BRITISH HEALTH POLICY: IT’S IMPLEMENTATION AND PENETRATION TOWARDS RURAL AREAS
CHAPTER-V

BRITISH HEALTH POLICY: - IT’S IMPLEMENTATION AND PENETRATION TOWARDS RURAL AREAS

As discussed in the previous chapter that Tropical Medicine was introduced in India in order to take care of the health of the Europeans and the British army. It was evident that no systematic health programme was started in India until the revolt of 1857. Nearly half of the nineteenth century witnessed the total negligence of the public interests.

The events of 1857 Revolt exposed many aspects in front of the British Government, –that the East India Company’s Administration had ignored the indigenous sensibilities and issues at all, that the Government had exploited the rights of the common people, and that the present Government had interfered into the Indian Cultural practices, which had twisted revulsion and jealously among the common poor people. The Government initiated to take interest into the public matters. For the purpose the Royal Commission on the Sanitary State of the India was appointed in 1859.

Thereafter various Commissions and Boards came into the existence and the British Government (after the transfer of power) tended to run a planned Health Policy in India. At first the policies were confined to Military Headquarters and European settlements only, thereafter it was very slowly penetrated towards the residences of local population.
The study of Colonial Health Policy in India clearly reflects the connection between the growth of knowledge of various diseases, the economic interest of various sections and the Government policy.\(^1\) Charles Curtis during this work at the Naval Hospital at Madras came to the conclusion that the diseases in India require the different form of treatment than in Britain.\(^2\)

The belief, that Indian diseases were different in nature than that of Europe, led the Europeans to consider the utility of new researches and of Indigenous medical knowledge also. The need was also felt to distinguish between healthy and unhealthy areas. For the colonial government, smallpox, cholera, plague, malaria was the big challenge. In 19\(^{th}\) century India smallpox carried away huge numbers. The Sanitary Commissioners for the Government of India wrote in the 1870 report:

‘The mortality which is due to small-pox is year by year so heavy that the prevention of non one disease is of so great importance to the people of India.\(^3\)

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\(^2\) Curtis C., *An Account of the Diseases in India, as they appeared in the English Fleet and in the Naval Hospital of Madras, in 1782 and 1783; with observation on Ulcers and the Hospital sores of that country*, pub. Edinburgh, 1807. p. XVI.

Medical Administration:-

By the beginning of 19th Century the British had established themselves as a responsible Government in India. Several Departments of civil services were developed. We see the progress in the field of science also. At first the public health departments in Bengal were opened for the purpose of caring British Military troops, and the European civilians. Public Health Commissioner and a Sanitary Commissioner were appointed. The work of the Medical and Sanitary Department according to Imperial Gazetteer of India included:-

‘Public Services, Hospitals, Dispensaries; Lunatic asylums, vital statistics, general sanitation and vaccination; the health of ports and shipping; medico logical, bacteriological and other scientific matters’.

Health Statistics:-

The Central Provinces of Bihar was the first to introduce the registration of birth and deaths in 1866. Punjab and United provinces followed soon after. In 1873, Bengal passed the Birth and Death registration Act. These registers used to record the place of birth, death, age, sex, marital status, religion, occupation and causes of death. The development of Census organization also played a vital role

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as the items collected in population census include personal characteristics, disabilities, fertility number of children (surviving, born, died) educational and economic characteristics etc. exhibition etc.

On the recommendations of Royal Commission of 1859, Commissions of Public Health were formed in Bombay and Madras Presidencies in 1864. Later on some posts of Sanitary Commissioners were created.\(^5\) Around 1888 Local bodies and Municipal Officers in the rural areas were appointed to look into the sanitation and health problems. The Central government had two advisors (a) Director General of Indian Medical Service (b) Public Health Commissioner. The Public Health Commissioner was responsible for submitting the Annual reports to Government of India, on the health of the country. His other functions were the consolidation and issue of vital statistical returns for the British India.

