

Chapter- I

Introduction

The proposed dissertation titled Western Medicine and Public Health Services in Jalpaiguri (1866 To 1947) aims to examine the introduction of Western medicine and the public health system in the Dooars and Jalpaiguri from 1866 to 1947. Before the introduction of Western medicine there seemed to be indigenous methods of treatment which included *Kabiraji system* mainly based on Ayurveda, the practice of *Ojha* mainly based on folk beliefs and customs, and others. The local scholars often observed that the folk-based medicine practices in the precolonial era were very body fitted for the indigenous peoples in this area. Charu Chandra Sanyal for instance, described the Rajbansis, who lived in large parts of northern Bengal– as being freer from any disease than others on account of the precautionary measures and folk-based medicinal practices they used – their nutritive food and drink, and the open-air positions of their house they build in the middle of the agricultural land, their villages were small and scattered. He observed the rise of environmental degradation of northern Bengal villages because of the British intrusion. Sanyal¹ Colonialist perception of this region however remained the same as the whole of South Asia, which commonly addressed this as the metaphor of the unhealthiest. All early colonial records of this region extremely noted the undesirable climate of the Dooars. D.H.E. Sunder's Settlement Report (1886-95) lists the autumn and summer months as especially unhealthy in the Dooars, though he considered the winter months (December-February) remarkably salubrious.² Grunning also recorded the region as 'well known to be unhealthy and the climate was 'notoriously bad'³

Whatever the debate the introduction of Western medicine resulted in some changes in the history of the health system in the region. The discussion of the present thesis has been started in the year 1866, three years before the formation of the Jalpaiguri district because the

first dispensary in Jalpaiguri district was formed in 1866 which undoubtedly marks an important era concerning the history of health and medicine of the Jalpaiguri area. On the other hand, as we all know 1947 was the year when India got independence. That is why the thesis remains limited to 1947 which marks the beginning of a new era in India. The thesis therefore looks into the colonial health policy and its implications in the region. Research on the history of medicine in colonial India though has burgeoned over the past two decades. Yet, region-specific studies in India are very few and far between. It may be mentioned here that in recent times a growing interest has been noticed among several historians and scholars in writing regional history. It is felt that the studies at the regional or micro level will help bring to light many untouched corners of the history of our recent past. It is out of such idea that this work is proposed to be undertaken in the context of the district of Jalpaiguri. Jalpaiguri finds little place in the mainstream historiography of social history, technological history, medical history, and environment popularly known as H.I.S.T.E.M, a term popularized by an eminent scholar in the 70s of the past century and enriched by Arnold⁴, Chakraborty,⁵ Kumar,⁶ Kumar,⁷ Dutta & Palit⁸, Barman⁹, Sarkar¹⁰, Bala¹¹ Bhattacharya¹², Harrison¹³, Pati and Harrison¹⁴, Sharma¹⁵, Cheema¹⁶, Ray¹⁷, Samanta¹⁸, Chatterjee¹⁹, Bhattacharya²⁰, Bhowmik²¹, Chattopadhyaya²², Dasgupta²³, Dasgupta²⁴. Roy²⁵, Sanyal²⁶, Alam²⁷, Kumar²⁸, Das & Dutaa²⁹, Kumar³⁰, Ramanna³¹, Gourlay³², Dabi³³, Baruah³⁴, Ramanna³⁵, Diseases & Medicine and many others on this theme. The above-said researchers have widely discussed Health and Medicines, but they have not given any special attention to North Bengal, especially since they have overlooked an important district i.e., Jalpaiguri. There are many books of local and international importance on Jalpaiguri but very few of them narrowly studied the colonial health system; thus this theme in the case of Jalpaiguri academically remained understudied and neglected at large by the mainstream scholars.

Making epidemics in colonial Bengal as its entry point and drawing heavily on social, cultural and linguistic anthropology to realize the purpose of health experiences, distribution of illness, prevention of illness, social relations of healthful engagement and business of pluralistic medical systems, the *Living with Epidemics in Colonial Bengal*³⁶ interrogates the social construction of medical knowledge, politics of health, and the changing paradigm of relationship between health of the individual and the perquisite of larger colonial economic formations. Smallpox, plague, cholera and malaria which visited colonial Bengal with epidemic vengeance, caught the people unaware, killed them in thousands, and changed the society and its demographic structures. This study shows how sometimes through mutual adjustment but more often by cultural protestation, people advantage on with their microbial fellow traveller, and how illness became metaphor for the social status of indecorous code of conduct, to be corrected only through personal expropriation of the sin committed, or by community worship of the deity supposedly responsible for it. As a result, Western medical science was often envoy to the background, and expatiate rites and rituals, purportedly having healing values, came to the forefront and were observed with much gathering fanfare.

Anil Kumar³⁷ unravels the political connection and social interactions between Western medical science and the British Empire in India, focusing on the period 1835-1911. He provides a contemporary critique of the imperialist-nationalist debate on research in history of medicine and also outlines the course of action the British sought to have taken to improve the health system in India.

