JSHC / Paper / F-W 2016

Women and Healthcare in Colonial Times: A Focused Study of the CDA

by

Mridul Megha

The paper is a minor exploration in the area of formulation of policies around venereal diseases and their control. The objective here has been to study venereal diseases and their control in the light of public health. The time period under consideration is that of the working of the Cantonment Act of 1864 and the Contagious Diseases Act of 1868, in particular. The paper attempts to highlight colonial concern as a hegemonic one far beyond the concern of the public health of the "natives", in particular, that of the prostitutes. Health and medicalization of the body hence, as a site for the construction of the British empire's authority and control.

Unlike other epidemic diseases like cholera which had a high mortality rate, venereal diseases were actually on a decline from about the 1860s when they captured public and medical attention.[1] There were other epidemic diseases which had a higher death toll and required immediate public health measures to be taken. So what was it that triggered this kind of attention towards venereal diseases?

It was not mortality from venereal diseases but its incapacitating effects which worried the British officials. The mortality levels with respect to venereal diseases were much lower than that of cholera, malaria and typhoid; however the regulatory actions of the British officials continued to be justified. The high rate of venereal disease in the British army led to increasing alarm. It was a major cause of invaliding and therefore anxiety about inefficiency. According to Kenneth Ballhatchet, one-third of the European troops lay in hospitals due to venereal diseases. The high levels of mortality, sickness and invaliding of British troops always meant invalidating the British Raj. Fevers (including venereal diseases), cholera, diarrhoea and liver diseases were the major causes of deaths among the troops. Hence, the rising mortality in the British army was not due to war but rather due to diseases and epidemics.[2] Maintaining the sanitary condition in the barracks became the need of the hour. A Sanitary Commission was set up in 1857 and again in 1859 to look into the sanitary state of the army.[3] The control of sanitary conditions in the segregated areas of residence was done through public health legislations.[4] Laws/legal sanctions were hence used to enforce these. The Cantonment Act XXII of 1864 was one such legislation.

This also brings us to what Arnold terms as -"the environmentalist" paradigm of medicine, where disease was attributed to the Indian climate, sanitary habits (the Indian prostitute was seen as part of such a disease-ridden environment).[5] According to the British officials, the disease in tropical regions acquired a particular virulence which made the contagion even worse. Judy Whitehead opines that the Victorian sanitarians as well as the officials in the

British Medical Service viewed diseases as results of environmental decomposition. The miasmatic theory for diseases continued to be prevalent in India till about the 1890s. The miasmatic theory spoke of how toxic concentrations of vaporous products of decay caused diseases. With the miasmatic theory being dominant, the British officials adopted the policy of a) sanitation and b) segregation. Sumit Guha has shown the important place sanitation and hygiene came to acquire in the British army in roughly the same period. Ann L. Stoler uses the term "cultural hygiene" of colonialism.[6] Sanitary rules were laid down for the use of the European troops for the year 1858. Guha points out that in order to regulate the spread of STDs cantonment magistrates were given the power to regulate prostitution, as well as to maintain the sanitary state of the area under their charge. The Indian Cantonment Act of 1864 allowed the local magistracy "to make special rules for the maintenance in a state of cleanliness of all houses occupied by registered prostitutes within the limits of the cantonment, and for the provision therein of a sufficient supply of water and of proper means of ablution".[7] The stress was on maintaining individual hygiene and to inculcate such knowledge (as opposed to ignorance and carelessness) into the soldiers that it did not matter much if their surroundings were germ free or not. Soap was supplied to soldiers who were encouraged to use it. In many stations, the endeavour was also to teach the soldiers how to guard themselves against enteric fever, malaria and venereal diseases.[8] The condom, though available, was mentioned far less. It was a more expensive preventive measure; also, it was linked to contraception and hence, came under moral scrutiny. Medical officers also acknowledged a gap between possession of the packets and

their use.[9] Military education on venereal diseases hence, became a major part of sanitary education. Ballhatchet makes mention of Surgeon-General Taylor (Principal M.O. to the forces in India) asking for "the provision of lotions and towels for the men in barracks".[10]

In the control of venereal diseases the second tool adopted was that of segregation and control. David Arnold wrote, "Western medicine is also sometimes seen as one of the most powerful and penetrative parts of the entire colonizing process".[11] In the military sphere especially, medicine was a very effective "tool of the empire". This brings us to the use of medicine and public health measures as an instrument of "social control". As Harrison points out, such instruments of social control provided means of knowing the indigenous population, and also served as rationales for social segregation. Fear of infection at times justified segregated residential patterns and also the right to isolate the infected ones.[12] Public health measures became powerful tools for the domination over "natives". Public health measures were often selective and degrading, through detention and isolation they controlled population movement to a great extent. The public health garb however portrayed as a sign of colonial benevolence helped reduce resistance to imperial rule. What the officials observed was that firstly, venereal disease endangered the "vitality of the race." Secondly, that it was the "dangerous neighbour" who had to be controlled.[13] Indigenous women were being projected as a terror for military men; their sexuality was seen as having a de-masculinising effect on the soldier. Official attempts were made to control sexual relations between the ruling race and

Indian women. The cantonments had regimental bazaars (*lal bazaars)* where the soldiers could satisfy themselves.[14] The idea was to control the movement of soldiers beyond the controlled environment of the cantonment which made them more susceptible to contracting diseases. Lock Hospitals were opened where suspected women were examined and infected women were admitted by force, if necessary, for treatment. The medical examinations, as it involved the genital area, were embarrassing and came to be resented. There was also the fear of both chaste as well as unchaste women being treated as prostitutes on the basis of mere suspicion. The objective here was not the health of the woman; the purpose was to provide safe pleasure for the soldiers.[15] The Acts had no provision of penalties for soldiers; the only "criminal" here was the prostitute. As a report of the Royal Commission observed "... we may at once dispose of any recommendation founded on the principle of putting both parties to the sin of fornication on the same footing by the obvious but not less conclusive reply that there is no comparison to be made between prostitutes and the men who consort with them. With the one sex the offence is committed as a matter of gain: with the other it is an irregular indulgence of a natural impulse".[16] In British official documents the Indian prostitutes have been portrayed as luring British soldiers into contagious surroundings and restraining them till their wages had been spent. Clearly, the rules were "for inspecting and controlling houses of ill-fame and for preventing the spread of venereal disease."[17] J.B. Hamilton (Surgeon-Major, A.M.D., In medical charge of the Cawnpore lock hospital) on the 9th of January 1878 justified the existence of lock hospitals.