In each province the administration of Medical and Sanitary matters, was under the control of Local government, whose principal advisors were the Inspector General of Civil Hospital and the Sanitary Commissioner.\(^6\) They Superintended and encouraged the sanitation of the districts, and towns within their circle, inspect dispensaries, hospitals etc. They used to advise them during

\(^5\) The Sanitary Commissioners used to submit their Annual Report, regarding the works done by the Sanitary Department.

the extraordinary situation. Also they used to deal with vaccination and vital statistics.\textsuperscript{7}

**Indian Medical Services:**

It was primarily a military service and its members were commissioned officers of the Army.\textsuperscript{8} The officers of the Indian Medical Service were mostly military surgeons of European origin, who were selected in England by competitive exam. In 1835, with the opening of Calcutta Medical College, I.M.S. fields were opened to the natives of India, who were selected to serve in subordinate military medical services as assistant civil surgeons.

Afterwards a network of hospitals was setup throughout India. In 1854, the Government of India agreed to supply medicines and instruments to the growing network of minor hospitals and dispensaries.

The Principal hospital was always situated at the head quarters of the district. It was under the immediate charge of the civil surgeon. The management of District dispensaries was usually under the local communities.\textsuperscript{9} Various types of hospitals came into existence.

- Military hospitals (for treating soldiers and sailors of the company).
- All hospitals established at the district head quarters.
- The General hospitals meant for the native civilians.
- The Charitable Hospitals.

\textsuperscript{7} Ibid., p.461.

\textsuperscript{8} Ibid., pp.461-463.

\textsuperscript{9} Ibid., pp.461-463.
Preventive Measures:

The significant aspect of Government policy was the preventive measures taken to deal with the severest epidemic diseases under the Epidemic Disease Act 1897.

Vaccination:

Vaccination of smallpox was started in India as early as in 1802. In 1827 Elphistone, the Governor of Bombay, introduced the new system of vaccination, under which vaccination was done at a large scale. In fact it provided a wide survey to understand the indigenous population to the British Empire.

There was a popular measure of combating Smallpox called Inoculation, which unlike Smallpox, was done by special practitioners known as Tikadars. This system was quite popular among the poor communities. As vaccination was a new technology, it found very difficult to convince the people about its better effects. E. Charles, the Superintendent General of Vaccination, with the Government of India, prepared the following pamphlet for popular information regarding vaccination.

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11 Introduction of Small Pox Vaccination in British Provinces:

<table>
<thead>
<tr>
<th>Year</th>
<th>Province</th>
</tr>
</thead>
<tbody>
<tr>
<td>1854</td>
<td>N.W.P.</td>
</tr>
<tr>
<td>1856</td>
<td>N.W.P. &amp; Bananas</td>
</tr>
<tr>
<td>1864</td>
<td>Meerut, Banaras, Gorakhpur &amp; Central Provinces</td>
</tr>
<tr>
<td>1865</td>
<td>Allahabad &amp; Jhansi</td>
</tr>
</tbody>
</table>

Table 5.1: Comparison between Inoculation and Vaccination

<table>
<thead>
<tr>
<th></th>
<th>Protection</th>
<th>Safety to community</th>
<th>Freedom from suffering</th>
</tr>
</thead>
<tbody>
<tr>
<td>People may die from inoculation</td>
<td>None die from vaccination</td>
<td>It may spread smallpox</td>
<td>It never spreads smallpox</td>
</tr>
<tr>
<td>Much paid, fever and uneasiness in inoculation</td>
<td>After vaccination there is a rule, very little pain &amp; slight fever no uneasiness.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Imperial Gazetteer of India provides the detailed information of vaccination, done in the British Provinces\textsuperscript{13}:-

Table 5.2: Vaccination done in British Provinces

<table>
<thead>
<tr>
<th>Smallpox vaccination</th>
<th>1880-81</th>
<th>1890-91</th>
<th>1900-01</th>
<th>1902-03</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons vaccinated</td>
<td>4,415,000</td>
<td>6,496,000</td>
<td>7,860,000</td>
<td>8,411,000</td>
</tr>
<tr>
<td>% of successful vaccination in each 100 estimated births</td>
<td>19.9</td>
<td>27.5</td>
<td>33.9</td>
<td>39.1</td>
</tr>
</tbody>
</table>

Quarantine, Segregation and Disinfection: -

Some Quarantine measures were adopted to prevent Plague disease in suspected areas. Whole villages were sometimes placed in Quarantine. The effects were fruitful. Health officers in every province had the power to segregate the infected person from his house.

