Public Health and State Power in Pakistan:
Case Studies of Medical Interventions from British Raj to Military Rule

Zujaja Tauqeer
Jesus College

Thesis submitted for the degree of Doctor of Philosophy in History (History of Science and Medicine and Economic and Social History)

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Abstract

This thesis provides the first historical survey of medical interventions and public health policies implemented by the governments that ruled in the territories of Pakistan over the 20th century. It sheds light on the objectives and challenges of governance during this period with respect to population health and welfare, and seeks to contribute to our understanding of the impact of colonial rule in the territories which became Pakistan—which are not well-represented in the literature on the history of medicine of British India—and to expand our knowledge of developments in the postcolonial period.

The narrative begins with the twilight of colonial rule, when the British Indian government was hindered from undertaking public health reform due to the growth of nationalist and anti-colonial sentiment in the North-West Frontier, Bengal, and the Punjab. The demand for local autonomy and public accountability in health decision-making in these provinces came at a time when Indians were simultaneously resisting Britain's political dominance over India. Even after independence, the conflict between provincial governments and successive central governments with respect to health policymaking persisted. Such tensions were exacerbated by the economic pressures of scarcity in Pakistan's early years which worsened pre-existing social and political cleavages between different groups. This material deprivation along with the historical legacy of tropical medicine in Asia resulted in acceptance of the country's status as an underdeveloped, backwards state by the country's leaders in return for international health aid from richer nations. Pakistan subsequently became a laboratory for developed world experiments on poverty and population control. The developments in health over the period from 1900 to 1960 make evident the manifold challenges to the sovereignty and authority of the colonial,

parliamentary, and military rulers as they attempted to intervene in the lives of subjects and citizens of British India and Pakistan.

Extended Abstract

This thesis takes as its object of study the history of medicine of South Asia, specifically the territories that would become Pakistan, from approximately 1900 to 1960. This is a very exciting period for studying political developments in this country, a time when colonial rule was swiftly followed by a succession of bureaucratic, militaristic and democratic regimes.

The main research questions are as follows: what kinds of medical interventions and health policies were implemented by governments ruling these territories, and how can histories of medical interventions in the lives of subjects and citizens in colonial and postcolonial Pakistan from approximately 1900 to 1960 illuminate the unique processes of governance and the relations between government and governed? In effect, this thesis seeks to provide an exploratory historical survey of the political economy of health and medicine in Pakistan during a turbulent century, shedding light on the nature of interventions in public health as well as the political impetus and challenges to their implementation.

The central premise of the thesis is that public health ultimately has a political objective: that as a form of collective social action, it illustrates the structural operation of power. The study of public health policies and the manner in which they are articulated and implemented provides insight into the ideology and modes of governance employed by those who hold political power. The methodology of this thesis has consequently been to use the history of medicine as a lens into the political; the space where the life of the individual intersects with public life. It illuminates the motives and determinants behind health policy formation and implementation, and where possible, the ways in which colonial subjects and postcolonial citizens responded to the various incarnations of the state in light of their own welfare needs. Public health thus serves as a heuristic tool with which to elucidate the role, efficacy, and constraints of the state in British India and Pakistan.

This field of inquiry into the sociopolitical insights provided by histories of disease and health has a long lineage but this dissertation is rooted in the work done by historians such as Charles Rosenberg, as exemplified by his seminal works on cholera in the US in the 19th century, and in the South Asian context by David Arnold and Mark Harrison who have analysed

medical interventions in colonial India in the 19th century and early 20th century. Dorothy Porter's work on public health and state development provides a framework on utilising public health as an interpretive parameter to examine the development of the modern state and the workings of health citizenship, and thereby illuminates the mutual expectations of state and civil society in western contexts.

The first three chapters of this dissertation engage with local case studies to contextualise the degree of control the British Raj enjoyed in those parts of its empire which became Pakistan: from Bengal to Punjab to the North-West Frontier Province (NWFP). The aim is to characterise relations between the colonial government and Indian aspirants to power on the eve of independence. Even though it was entrenched in Bengal for years, in the Punjab with elite support, and in the NWFP with the greatest military force, in each region the British Indian government was consistently hindered from implementing public health reform by strategic considerations arising from the growth of nationalism. At precisely the time when the Government of India and the governments of the presidencies tussled with native aspirants to power over the rights and responsibilities of these stakeholders in a vastly reconfigured political structure, the question of who had the right to determine public health policy became a highly charged one. These case studies as a whole illustrate the scope and limits of the colonial administration's ability to change sanitary attitudes and in the process help us reassess the degree of control the state exercised over Indian society in different regions of the subcontinent. This is significant because the differing impact of colonial rule across the various regions of India provoked a diversity of nationalist responses, resulting in markedly distinct visions of independent statehood even amongst the community of Indian Muslims.

In chapters six through eight, the narrative focus changes to newly independent Pakistan, demonstrating the debilitating impact of early crises and acute shortages on the country's development as the new state sought to achieve its ambitions of control over its people and borders. The refugee crisis arising from Partition raised questions about the acceptable limits of citizenship, while shortages of resources and near-famine conditions worsened pre-existing social cleavages between different geographical groups and provincial governments. It forced the

country to adopt the mantle of an underdeveloped state on the world stage, outsourcing social welfare work to richer nations for its continued sustenance while fulfilling foreign nations' strategic objectives in return.

After a decade of independent civilian rule, the country experienced a decade of military rule that saw the implementation of state-driven programs for economic growth and modernisation, which are detailed in chapter nine. The legacy of colonial era ideas of public health as well as the impact of newly-minted bilateral and multilateral technical aid agreements were evident in the national government's implementation of major disease eradication programmes in the country during this era of development. With the help of foreign researchers and donors, new economic development ideologies and historically-rooted public health practices intersected with newly developing nexuses of power. National disease eradication programmes added to the prestige and power of the military government at the Centre, but provoked strong provincial opposition. They also transformed Pakistan into a laboratory for developed world experiments on poverty and population control.

This dissertation concludes that the history of public health over the period under study was most strongly bound up with concerns regarding governmental power over people, territories, and resources, with public health policy and interventions serving as a proxy for the state's desire to control and impact social and political norms within its borders. From the 1920s to 1940s, control over health and welfare in colonial India had become a symbol of governmental power and responsibility, and therefore became a flashpoint in the struggle for self-government by the people and provinces of India. When Pakistan inherited some of these provinces in 1947, it also inherited their interprovincial rivalries and endemic diseases; the atmosphere of competition between these provinces worsened due to the loss of institutions, expertise, and resources with Partition as well as the addition of so many needy refugees. This provoked a reversion to centralised state control over social resources, including health. The drive towards more consolidated and streamlined control over the country's functioning culminated in the seizure of power by the military, which utilised this state of affairs as well as its international strategic alliances to implement and fund ambitious national programmes for health. The national

government's ability to negotiate with international health stakeholders and foreign governments for technical aid gave it the means to control health policy within the country but also produced a dependence on international aid wherein critical decisions about the intimate lives of people and the economic trajectory of the country were internationalised.

This is the first history of public health and health care in Pakistan and one of the rare few contiguous studies of medicine in South Asia that bridge the transition from colonial to postcolonial eras. Furthermore, this thesis has utilised sources from well-represented historical archives such as the British Library and the Rockefeller Archives, as well as from the National Documentation Centre and the National Archives of Pakistan which house historical Pakistan government documents related to health and welfare that have not been extensively utilised thus far. Having provided an overview of the major public health policies and interventions from approximately 1900 to 1970, it is hoped that this thesis will spur further scholarship on health in Pakistan, whether on specific issues within public health and medicine, or more provincial and local approaches to the political economy of health within the country.

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Acknowledgments

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Chapter 1: Introduction

This thesis provides the first history of medicine of colonial and postcolonial Pakistan. It discusses how various state medical interventions throughout the decades of the twentieth century reveal the imperatives and operation of state power as well as the relations between governments and governed in the shifting territories that became East and West Pakistan. In doing so, this thesis seeks to make contributions to our understanding of the history of health and medicine in South Asia as the region transitioned from the colonial to the postcolonial era, as well as the relationship between governance and health in Pakistan.

The topic of statehood and governance has featured prominently in the historiography of Pakistan but largely in relation to such themes as security issues, failures of nationalism and democracy, and studies of development.[1] Contemporary histories of Pakistan are often consumed with the "problem" of Pakistan, namely how this nation of 200 million has become a near-failed state rife with militancy and plagued by widespread poverty, and have succeeded in reducing the country's existence to its complicated religious nationalism, its continuous embroilment in political crises and scandals, and its international geopolitical role.[2] While these tropes have undoubtedly had a major impact on the country's current form and function, they regrettably distract from focus on the more "mundane" aspects of governance that pertain to the daily, lived experience of Pakistanis. As a result, Pakistan, unlike its neighbour to the east, boasts a far smaller proportion of social histories on topics such as peasant and labour politics, women's role in society, agriculture and nutrition, or population health, etc.[3] Without denying the immense role of political crises in impacting the political development of Pakistan, my aim in writing this thesis is to move beyond analyses of high politics, and ask instead what these political

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[1] Ian Talbot, *Pakistan: A New History* (3rd edn, New York, 2012), pp. 2-8.
[2] 'Failing, but Not yet a Failure', *The Economist* (7 Oct 2011) <http://www.economist.com/blogs/banyan/2011/10/pakistans-state-stumbles> [accessed 24 July 2015]; Hassan Abbas, 'Pakistan Through the Lens of the "Triple A" Theory', *The Fletcher Forum of World Affairs*, 30/1 (Winter 2006), 181–92.
[3] Markus Daechsel, *Islamabad and the Politics of International Development in Pakistan* (Cambridge, 2015), p. 9.

developments in the country have meant for the ability of the state to affect the well-being of its diverse subject populations.

In terms of ascertaining the well-being of populations over time, the field of the history of medicine is of critical importance. In the words of American historian of medicine Allan Brandt, 'To overlook the changing material conditions of life, changing age structures, and shifting patterns of births and deaths [is] to neglect the most basic parameters of social institutions and activity.'[4] The publication of Charles Rosenberg's *The Cholera Years* in 1962 cemented the narrative importance of histories of health and disease to our understandings of social organisation and sociocultural values. Rosenberg's study of cholera epidemics in the United States in the 1800s emphasised that disease, medicine, and medical knowledge were not merely reflections of objective biological realities. There was much to be learned in unearthing the social and cultural values behind these concepts as well as their political meanings and uses.[5] In recent decades, the study of history of medicine has added a bold new dimension to our understanding of the operation of social mores and concerns of political economy in diverse settings ranging from revolutionary France to colonial India to apartheid South Africa.[6]

In this vein, the works of David Arnold and Mark Harrison on colonial medicine and public health in British India have bolstered our understanding of the state of medical knowledge and technologies and the operation of public health in the history of South Asia. They have also provided great insight into the anxieties of colonial rule and the methods for governing and intervening in the lives and health of Indian populations.[7] The field of the history of disease and medicine in South Asia has continued to grow in size and complexity, and has undoubtedly

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[4] Allan M. Brandt, 'Emerging Themes in the History of Medicine', *The Milbank Quarterly*, 69/2 (1991), p. 208.
[5] Rosenberg, *The Cholera Years: The United States in 1832, 1849, and 1866*, 2nd edn (Chicago, 1987), pp. 5-7.
[6] For examples, see Toby Gelfand, *Professionalizing Modern Medicine: Paris Surgeons and Medical Science and Institutions in the Eighteenth Century*, (London, 1980); Mark Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine 1859–1914* (Cambridge, 1994); Randall M. Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley, 1989).
[7] Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley, 1993); Harrison, *Public Health in British India*.

helped broaden the geographical focus of the history of medicine as a whole to include non-Western lands.[8] It has also added richness to the multifaceted study of British colonialism in South Asia by extending it beyond the purely political, and demonstrating the role of health and medicine in characterising, manifesting, and transforming imperial objectives in the region.

The subject matter of this thesis therefore engages to varying degrees with two distinct disciplines: the social history of Pakistan, and the history of health and medicine in South Asia.

Public Health and State Power

Among the various institutions and actors that serve to validate an individual's self-conception of health or illness, the modern state is a prominent one. Through its various powers, it has the potential to dictate whether an individual perceives him or herself as afflicted by a particular malady, and may enable or prevent that individual from seeking remedy for that affliction.[9] As Paul Weindling notes, 'Doctors, welfare reforms and preventive medicine…function in accordance with social expectations and values, and within established economic and political constraints.'[10] In line with this, the history of medicine from its earliest has endeavoured to understand disease and medicine as both biological entities as well as socially produced and culturally embedded phenomena. As a domain within social history, this field has produced a large corpus of studies that focus on the role of formal political institutions, which serve as arbiters of social power, in engineering public health interventions.

There are two notable reasons behind the rising focus on the social and political context behind developments in health and medicine in the history of medicine, particularly since the 1980s and 1990s.[11] First, as Dorothy Porter explains, '[T]hroughout its history population

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[8] John V. Pickstone, 'A Brief History of Medical History', *Making History*, 2008 <http://www.history.ac.uk/makinghistory/resources/articles/history_of_medicine.html> [accessed 12 September 2015].
[9] S. R. Kellert, 'A Sociocultural Concept of Health and Illness', *Journal of Medicine and Philosophy*, 1/3 (1976), pp. 223-4. Mark Jackson, 'Perspectives on the History of Disease', in *The Routledge History of Disease*, ed. by Mark Jackson (Abingdon, 2016), p. 4.
[10] Paul Weindling, 'Medicine and Modernization: The Social History of German Health and Medicine', *History of Science*, 24/3 (1986), p. 293.
[11] Mark Jackson, 'Perspectives on the History of Disease', in *The Routledge History of Disease*, ed. by Mark Jackson (Abingdon, 2016), p. 4.

health…depended on the collectivist operation of power. In the history of public health in the early modern and modern periods this is especially crucial because the social contract of health has been inherently linked to state formation and the development of citizenship.'[12] The second major reason arises from the first. Since the implementation of public health programs by a state over its public serves to illustrate the collective operation of power in society as well as the ties of obligation between state and citizen, public health histories often give voice to contemporary ideas about the merits or demerits of particular forms of political organisation. As Ludmilla Jordanova has explicated, critiques of science, medicine, and technology in the twentieth century have often been political, going hand in hand with contemporary concerns regarding nuclear power, pollution, imperialism, medical ethics during war, etc.[13] As an example, Porter notes that public health history flourished as a discipline after the Second World War, hand-in-hand with the rising positive interest in the intellectual and political genealogy of modern welfare states and their tremendous successes in reducing mortality from epidemic disease in the West.[14]

Academic trends from the 1970s and onwards in the humanities and sciences produced a more sobering perspective on the state's import and its benevolent intentions with respect to population health and welfare, as seen in the works of Thomas McKeown and Michel Foucault.[15] Yet Foucault, too, characterised public health as an integral part of the modern state's functioning, stating that in the West, the state from the 18th century onwards could be distinguished from its pre-modern antecedent by its ability to 'make live'—to regulate mortality by using health as a technology of power.[16] The state sought to control the body of the people, whether it be their proclivity to pollute or their fertility or their spatial organisation.[17] Similarly,

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[12] Porter, 'The History of Public Health: Current Themes and Approaches', *Hygiea Internationalis*, 1/1 (1999), pp. 19-20.
[13] Ludmilla Jordanova, 'The Social Construction of Medical Knowledge', *Social History of Medicine*, 8/3 (1995), p. 365.
[14] Ibid., p. 9; this trend is best exemplified by the publication of George Rosen's *A History of Public Health* in 1958.
[15] James Colgrove, 'The McKeown Thesis: A Historical Controversy and Its Enduring Influence', *American Journal of Public Health*, 92/5 (2002).
[16] *The History of Sexuality, Vol. 1: An Introduction*, trans. by Robert Hurley (New York, 1990), p. 138.
[17] Ibid., p. 137.

Marxist-styled critiques of scientific and medical power sought to establish that nature and its cognates such as health and wellness were social goods, even as they acknowledged the medical profession's assumption of authority over these terms and the instrumentalisation and abuse of this authority by the state for the purposes of controlling populations and work forces and intervening in the context of class struggles.[18] One prominent example of the use of the authority of medicine to determine notions of fitness and the political appropriation of this authority is found in histories of modern eugenics.[19] In short, both supporters and critics of state power noted that the state had to attempt to exert control over the whole population in order to be able to effect changes in health and thereby mobilise the body of the people.

Even so, one may critique the relevance of the state in a region like South Asia where formal state authority has been very limited or marginally relevant during certain periods or in certain regions. To speak of the Pakistani state as a uniform, concrete political entity, as implied by the term 'state', is at best ambitious, and at worst presumptuous. Pakistan, some argue, may be better described as an amalgam of unevenly developed and linguistically and culturally distinct provinces united precariously under a weak federal polity, one which has suffered all manner of military coups and political assassinations.[20] These provincial groupings in turn mask further significant political and social divisions that are less formalized.[21]

Yet this thesis is as much about the *idea* of statehood and the *implicit expectations* concerning the state's role in facilitating health, as it is about the reality of statehood and the

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[18] Jordanova, 'The Social Construction of Medical Knowledge', p. 366.

[19] A notable example of this genre is Paul Weindling, *Health, Race, and German Politics between National Unification and Nazism, 1870-1945* (Cambridge, 1993).

[20] In the words of Pakistani political economist Kiren Aziz Chaudhry: 'Each of the four provinces in Pakistan are endowed with unique resources that create very different economic incentive structures as they integrate into international markets and each has a distinctive linguistic and cultural history that provides the terrain for historically "verifiable" claims for secession. All four provinces have dominant political parties that are at odds with each other.' In Kiren A. Chaudhry, 'Dis(re)membering \pä-Ki-ˈstän\', *Informed Comment* (2010) <http://www.juancole.com/2010/04/chaudhry-disremembering-pa-ki-%CB%88stan.html> [accessed 5 September 2015].

[21] Ayesha Jalal and Sugata Bose note that focus on the state has come under fire in recent decades in the historiography of South Asia in an effort to repudiate the 'homogenizing and hegemonizing tendencies of the centralized, colonial and postcolonial nation-states' in the name of 'restoring the subjecthood of subaltern and marginal actors.' Bose and Jalal, *Modern South Asia: History, Culture, Political Economy*, 3rd edn (New York, 2011), pp. 215-7.

frequent failure to meet those expectations. Questioning the validity of the state as a viable construct for analysing the flow of power in society ought not to obscure its importance as a site of discourse, contestation, resistance, and reversal. After all, Pakistan was founded in 1947 and came into being at a time when the welfare state—charged with providing its citizens with not only basic political rights but basic welfare in the form of health, housing, education, etc.—was considered to be the apogee of modern statehood.[22] This same era also witnessed the rise of an international political culture that explicitly embraced science and medicine as a tool of policymaking and as a measure of social progress.[23] Thus, as an independent nation, Pakistan has been deeply impacted by the high level of expectations around the provision of health and health citizenship. In this regard, medical interventions can help make manifest the obligations and operation of state power, even when they signify attempts by a "failing" state to strengthen government authority where it is weak and over populations that challenge the writ of state or the norms of society.

Thus, the focus on the state in this study arises from a recognition of the following facts: that public health can serve as a lens into the structural operation of power in society; that the state is often considered the default vector for political authority over populations residing within its borders, especially in the post-WWII era; and that the modern state has been and continues to be circumscribed by conventions concerning the rights and obligations of health citizenship, conventions which were existence in British India and independent Pakistan over the period under study.

Health and Medicine in South Asia

The history of public health in colonial India has grown remarkably since the original publication of works by Ira Klein, David Arnold, Radhika Ramasubban, Ian Catanach, and Mark Harrison. Subsequent works have sought to shed light on the diverse participants and preoccupations of colonial medicine and to increase our understanding of the disease

[22] Mahbub Ul Haq, *The Strategy of Economic Planning: A Case Study of Pakistan* (Karachi, 1966), p. 35.
[23] Sunil S. Amrith, *Decolonizing International Health: India and Southeast Asia, 1930-65* (Basingstoke, 2006), p. 17.

environment in the subcontinent by tracing disease and demographic trends over time.[24] They explicate the challenges of health in South Asia and how these have affected politics and society in the subcontinent.

The spread of western medicine in South Asia largely accompanied imperial endeavours, and until the late nineteenth century could most consistently be found in the army barracks and East India Company (EIC) outposts, the commercial bazaars, and missionary houses.[25] The extensive loss of European lives due to the ravages of disease in the tropics led to the creation of hospitals in the colonies, where medical treatment was attempted but where medical innovation and research relating to fevers and therapeutic remedies was also beginning to take place.[26] The empirical observations of tropical diseases and environments made by English physicians in military and naval hospitals and ships propelled the development of ideas about physiological adaptability to inhospitable climates as well as theories of disease causation and prevention.[27] This work helped alleviate concerns about the ability of Europeans to adapt to the harsh climates of the territories that came under their purview, and in India it paralleled the growth of the EIC as a territorial power and the expansion of the military medical establishment in British India in the form of the Indian Medical Service (IMS).[28]

The role played by medical missionaries was particularly important in regions not initially served by the state apparatus, such as the North-West Frontier and Baluchistan.[29]

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[24] Anil Kumar, *Medicine and the Raj: British Medical Policy in India, 1835-1911* (New Delhi, 1998); Biswamoy Pati and Mark Harrison, *Health, Medicine, and Empire: Perspectives on Colonial India* (New Delhi, 2001); David Arnold, *Science, Technology and Medicine in Colonial India*, ed. by Gordon Johnson, The New Cambridge History of India (Cambridge, 2000); Sumit Guha, 'Health and Environmental Sanitation in Twentieth Century India', in *Health and Population in South Asia* (London, 2001), pp. 156–66.

[25] Mark Harrison, *Public Health in British India*, p. 7; Pratik Chakrabarti, '"Neither of Meate nor Drinke, but What the Doctor Alloweth": Medicine amidst War and Commerce in Eighteenth-Century Madras', *Bulletin of the History of Medicine*, 80/1 (2006), p. 36; Rosemary Fitzgerald, '"Clinical Christianity": The Emergence of Medical Work as a Missionary Strategy in Colonial India', in *Health, Medicine, and Empire: Perspectives on Colonial India*, ed. by Biswamoy Pati and Mark Harrison (Basingstoke, 2001), pp. 88–136.

[26] Mark Harrison, 'Introduction', in *From Western Medicine to Global Medicine: The Hospital Beyond the West*, ed. by Mark Harrison, Margaret Jones, and Helen M. Sweet (New Delhi, 2009), pp. 1-32.

[27] Mark Harrison, *Medicine in an Age of Commerce and Empire* (Oxford, 2010).

[28] Ibid.

[29] Theodore Leighton Pennell, *Among the Wild Tribes of the Afghan Frontier*, 2nd edn (London, 1909), Project Gutenberg <http://www.gutenberg.org/ebooks/32231> [accessed 9 October 2013]; Henry Holland,

Though missionary medicine 'touched only the fringes of India's vast population,'[30] in the areas it did penetrate, the missionary hospital provided a means of interaction between western medicine and indigenous healing practices and social customs, and it also inspired the creation of rival secular hospitals or became subsumed into state medical institutions.[31] The development of exclusively state-funded hospital-based medical care in India for the indigenous population began formally in 1838 with the decision to provide government funding for dispensaries in Bengal and the North-Western Provinces, though part-funded and state-encouraged hospitals were established for the poor in Calcutta and other cities from around 1800. Samiksha Sehrawat notes that the state's administrative role in establishing these institutions was 'to encourage indigenous philanthropists to contribute to hospital funds, [while] acknowledging no obligation to provide medical care for the Indian population,' reflecting the preoccupation of colonialist utilitarians with improving the civic character of the Indian public.[32] Many of these institutions were established to meet the needs of the economy, as in the tea gardens of Assam and the industrial jute mills of Bengal.[33] Alongside the increasing production and distribution of medicines and the growth of the medical marketplace, these institutions helped propel the increased acceptance of western medicine in Indian society.[34] Demand for western medicine grew extensively over the 19th century with the rising interest in out-patient treatment, which was paralleled by the growth of urban-centric dispensaries.[35] As these developments were taking place, western concepts of medical practice and products were simultaneously being revised and moulded by the Indian context. The earliest vernacular forms of western medicine that composed 'daktari' medicine owed much to Bengali physicians who apprenticed at the new druggist shops

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Frontier Doctor: An Autobiography (London, 1959); David Hardiman, *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam, 2006),

[30] Fitzgerald, "'Clinical Christianity'", p. 131.

[31] David Arnold, review of *From Western Medicine to Global Medicine: The Hospital Beyond the West*, ed. by Mark Harrison, Margaret Jones, and Helen M. Sweet, in *Medical History*, 54/3 (2010), p. 423.

[32] Sehrawat, *Colonial Medical Care in North India: Gender, State, and Society c. 1830–1920* (New Delhi, 2013), pp. xx-xxvi.

[33] Margaret Jones, 'The Indian Government Worker and the Development of Hospital Provision in Nineteenth-Century Ceylon', in *From Western Medicine to Global Medicine: The Hospital Beyond the West*, ed. by Mark Harrison, Margaret Jones, and Helen M. Sweet (New Delhi, 2009), pp. 33–66.

[34] Ibid., p. xxxi; Chakrabarti, '"Neither of Meate nor Drinke, but What the Doctor Alloweth"'.

[35] Harrison, 'Introduction', in *From Western Medicine to Global Medicine*, pp. 1-32.

in Calcutta, studied at the British-founded medical colleges, or trained in Edinburgh and London, and subsequently rendered medical service at various levels in the colonial establishment.[36]

As western medicine and public health in India developed on these precepts, the advent of Crown rule led to a sudden increase in scrutiny into the state of health for Europeans in India. During the Sepoy Mutiny of 1857, ravages of epidemic disease had adversely impacted the fighting efficiency of Company troops. The consensus arrived at by the Commission appointed to look into this matter was that safeguarding the health of troops necessitated intervention into Indian society, with the recognition that '[p]hysical segregation was never total, and military cantonments and their environs were host to a variety of tradesmen, vendors, servants; all of whom were viewed as potential threats to the health of troops.'[37] As a result, legislative and administrative changes were pushed through relating to civilian public health in India at large and were accompanied at the local level by the organisation of sanitary and medical officers modelled on the English medical officers of health.[38] The primary activity of medical personnel who worked in provincial and municipal appointments was upkeep of local sanitation, while at the macro-level, sanitation and public health consisted of overseeing vaccination efforts, advising governments on measures to improve sanitary conditions, and spearheading the collection of vital and meteorological statistics.[39]

Some British officials saw evidence of great interest for preventive medicine amongst Indians but little state action, while others saw only the 'ignorance, apathy and prejudice of the native population' when it came to health and sanitation and bemoaned the fact that whenever innovations were proposed, 'the cry of "religion in danger" was "invariably raised."'[40] The tension between these two opposing views on the cause of insanitary conditions and high mortality in India is aptly illustrated by a heated debate that took place in a 1909 in a Madras

[36] Projit Bihari Mukharji, *Nationalizing the Body: The Market, Print and Healing in Colonial Bengal, 1860-1930* (London, 2009), pp. 35-8.
[37] Harrison, *Public Health in British India*, p. 76.
[38] Ibid., p. 9.
[39] Ibid.
[40] Arnold, *Colonizing the Body*, p. 245.

municipal council chamber between European bureaucrats and Indian political leaders on the issue of sanitation in Madras. An Indian Civil Service (ICS) official asserted, 'It is not the fault of the Health Department if Madras is dirty, it is the fault of the people,' to which he received the response, 'If the people are dirty it's the duty of the Sanitary department to put them right.'[41] Such historical debates were underpinned by important themes relating to responsibility, autonomy, and the relationship between state and subject as well as developing standards of hygiene and modernity.[42] The historiography of colonial medicine has tended to reflect that preoccupation with the question of who bears responsibility for controlling disease and health in a given setting and what constitute appropriate standards of sanitation and hygiene.[43]

Arguably it was the outbreak of plague at the end of the nineteenth century which brought about the first robust and sustained engagement between the colonial medical apparatus and the Indian population. Anti-plague ordinances and measures laid bare 'the desire to sanitate the Indian population, most evident among the military and certain officers of the IMS' which up until then had been 'held in check by financial considerations, logistical difficulties, and by opposition from British humanitarians and Indian elites.'[44] Municipal governments were granted expansive powers to enforce segregation and quarantine of suspected cases, to enter dwellings, and to inspect any ships or passengers, search, disinfect, evacuate or destroy dwellings, prohibit fairs and pilgrimages, and examine and detain travellers.[45] According to Arnold, these measures led to 'the greatest upsurge of public resistance to Western medicine and sanitation that nineteenth-century India had witnessed.'[46]

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[41] Ibid., p. 279.
[42] It is worth noting here the subjectivity inherent in evolving perceptions of 'high' mortality and 'unsanitary' conditions that developed over the nineteenth century. See Partho Datta, 'Ranald Martin's *Medical Topography* (1837): The Emergence of Public Health in Calcutta', in *The Social History of Health and Medicine in Colonial India*, ed. by Biswamoy Pati and Mark Harrison (Oxford, 2008), pp. 15–30.
[43] David Arnold, 'Crisis and Contradiction in India's Public Health', in *The History of Public Health and the Modern State*, ed. by Dorothy Porter (Amsterdam, 1994), pp. 336–8; *Colonizing the Body*, pp. 245-6; Harrison, *Public Health in British India*, p. 167.
[44] Harrison, *Public Health in British India*, p. 97.
[45] Arnold, *Colonizing the Body*, pp. 203-4
[46] Ibid., p. 211.

The plague epidemic also demonstrated the newfound political importance of medical professionals in colonial policymaking, namely the IMS, which was set up to meet the needs of imperial troops and which constituted the backbone of medical policy and practice in India.[47] During peacetime, the IMS consisted of an elite bureaucratic cadre of European medical professionals who practiced in British hospitals and led public health administration and policy-making. From a local perspective however, they were one of a multitude of practitioners, including indigenous practitioners of *Unani*, *Ayurveda* and western biomedicine, to whom the masses turned for individual treatment and the state's public health machinery turned to as needed for support in epidemic control.[48] With all the advances in laboratory medicine and sanitary reform in Europe around the end of the nineteenth century, an increasingly prominent voice of reform within the IMS sought to convince recalcitrant governments at the Centre and in the provinces to bolster public health legislation and expenditure.[49]

Despite these incitements, from the 1880s decisions about where to allocate administrative responsibility for public health were caught between the desire to retain control over the reins of power in India on the one hand and considerations of economy on the other 'We shall not subvert the British Empire by allowing the Bengali Baboo to discuss his own schools and drains,' had once been the refrain of British colonizers in India.[50] But eventually it became expedient to transfer the burden of health expenditure from the provincial coffers to municipal councils and district boards as part of the Ripon reforms in the early 1880s.[51] These reforms also aimed to satisfy a demand among Indians for more political privileges by granting them a greater share in running their affairs through increased participation in local government in the municipalities.[52]

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[47] Arnold, *Colonizing the Body*, p. 209
[48] Arnold, *Colonizing the Body*, p. 12; British Library (BL), IOR/V/27/856/59, Punjab Plague Manual, Lahore 1909, p. 12.
[49] Harrison, p. 139
[50] Sumit Sarkar, *Modern India, 1885-1947*, 2nd edn (Basingstoke, 1989), p. 1
[51] Bose and Jalal, *Modern South Asia*, p. 84.
[52] Ibid.

Public health in India was therefore not simply the product of British attitudes and policies towards Indians—whether benevolent or apathetic—but rather was the by-product of complex interactions between the colony and metropole, provincial and local governments, medical practitioners both trained and "untrained", the Indian public, and the biological conditions of the tropical environment. The numerous advances in our knowledge of the nuances and trajectories of medical practices in colonial India as described above obscure a significant geographical divide. Much of what we know of the history of medicine in colonial India relates largely to areas that became modern-day India, with little focus on the territories that constitute modern-day Pakistan, or what was once West Pakistan.[53] The provinces of modern Pakistan, particularly Sind, Baluchistan, and North-West Frontier Province (NWFP, now known as Khyber-Pakhtunkhwa), once formed the historic periphery of Britain's Indian empire, serving primarily as a militarised buffer protecting the heartland of empire against external enemies.[54] This may account for the particular absence of historical works on these provinces, even though all of them had been demarcated as separate, autonomous provinces of British India by the end of the 19th century.

Furthermore, the rich and varied scope of works on colonial South Asia provides a marked contrast to the paucity of works that trace developments in health in the postcolonial era. This glaring gap has been remedied by some recent publications in the *New Perspectives in South Asian History* monograph series.[55] This topic also receives a brief treatment by Sumit Guha in his book *Health and Population in South Asia from Earliest Times to the Present*, in which he discusses macro-environmental sanitation and trends in morbidity in twentieth-century

[53] West Pakistan consisted of Punjab (split between India and Pakistan), Sind, Baluchistan, NWFP, and parts of Kashmir. Bengal was split between India and Pakistan; the part inherited by Pakistan became East Pakistan and later declared independence as Bangladesh.
[54] Richard G. Fox, *Lions of the Punjab: Culture in the Making* (Berkeley, 1992), p. 6.
[55] See for example Sanjoy Bhattacharya, Mark Harrison and Michael Worboys, *Fractured States: Smallpox, Public Health and Vaccination Policy in British India 1800-1947* (New Delhi, 2005); and Bhattacharya, *Expunging Variola*: *The Control and Eradication of Smallpox in India, 1947-1977* (New Delhi, 2006).

India.[56] David Arnold's article on the nature and representation of science in modern India and Sunil Amrith's paper on the political culture of health in India provide two other notable examples.[57] Most volumes that purport to provide a contiguous history of medicine in India succumb to the temptation of creating binaries between an extractive colonial state and a benevolent postcolonial one, or else analyse public health from the perspective of development studies.[58] There are no histories of medicine of Pakistan.

A sufficiently broad longitudinal study can propel novel insights by providing a comparative framework that demonstrates the impact on health as governments change, social expectations evolve, and medical priorities shift. It can enable further inquiries into how rule by a colonial government historically compared to a military dictatorship or a parliamentary democracy in practical ways (e.g. attitudes towards health), and what difference the style of governance has made when it comes to grappling with the challenges of a tropical disease environment or enforcing public health legislation or changing health attitudes.[59] It can also illuminate the persistence of certain ideas, tropes, and behaviours over time and the origins and aetiologies of particular policies and trends in both politics and health. This becomes especially important when we consider the fact that many prominent medical institutions in Pakistan that are in use today were first established under British rule.

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[56] Guha, 'Health and Environmental Sanitation in Twentieth Century India', in *Health and Population in South Asia* (London, 2001), p. 166.

[57] Arnold, 'Nehruvian Science and Postcolonial India', *Isis*, 104/2 (2013), pp. 360–70; Amrith, 'Political Culture of Health in India: A Historical Perspective', *Economic and Political Weekly*, 42/2 (2007), pp. 114–21. For an interesting example set outside of the Indian context that traverses the colonial/postcolonial binary, see Christophe Bonneuil, 'Development as Experiment: Science and State Building in Late Colonial and Postcolonial Africa, 1930-1970', *Osiris*, 15 (2000), pp. 258–81.

[58] Amiya Kumar Bagchi, Krishna Soman, *Maladies, Preventives, and Curatives: Debates in Public Health in India* (New Delhi, 2006); Susan E. Chaplin, *The Politics of Sanitation in India: Cities, Services and the State*, (New Delhi, 2011).

[59] Such comparative studies have been more common in the field of political economy, featuring prominently in works by Daren Acemoğlu, Simon Johnson and James Robinson, especially 'The Colonial Origins of Comparative Development: An Empirical Investigation', *American Economic Review*, 91/5 (2001), pp. 1369–1401; and Acemoğlu and Johnson, *Why Nations Fail: The Origins of Power, Prosperity, and Poverty* (New York, 2012). In the history of medicine, the publication of William H. McNeill's *Plagues and Peoples* in 1976 inaugurated a similar but converse trend as it drew attention to the long-term historical impact of disease on the development of different political and social institutions and on the outcomes of wars and revolutions. See also J. R. McNeill, *Mosquito Empires: Ecology and War in the Greater Caribbean, 1620-1914* (New York, 2010).

Thus, while much progress has been made in the history of medicine of South Asia, there remains a significant lacuna in the literature on the evolution of public health in this region. The lack of contiguous histories of medicine across the pre- and postcolonial periods makes it difficult to ascertain the impact of developments in colonial medicine on the character of modern statehood and contemporary medical practice and public health intervention.

Historiography of Governance in Pakistan

Though the tropes of 'Allah', 'army', and 'America' loom large in academic and lay scholarship on Pakistan, there is a growing body of work reflecting interest in diverse and interesting subjects such as the vitality of sub-nationalisms, the evolution of literary and bureaucratic cultures, and the ethnic and linguistic dimensions of well-known politico-social processes in the country like militarism and urbanisation, among other interesting topics.[60] Nevertheless, the focus on the nation as a problem to be solved and the preoccupation with the state as an entity perpetually in danger of failing continues to be disproportionately represented in historical and political studies on Pakistan.[61] In defence of this circumstance, it is worth noting that the preponderance of these themes reflects the nature of public discourse.[62] And as implied earlier, it is impractical to dispense with the framework of the nation-state insofar as this

[60] See for example: Theodore P Wright, 'Center-Periphery Relations and Ethnic Conflict in Pakistan: Sindhis, Muhajirs, and Punjabis', *Comparative Politics*, 23/3 (1991), pp. 299–312; Kiren Aziz Chaudhry and Peter McDonough, 'State, Society, and Sin: The Political Beliefs of University Students in Pakistan', *Economic Development and Cultural Change*, 32/1 (1983), pp. 11–44.; Alyssa Ayres, *Speaking Like a State: Language and Nationalism in Pakistan* (Cambridge, 2009); and Naveeda Khan, *Beyond Crisis: Re-Evaluating Pakistan* (Abingdon, 2012).