It is not to be supposed that venereal disease, as a disease of the native population, is affected to any appreciable extent by the working of the lock hospital, but there is no doubt that if the police do their duty properly, and cause all women who prostitute themselves with soldiers to be registered, and if severe punishment is inflicted on unregistered women found prostituting themselves with the troops, the disease can be kept in check to a very large extent.

Not more than 10 per cent of the Europeans contracted disease from the registered women, and with stricter supervision on the part of the regimental bazaar authorities and police, even this small number might be much reduced.

There is a most important factor in the extent of venereal among Europeans for the past few years that has been quite lost sight of, viz., the army being now composed of much younger men , with a smaller proportion of married men, and very few old soldiers, is rapidly becoming a mere "venereal" army, so to speak, i.e., composed of men in whom the passions are stronger, and among whom a greater extent of disease is to be looked for than among the men of a few years back.

I will conclude by showing the work of the lock-hospital for the past four years (the strength of the garrison remained nearly the same all along):-

Year	No. of admissions from Europeans

1874	407
1875	283
1876	144
1877	175

> These figures speak for themselves, and taking the fact into consideration that only 82 cases were contracted from the registered women during 1877, I think the lock hospital may fairly claim to have done good service to the state.[18]

We here cannot overlook the excessive attention paid to controlling the sexuality of the "native" woman. We could conjecture that it was the association of the venereal diseases with immorality, control over women, and the need to maintain inter-racial divides (particularly after the rebellion of 1857 in the Indian context) that lead to greater attention towards venereal diseases. The ideas of racism and eugenics obviously then were working behind the regulation of "native" women, the prostitute in particular, in the garb of public health and preventive measures. The nineteenth century was a period where the act of having sex became a police matter. Sexual control was desirable for a variety of reasons. This was a period marked by talks of eugenics, racism, production of a healthy race, a healthy progeny and an ideal family. It is interesting to note how eventually juridical and medical control became the most effective means to execute surveillance over sex and sexuality. There was a certain idealization of the family. Indulging in sexual activities other than for reproductive purposes became a taboo. Law-taboo-

censorship in tandem became mechanisms of control to examine the sexuality of individuals outside family control. The law of prohibition and the threat of punishment became tools of sexual control. The Contagious Diseases Act enacted in 1868 was one such law. The most obvious targets were women. The law along with limiting its scope to the health of the troops alone, also came to regulate "native" women's sexuality. The body literally became a site for the construction of the empire's own authority, control and legitimacy.

An entire process of hysterization of women's bodies took place. The feminine body came to be analysed, qualified, and disqualified as being thoroughly saturated with sexuality. The feminine body was integrated into the sphere of medical practices. This medicalization of feminine sexuality meant her being kept under close watch. The nurturing mother versus the negative image of the "nervous/mad" woman (which can be read as the fallen or the more sexually explicit woman) became the most visible form of this hysterization. In the Indian context, the Indian prostitute too came to be controlled. According to Judy Whitehead, the sanitary legislations implemented as public health measures, the Contagious Diseases Act, in particular, were means of introducing disciplinary forms of Victorian respectability to Indian jurisprudence by means of the colonial state[19] – "the ideal Victorian woman was one whose upbringing had enabled her to completely sublimate sexual and aggressive impulses… … unlike middle class Victorian ideology however, women in North India were not thought to be passive, repressed beings, either creatively or sexually".[20] She became the contradictory site of desire and disease, of sexual danger and pleasure. She

emerges in the nineteenth century as the counter-point of the docile, familial, virtuous woman of the home. This is not to say however, that such interventions and the desire to control indigenous women went unchecked by the "native" population. Indian Nationalists' rhetoric of colonial officials attempt to infiltrate the "private" or the domestic lives of the Indian "natives" shows the contestation over women's bodies and women's sexuality between the colonizer and the colonized. The social reformers of the nineteenth century too came to identify her as "the victim, the fallen". In contrast to the *bhadramahila* (upper class woman) she stood as the "sexually perverse woman".

These decades also saw an intensification of legislation on prostitution.[21] While the making of the laws were a response to the fear of contracting the disease, the governing practices of police constables and inspectors, military medical examiners, British officials were purely administrative with very limited health concerns. These laws did not end the practices of prostitution, or soldiers buying sex, rather they only rearranged the relative power of the two parties involved. The very goals of preserving public health and public order led to the criminalisation of the common prostitute who did not work in the state sanctioned forms of the trade. The prostitutes were committing the crime and so it was them (the sources of venereal contagion) who were supposed to be punished and fined. It was particularly because of these laws - which penalised prostitutes in the nineteenth century that scholars like Judy Whitehead have read these laws as an export of Victorian sexual prudery from the metropole to the colony. Unlike in Britain the laws in the colonies were much

more biased against the prostitutes. They had to be regulated for they were propagators of a disease which was a major threat to the military strength of the empire. The scope of public health then was an idea confined to the soldiers. The laws were much more committed to preventing ill-health among the client white population than among the prostitutes. Public health in India, hence, to begin with was largely confined to the colonial enclaves and to the health of the soldiers. The colonial authorities simply had neither the political wherewithal nor public pressure to provide public health to the country at large. Instead, the excuse cited was a lack of funds. Radhika Ramasubban points to the general lack of interest in health needs beyond the army and the white community and labels it as "the colonial mode of public health".[22] Financial constraints considering the vast Indian public health needs were often cited as the reason behind lack of commitment on the part of the state.[23]

