

## **Is a change in the basic terms of reference necessary? : An examination of the case of the history of public health and medicine in South Asia, 1880-1980?**

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I must apologise, at the very outset, for presenting a paper that may not sit easily in this panel. When I sent in my abstract for consideration, I proposed a historiographical paper, in keeping with the overall theme of this conference. However, on receiving the conference schedule last week, I noted that my paper had been accommodated in a panel dealing with the theme of 'Medical theories in transition'. In light of this, I have conducted a hurried re-write, aimed at bringing the theme of this paper closer to the preceding presentation. This basically means that I will arrange this paper around a case study of Indian smallpox control campaigns, instead of also dealing with the insights provided by a detailed examination of the working of official dispensary networks in the sub-continent. On a bright note, this will make it easier for me to stick to the prescribed time limit!

### **I. Introductory comments**

The medical history of South Asia is still a relatively young field of enquiry. But although there has been a welcome surge of interest in this specialisation in the last ten to fifteen years, a very sizeable chunk of this work tends to portray officially-sponsored preventive and curative medicine during the colonial period in rather contradictory terms. While it is presented, on the one hand, as an effective tool of social control (measures that were offered only as they were a source of political information about subject populations), it is advertised, on the other, as a medical boon that was wilfully and systematically denied to Indians (in the form of immunisation and hospital provisions that were targeted primarily at European populations).

On closer examination, these generalisations seem to be based on a set of worrying trends – the unquestioning utilisation of pre-conceived theoretical models and sometimes, rather unfortunately, by a tendency to selectively use and/or over-emphasise the insights provided by one or more sets of historical materials. This can be partly attributed to an inclination to blindly repeat arguments presented in certain

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seminal works, without reference to the vast political, social and economic differences that existed across the sub-continent. We are frequently invited to accept this on the basis that major generalisations have already been 'proven' in existing work – a tendency that is indicated by footnotes that display 'evidence' that is drawn not from historical materials relating to the geographical and temporal context being studied, but from secondary works dealing with a different region and time-frame (sometimes even a different country!). Difficulties have also arisen from the inability of historians to conduct sufficient research in European and sub-continental archives, which hold a rich and varied collection of materials, published or otherwise. Whilst India-wide generalisations are often presented, there is often, in many cases, little evidence to suggest that any serious efforts were made to collect examples about different provincial contexts. Indeed, generalisations about all-India trends are often backed by a stray example from one province and a marked silence about what may have happened elsewhere. The main problem here, in my view, is that efforts to analyse, problematise and question the evidence contained in such publications has been remarkably rare, leading to the sustenance of suspect historical arguments.

All that said, work challenging the above trends is now gradually appearing, as scholars seek to question widely established viewpoints and present fresh new analyses on the basis of careful and detailed historical research. In view of the aims of this conference, this paper is a celebration of this welcome development, which is beginning to result in lively and important new debates that have not only stoked a search for new historical resources, but also fuelled fresh, imaginative and rigorous ways of interpreting the primary sources that have been the focus of previous scholarly analysis.

My presentation results from a decade of research conducted in repositories located in India, Britain, the United States and Europe. During the course of the production of two separate monographs – one dealing with the experience of the Second World War in colonial eastern India, the other with the control and eradication of smallpox in the sub-continent during the course of the nineteenth and twentieth centuries – I encountered a variety of historiographical problems, many of which still await resolution. While it is impossible to deal with all of these issues within the confines of a short article/presentation, it would be useful to flag up a few examples for discussion, in the hope that it would allow us to consider new avenues of research and analysis. These will deal with both colonial and independent India, as it is useful,

in my view, to highlight and understand the bases of the resilience of several policy continuities and trends that have been ignored – if not systematically downplayed – by historians in the past. In light of the fact that a variety of published and unpublished records relating to the period between 1947 and 1980 are now being made available to researchers, it is possible and useful to prepare detailed historical studies of different aspects of public health and medical policy in independent India.