Srilata³⁸ *Western Medicine and Colonial Society* studies the social and political environment that spurred the development of hospitals and asylums in Calcutta under the East India Company's rule from c. 1757 to 1860. This work attempts to bridge this gap by tracing the trajectories of hospital formation for the indigenous population, beginning with the early

military and European hospitals. The book also focuses on the growth of dispensaries in the suburbs of Calcutta, as well as speciality hospitals in the city. Based on a thorough examination of the eighteenth- and nineteenth-century records preserved in India and the UK, this study attempts to link the urban development of Calcutta, as the second capital of the Empire, with the social, political and cultural forces that fashioned the process of institutional health care in the city, and which became an important legacy for the organization of health care after India's Independence.

The institutionalisation of female medical education in India began in the last quarter of the nineteenth century when the medical colleges in the Presidencies started to open their doors to female students. However such education had started much earlier with the missionaries almost from the second quarter of the nineteenth century, and then with secular medical women arriving from Britain around 1880s. These European women doctors, missionary and secular, played a significant role in providing health care and medical education to Indian women. The scholarly explanation so far was that the European medical women were looking to the colonies for employment and the missionaries among them were sent to evangelize the indigenous women. They used the idea of providing medical care for Indian women for their own interest. Jharna Gourlay³⁹ in her questions that assumption and views it as a cross-cultural relationship between two groups of women where both parties played significant roles to empower each other. Just as the European medical women opened up a new professional dimension in Indian women's lives, this cross cultural relationship also helped to broaden the horizon of female agency in the western world. The medical women's achievements in establishing hospitals and training centres, in creating employment opportunities for women from various strata of the society, and their active support for Indian women in gender issues tell us a different story of feminist concern. Based on sources from

both Britain and India, this book explores the story of 'sisterhood' and contributes to the debate relating to the impact of colonial medicine on Indian women.

*Medicine and Integration of Frontier Tribes: The British and After in Arunachal Pradesh*⁴⁰ by Tajen Dabi traces the use of medicine as an instrument of diplomacy in British frontier policy and as a medium of integration in the post-Independence era in the state of Arunachal Pradesh. A new domain of knowledge within the sphere of British-tribal studies is presented here for the first time: the peculiar absence of medical missions; the 'political' role of doctors; the European-Indian divide over patronage to the tribes; the post-Independence government policy on the integration of tribes and the development of modern healthcare infrastructure. Aside from a summary of indigenous healing traditions, the volume also explores the origins of colonial epidemiology and dispensaries in the Brahmaputra valley during the nineteenth century through the necessities of the tea economy, a theme about which limited literature is available. The research in this volume hopes to contribute to historical narratives on British policies in tribal hinterlands by offering an alternate account of the contact between state systems and the tribes of Arunachal in the twentieth century, a period during which the region acquired its present constitutional, national, and evolving cultural identities.

Before Western medical systems became prominent, Ayurveda and *Unani* had evolved into specialized indigenous medicinal systems in India. *Health, Medicine, and the Encounter of Cultures in India* examines the social, cultural, and linguistic facets of medicine that influenced these indigenous systems. Exploring medical literature and other texts in Sanskrit, Arabic, and Persian from the eleventh to the nineteenth centuries⁴¹, traces the interactions and changes in the components and practice of medicine. The book focuses not only on the growth of medical systems in the subcontinent but also on physicians' standing in Indian society. Evaluating the impact of Europeans' entrance into India, the book argues that this

arrival resulted in the establishment of a new medical system and sheds light on the training offered to *vaidyas* and *hakims* in the early centuries following the former's arrival. From tracing the descriptions of numerous madrasas and *pathsalas* established after the formation of the Delhi Sultanate and, later, during the Mughal era, this book proceeds to discuss the establishment of different medical colleges under the British, and provides insights into the contours of this transformation during colonial times.

History of Public Health: Colonial Bengal 1921-1947,⁴² by Kabita Roy is the first systematic effort to study the public health history of colonial Bengal between 1921 and 1947. While examining the policy and programmes of the colonial health authorities, the book also analyses the social reaction to this policy. The roles of Voluntary and non-official organizations in the implementation of public health programmes have also been studied incidentally. The book is strongly based on archival sources. The author has also examined a very wide range of other sources, both official and non-official. The press reaction has also been identified to a very large extent.

*Facets of Public Health in Early Twentieth-Century Bombay*⁴³ by Ramanna Mridula focuses on some aspects of public health in the first three decades of the twentieth-century in the Bombay Presidency. We begin with a review of the Western and Ayurvedic medicines, infant foods, tonics, and toiletries, advertised in contemporary English language newspapers, to evaluate how far the copy reflected contemporary social perceptions and notions of health. An attempt is made to understand the health of men and women textile mill workers of Bombay and Ahmedabad and the welfare measures provided to them. The activities of the semi-official Bombay Presidency Baby and Health Week Association and the non-official Seva Sadan, in providing maternal and infant health care, and the training of nurses and health visitors by the latter, are also detailed. There is a micro-focus on localised attempts to

promote self-help schemes among women and to provide support to children and the visually challenged. To provide a contemporary American perspective, the observations of visiting officials of the Rockefeller Foundation on Medical Education in Bombay are discussed as are the public health issues debated in the Bombay Legislative Council, in the 1920s and 1930s. The inequalities in health care between urban and rural areas, inadequate funding of public hospitals and the extent of the state's responsibility in public health, highlighted in this study, have a resonance in today's scenario.