The system of lock hospital in India was borrowed from Britain of the eighteenth century. The rising incidence of venereal disease among the European soldiers in India at the turn of the eighteenth century saw the introduction of the system in the colony too. The efforts to check venereal disease began in India in 1816, when through a series of rules issued from the Governor-general of India, the medical surveillance of public women in regimental bazaars was ordered.[24] Keeping in view the demands for such hospitals, the Governor-general in council authorised the building of "hospitals for the reception of diseased women" at Behrampore, Kanpur, Dinapur and Fatehgarh.[25] Lock Hospitals were established at sixteen of the principal stations of the army. Regular inspection and

compulsory treatment of women found to be diseased were to take place. Women found diseased were to be kept in confinement within the Lock Hospitals till declared cured of venereal diseases. The staff of a lock hospital comprised of a matron and peons for taking up diseased women to the hospitals.[26] Their purpose was to check the spread of venereal disease among British soldiers. However what is interesting to note is that the term "Lock Hospital" was not used, even when, in practice, patients were forbidden to leave until they had been certified as cured. Statistics and reports on lock hospitals in the North-Western Province and Oudh and Central Provinces illustrate the working of civil and military lock hospital system. The reports describe conditions, staffing and expenditure of lock hospitals. Prostitute statistics show registration, attendance and punishment. These reports have tables which list instances of venereal disease (syphilis, gonorrhoea) in women and troops. They also include comments by military staff appraising the working of the lock hospital system. The reports were extracts from proceedings of the Cantonment Committee which assembled annually to examine the medical officer's reports. The Cantonment sub-committee was composed of the officers commanding the British corps, the cantonment magistrate, the senior medical officer of the British forces and the officer in medical charge of the lock-hospital. This committee met on the last Monday of every month and submitted their report. While going through the reports one notices – The Committee considered the medical officer's reports very satisfactory, as showing a great diminution of venereal disease during the past years, an improvement attributable chiefly to the city having been placed out of bounds, and partly also to greater vigilance on the part of the cantonment police.

The history of venereal disease in Cawnpore for instance pointed to one fact most prominently, that is, the focus and chief factor was to be found in the city. These reports mention various measures for control of prostitutes apart from keeping the city out of bounds. It was compulsory that all women practicing prostitution were registered and regularly examined, either in the city or the cantonments. No registration fee was to be levied. The reports suggest the registration of women in the cantonments had been quite successful and was extended to a circle of five mile radius. The women reported for absence were fined an amount of Rs. 135-140 which were levied and recovered. There were also arrangements in place for examining and treating the women. The city women were to be examined in the city by the civil surgeon, and all diseased women were sent in to the cantonment lock hospital. The examinations in the cantonments were conducted by the officer in medical charge of the lock hospital, and the women were assembled an hour before his arrival, and seated in a row under the supervision of police, to prevent their cleaning themselves immediately before examination. The speculum was used regularly. All cases of disease or suspected disease, according to the reports, were at once admitted and treated till cured. The women were dieted according to scale, and were supplied with cots and bedding if they were unprovided with the latter. Condemned bedding and clothing were obtained from the commissariat for the latter purpose. A “dhai” or “mahuldarni” was employed in the regimental bazaar. She also supervised the royal artillery bazaar.

The reports clearly suggest that the vast majority of the cases were contracted by city prostitutes, no doubt from intercourse with natives. Therefore,

immense importance attached to the order placing the city out of bounds never to be revoked, for if it was, there was no doubt that it would at once be followed by an outbreak of venereal among the troops. Women found to be "disordered" on "the customary days of inspection" were to be sent at once to the hospital.[27] At this stage, the establishment of Lock Hospitals was regiment specific, only those regiments which complained of a rising incidence of venereal diseases were granted Lock Hospitals. The military officials exercised control over the Lock Hospitals, and thereby only over the regimental prostitutes. These measures reveal the caution with which the authorities sought to tackle the problem of venereal disease.

Missionaries immediately reacted to such measures.[28] They argued that while the measures in England sought to reclaim the prostitutes and rehabilitate them, in India the concern for the health of the prostitute was only to sustain the immorality of the soldiers. As one missionary wrote:

> Lock Hospitals in Great Britain and Ireland are institutions having their origin, I believe principally, if not entirely, in private bounty, regulated by public law, having as their design not merely the treatment of diseased women, but chiefly the reclamation of them from evil to industrious habits, and the communication to them of religious instructions, with a view to their moral and spiritual reform; and having their end and fruit in the restoration of some fallen and unfortunate females to places of trust and credits and often in the reconciliation of others to their families. No institution of the kind in the British isles without these provisions is legal,

> and therefore none exists; institutions with such ends, rules and practices create the desire that they were more numerous than they are…
>
> In India no broken hopes linger about the system. The women is an object of concern, simply that she may not injure others; the care taken of her, the money expended, her cure if diseased, are all simply meant effect this that they may be a soldiery who may morally offend, but who must be physically uninjured. It follows then that men offend with official facility, and official sanction, and that the woman is the protégé of the state, that she may enter on and conduct her nefarious work with what advantage she may to herself, and without injury to her licensed customers.[29]