## **II. The 'state' and smallpox control policies**

It is widely recognised that 'the state' has always played an important role in mobilising public health policies and regulating medical practice, be it in the colonial period or in independent India. And yet, as even a cursory survey of the historiography reveals, extremely few medical historians have bothered to define what they think 'the state' represented. More often than not, we have to deduce their definition in this regard and, generally speaking, everyone seems to be referring to the central/federal government, which is presented as an all-powerful body, capable of getting all the policies it designed implemented all over the sub-continent. Except for Mark Harrison's work on public health in British India, such a simplistic definition of the state is widely applied. In the colonial context, 'the state' seems to be presented as an organisation that was composed of Europeans, who were seemingly in charge of all levers of power and who were all in the grip of a ceaseless urge to forcibly impose their policies in the face of civilian opposition and denounce Indian ignorance and superstition. It is argued that after independence, this level of administrative power was simply transferred to Indian politicians and bureaucrats, who were, once again, able to design policy in the national and provincial capitals and then get these implemented in the localities.

However, my work on official smallpox control efforts presents a much more complex picture. While varying smallpox control strategies were identified as being useful by officials based in the national and provincial headquarters, these were hardly ever implemented to the letter. A variety of other strategies were retained in the districts and sub-divisions, and policies developed by senior central and provincial health officials were re-adapted to local needs and conditions by officials who were able to retain significant autonomy (these officials would respond to local infrastructural, political, social, economic and geographical conditions). Thus,

district-level differences persisted right through the 19<sup>th</sup> and 20<sup>th</sup> centuries, which meant that a patchwork of policies persisted within the provinces and their districts. In addition, policy adaptations were forced even in contexts where district-level sanitary and public officials supported the goals of their provincial superiors. Generally speaking, this was caused by the fact that these officials were often not supported by bureaucrats attached to other departments, who were important to the implementation of all elements of sanitary and public policy, especially vaccination campaigns. Of great significance in this regard were the police and legal departments – efforts were made to mobilise their members in the face of local bureaucratic and civilian hostility.

In the time available to me today, it is perhaps best if I highlight what I consider to be some of my more important findings with regards to official smallpox control policies, which will, I hope, contribute to the larger argument that I am attempting to make about the need to review the use of certain historiographical categories with regards to South Asia. I will discuss each of these issues in general terms, in the hope that I will be able to go into greater detail during the question-answer session.

(1). The nature of the vaccination establishment: The establishment developed unevenly both in British and independent India due to the differing levels of financial support available in various administrative contexts. Generally speaking, urban centres were provided with more organised facilities than rural areas, and the provincial and district headquarters and cantonment towns tended to be far better resourced than the smaller sub-divisional towns. This caused routine vaccination work, supervision of operations and anti-epidemic measures to be deployed very differently in urban and rural contexts. Usually, urban centre tended to have substantially greater numbers of permanent, well-trained employees, whilst rural contexts tended to be provided with relatively untrained temporary officials. As is to be expected, this had an important effect on the quality of vaccination services provided in the two contexts – urban vaccination work tended to be carried out more carefully, vaccinations were more successful in that they ‘took’ more regularly, and there were fewer post-vaccinal complications. This is, of course, not to say that opposition to vaccination in urban centres disappeared completely. Indeed, officials consistently spoke of the need to provide high quality of vaccination services precisely so as to tackle the existing levels of civilian dissent, especially in a situation where compulsory vaccination was first introduced in cities and towns, which had access to

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well provisioned supervisory services. The provision of the best vaccinators in urban areas where laws of compulsory vaccination were in force was widely regarded as being an extremely important strategy. This policy was implemented at the expense of rural services (in independent India this trend was reversed only as late as the 1960s, when a concerted push was made to eradicate variola from the sub-continent – rural areas were at this time identified as a major problem).