[61] Philip Oldenburg, '"A Place Insufficiently Imagined": Language, Belief, and the Pakistan Crisis of 1971', *The Journal of Asian Studies*, 44/4 (1985), pp. 711–33; Elisabeth Leake, review of *The Struggle for Pakistan: A Muslim Homeland and Global Politics*, by Ayesha Jalal, in *Canadian Journal of History*, 50/1 (2015), pp. 196–97.

[62] Referring to the lack of adequate heating, hot water or electricity in his Lahore office during the cold winter of 2015, prominent Pakistani writer and journalist Ahmed Rashid wrote, 'A country without energy is a country in the process of dissolution, facing the same fate as Syria or Somalia. While the suffering hasn't yet reached these proportions, the words "failed" or "failing state" now trip regularly off the tongue and pen of every journalist.' See Ahmed Rashid, 'Pakistan's Slide into "Failed State" Status', *The Exchange*, Financial Times (11 Feb 2015) http://blogs.ft.com/the-exchange/2015/02/11/pakistans-slide-into-failed-state-status/.

construct has played a decisive role in shaping regional, linguistic, caste, class and religious perspectives in the postcolonial period.[63]

Traditional histories of Pakistan have produced much-needed information about the formal process of independence and the history of the Pakistani state and the various individuals and parties that have led it.[64] But while such works are essential to understanding the mechanics of how the state came into being, there are also shortcomings inherent to them. As Ranajit Guha—one of the foremost figures in the subaltern studies movement—stated with respect to Indian nationalist historiography in the 1980s, such studies 'equate politics with the aggregation of activities and ideas of those who were directly involved in operating these institutions, that is, the colonial rulers and their *élèves*—the dominant groups in native society'.[65] This is evident in the perspective on governance we see presented by political scientist and former High Commissioner of Pakistan Maleeha Lodhi in her highly praised volume *Pakistan: Beyond the Crisis State,* wherein she writes of the multiple historical governance challenges faced by Pakistan and concludes that resolution of these problems depends on 'whether Pakistan's political and governance structures—and the quality of leadership—are capable of addressing and surmounting the gravest challenges ever faced.'[66] Such works imply that it is the formal leadership of the state that alone has bearing on the process of governance, and therefore a resumption in the one-sided state-society dynamic is needed before proper functioning of society can resume and social ills can be corrected by the state. Another shortcoming of such histories is that because of the troubling political and security dilemmas the country has recently faced, there has been of late a prevailing assumption that the primary purpose of studying the history of Pakistan ought to be to understand how the state became mired in the various internal and

[63] Ayesha Jalal, *Democracy and Authoritarianism in South Asia: A Comparative and Historical Perspective* (Cambridge, 1995).
[64] One slight exception is Ian Talbot's *Pakistan: A New History* which provides a more social history-oriented approach.
[65] Guha, 'On Some Aspects of the Historiography of Colonial India', in *Selected Subaltern Studies*, ed. by Ranajit Guha and Gayatri Spivak (New York, 1988), pp. 39-40.
[66] Lodhi, 'Introduction,' in (ed.), *Pakistan: Beyond the Crisis State*, (London, 2011), pp. 1-6.

external conflicts that have dogged its history and plague its present, and its relevance to Western security concerns in Asia and the Middle East.[67]

In spite of these problematic trends, the study of historical and contemporary governance in Pakistan has been enriched in recent years by approaches from anthropology, political economy, and literature which provide nuanced and locally-rooted perspectives on the operation of state and society in a country popularly perceived to be lurching from crisis to crisis. The publication of Matthew Hull's *Government of Paper* in 2012 insightfully laid bare the importance of written documents and petitions to Pakistanis as markers of participation in a state that historically used language and literacy as a means of exclusion.[68] His book demonstrates that the state is far more diffuse and is entangled in the daily functioning of Pakistani society in manifold ways which lie outside the purview of high politics. Markus Daechsel has written extensively on the international and domestic representation of state power by writing histories of urban development during the 1960s under the leadership of Pakistan's first military ruler.[69] Matthew Nelson has probed the interplay between the landscape and content of Islamic education in Pakistan, consumer demands in the education sector, and efforts to teach principles of democratic citizenship in a country increasingly prone to sectarian violence.[70] These more recent analyses have chosen to focus on the practical impact of governance—in matters ranging from education and urban planning to labour rights and gender issues[71]—and thus provide a welcome additional perspective to the study of governance in Pakistan which has traditionally

[67] Stephen P. Cohen, *The Idea of Pakistan* (Washington, DC, 2004).; Jaffrelot, *A History of Pakistan and its Origins*; Husain Haqqani, *Pakistan: Between Mosque and Military* (Washington, DC, 2005).
[68] *Government of Paper: The Materiality of Bureaucracy in Urban Pakistan*, (Berkeley, 2012).
[69] *Islamabad and the Politics of International Development in Pakistan* (Cambridge, 2015); 'Sovereignty, Governmentality and Development in Ayub's Pakistan: The Case of Korangi Township', *Modern Asian Studies*, 45/01 (2011), pp. 131–57
[70] 'Dealing with Difference: Religious Education and the Challenge of Democracy in Pakistan', *Modern Asian Studies*, 43/03 (2008), pp. 591–618.
[71] On studies of labour movements in Pakistan, see Kamran Asdar Ali, 'Strength of the State Meets the Strength of the Street: The 1972 Labor Struggle in Karachi', *International Journal of Middle East Studies*, 37/1 (2005), pp. 83–107; on gender in Pakistan, see Saadia Toor, 'The Political Economy of Moral Regulation in Pakistan: Religion, Gender and Class in a Postcolonial Context', in *Routledge Handbook of Gender in South Asia*, ed. by Leela Fernandes (Abingdon, 2014), pp. 129–42.

focused on elucidating the role and status of political elites in the creation and running of the state.[72]

Nevertheless, there remains a resonant tone in scholarship on the political history of Pakistan that can be summed up by the theme of 'crisis' and the imminent failure of the state. The question of whether Pakistan can survive is not a new one—it was raised at the time of the country's founding,[73] has been resurrected at various junctures in history,[74] and is a mainstay of contemporary writings about Pakistan.[75] As David Gilmartin notes, '[T]he theme of crisis threatens to overwhelm, and in the process trivialise, the study of Pakistan,' relying as it does on the tropes of Pakistan as 'a "failed state", a "failed nationalism", or a "failed sovereignty".'[76]

Many insightful studies have honed in on the theme of 'crisis' to explore the meanings of contemporary Pakistani nationhood and citizenship.[77] However, in the words of Gilmartin, 'it is on understanding how tensions themselves not only disrupt, but also sustain social life that we should focus our attention.'[78] There is an interesting parallel here with the study of epidemics in the history of medicine. In their edited volume *Epidemics and Ideas*, Paul Slack and Terence Ranger explore the ways in which epidemics have historically created moments of tension/crisis that expose the seams that constitute the fabric of society—its ideologies, mores and norms— at the very moment that this new stressor challenges the viability and adaptability of those pre-existing structures.[79] This paradigm can be highly instructive in attempting to write a history of Pakistan while being mindful of the various 'crises' in its lifetime. By applying the framework

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[72] Ayesha Jalal, *The Sole Spokesman: Jinnah, the Muslim League and the Demand for Pakistan* (Cambridge, 1994); *The Struggle for Pakistan: A Muslim Homeland and Global Politics*, (Cambridge, 2014); Bose and Jalal, *Modern South Asia*; Christophe Jaffrelot, *A History of Pakistan and Its Origins* (London, 2004).
[73] Herbert L. Matthews, 'Pakistan Key to Indian Question: Creation of Divided Moslim State Seems Sure', *New York Times*, 25 May 1947, E4, ProQuest Historical Newspapers <http://search.proquest.com.ezp-prod1.hul.harvard.edu/docview/107949350> [accessed 4 July 2013].
[74] Rounaq Jahan, *Pakistan: Failure in National Integration*, (New York, 1972); Tariq Ali, *Can Pakistan Survive? The Death of a State*, (New York, 1983).
[75] William Dalrymple, 'Will Pakistan Survive?', *Outlook India* (30 August 2007) <http://www.outlookindia.com/website/story/will-pakistan-survive/235431> [accessed 4 July 2015].
[76] Gilmartin, 'Living the Tensions of the State, the Nation and Everyday Life,' in Naveeda Khan (ed.), *Beyond Crisis: Re-Evaluating Pakistan*, (New Delhi, 2010), p. 521.
[77] Khan, *Beyond Crisis*.
[78] Gilmartin, p. 530; p. 521.
[79] *Epidemics and Ideas: Essays on the Historical Perception of Pestilence* (Cambridge, 1995).

derived from the study of epidemics, we can move beyond a simplistic view that sees governance and social life as being paralysed by crisis and look instead at the way a society or its members thrust into these particular circumstances operate. In sum, we must pay attention to the progress of political, economic and social life because of or in spite of crises, such as conditions of war on the north-western frontier or the eruption of violence during Partition or the implementation of military rule, rather than becoming consumed with the crisis itself.

Towards a History of Medicine of Pakistan

The narrative of political instability as prevalent in the historiography of Pakistan thus makes the state *absent* from social life because of its preoccupation with elite history and its focus on crises. Recent studies of governance as cited above signal a move away from these trends. In this context, it is my contention that the study of the governance in Pakistan can be further enriched by an approach from the history of medicine. We find remarkably nuanced treatment of the state, or more precisely, governmentality, in the discipline of history of medicine. With respect to the South Asian context, Amna Khalid has investigated the role of indigenous subordinate officials in the public health sphere in colonial India and has discussed how the enforcement of sanitary regulations at pilgrimages and fairs by local police demonstrated at once the reach of the state into the intimate matters of bodily and spiritual health as well as the ways in which state power became diffuse and used for personal ends by individuals associated with the state.[80] Kabita Ray's study of the problem of food adulteration in Bengal demonstrated the Bengal Presidency's inability to muster the necessary legal force to prevent this pernicious practice while also acknowledging the role played by traders, whose economic interest compelled them to indulge in the practice, and corrupt practices amongst some food and sanitary inspectors, whose imperfect sense of duty enabled food adulteration.[81] Guy Attewell has discussed state patronage of *Unani tibb* education in the early twentieth century,

[80] '"Subordinate" Negotiations: Indigenous Staff, the Colonial State and Public Health', in *The Social History of Health and Medicine in Colonial India*, ed. by Biswamoy Pati and Mark Harrison (Oxford, 2008), pp. 45–73.
[81] *Food for Thought: Food Adulteration in Bengal, 1836-1947* (Calcutta, 2007).

and the desire amongst proponents and educators of *Unani* to use political capital to boost the standing of their profession.[82] These are just a few illustrative examples of how the theme of governance has featured in this discipline.

We can thus turn to the history of public health as one lens through which to survey the history of the Pakistani state in relation to the customs and needs of society over time. Political histories of Pakistan have been preoccupied with the form of governance rather than its substance. Meanwhile, one of the most essential operations of modern statehood—namely the ensuring of health—has been left absent from these histories despite the fact that the modern state has been charged with the custody of human life and health within its borders.[83] While this alone constitutes a powerful motive for undertaking a study of history of public health in Pakistan, a history of medicine approach can also help provide a more socially-oriented perspective on the operation of state power. Another advantage of approaching a history of the state through the lens of public health is that in the absence of documentary evidence of non-elite mentalities in traditional sources, this approach enables us to give recognition to the participation of lay Indians and Pakistanis in the creation and implementation of medical and health practices by utilising statistics of hospitals and dispensaries, reports of medical interventions, and anecdotes contained within memoirs of physicians and researchers involved in health work and policy.

In the first section of this dissertation, I analyse medical interventions and public health developments in the late colonial period. Moving from the tribal areas at the westernmost edge of the British Indian empire to the heartland of Punjab and then east to Bengal, I seek to characterise relations between the colonial government and Indian aspirants to power in these regions from the turn of the century to the eve of independence as reflected in their concerns about the health and sanitary state of their constituents. In each area, the British government was consistently hindered from implementing public health reforms because of strategic considerations arising from the growth of nationalism in India. Needing to make concessions to

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[82] *Refiguring Unani Tibb: Plural Healing in Late Colonial India* (New Delhi, 2007).
[83] Porter, 'The History of Public Health'; Amrith, 'Political Culture of Health in India'.

Indian demands for self-governance as well as having to be sensitive to international and domestic criticisms of its performance towards the public welfare of its colonial subjects, the British Government and its public health bureaucrats often found themselves retreating from ambitious plans to increase health expenditure in the tribal areas, to empower public health legislation in Bengal, or to bolster sanitary improvements in the villages of Punjab. At the same time, they and their subjects engaged in a contentious discourse regarding the rights and responsibilities of government as well as who was fit to discharge these.

In the second part, I focus on the trajectory of independent Pakistan and demonstrate the persistent, debilitating impact of Partition and acute shortages of food, materials, and manpower on the country's development. I show that the refugee crisis raised questions about the acceptable limits of citizenship. The unbearable burden of providing for millions of unexpected migrants prompted a political and social backlash against these newcomers, their indigence, homelessness, and contribution to insanitary conditions in the country's capital. To make matters worse, independent Pakistan was crippled by acute shortages of resources and near-famine conditions in its first decade, which only worsened pre-existing social cleavages inherited from the colonial era between different geographical groups and provincial governments.

The history of colonial engagement and the critical resource shortages prevailing immediately after independence forced the country to adopt the mantle of an under-developed state on the world stage for its financial survival. The promises of health and welfare prevailing in the post-WWII era of welfare states further pressured the country's leadership to outsource social welfare work to international actors in return for fulfilling foreign nations' strategic objectives in the region and submitting to the health priorities of international health organisations. This partnership relied not only on the legacy of colonial research into tropical diseases but also on a new discourse that played on western fears of the spread of communism and the perceived political threat from populations suffering from disease, hunger, and a high birth rate.

Failures of governance ultimately precipitated the takeover of power by the Pakistan Army, while decisions made up to this point placed the country in a web of international strategic

imperatives that would determine not only the priorities of government but the priorities of public health. The last part of this thesis will analyse developments in health under the dictatorship of Field Marshal Mohammad Ayub Khan, a period which saw the implementation of intensive state-driven programs for economic growth and modernisation, with foreign aid and expertise playing a significant role in the definition of public health priorities and medical interventions in Pakistani society. This period saw the peak of the internationalisation of the relationship between government and citizen as intimate matters—reproduction, nutrition, employment, and health attitudes—came to be dictated by international development priorities.

With regards to source material, this study has utilised documents from the British Library India Office, the National Archives, and the Bodleian Library in the UK. Material on the post-Partition era was collected from the National Documentation Centre and National Archives in Islamabad, Pakistan as well as in the USA from the Rockefeller Archives in New York. The largest corpus of documents used is government publications. Annual reports of the Public Health Commissioner or the Director-General of Health provide an overview of major projects in healthcare that were undertaken, while proceedings and memoranda provide some detail and insight into the developments of these reports and policies behind the scenes as well as the personal views of individuals who were involved. Institutional archives, such as those of the Population Council in the US, are full of personal correspondences that enable a more grassroots perspective on the history of family planning and population control in a country like Pakistan and provide insight on the petty rivalries and bureaucratic hurdles that have historically had as much impact on governance and public health as have the availability of funds and the development of technologies. Memoirs and diaries of physicians, researchers, and local officers have provided rich insight into the lives and habits of lay Indians and Pakistanis as these writers perceived them. Newspaper reports have been utilised to a small extent to reflect public debates and controversies around certain issues, such as the refugee crisis in the 1950s and the government family planning program in the 1960s. Due to limitations of time and fluency, only English language newspapers have been used.

The limitations of this source material can be said to lie in the fact that it reflects largely the views of the political and literate elite within India and Pakistan. For example, we cannot take into account, due to concerns of space, much of the debates happening in Whitehall during the colonial period which had an impact on the implementation of ideologies of rule in the colonial territories. For the independence period, there is a gap in source material from the provinces because of either the absence of archival records in the provinces or the immense logistical difficulty in accessing them. Nevertheless, this thesis is the first survey on this topic and seeks to shed light on some of the more salient and important themes in the medical history of Pakistan. It provides a starting point for further research into specific issues within health as well as local and regional perspectives on the political economy of health in the country.

Conclusion

The study of public health and welfare policies and the manner in which they are articulated and implemented provides a more nuanced perspective on the motives and modes of governance employed by those who hold political power and the relationship policymakers have with those subjects/citizens whom these policies are designed in view of. These policies—how they are envisioned, funded, developed, distributed, and received, etc.—can be a powerful heuristic tool enabling us to maintain a consistent perspective of state imperatives and processes across a series of different political systems (such as have been instituted throughout the history of Pakistan). As Asad Sayeed has written about the challenges of studying political economy in Pakistan,

> [P]olitical phenomena are explained by dichotomies of democracy vs. dictatorship, centralization vs. decentralization, etc.—usually the pattern is that the success of one is pitted against the failure of the other and the way forward is generally shown within this restricted choice set...Methodologically, it is necessary, however, to explain the social processes and more importantly the distributional struggles that underpinned policy failures or changes in formal political arrangements.[84]

This thesis seeks to do just that by avoiding a solitary focus on the running of the state to a broader view of medicine and health and the intersection of state and society within that space.

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[84] 'State-Society Conjectures and Disjunctures: Pakistan's Manufacturing Performance', in *The Postcolonial State and Social Transformation in India and Pakistan*, ed. by S.M. Naseem and Khalid Naqvi (Karachi, 2002), p. 204.

By wedding the history of governance in the Pakistan territories to developments in public health, I seek to interrogate the relationship between the two in order to arrive at a greater understanding of both and thereby remedy a significant gap in historical studies of Pakistan and contemporary studies of governance as well as in the literature on health and medicine in South Asia.

Chapter 2: Frontier

> [T]o the man in the streets of London the words 'North-West Frontier' meant little more than rushing newspaper boys screaming sensational catchwords about terrible murders of British officers, the abduction of British ladies, and other alarms and excursions in the wild mountain, somewhere in the top left-hand corner of the map of India, where for some reason or other there always seemed to be trouble.
>
> (Reginald J.H. Cox, *Signpost on the Frontier*)

In 1900, as a severe famine raged across India, a group of prominent Indian and European officials gathered in Calcutta to raise funds for famine relief. Her Majesty's representative in India, the Viceroy Lord Elgin was invited to speak, and while appealing to the benevolent impulses of the distinguished guests assembled, His Excellency made the following remarks about imperial responsibility: 'We are not asking you to relieve Government of its due burden, or to save us from one penny of expenditure that ought properly to fall upon our shoulders. Whatever you give us will make no difference in the extent or character of our outlay. That is fixed for us by the high conception that we entertain of our public duty.'[85]

Calcutta, where this speech about the vast scope of government responsibility was given, happened to be the provincial capital of Bengal, a province that by this point had been under British rule for nearly 150 years. The following year, Elgin's successor Lord Curzon made another speech to another distinguished official gathering, this time in the capital of British India's newest constituent province, the North-West Frontier Province. Among the Viceroy's guests were the chiefs of tribes from the westernmost mountainous districts of the frontier; these tribes lived outside the borders of the newly constituted province but within the formal borders of Britain's Indian Empire. While articulating the aims of British rule in the frontier region, Curzon turned to these men in the course of his speech and candidly noted, 'The policy of the Government of India towards the trans-border men is very simple and it is this. We have no wish to seize your territory or interfere with your independence…You are the keepers of your own house.'[86]

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[85] BL, IOR/V/27/830/26, Report of the Central Executive Committee, Indian Famine Charitable Relief Fund, 1900.
[86] BL, Mss Eur F111/528, Minute of 27 Aug 1900.

The contrast between the two statements is strong enough to motivate what on the surface seems like a redundant question: Did the British ever control the north-western frontier? Curzon's remarks to the Peshawar *durbar* were remarkably conservative in their expression of the government's duty to regulate the lives of a population formally brought under its sphere of control by 1893. Were the frontier tribes ever conceived of as subjects of the British to the extent that the Government of India (GOI) had good reason to perceive and act upon a 'due burden' with regards to their welfare?

While much attention has historically been paid to unravelling the notoriously opaque policies responsible for the political and military intrigue for which the western mountainous territories of the subcontinent have long been infamous, we can better illustrate Government's material relationship with the people of this region through a survey of medical interventions attempted here. The history of medicine of the north-western frontier will serve as the opening case study of this thesis, helping to characterise the nature of governance in the border territories under British rule and the conception of imperial responsibility and control *vis à vis* imperial subjects, while also demonstrating the use local populations had for western medicine. To achieve these aims, this chapter will begin with a brief history of the political evolution of the frontier, culminating in its formal incorporation into Britain's Indian Empire. Then, the chapter will move to a survey of the medical landscape in this region, identifying the stakeholders—public health bureaucrats, missionaries, political officers, and local tribes—and the available facilities and technologies of British medicine. In this way, I will broadly delineate British political imperatives in the region as well as the GOI's public health capacities. I will then characterise British governance of the transborder tribes as demonstrated by their policies towards the tribal welfare, taking into account the GOI's political and public health capacity to intervene in the lives of the tribes.

Political History of the North-Western Frontier

The original north-western frontier of India consisted of six districts immediately bordering the Indus to the west, which came into British possession with the annexation of the Punjab after the military defeat of the Sikh Empire in 1849. During the lieutenant-governorship

of the famed Punjab administrator and later Viceroy Sir John Lawrence, a group of military officers-cum-civil administrators who came to be known as John Lawrence's Young Men were sent to the hostile territory bordering these settled districts and charged with establishing British influence there. These men were called the Politicals—military officers responsible for maintaining a loose form of administration based on personal influence with the *jirgas,* or councils, of the various tribes in order to ensure that 'their divided loyalties remained—for the most part—pro-Raj rather than pro-Afghanistan.'[87]

Until 1900, interference in the lives of the tribes could not be too strongly condemned by the British Government as it operated in the shadow of a vaguely hostile neighbouring empire and thus faced the spectre of Russo-Afghan intrigues in Central Asia. Sir Robert Montgomery, one-time Lt. Governor of Punjab, explicated in a memorandum in 1877, 'If there be one principle more than another, to which all politicals of practical experience subscribe their unanimous consent, it is the necessity for avoiding anything like arousing the suspicions or hostilities of our independent neighbours.'[88] His position presented one extreme of opinion, which favoured non-interference; at the other end of the spectrum were former frontier hands like Sir Bartle Frere who advocated extending British dominion over these troublesome borderlands. Having supported the extension of administration on the Sind frontier in the 1850s as Commissioner of Sind, Frere argued,

> The principles laid down for the dealings of our frontier officers in the Punjab with the tribes over the border were, as I have been variously told by such officers, 'absolute non-interference,' and 'masterly inactivity'…I never yet met a good Punjab frontier officer who seemed to me quite satisfied with the principles on which he had been acting.[89]

Nevertheless, in 1877 the Secretary of State for India wrote in judgment to the GOI, 'A policy of conquest on your north-western frontier would lead to no advantage which would in any degree countervail the certain financial and political embarrassment it would cause.'[90]

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[87] Charles Allen, *Soldiers Sahibs* (New York, 2001), p. 6.
[88] BL, IOR/L/PS/18/A124, Memorandum by Sir R. Montgomery.
[89] BL, IOR/L/PARL/2/91, No. 6, Memorandum by Sir Bartle Frere.
[90] Ibid., No. 18, Sec of State for India to Governor-General of India, 29 Nov 1877.

The tribes over the border, technically considered independent, were thus delayed from formal, meaningful political integration until the end of the century, despite still being intermittently subject to British military operations. In 1893, the Durand Line—the border between British India and Afghanistan—was demarcated, clearly marking out the spheres of respective custody and territorial control between the two empires. The nodes of British influence in tribal territory were formally the unadministered agencies; from north to south these were the Malakand (composed of the native states of Chitral, Dir, and Swat) and then the Bajaur, Mohmand, Khyber, Orakzai, Kurram, North Waziristan, and South Waziristan Agencies.

Soon after, in 1897, a series of uprisings provided justification and opportunity for those in favour of greater control over the frontier tribes to push through a plan to finally bring the administration of the entire north-western frontier up to the border under the sole purview of the central government. Spearheading this was the new Viceroy, Lord Curzon. He argued that the matter of conducting political relations with the frontier tribes was becoming far too sensitive to be mediated by a provincial government, i.e. the Government of the Punjab. But first he had to make the idea of direct control palatable to the decidedly conservative India Office which had rejected earlier proposals of a similar nature. The greatest fear of the India Office was the potential violent fallout of attempting to enforce their rule over a volatile region; the second greatest fear was of financial insolvency.[91]

Curzon's genius lay in acknowledging these impediments and arguing in response that direct central government control was the only means to prevent a costly uprising. The Viceroy argued that Politicals be given greater powers to conduct affairs 'on the spot' and that the GOI promote the enlistment of local tribesmen in militias in the service of the British to police the border regions.[92] This hands-off policy would remove the prospect of foreign administration or occupation on the frontier, thus saving both publicity costs and financial outlays that would otherwise result from having extensive British troop presence on the ground. But this policy ironically engendered much greater interference in tribal life than formal government. It also

[91] BL, MF IOR 465, A146-A194, No. 133, Foreign Dept, GOI to Sec of State for India, 13 Sep 1900.
[92] Ibid., Minute by the Viceroy on Frontier Administration, 27 Aug 1900.

blurred the line between imperial aggression and imperial defence—was the military presence a means to conquer and police independent territory or to protect the neighbouring settled districts? The answer, unsurprisingly, is much more insidious and complex. We can see as much in Curzon's stated rationale for locally recruited militias: 'We take into our pay, and thereby acquire a hold upon the allegiance of the tribesmen, who, while their local patriotism is conciliated by employment as the guardians of their native hills and vales, develop, at the same time, under the influence of a quasi-military discipline, an ever-increasing loyalty to the British raj.'[93]

This seductive policy of depending on local militias to uphold British influence in the region came crashing down in 1919 during the Third Anglo-Afghan War. In the midst of ongoing hostilities between Britain and Afghanistan, tribal *lashkars* in British territory rose up in support of Afghanistan. In his comprehensive study of British military and political involvement in the north-western frontier, Christian Tripodi notes that the ease with which tribal opinion had turned prompted serious reconsideration of the idea that personal government by the Politicals had been enough to win the goodwill of the tribes.[94] More than that, a serious breakdown of the tribal militia system was an especially hard pill to swallow considering the attractiveness of the existing arrangement on financial, political, and publicity grounds. The immediate result was the implementation of a policy long denied by the British government. Beginning in 1921, the India Office and GOI approved the continuous occupation by British forces of Waziristan, the most restive area on the frontier, with the legal backing of a treaty signed with Afghanistan in November 1921. The treaty's description of Britain's policy towards the tribes was ambiguous: '[T]he British Government entertains feelings of good will toward all the frontier tribes and has every intention of treating them generously, provided they abstain from outrages against the inhabitants of India.'[95]

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[93] BL, MSS Eur F111/528, Minute by Lord Curzon, 19 June 1899.
[94] Tripodi, *Edge of Empire: The British Political Officer and Tribal Administration on the North-West Frontier 1877-1947* (Surrey, 2011), p. 132.
[95] Extract from Anglo-Afghan Treaty of 1921, quoted in Sir Olaf Caroe, *The Pathans, 550 B.C-A.D. 1957* (London, 1958), p. 465.

Just a few years earlier, Chief Commissioner of the NWFP, George Roos-Keppel had written to then-Viceroy Chelmsford in 1916 advocating military occupation and road-building instead of the predominant policy of disregard punctuated by periodic punitive expeditions. To bolster his position, he had quoted Bartle Frere's appeal to Prime Minister Gladstone regarding Britain's responsibilities towards the frontier tribes:

> The true causes…of the Afghan War, are neglect of neighbourly duties and responsibilities incumbent on a rich, civilised and powerful nation towards poor barbarous tribes on its borders. We have allowed a noble people, capable of rapid and permanent advancement in civilisation, to grow in numbers, whilst they festered in barbarism, till they became a serious danger to us.[96]

The military authorities, who had long advocated aggressive and direct assertion of control over the frontier, saw the outbreak of violence in Waziristan in 1919 as providing the perfect *casus belli* for occupation and eventual implementation of civil administration on the lines advocated for by officials like Frere and Roos-Keppel.[97] This came to be known as the Razmak policy.[98] Simultaneously, a serious policy of road-building was undertaken to facilitate the movement of troops throughout the region. This served as a symbol of the GOI's penetration of the area and its concerted effort to finally bring government, if not necessarily governance, to the tribal areas. By the late 1920s, the North West Frontier drew around a fifth of the British Army's entire strength in India.[99] These developments lent truth to Viceroy Curzon's initial prediction regarding the eventual fate of the frontier, wherein he had stated,

> [T]he establishment of control over its people or even of friendly relations with them may be rapid or slow, complete, imperfect or illusory. But the territory so demarcated has ceased to belong to any other political system and has fallen within the Protectorate of a Power, which, while it may not be anxious to assume, cannot in the last resort repudiate, its paramount responsibility.[100]

Frontier Public Health

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[96] BL, Mss Eur D613, Letter to Viceroy 13 Mar 1916.
[97] BL, Mss Eur F111/528, Proposal to bring the Shia clans in the Orakzai country under British protection. In 1904, in a session of the Members of Viceroy's Council presided over by Curzon, the military forces representatives strongly argued for annexation but were unanimously outvoted by the civil members.
[98] BL, IOR/L/MIL/716930, No. 12596-M.O.-1, Rawlinson, Commander-in-Chief to Sec to the GOI, Army Department, 24 May 1922.
[99] Brian Robson, *Crisis on the Frontier: The Third Afghan War and the Campaign in Waziristan 1919-1920* (Staplehurst, 2005), p. 241.
[100] BL, MF IOR 465, A146-A194, Minute by the Viceroy on Frontier Administration.

Medicine provides a unique perspective on state-subject interaction on the frontier. If we begin by concentrating on official perspectives on progress in health, then a survey of medical reports provides a great deal of information on the disease environment and the healthcare infrastructure, but it is important at the outset to be aware of the peculiarity of the tribal areas in this respect.[101] They were never formally annexed and therefore did not have a formal administrative apparatus. Nevertheless, in the day-to-day governance of the NWFP, the actual fluidity between the artificially divided settled and 'unsettled districts' was fully recognised and observed, so long as the GOI had responsibility for governing both the province and the land beyond. One might even say that a chief preoccupation of the Central Government-appointed administrators of this province was measuring the influence of their settled districts upon the neighbouring trans-frontier population. In line with this, after the NWFP was created in 1901, supervision of hospitals in the political agencies—the administrative divisions of the trans-frontier tracts—was transferred from the Political Agents (or Politicals) in the agencies to the Medical Officer of the NWFP to enable extension and coordination of medical work across the provincial border.[102] Statistics for the transborder hospitals began to be tabulated, with the express purpose of calculating the degree to which tribesmen were subscribing to European medical institutions and medical practices.[103] The Chief Commissioners' reviews of the hospital and dispensaries reports would repeatedly draw attention to or remark upon the trends and statistics for trans-frontier men, women and children being brought to British institutions.

The primary medical interaction on the frontier between British medical men and the Pathan tribes was through out-patient treatment.[104] The relative appeal of dispensaries in view of the particular problems of the frontier had been first recognised by missionaries, for whom the

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[101] North-West Frontier Province Medical Department, *Reports of the Hospitals and Dispensaries in the North-West Frontier Province, 1901-1945* (Peshawar, 1903-46) [henceforth, *NWFP Hospitals and Dispensaries Report*]; North-West Frontier Province Public Health Department, *Public Health and Vaccination Reports of the North-West Frontier Province, 1922-45* (Peshawar, 1923-46) [henceforth, *NWFP Public Health Report*].
[102] *NWFP Hospitals and Dispensaries Report, 1902.*
[103] ibid.
[104] *NWFP Hospitals and Dispensaries Report, 1914.*

western frontier of India held the same strategic import as it did for the British government. Duncan Dixey, who gained experience with frontier medicine in Henry Holland's missionary clinic in Baluchistan, honed in on the nomadic habits of frontier tribes along with the small density of population characteristic of these tracts; this led him to deduce the utility of having small dispensaries located in various centres through which populations passed on a seasonal basis and to which patients from outlying districts could be sent if needed.[105] For one of his dispensaries Dixey selected the winter headquarters of the local native state, and this district medical centre began to draw people in increasing numbers for treatment. From there, patients suffering from more severe conditions or needing major surgery could be sent to base hospitals in Quetta, the provincial capital of Baluchistan.[106] Holland described Dixey's work thus,

> Dixey hung on patiently, knowing that the people could be reached by no other means than the ministry of healing; that the only evangelistic work possible in this Muslim State would be within the four walls of the dispensaries. Once the dispensaries were established…this district medical work began to draw the people.[107]

Significantly, this attitude was also echoed by government officials. In 1907, the Secretary to the Chief Commissioner wrote, 'The Chief Commissioner notes with approval the increasing tendency to apply to Government Hospitals and Dispensaries in the case of the outlying Frontier Agencies, where the enormous majority of the patients belong to trans-border tribes.'[108] The medical officer for the province wrote in 1933, '[I]ncrease in the number of transborder patients is a healthy sign, indicating as it does the possibility of Hospitals playing a material part as civilizing agencies among the transborder tribes.'[109] Though these official comments were measured in tone, they paralleled the evangelising sentiment expressed by Dr. Theodore Pennell, another missionary physician, who was quoted as saying, 'There is one door which only the doctor can unlock, and that is the door of the Frontiersman's heart.'[110]

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[105] Holland, *Frontier Doctor,* p. 83.
[106] Ibid.
[107] Ibid.
[108] *NWFP Hospitals and Dispensaries Report, 1907.*
[109] *NWFP Hospitals and Dispensaries Report, 1933.*
[110] Holland, *Frontier Doctor,* pp. 55-6.

The missionaries' evangelistic approach provides a fitting parallel to government efforts towards influence-building in the hostile frontier. But this particular measure of administrative success could result in some absurd consequences. Unusual seasonal salubrity would cause anxiety in the early years of Britain's administration of the frontier because the decline in attendance might reflect badly on the performance of the institutions themselves. A hint of concern can be discerned upon reading the remarks of an administrative medical officer trying to explain to his superiors a marked fall in hospital attendance during a particular year. 'This I think may be attributed to the healthiness of the year. There is no reason for thinking that our Hospitals and Dispensaries are less popular than they were.'[111] Yet another absurd consequence of the medical missionary approach to health intervention—which operated in the shadow of a decidedly hands-off government policy—was that the provincial government was expending resources to build public institutions in an area that was constitutionally not even a part of British India.

In order to illustrate what kind of environment state medical authorities were dealing with and how they responded to it, it is helpful to survey developments in malaria, smallpox, and surgery. This will provide a detailed picture of health behaviours and facilities on the frontier, which is essential for evaluating government's public health capacity.