Though the criminalisation of prostitutes in colonial India has been studied as an expression of Victorian sexual restrictiveness, we cannot overlook how the laws in the metropole and the colony functioned differently.[30] Strategic/administrative needs and not rehabilitation and cure of the Indian prostitute were the agenda. The colonial assumption that prostitution was recognized in Hindu law books also led them to assume that there would be no resistance to medical inspections-

> for the confirmed prostitute no further degeneration is possible. And even if they were any deteriorating moral influences they were more than counterbalanced by good moral and physical results.[31]

The officials often looked at the problem of venereal disease as a "matter of police than of medicine", to most of the authorities it appeared as an established

fact that "the remedy lay in lessening the opportunities of intercourse with women likely to be diseased than in the cure of those that are so".[32] This attitude appears particularly important given the state of curative medicine at that time. The public dispensaries at this stage or the Lock Hospitals at a later stage, thereby, were increasingly seen as places where the diseased women could be confined, separated from the soldiers, so that the possibilities of intercourse with these women could be reduced. This policing attitude also explains the basis of coercive measures like the prohibitions on prostitutes leaving the hospitals until they were declared free of disease.

The emphasis on the maintenance of a special police to identify and bring the sick prostitutes to the hospitals seemed a general requirement during this period. This was so because the authorities often looked at "vagrant women" – those who lived outside the limits of the cantonment and did not profess prostitution as their prime calling as the real propagators of venereal disease among the troops. Officials often categorized the prostitutes as "clean" or "foul" commodities, thus making obvious that the focus of the official concern was limited to the idea of providing safe pleasure for the soldiers. Officials also looked at prostitutes as forming "ordinarily, a separate well-organized class or profession, recruited according to certain fixed customs, and they have often their rules of caste like other people".[33] This kind of perception appeared as strategically easier for the officials whose concern for the prostitutes were defined through the soldiers' sexual needs. Also, these ideas excluded the possibility of concerns like health and rehabilitation of prostitutes as the colonial state's

responsibility. An important and rather positive attribute of this classificatory scheme was that it helped the authorities in distinguishing the females of respectable households from those of professional prostitutes.

The cantonment committees of every cantonment were required to instruct the cantonment authorities to register these prostitutes and provide them with printed tickets in a prescribed form on which the results of their examination would be recorded. On detection of venereal disease, the prostitute was to be detained in the lock hospital until certified as cured. Registered prostitutes had to present themselves every seven days for medical examination. If found diseased, the diseased woman would be detained in a certified hospital until medical officers considered her fit to be discharged. The Contagious Diseases Act also gave massive powers to the police. They had the authority to demand that the prostitutes produce their registration tickets on demand, and penalize them on failure to do so. The Act both in England as well as in the colonies (particularly in India) sparked a political battle. The objections were that the compulsory examination system increased the power and the interference of the State, that it gave powers to arrest to a "moral police" who inspected only prostitutes and not their clients. "Compulsory and painful examination by vaginal speculum was held to constitute "instrumental rape by a steel penis", and the campaign harped upon "medical lust in handling and dominating degrading women".[34] The most abhorred element of the Contagious Diseases Act was the element of compulsory periodical medical inspection. The Act, by this element of supervision, was considered demeaning and violating the basic liberties of women. The Contagious

Diseases Act was also discriminatory in the sense that it did not affect the entire population as a whole; the language of the Act very clearly blamed women's bodies and not men. The Indian Contagious Diseases Act could penalize women for a variety of "crimes." Not possessing registration was grounds for imprisonment up to one month and/or a fine of up to one hundred rupees. If a woman refused to show her registration, she could be punished with a fine up to rupees fifty and imprisonment up to fourteen days. Contrary to this, there were only official suggestions to stop the soldier's pay while they laboured under disease in the hospital.[35]

The "crimes" for which the prostitutes were apprehended show the extent of control in their daily activities. The fact that they were imprisoned and fined speaks volumes about the Lock Hospitals. They were not centres of cure and rehabilitation, rather they acted as prisons with the Act functioning as barriers to control sexual relations between these women and the soldiers. We hardly find mention of soldiers being reprimanded, imprisoned or being fined.

The unpopularity as well as the failure of the Act can be gauged from the means employed by women to escape medical inspections. The theme of diseased women removing themselves from government scrutiny was a familiar grievance throughout the empire. In India, it was the new technology of transport which helped undermine the regulatory system by hopping on a train. To counter this, in the late 1880s, the Bombay Surgeon General called for the extension of the Indian Contagious Diseases Act beyond Bombay's limits to the suburb of Bandra. "Cheap railway fares exist between these two places, and… women on finding

themselves diseased, resort to this suburb to evade the police, coming into Bombay at night by the trains".[36] This trick was much used and there is evidence of a similar complaint, almost twenty years earlier from India's north-west region, where women avoided registration in Cawnpore, "when… to avoid interference (they) retired temporarily to other places, for which they have every facility by the East Indian and Oudh railways".[37] The laws ultimately came to be read as a failure. Targeted women often resorted to strategies to escape medical checks and confinements. There were innumerable cases of prostitutes flouting the regulations.