British government during the Plague epidemic did it forcefully and this created fear among the common people.\textsuperscript{14} It meant to destroy the articles by the Health Officer. Haffkine (\textit{the inventor of plague vaccine}) was commanded to convert his laboratory into a factory for the production of plague vaccine in bulk.\textsuperscript{15}

Sanitation and Water Supply:-

Sanitary Boards were appointed in 1864, in each presidency principally for the Army. Civil surgeons were particularly the Health officers of the district and probably by 1893 Boards were established in every province except Berar. In Bulandshahar, excessive humidity was caused by the canals, so the straightening and deepening of the smaller river and the innumerable drainage works, were done to improve sanitation. The Superintendents of vaccination were made Deputy Sanitary Commissioners, and were directed to supervise general sanitary work as well as vaccination and vital statistics.


\textsuperscript{15} \textit{Ibid.} p.95, See also Anil Kumar, \textit{Medicine and the Raj: British Medical Policy, 1835-1911, op.cit.,} p-95.
Surgery and Medical Research:

Surgery grew up to be especially an important part of hospital work. Cataract had been a common disease in India. F. Buchanan finds a number of people suffering from the disease in the regions of Bihar, Orissa and Assam and people would come to the hospitals for its treatment. Thus, in important areas, information on health and medical subjects was supplemented by the Research Institutions. Almost all senior posts in Research and Training Institutions and Medical and Health Administration were held by the officers of Indian Medical Service.

The Government of India basically felt concerned towards the new researches only after the Royal Commission in 1857, reported that mortality rates in the British army were greater than among civilian population.16

The Government of India appointed D.D. Cunningham, the officer of Indian Medical Service to take up the research on diseases, like Cholera, Malaria, Beriberi and Kala-azar in 1869. At the turn of 19th century London and Liverpool schools of Tropical medicine established a view that there is a great difference between ‘Tropical and Temperate Zone’, and therefore diseases like Black fever, Cholera,  

16 The Commission recorded 69 per thousand (death rate) among the British troops. Among the various causes the most prominent were poor drainage, ill ventilated barracks and improper sanitation. The commission also recommended in its report of 1863, that the distinct areas of European habitation should be created and the troops should be sent in rotation to hill stations 5 thousand feet above the sea level.
Malaria all distinct from the diseases of temperate climate and that they required special knowledge and research.\textsuperscript{17}

**Black Fever:**

Black fever (\textit{Kala-azar}) had been a major health problem in British India. More attention was paid to the disease when in 1875 it began to invade Assam. It swept up the Brahmaputra valley in three distinct epidemic waves between the periods of 1875-1917. As the cause of the fever was undiscovered, the treatment given to the patient did not prove successful in these periods. It was later discovered that the fever was caused by the bite of a sand fly.

**Malaria:**

Malaria research began in British India under the supervision of Sir Ronald Ross. During the years of 1896-1902 Sir Ronald Ross (1857-1932) conducted a series of laboratory experiments in Calcutta and Sikendarabad which determined that the anopheline mosquito carried the material parasite. For this discovery he was awarded the Nobel Prize for medicine in 1902.

**Cholera:**

Cholera research in British India started up as an emergency duty with patients deaths increasing by the day. Within the period of 1883-84 the German bacteriologist Robert Koch (1843-1910)\textsuperscript{21} discovered the specific cause of cholera in

the *commabacillus* while working in Egypt as a member of the German Cholera Commission.

In December 1884, the Government of India directed the establishment of India’s first medical laboratory at the Calcutta Medical College. In 1888, following the work of Koch, the English Cholera Commission was established under the leadership of British bacteriologists, Dr. Edward Klllen and Dr. Heneage Gibbs.²³

**Typhoid:**

Within the period of 1898-99 Almroth Edward Wright (1861-1947) of the Royal Army Medical College at Netley researched and developed an anti Typhoid Vaccine which was tried on 4502 British soldiers in India with victorious results.