(2). The vaccination establishment and the other arms of the colonial administration:

The vaccination establishment did not operate in a vacuum. Nor did it always get the support of other government departments and services – while public health officials based at the central and provincial capitals hoped this would be the case, it was notoriously difficult to ensure. For example, the judiciary and the police tended to be far less co-operative than vaccinators often wanted – those opposing compulsion were often allowed to get away with fines that were considered a pittance, and those guilty of attacking vaccinators were hardly ever jailed or slapped with heavy fines. Apart from causing much heartache amongst the vaccination services, it discouraged many officials to work less intensively than officials based within the provincial headquarters wanted. Put another way, administrative trends within the provinces caused vaccinators to oppose demands for regular and intensive vaccination coverage. Strikingly, these trends continued in independent India and even during the period when international health organisations began to push for smallpox eradication. Indeed, one of the main challenges faced by their sub-continental representatives was a high degree of bureaucratic and political opposition, which was overcome extremely slowly, and only when the assistance of a wide range of central, state- and district level officials and political representatives was forthcoming. Seen from this perspective, the official resistance played as – if not more – prominent role in limiting the scope of smallpox immunisation – or slowing the drive towards eradication – as civilian opposition.

(3). Vaccine research, production and sales:

Vaccine research and production received a great deal of attention, especially from the 1880s onwards, when ever-increasing efforts were made to centralise and standardise these activities. Notably, a great degree of provincial and central government assistance was made available for this work, and this continued well after the 1920s, a period that historians assume is

marked by financial devolution; an effect, it is argued, of the political devolution resulting from the Government of India Act of 1919.

A variety of official correspondence also highlights the development of more rigorous vaccine testing regimes, on human and animal subjects. The development of a safe vaccine was seen as an effective means of popularising vaccination, and central and provincial government assistance to such work was justified in these terms. Indeed, a safe and effective vaccine was considered a good means of encouraging the voluntary acceptance of vaccination (it was, of course, also seen as a means of making the use of compulsion easier). Official debates about vaccine research and production also highlight three important aspects. Firstly, the development of a safe and effective vaccine was a troubled one, and a number of techniques were found unworkable and inefficient, before standardised processes passed muster. Secondly, these documents – many of which were confidential – suggest to me that we can attribute the rise in vaccine coverage in the 1930s and 1940s to the development of an efficacious vaccine and less invasive and painful operating techniques, both of which combined to reduce civilian hostility to the procedure (especially in epidemic years). And finally, the relationship between the officials in charge of vaccine development and field officers was often very strained in a situation where they kept blaming each other for failures in vaccination. Although research officers tended to develop a great degree of confidence in many technologies they had tested in areas surrounding and/or near the vaccine institutes, these were often ineffective in rural contexts, where storage and operating conditions were often deeply flawed. This meant that some officials were far less confident than some of their colleagues about the potential effectiveness of vaccination in combating variola. These tensions can be seen very clearly in the fractious official debates about the uses – and the mode of deployment of – vaccinations, secondary vaccinations and re-vaccinations.

An assessment of the way in which vaccines were distributed and/or sold also throws up a range of complexities. Vaccines produced with generous central and provincial subsidies tended to be sold at a discounted rate during non-epidemic years, and additional stocks were provided free of cost to district and sub-divisional boards free of cost in epidemic contexts. The bill was picked up by special allocations from the central and state budgets, which were distinct from the monies available to the devolved departments annually. This was, of course, as noted just some time ago, a

period when financial and political devolution was supposed to have kicked in, especially vis-à-vis public health policy.

Many of these trends continued after independence. Indeed, the level of human experimentation appears to have gone up, despite the fact that this was scarcely discussed in official publicity. As regards the funding trends, these persisted as well – however, we have some commentators erroneously suggesting that these trends were novel; a direct result of the new nationalist commitment. It is important to problematise this argument, as closer examination of the financial details for the post-1947 period actually suggests that the amount of money made available by the central and state governments to local authorities for smallpox control policies actually fell in many instances. These financial allocations were only really increased on a consistent basis around the mid-1960s, almost twenty years after the achievement of independence and that too in a situation where the effort to back local chapters of an international eradication programme was considered necessary as it would allow India to join the club of ‘developed and modern’ nations.