Through the Contagious Diseases Act, the prostitute came to be "criminalized," she came to be seen as the unrespectable Indian female and it was the Act which helped shape the responses against this newly defined unrespectable Indian femininity. This also influenced other debates involving social reforms concerning women, such as education for girls and their age at marriage and the vexed issue of widow remarriage. The figure of the prostitute created by the colonial state, then, stood for a wide range of issues such as moral degeneracy, male power, declining public health, female deviousness – these came to affect not just the prostitutes but the policies too. The laws which began with prostitutes, regulating their sexual relations and medically monitoring them came to engage military officials, missionaries as well as nationalist social reformers in India. Racism, eugenics and women's sexuality, hence dominated the discourses of colonialists and the nationalists as well. Reproductive regulation became a concern for the British as well as the Indian patriarchy. The

women's body in Bengal during the colonial regime became a site for debates, however the question of women's health never came up. Despite, the emerging middle-class anxiety to impose its own norms of morality for its national well-being, maternal health became a topic of real concern only in the late 20th century. The Dufferin fund, an initiative to improve medical conditions for women had been in operation in the late 19th century. The fund aimed to supply female doctors and mid-wives to work in *zenana* (female) hospitals in India. Surprisingly, when it came to venereal diseases the British government in its endeavours to control venereal diseases had clearly laid out specific outlines to manage the Lock Hospitals. Nowhere in the Sanitary Commissioner Reports was there mention of maternal or reproductive health. The wives of the Indian soldiers were hardly mentioned in the sanitary reports. The one state medical measure before the 1880s which did have a direct bearing on women was the Contagious Diseases Act of 1868, but this was clearly designed to address the problem of venereal disease among British soldiers rather than the health of the prostitutes (or the soldiers' wives). There appears to have been no serious discussion of venereal diseases as they affected women in India before the 1920s. The primary arenas of state medicine in the first half of the nineteenth century – the army, the jails, even the hospitals – were primarily male domains in which women played little part. The diseases that preoccupied colonial medicine in the nineteenth century were epidemic diseases, the communicable diseases of the cantonment, civil lines and plantations, the diseases that threatened European lives, military manpower and male productive labour. It is indeed surprising that despite looking into venereal diseases, examining women, keeping them under

supervision for treatment, the health of the woman was completely side-lined. Despite talks of eugenics and the need to produce healthy progeny, reproductive health was completely omitted. Such neglect of women's health can be traced to contemporary times too.

The Sanitary Commissioner Report of 1868 is considered to be one of the most important documents, particularly for the study of venereal diseases as the Contagious Diseases Act came into force in 1868. This was also a period of the rise of utilitarianism. Paucity of funds had affected the sanitary measures too which were taken quite seriously by the colonial government. Colonialism's political, cultural and hegemonic concerns were over and beyond the concern of the public health of the "natives". The control of venereal diseases which already had a limited scope, sidelined the health of the "criminal" prostitute even further. The Sanitary Commissioner Report of 1868 put forth its inability to prevent venereal diseases amongst the masses quite clearly. The excerpt below from the Sanitary Commissioner Report of 1868 speaks for itself regarding the public health measures taken for the prevention of venereal diseases in colonial India. The Sanitary Commissioner in this report talks about his limitations. It will be useful to point out that it was in 1868 when the measures for the prevention of venereal diseases were at its peak, and when the Contagious Diseases Act was introduced here in India.

> With regard to paragraph 9 of the Resolution of the Government of India, I should wish to have all available information regarding Lock Hospitals now in operation in the Lower Provinces. I do not quite know where to obtain

such information; and perhaps it is not the wish of the Government that I should myself call for it.

If this be the case, I hope the Lieutenant Governor may see fit to issue such orders as may be necessary under the circumstances… … … .. It should be here observed that Indian Lock Hospitals are, as a rule, within the limits of military cantonments, regulated by a Cantonment Board of Health, and supported from cantonment funds… … …

If on the other hand, it is desired by the Government, that the lock hospital system should be extended generally beyond the limits of military cantonments, the greatest difficulty in the way of success will be the question of available public funds. The expense of effective establishments, organized for the protection of the general community must be considerable.

It seems, nevertheless, necessary to point to the fact that an absolute want of local funds may, in many cases, explain, why prophylactic measures, against contagious disease, are not effectually organized and carried through.

This one difficulty of "want of local funds" is for ever in the way of the Indian sanitarian, and it is but right that the fact should be fairly acknowledged… … .. It is important to note that the funds at present allotted in India for the general protection of public health are altogether insufficient for the great object in view.

Perhaps His Honour the Lieutenant Governor may be pleased to call for information as to the amount of available funds in the districts of the lower provinces for such a purpose as the prevention of venereal disease amongst the masses... ... .. need to bring about enactments and especially to allot such imperial resources as to render it practicable for public hygiene to be worked in a manner which, under existing circumstances is quite beyond the scope of possible fulfilment (GOI 1868: 23).[38]

References

Primary Sources

1) Govt. Of India Home – Legislative Proceedings. 1860-1881.
2) Govt. Of India Home – Public Files. 1860-1900.
3) Govt. Of India Home – Sanitary Files. 1870-1900.
4) Govt. Of India, Report of Sanitary Commissioner. 1868-1890.
5) Annual Report on the working of the lock hospitals in the Central Provinces (1876-1889).
6) Annual Report on the working of the lock hospitals in the North-Western Provinces and Oudh (1877-1883).

Secondary Sources

1. A.J. Loraine ed. Understanding Homosexuality: its biological and psychological bases (England: Medical and Technical Publishing Co Ltd, 1974).
2. Aparna Basu, *Role of Women in the Freedom Movement* in B.R. Nanda (ed.) Indian Women from Purdah to Modernity (Delhi: Vikas, 1976).
3. Margaret Hamilton, *Opposition to the Contagious Diseases Acts, 1864-*1886 in Albion: A Quarterly Journal with British Studies, Vol.10, No.1, Spring 1978, 14-27.
4. Arnold Kaminsky, *Morality Legislation and British troops in late nineteenth century India* in Military Affairs, Vol 43, 1979, 78-83.