**Plague:**

The significant aspects were the advancement of anti plague measures under the epidemic disease act and Municipal Act. In 1912 the Medical Registration Act was passed in Bombay legislature Council. The Act established a medical council and its responsibility for the regulation of medical qualifications and training in Indian Medical Schools.

**Pharmacy:**

It was the 19th century when government realized the value of Indian drugs and the Central indigenous drug committee in Oct. 1895 was formed. Number of books on the indigenous drugs of India was published.¹⁸ Some medicinal plants as

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Cinchona were brought from England and transplantation was started at Nilgiries Sylhet, Chittagong and Dargeeling.

**Mental Health:**

Lunatic asylums were established for insane persons under an act of 1858. These were under the control of the Civil Surgeon of each respective district. Central asylums were formed in Bengal, Bombay, Madras, United Provinces, and Punjab. Later, Government Mental Hospitals were established at provincial headquarters. Medical officers were encouraged to attend these facilities and conduct research for improving mental health.\(^{19}\)

**Lunatic Asylums & Leper Asylums:**

Leprosy was a big problem in British India. IMS medical officers did enormous amounts of research on the scientific treatment for leprosy. Despite its limitations and hardships, leprosy research in India received worldwide recognition; many Indian remedies for leprosy have been incorporated into western medicine.\(^{20}\) Because of G.A. Hansen’s discovery in 1873 that leprosy is spread by contact, H.V. Carter of the Bengal Medical Department gained an authority over leprosy control in India. After the 1889 Leprosy Bill, the National Leprosy Fund was

\[\text{References}\]


constituted by the British Empire under chairmanship of the Price of Wales. A Leprosy Commission was formed to investigate the etiology and epidemiology of leprosy. The Leprosy Commission concluded that leprosy is a disease *sui generis* caused by a bacillus having striking resemblance to tuberculosis and it is not a hereditary disease, that is spread by contagious means but the chances for that are very small. However, its spread is indirectly influenced by poor sanitation and malnutrition.

The Lyprosy Commission suggested that segregation might not be fruitful in India. It suggested a prohibition on the sale of food articles, prostitution, and other occupations involving direct interference with people like barbers or watermen by the infected people. It insisted on the improvement of sanitary and living conditions. However, the government of India passed the All-India Leprosy Act in 1898 and Leper Asylums were established in major parts of the country and forcible segregation of lepers was carried out.

**Local Self Government:**

Alfred Lyall the Secretary to the Govt. of India said in 1874:

‘It is in the municipalities that the progress of the sanitation must be looked for’.  

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22 India Office records P/525, Government of India, Home (Sanitary), Alfred Lyall, Secretary to the Government of India, 1874. Cited in Harrison Mark, *Public
To him Govt. is lacking the capacity to intervene in matters directly affecting the indigenous practices. It was necessary that local self-government should hold the responsibility for public health. Therefore during the period of Lord Ripon some changes were witnessed. Ripon’s resolution on local self-government of May 1882 gave opportunity for greater Indian representation in local self-government. The smallest local board covered a Tehsil or Sub-Division of a District; it had responsibility for sanitation, education, public works and medical services. The development of local boards in rural areas began later in 19th century. Imperial Gazetteer of India says:

‘The Primary duty of the local boards is the maintenance and improvement of the means of local communication. Their functions in particular are to promote light railways but in general the maintenance of hospitals, dispensaries drainage, water supply, sanitation and vaccination etc.’

The epidemic diseases act was passed in 1897 and the governor general of India conferred special powers on local authorities to implement the necessary measures for control of epidemics.

Health in British India: Anglo Indian Preventive Medicine, 1859-1914, op.cit., p.166.