Malaria was not only perennially prevalent but also perennially difficult to ascertain. It was an 'extraordinarily popular diagnostic decision.'[112] In 1902, reported cases of malaria numbered around 100,000.[113] By 1939, malaria continued to be the principal disease but this time it recorded nearly 578,000 cases, a rate of incidence that dwarfed the number of total outpatients seen in the whole province for various ailments during the entire 1901-2 year.[114] Medical officers at the time generally assumed malaria's *real* incidence to be about one-fourth of all out-door

[111] *NWFP Hospitals and Dispensaries Report, 1905.*
[112] *NWFP Hospitals and Dispensaries Report, 1916.*
[113] *NWFP Hospitals and Dispensaries Report, 1902.*
[114] Ibid., *NWFP Hospitals and Dispensaries Report, 1939.*

attendances, which seems to have been a reasonably accurate assessment.[115] Unfortunately, malaria was often over-diagnosed, confused with respiratory and sometimes intestinal diseases. This became a source of anxiety once it was apparent that tuberculosis was on the rise—concomitant with increasing urbanisation in the province—but was not being appropriately diagnosed.[116]

Two major efforts were undertaken by the provincial government to decrease the prevalence of malaria in the NWFP. The first targeted soldiers and militia troops. One method was paying military authorities to carry out anti-malarial measures in and around cantonments.[117] Antimalarial gangs consisted of coolies supervised by medical officers spraying Paris Green dust and using handblowers to destroy anopheline mosquitoes. Pooled water was oiled at regular intervals and mosquitoes were trapped in the barracks, alongside greater attention to the sanitation of barracks and water supplies. The second was distribution of quinine at a large-scale, beginning in 1912 with the experimental distribution of quinine and quinoidine as a prophylactic measure to paramilitary troops, and then after 1924 for therapeutic purposes.[118] Treatment for malaria and other diseases for the civilian population of the tribal agencies on the other hand could proceed only two ways. The first means was provision of quinine and cinchona bark by military authorities in barracks and forts to the surrounding civilian population.[119] The second method for procuring supplies for civilian malaria treatment was with the sanction of the resident Political who had to arrange for supplies which was impossible without the financial and material support of the neighbouring provincial authorities.[120]

The threat of endemic malaria happened to have been particularly noted in the Kurram Agency. To understand approaches to malaria in the tribal agencies, it is important to explain that

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[115] *NWFP Hospitals and Dispensaries Report, 1914*, cf. Klein, 'Malaria and Mortality in Bengal', *Indian Economic and Social History Review*, Vol. 9, No. 2 (1972).
[116] *NWFP Hospital and Dispensaries Report, 1914*; *NWFP Public Health Report, 1923.*
[117] *NWFP Public Health Report, 1934*.
[118] *NWFP Hospitals and Dispensaries Report, 1913*; *Hospitals and Dispensaries Report, 1918*; *NWFP Public Health Report, 1924*.
[119] *NWFP Public Health Report, 1929.*
[120] BL, IOR/L/PS/12/3148, Administration Reports of the NWF border 1940/41.

the role and duties of a Political Agent, who was the representative of the Viceroy to the various tribes, gave him a vastly broad scope and patronage within his particular agency. Essentially, he alone could liaise with Government on behalf of tribal groups to sanction any number of interventions, such as social and economic projects like schools, hospitals, and roads.[121] For residents of the Kurram Agency, it so happened that their resident Politicals were consistently active in coordinating medical relief from the settled districts. The written history of malaria in the Kurram began with a note of alarm in 1912 from the Political Agent and Civil Surgeon that the physique of the local Turi population was rapidly deteriorating due to the scourge of malaria.[122] An appeal was made to provincial authorities for help to combat malaria in the area, and so health workers in 1912 began widely distributing quinine. It was found that there was a strong 'prejudice' against taking quinine in liquid form in the area.[123] The following year, the Agency Surgeon worked to undo this prejudice and convince the local population to take quinine in liquid solution, though the details of how this was managed were not provided.[124]

The momentum established by the success of the quinine use campaign may have contributed extensively to better health-seeking behaviours towards other diseases. In 1915 an epidemic of cholera, brought in via Kabul, threatened to erupt in the agency. The local populace reportedly organised itself to form a quarantine against travellers and the epidemic was quickly brought under control.[125] A few years later when the Political Agent made provisions for a dispensary in the Agency capital with borrowed resources to provide medical relief to the civil population, the beneficiaries appreciated the aid so much that they ended up donating Rs. 230 towards the expenses.[126]

The Kurram came to be uniquely considered to be on par with the settled districts to the east in the ability of doctors to freely move about, and so it became an alternative to the settled

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[121] Akbar S. Ahmed, *Resistance and Control in Pakistan* (New York, 2004), p. 99; BL, IOR/L/PS/12/3148 (Report on the Administration of Border of the NWFP, 1940/41).
[122] *NWFP Hospitals and Dispensaries Report, 1912.*
[123] Ibid.
[124] *NWFP Hospitals and Dispensaries Report, 1913.*
[125] *NWFP Hospitals and Dispensaries Report, 1915.*
[126] *NWFP Hospitals and Dispensaries Report, 1922.*

districts as a destination for health-related migration by residents of the unsettled districts.[127] Also, the population here was recorded as being the first to repudiate the practice of inoculation openly and on a large-scale in favour of vaccination, with many petitions being received for the services of a Government vaccinator.[128] It was the only agency where full-time vaccinators were installed, with even the stable territories of the Malakand only having part-time vaccinators who were called at the request of the native rulers. For all these reasons the Kurram was several times singled out for having the best work done in the field of public health out of all the settled districts and agencies.[129]

This success prompted the medical officer of the NWFP to propose engaging other Politicals on the issue of promoting vaccination.[130] It also led to the residents of Lower Kurram developing a reputation for being 'comparatively tractable peoples'. [131] It is unclear whether this was a case where the population was predisposed to accept aid and advice in the matter of their health or whether the successful promotion of public health services by local British officers created a positive feedback mechanism. This was certainly the subject of debate between the NWFP's Chief Commissioner E.B. Howell and its Medical Officer Lt.-Col. Dennys. It is worth noting that the Turis of the Kurram were unique in having requested British administration of their agency (according to British accounts), which likely had something to do with the fact that they were a Shi'a tribe in a predominantly Sunni region and were actively opposing Afghan attempts to rule over their territory.[132] However, anecdotal evidence reveals that malaria treatments offered by British doctors were a sufficient draw on their own. The following incident related by the Agency Surgeon of Waziristan supports this hypothesis:

> I was just leaving the hospital to go over to the fort for lunch when, outside the gates, a wild-looking man approached me. Thinking he was after the ever-popular anti-malaria pills, I pulled out the bottle of mepacrines I always carry round with me and prepared to

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[127] *NWFP Hospitals and Dispensaries Report, 1937*; *NWFP Public Health Report, 1909.*
[128] *NWFP Public Health Report, 1909.*
[129] *NWFP Hospitals and Dispensaries Report, 1917.*
[130] *NWFP Public Health Report, 1905.*
[131] Ibid.
[132] William Stevenson Meyer and others, *The Imperial Gazetteer of India, Vol. XVI*, 3rd edn (Oxford, 1908), p. 50.

> tip a few into his hand. You can imagine my surprise and horror when he whipped his rifle up to his shoulder and fired point-blank at me.[133]

Anti-malarial prophylaxis was evidently in such demand that Waziri tribesmen, many of whom were otherwise extremely hostile to British military occupation of their territory, were willing to enter British military forts to seek these drugs. The mix of military and medical intervention produced a highly tense and ambiguous relationship between the two sides.

When it came to reports of anti-malarial work on the frontier, a key aspect to ascertain was whether populations seemed amenable to being converted to the cause of western medicine and public health. The death rate continued to fluctuate even into the 1940s in the absence of adequate conservancy arrangements throughout the rural areas of the Province. The level and manner of distribution of quinine and cinchona febrifuge produced no consistent decrease in deaths from fevers. Despite the ambiguity in results, representatives of the provincial government—even when it came to be helmed by Indians—in their evaluation of the reports continued to remark with enthusiasm when anti-malarial measures were well-received rather than commenting on their utility or efficacy. The new Minister for Transferred Departments Sir Abdul Qaiyum noted with regards to malaria in the NWFP in 1931, the first year of self-rule in the province, 'Fevers took a large toll as usual but Government is glad to know that value of quinine and cinchona febrifuge which was distributed free among the poor is popularly appreciated.'[134]

In contrast to malaria, smallpox came to present a more consistent picture. Throughout India, there were historical precedents relating to inoculations against this particular disease, and this was true of the Pathan territories as well. From the beginning of British administration in the frontier region, vaccination efforts were being conducted in both the settled districts and political agencies. In contrast to modern-day hard-line opposition to polio vaccination efforts in the tribal tracts, the inauguration of such efforts for smallpox were received without much opposition in the agencies. In the earliest days of health administration in the province, it was reported, 'The

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[133] Francis L. Leeson, *Frontier Legion: With the Khassadars of North Waziristan* (Fering, West Sussex, 2003), pp. 27-8.
[134] *NWFP Hospitals and Dispensaries Report, 1931.*

trans-frontier tribesmen are at present chary of trying new methods. Most of them have their own inoculators, but this passive, and in the latter case probably active, opposition will in time be overcome.'[135] The threat to the livelihood of hereditary inoculators seems to have been the only significant cause of opposition.[136] The issue of religion did not escape notice, but repeated assertions by the Chief Medical Officer (CMO) explicitly noted that it was not an obstacle to vaccination efforts in the Agencies.[137] In fact, one programme that was inaugurated in the agencies sought to enlist *mullahs*—clerical leaders—to bolster the number and appeal of vaccinators.[138] The number of people coming to get vaccinated and petitioning for vaccinators to be sent to their agency always spiked when an epidemic broke out, though once the outbreak was controlled apathy would set in without fail.[139] There was never any steady progress in getting the local population to subscribe to vaccination, as in the other provinces of British India, however there was a clear trend with respect to smallpox vaccination as well as continued and growing acceptance of it.[140]

The way for trans-frontier men, women, and children to access vaccines was by two methods: either visit dispensaries in the settled districts or travel to other tribal agencies where reasonably permanent or frequent health facilities existed (e.g. Kurram or one of the native states of Swat, Dir, Chitral). We find a detailed description of this practice in accounts such as the following by missionary doctor Reginald Cox:

> During the autumn the tribesmen come down the passes with their camels and bring their cattle and goats to graze on the rich pastures of Peshawar...Now it is springtime and they are returning home…On the way they are dropping in to get 'patched up' at the mission hospital. They know well that once over the border in tribal territory no proper medical treatment is obtainable. [141]

This obviously required freedom of movement—which was anything but a given in the unadministered districts, especially during periods of ongoing hostilities. Blockades and air

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[135] *NWFP Public Health Report, 1904.*
[136] *NWFP Public Health Report, 1907.*
[137] *NWFP Public Health Reports, 1911-15.*
[138] *NWFP Public Health Report, 1909*
[139] *NWFP Public Health Report, 1904.*
[140] Ibid.
[141] Cox, *Signpost on the Frontier*, p. 9.

operations ruthlessly restricted movement out of those villages where a person of interest or their relatives were located, even to the point of denying inhabitants of the village access to water wells and medical facilities.[142] Other than military operations, malaria also played a role in restricting mobility, and extraordinary outbreaks resulted in vastly decreased attendance by the civil population at military and civil dispensaries and hospitals.[143]

Emphasis was not placed on how medical workers tackled diseases. It was on whether medical facilities, individuals and programmes were building networks of influence among the target population. The primary focus of medical reports therefore shifted away from following disease trends over time. This contrasts with the detailed epidemiological approach characteristic of reports of the health of the military, the annual reports of the Public Health Commissioner of India, or the provincial Malaria Surveys which all utilized detailed statistics to understand factors influencing the outbreak of epidemics and the endemicity of particular disease in other regions, including Bengal, Punjab, and Sind. In the NWFP, the focus was on parsing trends in health-seeking behaviours, e.g. the number of people being vaccinated or seeking eye surgery in mission hospitals, as a proxy for influence-building. This had great bearing on policy, as is evident for example when we read of provincial staff deputed as vaccinators in Kurram Agency being permanently assigned there not based on their efficiency or experience, but because those vaccinators were seen as having developed a unique knowledge of the local populace, an indication of their familiarity with and therefore acceptance amongst the people there.[144]

This also indicates that greater subscription of tribal groups to British medical facilities was not seen necessarily as a sign of greater affinity for European medicine, but a reaction to the skill and popularity of particular individuals. The credit did not reflect upon the functionality of the role of health worker, but rather the personal charisma of the individual occupying it, and this paradigm seemed to have largely defined medical interaction on the frontier. Certainly individual reputation and popularity are important elements affecting patient behaviour, but too much

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[142] BL, IOR/L/PS/12/3231, Tribal Disturbances in Waziristan, White Paper Presented by the Sec of State for India to Parliament, 14 June 1937.
[143] *NWFP Public Health Report, 1916.*
[144] *NWFP Public Health Report, 1905.*

emphasis on these aspects in medical reports and memoirs detracts from a growing appreciation of western medicine and government dispensaries and hospitals among the frontier tribes. For example, based on the utility of dispensaries in the Malakand and Khyber agencies, the local population appealed to Government to send a lady doctor so that women would also have access to medical expertise.[145] The immense credit given to force of personality is understandable given that personal influence was privileged as the currency of frontier politics—where Politicals rather than bureaucrats determined policy.[146] But it cannot explain the growth of medical work on the frontier especially when considering the great deal of instability when it came to personnel.

The medical officers who undertook civil work in the province and border areas were responsible in the first instance for the health of regiments and militias posted in particular agencies and were often recalled to duty and therefore unavailable for civilian work.[147] There were also frequent changes in the officers holding medical charge of various hospitals, especially the well-attended ones in Swat. Here, a major increase in attendance was reported in 1919, despite the fact that many medical officers had been deputed to war duty.[148] Though the Chief Commissioner in 1907 attributed the increasing tendency of transborder tribes to apply to government hospitals and dispensaries as a sign of the tact and skill of the medical officers and subordinates, it is not true that the popularity of particular individuals alone or even primarily drew large numbers of transfrontier men and women. There was a genuine demand for the facilities and resources of British medicine, which even included *hakims* and hereditary inoculators who were at times recruited by government as stop-gap measures.[149] One quarter of all in-patients treated at five Municipal hospitals in the province came from across the border.[150] Similarly, out-door dispensaries continued to be remarkably popular even if the physical building in which they were located was virtually defunct. In Chitral, the number of patients attending the

[145] BL, IOR/L/PS/12/3148, Report on the Administration of the Border of the NWFP, 1938/39.
[146] BL, IOR/L/PS/12/3265, GOI to Secretary of State for India, Subject: Examination of the present policy on the North-West Frontier, 22 July, 1939.
[147] *NWFP Hospitals and Dispensaries Report, 1913.*
[148] *NWFP Hospitals and Dispensaries Report, 1920.*
[149] *NWFP Public Health Report, 1905.*
[150] *NWFP Hospitals and Dispensaries Report, 1914.*

civil hospital remained constant despite the actual building having been destroyed by floods and no replacement having been built.[151] Many in the agencies had to turn to military institutions for civil medical assistance even though patients could not easily be induced to enter a British fort for treatment;[152] nevertheless, attendance at these hospitals increased consistently over the period recorded, more than can be accounted for by greater recruitment of the local population in the Frontier Corps, Scouts, and Khassadars.[153] In-patient surgical treatment was immensely popular, with those being operated on for eye diseases increasing annually and tribesmen increasingly bringing their wounded to these institutions during times of disturbance and hostilities.[154] Medical officers responded to these trends by trying to provide what was wanted in the manner it would be best accessed. They attempted to train *mullahs* and hereditary inoculators to administer vaccines, opened up hospitals at scout posts to civilians despite the risk of spreading sickness to troops, and made provisions for migrating populations seeking medical aid en route to their destinations.

No anti-western-medicine protests on the border are mentioned in colonial records. The first refusal to submit children for vaccination recorded in the medical reports did not occur in the tribal areas, as one might suppose, but due to anti-government propaganda in the settled districts of the NWFP.[155] The 1911 report on vaccination in the NWFP noted, 'The attitude of the people towards vaccination is not one of hostility by any means.' Indeed their negligence was attributed to something far less sensational—'the usual amount of apathy, of laziness, and of disinclination to be annoyed.'[156] Furthermore, it might arguably be said that it was the lack of effective resources and personnel available for vaccination that were the greatest hindrance to the popularisation of the practice than local prejudices. Underpaid vaccinators would often seek bribes and the efficacies of samples would deteriorate over the large distances travelled.[157]

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[151] *NWFP Hospitals and Dispensaries Report, 1916.*
[152] *NWFP Hospitals and Dispensaries Report, 1908.*
[153] *NWFP Hospitals and Dispensaries Report, 1907.*
[154] *NWFP Hospitals and Dispensaries Report, 1916.*
[155] *NWFP Public Health Report, 1932.*
[156] *NWFP Public Health Report, 1911.*
[157] *NWFP Public Health Report, 1918.*

Progress was probably also hindered because of instructions from the Chief Commissioner's office to the CMO to abstain from actively promoting adherence to the practice of vaccination and to avoid harassing Politicals about the issue. It was considered prudent to avoid taking a strong stance on the matter. As one report put it, 'Though the Chief Commissioner has no wish to discourage the Administrative Medical Officer in his proposed attempt to extend vaccination in the other Agencies, he does not regard the project with much confidence.'[158]

Not fully appreciating the importance of these facilities to the lives of the residents of the border territories may have contributed to certain policies that prevented health access. In 1917 the end of a blockade of Upper Swat resulted in a very large increase of patients to the Minto Swat Hospital.[159] The outbreak of hostilities against Afghanistan in 1919 resulted in massive reduction of attendance in municipal hospitals.[160] A report on the administration of North Waziristan in 1939-40 remarked, 'Unsettled conditions have made it difficult for the medical officers to visit villagers; when they have done so the entire population has turned out for inspection.'[161] During a committee meeting deliberating self-rule in the NWFP, Sir Dennys Bray anecdotally referred to a petition by a contingent of the Mahsud tribe—which was often at war with the British authorities—for a female doctor in 1930; this petition promised to provide the lady doctor with facilities and medicines.[162] Bray drew laughs by describing the amenities being offered as 'loot in the last Mahsud expedition,' but he clearly ignored the formal, organised, and deliberate nature of the appeal requesting medical provisions from the British government.

The most detailed descriptions of the attitudes of the Pathan tribes of the unadministered territories towards western medical interventions can be found in accounts provided by missionary physicians. Missionary institutions were immensely popular relative to other available medical facilities in the province and border territories. Several of them consistently placed within the top ten of medical institutions within the entire province in terms of number of

[158] *NWFP Public Health Report, 1905.*
[159] *NWFP Hospitals and Dispensaries Report, 1917.*
[160] *NWFP Hospitals and Dispensaries Report, 1919.*
[161] BL, IOR/L/PS/12/3148, Report on the Administration of the Border of the NWFP, 1939/40.
[162] BL, IOR/L/PS/12/3135 Extract from Official Report of the Legislative Assembly Debates, 14 Mar 1928.

patients seen. Indeed, there were several aspects in which the work of mission hospitals exceeded that of Government and local fund institutions. The first was in-patient treatment. Surgery was a particular specialty. The Bannu Mission Hospital for example consistently came in first, by a long margin, for the number of in-patients and eye operations done. Skilled medical and surgical care for women provided by the aided hospitals—so-called because of partial financial support provided by Government—was also heavily promoted by Government, especially the Duchess of Connaught Mission Hospital in Peshawar which was under the charge of a European Lady Doctor.[163] The second major advantage of mission hospitals was their role in training of subordinate health workers.[164]

Those responsible for mission and aided institutions were often times very well known—one instance where the power of individual charisma certainly played a prominent role. The Bannu Mission Hospital, which became renown throughout the province for its ophthalmological work, was run by Dr. Theodore Pennell, a well-travelled medical doctor-cum-anthropologist-cum-missionary. He left behind an invaluable account of his acquaintances and experiences on the frontier with information on native medicines and health-seeking behaviours.[165] In the memoirs left behind by British missionary physicians, we can discern the complex and fascinating synthesis which the populations of the area created between western medicine, its practitioners, and local practices and notions of independence. In his memoir of his time on the frontier, Reginald Cox recounted the story of an Afridi surgical patient which provides interesting details of the hazards to health and the medical options on the frontier:

> [H]e was out in the hills one day when he met an acquaintance who was stalking an enemy. The friend called him to join in and help, but he refused as he already had a blood feud of his own and did not want to start a fresh one. The man immediately fired and hit him in the knee. The wounded man went to a mullah, or Moslem priest, who treated it for four months by tying on charms and plastered the wound with ‘holy’ mud from a shrine. He naturally got no better, so came along here at last. An operation was performed and all sorts of mess removed from the wound such as dead bone, bits of charms, pieces of trouser, and finally quite a good bullet.[166]

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[163] 1904 NWFP Hospitals and Dispensaries Report
[164] Holland, *Frontier Doctor*, p. 177; Cox, *Signpost on the Frontier*, p. 26.
[165] Pennell, *Among the Wild Tribes of the Afghan Frontier*.
[166] *Signpost on the Frontier*, p. 4.

Other anecdotes demonstrate how western medicine became an integral part of tribal social activity and how both were transformed as a result. The Miranshah Hospital acquired a reputation for curing gun-shot fractures, 'a common injury where most disputes are settled with firearms.'[167] At the Bannu Mission Hospital, Pennell recounted several conversations with patients with significant injuries who pleaded the doctor to somehow heal them faster or better so they might be in a position to avenge their injuries—revenge being an oft-cited element of the Pathan social code in European memoirs. A most striking example of the intricate negotiation between longstanding tribal practices and the new-fangled possibilities of western surgical intervention can be found in the story of a Pathan man who brought his wounded son to Pennell. The son had been shot in the thigh due to a feud with a local tribal leader, and the father was told that the son's leg had to be immediately amputated:

> The old man, visibly restraining his emotion, said: 'If you amputate the leg, can you promise me that he will recover?' 'No,' I said; 'even then he might die, for the injury is severe, and he is weak from loss of blood; but without amputation there is no hope.' 'Then,' said the father, 'let it be as God wills: let him die, for, by our tribal custom, if he dies as he is I can go and shoot my enemy; but if he dies from your operation then I could not.'[168]

Similarly, Pennell wrote of a patient brought to him with a gunshot wound: 'This Wazir submitted to amputation, and is now going about the hills the proud possessor of an artificial limb from England, which his father sold a rifle to buy, and which is the wonder and admiration of his neighbours.'[169] In this way, mission hospitals and missionary doctors became intimately (and perhaps unwittingly) involved in an economy that often traded in violence.

Of course, limbs and surgical interventions were useful not only for exacting revenge but also for securing marriage prospects. A parallel incident to the one above was reported by Cox regarding a Pathan man who came to the mission clinic with his daughter, the girl suffering from apparent gangrene of the leg secondary to a typhoid infection. Cox related, 'The father absolutely refused to allow an amputation. "What is the use of a girl with only one leg? Who would marry

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[167] BL, IOR/L/PS/12/3148, Report on the Administration of the Border of the NWFP, 1939/40.
[168] Pennell, *Among the Wild Tribes*, p. 83.
[169] *Among the Wild Tribes*, p. 85.

her?" he demanded. "But if the leg is not removed she will die, and what will you do then?" "We can bury her," he replied, and took the girl away.'[170] In a similar vein, a 1940 report on the administration of tribal agencies noted, 'The Wazir, who believes that a handsome face attracts a fair lady, is beginning to realize the value of vaccination to prevent small-pox.'[171]

Even as the hospital became a site integrated into the process of tribal feuding, it also became a neutral ground where all could turn to for help. While visiting a Wazir chief at his border fort, Pennell was told, 'You can do what we cannot possibly do…You can go into any of our villages and among all the tribes, although you have not even got a revolver with you.'[172] Likewise, Frank Leeson enviously remarked to the medical officer of the fort where he was stationed, 'You must be one of the safest men in the Agency…Nobody could want to assassinate or kidnap you. You're too useful.'[173] The reasons for this restraint towards medical men were practical. Cox was told by an Afridi patient, '"We know for certain that you and your staff cannot be influenced by our enemies to poison us."'[174]

The Politics of Welfare and Responsibility

Despite the reality of medical practice on the frontier and the demand for it, when it came to devising an official policy to develop the frontier and improving the welfare of the tribes, Government's position was heavily determined by the intensely militarised interaction between the Foreign and Political Department and the tribes and financial stringency.

The centrepiece of frontier policy as originally devised by Curzon was the militia system, also known as the *Khassadari* system. The *Khassadars*, a specific frontier militia force, were recruited on a tribal basis. This provided one of the few sources of employment for the population of the unadministered districts. More importantly, the *Khassadari* system became synonymous with welfare policy and was attractive on many grounds: it brought revenue into tribal society and a trickle-down effect that would improve the economic condition of the tribes;

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[170] *Signpost on the Frontier*, p. 7-8.
[171] BL, IOR/L/PS/12/3148, Report on the Administration of the Border of the NWFP, 1939/40.
[172] Ibid.
[173] Leeson, *Frontier Legion*, p. 27.
[174] *Signpost on the Frontier*, p. 13.

it did so without requiring added expenditure on social work; for the ideologically minded it was appealing because it discouraged dependence on the dole.[175] This provided a convenient and inexpensive welfare policy to please those who criticised Britain for not carrying out its imperial responsibility on the frontier.[176]

The discourse about Britain's imperial responsibility had emerged in the 1920s, leading to the convening of the Howell Committee to look into tribal control and defence in 1930. This was the first committee, Viceroy Linlithgow recalled later, which expressly made reference to 'peaceful penetration' as a tool of British policy.[177] With the adjacent North-West Frontier Province finally gaining self-government, the question put to the Committee was how the tribal areas of the frontier could be kept under Central control.[178] The problem for the Committee was that control and defence of the tribal areas was becoming financially burdensome while at the same time the policy of military occupation of the area without prospect of political development was under potential threat from the criticisms of an increasingly vocal British public and an increasingly powerful Indian elite.

In the post-WWI era, principles of self-determination germinating in the colonies as well as the great emphasis on imperial responsibility in the motherland ushered in a period of greater accountability for imperial policies towards subjects. According to the Viceroy,

> Frontier policy has become moreover of great interest to those Indian politicians, who desire to see the establishment of a responsible system of Government at the Centre. Our difficulties on the Frontier provide them with a welcome weapon of criticism, which united the Hindu and Moslem in defence of the so-called 'independence' of the marauding tribes.[179]

Meanwhile, in Britain, Labour and socialist forces were openly and in unison decrying what they found to be the inhumane aspects of empire. As the *Manchester Evening News* reported in 1939 on the hostilities in Waziristan against the anti-British Fakir of Ipi, 'These are names strange to

[175] BL, D696/3, Papers of Sir Arthur Parsons: Report of the Frontier Watch and Ward Committee, 1936.
[176] Tripodi, *Edge of Empire*, pp. 145-8.
[177] BL, IOR/L/PS/12/3625, GOI to the Sec of State for India, Subject: Examination of the present policy on the North-West Frontier of India, 22 July 1939.
[178] Ibid.
[179] Ibid.

most people in England and little has been heard of the campaign...The man-in-the-street will welcome news of the peace, but what does he know of the rights and wrongs of the struggle? Yet it is in his Empire it has happened. He is ultimately responsible.'[180]

The talk of responsibility became more critical in light of the controversial policy of air bombardment, increasingly implemented by the British in the tribal areas after the 1920s.[181] Considering that tribal territory was traditionally 'independent', the fact that bombardment was carried with impunity within tribal territory signalled a bold pivot in British policy regarding responsibility towards tribal law and order and monopoly on the use of violence in the territories. One Member of Parliament asked the Secretary of State for India with respect to the territories being bombarded, 'Do we understand that these tribesmen are at present in their own territory?' to which he received the frustratingly inconclusive response: 'It depends what the words "their own" may mean.'[182]

Records of the Foreign and Political Department contain several exchanges between the India Office and GOI revealing a persistent uncertainty on the part of the Government of India—from the Viceroy down to the Chief Commissioners of the NWFP—as to the status of the tribesmen. They were constantly referred to by the GOI as British subjects, to which several corrections throughout the years had to be issued by the India Office pointing to their status as only 'British protected persons'.[183] The intensity of bombing tribesmen, perhaps operating in their own territory, seemed to signify to international observers that the British had a clear responsibility towards the behaviour and actions of these tribes in their own societies. Members of the British public vocally expressed their opposition to the policy of bombardment and expressed their desire for a policy of social and economic uplift in its stead.[184] Meanwhile, similar demands were coming from within India.

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[180] BL, IOR/L/PS/12/3231, Extract from Manchester Evening News, 30 May 1939.
[181] For a detailed study of air-policing in the British Empire, see David E. Omissi, *Air Power and Colonial Control: The Royal Air Force, 1919-1939* (Manchester, 1990).
[182] BL, IOR/L/PS/12/3126, Parliamentary Question No. 12, 2 June 1930.
[183] BL, IOR/L/PS/12/3171, Extract from Official Report of Legislative Assembly Debates, 24 Sept 1935.
[184] BL, IOR/L/PS/12/3231, Waziristan disturbances 1936-37; Parliamentary questions and White Paper.

A pertinent example of the new criticism being level against the GOI by Indian politicians was Sir Abdul Qaiyum's rebuke of the British Government's treatment of Pathan tribes in the course of demanding right of self-governance for the NWFP,

> At least the Amir [of Afghanistan] did what he could for whatever small tribes fell into his power. Whether it was coercion or whether it was uplifting, or whatever it was, he applied the word 'civilising' to them. Whatever civilisation his country had, he applied it to these people. But what about your people? You still treat them like step-sons. Then what justification have you got for claiming them to be under your sphere of influence? If there is any justification for your claiming that they are under your sphere of influence, why do you say in this Memorandum which you have sent to us that it is India but not British India? What sort of India is it?[185]

Colonial officials acknowledged, 'We must now also take into account the severe restrictions imposed by public opinion both in India and abroad on the effective use of air action especially against those whom we claim to be our own subjects.'[186] "Responsibility" became the new watchword of imperial policy throughout India, and this led directly to the articulation of the policy of peaceful penetration. Strategic worries could no longer be marshalled to justify the Centre's prerogative over frontier policy—'the development of self-governing institutions in India and particularly in the North-West Frontier has awakened alarm and dissatisfaction among the more fanatical tribesmen…The influence of the tribal elders, through whom we enforce tribal responsibility, has been greatly weakened by the spread of democratic ideas.'[187] The Howell Committee therefore took a new step in singling out the characteristics of the tribes themselves as making them unfit for self-rule, thereby undermining any moves to turn over the area to standard government. The report stated the chief factors of the tribal problem to be: the virile and martial qualities and predatory instincts of the tribes, their inaccessibility, their ready access to firearms, and their kinship with and easy access to the Afghan tribes.[188] Further influences were seen to be 'fanaticism', economic underdevelopment, Afghan intrigue, and the ambivalence of Government's own position towards the tribes.[189] This view impacted Government's approach to

[185] BL, IOR/L/PS/12/3171, Extract from Official Report of Legislative Assembly Debates, 24 Sept 1935.
[186] BL, IOR/L/PS/12/3265, Review of Frontier policy: Viceroys memorandum of 22 July 1939.
[187]Ibid.
[188] Ibid.
[189] Ibid.

the issue of tribal welfare. In discussing the need for jobs in Waziristan, one official wrote, 'The Mahsud is his own worst enemy, and efforts to find employment for him are made more difficult by his suspicious and unstable character. He is the spoilt child of the Border.'[190]

The Howell Committee found the financial costs required in the extension of full British control up to the Durand Line to be impossible in the financial climate. In this, they were merely resuscitating a longstanding aversion on the part of Government to becoming genuinely involved in governing the border even as it could not resist interfering in it. A note in the files of the Foreign and Political Office dating to 1908 admitted as much when stating the reasons for demarcating the Anglo-Afghan border was that 'we may be able to say definitely to the Amir "thus far shall thou go and no further". The object of the Durand Line was not so much to secure a boundary up to which we should exert influence as to secure one beyond which the Amir should not.'[191]

The Howell Committee suggested as a solution the revival of the Sandeman method for bringing tribal areas under control wherever possible. The Sandeman method, perfected in Baluchistan, was equivalent to peaceful penetration. According to Sir Denys Bray, peaceful penetration was 'swadeshi swaraj - i.e. indigenous home rule - the pacification and administration of tribal country as far as possible - *as far e.g. as Western conscience and Imperial needs permitted* - on tribal lines according to tribal custom by tribesmen themselves under the shelter and control of the pax Britannica.'[192] It entailed implementation of governmental control on local precepts with some benevolent measures such as the building of schools and hospitals aimed at improving the life of the tribes and making them economically sufficient in order to encourage them to desist from 'criminal' behaviour.[193] The GOI clarified this policy to the India Office, stating that it sought to encourage extension of employment in

[190] BL, IOR/L/PS/12/3148, Report on the Administration of the Border of the NWFP, 1939/40.
[191] BL, MF IOR 465, A146-A194, Note on Anglo-Afghan Border, 17 Aug 1908.
[192] IOR/L/PS/12/3171, Note by Sir. D. Bray. 27 March 1934. Italics added.
[193] Christian Tripodi, '"Good for one but not the other": The "Sandeman System" of Pacification as Applied to Baluchistan and the North-West Frontier, 1877-1947, *Journal of Military History*, vol. 73, no. 3, (2009), pp. 767-802

militias and building of schools and dispensaries and '[i]f these benefits are liberally conferred upon the existing protected areas it may be hoped that the inhabitants of other areas will begin to recognise the value of some measure of government administration and will ask for protection instead of resisting to the death any encroachment upon their internal autonomy.[194]

In addition to employment provided by militias, the Howell Committee also suggested that *maliks*, designated tribal heads, could be persuaded to contribute from the allowances given for the *khassadars* towards maintaining a bed in a hospital or establishing a scholarship in a school.[195] This was similar to the ethos animating state efforts to promote indigenous fundraising towards hospitals and dispensaries in India at large.[196] Unfortunately for the British, the problem with this policy, which was intended to win over allegiance of potentially hostile tribes by awarding them lucrative benefits, was that it provoked the very kind of disturbance it was intended to prevent. Tribes had a vested interest in creating the kind of hostilities that needed to be combatted.

The idea of *Khassadari*-as-welfare relied consciously and unconsciously on anthropological claims about the tribal population. The Pathans were considered a martial race[197]; giving them continued access to military employment was thought to prevent the kind of degenerating influence that welfare and civilisation seemed to have had on Indians elsewhere, e.g. in south India. To prevent racial decline, it was essential to avoid policies that might make them weak or dependent on the dole.

The idolization of the Sandeman system obscured the unavoidable need for the state in any sustainable effort to build a healthcare infrastructure. In provincial medical reports, one can see the correlation between government expenditure and building projects, which demonstrate

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[194] BL, IOR/L/PS/12/3625, GOI to the Sec of State for India, Subject: Examination of the present policy on the North-West Frontier of India, 22 July 1939.
[195] BL, IOR/L/PS/12/3171, Frontier policy: question of assisting the tribes to become self-supporting.
[196] Sehrawat, *Colonial Medical Care in North India*.
[197] As noted in 1894 by Sir Edward Collen, '[I]f if the commanding officers of the Indian Army were polled and their views accepted, the whole army would be composed of Sikhs, Pathans and Gurkhas.' See Heather Streets, *Martial Races: The Military, Race and Masculinity in British Imperial Culture, 1857-1914* (Manchester, 2004), p. 101.

that infrastructure and facilities were built only if and when government funds were available.[198] However, the larger theoretical point regarding which authority is ultimately responsible for investing in health is also worth considering: though the *Khassadari* system was seen to improve tribal welfare through the injection of a revenue stream and could be channelled towards benevolent projects, it could not provide or sustain the kind of investment needed for infrastructure building. Essential elements of health intervention, like training of health officers or procurement of medicines, required a kind of expertise not existing in the regions where the Pathan tribes were living and migrating.

In his anthropological study of tribal society and politics in Waziristan, one-time Political Agent of Waziristan Akbar S. Ahmad wrote, 'Before the creation of Pakistan the tribes had rejected development schemes as symbols of British imperialism and a method of penetration.'[199] He went on to say, 'The lack of the most basic facilities, such as primary schools is understandable only in this context,' and adds that condemnation from local clerics was the cause.[200] In this view, he is supported by the last British Governor of the NWFP, George Cunningham who asserted in 1945 that independence—i.e. freedom from Government courts, officials, taxes—was still of paramount importance to the tribesman. 'He would rather be free and undeveloped than developed and administered.'[201] This is similar to the sentiment expressed by the GOI in its reports:

> From his hills, where he continues a manner of life handed on unchanged down the centuries, the tribesman looks out over the plains where men live under the rule of a modern government. He prefers his own life of independence to that of the plainsman. He sees disadvantage in order, taxes, police, prisons, and does not understand that an organized society means also hospitals, schools, and canals.[202]

But what emerges from a focused survey of medical interventions on the frontier is something far more complex than complete neglect or self-interested aggression on the part of the British and an all-abiding love of independence on the part of the tribes. Despite military

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[198] *NWFP Hospitals and Dispensaries Report, 1902-05.*
[199] Ahmed, *Resistance and Control in Pakistan*, p. 98.
[200] ibid, pp. 98-9.
[201] BL, IOR/L/PS/12/3266, Comments by Governor of NWFP on the Frontier Committee's Report, 1945.
[202] BL, IOR/L/PS/12/3148, Report on the Administration of the Border of the NWFP, 1939/40.

occupation in the region after the Third Anglo-Afghan War, the British repeatedly acknowledged their failure to bring tribal territory under formal administrative control, only conceding in 1930 with the convening of the Howell Committee that instead of occupation, formal efforts at 'peaceful penetration and civilisation of the tribes' be inaugurated which the GOI accepted subject to financial concerns.[203] Several colonial officials claimed that this was not due to lack of effort on their part but rather due to opposition of local inhabitants to development and was justified by referring to the trope of the independent tribesman. Yet the notion of creating a formal local administration, such as for health, was put forward only in 1945.[204] At the same time, expenditure on the frontier remained rather lopsided. The figures for 1929-30 showed approximately Rs. 17 million in civil expenditure for the frontier, most of which was for political charges and civil defence, while the remainder of nearly Rs. 82 million was spent on military concerns.[205] Finances were indeed a major concern. 'Lack of funds is the greatest obstacle to progress, as the tribesman's original hostility to new methods has by now turned into an insistent demand for them,' reported the Border Administration in 1940, while at the same time resigning itself to the reality that it was 'unfortunate, but no doubt inevitable, that in times of financial stringency the Government's constructive work should be the first to suffer.'[206] The result was that the engagement between Government and the tribes was and remained heavily militarised, with the formation of militias in this restive region superseding the building of health capacity and educational facilities as the means of promoting tribal welfare.