Tribal development has received a great deal of attention since independence resulting in spurt of studies on tribal communities. Unfortunately, specific studies on the tribals, particularly the tribal worker in tea plantations in Assam, dealing with health disease and treatment are very scarce. A good number of studies carried out particularly in social epidemiology in the recent past, have made it inarguably clear that man's social environment is a component in the etiology of nearly all diseases and the outcome of treatment depends equally upon how favourable the social environment is. Thus, to identify different communities' health needs, it is important to gain an understanding of the social and cultural contents of people's lives and to identify needs within and in terms of such contents. The book by Baruah Tultul titled '*Mundas in Tea Plantation A study in their Health Behaviour*'⁴⁴, is perhaps the first of its kind in North East India dealing with tribal health is based on data generated from intensive prolonged anthropological investigation carried out among the migrant Mundas working in Assam tea plantations.

*Dreadful Diseases in Colonial Bengal*⁴⁵ brings together selections from official reports on cholera, malaria and smallpox the three diseases which repeatedly struck colonial Bengal as epidemics. Its objective is to provide a useful resource for researchers, with ready entry points for reconstructing the incidence of these diseases, their mortality rates, social and

economic effects as well as colonial medical interventions to contain them. The COVID-19 pandemic has highlighted the importance of studying epidemics that have struck human society in a historical continuum and the significance of the present collation needs to be viewed in this context.

This book *Tribes of Sub-Himalayan Region: Meches, Rabhas, Totos and Garos*,⁴⁶ deals with the tribes of Mech, Rabha, Toto and Garo of Sub- Himalayan North Bengal region from the days of antiquity to the first decade of the twenty-first century, in order to understand their origin, religion, culture, diseases and medicine, tradition, different social institutions like family, clan and marriage, social and economic structure and social stratification. This book focuses on traditional folklore, arts and crafts, customs, rituals, etc. It also discusses at length the socio-economic and political changes and their impact on the said tribes. This work is to explore their changing livelihoods and the real problems they face. It is a new interpretation as a whole. The positive role of Central, State Government, and social organisations play for the development of the underdeveloped tribes of this region. This study will convey the multidimensional aspects of the religion, culture, and folk medicine of the society. This book will help teachers, interested readers, research scholars, and field workers to have more information about the Mech, Rabha, Toto, and Garo tribes.

*Colonizing the Body State Medicine and Epidemic Disease in Nineteenth-Century India*⁴⁷ by David Arnold analyses the medicine and disease in colonial India. David Arnold explores the vital role of the state in medical and public health activities, arguing that these activities were a critical site of interaction and conflict between the British authorities and their Indian subjects. Arnold focuses on three major epidemic diseases-smallpox, cholera, and plague to illustrate the varied forms and impact of medical interventionism and mark the principal stages of emerging public health policy. He examines such colonial enclaves as the army and

the jails, where colonial medicine seemed most powerful, as well as the nature of popular resistance and the contrasting character of indigenous medical beliefs and practitioners. As part of a dominant environmentalist and Orientalist paradigm, he argues, Western medicine became a critical battleground between the colonized and the colonizers, but also prepared the way for a later nationalist hegemony.

The *'Health Has a History Revisiting Bengal'*⁴⁸, probes into various aspects of social history of medicine and public health in colonial Bengal, shedding as it does, fresh light on the latest researches on the subject. The contributors of this book have explored newer archives to examine the cultural responses to diseases, health movements, health education as also multiple meanings of public health.

Poonam Bala has shown that in the early years of colonial rule there had been friendly coexistence between the established Indian and western system medicine, but from the 1860s there was increasing criticism of the lack of refinement of indigenous medicine. Moreover in the late nineteenth century, saw western medicine move away from indigenous medicine, owing to increasing professionalization that led medical practitioners both in Britain and in India to discard the humeral basis of diagnosis.⁴⁹ The growing influence of Utilitarian ideas in the British administration of India by the 1860s.⁵⁰ Meant that many colonizers believed that 'it was more important to civilize than subdue'⁵¹ and that many intended that 'the whole of Indian society would undergo a vast transformation, setting it on a rapid advance up the scale of civilization'.⁵² In other words the British colonials fantasized that they would transform India from 'uncivilized', that is irrational and unproductive, to 'civilized', that is ordered, industrious and regular.