Hunter W.W., Imperial Gazetteer of India: The Indian Empire, Vol.-IV, (Administrative) op.cit, p.300.
FEMALE HEALTH POLICY:

(i) Midwifery and Maternal Health Associations:

The Colonial State’s first intervention in the field of Indian women’s health came in 1868. The 1880s also saw the entry of Indian women in the Medical Colleges. But it was not until 1885 that attempts were made to legally regulate midwifery. In that year the Dufferin Fund was established for supplying medical aid to the women. In 1892 the training of the compounders, nurses, and midwives was carried on at the four centres of Allahabad, Banaras, Barreilly and Lucknow. There was progress in the admissions taken by the Indians and the number of the students is exhibited in the following table:

Table-5.3: Number of trained Students in certain districts (1892)

<table>
<thead>
<tr>
<th>Centres</th>
<th>No of Students who attained training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allahabad</td>
<td>28</td>
</tr>
<tr>
<td>Barraily</td>
<td>04</td>
</tr>
<tr>
<td>Benaras</td>
<td>14</td>
</tr>
<tr>
<td>Lucknow</td>
<td>12</td>
</tr>
</tbody>
</table>

There was an increase in the number of patients who came for the treatment of different diseases. Among them most of the patients were females who used to come for delivery, and other related problems. These patients were also given guidance for child care also. The figures below show the number of indoor and outdoor patients treated during the year 1892 and 1893. (Excluding Moradabad).\textsuperscript{25}

\textbf{Table-5.4: Number of Indoor & Outdoor patients (1892)}

<table>
<thead>
<tr>
<th>Year</th>
<th>Indoor patients</th>
<th>Outdoor patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Treated at Hospital</td>
<td>Treated at Home</td>
</tr>
<tr>
<td>1892</td>
<td>5,935</td>
<td>2,87,742</td>
</tr>
<tr>
<td>1893</td>
<td>6,350</td>
<td>3,00,371</td>
</tr>
</tbody>
</table>

By 1900 a number of female hospitals were established in almost all important districts. However we have evidences that wherever the proper funds were released the patients were treated properly but the situation was worse where there was lack of funds.

\textsuperscript{25} Ibid., p.22.
The Annual reports submitted by the Chairman and Secretaries to the countries of Dufferin fund, presents the actual situation of these funded hospitals. We have the sample records of two districts.

**Distt. Aligarh:**

*Extract from:*

A letter from Tota Ram, the secretary, to the Honorary Secretary of the countess of Dufferin’s Fund, Provincial Branch, North Western Provinces and Oudh Branch, Allahabad 1 Dec., 1893.26

‘.........The financial position of the branch is better this year than in previous years....... Our committee will be glad to support any female student who would like to study at the Agra Medical School..., the hospital is now on the way of gaining popularity’.

**Distt. Bijnor:**

*Extract from*

A letter from H. Fraser, the Chairman to the Honorary Secretary of the countess of Dufferin’s Fund, Provincial Branch North Western provinces & Oudh Branch Allahabad – 1 Dec., 1893.27

‘......... The Government grant in Aid is short...., Europe medicine has not yet been drawn....... The hospital sadly needs a store room, a Chawkidar and Kaharin’s storeroom, there is no female cook, and it is necessary in many cases of sickness of a serious nature to prescribe a hospital dietary otherwise the patients

26. Ibid., p.55.
27. Ibid., p.95.
purchase food from bazaar, which produces a relapse of sicknesses’

Almost in every hospital there was the same problem of paucity of funds. Despite these difficulties mentioned by the secretaries, there were signs of improvements in Female health. The death rate fell steadily. Mostly, the women preferred to go to the maternity hospitals established by the British government. The census records show the decline in maternal mortality, in the United Provinces of Agra and Oudh. \(^28\) The following table and graph shows decline in the United Provinces of Agra and Oudh during 1905-1910.

**Table-5.5: Decline in maternal mortality in United Provinces of Agra & Oudh during 1905-1910**

<table>
<thead>
<tr>
<th>Age</th>
<th>1905</th>
<th>1906</th>
<th>1909</th>
<th>1910</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-20</td>
<td>47,413</td>
<td>33,048</td>
<td>26,259</td>
<td>31,211</td>
</tr>
<tr>
<td>20-30</td>
<td>112,978</td>
<td>84,062</td>
<td>73,634</td>
<td>88,997</td>
</tr>
</tbody>
</table>

(ii) **Infant Welfare Services:**

Though there is a very little evidence of such activities before World War I (1914) hence infant welfare services developed as an adjunct to the development of midwifery. The records suggest that there were provisions of opening of childcare centers along with the maternity hospitals. Christian missionaries played a vital role in this regard as publication of booklets on maternal and childcare. They also used to give proper instructions for infant feeding.
GOVERNMENT’S INITIATIVE: Health Policy or Imperial Policy?