Conclusion

By 1930, the trans-frontier tribes were greatly dependent socially and economically on the British.[207] There was a demonstrable desire on behalf of tribal groups for development of

[203] BL, IOR/L/PS/12/3625, GOI to the Sec of State for India, Subject: Examination of the present policy on the North-West Frontier of India, 22 July 1939.
[204] BL, IOR/L/PS/12/3266, Tuker Frontier Committee Report, 1945.
[205] BL, IOR/L/PS/12/3171, Report of the Tribal Control and Defence Committee, 1931.
[206] BL, IOR/L/PS/12/3148, Report on the Administration of the Border of the NWFP, 1939/40; IOR/L/PS/12/3148, Minute Paper, Subject: North-West Frontier Border Administration Report for the year 1938/39.
[207] BL, IOR/V/27/247/7, Five-year post-war development plan for the North-West Frontier Province and tribal areas.

public facilities like hospitals and schools.[208] Experienced frontier officials and health bureaucrats themselves also believed that health facilities would win over the tribes to British rule.[209] Moreover, they could help pacify the frontier by being a means for the Government to exert influence over the population. As Dennys Bray remarked, 'There is no greater civilising influence than a good hospital.'[210] Social development would bring with it attention to 'practical application to the country's prosperity, personal hygiene, modern interpretation of Islam, civics and simple vocational training in all fields.'[211] Tribesmen eagerly subscribed to health services provided by missionaries and health workers in the settled districts. The idea of the independent tribesman, however, proved a major obstacle, or rather provided a convenient excuse, to delay attention to development. It may not have been a complete myth, but it was an exaggeration which hindered productive socioeconomic engagement and political development on the frontier. Writing of development on the frontier in 1947, Chief Secretary to the Government of the NWFP Leslie Mallam wrote,

> It is commonly alleged that Pathans are different from all other human beings in that they do not desire good government…Their characteristics and reputation have made it easy to label the people and their system as barbarous, but looks can be deceptive. It does not follow that if the Pathan tribes are at present in a state of anarchy, they have always been in that state or that because a man is poor, uncultured, uneducated and forced to defend himself against an armed and treacherous enemy, he <u>enjoys</u> living always in that state.

This not only indicates that within Government itself there were critiques of the hands-off policy with respect to tribal health, welfare, and development, but that the change in official discourse only came in the late 1930s and in the 1940s. As last as 1937, Sir Arthur Parsons of the GOI who had served in many official capacities on the frontier stated, 'The policy of Government is to introduce sufficient control into these tribal areas which are part of India and to carry out their responsibility, which, as I said, is of a three-fold character—first to Afghanistan, second to the

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[208] IOR/L/PS/12/3148, Report on the Administration of the Border of the North-West Frontier Province 1939-40.
[209] Minute Paper, P.Z. 4015/40, Subject, North-West Frontier Border Administration Report for the year 1938-39, J.A.K. Harrison, 26/7/40
[210] BL, IOR/L/PS/12/3135, Summary of the Proceedings of the First Meeting of Sub-Committee No. V (NWFP), 18 Dec 1930.
[211] BL, IOR/L/PS/12/3266, Report of the Frontier Committee, 1945.

administered areas, and thirdly to the actual inhabitants of the tribal areas.'[212] By the time that the social needs of the border populations began to become a priority, it was already too late.

In the context of the larger argument of this thesis, this chapter seeks to demonstrate that the geostrategic position of the frontier, which the British government was anxious to control during a time of political devolution in India, prevented the development of a stable, accountable political structure in that region. Rather than interventions being limited by the state's inability to reach the populations of its domains, as was the case in the regions that will be studied in subsequent chapters, this was a case of government deliberately choosing not to intervene medically in the lives of people it was hesitant to assume constitutional and legal responsibility for, which might potentially disrupt its political and military objectives in the region.

The history of medicine also makes clear that a narrative of life on the frontier which refers only to the region's strategic import and its bit part in the rise and fall of empires misses much about the relationship between resident populations and the governments that have attempted to settle these areas. The Khyber Pass was not only an entryway for imperial invaders and marauders seeking the riches of Asia but also the indigent and sick seeking medical aid from mission clinics and government dispensaries. British medicine on the frontier was as important to those imperialists hoping that British governance would one day civilise the region as it was to the patients who thought the British doctor had the cure for all ills. As the *Morning Post* pointed out in December, 1932: 'The merit of the British system is that it does not rest merely on guns and bastions, but also on British doctors who are pioneers in making life in those regions worth living.'[213] However, if British doctors and public health officials and politicals were concerned with making life on the region worth living, the British government's Foreign and Political Department often pursued policies that could be cross-purposes, choosing for example to extend imperial influence by flooding border villages with 'defence rifles' and enlisting ever greater

[212] BL, IOR/L/PS/12/3171, Extract from Legislative Assembly Debates, 6. Sep 1937.
[213] Cox, *Signpost on the Frontier*, p. 46.

number of tribesmen into militias which resulted in closures of schools even as it provided employment and government funds.[214]

The Government's awareness of its 'due burden' with regards to the frontier population evolved only gradually, in response to political pressures arising out of a changing global political environment. Active intervention had its supporters: the military, missionaries, and medical workers. However, it had its staunchest opponent in the British government which continued to promote in increasingly desperate ways the characterisation of the border areas as 'independent' or uncontrollable. Claims of tribal independence and ambitions of British dominion over the frontier warred with each other and the idea of the fierce, independent tribesman became a stubborn fact—deeply entrenched to this day[215]—which elided the realities of government-tribal relations, allowing the Centre to keep greater control over frontier affairs while minimising financial outlay on socioeconomic development.

[214] BL, IOR/L/PS/12/3148, Report on the Administration of the Border of the NWFP, 1941/42.
[215] Imran Khan, *Warrior Race: Journey through the Land of the Tribal Pathans* (London, 1993).

Chapter 3: Punjab

> To deal with the best manhood of India, we had the best men of the Indian Government, the warmest interest of the governor general himself, and a lavish employment of time, labour and treasure. It was an imperial experiment, imperially conducted, and crowned with an auspicious result which must be divided between the rulers and the ruled. If few Governments can begin with such advantages as that of Lahore, few can boast of having substituted, in the short space of four years and a half, order for anarchy, obedience for irregular impulse, gardens for jungles, plenty for barrenness, peace for war.
>
> (Edwin Arnold, *The Marquis of Dalhousie's Administration of British India, Vol. 1*)

The northwestern frontier and the Punjab had vastly different experiences of colonialism. Yet both regions in their unique ways openly challenged the Central Government's ambitions of control. This is not so readily apparent in histories of colonial rule in India. The Punjab stood in colonial imagination as the citadel of empire, as the province where the British officer wielded the greatest authority as he exercised a paternalistic form of rule, looking after his charges while manifesting in his person the forces of law and order.[216] This optimistic outlook was reflected in historical writings describing the trajectory of colonial governance in the subcontinent. *The Imperial Gazetteer of India* wrote in 1908,

> [T]he history of the [Punjab] has been one of uninterrupted progress. Canals have spread irrigation over its thirsty fields; railways have opened new means of communication for its surplus produce; and British superintendence, together with the security afforded by a firm rule, has developed its resources with astonishing rapidity.[217]

For these reasons and more, the Punjab was considered a rewarding and agreeable province over which to exercise colonial fiat. A cursory survey of works on the history of British rule in the Punjab makes clear that the descriptor most often used for the province was 'loyal'.[218] From its colonial origins as a geographic buffer against Afghanistan to its staunch support of the East India Company during the Sepoy Mutiny, the Punjab certainly earned its reputation for

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[216] Ian Talbot, 'The Punjab Under Colonialism: Order and Transformation in British India,' *Journal of Punjab Studies*, Vol. 14, no. 1 (2007), pp. 3-10; Clive Dewey, *Anglo-Indian Attitudes: The Mind of the Indian Civil Service* (London, 1993), p. 43.
[217] Meyer and others, *Imperial Gazetteer of India, Vol. 20*, pp. 276-7.
[218] Ian Talbot, 'British Rule in the Punjab, 1849–1947: Characteristics and Consequences', *The Journal of Imperial and Commonwealth History*, 19/2 (1991), p. 204; Tan Tai Yong, *The Garrison State: The Military, Government and Society in Colonial Punjab, 1849-1947* (New Delhi, 2005), p. 90; Fox, *Lions of the Punjab*, p. 100; Shalini Sharma, *Radical Politics in Colonial Punjab: Governance and Sedition* (London, 2010), p. 18.

loyalty. But it was arguably the province's unparalleled material contribution to the forces of the British Indian Army that constituted the ultimate sign of its fidelity to the imperial regime. By the turn of the 19th century, more than half of the Indian soldiers fighting for the British called Punjab home, earning the province its reputation as the 'Sword Arm' of India.[219]

Conversely, the state's deliberate intervention in the agricultural economy of the province resulted in two major developments that reciprocally embedded the Punjab in Britain's imperial agenda. Improvements in security, communications, and engineering works from the 1860s onwards heralded an era of vastly increased agricultural productivity, with the Punjab producing a tenth of British India's total cotton crop and a third of its wheat crop, even as other regions, among them Bengal, were experiencing agricultural depressions.[220] This was compounded by legislative policies that sought to ensure that landholdings remained in the hands of loyal agriculturists, and a class of 'natural leaders' were thus identified and established to serve as intermediaries between the Raj and 'the mass of the people' in the province.[221] The motivating imperative behind these policies was the need was to ensure rural stability and political strength, which depended on the 'loyalty and contentment of the sturdy yeomanry from whose ranks we draw our native soldiers, the safe foundation upon which our rule can rest secure.'[222]

Despite the fact that the Punjab had become a part of Britain's Indian Empire after Company rule had already been established over much of the subcontinent, it soon became an exemplar among colonial India's constituent provinces, and proved so popular a destination for colonial officers that special rules had to be instituted to ensure parity for the other provinces in the recruitment of able administrators.[223] Describing the view of colonial officers on service in the Punjab, Sir Richard Temple wrote, 'To us the Punjab loomed grandly as the land of

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[219] Yong, *The Garrison State*, pp. 17-8; Shuja Nawaz, *Crossed Swords: Pakistan, Its Army, and the Wars within* (Karachi, 2008), p. 10.
[220] Talbot, 'Punjab Under Colonialism,' p. 5.
[221] Ibid., p. 6; Talbot, 'British Rule in the Punjab,' p. 205.
[222] Denzil Ibbetson, quoted. in N.B. Barrier, *The Punjab Alienation of Land Bill*, (Durham, 1966), pp. 37-8. Ibbetson was revenue and agriculture secretary of India.
[223] Talbot, 'The Punjab Under Colonialism,' p. 3.

promise…the people were known to have in their character the hard grit and high stomach which demanded the governing faculty that Englishmen instinctively love to exercise.'[224] As this quote indicates, the Punjab had cultivated a paradoxical image of strength and docility that made it irresistible to many would-be administrators seeking to cultivate the Indian 'character'.[225] Temple's words are also notable because they were an expression of the civilising impulse of colonialism, the desire to apply colonial governance towards engendering social change.[226] And as Harrison has noted in his study of public health in colonial India, the authoritarian paternalism that informed this 'civilising impulse' found its strongest expression in demands for sanitary reform.[227]

Thus, among the many aspects of Indian society that were targeted for intervention, two important ones were the health environment and the health behaviours of ruralists. In the first part of this chapter, I will delineate the design of Punjab's medical institutions, public health programs, and sanitary engineering projects, which reveals the policies and biases of colonial medicine in this province. Similar to the section on Frontier Public Health in the previous chapter, this will help to establish the kinds of priorities that animated the Punjab Government's efforts to extend access to medical aid, and the health habits it wanted to cultivate among its subjects. Then I will transition to the main case study of this chapter, which is the establishment of the canal colonies in the previous arid plains. The ambitions of Government to reengineer villages in these canal colonies to a different sanitary standard than existing Punjabi villages encountered stiff resistance from rural elites. The entire episode helps illustrate the scope and limits of the colonial administration's ability to change sanitary attitudes, and at a broader level

[224] Talbot, 'British Rule in the Punjab,' p. 204.
[225] See Dewey, *Anglo-Indian Attitudes.*
[226] Khushwant Singh quotes from Bosworth Smith's *Life of Lord Lawrence, Vol. I*, which states that when John Lawrence was commissioner of Jullunder Doab, he would instruct landholders when renewing their leases to repeat the following instructions loudly: *'Bevā mat jalāo'*—Do not burn widows. *'Betī mat māro'*—Do not kill daughters. '*Koṛhī mat dabāo*'—Do not bury lepers. From Bosworth Smith, *Life of Lord Lawrence, Vol. I*, p. 197, qtd. in Singh, *A History of the Sikhs: Volume 2, 1839-2004* (Oxford, 2004), p. 95.
[227] Harrison, *Public Health in British India*, p. 230.

calls into question some assumptions about the Punjab's loyalty to the colonial state and the degree of control the state exercised over Punjabi society.

Medical Institutions and Social Boundaries

The earliest site of intervention in the health habits of Punjabis was the city, specifically the capital city of Punjab, the ancient city of Lahore. It became home to two institutions that today stand as the greatest monuments in Pakistan to the legacy of British colonial medicine—the King Edward Medical College (KE) and the Mayo Hospital. KE predated the Mayo Hospital by about a decade, but the two became attached institutions ten years after the latter's founding in 1872. Much of the information regarding the history of KE, and by extension the Mayo Hospital, comes by way of the writings of Dr. William S. Carter, the Associate Director of the Division of Medical Education at the Rockefeller Foundation. He was sent to British India in 1926 to investigate the state of medical education in the colony and the detailed reports of the medical schools of British India he submitted to the Foundation include an invaluable account of the history and priorities of KE, which later became the only medical college West Pakistan inherited on independence.[228]

The original Lahore Medical School was initially composed of two classes of medical trainees, one taught in English and the other in the vernacular. The institution trained licentiates for Assistant Surgeon positions in its English class while its Urdu class was for subordinate staff, prospective Hospital Assistants and others seeking to compete for employment by local authorities in their home provinces or Native States. The Urdu class also trained aspiring *hakims* and those relatives of *hakims* who were given scholarships by the Punjab Government and Punjab University to study their trade, ostensibly to meet the medical needs of the native population.[229] While these latter trainees were not provided with salary or jobs after graduation, they were expected to return to their native towns to practice. By 1920, this policy of

[228] Rockefeller Foundation [henceforth RA], RG 1.1, Series 464, Box 8, Folder 62, W.S. Carter, 'The King Edward Hospital Medical College, Lahore, Punjab,' Volume XVI, 1926.
[229] For a discussion of the Punjab administration's initial accommodation of indigenous medical traditions, see J.C. Hume, 'Rival Traditions: Western Medicine and Yunan-I Tibb in the Punjab, 1849-1889', *Bulletin of the History of Medicine*, 51/2 (1977), pp. 214–31.

accommodation was at an end, and what had previously consisted of the vernacular class was thereafter moved to Amritsar. What was formerly the English class became the Lahore Medical College. When it was rebuilt and renamed in 1910 as a memorial to the death of the British monarch, half of the funds for its building were summarily donated by Indians in Punjab and the Native States. Though the Medical College was responsible for meeting the needs of all the north-western provinces of India—modern-day Pakistan—students generally came from Punjab with a smaller contingent from the NWFP.[230] Eventually however, the entire class of approximately 75 students came to be funnelled in from the Punjab Government College of Arts and Science in Lahore, which was notable for the number of European instructors on its staff.[231]

KE's commitment to hiring and training the future elite of the IMS received an inordinate amount of praise from Carter. He was in support of an exclusive IMS because he saw the prospect of entry into the selective medical corps as providing a 'constant stimulus and incentive' for potential candidates to perform better and thereby raise the quality of entrants.[232] Simultaneously, this exclusivity provided a social reward for the select few who received admission and perpetuated the august position of the imperial service. Prestige was a costly currency, however; it made the medical school and Mayo hospital the most expensive in all of India to run because of the high proportion of IMS officers serving on staff as instructors and administrators.[233] The slow speed with which Indianisation of the superior services was carried out in the province also threatened to deplete precious stores of political capital at a time of increasing demands for greater political and administrative privileges for Indians in the running of own country. The fact that the medical schools and hospitals of the Punjab remained a citadel for European and IMS officials into the 1920s despite the reforms of 1919 that devolved political power to Indians was no coincidence. The competition between those within and without the service and between Europeans and Indians had stiffened to such a degree that the Secretary of State became obligated to supersede the Government of India and Government of Punjab in those

[230] *NWFP Hospitals and Dispensaries Report, 1908*.
[231] RA, RG 1.1, Series 464, Box 8, Folder 62.
[232] Ibid.
[233] Ibid.

hiring decisions which threatened to give preference to natives or those not belonging to the imperial services. When two teaching appointments at KE opened up in 1929 and permission was sought to recruit both European and Indian candidates for the posts, the Secretary of State for India telegrammed from London to assert that the authority for such a decision lay not with the local government but rather with the Government of India, 'on whom responsibility for protecting rights of these [IMS] officers devolves in the first instance'.[234] In fact, in the matter of *any* recruitment from outside the IMS, it was incumbent upon the GOI to inform the Secretary of State whether there was any officer belonging to the superior services who wished to be considered before making any final decision.[235]

Thus, the British government was loath to give up the privileges it enjoyed in the Punjab at a time when such privileges were being dismantled elsewhere. The slow speed of change was exacerbated by the fact that there was as yet an unresolved contradiction in the attitude of Indians who wished for appointment to the IMS to be opened up to more Indians and in the demands of *Unani* and *Ayurveda* practitioners and educators who sought government support for their profession/institutions. They sought to enhance their reputation and prospects by attaining the patronage of the state, but it was precisely the resistance to Indianisation which underpinned the exclusivity and prestige of institutions like KE and the IMS and which exercised the envy of subordinate services and indigenous medical practitioners. The exclusivist legacy of colonial rule perverted efforts to "decolonise" the medical profession—the desire to retain or acquire prestige and social capital through admittance to small, exclusive professional clubs overwhelmed the original, democratic logic of Indianisation.[236]

Nevertheless, the Punjab could not stand against the winds of change for long. Professorships that for so long were reserved for the IMS were soon opened up; however, this concession came with a simultaneous downward trend in the scale of pay and in the terms of recruitment.[237] This makes it evident that the opening up of previously closed off professional

[234] BL, IOR/P/11933, Telegram from Sec of State, India Office to GOI, 7 Aug 1929.
[235] Ibid.
[236] BL, IOR/Q/11, Memorandum of the Indian Provincial Medical Services Association.
[237] BL, IOR/P/11933, Nov. 1931, Pro. 1-7, Letter from Sec to GOI to Govt of Bengal, 29 Sep 1931.

and political opportunities did not always result in the elevation of Indians to the status previously occupied by Europeans. In fact, it often resulted in a downgrading of standards to those prevailing in the subordinate services to which Indians had traditionally been relegated.

Indianisation did not always lead to positive outcomes in terms of improving access to schools, jobs and promotions. The manner in which Indianisation was carried out could lead to a multiplication of grievances. N.G. Barrier for example has addressed the issue of increasing communalism in public life in response to the opening up of new opportunities in government jobs and educational institutions in the late 1880s which increased Hindu-Muslim tensions.[238] At KE, selection based on caste and religion became mandatory post-Indianisation. 'It is necessary for peace and order in Indian institutions,' opined Carter, 'If the selection were made on scholarship basis alone, there probably would be a preponderance of Hindus.' These were no small grievances, for it was this very demand for access to privileges such as seats in schools and selection for government jobs that formed the platform of the Muslim League and paved the way for the creation of Pakistan.[239] In the words of one Muslim who wrote of this issue to Mohammad Ali Jinnah, the founder of Pakistan, 'In all departments of the Govt., [at the] Centre and [in the] Provinces, there is high-handedness of Hindus. They have been trying to snatch away Muslim share of posts and encroach upon their legitimate rights by hook or by crook.'[240]

Of course, the nature of medical professionalization was not relevant only to the ambitions of medical practitioners. The presence of only a limited amount of social capital to be rationed between medical men of various backgrounds created vested interests against the planned expansion of medical relief and greatly impacted access to medical care in rural areas. [241] In the 1920s, the Punjab Government proposed a plan to expand medical services in the rural

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[238] 'The Punjab Government and Communal Politics, 1870-1908', *The Journal of Asian Studies*, 27/3 (1968), pp. 531-534.
[239] Liaquat Ali Khan, *Muslim Educational Problems*, Pakistan Literature Series, 7 (Lahore, 1952).
[240] Z. H. Zaidi, Quaid-i-Azam Papers Project, *Consolidating the Muslim League for Final Struggle, 1 August 1944-31 July 1945*, Quaid-I-Azam Mohammad Ali Jinnah Papers, 11 (Islamabad, 2005), Document 44.
[241] Douglas M. Haynes, 'Social Status and Imperial Service: Tropical Medicine and the British Medical Profession in the Nineteenth Century', in *Warm Climates and Western Medicine: The Emergence of Tropical Medicine, 1500-1900*, ed. by David Arnold (Atlanta, 1996), pp. 208–26.

areas of the province. Carter explained that the expansion was intended to create positions for medical practitioners of the sub-assistant surgeon grade 'but not for those with the M.B., B.S. degree.' In other words, there was little contribution to be made by graduates of this esteemed medical institution because, as Carter put it, 'King Edward College is furnishing the higher type of medical practitioner,' the kind destined for private practice in Punjab, the NWFP, and the Native States.[242] Jealousies over state patronage and social prestige also enabled the hardening of divisions between western and orientalist forms of knowledge in India.[243] At the time of the annexation of the Punjab, a far-reaching program had been devised to utilise the help of *hakims*, trained and certified by colonial institutions like the Lahore Medical School, to expand access to medicine in those areas not adequately served by centrally located government-funded dispensaries. These efforts were obstructed due to the efforts of those in the provincial administration who felt uneasy about the possibility of *hakims* using this operation as a platform to promote the interests of local medical traditions at the expense of practitioners of biomedicine.[244]

The medical school's two affiliated hospitals, the Mayo and later the Albert Victor, were designed with colonial ideas of separation in mind and organised according to an apparent hierarchy of social groups. The Mayo Hospital was for natives and was the teaching hospital for the Medical College, whereas the Albert Victor Hospital was for the use of Europeans and Anglo-Indians only and it provided private medical treatment. Sehrawat has written extensively on the manner in which dispensaries and hospitals founded by the colonial state were a means to disseminate Western ideas of hygiene and medicine to indigenous society.[245] Through the Mayo Hospital, the Punjab Government sought to change the health-oriented behaviours of patients, its urban-centric location drawing attention to the material presence of the state and its funding by

[242] RA, RG 1.1, Series 464, Box 8, Folder 62.
[243] For a discussion of the evolution of ideas in colonial science and medicine, see Mark Harrison, *Climates and Constitutions*, (Oxford, 1999); for a history of the interaction between local and western forms of knowledge in colonial India see Arnold, *Science, Technology and Medicine in Colonial India*.
[244] John Chandler Hume, 'Colonialism and Sanitary Medicine: The Development of Preventive Health Policy in the Punjab, 1860 to 1900', *Modern Asian Studies*, 20/04 (1986), p. 722.
[245] *Colonial Medical Care in North India*, p. xxvi.

indigenous notables in Punjab serving as a triumph to the ideologies of colonial governmentality.[246] The building of this hospital institutionalised certain forms of knowledge and attitudes which would thereafter seep into local cultural consciousness. As I will discuss below, beyond the medical treatments it afforded, the Mayo represented the advent of modernity with respect to health in the Punjab through its demonstration of institutionalised, compartmentalised, western medicine.

Established in 1871, the Mayo was opened for the use of 114 Europeans, Anglo-Indians, and Indians, however it was created primarily for the benefit of Lahore's resident European population.[247] The first year that the hospital was up and running, special wards were set up for housing and treating a dangerous but distinct class of patients—European lunatics and drunkards—separated from the Indian patients. Other forms of segregation were subsequently carried out. First, the wards of the contagious diseases patients were separated from the public road passing nearby the hospital, which was considered to be insufficiently guarded. This was meant to change society-at-large's interaction with the hospital and with the sick. Writing about the need to erect a wall between the contagious diseases ward and the public lane, the Principal of the Lahore Medical School explicated, 'During the late epidemic of cholera, it was found that many persons passing along this lane were induced by curiosity to stay and watch the cases of cholera which were being treated in the separate ward, and some even climbed over the wall or remaining sitting upon it to do so.'[248]

Though the problem of contagion seems to be the obvious reason for effecting this separation, it was not the sole reason. The hospital administration expressed concern about the short height of the wall surrounding the hospital 'as this affords opportunities to some of the convalescent patients to climb over the wall and escape to the bazar, where they spend their time begging and only return in time for the distribution of food at night in the hospital.' Seclusion of danger was an important component of early forms of segregation in the hospital, but

[246] Ibid., p. xxix.
[247] RA, RG 1.1, Series 464, Box 8, Folder 62.
[248] BL, IOR/V/24/731, Report of the Mayo Hospital for the Year 1872; RA, RG 1.1, Series 464, Box 8, Folder 62.

increasingly, boundaries came to be delineated based on principles of expected behaviour. From this anecdote, it seems that patients allowed to convalesce in the hospital were not envisioned as those who were escaping homelessness or penury, but rather those who were afford the privilege of hospital medicine. Eventually, the criteria for separation became even less medically relevant, as epitomised in the building of the Albert Victor Hospital within 20 years of the Mayo Hospital's founding. Housing European patients for private treatment, it was closed off to teaching, and so the Mayo with its population of Indian patients served to provide the subject matter for clinical teaching in the medical school.[249]

The hospital and medical school offer illustrative examples of how preeminent institutions of medical education and treatment could be built, staffed, and run according to the highest principles of colonial rule and western biomedicine, and be entirely unsatisfactory for the needs of the local population. They exemplified the distinction between biomedicine as an ideal and biomedicine as a practice in the colonial context, the former aiming to be benevolent and universal, the latter manifesting as particularising and patronising. They also provide critical information on the origins of institutional health behaviours which persisted in independent Pakistan. Proper behaviour in hospitals had become a matter of public etiquette by then. Writing to the *Dawn* newspaper in 1950, one Pakistani citizen complained of the presence of food sellers in hospitals who posed a danger to the sanitary environment. 'It is common knowledge that in hospitals rigid restrictions are enforced on the diet of the sick and it is, therefore, needless for me to add that free access to eatables as referred to above, will assuredly retard the speedy recovery of patients therein.'[250] In another instance, the editorial board of the same newspaper wrote of the need for proper funding and building of health institutions following floods in Punjab with the same preoccupation with public virtue underlying it as was evident in colonial discourse: 'We repeat our suggestion that the new habitations should be built with strict regard for ventilation,

[249] Ibid.
[250] Mahboob Ali Khan, 'Hawkers in Hospitals', *Dawn*, 31 Oct 1950.

drainage and general sanitation…This will be a test of administrative efficiency, public spirit, and much more.'[251]

Public Sanitation in the Canal Colonies

> …to protect settlers from the consequences of their own want of thrift and foresight and to create villages of a type superior in comfort and civilisation to anything which had previously existed in the Punjab.
>
> (Report of the Colonies Committee)

The influence of the state on the health habits of the people did not only come strictly by way of medical institutions. In Punjab, the most dramatic impact on public sanitation came with the construction of canal irrigation, in both good ways and bad. British irrigation infrastructure in India has been described as one of the 'greatest monuments to British rule'.[252] The canal colonies that resulted from the expansion of irrigation were the product of a grand experiment to bring water to the sparse, periodically cultivated dry plains of west Punjab. Begun in 1892 with the launch of the Lower Chenab Canal Colony, by 1931 the process had resulted in the development of settled agriculture across more than 13 million acres and the migration of over one and a half million people into the colonies.[253] It transformed the 'arid wilderness' of central-west Punjab into the richest piece of land in all of Punjab, with the eight colony districts contributing more revenue to the coffers of the GOI than all the 21 remaining districts of the Punjab put together, and made the colonists of the central Punjab the richest farmers in India.[254] But the aim of expanding canal irrigation was not solely to multiply the material output of British India.[255] By reclaiming the land for cultivation and redesigning the village space, colonial administrators and engineers sought to make not only agriculture more efficient but agriculturists as well. 'The spread of settled agriculture went hand in hand with the "reclamation" of the *Janglis*, the original

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[251] 'Editorial: Punjab Floods', *Dawn*, 10 Oct, 1950.
[252] Ian Stone, *Canal Irrigation in British India: Perspectives on Technological Change in a Peasant Economy* (Cambridge, 1984), p. 1.
[253] *Chenab Settlement Report* (Lahore, 1915), p. 1 qtd. in Indu Agnihotri, 'Ecology, Land Use and Colonisation: The Canal Colonies of Punjab', *Indian Economic & Social History Review*, 33/1 (1996), p. 38.
[254] Ibid., p. 39; Dewey, *Anglo-Indian Attitudes*, p. 62.
[255] Agnihotri, 'Ecology, land use and colonisation,' p. 38.

inhabitants of this region,' writes Indu Agnihotri.[256] The colonisation scheme's impact on these *jangli* or "wild" inhabitants was heralded as an 'administrative achievement'.[257] Beyond all that, the canal colonies reflected the vision and fiat of the colonial administration as it attempted to strictly enforce sanitary codes and policies.

On the basis of these developments alone, canal irrigation merits serious consideration in the historiography of colonial rule in India. The demographic and economic changes put into motion by the material success of this campaign touched on countless aspects of colonial politics, economy, and society.[258] There is a body of literature explicating the political economy of agriculture and irrigation in colonial Punjab.[259] In the sub-discipline of history of science and medicine, several works have elaborated on the transformative effects of technical innovation on agricultural expansion and also the medical impact of canal irrigation, largely with respect to the incidence of malaria.[260] The relationship between canal irrigation and increasing incidence of malaria, which culminated in the 1908 malaria epidemic in Punjab, was the subject of intense scrutiny at the time it occurred. Writing in 1911, one of the leading malariologists in India, Major S.R. Christophers concluded that 'epidemic prevalence is in no way due to these great irrigation works,' and instead posited that conditions of famine increased susceptibility to disease while

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[256] Ibid.
[257] *Chenab Settlement Report* p. 45, qtd. in Agnihotri, 'Ecology, land use and colonisation,' p. 39.
[258] For some general works on canal irrigation in British India, see Stone, *Canal Irrigation in British India*; Elizabeth Whitcombe, *Agrarian Conditions in India*, (Berkeley, 1972); Imran Ali, 'The Punjab Canal Colonies, 1885-1940', (Australian National Univ., Ph.D. thesis, 1980).
[259] Elizabeth Whitcombe, *Agrarian Conditions in Northern India* (Berkeley, 1972); B.H. Farmer, *Agricultural Colonization in India since Independence* (London, 1974); Mridula Mukherjee, 'Some Aspects of Agrarian Structure of Punjab 1925-47', *Economic and Political Weekly*, 15/26 (1980), pp. A46-A58; Naved Hamid, 'Dispossession and Differentiation of the Peasantry in the Punjab during Colonial Rule', *The Journal of Peasant Studies*, 10/1 (1982), pp. 52–72.
[260] David Gilmartin, 'Scientific Empire and Imperial Science: Colonialism and irrigation technology in the Indus Basin,' *The Journal of Asian Studies*, Vol. 53, no. 4 (1994), pp. 1127-1149; D. Arnold, *Science, Technology and Medicine in Colonial India*, (Cambridge, 2004), pp. 115-121; E. Whitcombe, 'The Costs of Irrigation: Waterlogging, Salinity and Malaria', in D. Arnold and R. Guha (eds.), *Essays on the Environmental History of South Asia* (New Delhi, 1995), pp. 257-59; Sandra Zurbrigg, 'Re-thinking the Human Factor in Malaria Mortality: The Case of Punjab, 1868-1940', *Parassitalogia*, no. 36 (1994), pp. 121-35; Kohei Wakimura, 'Famines, Epidemics and Mortality in Northern India', in P. Robb, K. Sugihara and H. Yanagisawa (eds.), *Local Agrarian Societies in Colonial India: Japanese Perspectives* (London, 1996), pp. 280-310; W.F. Bynum, 'An Experiment that Failed: Malaria Control at Mian Mir', *Parassitologia*, no. 36 (1994), pp. 107-20; B.M. Bhatia, *Famines in India* (3rd edition, Delhi, 1991), pp. 123-7, 196-200. Also, see Lauren Minksy's paper on smallpox in the Punjab, "Pursuing Protection from Disease: The Making of Smallpox Prophylactic Practice in Colonial Punjab," *Bulletin of the History of Medicine*, Vol. 83, no. 1 (2009), pp. 164-190.

increased rainfall in Punjab created an environment conducive to the spread of malaria.[261] However, Randall Packard has argued that canal lands were indeed implicated in the lethality of the malaria epidemic because the lack of regulation by the state in development of agriculture in other areas of the Punjab, such as the southwest where land had newly came under irrigation by these canals, led to destitution among farmers and water-logging, ultimately contributing to famine conditions to which Christophers alluded.[262] Also aggravating the problem was the environmental and economic impact of droughts, which helped create conditions conducive to the spread of epidemic disease and worsening impact of food scarcity.[263]

In the vein of recent works in the historiography of colonial rule in the Punjab which have re-examined the rosy picture of state-society relations in the Punjab, this chapter will focus on the central Canal Colonies, which were part of the British Punjab Government's project to 'revitalize Punjab's agricultural economy' to understand how the state attempted and failed to implement sanitary reforms in the province.[264] In contrast to the southern canal lands, the state retained ownership of these lands and was active in enforcing agricultural regulations. Because they were subject to such intense control and because they were to be a model for state-driven agricultural modernity, the sanitary design of the central Canal Colonies reflected the ideologies and ambitions of the ruling regime in Punjab. It also reveals the relationship between the Punjab Government and the intended beneficiaries of the colony scheme as evidence by their response to the state's effort to remake their living space.

It is important to first lay out the views of public health officials and agricultural engineers on the existing state of sanitation in the Indian village in order to provide sufficient context for understanding the goals of the Canal Colonies' engineers when they attempted to remake this environment. The earliest official opinions published on the state of health and

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[261] *Malaria in the Punjab*, (Calcutta, 1911), p. 103.
[262] Packard, *The Making of Tropical Disease: A Short History of Malaria*, p. 99.
[263] Mark Harrison, 'Public Health and Medicine in British India: An Assessment of the British Contribution', *Bulletin of the Liverpool Medical History Society*, 10 (1998), p. 46.
[264] Ibid., p. 99; Imran Ali, 'Malign Growth? Agricultural Colonization and the Roots of Backwardness in the Punjab', *Past and Present*, 114/1 (1987), pp. 110–32; Mukherjee, 'Some Aspects of Agrarian Structure of Punjab'; Hamid, 'Dispossession and Differentiation of the Peasantry in the Punjab'.

sanitation in India were concerned with the dangers to the health of Europeans. Reports on the health of troops stationed in the cantonments described the environment surrounding the cantonments and the Indians who regularly came into contact with the troops as reservoirs of disease.[265] Views of the Indian village tended to be similarly negative, as indicated by anecdotal evidence provided in the official and personal accounts of government administrators. 'To a stranger the most striking points about the village are common to almost all the Punjab villages—the complete absence of glass from all the houses, and the very insanitary surroundings…There is hardly a village of the Central Punjab of which this description is not true,' proclaimed an economic survey on the village of Gaggar Bhana by the Punjab Board of Economic Enquiry authored by a Punjabi Indian.[266] British-born ICS officer F.L. Brayne had a similar reaction to the rural environment, though his description was far more visceral:

> The first thing that struck me on approaching the village was the overpowering stink. Then, from the objects on the ground I thought I had strayed into a latrine. A breeze was blowing, and my eyes, nose and mouth were assailed with bits of flying filth and poisonous dust. I found heaps of foul rubbish everywhere. Finally, the dear children came into view and I was shocked at their filthy condition. Most of them looked as if their parents did not know what water was or what washing meant.[267]

Any views to the contrary were often exceptions that proved the rule. One government official in the Punjab noted in his report on the administration of the colonies that he had been '"*astonished* at the high standard of cleanliness maintained in the interior of the houses inhabited by the *Janglis*."'[268] Malcolm Darling, who was a contemporary and colleague of Brayne's, gave further proof of the nature of prevailing opinion when he wrote, 'it is a complete fallacy to suppose, as stated in a book which I was reading to-day, and as believed by many who live in this country, that most peasants live "in filth and squalor".'[269]

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[265] Harrison, *Public Health in British India*, pp. 76-77.
[266] BL, IOR/V/25/800/7, Economic survey of Gaggar Bhana.
[267] Qtd. in Dewey, *Anglo-Indian Attitudes*, p. 71.
[268] *Punjab Colonies Report* (Lahore, 1932), qtd. in Malcolm Lyall Darling, *Wisdom and Waste* (London, 1934), Internet Archive [eBook] <https://archive.org/details/wisdomandwaste033049mbp> [accessed 5 July 2014].
[269] Darling, *Wisdom and Waste*, p. 144.