Roger has pointed out that imperialism played a vital role against indigenous healing traditions by depriving practitioners of elite patronage in India.⁵³ Though till the close of the

nineteenth century, attendance at childbirth had always been the preserve of women. Midwives assisted women in labour, while the labouring woman's close women friends and relatives attended and assisted. Their experience and knowledge about birthing was passed from one generation of women to the next. Throughout the twentieth century a struggle took place between female midwives and the emerging male-dominated medical professionals over the control of intervention in the birth process. Due to increasing medical regulations and municipal ordinances designed to exclude women from obstetrics female midwives were discredited and marginalized. Attempts to professionalize medicine led to competitiveness amongst physicians, surgeons, barbers and midwives to establish control over fields of medical practice. Scientific knowledge became valorized over experiential knowledge, and women midwives were denied access to medical training. The 'man midwife' came into being in the earlier decades of the 20th century, and treatises of midwifery began to be written for male practitioners and criticized the female-dominated ceremony of childbirth. Moreover, on the other hand, technical intervention rapidly became the hallmark of male medical practice and a means of excluding women.⁵⁴ Social and educational background, training, career patterns, and aspirations were the key factors in men's clinical and institutional development of this specialization.

Dr. Kenneth McLeod's Sanitary Report mentioned that in 1868, Julpiguree 26°0' and 27°0' north latitude, and between 88°20' and 89°53' East longitude; ⁵⁵ it contains an area of 2,961 square miles. The administrative headquarters of the Rajshahi division situated on the West or right bank of the Tista River in 26°32' North and 88°43' East. The name Jalpaiguri is derived from *jalpai*, (an olive tree), and *guri*, (a place); it means, therefore, the place of the olive trees.⁵⁶ The Jalpaiguri district as an administrative unit was formed in January 1869 by the British administrators. The five police stations of Rangpur, namely Boda, Panchagarh, Tetuliya, Patgram, and Debiganj,⁵⁷ were joined with the newly annexed Western Dooars

(Western Dooars was annexed by the British after the Anglo-Bhutanese war in 1865) to form the district Jalpaiguri. It was bounded by Purnea district of Bihar and Darjeeling district on the West; on the north by the Himalayan Kingdom of Bhutan and some part of the Darjeeling district; on the south by the districts of Rangpur, Dinajpur, and Princely State of Koch Bihar; on the East Goalpara district of Assam and some parts of Koch Bihar. (See map I- A)



Map- I. A : Physical Map of Jalpaiguri in the 19th-20th centuries

[Source: Sanyal, Charu Chandra, *et al.* *Jalpaiguri Jela Satabarshiki sharak Grantha, Jalpaiguri District Souvenir, 1869-1968, Jalpaiguri, 1970.*]

The district consisted of two familiar tracts that differed from each other by their physical appearance, geographical formations, economic and production performances, tenurial arrangement, and administrative types of machinery in the colonial period. One tract covering an area of 879 sq. miles consisted of the Patgram and the western region of the River Tista came under British rule after the obtained of the *Dewani*; this region was a Regulation area and a part of the permanent settlement area. The other tract lying to the east of the River Tista having an area of 2053 sq. miles was known as Western Dooars or in general Dooars annexed after the Anglo-Bhutanese war in 1865; this was a non-Regulation area and not a part of the permanently settled area. During this period there was the settlement of a large number of outsiders either as colonial masters, landlords, officers, businessmen, entrepreneurs, or labourers in the tea plantations; It also changes the composition of the population as well as a radical change in health

The colonization of Jalpaiguri in the nineteenth century inaugurated many shifts and changes. The first tea garden was established by Dr. Brougham at Gazaldoba in 1874. Henceforth, the growth of tea plantations in the region was extremely rapid. By 1876, 13 gardens had been started. In 1878, the Dooars Planters Association (DPA), a body composed of European planters, i.e. European managers, assistant managers, supervisors, etc., was established. Entrepreneurship in Dooars tea gardens in the initial years (like elsewhere in north-east India) was under British control- the bulk of the capital of the Sterling companies, which invested in tea, was raised in India out of the earnings of firms owned and managed by British citizens or from British individuals who had made money out of various activities. The period between 1910-30 witnessed the high watermark of Indian entrepreneurship in the Dooars, pushing the number of gardens owned by Indians to 47, owns 37 percent of the total capital invested in the gardens of the district. The impact of the plantation as well as the extension of roads, railways, and communications provided stimulus for the commercialization of the district's

subsistence-oriented agriculture and for the extension of cultivation and consequently led to the integration of the economy with the British Indian market and the wider colonial economy. The change took the form of large-scale migration of tribal peasants, particularly Oraons, Mundas and Santhals from Chotanagpur and from Santhal Parganas to the tea gardens as labourers. The indigenous population (which stood at 100,11 in 1872) primarily consisted of Rajbansish, Muslims Meches, Bhutias, and Totos. The jump in population figures, which was primarily due to large-scale immigration, is astounding. Between 1872-1921, the population of the district had increased by 244.2 percent.