5. Kenneth Ballhatchet, Race, Sex and Class under the Raj: imperial attitudes and policies and their critics, 1793-1905 (London: Weidenfield and Nicolson, 1980).
6. Radhika Ramasubban, Public Health and Medical Research in India: Their Origins under the impact of British Colonial Policy, (Stockholm:SAREC Report,1982), 21-24.
7. David Arnold, *Cholera and Colonialism in British India* in Past &Present, No.113, Nov 1986, 118-151.
8. K.N. Pannikar, *Editorial Introduction for the special issue on Essays in the Intellectual History of colonial India* in Studies in History, Vol. 3, No.1, Jan-June 1987, 1-8.
9. Partha Chatterjee, *Colonialism, Nationalism and Colonized Women: The Contest in India* in American Ethnologist, Vol. 16, No.4, Nov 1989, 622-633.
10. Ann L. Stoler, *Making Empire Respectable: The Politics of Race and Sexual Morality in 20th century Colonial Cultures* in American Ethnologist, Vol. 16, No.4, Nov 1989, 634-660.
11. Ronald Hyam, Ronald, Empire and Sexuality: The British Experience (Manchester and New York: Manchester University Press, 1991).
12. Rosalind O'Hanlon, *Issues of Widowhood: Gender and Resistance in Colonial Western India* in Douglas Haynes and Gyan Prakash ed. Contesting Power: Resistance and Everyday Social Relations in South Asia (Delhi: Oxford University Press, 1991) 62-108.

13. Veena Talwar Oldenburg, *Lifestyle as Resistance: The Case of the Courtesans of Lucknow* in Douglas Haynes and Gyan Prakash ed. Contesting Power: Resistance and Everyday Social Relations in South Asia, (Delhi: Oxford University Press, 1991), 23-61.
14. Gyan Prakash, *Postcolonial Criticism and Indian Historiography* in Social Text, No. 31/32, Third World and Post-Colonial Issues, 1992, 8-19.
15. David Arnold, Colonizing the Body: State, medicine and epidemic disease in nineteenth century in India (Berkeley: University of California Press, 1993).
16. Sumanta Banerjee, *The 'Beshya' and the 'Babu': Prostitute and Clientele in the Nineteenth Century Bengal* in Economic and Political Weekly, 28.45, 1993, 2461-72.
17. Mark Harrison, Public Health in British India: Anglo-Indian preventive medicine 1859-1914 (Cambridge University Press, 1994).
18. Leela Kasturi and Vina Mazumdar, *Women and Indian Nationalism* Centre for Women's Development Studies- Occasional Paper, Vol.20. pp 1-33, 1994. *(*pdf accessed online on 11th July 2013).
19. M. Shamsad Khan, Medicine, Health and The Nationalist Discourse in Colonial India (New Delhi: Unpublished dissertation submitted to Jawaharlal Nehru University, 1994).
20. Judy Whitehead, *Bodies clean and unclean: Prostitution, sanitary legislation and respectable feminity in colonial north India* in Gender and History, 7.1, 1995, 41-63.

21. Judith Walkowitz, *Bodies of evidence, bodies of rule: The Ilbert Bill, revivalism, and age of consent in colonial India* in Sociological Bulletin, vol 45, no. 1, March 1996, 29-33.
22. Philippa Levine, *Rereading the 1890s: Venereal disease as constitutional crisis in Britain and British India* in Journal of Asian Studies, Vol.55, 1996, 585-612.
23. S. Anandhi, *Reproductive Bodies and Regulated Sexuality: Birth Control Debates in early 20th Century Tamilnadu* in Mary John and Janaki Nair ed. A Question of Silence: the sexual economies of modern India (New Delhi: Kali for Women, 1998).
24. Sabya Sachi Raman Mishra, The Colonial 'Vice': prostitutes, soldiers and venereal diseases during British rule in India, c. 1860-1900 (New Delhi: Unpublished PhD submitted to Jawaharlal Nehru University, 1999).
25. J.R. Ackerley, Hindoo holiday: An Indian journal (New York: New York Review Books, 2000).
26. Sumanta Banerjee, Dangerous Outcast: The Prostitute in Nineteenth Century Bengal (Calcutta: Seagull Books, 2000).
27. Meera Kosambi, *A window in the prison house: women's education and the politics of social reform in nineteenth century western India* in History of Education, Vol.29, No. 5, 2000, 429-442.
28. Mark Harrison and Biswamoy Pati, Health, Medicine and Empire: Perspectives on Colonial India (Orient Longman, 2001).
29. Imrana Qadeer ed. Public Health and the Poverty of Reforms: the South Asian Predicament (New Delhi: Sage, 2001).

30. Kumkum Sangari, Politics of the Possible: Essays on Gender, History, Narratives, Colonial English (New Delhi: Tulika, 2001).
31. Tanika Sarkar, Hindu Wife, Hindu Nation: Community, Religion and Cultural Nationalism (New Delhi: Permanent Black, 2001).
32. Suchetana Ghosh, Interpreting Prostitution: Violence Commodified (New Delhi: Unpublished dissertation submitted to Jawaharlal Nehru University, 2002).
33. Ruth Vanita ed. Queering India: Same-sex love and eroticism in Indian culture and society (New York and London: Routledge, 2002).
34. Sikata Banerjee, *Gender and Nationalism: The Masculinization of Hinduism and Female Political Participation in India* in Women's Studies International Forum, Vol. 26, No. 2, 2003, 167-179.
35. Uma Chakravarti, Gendering Caste: Through a feminist lens (Calcutta: Stree, 2003).
36. Philippa Levine, Prostitution, Race and Politics: Policing Venereal Disease in the British Empire (New York and London: Routledge, 2003).
37. Edward Said, Orientalism (New York: Vintage, 2003), 5-7.
38. Sanjay Srivastava and Howard Brasted ed. Sexual sites, seminal attitudes: Sexualities, masculinities and culture in South Asia (New Delhi: Sage Publications, 2004).
39. E.M. Forster, A passage to India (New Delhi: Penguin Classics, 2005).
40. Sanjay Srivastava, Passionate Modernity: Sexuality, class and consumption in India (New Delhi: Routledge, 2006).