The most useful contemporary account of the developmental goals and societal impact of the Canal Colonies was authored in 1930 by Paul Paustian, a professor of agriculture from Columbia University in New York who spent five years residing in the Punjab.[270] His descriptions of the rural environment fell in line with predominant characterisation of the landscape as unhealthy, disorderly, and profoundly inefficient. To Paustian, the average Punjabi village was 'generally quite bereft of order, its streets wandering crookedly about.'[271] Its inhabitants were generally content to do nothing more than 'bring out their charpais and spend the long summer days smoking the hookah while they discuss the petty gossip and social problems of the village in the shade of the tree.'[272] His perceptions of rural habits and customs were saturated with the implication that disease and sickness overshadowed the lived experience of Indians 'from their soiled cradles to their premature graves'.[273] This attitude was illustrated for example in his discussion of the cultural preference among villagers for having sons. Paustian saw this inclination as being the cause of India's excessive maternal mortality rates; in light of the relatively low chances of survival for a child in the insalubrious rural environment, the need to produce a living male child created a public health burden because it led to a heavy birthing rate, and the risks to the mother with each birth caused a heavy death rate among women.[274] G.S. Singh also made a point of mentioning dangers to child health in his report to the Punjab Board of Economy Inquiry on the conditions prevailing in the village of Gaggar Bhana. 'For sick persons and infants…conditions could hardly be worse,' wrote Singh, 'Every possible circumstance seems to be present to hinder recovery or to shorten life.'[275]

The rural environment was not only a danger to public health but also to economic productivity. The discussion of health risks and mortality rates in the various economic reports and accounts mentioned above indicates that administrators and technical experts viewed disease

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[270] *Canal Irrigation in the Punjab: An Economic Inquiry Relating to Certain Aspects of the Development of Canal Irrigation by the British in the Punjab* (New York, 1930).
[271] Ibid., p. 98.
[272] Ibid.
[273] Dewey, *Anglo-Indian Attitudes*, p. 62.
[274] Paustian, *Canal Irrigation in the Punjab*, p. 100.
[275] BL, IOR/V/25/800/7, Economic survey of Gaggar Bhana.

as being related to economic mismanagement, and it is unsurprising therefore that in the case of the canal colonies, public health improvements were justified as being an integral part of the overall economic development strategy. Again, with reference to the problem of cultural preference for sons, Paustian warned not only of its health risks, but also expressed worries that the resulting overpopulation would undo the economic gains made from increases in cultivable land.[276] Without being able to secure these gains, the nutritional advantages of the increased food supply in helping the population ward off disease would be lost.

The source of sanitary and economic inefficiency in the village was primarily the inability to utilise spaces in the most optimum way. At one point in his monograph, Paustian discusses at length the problem of manure, a topic that generated a not insignificant amount of interest among British officials.[277] Though indignant about the offensive and malodorous fumes and accompanying flies that emanated from the manure placed by the walls of village houses, the American professor was quite possibly even more disturbed by the economic losses it entailed. The use of manure for fuel by Punjabi villagers openly thwarted British efforts to encourage the use of manure in the fields and thereby increase agricultural outputs (and revenue receipts).[278] '[T]o burn it as fuel is to kill the goose that lays the golden egg.'[279]

The envisioned model villages of the canal colonies were not to be like these villages of old, which sprung up unthinkingly and were beholden to the yoke of tradition. The colonies were to be the output of the rhetoric and applied logic of scientific imperialism. They were, as Darling put it, evidence of the 'beneficent hand of man'—a phrase that encompasses the imperial ethos of obligation, confidence in western technical knowledge, and the ambition to apply that ethos and confidence to reshape the unhealthy and uneconomical landscape of an uncivilised land.[280] Notably however, irrigation works had been undertaken in the region since before the time of the

[276] Paustian, *Canal Irrigation in the Punjab*, pp. 78-9.
[277] Dewey, *Anglo-Indian Attitudes*, p. 68.
[278] Paustian, *Canal Irrigation in the Punjab*, p. 98
[279] F.L. Brayne, *Better Villages*, (3rd edn, Bombay, 1945), p. 46, qtd. in Dewey, p. 68.
[280] Malcolm Lyall Darling, *The Punjab Peasant in Prosperity and Debt* (London, 1928), Internet Archive [eBook] <https://archive.org/details/punjabpeasantinp032066mbp> [accessed 5 July 2014].

British, and indeed initial efforts to reclaim land in Punjab relied on the existing though dilapidated irrigation infrastructure left behind from Mughal rule.[281] But the modern British approach was considered to be distinctive in many ways. The first element of this distinctiveness was the apparently unique application of expertise and foresight. Whereas Indian villages sprang up carelessly and with no regard to the principles of hygiene or economic productivity, and whose environment seemed to define rather than be defined by the needs of their residents, the canal colonies were purposefully designed by trained engineers who exercised full control over the spaces and determined their boundaries and divisions. Those public works engineers who were reimagining the village space were also validating certain aspects of rural life when they deigned to grant any particular activity a discrete and demarcated space, whether it was public grazing grounds or accommodations for village servants or communal areas where caste customs and traditions could be carried out.[282]

'The colony villages which are thus methodically planned naturally possess marked sanitary advantages over the ordinary Punjab villages which just grow with the needs of the community without definite plan and certainly without serious attention to sanitary requirements,' Paustian wrote.[283] On the surface of it, laying out canals, making maps, fixing boundaries, and allotting holdings may not seem particularly significant to demonstrating the will to power of colonial administrators and technical experts. However, it is important to consider that up to this point, efforts to change sanitary behaviours largely took place within the colony's scarce few western institutions, like the Mayo, which were littered across a vast and seemingly apathetic subcontinent. The experience of the colonisers up to this point had largely been reactive as they tried to mitigate the immense disease burden of the tropical environment with hopelessly inadequate interventions imported from the West. Some anecdotes from Dewey's *Anglo-Indian Attitudes* regarding efforts to tame endemic and epidemic diseases in rural Punjab make this clear. He describes Brayne's efforts to bring down malaria in the district of Gurgaon through the

[281] Agnihotri, 'Ecology, land use and colonization', p. 39.
[282] Paustian, *Canal Irrigation in the Punjab*, p. 65.
[283] Ibid.

drainage of all pools of stagnant water, 'Draining all these collections of water would have involved public works projects on a scale dwarfing the Indian railways and a degree of social discipline never attained in rural India,' Dewey dryly notes.[284] Regarding the efforts to eradicate plague, he states, 'The only permanent solution was rat-proofing…Rat-proofing an Indian village would have meant rebuilding it to a standard no underdeveloped country could afford.'[285] But with the canal colonies scheme, the colonial regime was in fact attempting to transform the very heart of Indian civilisation—the primordial village—in order to pre-empt social ills such as bad sanitation and the spread of disease, to change India itself and not merely respond to it.

The lands that formed the Canal Colonies were literally 'Waste Lands,' appropriated by the Crown as they were under no other proprietary claim (or more precisely, under no claim that was recognized, e.g. from the semi-nomadic pastoral population which had inhabited the arid *doab* or interfluvial region in sparse numbers up to that point).[286] Being the owner of the water supply and now the lands, the colonial regime possessed unmatched resources and capital to undertake major interventions and infrastructural projects, and its officers on the ground proceeded to eagerly flex their administrative muscle—it is worth noting that this provides a marked contrast to the state of affairs in the western frontier. At the broadest level, the state determined the developmental goals for these lands, which were to ease congestion on agricultural lands elsewhere and to promote agriculturists 'of the best type' to help the government in its endeavour to boost provincial land revenues.[287] At a microcosmic level, the state exercised 'fatherly discipline' as it 'insisted on village sites being laid out on a regular pattern…[and] on certain sanitary rules being followed.'[288]

The state thus leveraged its physical assets to exert its material authority. British officials were well aware that '[a]ccess to such assets enhanced the economic well-being and the socio-

[284] Dewey, *Anglo-Indian Attitudes*, p. 72.
[285] Ibid., p. 76.
[286] Ali, 'Malign Growth,' p. 116; Agnihotri, 'Ecology, land use and colonisation', p. 43.
[287] N. Gerald Barrier, 'The Punjab Disturbances of 1907: The Response of the British Government in India to Agrarian Unrest', *Modern Asian Studies*, 1/04 (1967), p. 355.
[288] James M. Douie, 'The Punjab Canal Colonies', *Journal of the Royal Society of Arts*, 62/3210 (1914), p. 617.

political power of those who obtained them.' They did not only apply hydraulic engineering to the landscape of the Punjab, but used social engineering to create a new elite class through geographic and socioeconomic consolidation. The people who were the beneficiaries of the settlement drive in these canal-irrigated lands were a narrow, select group culled from Punjabi society. Though the majority of the land in each colony was parcelled off in small holdings intended for grantees drawn from the peasantry, actual policy was designed in such a way that the only eligible groups for land grants were those belonging to the hereditary landowning peasant castes.[289] In the words of a former colonial official, the scheme was mainly intended for 'the best class of agriculturists, who will cultivate their own holdings with the aid of their families and of the usual menials, and will constitute healthy agricultural communities of the best Punjab type.'[290] Among this group were the civilians and former soldiers who had served the government in some way, and were being rewarded through the auctioning and gifting of government lands. 'The dispensation of resources proved a lucrative element for the development of collaborative ties between the rulers and their beneficiaries. Such wherewithal for winning allegiance certainly seemed to have given the British greater authority in the Punjab than in other parts of their Indian empire,' writes Imran Ali, a historian of colonial rule in the Punjab.[291] Drawn from the privileged classes, these individuals quite naturally already had existing properties and occupations in other urban and rural towns, and were sometimes unwilling to leave their existing properties to tend to their new holdings, especially when they might instead rent out the land.[292] This class, the most susceptible of being moulded by the colonial government due to its close association with the regime and the positive reinforcement it merited from the administration, nevertheless became increasingly dissatisfied with its role in the government's land colonisation scheme.

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[289] Ali, 'Malign Growth?', p. 117.
[290] Douie, 'The Punjab Canal Colonies', p. 614.
[291] Ibid., pp. 116-7.
[292] This government was a major culprit responsible for the absenteeism it blamed on the tenants. Douie explained, 'when genuine agriculturists were selected and recommended by deputy commissioners, it naturally happened that the men they wanted to reward—and a colony grant was soon immensely coveted—were the very men who were most useful in their own districts, who did not wish to leave, and whom he did not wish to spare.' Douie, 'The Punjab Canal Colonies', p. 618.

Barrier has explicated the various aspects of administration that made tenancy arrangements untenable. Grantees had to live on their land, cut wood from specified areas, abide by particular sanitary and conservancy codes, and could not aspire to ownership of the lands they held. 'The Colonization Officer and his subordinate Indian staff supervised all the details of colony life in order to ensure that each colonist fulfilled his conditions and contributed to the well-being of the entire community. The officer was virtually a dictator. His word was final in all disputes over revenue or conditions.'[293] Officials in the Punjab administration fully acknowledged that the actions of government officials tended towards the autocratic, even those who were sympathetic to the program, such as James Douie, one-time secretary to the Financial Commissioner of the Punjab. He believed that such benevolent autocracy 'was just what was wanted at the time'.[294] The colonists for their part refused to be subjugated to the increasingly onerous administrative regulations regarding their tenancy responsibilities, or put up with corruption from Indians of lower status than themselves who aided the Colonization Officers in carrying out the duties of administering the colonies.[295] They did not hesitate to express their dissatisfaction over being relegated to the status of mere tenants when the state refused to give up its right of ownership.[296] It became clear that they treated their inclusion in Government's vaunted development effort as a sign of social recognition, not administrative obligation, and were disappointed by the myriad ways in which their position in the colony scheme reflected subordination rather than partnership with the colonial government.

What was the source of the dissatisfaction? Apart from the inability to gain ownership over the lands in the colonies, the aggravating issue for the colonists was the cumbersome sanitary regulations. Though works on the political history of the Punjab address the development of the canal colonies and the political strife that developed from 1907 to 1910 in the province, little emphasis, if any, is given to the fact that it was the state's imposition of sanitary and public health duties on the population and the manner in which these were imposed which

[293] Ibid., p. 357.
[294] Douie, 'The Punjab Canal Colonies', p. 614.
[295] Ali, 'Malign Growth,' p. 119.
[296] Ibid., p. 120; Barrier, 'The Punjab Disturbances of 1907', p. 357.

ultimately brought state and society to blows. The presence of filth in compounds, houses, even cattle-sheds, was subject to disciplinary measures. Failure to undertake certain measures such as the removal of manure was subject to fines. But there were not only problems of commission but of omission. Dug pits had to be vigilantly kept protected from becoming cesspools, and failure to plant trees was a punishable offence. Countless fines were levied to punish various forms of rural pollution. There were constant inspections being carried out of the sanitary conditions of the compounds in the villages, often by multiple officials ranging from the settlement commissioners to local clerks known as *patwaris*. Most importantly, the insistence upon cleanliness in so particular a manner opened up countless opportunities for bribery and extortion through the subordinate bureaucracy 'which was entirely native in composition and ever ready for corruption and coercion.'[297]

Two documents which formed part of the Punjab Government's investigation into the Canal Colonies disturbances help us to understand the divergent expectations of the colonists and the government.[298] The first was a letter representing the interests of the landholders and the second was a report by the Settlement Officer of the Chenab Colony. These documents reveal that colonists were not opposed to the civilising ambitions or sanitation goals of the government—these were not objectionable as long as they could be ignored whenever they were at cross purposes with personal convenience. The real complaint seems to have been the fact that these policies were being perpetuated in a manner not commensurate with the social status of the land grant holders. The fact that they were being instructed in how to design the layout of their houses, where to dispose of the waste, or how to maintain their compounds in a manner least offensive to the administration was a galling reminder that they were not masters of their own lands. The fact that the greatest outpouring of opposition in the colonies—as evident by the flurry of political meetings and pamphleteering—came in 1907 after the government tried to push

[297] Ali, 'Malign Growth,' p. 119.
[298] Mss Eur D573/12: Letters from Minto to Morley, 1907.

through legislation which threatened to perpetuate the status of grantees as tenants and prevent them from becoming owners gives validity to this interpretation.[299]

The letter from the landholder's association on the subject of grievances against the Canal Colonies administration confirms that the indignation of the colonists regarding their status in the colony scheme was the main explanatory factor for the agitation that resulted, and the sanitary regulations reinforced this status. The letter drafted by barrister Mohammad Shafi described in brief the history of the colonisation of the lands and the prominent role played by the monied classes—'the radical lawyer politician, the wealthy gentleman-at-large, the man who had enriched himself by means of commissariat and other Government and private contracts'—as well as officers of the civil and military departments, all leading men from the agricultural tribes of the Punjab and other persons of influence who had rendered service to the Government. These were men of standing in Punjabi society; such status was the very basis of their eligibility for land grants.[300] These type of men acutely sensed the insult of being shaken down by an Indian of lower social status or 'a young civilian of comparatively little experience in service whose acquaintance with the manners, customs, and feelings of the various classes….was of the slightest, and who treated the colonists of all ranks with equal iron sternness,' on top of the financial injury of increasing penalties. While Shafi conceded that government's objective was to frame rules 'for the proper sanitation of these model villages,' it was not the prerogative of government to *impose* these rules on the agriculturists. 'These classes, consisting as they do of the wealthiest and the most influential persons of various tribes and creeds, should not be subject to any special legislation,' and certainly not by their social inferiors or those members of government who sought to do business with them without acknowledging their superior status.

The government's response was exasperation; '[I]t is quite likely that in the desire to make the colony a model settlement in every respect the thing was overdone. But it is hopeless to avoid a good deal of interference if the sanitary evils which are prominent in eastern villages are

[299] Ali, 'Malign Growth,' p. 119.
[300] Douie, 'The Punjab Canal Colonies', p. 617-8.

to be kept under in new colonies.'[301] F. Popham Young, the Settlement Commissioner, wrote to Government clarifying the sources of discontent and hoping to set straight the criticisms that were raining down on the administration.[302] Young contended that the officers only did what was logically incumbent upon them according to the responsibilities vested upon them by Government and certainly this kind of micromanagerial and interventionist role is exactly what was expected of the inspecting officers. According to the Report of the Canal Colonies Committee, the Colonization Officer 'was expected to have the inhabited sites laid out in an orderly method, to secure sanitation foreign to the customs of the settlers and to see that the colony provided itself with trees to replace the natural growth destroyed in the process of colonization.'[303] More broadly, the Officer 'was expected, in the expressive phraseology of the East, to be the settler's "father and mother,"' and naturally as a result he 'exercised fatherly discipline in ways that were less welcome.'[304] From Government's perspective, its massive capital investment in agrarian and infrastructural innovation made such policies and methods necessary. Without retaining proprietary rights and imposing strict regulations, the state would not have been able to direct economic development in the region nor act in its capacity as a driver of innovation.[305] Furthermore, the effort to impose sanitary regulations in a sustained manner spoke to the moral obligations of colonialism, which intimately accompanied its economic motives. As Barrier has explained,

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[301] Ibid., p. 617.
[302] This was the same F. Popham Young in whose praise a poem was written by a resident of Chenab Colony—'a local Homer'—of which a few lines are worth quoting:
How of old the Bar was of thieves the prey,
The shelter of jackals, and rats, and deer.
Now no barren jungle remaineth here—
Young Sahib has peopled the land
…Where the whirlpools churn,
The river was curbed and a weir was made—
Young Sahib has people has peopled the land.
He indeed is a mightly ruler
On whom he looks with a favourable eye;
Him in a moment he lifteth high.
From Douie, 'The Punjab Canal Colonies', p. 614.
[303] BL, IOR/V/26/315/1, Report of the Canal Colonies Committee.
[304] Douie, 'The Punjab Canal Colonies', p. 614.
[305] Ali, 'Malign Growth,' p. 121.

> [T]he Chenab colony was to be a social and economic experiment, a model farm for the rest of the Punjab. Healthy agricultural communities "of the best Punjab type" would be established and kept under constant supervision. These in turn would demonstrate to other Punjabis how proper sanitation, careful economic planning, and co-operation with the government could result in a higher standard of living.[306]

Some colonial officers sympathetic to the colonization scheme claimed that it had indeed changed the rural sanitary environment. Douie proclaimed, 'A Jangli village site is a picture of orderly neatness and cleanliness. One might really, without much exaggeration, say that you could eat your dinner off the floor.'[307] Malcolm Darling chose more stirring words to describe the impact of the sanitary re-engineering of village spaces in the model villages of the Canal Colonies, in contrast with areas to the west:

> In the last chapter [concerning the westernmost regions of Punjab] we were in an atmosphere of poverty, ignorance, and oppression. In the great Canal Colonies that are about to be described, we feel everywhere the beneficent hand of man. In the former, life is the immemorial life of India, primitive, isolated and fatalistic; in the latter, it is the new life brought in by the Pax Britannica, prosperous, progressive and modern. But for the imagination and enterprise of a dozen engineers and bureaucrats, virtually the whole country between the Jhelum and the Sutlej, west of the main line of the North-Western Railway, would have had to be included in the area dealt with in the last chapter.[308]

The changes in sanitation were intimately connected with the broader efforts to civilise the Punjab and create a new class of subjects by changing the environment and living conditions of well-off agriculturists. 'The standard of comfort has obviously risen and it is clear from the pride which the majority exhibit in their well-planned…villages that their ideas of sanitation have advanced far beyond those still obtaining in the districts from which they came,' proclaimed the administration.[309]

Popham Young, who was the mastermind of the social engineering aspect of the colonization scheme which had sought 'to transform the Bár nomads from cattle thieves into industrious farmers,'[310] conceded that in the matter of enforcing sanitary rules, 'it will be wise and right, to ease off considerably in the enforcing of rules, the correcting of faults, and the

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[306] Barrier, 'The Punjab Disturbances of 1907', p. 356.
[307] Douie, 'The Punjab Canal Colonies', p. 617.
[308] Darling, *The Punjab Peasant*, p. 128.
[309] BL, IOR/V/26/315/1, Report of the Canal Colonies Committee.
[310] Douie, 'The Punjab Canal Colonies', p. 617

general education of the colonists in the conduct of life.'[311] Consequently, in the sphere of sanitation, official attitudes became more acquiescent as the sanitary ambitions of the colonial government were not worth losing precious allies. 'We now try to gain the same end by more indirect means,' explained Douie, 'namely, by rewards for cleanliness, and by making the insanitary state of a colony village a reason for deferring the purchase of a proprietary title by the settlers.'[312]

Young believed that the intentions of the administration were good and the sanitary principles objectively sound, yet Government had ultimately failed to show resolve in its initiative to improve the living habits of the people:

> [I]n their efforts to induce the colonists to lay out and build spacious and well-ordered villages, and to keep these clean and sanitary, they have, as agents of the Government, initiated a policy of which Government can but approve…although I am aware that certain high officers of Government talk as if we should have done better had we left the people to herd together in their villages just as they pleased.[313]

That, Young writes, would have been cowardice. *The Report on the Canal Colonies Committee* certainly affirmed the Government's capitulation, noting in the aftermath of the zamindars' agitation, 'They [the Committee] prefer to rely largely…on the gradual reduction of Government interference in every direction when and where that can be done; thus ultimately bringing the colonies as closely as is possible into line with the old districts of the Punjab.'[314] They sacrificed sanitary and public health reform at the altar of political expediency.[315]

The conclusion that it is possible to draw from these findings is that the Punjab government originally saw itself as imposing civic duties on a class of Punjabis who were loyal and occupied a high social position, which would ideally make them amenable to the state's suggestions for social change and serve as a model for the other classes.[316] These engineering

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[311] Mss Eur D573/12: Letters from Minto to Morley, 1907.
[312] Douie, 'The Punjab Canal Colonies', p. 617
[313] BL, IOR/V/26/315/1, Report of the Canal Colonies Committee.
[314] Ibid.
[315] Imran Ali makes this point strongly in his article, bluntly stating that the state 'forfeited' its role as an agent of economic development, innovation, and social improvement which had formed a major portion of the initial enthusiasm for investing in land settlement in the *doab*. Ali, 'Malign Growth,' pp. 121-2.
[316] Barrier, p. 356.

projects, for all that their immediate economic benefits, would also have been considered to be immensely significant to proving the ability of the British to develop backward India – to fulfil their responsibility to apply the technical skills and superiority of knowledge they had by 'raising the standard of civilization in rural communities which had been specially vouchsafed to us.'[317]

The landowning classes, on the other hand, viewed their inclusion in government's vaunted development effort as a sign of social recognition—a means for them to acquire more social capital by associating themselves with the government's scheme—and not a source of obligation, because they believed that the land was in effect being granted as a gift for services already rendered, i.e., loyalty to the colonial regime. From their point of view, the colony holding was a token of patronage from the Punjab government, in the manner of the kind of client-patron relationship existing between the Mughal kings and nobles. Young explicated the mindset of a typical land grantee as follows:

> The Sarkar is offering me this reward because the Sarkar is pleased with my services. Of course I accept what the Sarkar offers. There is a condition attached about residence in the Colony which seems to be inappropriate. But no doubt the Sarkar only means that I must take care that my land is properly cultivated, that my tenants have proper houses to live in, and that someone is present to do the Sarkar's bidding. And if in the future there is any difficult about this matter of residence, why then I will ask the Sarkar to excuse me, and all will be well.[318]

The ultimate failure of such grand hopes in the matter of social policy, which was based on British confidence in imperial strength and scientific genius, reveals the precariousness of Britain's political presence in Punjab. This challenges the triumphant narrative of infrastructural modernization, the dramatic economic benefit the province derived from colonial intervention, and the oft-cited loyalty and amenability of Punjabi subjects. This is contrast to the more resilient impact of institutional health in Punjab.

Conclusion

In his speech to the Royal Society of Arts delivered in 1914, James Douie proclaimed,

> The growth of the Punjab in wealth and prosperity has been the outcome of the harnessing of the rivers by a succession of able engineers. It is not without reason that the motto of the province, "Crescat e fluviis," was adopted. An irreverent person, whose

[317] Mss Eur D573/12: Letters from Minto to Morley, 1907.
[318] Ibid.

> nose has been assailed by the odours of a Punjab village in the cold weather, may say in his haste that an *f* has dropped out and that "Crescat effluviis" would be more appropriate.[319]

His comments help inform us that when it came to any kind of development scheme or strategy being pursued in the Punjab, the province's sanitary state was never far from the official mind. Clive Dewey's masterful study of the Indian Civil Service also does not fail to mention the significant amount of attention paid by colonial officials to matter of rural health in Punjab. The Canal Colonies, though they were ostensibly an agricultural development scheme, were also susceptible to this overarching preoccupation with rural sanitation and the underlying ideological purpose of British rule in India which was to fashion a new type of subject according to the fiscal needs and social values of British civilisation. Speaking about the decision to impose fines, penalties and other stringent measures, the Punjab Government's representatives wrote,

> [I]t would be wrong to neglect the opportunity afforded by colonization schemes of educating the agricultural classes in civilised and sanitary habits. They strongly deprecate resort to disciplinary measures in relation to acts which imply no moral turpitude. But they do not think that mere exhortation will suffice to wean the people from the careless habits of centuries.[320]

But as this investigation of the administrative history of the canal colonies demonstrates, the Punjab Government's grand hopes, which were based on confidence in imperial strength and scientific genius, were ultimately humbled by the precarious foundations of Britain's political involvement in India. This may seem surprising in light of how dramatically the province benefited from colonial intervention, but it ought to challenge our understanding of what the Punjab's loyalty to the colonial regime actually signified. It demonstrates the state's immense difficulty in inaugurating any meaningful or sustained change in behavioural health or environmental sanitation in the rural environment of India. The British Indian's Government's political capital garnered it loyalty, but it was not by any means correlated with a capacity to effect social change.

It is evident from the example above that the Government of Punjab had been eager for the opportunity to utilise its influence for inculcating change in society. But its eventual

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[319] 'The Punjab Canal Colonies', p. 611.
[320] BL, IOR/V/26/315/1, Report of the Canal Colonies Committee.

capitulation in the matter of sanitary regulation in the colonies ended up elevating the social and political power of the elite classes of zamindars and government servants and military men without the concomitant broad-based social transformation that their selection for residence in the pioneering Canal Colonies was meant to inaugurate.[321] It became apparent that these agriculturists were unwilling to deviate from pre-existing sanitary norms and practices even as they absorbed the agronomic infrastructural improvements and technologies made newly available to them by the Punjab Government. Their political position was entrenched at the expense of peasant farmers who might have benefited from the more 'egalitarian' treatment under the canal colonies' framework which made sanitary arrangements and amenities uniform for all colonists on the basis of environmental hygiene principles. This by no means implies that there was equality in the matter of dividing and allocating land or in the impact resulting from burdensome fines and penalties for sanitary infractions—being poorer they might generally have less wherewithal to maintain properties in the manner desired by Government or to bribe *patwaris* to overlook infractions that might give cause for eviction. But the arguments made by the zamindars' association indicated that its members expected to be outside the purview of rules established for public welfare even as their private incomes from agriculture flourished thanks to public investment and works, and further exacerbated that political and social inequality in the realm of public health and sanitation.

[321] Ali, 'Malign Growth', p. 132.

Chapter 4: Bengal

> [T]he educated Indian has come to the front by hard work; he has seized the education which we offered him because he first saw its advantages; and it is he who has advocated and worked for political progress…He has made a skilful, and on the whole a moderate, use of the opportunities which we have given him in the legislative councils of influencing Government and affecting the course of public business…Helped by the inability of the other classes in India to play a prominent part he has assumed the place of leader; but his authority is by no means universally acknowledged and may in an emergency prove weak.
>
> (E. Montagu and F. Chelmsford, *Report on Indian Constitutional Reforms*)

In the history of South Asian independence from colonial rule, the devolution of power in colonial India during the early 20th century can be cited as one of the major milestones that enabled the provinces of India and Pakistan to exercise the privilege of self-rule.[322] With the independence of these nations now in hindsight, the governance reforms of 1919 and 1935 can seem rather deterministic. However, as the analysis of the NWFP and Punjab demonstrated, the desire of the British colonial apparatus to retain control over policymaking did not fade in the face of growing demands for autonomy. The same was true in Bengal. Public Health and Sanitation was one of the key subjects transferred to local governments during the first Government of India Act of 1919, however there was a residual effort by bureaucrats to maintain some form of centralised control over health in the Bengal Presidency. It is worthwhile therefore to consider how shifting responsibilities for health can shed light on the process by which self-rule was actualized in India.

The subject matter of this chapter follows on the theme arising out of the previous two chapters, namely the tension between imperial ambition and the desire for local autonomy. This chapter will use the period during which responsibility for governance and health was being deliberately shifted to Indians to describe prevailing ideas held by British colonists and Indian politicians about the rights and responsibilities of government in determining policies that affected population health and well-being. The immense political stakes underlying the devolution of power grant further significance to the debates about government responsibility for

[322] Metcalf and Metcalf, *A Concise History of Modern India*, (Cambridge, 2006), p. 167.

public health. At precisely the time when the Government of India and the governments of the provinces tussled with native aspirants to power over what were to be the mutual responsibilities of these stakeholders in a vastly reconfigured political structure, the question of who had the right to determine public health policy became a charged one. In this way, the discussion below draws attention to the privilege and power that was signalled by the right to intervene in matters of population health, a privilege that became hotly contested in the climate of nationalism.

The case study for this chapter will be the Bengal Presidency, where in 1919 a series of debates and discussions were held regarding a potential Public Health Bill that would dramatically change the British-controlled Bengal Government's interference in the lives and health of Bengali subjects. This Bill was particularly significant because it was contemporaneous with the landmark Government of India Act of 1919. Though modern local government infrastructure had formally been in operation in certain parts of British India since the Ripon reforms of the 1880s, the legislative reforms of 1919 marked a major step forward.[323] The Ripon reforms had granted Indians a say in local affairs while giving them the responsibility of raising new taxes to fund local development works.[324] But the new Act changed the distribution of power. In response to pressure to devolve authority, which was particularly acute in places like Bengal, the Government of India Act of 1919 introduced a series of reforms at all-India and provincial levels that aimed to increase Indian participation in governance by transferring to provincial and local authorities matters that were previously the responsibility of the central and provincial governments, respectively.[325] It also introduced the principle of diarchy, wherein responsibility for less sensitive portfolios (education, health, agriculture, local government) was placed in the hands of non-official Indians ministers, i.e. officials not already serving within the government itself, who were responsible to the legislatures at the provincial level.[326] The legislation also made provisions for an increase in proportion of elected members in municipal,

[323] Hugh Tinker, *The Foundations of Local Self-Government in India, Pakistan and Burma*, (London, 1954), pp. 44, 106.
[324] Bose and Jalal, *Modern South Asia*, p. 84.
[325] Ibid., p. 106; Bose and Jalal, *Modern South Asia*, p. 105.
[326] Bose and Jalal, *Modern South Asia*, p. 105.

district, and local boards.[327] However, the British government in India firmly retained authority to determine the extent of this devolution of power, to command the first cut from local revenues, and to define the scope of responsibility and hierarchy of relations on these transferred subjects between local administrations and bureaucratic officials.

Far from signalling a commitment by the British Raj to set India on the path to independence, historians of Pakistan and Indian nationalism such as Ayesha Jalal, Sugata Bose, and Sumit Sarkar have noted that these reforms were not so intended, as evidenced by the persistence and increasing intensity of mass nationalist movements.[328] Instead, they were meant to drive competition among different groups at the local level and thereby divert attention away from the Centre where the Raj continued to wield control over essential matters of state including defence, international relations, and trade. They were also underpinned by a desire to transfer the unpopular work of raising funds for social improvements to elected politicians and local governments. Through the lens of public health policy, I intend to further show that these concessions, rather than spurring a change in governance attitudes, instead propelled concomitant effort by colonial officials to retain control over policy formation and the means to enforce compliance along policy lines. This was not merely out of a jealousy for power but due to a concern for efficient coordination of sanitary and public health works. The resulting battle between Indian aspirations for political and professional autonomy on the one hand and the entrenched position and prestige of government bureaucrats on the reveals much about the views of Indians and British officials on the causes of ill-health in India and the readiness of Indians for self-governance.

Foremost, this chapter will discuss the political changes that were occurring through the case study of the draft Bengal Public Health Bill. The Bill generated much discussion and correspondence between the Government of Bengal, its civil servants, and local politicians about how developments in the legislative sphere would affect efforts to improve the sanitary and

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[327] Edwin Montagu and Frederic Chelmsford, *Report on Indian Constitutional Reforms* (Calcutta, 1918), p. 123.
[328] Bose and Jalal, *Modern South Asia*, pp. 104-5; Sarkar, *Modern India*, pp. 144-5.

health situation in the districts of the Presidency. Subsequently, the landscape of public health policymaking in the Bengal (with some examples from other provinces) will be analysed, with reference to the various actors associated with the Government public health apparatus. Similar to the Punjab, the Bengal Presidency's Government recognised that efforts to promote health were critical to retaining its prerogative to rule at a time when elite Indians and nationalists were contesting that privilege. This illustrates that public health held tremendous importance precisely because it signified the right to assume political responsibility for Indian lives.

Sanitation and Administration

The proposed Public Health Bill of 1919 followed on the heels of the 1919 Village Self-Government Act in Bengal, which aimed to rehabilitate rural governing institutions through the establishment of new institutions of local government—the union boards.[329] Above these boards were local boards which were responsible for a given sub-division, and above them still were the district boards—this constituted the hierarchy of local government in rural Bengal.[330] The district boards had extensive powers over road-building, water-supply, sanitation, and education, and also had the power to levy taxes.[331] In light of these initiatives taking place in the political realm, the Sanitary Department aimed to take advantage of these newly reinforced local structures to bring rural public health provisions up to par with those existing in municipalities, while strengthening those aspects that had by experience been shown to be lacking.[332] The draft Bill was thus public health officials' response to self-government legislation, based on the notion that public health could be a means of training Indians in the principles of self-rule and local self-government. In the words of Sanitary Commissioner Charles A. Bentley:

> Just as in the case of England and Wales, Scotland and Ireland it was necessary in 1872 to create for the purpose of sanitary administration special *ad hoc* authorities which eventually became general units of local self-government, so also in the case of Bengal

[329] Sugata Bose, *Peasant Labour and Colonial Capital: Rural Bengal since 1770* (Cambridge, 1993), pp. 169-70.
[330] John A. Gallagher, *The Decline, Revival and Fall of the British Empire: The Ford Lectures and Other Essays*, ed. by Anil Seal (Cambridge, 1982). pp. 166-7.
[331] BL, IOR/V/24/3823, 'Report of the Director of Public Health'.
[332] BL, IOR/P/10983, 'Proceedings of the Govt of Bengal in the Local Self-Government Dept, Public Health, Dec 1921, Second Note'.

> considerations of the public health are likely to be the dominant factor in shaping the growth and stimulating the developing of efficient self-governing institutions.[333]

According to Bentley, 'the first essential of a successful public health administration is the organisation of a sufficiently numerous staff of trained sanitary officials.'[334] As matters stood at this time, there was no general scheme outlining the principles of public health policy, no defined responsibilities for government and local bodies, few instances of localities employing sanitary officers, and scattered legislation with no enforcement powers. Additionally, legislation as it existed 'wholly neglected' the rural areas. Believing that 'public hygiene in Bengal is in the same state as it was in England 50 years ago,' Bentley claimed that principles of public health administration devised in England during 1869-71 would apply equally well to Bengal in his day. Public health administration in England was the product of the recommendations of the Royal Sanitary Commission of 1869; that Commission had emphasized that sanitary staff should be 'in every place' so that no area should be without a local sanitary authority. This had required the whole country to be divided into units of administration suitable for public health purposes, local sanitary authorities to be constituted therein, and some superior authority be granted powers to ensure no part of the country remained without sanitary control.[335]

According to British district officials, the nature of public health work in the villages and its attendant issues demanded that the potential local sanitation authority represent as small an area as financially and administratively possible.[336] This could be done through reconstituting pre-existing governing structures in rural areas, like the local boards, or by creating new ones, like the union boards.[337] Furthermore, the financial repercussions of the potential administrative changes had to be taken into account. Government had no intention of ceding control over the finances of the province, even as it was being forced to cede a measure of administrative

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[333] BL, IOR/P/10983, Proceedings for Dec, Note by the Sanitary Commissioner, Remarks on Mr. Goode's Note on a Public Health Act, 8 Aug 1919.
[334] BL, IOR/P/10983 Proceedings for Dec, Note by Mr. Goode, Special Officer, 5 June 1919.
[335] BL, IOR/P/10983, Proceedings for Dec, Note on the need of a Bengal Public Health Act.
[336] BL, IOR/P/10983, Second Note.
[337] Ibid.

control.[338] The primary consideration therefore for public health officials in Bengal was choosing a suitable administrative unit to bear the burden of sanitation and preventative health work while meeting the requirements of administrative efficiency.[339]

In light of these criteria, the Government of Bengal recommended constituting local boards as the new sanitary authority in rural areas rather than the district boards. The current arrangement was for the district board to depute sanitary officials to the subdivisions, a policy that had thus far proved disappointing. Unsatisfactory efforts by district boards to staff qualified health officials, as well as the practical difficulties of public health work in the village—where population was widely scattered, modern infrastructure was lacking, and knowledge and practice of basic sanitary measures was low—meant that access to sanitary services and health workers was inefficient. Decentralizing sanitation operations was presented as being more conducive to facilitating greater local participation and greater ease of operations, though officials remained concerned about the scarcity of trained men and general apathy of public opinion in districts outside the municipalities. An alternative offered in light of the problem of personnel was the training of vaccination inspecting staff in sanitary work towards their employment as local health officers.[340]

According to Roger Goode, the Special Officer appointed to investigate the issue of sanitary reorganization in Bengal, the primary obstacle standing in the way of the implementation of this policy was the inability of District Boards to realize the importance of real public health work—inspection, education, and data collection, all of which formed the basis for the development of policy by the central department of public health—and that was because of the dearth of a trained sanitary staff.[341] British public health bureaucrats were making a strong case for the importance of expertise in the development and implementation of health policy, as well as central coordination of all this word, and by the same token casting aspersions on the

[338] BL, IOR/P/10983, Proceedings for Feb, Sec to Govt of Bengal, Municipal Dept to Commissioner of Rajshahi Division, 22 July 1920.
[339] IOR/P/10983, Proceedings for Dec, Letter from Sec to Govt of Bengal to All Commissioners of Divisions, 3 Sep 1920.
[340] Ibid.
[341] IOR/P/10983, Note by Mr. Goode.

ability of Indian electorates to give the matter adequate and appropriate attention. The passage of self-government legislation threatened to result in sanitary operations being left to 'an untrained honorary agency'—i.e. local governments—that held persistently wrong views on sanitation policy. 'We may expect them to urge that the amount spent on staff could be more usefully expended in digging a few more wells or tanks,' added Goode. 'The value of small village improvements (digging of wells, etc.) cannot be denied,' he acknowledged, 'but it is urged that any advance to a larger system of sanitation and public health involves primarily the development of a trained staff.' Since 'it must be expected that for many years to come the District Board will be reluctant to budget for a sanitary staff on anything but the most niggardly scale,' it would be necessary to ascribe clear responsibilities and functions to local authorities, compel them to appoint a sufficient number of trained staff, and empower the central sanitary authorities—i.e. the provincial government—to enforce compliance in local areas with departmental directives.[342]

The Bill would have obliged urban and rural authorities to act towards the inspection, deterrence, and abatement of a range of broadly defined sanitary 'nuisances' for the prevention of infectious and communicable diseases.[343] From the prevention of overcrowding in factories and houses to the planning of drainage works to the proper feeding and watering of animals, a wide range of daily life activities were brought under the legal control of local officials. All urban and rural authorities would be required to appoint a Medical Officer of Health and/or Sanitary Inspectors with the necessary qualifications for public health work (while making allowances for local conditions as needed in attracting and securing qualified workers). The objective of this army of health officers to be established throughout the presidency was the collection of information.[344] The Medical Officer of Health of every rural authority was to stay informed on the public health and sanitary condition of the local area and report this information in a timely manner to local authorities and to the Sanitary Department for further direction.[345]

[342] Ibid.; BL, IOR/P/10983, Note on the need of a Bengal Public Health Act.
[343] BL, IOR/P/10983 Proceedings for Dec, Bengal Public Health Bill, 1919.
[344] Ibid.
[345] Ibid.