This was also reflected in the manner of indigenous communities' treatments related to disease, health, and medicine. Among the prominent tribal communities, one ought to refer to the Kandhas, Santals, Mundas, Hos, Kols, and Bhumijis in Jalpaiguri. The indigenous population primarily consisted of Rajbansish, Nasya Sekh Muslims Mechs, Bhutias, and Totos. These indigenous communities had and still have an oral tradition that offers us fascinating clues to grasp their visions and worldviews related to the issues of health, disease, and medicine. The colonial officials and bureaucrats associated these practices with the world of magic, spirits, and ghosts which may be called as mono-dimensional explanations. Indigenous medicine used to the in these District Dhenus (*Abelmoschus esculentus*), kunch (*Abrus precatorius*) upang (*Achyranthes aspera*); bach (*Acorus calamus*); bel (*Aegle marmelos*); chireta (*Agathoteschirayta*); ghritakumari (*Aloe Indica*); kulinjan (*Alpinia galanga*); chatin (*Alstonia scholaris*); kalapnath (*Andrographis paniculata*); KhasKhas (*Andropogon muricatum*); Sialkanta (*Argemone mexicana*); Nim (*Azadirachta Indica*); Jaipal (*Grotontiglium*); Pudina (*Mentha Sativa*) Haldi (*Curcuma longa*); Bhand (*Clerodendron viscosum*); (Akhund *Calatropis gigantea*); Ganja (*Cannabis Indica*).

The chief diseases of the area were epidemic cholera, endemic fever, both remittent and intermittent, Black water fevers (Kala-azar) diarrhoea, dysentery, goitre, rheumatic afflictions, etc. The gazetteers and settlement reports are silent regarding smallpox, though there are some stray references to cholera epidemics. A cholera epidemic ravaged the district in 1856, breaking out in a gang of prisoners from the Rangpur jail, who were building barracks for troops at Jalpesh. In 1869 another outbreak of cholera occurred in the district, with the Dooars region particularly affected. The year 1872 recorded another outbreak, however mortality figures are almost absent which makes it difficult to assess the impact of the epidemic in the Dooars region. The stationing of the army in the Buzia region and the experience of the 1865-66 war when a quarter of the army was sent off on sick leave might have made such cholera epidemic serious to colonial government. Perhaps malaria and Kala-azar, more than other diseases, became the primary concern of the colonial rulers in the Dooars. Malaria was a barrier to colonial expansion and here it was complicated by the occurrence of Black water fever. In eight out of the ten years ending in 1901, Jalpaiguri figured among the six districts with the highest mortality rate from fever in the province of Bengal. The Dooars no doubt accounted for the maximum malarial cases since the other part of the district (i.e. the Western part, with Jalpaiguri town and surrounding agricultural area) had a far lower malarial index.

In the colonial era, the primary reason for the introduction of western medical practice in Jalpaiguri was the preservation of British soldiers. The aim of which was to keep the health of Indian women, but its main objective was to prevent the transmission of sexual intercourse among British soldiers. During the colonial rule, the number of deaths of British soldiers in Jalpaiguri district was very high. It was mainly because of two: malaria and sexism. For this reason, European safety and security took these steps. In 1901, Royal Societies Malaria Commission under Dr. Stephens and Christophers and Captain S. P. James (IMS) compiled

the malarial endemicity index, and one can see how the incidence of malaria shoots up as one moves from west to east, which is towards the Dooars region. However, the continuous scourge of malaria forced the DPA to make an urgent appeal to the Indian government to survey the region. The resultant comprehensive survey, titled *Black Water Fever: Being the First Report to the Advisory Committee appointed by the Government regarding Blackwater and prevalent in the Dooars* was conducted by S.R. Christopher and Dr. C.A. Bentley, and provides a good account of the contemporary conception of malaria and its prevention and the ongoing debate about the origins of Blackwater fever. The Report pointed out the high incidence of malaria among Europeans. Visitors to the district, no matter what the season, usually suffered from the disease from one to three weeks after their arrival. The Dooars Enquiry Committee of 1911 pointed out the highly inadequate state of medical facilities and food supply and was highly critical of the substandard medical services rendered to the people. The committee blamed the absence of good doctors and the polluted water supply as the chief causes of ill.

For the improvement of public health few measures were taken by the colonial government as tea was one of the most profitable industries of Jalpaiguri. A good number of measures, inquiries, and surveys were undertaken to improve the health conditions of the tea garden workers of Darjeeling and Jalpaiguri Districts during the period. For example, local *hats* were located in colonial discourse as a site from where diseases were disseminated and the colonial government took measures to control this. Thus, Sunder's letter to the deputy commissioner (8 March 1888) pointed out the unsanitary condition of markets in the western Dooars and submitted a scheme for keeping them clean and in order. There is a relationship between indigenous and Western systems of medicine. The initial policies favoured the utilization of indigenous drugs and encouraged the training and employment of indigenous medical Practitioners. This was facilitated by the similar basis of diagnosis and treatment in the

Indian and Western medical sciences. They constructed dispensaries and hospitals and appointed medical practitioners, midwives, and nurses in the district. In 1930 a Medical School named Jackson Medical School was formed in Jalpaiguri. A scheme for educating native women in practical midwifery was also tried at Jalpaiguri dispensary in 1870-71 after consultation with the Divisional Commissioner. For the labourers in plantation industries, the Britishers arranged comfortable houses, good drinking water was supplied to them they were regularly looked after by a Native doctor, often by a qualified European doctor on a high pay; medicines were issued to them free of charge. The government has taken various sanitation programs so that the European will not be attacked. In many cases, the government must stop compulsory vaccination, arbitration or religious firing, to prevent disease, examining people who are suffering from the disease. As the colonial government policy, the principle adopted by the East India Company for military or civilians in the medical field was not taken for Indians.

