the British responses in the villages of *Jullundur* and *Hoshiarpur* showed some success. However, it was overcome by the focus on control over care. It reflects colonial priorities over public health.

The British medical response

Responses of 1897-98 plague in *Jullundur* and *Hoshiarpur* included disinfections, caste-based segregation, vaccinations and police cordons. It was called a scientific campaign, but in reality, these actions mixed disease control with political control of colonial powers.

The evacuations of the villages at first reduced the plague cases especially among the lower caste groups. But reinfections occurred when people returned to clean their houses shows a flawed policy making. Making caste-based camps, using force to evacuate and limit movement of the people. Lack of cleaning supplies shows weak rural administration. Haffkine's plague vaccination was a new tool and more than 2400 people were vaccinated. However, mistrust of people, their low engagement and poor timing showed that proving the power of the state was more important than preventing of the disease.

Briefly, we can say that practicing of power rather helping people illustrates what historian Mark Harrison calls the "authoritarian turn" in the colonial epidemic management.

Discussion

The plague outbreak in *Jullundur* and *Hoshiarpur* shows that the British medical response was driven by politics and was uneven. Evacuations as well as disinfections reduced the spread of the infection, but because of lack of resources exposed the fragile nature of British efforts. Their success depended heavily not only on the resources but manpower and compliance.

Inoculation campaigns were considered a landmark but met with skepticism by public. This mistrust showed limited results, British however celebrated it as a scientific progress and was successful in portraying a modern image and medical achievement. At political level the coercive measures by police cordons shows the reinforce surveillance and British authority in essence, the plague not only tested the boundaries of the colonial medicine but also their credibility politically. Disease control was inseparable from political control of the population.

Conclusion

In conclusion we can say that the plague management blurred the lines between governance and medicine. The British effort was not only for neutral public health, but it became a tool for practicing power under the guise of scientific intervention.

All the adopted policies by the British were framed as rational responses, but were unevenly applied. The success was limited and temporary as it dropped the infection, but it came back eventually and people died. Caste segregated camps and forceful evacuations made it British social and political hierarchy. The British undermined the community cooperation and it turned the medicine into a symbol of power rather protection.

The experience of Punjab exposes a deeper level contradiction at the center of colonial public health. Science was used not only to empower populations but to consolidate the rule. Scientific authority was not only for the public welfare but for the sustenance of imperial legitimacy. They turned health policy into a power instrument.

The plague of the Punjab can be studied as an early example of what present day theorists of biopolitics explains as public health was a mechanism for management of the populations, entrenching political systems and regulating of the bodies. Plague did not only test the medical knowledge of that time but it also exposes the political stakes of it. It shows the tangled link between power, health and social hirearchies in the colonial Punjab.

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