Rural Areas and Health Programme:

Imperial Gazetteer of India says ‘Only 1/14th of the population of the British India lies within the municipal limits’\(^{29}\) by 1863 there was no organization for the prosecution of the sanitary work outside the presidency town. Municipal and District boards were being unable to control the ravages of plagues and other epidemics in Northern and Western India between 1896 and 1907. Thus Sanitary Commissioner repeatedly drew attention to the consequences of the absence of the effective public health organization outside the towns and to the necessity for full time subordinate staff. For the purpose Government passed number of Village Sanitation Acts during 1865-71, and Local Boards were also started.

In Bombay the Village Sanitation Act was in force in 294 villages in the year 1902.\(^{30}\) But the figure was not sufficient against thousands of villages and the number of villages still remained untouched to the authorities. Similarly the system of rural boards was started during the period of Lord Ripon (1882) which was applied by the provincial government of India and which carried out the work like construction & maintenance of roads, village education etc.,

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but the funds were so small less than £50,000 in 1886 for 200,000 square miles of country that we find the Government urging the committees to encourage local subscriptions in aid of the work. Money was also raised by small percentage of tax and revenue which was opposed by the villagers. Thus we may refer to these land marks in the history of Public health administration in our country.

1. Appointment of Royal Commission to inquire into the health conditions of the army in India in 1859.
3. Reforms introduced by the government as sanitary commissioner in 1864.

The purpose of the appointment of the Royal Commission and other commissions was principally to look into the health conditions of Army. Radhika Ramasubban and others have identified colonial Public health as being the health policy of the army, the European population. Whenever the Government felt the threat to the imperial interest the health

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conditions of the indigenous people were taken into consideration as deadly fever *Kalazar* in Assam alarmed the government that the people associated with the tea plantation were being affected from the disease.\(^{35}\) Only selective experiments were made regarding the diseases that took epidemic shape and took a heavy toll of human lives.

However, general health conditions of the common people were not the subject of concern of the Imperial Government. The records also suggest that a number of rural areas did not receive any transportation, communication and medical facilities.\(^{36}\) Bhore Committee found that –

‘There was a wide prevalence of insanitary conditions in urban and rural areas. The provision for protected water supply and drainage was totally adequate and the committee found the total absence of the concept of simultaneous application of preventive remedial measures’.

The committee further reported that the incidence of disease among industrial workers, who were generally migrants from rural areas, was high and migration from rural to urban was an important cause for the spread of infection disease like tuberculosis. There was overcrowded and inadequate

\(^{35}\) Dutt A.K., ‘Medical Research and Control of Diseases, Kala-azar in British India’ in Harrison Mark, *Social History of Health and Medicine in Colonial India*, op.cit., pp.93-100.

housing among industrial workers. There was lack of facilities for health work among women laborers in factories.\(^{37}\)

The Zamindars who were to look into the basic needs of the poor were indifferent towards their duties. Though many local boards and village sanitation Acts were made in 186-71 and all Sanitary measures were directed to the communications, schools and dispensaries etc. but still British Health Policies could not be successfully penetrated towards the rural sectors. The Imperial Government had its focus on scientific researches into disease, rather than Public Health measures. The Colonial Government did the developments only in the field of their interest or from where the revenues could be collected. Thus we see the flourishing of religious fairs and yatras in British period. It was beneficial for them as they could come into the contact of common people and could collect the pilgrimage tax.