They gave special emphasis on Western medicine. The imperative British government was able to look at the health of the Indian people to maintain Indian colonization and establish mastery in India, from its political point of view. In total, the British have looked after the health and medical care of British soldiers. They aimed to carry Indians for the treatment of Indians and western medicine would spread. Unfortunately, a huge number of workers could not get the benefits of those steps.

The health policy of the British Government had a deep impact on the society and economy of Jalpaiguri. It not only affected agriculture and industry but also affected the social structure of the families. The reluctance on the part of the British Government to set up hospitals and dispensaries was compensated by the local kings, landlords *jotedars*, and other individuals. The Christian missionaries also contributed to the betterment of the medical needs of the

people of Jalpaiguri. The women played a great part in the medical rejuvenation of Jalpaiguri. Though there emerged the Western medical system it was not so popular during this period under studied? Apart from the tribal medicine, the *ayurvedic*, *unani*, *Tibetan*, and homeopathic systems of health care practices also grew in the districts of Jalpaiguri to fulfill the medicinal and health care requirements of the inhabitants of Jalpaiguri. All the above-mentioned medicinal systems excluding *unani* were popular in different parts of the region despite the incredible presence of the Western system of medicine.

Thus from 1866 to 1947, there experienced different dimensions in the health and medicinal aspects of Jalpaiguri. But the historians have shown their indifference to highlight the health care system of Jalpaiguri. As a result, not a single book has been published analyzing a comprehensive medicinal history of Jalpaiguri rather only a few articles have come out describing the brief history of health and medicine of the district. This lacuna or hiatus instigated me repeatedly to pick out such a topic for research and thus it will be a pioneering work in its field. The study intends to examine whether the environment was the sole factor responsible for the outbreak of diseases in Jalpaiguri. The role played by the British Government to furnish medical facilities to the people of Jalpaiguri is another theme of the study. The purpose of the present study is to underscore the medicinal beliefs and practices of the indigenous people of Jalpaiguri, many of them were in an extinct position. Thus it will help to restore the medical system, the culture, and the heritage of the ethnic peoples of Jalpaiguri. The objective of the study is also to highlight the health conditions of the population of the tea gardens of Dooars. It will bring into light the essence of malaria and black water fever surveys, the nature, and causes of various diseases that attacked the garden labourers, the reasons for the dearth of efficient doctors in tea estates, and the consequences of the existence of those inefficient doctors. The study will also find out the causes of the repugnance of the workers of the tea estates to visit the health centers. The social and

economic impact of health policy in Jalpaiguri is also an important subject of discussion in the study.

On the other hand, what is the reaction of Indians to this medicine and how acceptable is this medicine to them? It also helped to determine. In discussing Western medicine and indigenous medicine, In particular, the analysis of the interrelationship between Western medical science and Indian women's society opened up new horizons of research. Researchers have all concluded that Western medical science has expanded to the neglect of indigenous medical systems. By exploiting Western medical science, colonial rulers established Western control over Indian bodies. That is, thus the foundation of the empire was established more firmly. Moreover, British imperialism used Western efforts to spread medical science as an 'excuse' to expand its power. But if judged quantitatively, it can be seen that Western medicine did not reach the common people of this country, they were dependent on indigenous medical systems. However, the educated Indian community adopted the Western system of medicine as a profession and placed it above the indigenous system of medicine. However, there was also some encouragement from the British administration to promote indigenous systems of medicine in the region. The government constructed several General Councils and the State Faculty of Ayurvedic Medicine which constituted a landmark in the history of Ayurvedic medicine in the localities.

Analyzing the relationship of Western medicine with the Indian women's society, it can be seen that Western medicine was used as a tool to establish control over the Indian female body. The imperialists were critical of Indian social evils such as male-female relations, gender inequality, veiling, child marriage, etc. Also, the lack of medical treatment for women reinforced their perception. Increasingly, the colonial government was able to create the impression that the intervention of the imperialist power was necessary to alleviate the plight

of indigenous women. Western women took a leading role in this. With the introduction of Western medicine, some valuable old institutions were lost. If we calculate what Western medical science has been able to give to Indian women instead of this loss, educated women have opened the way for professions like medicine, nursing, etc. Moreover, it brought opportunities to the women of the wealthy and educated urban communities along with indigenous medical systems as well as Western medical systems.