41. Padma Anagol, Padma, *Rebellious Wives and Dysfunctional Marriages: Indian Women's Discourses and Participation in the Debates over Restitution of Conjugal Rights and the Child Marriage Controversy in the 1880s and 1890s* in Tanika Sarkar and Sumit Sarkar ed. Women and Social Reform in Modern India (Ranikhet: Permanent Black, Vol 1, 2007), 420-465.
42. Sekhar Bandyopadhay, *Caste, Widow-Remarriage, and the Reform of Popular Culture in Colonial Bengal* in Tanika Sarkar and Sumit Sarkar ed. Women and Social Reform in Modern India (Ranikhet: Permanent Black, Vol 1, 2007), 145-171.
43. Brinda Bose and Subhabrata Bhattacharya ed. The phobic and the erotic: the politics of sexualities in contemporary India (Calcutta: Seagull Books, 2007).
44. Lucy Carroll, *Law, Custom and Statutory Social Reform: The Hindu Widows' Remarriage Act of 1856* in Tanika Sarkar and Sumit Sarkar ed. Women and Social Reform in Modern India (Ranikhet: Permanent Black, Vol 1, 2007) 113-144.
45. Kailashbasini Devi, *The Woeful Plight of Hindu Women* in Tanika Sarkar and Sumit Sarkar ed. Women and Social Reform in Modern India (Ranikhet: Permanent Black, Vol. 2, 2007) 288-312.
46. Geraldine Forbes, *Education for Women* in Tanika Sarkar and Sumit Sarkar ed. Women and Social Reform in Modern India (Ranikhet: Permanent Black, Vol 1, 2007), 83-112.

47. Lata Mani, *Production of an Official Discourse on Sati in early nineteenth century Bengal* in Tanika Sarkar and Sumit Sarkar ed. Women and Social Reform in Modern India (Ranikhet : Permanent Black, Vol 1 , 2007), 53-82.
48. Rammohan Roy, *Tracts against Sati* in Tanika Sarkar and Sumit Sarkar ed. Women and Social Reform in Modern India (Ranikhet: Permanent Black, Vol 2, 2007), 277-287.
49. Tanika Sarkar, *Conjugality and Hindu Nationalism: Resisting Colonial Reason and the Death of a Child-Wife* in Tanika Sarkar and Sumit Sarkar ed. Women and Social Reform in Modern India (Ranikhet: Permanent Black, Vol 1, 2007), 385-419.
50. Mrinalini Sinha, *Gender in the Critiques of Colonialism and Nationalism* in Tanika Sarkar and Sumit Sarkar ed. Women and Social Reform in Modern India (Ranikhet: Permanent Black, Vol. 2, 2007), 211-242.
51. Anand A. Yang, *Whose Sati? Widow Burning in early nineteenth century India* in Tanika Sarkar and Sumit Sarkar ed. Women and Social Reform in Modern India (Ranikhet: Permanent Black, Vol 1, 2007), 21-52.
52. J. Devika, Individuals, Householders, Citizens: Malayalis and Family Planning, 1930-1970 (New Delhi: Zubaan, 2008).
53. Gayatri Chakravorty Spivak, *Nationalism and the Imagination* in Lectora, Vol.15, 2009, 75-98.
54. Ashwini Tambe, Codes of Misconduct: Regulating Prostitution in Late Colonial Bombay (New Delhi: Zubaan, 2009).

55. Uma Chakravarti, *Whatever happened to the Vedic Dasi: Orientalism, Nationalism, and a Script for the Past* in Kumkum Sangari and Sudesh Vaid ed. Recasting Women: Essays in Colonial History (New Delhi: Kali for Women, 2010), 27-87.
56. Partha Chatterjee, *The Nationalist Resolution of the Women's Question* in Kumkum Sangari and Sudesh Vaid ed. Recasting Women: Essays in Colonial History (New Delhi: Kali for Women, 2010), 233-253.
57. Kedar Vishwanathan, *Aesthetics, Nationalism, and the Image of the Woman in Modern Indian Art* in CLCWeb: Comparative Literature and Culture, Vol.12, Issue 2, Article 4, June 2010 (accessed online http://docs.lib.purdue.edu/clcweb/vol12/iss2/4 on 11th July 2013).
58. Maitrayee Chaudhury, *Nationalism is not what it used to be, can Feminism be any different: A View from India* in Journal of Gender Studies, Nov-Dec 2010.
59. Maitreyee Chaudhary, Indian Women's Movement: Reform and Revival (New Delhi: Palm Leaf Publications, 2011).
60. Prabha Kotiswaran ed. Issues in Contemporary Indian Feminism: Sex Work (New Delhi: Women Unlimited, 2011).
61. Pravinkumar Ruprao Shirsat, Colonial Regime and State-led Modernity: an examination of Health Discourse in Colonial India (New Delhi: Unpublished PhD submitted to Jawaharlal Nehru University, 2011).
62. Samita Sen, ed. Intimate Others: Marriage and sexualities in India (Stree, School of Women's Studies, Jadavpur University, 2011).

63. Charu Gupta, Gendering Colonial India: Reforms, Print, Caste and Communalism (New Delhi: Orient Blackswan Private Limited, 2012).
64. Prabha Kotiswaran, Dangerous Sex, Invisible Labour: Sex Work and the Law in India (New Delhi: Oxford University Press, 2012).
65. Sanjay Srivastava, ed. Sexuality studies (New Delhi: Oxford University Press, 2013).
66. Revathi Krishnaswamy, Effeminism: The economy of colonial desire (Ann Arbor: The University of Michigan Press, 2014).