With regards to curative health provisions, the Bill was largely permissive in nature. Local Indian authorities were allowed to build and maintain hospitals and dispensaries and, if they wished, provide visiting nurses and health workers to home-bound patients suffering from infectious disease and to expectant and new mothers.[346] Though measures regarding the educative aspect of public health were relegated to the last part of the act, mentioned only in the context of a developing collaboration with the Department of Education, local British administrators seemed to think that the primary duty of the health officers would be education of the populace in preventative health.[347]

Even as it transferred greater administrative and financial responsibility to the local boards, the British-controlled Bengal Government continued to direct the collection and disbursement of local funds. In conjunction with proposing the Public Health Bill, Government recommended amending the Sanitary Cess Act of 1885, which allowed for a tax in municipalities to collect funds for sanitation works, to extend it to rural areas. This and other cesses were levied on land tenure and holdings—the focal point of Britain's relations with Indian society.[348] In Bengal, the system of land revenue was *zamindari* whereby the landlord responsible for a village was charged with collect tax from the cultivators of the land and paying it to the government.[349] The Central Government would determine how local governments then distributed its portion of these funds amongst themselves. Local authorities would also be required to run their past receipts and proposed expenditures for approval by the District Boards and District Magistrate, a government-appointed official.[350]

In the opinion of department officials, for any improvements in public health administration to become an effective reality, the Government had to be granted coercive powers

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[346] Ibid.
[347] BL, IOR/P/10983, Proc for Dec, District Magistrate of Tippera to Commissioner of Chittagong Division, 12 Oct 1920.
[348] Meyer and others, *Imperial Gazetteer of India, Vol. 4*, p. 271; B. R. Tomlinson, *The Economy of Modern India, 1860-1970* (Cambridge, 1993), p. 42; BL, IOR/P/10983, Letter from Sec to Govt of Bengal to All Commissioners of Divisions, 3 Sep 1920.
[349] B.R. Tomlinson, *Economy of Modern India*, p. 44.
[350] BL, IOR/P/10983, Bengal Public Health Bill, 1919.

over the sanitary authorities in local areas as well as the right to supersede local governments in the case of default in order to compel them to fulfil statutory obligations concerning the appointment of sanitary staff and levying of a sanitary cess in all areas of the presidency. As Goode suggested, 'There must, I think, be a statutory obligation on the District Board to allot some portion of its revenues to the Local Board…while the Local Government must have statutory powers to compel District and Local Boards to employ a minimum sanitary staff.'[351] British health officials in India were not confident in the responsiveness or the managerial capabilities of rural authorities when it came to department directives for sanitation, which bolstered the argument for greater central control. A.G.R. Henderson, ICS, the Magistrate of Jessore, remarked

> I expect that the great majority of the members of a rural Sanitary authority simply will not believe the opinions of their expert staff with regard to insanitary conditions in the area under their control. If it were not for the coercive powers to be given to the Local Government, the Local Sanitary authority would probably do nothing.[352]

Goode pointed out the need to remediate Government's past hesitation in exercising its right of intercession in the affairs of local government, which he chalked up to the prudishness of British officials and to an essential difference of political character between English and Indian. He wrote, 'Indian conditions are obviously different…and the resentment with which an English town might view any drastic curtailment of its liberties is not likely to be felt by a superseded Indian municipality, or at any rate by the majority of its taxpayers.'[353]

These developments confirm Sehrawat's analysis of the ideological effort by the British Raj to limit aid from the Centre towards the medical care of the Indian population and its gradual assumption of a financially minimalist role. In addition to the emphasis on native philanthropy for increasing capacity for health provision which Sehrawat has described, limited financial involvement by the colonial apparatus was also based on the expectation of local governments taking responsibility for self-financing of health works. With the reconstitution of local governments and devolution of responsibility for sanitation, British officials expected that local

[351] BL, IOR/P/10983, Note by Mr. Goode.
[352] BL, IOR/P/10983, Magistrate of Jessore to Commissioner of Presidency Division, 23 Nov 1920.
[353] BL, IOR/P/10983, Note by Mr. Goode.

funds would be utilised appropriately for health works even as they paradoxically committed themselves to less interference. Thus, a situation developed wherein public health bureaucrats including the Sanitary Commissioner of Bengal were involved in a plan to impose mandatory appointment of sanitary officers in all local bodies across the province even as the Secretary to the Government of Bengal explicitly asserted that the provincial government was under no commitment to allot funds for public health to local governments.[354]

Bureaucrats vs Politicians

One of the most contentious aspects of this draft Bill was the question of where to place local sanitary authority, and opinions tended to fall along administrative lines, with members of the elite Indian Civil Service—composed of British colonial officials who served as divisional commissioners and district magistrates—generally supporting the Government proposal to bestow authority for sanitary matters to the smallest possible local government structure (with some caveats). On the other hand, District Boards, which were composed of local Indian leaders, expressed opposition to the idea.[355] This would seem to demonstrate a paradox: with British officials standing for greater devolution of power and Indian politicians rebuffing these efforts. However, this paradox hinges on the understanding that by devolving administrative duties, the Central Government would actually accrue to itself more power over local boards in a way it could not if it had to exert its managerial authority over district boards instead. This can be readily inferred from the remarks made by the Magistrate of Dinajpur about the proposed sanitary authorities. 'Without any control proposed to be exercised over them by Government,' he wrote, 'there will be lack of efficient management and if coercive power is not vested in Government there will be no remedy for willful or negligent default.'[356] Babu Hem Chandra Ray Chaudhury, chairman of the Sadar Local Board, displayed an awareness of this intent behind the Bill in his disapproving note. 'By the present Bill, the Government have reserved to them more

[354] BL, IOR/P/10983, Letter from Sec to Govt of Bengal to All Commissioners of Divisions, 3 Sep 1920.
[355] BL, IOR/P/10983, Deputy Commissioner, Darjeeling to Commissioner of Rajshahi Division 18 Nov 1920.
[356] BL, IOR/P/10893, Proc for Dec, Opinion of Magistrate of Dinajpur on Bengal Public Health Bill 1919.

power [than] they should have done in these days when they are granting more power to the people in the matter of self-government, e.g., they can force a sanitary authority to do a thing which in their opinion should be done.'[357]

Though some colonial officials whose comments on the draft Bill were solicited were of the opinion that it would be prudent to wait until the results of the ongoing initiative by district boards to employ more sanitary workers could be evaluated, others maintained that there were concrete reasons why devolving sanitary work was a better arrangement. These reasons related to education and to access. Several ICS officers in support of the draft Bill acknowledged that statutory obligations towards the removal of nuisances would be futile without an accompanying—or even preceding—change in the levels of understanding about sanitation and public health.[358] D.H. Wares, the District Magistrate of Tippera, put it as follows: 'At present, nearly everywhere rural opinion is absolutely apathetic on this point, where indeed it is not even opposed to sanitation on the ground of the expense involved.'[359] To remedy this situation, a program of intense propaganda work was needed. 'An energetic officer, touring through the villages, could do much to dispel this apathy,' he proposed, making a strong case for having sanitary officials located closer to their field of operations. Furthermore, the operational and personnel costs of sanitary improvements in rural areas could be lowered through local boards, whose proximity would make it possible for villagers to be able to contribute their own labour to the effort, thereby engendering local sanction and cooperation for sanitary works in the villages while also saving the districts the trouble of deputing officers from the centre.[360]

Bentley's view on the potential of local bodies to undertake public health work was a mix of frustration and optimism that seems to have developed out of his work in trying to promote anti-epidemic initiatives in the province. His disappointment with the shoddy reporting

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[357] BL, IOR/P/10983, Proc for Dec, Opinion of Chairman, Sadar Local Board on Bengal Public Health Bill, 23 Nov 1920.
[358] BL, IOR/P/10983, Proc for Dec, District Magistrate of Hooghly to Commissioner Burdwan Division, 7 Dec. 1920.
[359] BL, IOR/P/10983, Proc for Dec, District Magistrate of Tippera to Commissioner of Chittagong Division, 12 Oct 1920.
[360] Ibid.

and prevention work done by municipalities and districts, which frequently failed to utilise the skills of their resident health staff, was matched only by his dogged advocacy on behalf of these very same local authorities for access to Government resources when they agreed to undertake public health initiatives in areas.[361] In support of the capacity of local governments to undertake this work, he argued,

> The very existence in a locality of such institutions as a dispensary…obviously infers the presence therein of a certain number of persons possessed of intelligence, education and ability above that of the ordinary individuals composing the rural population. There is every reason why these people should be encouraged to show interest and take some responsibility in respect of matters of local concern such as prevention of disease.[362]

It is important to note that British civil servants working in the districts did not share Bentley's positive outlook, even those who recorded their support for the Bill. The Magistrate of Murshidabad, W.S. Adie, ICS pointedly noted, 'I think the Bill is in advance of the requirements of present Indian society and would require very careful, detailed and prolonged scrutiny by persons intimately acquainted with *mufassal* life and the habits of the people.'[363] The officiating commissioner of the Rajshahi Division, W.A. Marr, was one of the few ICS officials against the Government measure. He remarked, 'I am inclined to think that the initiation of an active and progressive public health policy should be handed over in rural areas to the strongest available local organization, i.e., to the district boards.'[364] However, it may be inferred from his subsequent comments that this strength which he attributes to district boards may have derived from the greater management they were allowed over their finances, and the idea that the further away a local institution was from controlling its own revenues, the more apathetic it was to designing policy and programs and implementing them. As he wrote, 'Beyond the allotment of…sums [from District Boards] to various projects the Local Boards do little or no work and the minutes

[361] BL, IOR/P/10983, Proc for Mar, C.A. Bentley to Sec to Govt of Bengal, Municipal Department, 9 Dec 1919.
[362] BL, IOR/P/10983, Remarks on Mr. Goode's Note on a Public Health Act.
[363] BL, IOR/P/10983, Proc for Dec, Magistrate of Murshidabad to Commissioner of Presidency Division, 16 Oct 1920.
[364] BL, IOR/P/10983, Proc for Dec, Officiating Commissioner of Rajshahi Division to Sec to Govt of Bengal, Local Self Government Department, 7 Jan 1921.

of their meetings usually disclose little of interest or importance.'[365] Some British officials also pointed out the greater proportion of elected members as being responsible for the unwillingness of these boards to impose additional, unpopular taxes on local residents as a factor that may have circumscribed their effectiveness, in contrast to the unelected colonial bureaucracy which was not subject to the same pressures.[366]

Indian members of district and local boards whose opinions were solicited on the matter were unanimous in their opposition to the Government's proposals. Unsurprisingly, taxation was by far the largest topic of concern evident in their responses. The recently passed Village Self-Government Act—which would later be repealed—had added to the tax burden of the rural populace and the idea of an additional Sanitary Cess to be paid by cultivators seemed to these elected officials to be not only impractical but also callous.[367] The Bengal Government's remarks on the causes of and solutions to the insanitary state of rural India evinced a strong bias towards assuming intransigence as the cause and coercion as the solution. Though some bureaucrats who were polled seemed content to chalk up the woeful state of sanitary provisions in the Presidency primarily to laziness and neglect on the part of local authorities, the Government's note to the Commissioners of the divisions did acknowledge that one criticism that could be levelled against its draft Bill was that perhaps local boards were too financially strapped to afford the expense of employing sanitary staff.[368] The chairman of the district board in Khulna bluntly remarked in response that it was not the government's poverty that was the problem but that of the public. 'People in general have been driven to the verge of starvation owing to high prices of foodstuffs and other necessaries of life,' wrote Mr. A.L. Rana.[369] It was left to government civil servants to point out that this was not an auspicious time to be imposing new taxes.[370]

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[365] Ibid.
[366] BL, IOR/P/10983, Proc for Dec, District Magistrate of Hooghly to Commissioner Burdwan Division, 7 Dec 1920.
[367] BL, IOR/P/10983, Proc for Dec, Chairman, Local Board Feni to Vice-Chairman, District Board, Noakhali, 2 Oct 1920; Chairman, Local Board Feni to Vice-Chairman, District Board, Noakhali, 2 Oct 1920.
[368] BL, IOR/P/10983, Letter from Sec to Govt of Bengal to All Commissioners of Divisions, 3 Sep 1920.
[369] BL, IOR/P/10983, Proc for Dec, Opinion of Mr. A.L. Rana, Chairman, District Board, Khulna.
[370] BL, IOR/P/10983, District Magistrate of Hooghly to Commissioner Burdwan Division, 7 Dec 1920.

Goode's argument that imitating the Western principle of self-taxation would build much-needed political character in India also did not impress locals. Reinterpreting the history of Western public health and development of local self-government, which Bentley and Goode had referenced, Rana countered, 'In western and other countries where sanitary measures have been adopted for improving the public health, the people are sufficiently well off to bear the consequent taxation. Conditions are quite different in our country.' His conclusion is sobering: 'Any new tax would mean deprivation of the portion of half meal on which people in general are living at present.' Rather than improve the condition of the rural populace, he maintained that keeping up the revenue stream required to fund new sanitary provisions would lead to deterioration. Giving a concrete example from experience to explain this conclusion, he wrote, 'Since last year the number of boys in every school is falling off. The reason is not far to seek. Parents and guardians of these boys can no longer afford to pay for education of their boys as they find it hard to make both ends meet.' With this, he injected a dose of humanity to the largely technical debate on health sector reform.[371]

Both government bureaucrats and elected local representatives acknowledged the poor insanitary state of the villages, but predictably they proceeded from different causes and arrived at different solutions, stemming from their distinct vantage points into the problems afflicting the contemporary Indian village. British health policy makers in India had the wealth of English experience against which to compare the Indian situation. Indian politicians had the knowledge of past Indian experience against which to judge their present situation. The merits of either approach may be open to debate but one can comfortably conclude that there was a greater unity of opinion on the British side than on the Indian side. Government representatives and civil servants all identified the primary problem of public health work as a lack of centralised control over an apathetic public. At a time when Indians were being granted greater control over their own affairs, Government concluded that there was greater need than ever to be able to direct them to exercise this newfound power for the right ends.

[371] BL, IOR/P/10983, Opinion of Mr. A.L. Rana.

On the other hand, Indians pointed to a variety of factors responsible for the ill condition of their areas. Some like A.L. Rana bemoaned the death of indigenous structures for social welfare, and his description of the problem was stirring, if rather sentimental:

> In days gone by most of the zamindars used to live in villages, the effect of which was that the villagers were provided with good drinking water, tanks and roads. Unfortunately 98 per cent. of the zamindars being attracted by the luxuries of Calcutta have become non-resident. Consequently the villages in Bengal are now in a neglected condition. The next class of people were the middle class men. There are very few of them [that] left their native villages in search of employment or pleasures as they had according to their own ideas for the time being enough in their village homes of their food and necessaries of life. This class of people also used to look after the health and improvement of their native villages. This class of people have almost left their native villagers as they availed themselves of the first opportunity to get western education and secure Government service in various parts of the country.[372]

On the causes behind the breakdown of village social structures, he was in agreement with Goode who considered sanitary interventions to be part of the greater narrative of Britain's purpose in the colony, i.e. 'the opening up of India, through this and roads in NWFP tribal areas, to the new capitalism mode.'[373] Babu Indu Bhusan Mallik concurred with Rana's assessment of the deterioration of the rural poor as the cause of rural insanitation, though he identified poor nutrition, and by extension economic conditions, as the reason for this not, not class interests. Furthermore, he considered the colonial government to be the culprit. 'Fifty years back there was no need of this sort of legislation or Sanitary Boards,' he said, because Indians had had the means to secure their daily needs and were thus able to resist diseases, in contrast to now when the exorbitantly high price of foodstuffs had forced many to the point of starvation. 'It is duty of the Government to think over the matter and to do something for the amelioration of their deplorable famished condition,' he admonished, leaving responsibility fully at the door of the British Indian government.[374]

The perception of rural decline in Bengal evoked by these men and the complex causes they cited were a microcosm of a much larger political discourse that had developed in the

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[372] Ibid.
[373] BL, IOR/P/10983, Note by Mr. Goode.
[374] BL, IOR/P/10983, Chairman of Meherpur Local Board to Chairman of District Board, Nadia, 26 Nov 1920.

province by the end of the nineteenth-century, and which by the early 1900s had come to inform fears that the Bengalis were a 'dying race'.[375] David Arnold notes that increase in statistical sanitary awareness amongst the Bengali middle class through the publication of reports on the incidences of disease by Government provided 'incontrovertible evidence that malaria was the greatest single threat to health in rural Bengal'.[376] Statistics demonstrating the 'dwindling' population in districts such as Jessore, where the decline in population had first been noted with the 1891 Census,[377] continued to occupy the minds of many, both Government and its critics, at the start of the second decade of the 20th century and became ammunition for the newly empowered Indian members of the Bengal Legislative Council with which they could take the Government to task for the deteriorating health condition of Bengalis, with particular emphasis placed on Government's duty to stem malaria epidemics in rural areas.[378]

There were other supporting causes as well that were publicly implicated in the decline, as evinced above in the responses of Indian politicians to the Public Health Bill.[379] The most prominent were malnourishment and the environmental changes wrought by the introduction of railways, roads, and other works of economic developments that interfered with drainage.[380] Arabinda Samanta has noted evidence of public concerns over the deleterious changes in the health of Bengalis to as early as 1862 when the food situation in certain districts of the Presidency came under official notice.[381] Here again, we see that statistical knowledge promoted this awareness of decline, as the greater impact of malaria in the Hindu-majority western and

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[375] David Arnold, '"An Ancient Race Outworn": Malaria and Race in Colonial India, 1860-1930', in *Race, Science and Medicine, 1700-1960 (studies in the Social History of Medicine)*, ed. by Waltraud Ernst and Bernard Harris (London, 1999), pp. 134-7.
[376] Arnold, '"An Ancient Race Outworn"', p. 135.
[377] Ibid.
[378] BL, IOR/P/10983, Proc for March, Council questions asked at meetings of Bengal Legislative Council to Minister in Charge of Department of Local Self-Government.
[379] Some notable investigations into the historical epidemiological circumstances of malarial morbidity and mortality in India are Ira Klein, 'Malaria and Mortality in Bengal, 1840-1921', *Indian Economic & Social History Review*, 9/2 (1972), p. 139; and Packard, *The Making of a Tropical Disease*; Zurbrigg, 'Re-thinking the Human Factor in Malaria Mortality'; and Wakimura, 'Famines, Epidemics and Mortality in Northern India'.
[380] Klein, 'Malaria and Mortality in Bengal', p. 139.
[381] Arabinda Samanta, *Malaria Fever in Colonial Bengal 1820-1939: Social History of an Epidemic* (Calcutta, 2002), p. 30.

central districts compared to the Muslim-majority eastern districts was seen to be attributable partly to the less varied and less nutritious diet of the former.[382] Thus, improvements in the Bengali diet came to be identified as an important element of the social response to high death rates in addition to anti-malaria efforts mentioned above.[383] By the late nineteenth century British health officials and engineers and Indian officials had also begun to note a link between infrastructural development and proliferation of malaria.[384] This led Bentley, as Bengal's Sanitary and Public Health Commissioner, to undertake and publish epidemiological studies in the 1920s demonstrating the link between malarial infection and railway construction and later labour migration.[385] Just as the development of disparities between the western and eastern districts had created a perception of racial decline amongst Bengali Hindus in the late nineteenth and early twentieth century, a reversal of disparities in malaria mortality between these districts over the early twentieth century created similar concerns over economic development and the changes it brought in the increasingly malarial eastern districts.[386] Nevertheless, considering the disproportionate number of questions asked about population decline and anti-malaria efforts in the Legislative Council, it was clear that the predominant belief was that scourge of malaria was primarily responsible for this decline.[387]

The debates over the relationship between malaria and mortality thus reveal the paradoxes inherent in public health policy in the era of devolution. The all-India political reforms empowered Indians to express vocal opposition to the British using the colonial state's own executive bodies and its diligent data-gathering on mortality, morbidity, and environmental sanitation. They made it possible for Indians to demand of the colonial apparatus that it do more

[382] Arnold, '"An Ancient Race Outworn"', p. 137.
[383] Ibid., p. 139.
[384] Klein, 'Malaria and Mortality in Bengal', pp. 139-40, 145.
[385] Ibid., p. 141.
[386] S.R. Christophers and C.A. Bentley, *Malaria in the Duars* (Simla, 1911); figures from Annual Public Health Reports for Bengal showing malaria mortality in the western and eastern districts from 1921-40 were kindly provided by Prof. Mark Harrison.
[387] Arnold, '"An Ancient Race Outworn"', pp. 125, 136-7.

for the welfare of the public even as they sought to wrest power from the colonial Raj in the name of the public.

The draft Public Health Bill also provides insight into how British bureaucrats responded to the prospect of increased self-governance in India. The Government's concern was also to pick an area secure enough financially to bear the burden of sanitary work in localities, and in conjunction to reform local governments.[388] However its focus was also on passing strong measures by which to empower itself to improve the sanitary condition of villages. This is because many ICS officials were of the opinion that Indian local governments were themselves not presently at a stage advanced enough to take effective responsibility for the condition of health and disease in their spheres of governance. They often had a very low opinion of the state of leadership in these communities and its capacity for mobilisation for the improvement of the sanitary state of municipalities and districts. The Magistrate of 24-Parganas, W.D.R. Prentice, ICS, lamented, 'In far too many cases reforms urged by the sanitary staff have to be dropped because of the opposition made to them by private individuals and of the lukewarm support or apathy if not hostility of individual Municipal Commissioners.'[389] The Magistrate of Jessore believed that the public as yet was blind to the utility of good health. 'My examination of boys in various schools has led me to believe that they regard hygiene merely as a school subject with no reference to real life and serving no useful purpose.'[390] A complementary sentiment was expressed by the Magistrate of Murshidabad who noted that the Public Health Bill sought to interfere with the life and habits of the people, 'to aim at a state of efficiency which the public do not desire'.[391] Government bureaucrats thus often took a dim view of the civic sense prevailing in local bodies though medical officers considered public health to be a means to develop civic responsibility among Indians.[392]

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[388] Harrison, Mark, *Public Health in British India: Anglo-Indian Preventive Medicine 1859-1914* (Cambridge, 1994), p. 166.
[389] BL, IOR/P/10983, W.D.R. Prentice, ESQ, ICS, Magistrate of 24-Parganas to Commissioner of Presidency Division, dated 4 Jan 1921.
[390] BL, IOR/P/10983, A.G.R. Henderson to Commissioner of Presidency Division, 23 Nov 1920.
[391] BL, IOR/P/10983, W.S. Adie to Commissioner of Presidency Division, 16 Oct 1920.
[392] ibid., p. 8.

It is important to acknowledge here that these debates and developments within government echoed earlier developments in Bengal in the aftermath of the Ripon reforms, which had targeted sanitary policy and local government in the municipalities and which have been detailed by Mark Harrison. He has noted that medical officers were supportive of administrative devolution, believing it would stimulate interest in public health activity, while ICS officials resisted these proposals for greater political responsibility for Indians as 'premature'. Harrison has also shown that the introduction of local self-government had indeed resulted in increased overall allotments for sanitation in the municipalities, concomitant with rising incomes, though the willingness of the provincial government to provide loans and grants-in-aid also made possible increases in sanitary improvements. At the same time, he has also provided clear evidence that there was some resistance based on financial, religious, and cultural grounds towards sanitary improvements by Indian ratepayers and municipal commissioners, particularly in Calcutta.[393]

Ultimately, the tension between civil service officers and elected officials seemed to stem from their unstated assumptions about what constituted proper activity in the sphere of health and sanitation. Bentley was frustrated by his attempts to encourage anti-epidemic works among district boards, as rural authorities in Bengal preferred to spend most of their funds on public ways and drains.[394] The bare consensus among local politicians was that deplorable economic conditions were far too pressing for sanitary reform to be an immediate concern, and that these economic conditions were in fact primarily responsible for ill health, not poor sanitation, as they worsened immunity to disease.[395] Persistent misconceptions among locals about the functions of various levels of government, and in fact their own fiscal and administrative responsibilities, helped to exacerbate grievances about an apathetic

[393] Harrison, *Public Health in British India*, pp. 168-83.
[394] BL, IOR/P/10983, File No. P.H.C.-4, C.A. Bentley to Secretary to Government of Bengal, Municipal Department, No. 5030, dated 15 Mar 1919.
[395] BL, IOR/P/10983, Opinion on the Public Health Bill by Local Board of Ranaghat.

Government.[396] Indian politicians assailed the Bengal government for inaction in passing measures to effect improvements in the villages even as they complained about its intrusiveness and insincerity in granting substantial political autonomy to Indians, while Government remained exasperated by local disinterest in moving forward proposals for sanitary reform. Reflecting on the scourge of malaria in Bengal, Bentley stated to the public, 'You and I, the Government and the people, must co-operate to rid the country of malarial fever, or at any rate reduce its scope and the range of its malignant influence. Popular information and expert knowledge must be combined and co-ordinated for one great and common purpose.'[397] But with the fracturing of political power and governmental responsibility across multiple levels of government, there was not only a multiplicity of views of what was wrong and how to improve human well-being, which made centralised planning and coordination of health interventions difficult, but there was also an increased measure of defensiveness on the part of local officials to concede any political privileges to higher authorities.

This is not to make a generalised claim criticising the ICS perspective or to assert instead that there was indeed widespread activity among Indian local governments in the sphere of health. But apathy in the manner of health and sanitation was not necessarily a given amongst the various local governments in cities, towns and villages, even within the Bengal Presidency.[398] Even if apathy was present—and it is difficult to ascertain this aspect without relying heavily on the prejudice that might animate accounts written by colonial officials—it could not be reduced merely to illiteracy or scepticism among the people as to the importance of health to improved living standards. After all, even as A.G.R. Henderson, the Magistrate of Jessore was complaining that the schoolboys in his charge evinced little care for the practical utility of hygiene, about 73

[396] BL, IOR/P/10983, Proc for Feb, Sec to Government of Bengal, Municipal Dept to Commissioner, Rajshahi Division, 22 July 1920; IOR/P/10983, A.N. Moberly, ESQ, ICS, District Magistrate of Hooghly, to Commissioner Burdwan Division.
[397] BL, IOR/P/10983, Proc for March, Question raised in Bengal Legislative Assembly, 5 Sep 1921.
[398] Mark Harrison undertakes an extensive analysis of this topic in *Public Health in British India*, see chapter 7 especially.

km away in Khulna, the number of boys attending school was decreasing because their education was becoming too expensive for parents and guardians to afford.[399]

Contesting Public Health at a Time of Reform

As these tensions developed, Bengal became an outpost of vocal opposition to Central fiat in determining matters related to public health. This can be seen in the critiques expressed to a proposed piece of legislation in Bombay in 1933 limiting the use of certain medical qualifications by non-qualified personnel, specifically the use of titles and descriptors such as 'doctor' and 'medicine' by those practicing in oriental medical traditions or homeopathy or others outside the pale of western biomedicine.[400] Whereas the Governments of United Provinces and Punjab approved of the restrictive measures and expressed their sympathy with the object and scope of the Bombay Government's bill, the Bengal Provincial Government questioned the presumptions about the profession and the need for such protections, claiming it was 'doubtful' whether the use of such titles in Bengal deceived the public.[401] The nature of their rebuttal to the proposed legislation conveys a sensitivity to government overreach over public action more than it constitutes a commitment to defending the validity of non-western medical practices: 'The whole object of the [Bombay Government's] Act is the protection of the public. The public can go to any body they like, but they must not be deceived into thinking that the man they go to had qualifications which in fact he has not...*This goes beyond the principle of protecting the public from deceit*.'[402] This expression of discontent led the GOI to advise the Government of Bombay against this measure, which was 'certain to arouse controversy,' because the 'unofficial element in the Assembly will be likely to regard the proposals as an arbitrary attempt to prohibit the use of certain words by all but allopaths.'[403]

The same antagonistic tone taken by the Bengalis on the issue of medical qualifications was on display in 1929 on the question of provincial governments' right to buy medicines and

[399] BL, IOR/P/10983, Opinion of Mr. A.L. Rana.
[400] BL, IOR/P/11933, Government of India Proceedings, June 1931, Proceedings No. 38-39.
[401] BL, IOR/P/11933, Letter from Secretary to Government of Bengal, No. 417-Medical, dated 2 Feb 1927. italics added
[402] Ibid. italics added.
[403] BL, IOR/P/11933, Letter to Secretary of Government of Bombay, No. 1183, dated 10 Aug 1927.

drugs on the open market rather than being required to buy at the prices offered by GOI's Medical Stores Department. The letter from the Secretary to the Government of Bengal expressed a dismissive attitude towards the legitimacy of such a policy, one that had been established at a time when medical administration was under Central control, a situation which no longer prevailed. Though the matter in question was ostensibly one of medical policy, the tone of the Bengal Government was political. '[I]t is necessary to examine the whole position from the view of a Transferred Department responsible for conducting its services with the minimum delay and the minimum cost,' the letter noted, referring specifically to the status of Public Health as a 'transferred subject,' i.e. one that had been shifted from Central Government control to provincial authority and therefore no longer under the former's jurisdiction. The Medical Stores Department protested the accusation that their prices were consistently higher, but also pleaded to a social arrangement between the provinces under the aegis of the GOI that made it possible to share the costs for mass manufacture of medical supplies in order to make lower prices for all possible. If local governments stopped buying from it, this Central Government department would lose its volume of sales—its survival depended on the provinces choosing to subsume their interests to effective coordination at the Centre. The stance of both the Central Government and the Bengal Government are thus rather emblematic of the larger political issues consuming India during this era.

The superior civil services, such as the ICS and the IMS, were the clearest symbols of entrenched colonial prestige and privilege at a time when the winds were blowing in the opposite direction. Various European members of the ICS and IMS indicated their discomfort with the uncertain future that awaited members of these all-India services in light of political changes in the colony. All agreed that the position of the services was not secure in the current political climate without at least an assurance by the Secretary of State for India that control over the services would continue to remain in his hands now that the Government of India was forced to share its powers with the provinces. That was the opinion of G.B. Williams, Chief Engineer of Bengal's Public Health Department who noted that the status of the services 'depends on how far guarantees that will rest in the last resort upon the faith of an elected Government in India, can be

considered adequate.'[404] He went on to say, 'I personally mistrust such a safeguard and consider that no guarantees short of one given by the Secretary of State on behalf of the British Government can be considered sufficient.'[405]

Government proceedings reveal the direct and explicit intervention of the Secretary of State in protecting key positions and perks for IMS officials in the medical institutions of the province, such as the medical school and hospital at Lahore.[406] This was responsible for professional grievances amongst Indians, as indicated in the responses of Indian medical officers to the Royal (Lee) Commission's proposal for the reorganisation of superior civil services. Claiming that their members' position was inferior to all other provincial services, the Provincial Medical Services Association blamed this situation on the exclusivism of the Indian Medical Service. Promotion to the IMS was barred at this time to aspiring entrants from the Provincial Service, which was composed of Indians. This along with other policies negatively impacted the efforts of their members to improve their profile within medicine.[407] '[I]f the provincial medical service was not able to create an impression with the Government or the general public till recently, it was because the members of our service were all serving in a subordinate capacity where they were not privilege to partake in the more responsible professional work of well-equipped hospitals.' They argued that being stuck in routine work in a subordinate capacity did not enable them to demonstrate their skill and fitness, 'and it is not a matter of surprise that under such circumstances, there should have been doubts expressed in certain quarters as to the fitness of our members to hold these responsible posts.' This was detrimental to the interests of the Indian people in their view, as the Association was 'the only opening available in the public

[404] BL, IOR/Q/11/16 No. 543.
[405] Ibid.
[406] BL, IOR/P/11933, Telegram from the Secretary of State, No. 2452, dated 7 August 1929.
[407] Access to jobs in government service was highly desirable for the economic and social capital it signified, and this grievance over limitations in vertical mobility were compounded by communal rivalries between Muslims and Hindus for the positions that were available, constituting a significant source of grievances amongst Indian Muslims in the lead-up to the demand for Pakistan. See Liaquat Ali Khan, *Muslim Educational Problems*, Pakistan Literature Series, 7 (Lahore, 1952).

service of this country for medical graduates in India,' and therefore the existing policy was vastly discriminatory towards the prospects and aspirations of Indian medical graduates.[408]

Conclusion

The battle between Indian aspirations for professional autonomy and the entrenched privileges of British-run medical services was a microcosm of politics at large in India and the struggle for independence from colonial domination, particularly in Bengal.[409] In the same way that the fluctuating power of the GOI in India was a concern to British bureaucrats, spurring a flurry of surveys and correspondences from London to reassure them of their status in a vastly reconfigured India, so too were subordinate medical officials galvanised by the potential changes in their status that would be made possible by greater political decision-making power for Indians in India. The desire to retain or assume control over the matters of government was a desire for the power it signalled, and this informed the attitudes of colonial officials, subordinate officers, and local and national Indian politicians towards public health in the era of governance reform. Squabbling over the powers due to each level of government stemmed from anxieties over the fluctuating political atmosphere, in which stakeholders of all backgrounds sought to ensure their access to power in a dynamic political structure. These tensions which solidified during the twilight of colonial rule continued to exert a palpable impact on relationships between the central and provincial governments in East and West Pakistan after independence.

[408] BL, IOR/Q/11/16 No. 543, Memorandum of the Indian Provincial Medical Services Association.
[409] Bose and Jalal, *Modern South Asia*, pp. 121-2.

Chapter 5: Nationalism

> Fifty per cent of the children in our country are ill. The hospitals are meant for the English. The country is ours, the money is ours, everything belongs to us, but we are hungry and naked in it.
>
> (Khan Abdul Ghaffar Khan, *My Life and My Struggle*)

> …wherever I went, everyone kept saying *bhai* (brother), if we did not vote for the League we would have become *kafir* (an infidel).
>
> (Metcalf & Metcalf, *A Concise History of Modern India*)

The passage of the governance reforms of 1919 gave Indians some measure of control over their affairs in the provinces, but these changes did not signal complete self-governance. The Centre, and with it the control of the entire Indian subcontinent, still remained out of reach of Indians while the discrimination inherent in colonial rule continued unabated, frustrating indigenous political ambitions and professional aspirations.[410] These frustrations formed an important component of the growing spectre of Indian nationalism, a vast and complex phenomenon that provoked mass protests on the streets, with *kisans* and *bhadralok* marching against the British Raj, and negotiations in the halls of power, where representatives of India's religious and ethnic communities and its major political parties tussled with the GOI and each other to demand further political concessions within the framework of constitutional politics.

Within this overarching effort to seize control of India's destiny from British imperialists was the struggle of India's Muslims for greater political and social rights. This was by no means a cohesive or unified struggle, but in discrete and concrete ways over the early 20th century, various groups of Muslims in Punjab, Bengal, Sind, Baluchistan, and NWFP as well as in the Hindu-majority provinces began to put forth their own political visions to protect and advance their interests in a hastily changing India. Notably, issues relating to health and medicine played a role in the development and implementation of these political formulations. This topic has been discussed with reference to Indian nationalism,[411] however comparatively little is known about

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[410] Barbara D. Metcalf, 'Nationalist Muslims in British India: The Case of Hakim Ajmal Khan', *Modern Asian Studies*, 19/01 (1985), p. 11.
[411] Joseph S. Alter, *Gandhi's Body Sex, Diet, and the Politics of Nationalism* (Philadelphia, 2011); Arnold, *Colonizing the Body*, pp. 280-9; 'Nehruvian Science and Postcolonial India', pp. 361-5; Pratik Chakrabarti,

ideas regarding health and medicine among Indian Muslim nationalists. This chapter will therefore seek to remedy this gap by illuminating the trajectories of two nationalist parties that operated in the future territories of Pakistan, the Khudai Khitmatgars and the Muslim League, delving into their political programs and visions for public health and illustrating the multivalent nature of Muslim nationalism in India at the twilight of colonial rule.