The primary reason for the introduction of Western medicine in colonial India was to protect the health of British soldiers. 1868 AD: Contagious Disease Act. passed Ostensibly intended to protect the health of Indian women, its secondary purpose was to prevent the transmission of sexually transmitted diseases among British soldiers. The death rate of the British army in India was very high. The two main causes were malaria and venereal disease. The imperialist government believed that prostitutes were responsible for the transmission of sexually transmitted diseases. With the help of the above law, prostitutes suspected of having sexually transmitted diseases could be arrested and treated. According to historians, this law not only recognized the colonial government's control and guardianship over women's bodies but also" Added a new dimension to social conflict by highlighting the distinction between 'other' and 'gentle' class women. That is, the infection provided a perspective on the differentiation between diseased lower-class female bodies and disease-free upper-class female bodies. The Act was repealed in 1888 after strong opposition and criticism from Britain. But the new 'Military Cantonment Act' passed in 1889 left a way of repressing sex workers by declaring them medically compulsory.

In the 1860s and 1870s, Christian missionary women were the first to bring Western medical science to indigenous women. They initiated the establishment of women's hospitals, the spread of Western medicine, and the teaching of midwifery and nursing to Indian girls. Clara

Swain came first from America, and Fanny Butter from England. Foreign women doctors realize that Indian men educated in Western medical science have failed to take appropriate measures to protect the health of Indian women, hence the need for properly educated women. For this purpose, in 1885 AD Lady Dufferin (Lady Dufferin) established "The National Association for Female Medical Aid to the Women of India". It had three goals. Provision of medical education for women, proper treatment of girls, and provision of female nurse midwives in hospitals and homes. The political significance of setting up this institution was quite profound. Two ideas had already been established. Firstly, Indian women are not looked after properly by Indian male society. Secondly, women should come forward for the treatment of indigenous women. It was said that Indian women are victims of various social evils. They could not be treated by an unmarried male doctor due to veiling. But in reality, many Ayurvedic doctors and male poets treated *Anthapurikas*. But the imperialist rulers had a dual purpose first, to show that it was the duty of the advanced Western civilization to uplift the backward Eastern civilization and thus establish the British imperial ethos. Second, establishes the superiority of Western medicine. However, the Dufferin Fund recognized the practice, despite condemning the practice of veiling by providing treatment for poor women. Although it did not improve the health of Indian women, it greatly facilitated the work of British women doctors in this country. It is necessary to discuss how the women of this country utilized it by learning Western medicine. Westernisation among Indian women since the 1870s Demands to provide medical treatment began to rise. With government support and the encouragement of educated Indians, girls get the opportunity to study medicine. The first medical education was introduced in Madras, overriding strong opposition from doctors in the Indian Medical Service. 1883 AD: Kadambini Bose, the first female graduate in the British Empire, was admitted to Calcutta Medical College. 1886 AD: Kadambini got the title of Graduate of Bengal Medical College. He is the first in India to hold a professional

qualification in Western medical education. He established and gained a reputation as a successful and competent physician. 1888 AD: Kadambini joined Lady Dufferin Hospital. Due to her marriage with the famous Brahmin reformer Dwarkanath Ganguly, she had to face social opposition from the conservative society, while the progressive male society of the time helped her as much as possible. Conservatives of the time believed that if girls entered the profession by following the dividing line between inside and outside, it would destroy their sanctity and interfere with the pursuit of chastity and fertility. However, Kadambani was able to overcome all obstacles due to her immense courage and patience. In 1893 he went to Edinburgh and returned successfully. But along with social censure, Kadambani had to face caste discrimination. In contemporary times, many hospitals were opened under the initiative of the Dufferin Fund, but the Kadambani were deprived of their qualifications and appointed *Shetang* doctors. She alleged that as a result, Indian women doctors were not getting the opportunity to gain experience and skills. Another doctor in contemporary Bengal was Himvati Sen. Haimvati was born in 1866 AD in a well-to-do Zamindar family in Khulna. His autobiography was translated into English by Dr. Tapan Roychowdhury. The widow Himvati came to Calcutta from Benares in 1890 and got married to the Brahmin preacher Kunjbehari Sen. In 1891 he entered Campbell Medical School and received the Vernacular Licentiate in Medicine and Surgery or VLMS degree. In 1894 he joined Dufferin Women's Hospital as Assistant. However, he also had to accept discrimination in the field of employment. Himvati was successful in the field of medicine as well as personally.

Around the same time as Kadambani, Anandarai Joshi of Maharashtra also obtained his doctorate. In 1886, he received his medical degree from Pennsylvania Medical College in America. In the 1880s there were many changes in the society of Maharashtra One of these was the establishment of Mahila Arya Samaj by Pandit Ramabai in 1882. Their aim was also to oppose various types of oppression and social evils against women. If we are to discuss the

changes in social and political life brought about by access to Western medical science education among women, we will see that there are two main aspects. First, when Kadambani Bose was subjected to caste discrimination at work, it created social protests that strengthened Indian nationalism. Secondly, many like Hemvati created security and recourse by taking up medicine as a profession. Therefore, it can be said that the opportunity of Western medical science among women, which created the environment for future feminism and humanitarianism, undoubtedly helped Indian women.