Author bio:

Mridul Megha specializes in Modern Indian History. She is currently pursuing her Ph.D. in Social Medicine and Community Health at Jawaharlal Nehru University, India. Her research interest is concerned with Public Health in British India and falls within the larger domain of 'History of Medicine'. In her work she has looked at the formulation of policies in British India around venereal diseases and its control in the light of public health. Currently, she is working around themes of body politics, sexuality, health and hygiene in the colonial era. Issues around accessibility of health care by the rural and urban poor in contemporary times concern her - the interplay of class, caste and gender prevent them from accessing basic amenities such as healthcare.

Endnotes:

[1] Philippa Levine, *Rereading the 1890s: Venereal disease as constitutional crisis in Britain and British India* in Journal of Asian Studies, Vol.55, 1996, pp2.

[2]Kenneth Ballhatchet, Race, Sex and Class under the Raj: imperial attitudes and their critics, 1793-1905, (London: Wedenfield and Nicolson, 1980).

[3] Radhika Ramasubban, *Public health and medical research in India: Their origins under the impact of British colonial policy* in SAREC *Report*, 1982, pp 21-24.

[4] According to the environmentalist paradigm of causation of disease, it was the hot Indian climate which produced certain diseases. Measures adopted to control spread of miasma involved segregation, setting up European residences in hill stations (the climate was considered to be similar to that in England), cantonments, building up of walls between native troop locations and the British ones – all this was done to keep the miasma out.

[5] David Arnold, Colonizing the Body: State, medicine and epidemic disease in nineteenth century in India (Berkeley: University of California Press, 1993).

[6] Ann Stoler, *Making Empire Respectable: The Politics of Race and Sexual Morality in 20th century Colonial Cultures* in American Ethnologist, Vol.16, No.4 (Nov 1989), pp 634-660.

[7] Philippa Levine, Prostitution, Race and Politics: Policing Venereal Disease in the British Empire (New York and London: Routledge, 2003), pp 306.

[8] Sumit Guha, Health and Population in South Asia- from earliest times to the present (New Delhi: Permanent Black, 2001).

[9] Philippa Levine, 2003. *op cit*.

[10] Kenneth Ballhatchet, *op cit*. pp 95.

[11] David Arnold, *op cit*.

[12] Mark Harrison, Public Health in British India: Anglo-Indian Preventive Medicine1859-1914 (Cambridge University Press, 1994), pp 2.

[13] A term used by Colonel J. Reid, Commissioner Lucknow Division in a Report on the working of the cantonment lock hospital, 1876.

[14] Kenneth Ballhatchet, *op cit*.

[15] Ronald Hyam, Empire and Sexuality: The British Experience (Manchester and New York: Manchester University Press, 1991). Ronald Hyam in this text mentions the existence of innumerable instances of masturbation, homosexuality and paedophilia as the forms of sexuality, which later in the Victorian era came to be dreaded. The provision of safe pleasure (prostitutes in cantonments) was a solution to this.

[16] Report of the Royal Commission on the administration and the operation of the Contagious Diseases Act, (1866-69), 1881 quoted in Judith Walkowitz, Prostitution and Victorian Society (1990), pp 71.

[17] Kenneth Ballhatchet, *op cit*. pp 40.

[18] Fourth Annual Report on the working of the lock-hospitals in the provinces of North-Western Provinces and Oudh for the year 1877, North-Western Provinces and Oudh Government Press, Allahabad, 1878.

[19] Judy Whitehead, *Bodies clean and unclean: Prostitution, sanitary legislation and respectable feminity in colonial north India* in Gender and History, 7.1, 1995, pp 41-63.

[20]Judith Walkowitz, *Bodies of evidence, bodies of rule: The Ilbert Bill, revivalism, and age of consent in colonial India* in Sociological Bulletin, vol 45, no. 1, March 1996, pp32.

[21] Kenneth Ballhatchet, *op cit,* pp 40.

[22] Radhika Ramasubban, *op cit,* pp 9-10.

[23] Mark Harrison, *op cit*.

[24] Kenneth Ballhatchet, *op cit*.

[25] *ibid,* pp 11.

[26] Office Memorandum No.528, Military Department, dated 19th December 1863; Home files, legislative branch, March 1864, No.11-13, Part B.

[27]Kenneth Ballhatchet, *op cit,* pp 11-12.

[28] Despite emphatic moral arguments against the continuation of any such Act, their protests were full of racial undertones. The broader moral tones of the petitions and memorials of the missionaries were undercut by a desire to preserve the Western Christian values (which was another representation of the colonial state itself).

[29] Report on Lock Hospitals by Thos. Carr, Archdeacon, Bombay, dated 20th September 1834, Home files, Legislative branch, March 1864, No.11-13, Part B.

[30] Mark Harrison, *op cit*.

[31] Memorandum on CDA by W.J.Moore, Surgeon general, Home sanitary files, June 1888, No.102-129, Part A.

[32] Kenneth Ballhatchet, *op cit*.

[33] Letter from the secretary of state for India to the governor general in council, No. 297, dated 15th Aug 1863; Home files, Legislative branch, March 1864, No. 11-13, Part B.

[34] Ronald Hyam, Empire and Sexuality: The British Experience (Manchester and New York: Manchester University Press, 1991), pp 64.

[35] Report by Surgeon Marshall, 84th regiment, dated 31st 1848, Home files, Legislative branch, March 1864, No. 11-13, Part B.

[36] Philippa Levine, *op cit*. pp 311.

[37] *ibid*.

[38] First Annual Report of the Sanitary Commissioner for Bengal ,1868. Alipore Jail Press (printed by William Jones), Calcutta. pp 23.