The Struggle to Unite India's Muslims

The nationalist agitations that erupted across India after the passage of the 1919 Act eventually compelled the passage of the 1935 Government of India Act, which expanded the franchise to 35 million Indians and abolished diarchy, thereby giving Indian ministers equal decision-making authority with their bureaucratic counterparts in virtually every department of provincial concern.[412] Though the British continued to refuse to concede control over governance of India at the Centre—retaining thereby the critical portfolios of defence, foreign policy, and communications—the events set into motion by the passage of the 1935 Act put the major political parties of India in a position to contest that stranglehold for the first time. The 1937 elections that took place in the provinces catapulted both the Indian National Congress and the All-India Muslim League to a position of national significance, as opposed to being sequestered into local and provincial concerns.[413] As detailed magnificently in Ayesha Jalal's ground-breaking study of the Muslim League's demand for Pakistan, the electoral dominance of the secular, Hindu-majority Indian National Congress across multiple provinces gave it the political capital it needed to make a claim for control of India's affairs at the federal level. However, as a consequence of their political triumphs, large swathes of Muslims came under Hindu political control for the first time in the modern history of the subcontinent. Whereas in the 1910s, perceived slights by the colonial regime had pushed significant numbers of Muslims to find common cause with non-Muslims in their opposition to the British Raj,[414] now the threat of

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'"Signs of the Times": Medicine and Nationhood in British India', *Osiris*, 24 (2009), pp. 188–211; Roger Jeffery, 'Recognizing India's Doctors: The Institutionalization of Medical Dependency, 1918-39', *Modern Asian Studies*, 13/2 (1979), pp. 307-16.

[412] Jalal, *The Sole Spokesman*, p. 15.

[413] Ibid., p. 18.

[414] Metcalf, 'Nationalist Muslims in British India', p. 19.

Congress domination at the federal and provincial levels propelled fears of a 'Hindu raj' and finally motivated the hitherto scattered sections of this minority community to begin to unite their interests under the banner of the All-India Muslim League (AIML) and its spokesman Mohammad Ali Jinnah in order to be prepared to compete for political representation and privileges on parity with Hindus in the oncoming battle for control of all-India.[415]

As the ambitions of national secular and communal parties grew, they faced challenges in providing a compelling plan for the future of India that could unite a multiplicity of economic and social groups and commandeer the allegiances of a plethora of local interest groups and competing parties. In the case of the AIML, this was exacerbated by the fact that the constituents on whose behalf it demanded national representation were a narrowly defined subset within Indian society. Furthermore, the Muslims were hopelessly split in their allegiances between a multiplicity of parties. The NWFP was firmly in the hands of Congress, the Punjab was run by the Unionist party, Bengal was to be governed by a coalition government that included the AIML, and Sind was governed by an independent ministry. Thus, a mere 10 years before Pakistan was to achieve the status of an independent nation-state, the allegiances of its constituent provinces were markedly fractured and their political trajectories entirely uncertain. The AIML's influence was so weak that at this time the Congress party could lay claim to speaking for a greater number of Indian Muslims than the Muslim League itself.[416]

It is clear that while the Muslim League may understandably be the movement most closely associated with Muslim nationalism in India, the Muslim League's was not the only narrative of nationalism that was present in the Pakistan territories. The unique political pressures prevailing in each of the Muslim-majority provinces of India produced divergent and distinct nationalist responses therein, which in turn produced markedly different visions of social welfare in the era of self-rule. Though in the populous and influential provinces of Punjab and Bengal local coalitions warily threw in their support with the Muslim League, in the North-West Frontier a separate movement was challenging the ambitions of the League. The Khudai Khidmatgars

[415] Jalal, *The Sole Spokesman*, p. 33.
[416] Ibid., p. 35.

(KK), led by Khan Abdul Ghaffar Khan, was a Congress-affiliated provincial movement of Pathan nationalists residing in the settled areas of this overwhelmingly Muslim region who agitated against the British government for the right of self-determination, but also resisted AIML's encroachment on the frontier as well as its demand for Pakistan. In contrast to the Muslim League's reliance on religious culture as a source of unity, the KK's politics were rooted in ethnic Pathan identity. The nature of social planning advanced by these two movements before independence reveals the different visions of health and welfare that were advanced in the provinces of future Pakistan.

Grassroots Politics of the Khudai Khitmatgars

The politics of the Khudai Khitmatgar movement in the settled districts of the NWFP provides a marked contrast to the political milieu prevailing in the tribal districts described in chapter 2. Though the border tribes had their *jirgas* and sometimes the ear of the resident Political Officer, their ability to make demands of the British authorities was severely circumscribed. Representation (to the colonial regime) was indirect and the ability to legitimately air grievances was heavily constrained. But dissent or deviation from the rules of the relationship as laid out by the India Office was swiftly punished.[417] Agitation was summarily dismissed as 'fanaticism'.[418] The settled areas were an entirely different matter. Within a matter of years following the conquest of the frontier, this part of the NWFP had been demilitarised and integrated into British India's governing apparatus.[419] As tax-paying subjects, the Pathans in the NWFP could not be dismissed as fanatics; as British Indians their demands could not be entirely silenced by a lone British officer's threat to deprive them of emoluments or to attack them with air firepower, though it was attempted often enough even in the settled areas.[420] Though the GOI imposed repressive laws banning political organisation and free expression and though the NWFP was one of the last provinces to enjoy the privileges of provincial self-governance, its

[417] Diwan Chand Obhrai, *The Evolution of North-West Frontier Province : Being a Survey of the History and Constitutional Development of N.-W.F. Province in India*(Peshawar, 1938), p. 49.
[418] BL, MSS Eur F111/528, The Orakzais.
[419] BL, MSS Eur F111/528, Administrative results of the formation of the North West Frontier Province.
[420] BL, IOR/L/PS/12/3171, Extract from Legislative Assembly Debates, 3-6 Sep 1937.

residents enjoyed, in a very limited capacity, the right to express their own grievances in provincial assemblies with some expectation of being heard, and, failing that, to tap into the national discourse of discontentment.[421]

This contrast aptly explains why the Khudai Khitmatgars under the leadership of Badshah Khan diverged in practice from men like the Haji of Turangzai in the tribal areas who waged armed revolts against the British occupation and were actively hunted by the British army during the 1930s and 40s. These two well-known opponents of the British regime came from neighbouring villages and were related by marriage. Both began their work starting schools in the villages of the settled areas; indeed, Badshah Khan was invited by the Haji to inspect schools the latter had started as he went touring through the villages.[422] However, the militant firebrand soon left for the tribal areas to escape the colonial authorities seeking to arrest him, and later declared his violent opposition to the British from his new residence. Government telegrams labelled him a 'fanatic'; the newspapers described him as relentless in his effort to incite the tribes in open rebellion against Government.[423] When Khan himself was arrested for his association with the Haji's activities leading to the closing of his newly built schools and arrest of the teachers, he realised that any kind of violent uprising could not match the superior firepower of a Government ever-anxious to defend its vulnerable frontier. 'Earlier, violence had seems to me the best way to revolution,' wrote Khan, but he quickly realised, 'we did not have the necessary wherewithal for it and that we would lose badly.'[424]

Among the diverse motives for anti-colonial political mobilisation in the NWFP, two important ones were the British interventions in destabilising Afghanistan and its reformist king Amanullah Khan as well as the repressive policies that were implemented to ensure that the

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[421] BL, IOR/L/PJ/5/211, NWFP Fortnightly Reports, 17 Apr 1937, G. Cunningham to Sir Findlater Stewart; BL, IOR/L/PS/12/3135, Summary of the Proceedings of the First Meeting of Sub-Committee No. V (NWFP) held 18 Dec 1930.
[422] Mukulika Banerjee, *The Pathan Unarmed: Opposition & Memory in the North West Frontier* (Oxford, 2000), p. 48; Abdul Ghaffar Khan and K. B Narang, *My Life and Struggle: Autobiography of Badshah Khan*, trans. by Helen H. Bouman (Delhi, 1969), pp. 29, 37-8.
[423] BL, IOR/L/PS/3128, Haji Who Plots Against Border Peace.
[424] Banerjee, *Pathan Unarmed*, p. 49.

NWFP was denied self-rule.[425] Both of these were implicated in the continued neglect of the social development of Pathans. The British GOI's reason for opposing Amanullah was that 'extraordinary progress of reforms in a neighbouring [Muslim] state would support the demand for similar institutions in the Frontier Province, a demand which it was the policy of the Government to resist.'[426] Likewise, the lack of representative rule in the province, wherein the Chief Commissioner and Governor could veto or disallow decisions on matters they considered to be within their jurisdiction, could obstruct social projects. This was as evident in British opposition to Badshah Khan's effort to build schools in the province as it was of bureaucratic opposition to British Army officer Leslie Mallam's self-described efforts to design a development programme for the Frontier in the postwar period. In his memoir, he details his request to Governor George Cunningham to be appointed Planning and Development Commissioner:

> Cunningham looked at me blankly. A guess at the working of his mind would go something like this: 'Development on the Frontier? They very idea is absurd even slightly effeminate. The Frontier is a place where MEN live and fight and kill, and they will go on like that for ever.' What he said was, 'What is there to develop in these rocky hills and stony valleys?'[427]

He was able to implement his plan because by this point, representative rule was a reality in the NWFP. 'The Muslim League Ministry was in office. I talked to the Chief Minister and others on the theme, "All other provinces in India are preparing post-war development plans; should not the Frontier Province do the same?"…As was to be expected, I obtained an immediate response; and was appointed in due course Planning and Development Commissioner for the Province.'[428]

Years before self-rule became a reality, however, Badshah Khan remained frustrated by the lack of social investment on the Frontier, particularly in education.[429] Though his brother was

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[425] BL, IOR/L/PS/12/3135, Summary of the Proceedings of the First Meeting of Sub-Committee No. V; Sayed Wiqar Ali Shah, *Ethnicity, Islam, and Nationalism: Muslim Politics in the North-West Frontier Province 1937-1947* (Karachi, 1999), p. 25; Banerjee, *Pathan Unarmed*, p. 104.
[426] 'A Secrete Note on the Situation in the NWFP', E.B. Howell, 24 May 1930, F. No. 206/1930, National Archives of India, qtd in Shah, *Ethnicity, Islam, and Nationalism*, p. 25.
[427] Leslie Mallam, *Frogs in the Well* (Kinloss, Moray, 2010), p. 215.
[428] Ibid.
[429] Khan and Narang, *My life and struggle*, pp. 26-9.

an IMS officer who worked for the British Government, he was imprisoned in Punjab under the Frontier Crimes Regulations for activities deemed subversive by the government of the NWFP, a period during which he developed a growing awareness of wider nationalist movements in India.[430] Though Badshah Khan's brother Dr. Khan Abdul Jabbar Khan knew Jawaharlal Nehru personally, and Badshah Khan had himself met both Gandhi and Nehru and thrown in his support with Congress, Britain's active role in overthrowing the Afghan king Amanullah Khan in 1929 made obvious to the Pathans the need for a political movement committed purely to the political interests of the Frontier, which were not represented within other political parties.[431] But to succeed in creating a sustainable movement, Khan needed mass support that would not wilt under divide and rule tactics, especially for a society where tribal feuds were common.[432]

For Khan, the political problem of attaining self-rule and the acute need for social reform was undergirded by the same issue—'the cultivation of a greater sense of *service* in Pathan society.'[433] It was through social uplift and sanitation work that the goals of the Pathan self-determination and self-improvement were reconciled. This aspect of the KK's activities has been detailed in Mukulika Banerjee's oral history of the movement, *Pathan Unarmed*. Badshah Khan, wherever he set up new chapters of the KK, instructed the volunteers to start the programme of reform by undertaking cleaning work in the villages.[434] The work he inaugurated was particularly well-suited to the task of building a social movement in a primarily rural society where the proclaimed ideas of British imperialism to build civic character and social character had lagged behind in their application compared to the rest of India. Sweeping, digging latrines and drainage trenches—this was the kind of constructive and manageable work which was in the capacity of laypersons and which allowed villagers to tackle problems immediately relevant to them.[435] In

[430] Ibid., pp. 60, 70, 76.
[431] Shah, *Ethnicity, Islam, and Nationalism*, p. 27.
[432] Banerjee., p. 97.
[433] Ibid.
[434] Ibid., p. 53.
[435] Ibid., p. 52.

the same vein, focusing on sanitary improvements provided a concrete skill-building focus for teaching the work ethic, focus, and discipline needed in a strong, united political movement.

The English Congress sympathiser Mary Barr visited a KK camp in 1941 and left a useful account of the import of cleaning and cleanliness on morale and discipline building within the KK movement, also called 'Red Shirts' for the colour of their uniform.[436] The two primary activities on the daily schedule were village cleaning parties and political education, which underpinned the political purpose and social discipline of its members.[437] The camps also cultivated spatial awareness and therefore political consciousness. Amongst the few marquees in the camp Barr visited, there was a small mosque but also a medical dispensary—a noticeable reimagining of the rural landscape where dispensaries and hospitals were usually few and far between.[438] Furthermore, the fact that the KK targeted certain spaces for its cleaning indicates that this cleaning of physical spaces was a subtle political strategy aimed at critiquing existing political and social norms on the Frontier. This is best evidenced by the fact that the *hujras*, or guest houses, within the homes of the *khans*—the landlord class of Pathans notorious for collaborating with the British regime—were one of the primary targets for cleaning tours by the KK. In the words of one KK member, 'The *khans* of Matta were in the pay of the British. So we used to sweep the *hujras* of the *khans'* houses so that they would soften their stance towards the KK.'[439] With respect to cultivating social awareness, it seems fitting that a primary focus of the movement was to undertake cleaning and sweeping of the *hujras* of village houses in light of the extreme importance of hospitality in *Pakhtunwali*, the Pathan code of ethics.

In the camp, Barr specifically noted the impeccable cleanliness of their tents, the straw and carpets orderly and clean as if a symbol of the moral rightness of their cause.[440] This effect was deliberately created through the training program of the movement. The recourse to sanitation was not a simple-minded effort to clean physical spaces—there was an indoctrination

[436] F. Mary Barr, 'A "Red Shirt" Camp', *Modern Review*, 71/1 (1942), pp. 54-6, qtd in Shah, *Ethnicity, Islam, and Nationalism*, pp. 268-71.
[437] Ibid., p. 268.
[438] Ibid., p. 269.
[439] Banerjee, *Pathan Unarmed*, p. 78.
[440] Qtd in Shah, *Ethnicity, Islam, and Nationalism*, p. 269.

and experiential learning component to it that enabled the KK to impart skills upon its members. Those participants that were not sent out on village duty remained in the camps to be instructed on proper cleaning and sanitation techniques, which were then practiced by cleaning the tents and grounds of the camp. It was the most practical and hands-on aspect of the educative process, and in the reminiscences of one KK member, we see how formative this experience was to large scale politicisation: 'After I joined the movement my life changed. Life was too simple before Badshah Khan came on the scene. People were ignorant. They did not know that the British were ruling us…But Badshah Khan changed all that.'[441] Indeed, by raising awareness of the filth of their surroundings and the need for cleaning, he drew attention to the absence of the Government in doing so. As Khan argued to the Chief Commissioner of the province, '[W]hat we are doing ought to be done by the Government of the country. If you cannot take over the social work our movement is doing, you ought at least to give us all the help you can, rather than stop us!'[442]

Sanitation activities were thus a constructive but unobjectionable way to raise communal consciousness, i.e. awareness of what the Pathans were capable of when organised. But they also drew attention to the neglect that the people of the frontier had bought so dearly with their taxes and the complicity of their local leaders in this state of affairs. Draconian laws banned political expression in the NWFP, so sweeping village roads was a practical and safe method of making political statements. 'In the context of the colonial regime's acute neglect of educational and social infrastructure, such activity was a clear statement of Pathan self-assertion, of a defiant refusal to continue to submit meekly to such neglect.'[443] It was also attention-grabbing; Sadar Musa Khan, who joined the movement in 1930, reminisced about Badshah Khan's instruction to his followers to clean the *hujras*, or guesthouses, of the big *khans*, or landlords.[444] It was an arresting sight, to see Pathans so humble themselves without regard to their dignity in front of others, but it was also an audacious method to confront collaborators.[445] Badshah Khan employed

[441] Banerjee, *Pathan Unarmed*, p. 62.
[442] Khan and Narang, *My life and struggle*, p. 102.
[443] Banerjee, *Pathan Unarmed*, p. 53.
[444] Ibid., p. 173.
[445] Jalal, *The Sole Spokesman*, p. 114.

a double-edged sword to attack this internal threat of elite collaborators; he combined the social overtures to the agriculturists with political instruction to villagers to form their own *jirgas* to repudiate the 'bastardized' ones run by *khans* allied to the British.[446]

By recognising and cleaning the filth of their surroundings, Badshah Khan's followers uncovered the hidden realities of frontier politics. This was where the greatest amount of repression was practised, the least amount of political rights allowed, but where the British military presence was the greatest. Yet many of Khan's compatriots were not aware that their grievances could be traced to the impact of foreign rule. In the words of one former KK member, 'I myself did not know that the British were ruling India until Badshah Khan made us aware of the fact.'[447] But this was precisely the aim of Khan's political agitation.

Banerjee writes that the KK movement was essentially the means by which a feudal society through mass, nationalist mobilisation would enter modernity, intimately connected to the process of state formation.[448] In their demand for advancement in their status as a Governor's province on par with the other provinces in British India,[449] the KK's opposition conformed to the logic of the British Indian regime even as they fought against it, unlike the border tribes whose methods and discourse were so alien that they could have no traction in a political and social space irrevocably moulded by colonial ideas of good government and civilised behaviour. Badshah Khan, though he ostensibly worked outside the regime, was seeking approval in the language of the colonial state. His method was equally colonial in its construction, as he castigated the ruling authorities for not upholding the duties they had set for themselves *vis à vis* their subjects, that is political development and "civilisation". As Banerjee writes,

> Badshah Khan recognised that Pathans were acting in ways which entirely confirmed the British stereotypes, thereby undermining their own dignity and worth, and the precepts and activities of the Khudai Khitmatgars can be seen as a deliberate attempt to disprove each negative stereotype. In place of ungovernability a process of self-reform…in place of extravagance and fecklessness, an austerity and sense of service.[450]

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[446] Banerjee, *Pathan Unarmed*, p. 61
[447] Ibid., p. 62.
[448] Ibid., p. 190.
[449] BL, IOR/L/PS/12/3135, Summary of the Proceedings of the First Meeting of Sub-Committee No. V.
[450] Banerjee, *Pathan Unarmed*, p. 212.

The Pathans would demonstrate their capacity for self-rule when they would do what the British should have done. In that sense, while the inward struggle was to clean their surroundings, in a physical and political sense, the outward struggle was to repudiate the negative perception of Pathans in the minds of outsiders as it was proving to be an obstacle to self-rule.[451]

Such reform involved cutting away at the perceived fatalism that Khan believed prevented Pathans from doing much to improve their material well-being, a perception shared by his British opponents who argued that Indian fatalism was a major obstacle to reduction of disease and death in India.[452] Another obstacle was the Pathans' infamous factionalism and 'democratic spirit' that not only permitted endless feuding among groups over perceived offenses but gave every Pathan the right to order his own affairs as he pleased as opposed to under the direction of an elected government.[453] By asking his fellow men to adopt a posture of solidarity for the sake of communal improvement, Khan was also asking them 'to adopt a method of non-violent protest which was quite contrary to their martial traditions and ferocious responses to insult'.[454] Within this political project, there was also a discrete domain of social reform that was aimed at regenerating traditional Pathan culture and values. This entailed reviving the *jirgas*, expanding the rights of non-landowning Pathans to establish their own *hujras* and increasing printing of Pashto works, for example.[455] This blend of derivative and culturally regenerative discourses within the Pathan demand for self-determination fits the modus operandi of Asian and African nationalisms in the postwar era as described by historian Partha Chatterjee.[456]

Ultimately, because of its discipline and attention to local needs, as well as its support from the Congress party, the Khudai Khitmatgars managed to gain control of power in the NWFP and led a Congress ministry in the province in 1937.[457] In the estimation of the British

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[451] BL, IOR/L/PS/12/3171, Report of the Tribal Control and Defence Committee, 1931.
[452] Banerjee, *Pathan Unarmed*, p. 151; Arnold, *Colonizing the Body*, p. 42.
[453] BL, IOR/L/PS/12/3171, Report of the Tribal Control and Defence Committee, 1931.
[454] Ibid., p. 75
[455] Khan and Narang, *My life and struggle*, pp. 88, 101; Banerjee, *Pathan Unarmed*, p. 168.
[456] *Nationalist Thought and the Colonial World: A Derivative Discourse?* (London, 1986). This topic has also been explored with reference to the role of science in the formulation of this 'hybridized nationalism' by Gyan Prakash in *Another Reason: Science and the Imagination of Modern India* (Princeton, 1999).
[457] Banerjee, *Pathan Unarmed*, pp. 167-8.

Government, 'Their loyalty to their organisation and its principles, and their firm suppression of individual interests, compel admiration, and may possibly result in the undoing of the loyalists, who are so rent by faction and jealousy that up to now they have found it quite impossible to combine, or to achieve any sort of effective organisation.'[458] This was a marked condemnation of the efforts of the KK's rival, the Muslim League, which despite Government's overt support was unable to make a dent in the dominance of Congress in the NWFP.

Power, Prestige, and the All-India Muslim League

The trajectory of the KK was in marked contrast to that of the Muslim League, which did not even have a province in which it could claim a clear mandate. It was only after the elections of 1937 that the superior showing of Congress in eight out of 11 of British India's provinces essentially handed the League its first social mandate and its separatist platform gained traction.[459] The Indian National Congress and the All-India Muslim League had initially joined hands, but over the twenties and thirties there developed hardened opposition as Congress' demand for a strong federal government at the Centre created an unfavourable political situation for the Muslim provinces. The prospect of such a constitutional arrangement 'ignited fears of Hindu raj' which would relegate Muslims to the status of a perpetual minority in any constitutional arrangement.[460] This gave Mohammad Ali Jinnah, the founder of Pakistan, the momentum he needed to make a play for recognition of the Muslim League as a major player in the design of India at-large's federal structure: '[His] entire career and thinking had concentrated upon the centre, and getting Muslims a share of power in it' because only here could he assure the interests of both Muslim majority and Muslim minority provinces.[461] This political maneuvering coincided neatly with the growing notion that the Muslims of India represented a nation, equal with the Hindus of India despite the numerical disparity between the two. Jinnah's eventual demand for Pakistan aimed at negotiating a new constitutional arrangement in which

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[458] Griffiths to Lillithgow, 9 Nov 1936, qtd in Jalal, *The Sole Spokesman*, p. 28.
[459] Z. H. Zaidi, *Pakistan: The Goal Defined, 1 January-31 August 1940*, Quaid-I-Azam Mohammad Ali Jinnah Papers, 15 (Islamabad, 2007), Appendix II Document II.1.
[460] Bose and Jalal, *Modern South Asia*, p. 142.
[461] Jalal, *The Sole Spokesman*, p. 57.

Muslims would have an equitable share of power in a Centre reconstituted on the basis of a partnership between two essentially sovereign states, Pakistan (representing the Muslim majority provinces) and Hindustan (representing the Hindu majority provinces) and their shared interest in the welfare of their coreligionists living within the other's domain.[462] This was anathema to Congress, which wanted a strong Centre and no obstructionist faction that would stand in the way of its future plans for India.[463]

In order to reasonably accomplish any of this, Quaid-e-Azam, or the 'Great Leader' as Jinnah was known, had to build the League's support in a staggeringly diverse political and socially milieu, which militated against the kind of targeted social improvements undertaken by the KK. As Jalal writes, '[S]upport could not be won by too precise a political programme since the interests of Muslims in one part of India were different from those of Muslims in others.'[464] George Cunningham recalled a conversation with the Quaid's deputy Aurangzeb Khan wherein he urged the latter to develop a concrete programme for socioeconomic uplift aimed at Muslims. 'I told him Muslim League would merely be a danger if they had no constructive programme, e.g. improvement of agriculturists or something of the kind. He seemed to agree but said that for the present they would have to depend more on the religious appeal.'[465] Jinnah knew such a programme 'was bound to be resisted by landed oligarchs who dominated local politics and, given the limitations of the franchise, prove utterly impracticable' and he 'could not afford to incur the wrath of the landed notables in control of local politics.'[466] The best tactic was to build bridges with as many local bigwigs as possible while '[l]etting his wayward followers make of "Pakistan" what they pleased'.[467] In the meantime, the Quaid-i-Azam kept his sights on negotiations at the Centre.

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[462] Metcalf and Metcalf, *Concise History of Modern India*, p. 212.
[463] Ibid., p. 213.
[464] Jalal, *State of Martial Rule*, p. 17.
[465] Mss Eur D670/1-6, Sir George Cunningham, Governor of North-West Frontier Province 1936-46, 1947-48: diaries.
[466] Bose and Jalal, *Modern South Asia*, p. 146.
[467] Ibid., p. 147.

The nature of the political exigencies facing the AIML thus limited the types of policies envisioned in the fields of health and welfare. It prevented the development of a concrete program of social uplift until the Pakistan demand had been secured and the ML's mandate assured. Only after the adoption of the Lahore Resolution, which in 1940 formally called for the creation of Pakistan, did Jinnah began to speak openly and frequently of the need to plan concrete measures to uplift Muslims, who he claimed were 'at the bottom compared to other communities'.[468] Though planning—both political and economic—had for various reasons become a major trend by the post-war period, the League was rarely in position or possessed of a mandate to formulate a program of socioeconomic reform, as its only instance of rule was a temporary period of ascendancy in the NWFP.[469] A plan for the uplift of Muslims in advance of the creation of a territorially and administratively ambiguous Pakistan came only in 1943.

Preparations for an economic plan were instigated by an appeal made by the president of the Sind Muslim League on behalf of Sind peasants at the annual session of the AIML in 1942: 'The inhabitants of this land mostly belong to the agriculture profession and are very backward in trade and industry. Your (Indian Muslims') money and experience could remove this drawback.'[470] His statement provides evidence of a perceived social gap between the masses of Muslims and the elite leadership of the movement which crafted and implemented the programme for Pakistan. When the Muslim League planning committee was put together, it was faced with several obstacles. The assembled committee members did not have any idea of what planning entailed and were really learning on the fly, such as by copying what Congress was doing.[471] Secondly, their range of possible actions was constrained by the fact that the Muslim League did not have control over the Central Government and therefore did not have the access to power or experience in government needed to organise a concrete platform and plan for state-building. At the same time, the idea of Pakistan had not yet come to denote separate statehood,

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[468] Khalid Shamsul Hasan, *Quaid-I-Azam's Unrealised Dream: Formation and Working of the All India Muslim League Economics Planning Committee* (Karachi, 1991), p. 18.
[469] Mallam, *Frogs in the Well*, p. 215.
[470] Hasan, *Muslim League Economic Committee*, p. 17
[471] Ibid., p. 19.

and so the committee also had to consider and plan for the needs of Muslims in areas where the ML did not control provincial governments, areas which eventually did not become a part of Pakistan.[472] Most debilitating to this effort to plan for social and economic uplift was the fact that '[e]xperts among the Mussalmans are not many and [only] some of them are in Government Service…in most walks of life the Mussalman is nowhere near the fore-front.'[473]

The goal for the planning committee as laid out by Quaid-e-Azam was to 'prepare for natural development in the direction of commercial and agricultural expansion and industrialization.'[474] The second was to ascertain the material potential of the Pakistan areas, while the last objective was to focus on a general levelling up of the standard of living of the masses. It is evident that the foremost concern of the AIML was that the new state under their charge be able to economically compete with Hindustan. This would be better achieved not through the cleaning of villages and improvement of nutrition and general health, but through rapid economic advancement and creation of big businesses and industries. The high rate of investment needed to speedily grow productive undertakings in Muslim areas would have to come at the expense of social services.[475] Ultimately, the objective of development was to achieve a certain metric of power, projected at the level of national wealth, rather than focus on self-improvement at the lowest level, as better befit a grassroots movement.[476]

Health was a small, almost negligible concern in a wider grievance over Muslim backwardness with respect to economic advancement and political prestige. Communal backwardness in this imagining was not symbolised by rural poverty, epidemic disease, mass illiteracy, or poor standards of hygiene. These were acknowledged to be present and would ideally be ameliorated with greater economic advancement—but they were a general, 'Indian' problem.[477] Certainly in independent Pakistan the preponderance of unsanitary and diseased

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[472] Ibid.
[473] Ibid., p. 15.
[474] Ibid., p. 22.
[475] Ibid., p. 40.
[476] Kingsley Davis, 'Population Policy and the Future,' in Sharad Chari and Stuart Corbridge (eds.), *The Development Reader*, (London, 2008), p. 150.
[477] Hasan, *Muslim League Economic Committee* p. 87.

bodies became symbols of backwardness.[478] But in as-yet-unpartitioned India, the issue that encapsulated backwardness in the Muslim League's perspective was that which would have galvanised the kind of men who were competing with Hindus at the highest political and economic levels of government and finance—namely, the dearth of prestigious government jobs, the lack of sufficient numbers of big businessmen, and the irrelevance of Muslim communities in matters of commerce.[479] As described earlier, one League-supporter wrote of this issue to Mohammad Ali Jinnah in 1945, complaining of the rivalry with Indian Hindus for government posts at the Center and in the provinces.[480] Thus, the social reforms the League did envision were greatly influenced by the fact that it was founded originally as a party of elite educated and landed Muslims whose primary concern was ensuring the political interests and cultural respect of this class.[481] Its concerns were shaped by the particular environment of India, where power had become synonymous with the bureaucracy, where the most secure and prestigious jobs were in government, and where representation in politics as in schools and hospitals was divided on a communal basis. Their thirst for political patronage and their aspirations towards communal uplift found its expression in the demand for greater access to political patronage from the colonial state, and failing that, for outright independence.[482]

Within the development programme of the League, the problem of uplifting the masses was made a corollary to elite economic advancement. One way of accomplishing this was by promoting the idea that advancement of industry by the state, as outlined by the Committee, served a 'social function'. Its driving force would be communal consciousness and obligation, and it would provide work and therefore make people self-sufficient through the creation of earning power—with some vague principle expressed by the Planning Committee of the state's role in imposing standards ensuring adequate work and pay. As discussed earlier with respect to

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[478] Ayub Khan, 'Pakistan Perspective', *Foreign Affairs*, July 1960.
[479] Hasan, *Muslim League Economic Committee*, p. 30.
[480] Zaidi, *Consolidating the Muslim League*, Document 44.
[481] Metcalf, 'Nationalist Muslims in British India', p. 10.
[482] Thomas R. Metcalf and Barbara D Metcalf, *A Concise History of Modern India (Cambridge Concise Histories)*, 2nd edn (New York, 2006). pp. 106, 160, 213.

Bengal, poverty and its relationship to malnutrition had already been identified by Indian politicians as a leading cause of morbidity and mortality; this poverty, to which Indians had been relegated under colonial leadership, was considered to be the cause of their inability to afford food and therefore health.[483] The Planning Committee concurred with this assessment. 'Public health is largely dependent upon food and nutrition…There may be normal nutrition without normal health but there can not be normal health without normal nutrition.' Naturally, greater individual earning power made possible by economic growth would be a solution to that problem.

The state had to ensure adequate wages and a suitable environment for living (e.g. drainage and roads) but its primary function was merely to uphold man's own capacity (and willingness) to resist disease. The lack of discussion regarding infrastructural requirements such as hospitals and sanitary planning is telling, but we can also infer that the formulation of health needs in the new state was grounded in extreme economy and stopgap measures for coping with disease. In light of the cost of 'present methods'—ostensibly a reference to western hospitals and clinic medicine—greater economy was to be effected through increased reliance on *Ayurvedic*, homeopathic and *Unani* practitioners, and even the use of home-made drugs. Very little importance was given to the needs of sanitary reform and village planning in rural areas. With respect to ensuring adequate housing, the AIML committee was adamant that 'the task of housing the poor is gigantic…[but] it is clear that housing cannot [sic] be regarded as public utility service and undertaken by the State.' It settled instead for an advisory role for the government in the matter of village and town sanitation.[484]

Poverty in the view of Indians within government during the early-to-mid-20th century was the result of extractive policies of colonial rule. Government's primary job with regards to welfare was to give people economic security to ensure health, but the extractive nature of

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[483] For further discussion of the relevance of this discourse on poverty, malnutrition, and disease to the development of health policy in India, see Sunil Amrith, 'Political Culture of Health in India: A Historical Perspective', *Economic and Political Weekly*, 42/2 (2007), p. 115.
[484] Hasan, *Muslim League Economic Committee*, pp. 87-88.

colonial rule had meant that government had not adequately undertaken this primary task of welfare provision.[485] This provided a somewhat rosy view of the prospects of indigenous administration of the economy in the interests of the people, a view which became quickly disillusioned wherever natives assumed the reins of government, whether district commissioners in British Bengal after the Montagu-Chelmsford governance reforms, or Pakistani statesmen after full independence.[486] Furthermore, in viewing industrial development as a sufficient means to effect social improvement in housing, nutrition, literacy, and sanitation, the AIML's theory of economic and social change was well-suited to the international developmentalist paradigm that would develop in the post-WWII period, and which would be enforced in countries like Pakistan, wherein social programs were subordinated to the dictates of modernisation theory's focus on rapid industrialisation.

The plan conceived for the immediate future in British India and a further-off future in Pakistan clearly demonstrates the biases and outsize influence of the *salariat* class, as defined by eminent Pakistani social scientist Hamza Alavi, in shaping the Pakistan demand.[487] The concerns of this class related to bolstering their access to the prestigious, lucrative socioeconomic positions in society, and these were the groups likely to apply for government and professional jobs that had been first established by the British in India.[488] Viewed through that lens, the problem of the masses would be fixed by the fulfilment of the interests of the elite classes. For the members of the ML, the purposes of power were very limited and ended up vastly limiting the possibilities envisioned for promoting change in the lives of the majority of the Indian masses. Only the design of administrative and legislative measures which could be implemented at the provincial level were drawn up to address social, educational and economic concerns.[489] Furthermore, till the end, the Committee continued to disagree regarding whether its plan

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[485] Amrith, 'Political Culture of Health in India', p. 115.
[486] BL, IOR/V/24/2858, Report on the working of the municipalities in Bengal, during the year 1939-40; Mahbub ul Haq, *The Poverty Curtain: Choices for the Third World* (New York, 1976), p. 13.
[487] Hamza Alavi, 'Social Forces and Ideology in the Making of Pakistan', *Economic and Political Weekly*, 37/51 (2002), pp. 5119–24.
[488] Ibid.
[489] Hasan, *Muslim League Economic Committee*, p. 20.

concerned only the Pakistan areas or should be a plan for united India, demonstrating that the logic of Muslim separatism had not really seeped in for many members and that there was little understanding of the scope and purpose of the ML in a postcolonial India.[490]

Conclusion

On the eve of independence, it was by no means evident or inevitable that the Muslims of India would separate themselves entirely under the banner of the Muslim League. Nor was it assured that Pakistan, a separate state for India's Muslims to grant them parity with—if not outright independence from—Congress-ruled Hindustan would become a reality. There were competing forms and motives for political organisation that manifested with distinct approaches to the question of improving community well-being and health in an India or Pakistan free of British rule, and this can be attributed to the fact that the slights of colonial dominion were felt in different ways by different regions and communities. Ironically, the dissatisfaction of these different groups with colonial government and their desire for self-rule were a consequence of the assimilation of British ideas regarding government responsibility for public health and education and the growing ambitions of a professional class that desired the prestige that came with representation in the institutions developed by the British in India, the universities and medical schools, municipal and district boards, legislative councils and viceroy's council.

In his history of Frontier politics during the last decade of British rule, Sayed Wiqar Ali Shah writes that the KK's emphasis on Pathan identity meant it had little cache outside of this narrowly defined community, but within this ethnic group, different classes and groups interpreted the movement's platform for their own ends.[491] Indeed, the KK sought to address the Pathans' political concerns while functioning as one of a national patchwork of regional interests within the umbrella organization of the Indian National Congress, endorsing the political programme of Congress at the national level while pursuing its own particular programme at home. Indeed, cultural associations of this type were among some of the first to draw attention to

[490] Ibid., p. 38.
[491] Shah, *Ethnicity, Islam, and Nationalism*, p. 27.

everyday programs in the localities, engaging in welfare-related activities neglected by the colonial state and thereby strengthening communitarian bonds.[492] The Muslim League by contrast sought to bring many disparate, far-flung groups across the vast landscape of India under one unified political programme, largely because the only way it could make a justifiable claim to holding significant political power in an independent India was by unifying the interests of as many of India's Muslims as possible within one policy-making body.