Daniel Headrick is a prominent name among the critiques of western medical policies. To him medicine had been among the several *Tools of Empire*\(^ {38}\) that enabled and facilitated western penetration and domination of European world. Deepak Kumar has found colonial interest in the development of technology and medicine because only selective experiments were made and their approaches were also carried by the colonial interest.\(^ {39}\)

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Proper funds were not granted by the Government to meet the challenges. Even Ronald Ross also criticized about the paucity of funds for proper researches. He argued that the government of India did not consider it necessary for the doctors to know how to fight with the diseases.\textsuperscript{40}

There was a lack of consciousness among the Government officers and so proper investigation into the general health problems and sanitation were not done. It was necessary that the endemic areas of the particular diseases were to be properly investigated to overcome the disease.

We cannot deny the fact that only policy making is not sufficient to say that public health measures were done, its development and proper implementation is totally depended on active co-operation between the Government and the people.

It also requires direction and more specifically, financial support from the Government.\textsuperscript{41} But we don’t see the proper access of health policies (may be because of imperial interest or because of racial superiority) and the indigenous section also did not show its awareness towards health problems, diseases and malnutrition.

On the basis of above criticisms we may have an argument:


\textsuperscript{41} Harrison Mark, \textit{Public Health in British India: Anglo-Indian Preventive Medicine 1859-1914}, \textit{op.cit.}, p.234.
that the primary initiative of the government was health policy was the preservation of the health of European conquerors and administrators of Empire. As Ray Macleod and Milton Lewis argues,

‘The Colonial Medical services in Britain, France, Belgium, Caribbean, Southeast Asia and Pacific all began by serving the imperial military, political and trading interests.’

that the health policy served as an agent of social control of oppressed populations. Vaccination and Sanitation proved to be the best means for Imperial Government to know about the indigenous population.

that the medicine legitimized Imperial rule in India. Clean water supplies water borne sewage systems, clinics, medical training and so on have been recognized as one of the great ‘civilising’ benefits of European rule by the contemporaries and by historians. As Arnold has argued Imperial powers used medicine as a ‘demonstration of benevolent and paternalistic intention as a way of winning support from a newly subject population.’

Sanitation includes not only the provisions of Sanitary houses and streets, proper method of drainage and water supply and collection and


removal of town refuse, but everything which tends to improve public health and to prevent the spread of disease, including the investigation into the causes of sickness and death, the provision of hospitals, medical relief, registration of births and deaths, health visitors and instructions in personal hygiene and found and milk supplies.\textsuperscript{44}

We see during the colonial rule, no emphasis was given to proper sanitation especially village sanitation. The rural environment was exploited with the expansion of roads. By 1872 many areas were connected by Roads and Railways, (Please see map A.1 and Map A.2 in Appendices). All these areas were subjected to unhealthy conditions remaining fetches of stagnant water on the either sides. The Sanitary Commissioners never cared for rural health care. The medical officers or health visitors never turned towards the remotest rural areas of registrations, vaccinations, and to give instructions in personal hygiene etc.

However, underlying the epidemic diseases like plague, cholera, smallpox, malaria, there were many other diseases that were less dramatic in their effects were every time prevalent among the people like slow poison, the fatal effects of those diseases were not figured prominently in accounts. Among them were widespread poverty and malnutrition which were the strongest

\textsuperscript{44} J.A. Turner, ‘Sanitation in India’ in, \textit{Transactions of the Bombay Medical Congress 1909}. Bombay Printed and Published by Benett Coleman The Times Press. p.462.
cause of the prevalence of disease in the region rather than climate and environment.

Though in some reports it was accepted that the immunity the people will continue to be decayed, if poverty is not controlled.

Indian Famine Commission 1901 recommended

‘There is no greater evil than the depression of the people. It is a matter of universal experience that moral depression leads down a sharp incline to physical deterioration.’

Neither the diet taken by the poor people was of nutritive value, nor were they aware of nutrients found in different food items. The British health policy did not include such programme which could provide poor people, information about balanced diet. Moreover, the Government imposed further taxes upon the poor people in the name of improving sanitation and providing pure water supply, which created indifference among the people.

Now we shall discuss why and how the Indian people responded towards the whole situation whether the constructive relationship was formed between the government and people or not.

\[45\] Report of Indian Famine Commission 1901, op.cit. p.11.