(4). Patient attitudes & their effects on vaccination: A lot of the available work has informed us of the secularity of vaccination, and the problems this caused for officials who were attempting to displace variolation and the cultural traditions that accompanied this operating technique. However, this view needs to be questioned on a number of bases. For instance, information on variolation is sketchy and it does not tell us whether the same technique of variolation was used all over British India and whether all classes of the population – and members of different communities – practised it in the same way. Indeed, recent research done on Madras presidency shows us quite definitively that variolation remained limited to certain well-off classes, and quite rare amongst the poorer sections of society in the nineteenth century. Vaccination, too, evoked a variety of reactions amongst the patients, but this was most marked when the vaccination operation was painful and unreliable. Indeed, a careful reading of petitions opposing the implementation of compulsory vaccination shows that while culturally informed objections got frequent mention in these documents, reference was made as – if not more – consistently to the safety and efficacy of vaccines. Unfortunately, many historians have tended to play down the reference to this important aspect of civilian opposition, thereby preventing the preparation of more rounded analyses of the nature challenges facing sub-continental vaccination.

Finally, the complexity of patients' attitudes to vaccination, secondary vaccination and re-vaccination also need to be assessed, as this shows that parents opposed the carrying out of more than one painful operation, in quick succession, on young infants – while the opposition was often articulated as being religiously informed, a careful study of petitions and reports from local officials reveals that the question of harmful side-effects of multiple operations exercised the parents' anxieties as well.

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### III Concluding comments

When referring to 'state medicine', historians have generally avoided trying to understand the complex nature of the colonial and independent Indian state apparatuses. This is problematic as it prevents a nuanced description of official medical facilities and schemes, the political and administrative structures they had to interact with and grow in relation to, as well as the multiplicity of local adaptations made in schemes and strategies imported from Europe and North America. This issue is significant from another historiographical standpoint as well. In my opinion, far too much has been incorrectly inferred by historians of medicine about the timing and the effects of the 'Indianisation' of the colonial public health and medical bureaucracy, the turf battles that these stoked and the negative effects these had on the effectiveness of health plans. However, these statements are based on an assessment of the developments at the level of central and provincial headquarters. We need to remember the important point that the running of medical services and day to day implementation of health policy at local levels had historically been largely in charge of Indian personnel, of various classes, castes and communities, whose influence on developments in the field has been greatly underestimated. In fact, their ability to slow down, weaken and adapt schemes put forward by international health agencies after independence – and the need to lobby their support in order to increase the prospects of success – has also been greatly downplayed and is only beginning to be recognised. In addition, once we recognise the important point that medical and public health officers did not find it possible to work in a vacuum and they were forced to co-operate with officials attached to other departments, we also have to accept that the effects of Indianisation were far more marked and varied than previously acknowledged – Indian judges, lawyers, police personnel and revenue officials were



far more involved in the running of socially invasive immunisation campaigns than existing works would have us believe.

In light of all these trends, I wonder whether we need to look at the history of South Asian public health and medicine from new perspectives. No one is trying to say colonialism was a good thing. Nor am I saying that the waves of international agency support provided to India in 1947 were unambiguously beneficent. At the same it is obvious that some public health and medical schemes worked better than others – it would be useful, in my view, to examine the complex factors that attended these developments from a historical perspective, and see how local negotiations re-shaped and re-defined colonial and internationally-supported health campaigns.

It has been suggested to me in the recent past that any attempts to seek answers for such concerns and to seek to recover the voices of local officials' voices, especially in relation to schemes that proved unworkable, despite the provision of what was identified across the board as sufficient funding, was tantamount to 'blaming everything on the natives'. I believe that is a simplistic attitude to have. Saying that local officials who did not believe in the efficacy of specific plans and programmes had the capacity to weaken these initiatives, and quite fatally at that, raises fundamental issues about how medical/scientific knowledge has been transmitted, interpreted and implemented in myriad ways in a diverse country like India. Central and state governments are, it seems, not as powerfully as they suggest and it is perhaps high time that historians note all the evidence that this points towards the need to underline this assertion. Apart from allowing us to prepare more rounded histories, this may well provide valuable insights into why so many structural problems and inequities continue to flourish in the sub-continent so many years after the attainment of independence.

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