Aims and Objectives

However, the main objectives of the chapter are to critically examine the continuous changes in the health system in Jalpaiguri, especially in the villages of Western Doars. The thesis studies the health policies adopted by the British administrators as well as the Western glimpses of the indigenous medicine in Jalpaiguri. The thesis also explores the socio-cultural impacts of Western Medicine among the rural population of Jalpaiguri and also examines the reason for the entry of Western medicine. The role of the missionaries, personal efforts, and government, etc are also the part of discussion in the thesis. The thesis studies the efforts to prevent British spring diseases by vaccination in Jalpaiguri. The thesis examines the impact of malaria in the Tea Gardens of Jalpaiguri and the system of treatment by the British government. The thesis also examines the circulation of Western medicine and its social ability for women in Jalpaiguri tea gardens. The most important part of the thesis examines the role of locals in the colonized Jalpaiguri as a form of midwife.

Chapter wise description:

However, keeping in mind the above circumstances the present study on the Western Medicine and Public Health Services of Jalpaiguri district, the present thesis has been formulated with several following chapters. Followed by the introductory chapter, the second

chapter titled, *Indigenous Medicine: Traditions and Practices* examines the health and medicine issues of various indigenous and other communities which incorporates the beliefs and folk traditional practices and the demographic structure in the district. All these have been analysed through statistical data. The next chapter *Introduction of Western Medicine and Public Health System: Hospitals and Health Centers* looks at the introduction of Western Medicine with the establishment of colonial expansion in the Jalpaiguri district specially Dooars and the public health system. Before Western medicine, there were indigenous methods of treatment but the Western medicine has resulted from some changes in the health system of the region. On the other hand, 61 years after the formation of Jalpaiguri district, the Jackson Medical School was established in 1930, in which the recruitment committee played an important role. The next chapter titled, *Responses to the Health Problem: Diseases, Cure, and Vaccination* analyses and reviews of responses of the people and certainly indigenous communities of Jalpaiguri district, who immensely were suffered from cholera, malaria, smallpox, kala-azar, goiter, leprosy, asthma dysentery, diarrhea, etc. Due to the severe malarial fever, cholera, smallpox and other diseases the death rate remained such alarmingly high that 'the Western Dooars was prohibited from living by the inhabitants, European and even locals. Despite governmental efforts responses to Western medicines were very unpopular among the locals specially considering the vaccination program. It was also unpopular among the unhealthy tea garden areas but also surprisingly in urban areas population. The study concerns the social and political construction of major four vital diseases, viewed from the perspectives of the government policy of the state and the cultural fixities of the victims. Acceptance of inhabitants' people's responses and reactions to the Western health system will be discussed. Establishing quarantines was the first expected reaction of the British administration during this epidemic. Special attention was paid to boats arriving from cholera-infected areas. Both the land and waterways were also important

in the colonial health and medicine history of Jalpaiguri. Overland outposts were arranged with procedures and procurement of health sanitary systems. At the same time quarantine measures in Jalpaiguri were designed to prevent the entry of cholera into the region through waterways because more people relied on water transport than overland routes. To guarantee control, all water systems that led to the town and villages were under the supervision of the authorities. Time, however, proved the ineffectiveness of quarantines. Finally, the chapter *Medical Practitioners, Midwives, and Nurses* examines the activities of medical practitioners both locals and Europeans. The indigenous *dai* system and a brief discussion on the Midwife's role in Jalpaiguri have been included in this chapter. The trained midwives were in great demand and were often hired by hospitals, nursing homes, municipalities, and health centers when necessary. In Jalpaiguri one of the most important institutions for training nurses and midwifery was Ramkrishna Ashram. Such training centers were attached to the Hospital in Jalpaiguri. These more experienced nurses played an important role in the spread of the Western medical system in Jalpaiguri. The last part of the thesis includes the observations and concluding remarks.

Methodology:

The design of the present research has been formulated based on the nature of the study of health, environment, and disease history during 1866-1947 in Jalpaiguri. The study is designed as an analytical-theoretical and other form of method like normative survey, correlation methods, and explanation of the available sources, etc. by using both primary as well as secondary sources. Both the conventional and modern techniques of methodology have been used in collecting the data from Archives throughout India and abroad, archival materials from DPA, and others. The chief sources of information for our purpose were the proceedings of the Government of Bengal in General proceedings, Local self-government,

Public Health Branch, and Medical Branch Departments from the West Bengal State Archives (6, Bhawani Dutta Lane). Certain rare documents and reports have also been collected from the Dooars Branch Indian Tea Association (DBITA), which is in Banarhat, Lish River Hospital, Kumlai Hospital, Ranicheera Hospital, and Damdim Hospital. Besides these, the sources have also been collected from the National Archives of Kolkata, the District Collectorate Record Office, Oodlabari Library, and the oldest library of different districts which are in West Bengal. I have made considerable use of District Gazetteers, Statistical Accounts, and local materials such as contemporary publications, journals, periodicals, weeklies, newspapers, and District records which are valuable for the writing of this thesis.

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