Ultimately, however, the trajectory of Muslim nationalism politics did follow the latter as political expressions of unity failed. Barbara Metcalf in her study of the politics of the prominent *unani-tibb* practitioner and educator Hakim Ajmal Khan provided a unique perspective on how political expressions of unity failed through the lens of the history of medicine. She masterfully describes how Ajmal Khan's nationalist aspirations and desire for social respect along with his desire for state recognition for indigenous systems of medicine united his interests with those of non-Muslims in the era of nationalism. At the same time, his personal, familial, and religious connections made him committed to the renaissance of Muslim cultural symbols and the glorification of linguistic, historical, and artistic contributions of Muslim civilisation to the subcontinent. Ajmal Khan represented a strand of Indian Muslim nationalism that was rooted in an appreciation of the uniqueness of Muslim culture and the political interests of elite, educated Muslims, but nevertheless remained committed to Hindu-Muslim unity. And this stance was made possible by his particular role as a leader and practitioner of an indigenous medical tradition, which prided itself on its cultural distinctiveness while being beset by the same problems that afflicted its sister institutions, of *Ayurveda* for example, in colonial India.[493]

Metcalf argues that Ajmal Khan's blend of culturally-rooted nationalistic unity signified the possibility of a public and political expression of Muslim identity and cultural distinctiveness that could nevertheless still function as a complement to a more composite nationalism.[494] She

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[492] Ayesha Jalal, *Self and Sovereignty: Individual and Community in South Asian Islam since 1850* (London, 2000), p. 81.
[493] Metcalf, 'Nationalism Muslims in British India'.
[494] 'Nationalist Muslims in British India', p. 27.

writes, 'His own career in both medicine and politics had been built on forging alliances among the elite—with the princes, with the British, with professional allies, and with political leaders…He created in indigenous medicine an area of accomplishment and a symbol of both communal *and* national pride.'[495] However, she also admits, 'In the situation of British India, however, the encouragement of separate organizations and identities only served to exacerbate competition and communal tension.'[496] The truth to Metcalf's statement regarding the increasing communal tension of Indian nationalism is demonstrated by the repudiation of Ajmal Khan's politics by other practitioners of *unani-tibb* who threw in their support with the Muslim League. Writing to Jinnah in 1944, one Leaguer remonstrated, 'Hakim Ajmal Khan Sahib in the prime of his effort at reviving unani medicine lost himself by turning a nationalist in good faith of the Gandhian type and shunned [sic] the progress of unani.'[497] It was the opinion of this writer that 'Ayurveda finds a place in the national life of the Hindus whereas unani failed to progress due to neglect of Musalmans'. Consequently, the appropriate political stance for the League would be to focus on the social interests of their own people. '[I]f you are sufficiently convinced that unani, as science and art of healing, can still serve the people, you may include revival and encouragement of unani in the reconstruction programme of the League,' the writer suggested to Jinnah.

This gives some indication of the increasingly separatist tone of Muslim nationalism in India, wherein the interests of the Muslims, even within the domains of health and healing, were under assault from Hindu hegemony and deserved their own political arena to flourish.[498] In Jalal's words, 'Indian Muslims…displayed a healthy scepticism of an inclusionary nationalism unable to shed the premises of its religious majoritarianism.' This sentiment eventually drove the demand for Pakistan, as evidenced by the words of a young Zulfiqar Ali Bhutto, future Prime

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[495] Ibid. italics added.
[496] Ibid.
[497] Zaidi, *Consolidating the Muslim League*, Document 87.
[498] On the topic of Muslim separatism, Ayesha Jalal has written, 'What has been branded "separatism" may well have been something more akin to exclusion on the part of that variant of the Indian nationalist discourse which rose to a position of dominance.' For a thoughtful discussion of the history and historiography of Muslim nationalism in South Asia, see Jalal, *Self and Sovereignty*.

Minister of Pakistan, who wrote to Quaid-e-Azam in 1944 regarding the Khudai Khitmatgars's support for Congress, 'How can…others such as Dr. Khan Sahib call themselves Musalmans when they fall victim to Congress policy…Musalmans should realize that the Hindus can never and will never unite with us… You, Sir, have brought us under one platform and one flag, and the cry of every Musalman should be bound to Pakistan…We are a nation by ourselves.'[499]

The tensions between these competing groups—of Muslims and non-Muslims, *Unani* and *Ayurveda*, British and Indians—would reach a fever pitch as India hurtled towards independence. But before the dust had settled from the all-India governance reforms of the 1930s and the elections of the 1940s, before colonial bureaucrats, Indian elites, and the politicized masses had finished jockeying for power in the individual provinces and territories, before even the borders of the successor states had been clearly delineated, the former British Empire in India was plunged into catastrophic violence.

[499] Zaidi, *Consolidating the Muslim League for the Final Struggle*, Document 462.

Chapter 6: Partition

> The catastrophe with which we are faced is unprecedented both in magnitude and immensity in the annals of the world. The Medical Department staffed for the normal requirements of normal times is up against a colossal task. In this crucial moment in our destiny I appeal to philanthropic institutions and individuals in the Province for all out help to the Medical Department in organising efficient treatment and care of the sick and wounded refugees.
>
> (*The Pakistan Times*, 7 October, 1947)

On 3 June, 1947 came the announcement that 200 years of British rule on the subcontinent would draw to a close that year with the partition of India into two nations. The British, anxious to "quit India" after centuries spent in the concerted effort to establish supremacy over its land, resources, and people, gave the leaders of Congress and the Muslim League 72 days to create democratic states capable of securing violently contested borders and discharging the rights due to a new class of political actors on the subcontinent—the citizens—most of whom as landless subjects of the Raj had never voted before. The future leaders of India and Pakistan further had the unenviable task of creating these centralized nation-states out of a multitude of provinces and territories, which, as the previous chapters indicate, were essentially semi-autonomous fiefdoms in their own right with incongruous political systems, unique social milieus, and divergent needs, only loosely tied to each other by the history of a shared imperial claim and an even shorter history of nationalist solidarity.

It is difficult, perhaps impossible, to provide an adequate narrative transition from the political processes and concerns preceding independence to what came after. Partition itself was not a transition, it was a conflagration. Partition set in motion the largest mass migration in human history against the backdrop of horrific communal bloodshed. It made a mockery of the hastily-laid out plans for the subcontinent's political future. It caused millions of Muslims, Hindus, and Sikhs to leave ancestral homes and lands to cross unknown borders without any instruction or direction other than the overriding need to seek safety among one's religious compatriots. In total, over nine million Muslims made the perilous journey across violent

borderlands to seek the succour of the new Pakistani state.[500] Within three and a half months of the disappearance of British authority on the subcontinent, nearly five million Muslims had left the newly partitioned province of East Punjab alone.[501] The magnitude of loss confounded belief. The most conservative estimates posit that at least two hundred thousand people were killed or died from malnutrition, epidemics, or exhaustion on the way, while other assessments go as high as 1,000,000 deaths.[502] Those Muslims that somehow made it to the new state of Pakistan arrived in a state of utter destitution and shattered health, bringing with them poverty, disease, and epidemics. As Jalal writes, 'The gift of independence in 1947 came like a shroud of death for the vulnerable, weak and infirm.'[503]

The sudden exodus of the British from India and the spiralling crisis of Partition presents a narrative departure from discussions of state-driven health policymaking as large scale interventions in health during this period proceeded in the absence of cohesive political systems and coherent health policies. By exploring the well-documented but little-studied accounts of medical trauma endured by migrants to Pakistan,[504] we become cognisant of the suddenness of the crisis and the financial, physical and psychological pressures put on the nascent state, and thereby concretely understand the social problems and governance challenges created by the partition of India. With the exception of the war over Kashmir, a major part of Pakistan's problems in the early days were related to health because this was the primary danger faced by refugees and because refugees were one of the primary dangers faced by Pakistan. For Quaid-e-Azam and his subordinates, the refugee crisis became an overriding concern. 'Since we assumed office my Government and myself have been spending the best part of our time and energy in dealing with this grave crisis which continues to assume greater proportions as one disaster

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[500] Government of Pakistan, Office of the Economic Advisor, *Economy of Pakistan, 1950* (Karachi, 1951), p. 385.
[501] Talbot, *Pakistan: A Modern History*, p. 101.
[502] Ibid.
[503] Jalal, *Self and Sovereignty*, p. 564.
[504] This chapter will use government documents, newspaper articles, and personal correspondences compiled by the National Documentation Centre of the Government of Pakistan [hereafter NDC] in the archival volume *Journey to Pakistan: a documentation on refugees of 1947* (Islamabad, 1993) accessed through the Bodleian Library, Oxford.

follows another,' he stated.[505] At a time when attention was needed for state-building efforts, the refugee crisis proved to be frustratingly endless. As this chapter will show, the unwanted burden of millions of hungry and diseased Muslim refugees to Pakistan hindered the development of a cohesive, autonomous state authority, and the persistent dependence of the refugees on welfare and public hospitality challenged developing notions of citizenship in the new state.

Making the Journey

On 21 December 1947 at 11 a.m. the last foot convoy of Muslim refugees arrived from Hindustan, crossing the Sulemanki bridge into Pakistan. The contingent was made up of 7,000 Muslims from the Gurgaon District, who had been awaiting evacuation for months. They were one of the last pockets of Muslim refugees in East Punjab who had been unable to relocate to the larger camps—which had been evacuated months earlier—for fear of their non-Muslim neighbours. Along with them were 'the remnants' of Meo and Rajput Muslims who had emigrated from Alwar and Bharatpur states. The Gurgaon Muslims, who were relatively close to the border, 'arrived in the promised land after 25 days of travel'; the Alwar and Bharatpur refugees had been on the road for as long as six months and had lost most of their relatives during 'their incessant wandering'.[506]

The Muslims of India and the Hindus and Sikhs of Pakistan became refugees in their own countries seemingly overnight in August 1947. The journey to Pakistan for the Muslims who left India began when they left or were driven out of their homes to evacuee camps within Hindustan. In fact, most of the men, women and children who came over to West Punjab had come after prolonged stays in one or more camps in India.[507] Massive departures of Muslims from their homes in Amritsar, Gurdaspur, Kandra, Hoshiarpur and Ludhiana districts took place due to fear of communal violence and Indian and Pakistani military officers escorted large contingents of these evacuees to camps in anticipation of their eventual journey to their new

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[505] Yasmin Khan, *The Great Partition: The Making of India and Pakistan* (New Haven, 2007), p. 148.
[506] Arrival of the Last Foot Convoy From East Punjab', *The Pakistan Times*, 21 December 1947, in *Journey to Pakistan*, p. 311.
[507] 'Report Dated 15 Jan 1948 on Management of Refugees Camps by A.M.K. Leghari, Refugees Commissioner', in *Journey to Pakistan*, p. 45.

home.[508] Even in these areas which were very close to the border, Muslims were resident in camps for weeks and even months before they could leave for Pakistan or be escorted there.[509] Their reported condition after residing in these camps was miserable and it is not hard to imagine why—when governments were struggling to provide resources for their own, medical aid and supplies of food could scarcely be spared on those perceived as the enemy.[510]

Unfortunately, the situation would worsen considerably once these migrants left the camps. We get a sense of their trials in a note by the Pakistan Ministry of Refugees which was following the progress of the Gurgaon refugees before they found their way to Pakistan. Three months after independence, the Ministry wrote of their progress:

> According to our latest reports they are now without food; their cattle are rapidly dying for lack of fodder, or are being slaughtered by them for eating; their bullock carts (wherever they had any) are being used as fuel-wood and other difficulties are aggravated by the onset of winter which with their physical debility will make them an easy prey to diseases like pneumonia and influenza.[511]

Along the way the convoy was also attacked by an epidemic of smallpox. Its travails were by no means extreme or unrepresentative, for this was the combination of dangers that migrants faced as they sought the safety of religious majority.

Partition also imposed intense physical demands on migrants. The Gurgaon refugees for example were primarily agriculturists, and were expected to make the journey on foot. Despite the fact that their state of physical exhaustion as determined by the authorities in charge suggested that the only humane way to get them to Pakistan would be by train, they were forced to make the journey on foot up to December. However, because Sikhs had already been evacuated from West Punjab to East Punjab, there was the very real threat of violence for the incoming refugees as they began their trek across East Punjab, the last geographical barrier

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[508] 'A Note Dated 9 November 1947 on Refugees Movement by Mian Muhammad Iftikhar-ud-Din, Minister for Refugees and Rehabilitation, West Punjab', *Journey to Pakistan*, p. 29.
[509] 'Note Dated 9 November 1947 on Refugees Movement', in *Journey to Pakistan*, p. 30.
[510] 'Report Dated 15 Jan 1948', in *Journey to Pakistan*, p. 45
[511] 'Note Dated 9 November 1947', in *Journey to Pakistan,* p. 34.

before arriving in Lahore. At this time, and for this reason, the Pakistan Army was deputed to escort these and other refugees to Pakistan through the dangerous train route via Punjab.[512]

The Pakistan Military Evacuation Organization was set up on 28th August, exactly two weeks after Partition, to cope with what had become by this time 'an accepted and inevitable exodus of Muslims' from India.[513] Before the creation of Pakistan, Jinnah had envisioned an organised and efficient transfer of populations being undertaken by India and Pakistan.[514] The reality was that political authority was weak and security provisions were non-existent. In this vacuum, the armed forces, themselves including many refugees and those who had lost family members in the violence of Partition, were tasked with escorting refugee trains across the Punjab, guarding convoys and caravans, carrying food to refugee camps, looking after stranded refugees, and protecting Muslim refugee camps in Indian Punjab.[515] Suffering from disease and slow starvation, the refugees were found in such a state that the first duty assigned to the military forces was to provide humanitarian relief in terms of shelter, food, clothing and medical aid. Members of the armed forces were the first point of contact for many refugees, and many of the officers and soldiers protecting and escorting the refugees across borders were at that very moment uprooting their own ancestral homes in India.[516] The trust reposed by the Muslim migrants in the Muslim armed forces seems to have been strong enough that it was used on at least one occasion by criminals impersonating military officers to trick refugees into trusting and following them in order to murder them.[517]

The intense communal hatred and the damage that resulted from Partition paradoxically forced the governments of India and Pakistan to work together against their better wishes.

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[512] Ibid.
[513] 'Note Dated 27 April 1948 on the work done by the Ministry and the Pakistan-Punjab Refugees Council, by W.V. Grigson, Secretary, Ministry of Refugees', in *Journey to Pakistan*, p. 58.
[514] UK NA, FO 371/63533, Speech by Muhammad Jinnah on the partition of Bengal and the Punjab, 4th May 1947.
[515] Office of the Economic Adviser, *Economy of Pakistan, 1950*, (Karachi, 1951), p. 385.
[516] Khan, *The Great Partition*, p. 115.
[517] 'Arrival of the Last Foot Convoy from East Punjab', *Pakistan* Times, 21 December 1947, in *Journey to Pakistan*, p. 311; 'A Brief Report Dated 4th October 1947 made by K.B. Malik Khuda Baksh, Regarding the Districts of Ambala, Kanal, Rohtak, Hissar, Simla, Ludhiana and Jullunder', in *Journey to Pakistan*, p. 203.

Yasmin Khan writes that at one point during the division of assets between the future leaders of India and Pakistan, 'Liaquat Ali Khan told Mountbatten that the situation had become so tense between Pakistani and Indian officials that he did not know how much longer they could continue working together.'[518] But the threat and disruptive nature of epidemics made collaboration necessary. In September there was a severe outbreak of cholera on both sides of the border. 330 cases of cholera among non-Muslim refugees arriving in Delhi were discovered, prompting the new Government of India in October 1947 to finally release for shipment over 1.6 million ccs. of anti-cholera vaccine from Bombay to Karachi.[519] Similar efforts were made to recover abducted women and exchange inmates of psychiatric institutions.[520]

Cholera was a never-ending concern in the care of refugees. 'From the very beginning, cholera has been the West Punjab refugees authorities [sic] worst headache,' proclaimed the *Pakistan Times*.[521] The tragedy of cholera among the migrants to Pakistan provided an ironic twist to the 'promised land' narrative of the journey to Pakistan. After suffering from slow starvation in refugee camps in India and enduring the exhausting march across the hostile East Punjab, Muslim refugees reached Pakistan only to then die from cholera. The prospects for refugees arriving to West Punjab within the first 48 hours of arrival were dismal, according to the Refugees Commissioner: 'Most of the cholera cases were hopeless from the medical point of view…only their will to get to Pakistan helped them to complete the journey.'[522] They were not only killing themselves in making the journey to Pakistan while being malnourished and constantly exposed to disease, but they were also posing a mortal threat to their newfound compatriots. After the crisis of Partition was over, refugees would continue to be seen in this light due to their insanitary dwellings and proximity to residential dwellings and water supplies.

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[518] Khan, *The Great Partition*, p. 122.
[519] 'Exodus of Refugees and Communal Disturbances in Indo-Pak Sub-Continent 1947-48', *Keesing's Contemporary Archives, Vol. VII, 1948-50*, qtd. in *Journey to Pakistan*, p. 326.
[520] This became the topic of one of the best known novels produced by a Pakistani writer, *Toba Tek Singh*, by Saadat Hassan Manto who himself migrated from Delhi to Lahore.
[521] 'Walton Camp: Completely Rid of Cholera', *Pakistan Times*, 1 November 1947, in *Journey to Pakistan*, p. 288.
[522] Ibid., p. 289.

A few months in, the situation had spiralled so far out of control that the Government of Pakistan was reduced to hoping that no more Muslims would come to Pakistan, which had been established precisely as a haven for the Muslims of India. In a January 1948 report, the Commissioner of Refugees wrote that the capacity to feed the refugees was reaching crisis point and could only be averted if the 'Indian Dominion does not embark on a policy of driving out large blocks of their Muslim nationals.'[523] The high point of migration ended in November of 1947, when over 1.2 million Muslims were evacuated from East Punjab, compared with just 600,000 in September (the first full month for which statistics were tabulated).[524] Only once the machinery of Partition had become well entrenched that epidemic conditions were finally ameliorated. The refugee authorities in November were able to manage four days without a death 'after a month's ceaseless campaign against cholera,' which involved intercepting refugees at the border and immediately administering inoculation.[525] The ability to impose quarantine in an effort to stem the spread of an epidemic necessitates a certain capacity to surveil and control the movement of populations. Therefore, the proactive approach taken by the Pakistan authorities to stopping cholera epidemic at the border towards the end of 1947 indicates the increased degree of control over the disease by a strengthened public health apparatus. However, it is also a sign of the establishment of control over people and over territory thereby providing valuable evidence of the establishment of state authority by the nascent republic.

Over one million refugees continued to remain shelterless by 1951.[526] But in 1947, when the extent of the crisis was still unknown, this meant that those who were making the harrowing journey across the bloody border of the Punjab expected to face at least a brutal winter without hope of relief. This was related most poignantly by a *Pakistan Times* journalist writing about a midnight run through the city of Lahore one night when the temperature reached below freezing.

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[523] 'Report Dated 15 Jan 1948', in *Journey to Pakistan*, p. 45.
[524] 'A note on work done by Ministry of Refugees and Pak Punjab Joint Council', Cabinet Record, Cabinet Division, Islamabad, 128/CF/48, in *Journey to Pakistan*, p. 75.
[525] Ibid., p. 288.
[526] NDC, 172/CF/51, Conference of the Provincial Governors and Chief Ministers held on July 1951 and 4th to 9th April 1952.

It is worth reproducing the account in full to demonstrate the shock of a Pakistan civilian at the living reality of refugees:

> After midnight on Wednesday I accompanied the Bait-ul-Mal workers on their 'mercy round' in the city in a truck loaded with razais [quilted blankets] and other woollen stuff. We rattled through the wide, empty streets and halted near the Braganza Hotel, outside the railway station, where one can generally find hundreds of homeless people huddled up together for the night. We debussed, carrying bundles of razais, and fanned out into different directions for their distribution. As we approached the place we heard subdued groans that escaped hundreds of lips as the slashing, icy cold wind cut into their limbs. They were lying huddled together with their legs drawn up to their bellies to have some warmth. As we approached them we saw that a fairly large number had only one cotton khais [shawl] to cover them and the rest had a thin rami or a blanket to warm them up. Many mothers were leaning over their children to protect them against the biting cold. Many others blew at the dying embers of a chilam [hashish pipe] and toasted their hands at the glow. Men, women and children were coughing and sneezing and suckling babes were crying with cold. That night we visited many places and distributed about 250 razais and some 100 blankets, a number which is hopelessly inadequate to meet the present requirements.[527]

Unfortunately, for these refugees, the housing problem in Lahore would continue to remain at crisis levels. In 1944, the Chairman of the Lahore Improvement Trust had estimated that between thirty to forty thousand new houses were required for the city's needs.[528] With Partition riots, an additional four thousand homes were destroyed. And yet, from 1947-50, Lahore absorbed an additional population of one million souls who required shelter from the hazards of life on railway stations and city sidewalks. Some resettled in homes and lands left behind by evacuees to India but many were subjected to dangerous living conditions with collapsing dwellings causing several deaths of Partition refugees not just in the difficult months of 1947 but even a decade later.[529]

In the Camps

For those refugees that did not seek charity, housing, or employment elsewhere but came instead to the camps, their first experience of Pakistan was immediate inspection upon arrival for signs of cholera before they were taken to the camp itself where they were given tea and handed

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[527] Quoted in Khan, *The Great Partition*, p. 70
[528] Ian Talbot, 'A Tale of Two Cities: The Aftermath of Partition for Lahore and Amritsar 1947–1957', *Modern Asian Studies*, 41/01 (2006), p. 161.
[529] Talbot, 'A Tale of Two Cities', p. 162.

warm coats.[530] The migrants arrived in Pakistan to overflowing camps. The refugee problem had begun in earnest on 11 August, before anyone—including the leaders of the two countries—knew which areas would be bequeathed to which nation. Muslims had already begun leaving Amritsar district, which was adjacent to Lahore, en masse. The Boy Scouts Headquarters in Lahore was quickly made available to refugees, and the staff of the institution presented themselves for the care of refugees. But within days that camp had overflowed and a second camp was opened at Walton. In another few days—now two weeks since Partition—that second camp had also overflowed to over 85,000 and another was opened in the same area. By the end of October, six more camps had to be opened in various districts in the Punjab.[531] The people who arrived were physically on the brink of death—the death rate on arrival once refugees arrived in West Punjab varied anywhere between 1 per 500 to 1 per 1000 during the first 48 hours. The biggest culprits were exhaustion but also, as noted above, epidemics. The camps from which many refugees were fleeing had suffered raging cholera epidemics. In view of the fact that refugees generally arrived in a starved state, transit camps like Walton had food for as many as 10,000 people ever-ready.[532]

The evolution of conditions prevailing in the camps provide a picture of how a mixed panoply of individuals, organisations, and political groups presented themselves for refugee relief and rehabilitation—or found themselves in the role—in the absence of a visible and functioning state authority. Initially, it was not the Pakistan Government that was undertaking coordination of charitable relief operations in the early days of independence, but technically the Muslim League leadership.[533] When on 10th August, thousands of Muslims began streaming out of Amritsar, Jullundur, Hoshiarpur, and Ludhiana, the Muslim League appointed a Relief

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[530] 'Report dated 31 Jan. 1948 on Refugees Camps by R.F. Mudie, Governor, West Punjab' in *Journey to Pakistan*, p. 50; 'Walton—The Shelter for the Shelterless', *Pakistan Times*, 23 October 1947, in *Journey to Pakistan*, p. 285; 'Arrival of the Last Foot Convoy from East Punjab', 21 December 1947, in *Journey to Pakistan*, p. 311.
[531] 'Report Dated 15 Jan 1948', in *Journey to Pakistan*, pp. 42-3.
[532] 'Note Dated 27 April 1948', in Journey to Pakistan, p. 62.
[533] 'Refugees Situation in East Punjab: Relief Work By Muslim League', *Pakistan Times*, 14 August 1947, in *Journey to Pakistan*, p. 226.

Committee in Lahore—which would become the office of refugee operations in Pakistan—to oversee several relief centres in different parts of the city and its suburbs. These official camps, which contained their own kitchens, small dispensary and transport facilities, were in addition to the volunteers who offered to take in refugees, in some cases.[534] While charity funds collected under its auspices were helping feed and clothe the refugees, the League had to pressure its own provincial government in the Punjab to take over responsibility for sheltering and feeding Muslims as it had done for thousands of non-Muslim refugees displaced in West Punjab earlier in the year due to communal violence.[535] The military was despatched by the League to India, while experienced government officials and civil service officers assumed positions in Pakistan and began to coordinate evacuation and reception programmes at Amritsar and Lahore, respectively.[536] To these were added further subordinate workers assisting government officials, and they included not only clerks, accountants, typists but also food inspectors, orderlies, sweepers, nurses, and doctors as well as clerics and officers of morale.

The scale of the problem and the shortcomings in organization were best exemplified by the mounting frustration expressed over the insanitary state and squalor of the refugee camps. Speaking of the camps in Lahore established on the spacious grounds of the Boy Scouts headquarters at Walton, the *Pakistan Times* remarked, 'At one time it presented a ghastly sight with hundreds of dead bodies littered all over,' and referred to it as a 'plague spot.' [537]

Given the speed with which the capacities of the respective camps were reached, as well as the hasty nature of preparations, there were considerable complaints about the state of the camps. They all revolved around matters relating to health—the vagaries of food distribution, the sanitation issues and lack of medical aid. A letter to the editor in the *Pakistan Times* regarding the camps housing Amritsar refugees published within a week of independence remarked that 'all [these] complaints appear well-founded.' In the refugees' first home in Pakistan, '[t]he whole

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[534] Ibid.
[535] Ibid., p. 227.
[536] 'Despatch of Armed Trucks to East Punjab: Relief Work by Muslim League', *Pakistan Times,* 14 August 1947, in Journey to Pakistan, p. 227.
[537] 'Walton—The Shelter for the Shelterless', in *Journey to Pakistan,* p. 285.

atmosphere was filthy.' The writer also pointed out the inadequacy of medical arrangements, warning that several more dispensaries were needed to meet the needs of the camp. This concerned citizen estimated that three fourths of the food went to waste due to mismanagement and fraud as some evacuees received food supplies two or three times while others went completely without.[538]

The problem of food quickly became a major crisis and would remain a national issue for at least a decade. The provincial government in the Punjab initially had plentiful food supplies, but refugees still went hungry and the threat of bread riots became increasingly acute. This was clearly a historical political problem. The Muslim provinces of India had faced breakdowns in communication and transport amidst food scarcity before Partition as well. These were the same conditions prevailing in 1943 when a severe famine had raged across Bengal. At that time, Bengali Muslim League leader M.A. Hassan Ispahani had predicted the dangers presented by lack of unity among the provinces. Writing to Jinnah in September of 1943, he warned, 'I see bad days ahead, days that no Government in the province, whatever be its composition, can prevent from dawning unless drastic steps are taken and serious efforts made by the Central Government to bring into Bengal a large and continuous flow of food-grains from provinces more happily situated,' namely the Punjab.[539] A month later he had written to the Quaid-e-Azam again and addressed the ideological importance of non-cooperation for the future of Pakistan:

> The present relationship existing between the two provinces of Bengal and Punjab is one to cause ridicule as both these provinces are included in the area of Pakistan, and yet one section is starving while the other is holding on to foodstuffs for higher prices. If this is going to be the co-operation between one section of Muslim India with another, what hope is there in years to come of unity amongst Muslims.[540]

Even after the two provinces—both halved—joined together as equal members of Pakistan, the legacy of famine and challenges of administration were making it difficult for food

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[538] 'Walton Relief Camp: A Letter to Editore [sic] Reviewing its Conditions', *Pakistan Times*, 23 August 1947, in *Journey to Pakistan*, p. 231.
[539] Z.H. Zaidi, *Quest for Political Settlement in India, 1 October 1943-31 July 1944*, Quaid-I-Azam Mohammad Ali Jinnah Papers, 10 (Islamabad, 2004), Document 6.
[540] Ibid., Document 28.

to be distributed just within the province of Punjab itself let alone getting adequate supplies to East Bengal.[541] As India's bread-basket, the Punjab entered August 1947 with a reserve of over 1 crore tons of wheat.[542] For it to fall short in feeding from its surplus stocks the initial surplus population that entered its borders was indeed an unexpected and tragic failure. But problems with hoarding and profiteering and inadequate provisions for transportation created bottlenecks in supply that, along with mismanagement of food supplies in camps, added to the misery of refugees.[543] There was not sufficient central government authority in place then, nor in the decade after when food shortages and provincial hoarding continued to run rampant, to ensure a steady nationwide supply of food.[544] The Centre's inability to force the provinces to do its will also meant that the provinces were free to ignore their individual responsibility to host and rehabilitate their agreed upon quota of refugees, creating frustration within the Refugees Ministry which needed the Centre to enforce this policy but which had resigned itself to the likely failure of the national government to do so.[545] In light of the failure to coordinate food supplies and refugee rehabilitation between provinces, it is evident that despite its outward assumption of political and territorial sovereignty, internally Pakistan functioned less as a strong and unified nation-state and more an amalgam of historically autonomous, unequally endowed provinces.

By December 1947, West Punjab had received one million more people than it realized it would be able to rehabilitate.[546] According to the West Punjab Refugees Commissioner, the problem began to escalate after November when the proportion of refugees in the province continued increasing without a corresponding increase in the number of evacuees. The government camps constituted to house refugees to Pakistan stretched from Lahore, near the

[541] NDC, 244/CF/49, Report on the proceedings of the Second Session for the Eastern Mediterranean; Khan, *The Great Partition*, p. 149.
[542] 'A note on refugees camps', in *Journey to Pakistan*, p. 25.
[543] Ibid., p 26.
[544] NDC, 18/CF/49, Desirability or otherwise of decontrolling movement of wheat and other foodgrains in Western Pakistan, dated 22 Sept 1949.
[545] 'Plan dated 5 July 1948 for the Rehabilitation of Refugees by A.M.K. Leghari, Refugees Commissioner', in *Journey to Pakistan*, p. 84.
[546] 'Report Dated 15 Jan 1948', in *Journey to Pakistan*, p. 42.

Indian border to Dera Ghazi Khan, in the heart of Pakistan.[547] In terms of numbers, by 1951 the proportion of refugees as estimated by the census was 6.5 million for West Pakistan and 750,000 for East Bengal, with an estimated 70% in rural areas in West Pakistan, most of these in the Punjab. Karachi absorbed the greatest proportion of urban refugees.[548]

A year after independence, the Punjab had become fed up of bearing the burden of the 'refugees problem.' The other provinces had failed to honour their pledges regarding refugee rehabilitation. The NWFP for example had lost some 300,000 non-Muslims but had taken in only 30,000 refugees. The Punjab Refugees Minister questioned whether 'West Punjab can depend on the Centre to make the other Provinces of West Pakistan take over their agreed quotas' and concluded that the province would have to plan for this expectation to not be met.[549] Already, therefore, trust in the federal authority had been eroded, or perhaps the bias against the Centre had continued into the era of independence. The West Punjab claimed to be caring for 25% more people than before, having to feed extra mouths while cultivable land was laying untilled.[550] For several months, the Punjab authorities did indeed feed many refugees and the other provinces on a surplus, though by January the stocks of wheat had been used up.[551] Alongside the now-present food problem was the fact that more people had been brought into the country but no new land had been brought under cultivation to account for the increase in mouths to feed. Acres upon acres of land remained completely uninhabited while hundreds of thousands still remained to be settled in camps and in villages.[552]

Inter-governmental conflict did not end there. There was also tension between provincial and local authorities. To the Punjab provincial administration, it seemed as if everyone was intent on making them responsible for the feeding and housing of countless unproductive and

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[547] Ibid., p. 42-43.
[548] NDC, 172/CF/51, Revised Agenda for the meeting of the Governors' Conference to be held on the 7th April 1952, Ministry of Refugees and Rehabilitation, Note, p. 1.
[549] 'Plan dated 5 July 1948 for the Rehabilitation of Refugees by A.M.K. Leghari, Refugees Commissioner', in *Journey to Pakistan*, p. 84.
[550] Ibid, p. 83.
[551] 'Note of Refugee Camps by Mian Muhammad Iftikhar-ud-Din', in *Journey to Pakistan*, p. 25; 'Note Dated 27 April 1948', in Journey to Pakistan, p. 62.
[552] 'Plan dated 5 July 1948 for the Rehabilitation of Refugees by A.M.K. Leghari, Refugees Commissioner', in *Journey to Pakistan*, p. 84.

unambitious refugees for the foreseeable future, including their own local auxiliaries. 'The restoration of the economic life of the Province has been enjoined on D.Cs [District Commissioners] and others time and again, but its importance seems almost to have been entirely ignored.' Instead of making areas outside the camps appealing, 'Subordinate officers still act as if their main object was to hamper trade and destroy confidence,' which consequently dissuaded refugees from moving on to other provinces and areas, slowing down the relief of Punjab and the process of refugee rehabilitation. If district officers did not actively promote alternative opportunities, argued the Refugees Minister, 'refugees will not find the Administration sufficiently sympathetic and will run away in the face of hardships.'[553]

It is hard to gauge the relative relations between the various levels of government but it would be accurate to say that the process of refugee administration was weakest at the local and the central level while the provincial governments emerged strongest. The centrally managed camps were only in Lahore. These were run by the Pakistan Punjab Refugees Council which was made up of provincial and some central authorities, but once the Council was shut down it was the West Punjab government that was made responsible for the three-quarters of a million refugees still in the camps and rural areas and their rehabilitation. They were able to institute measures that would require all movement of refugees to be controlled, and control the benefits refugees were entitled to through the distribution of identity cards.[554]

While these were certainly the best managed, many more camps were opened elsewhere by Deputy Commissioners of divisions but these were openly acknowledged to be of a far lower standard and sometimes consisted of nothing more than huts and temporary structures built from the used materials of Lahore camps no longer in use—if these were available.[555] They also had to make use of defunct evacuee institutions to house refugees at night.[556] But the question of evacuee and refugee property in both nations was left up to the Central Government and it is clear that not much satisfactory progress was made on this end. In fact it appears that there was

[553] 'Plan Dated 5 July 1948,' in *Journey to Pakistan*, p. 84.
[554] 'Plan Dated 5 July 1948,' in *Journey to Pakistan*, p. 85.
[555] 'Report Dated 15 Jan 1948,' in *Journey to Pakistan*, p. 43.
[556] Ibid., p.44

conflict between the national government and its own provinces on this issue. In view of the burden it would have to bear in providing shelter and clothing if refugees did not find a place to settle down as well as the shortage of food if open land lay uncultivated, the Punjab Government defiantly took a hard line whenever it appeared that the Pakistani Government might give in to India's demands for recompense for evacuee property, bluntly stating at one point that it would refuse any order 'to move refugees who are not willing to vacate the land where they have after their wanderings finally settled down in West Punjab.'[557] Had the central and provincial governments shown perfect administration and coordination, there still would have been difficulties in protecting the refugees from disease because supplies so necessary in this regard were extremely short. After the rapid construction of additional refugee camps outside Lahore, building materials like bricks and iron sheets, needed to construct additional camps capable of protecting the people from the cold, were extremely limited and the only option left was to house them in areas evacuated by non-Muslims.[558]

While medical returns are not available for refugees during the early months, there is some documentation of the kinds of maladies afflicting refugees as they remained in the camps for prolonged periods. Once anti-cholera precautions could be successfully implemented, we see from returns of camps for one week in April that the next greatest danger came from pneumonia and gastrointestinal disorders, and these trends seem to coincide with the known problems of food availability and environmental hazards to health. The populations were also susceptible to outbreaks of smallpox. Women and children had the highest mortality rates. A provisional comparison of the population versus reported mortality rates indicates that the weekly rates of illness in the camps fluctuated between 1 per 25 to 1 per 100.[559] Medical relief changed to match the dynamic needs of the Partition refugee crisis. At first, medical units were concerned with reaching the convoys as they were arriving from East Punjab. Later however, they became static

[557] 'Plan dated 5 July 1948', in *Journey to Pakistan*, p. 87.
[558] 'Note of Refugee Camps by Mian Muhammad Iftikhar-ud-Din', in *Journey to Pakistan*, p. 25.
[559] 'Statement Showing Illness and Death Among Refugees During the Week Ending 28 Feb 1948', in *Journey to Pakistan*, p. 114.

as the refugee population became localized, situated in the camps or in those locations where there were concentrations of refugees.[560] By April, the authorities concerned were beginning to contemplate the reduction of volunteer staff wherever conditions allowed.[561]

A Government of Volunteers

Civil society became important at the time of Partition in improvising aid and filling the gaps in party/state administration. This process too, like that of becoming a refugee to Pakistan, began in India. With many aspects of state authority not having been concretized and formalized as yet in Pakistan in the immediate days after independence, Muslims in local positions of authority in East Punjab towns played an important role in trying to liaise with the Indian authorities, assessing the condition of Muslims in the town and surrounding villages, and trying to arrange aid from their friends and relatives, while Muslims leaving India who were bringing with them specialist skills such as doctors were called on to serve and help their coreligionists who were making the journey to Pakistan with them.[562]

Drastic arrangements were needed to meet the medical needs of the population. Shortcomings in supply, medical and otherwise, were severe. And so when it came to medical institutions and practitioners, resources were routinely stretched beyond their breaking point and there were chronic severe shortages of medical personnel. The Inspector-General of Civil Hospitals, Punjab appealed to philanthropic institutions to help the Medical Department which desperately needed more doctors, nurses, non-technical voluntary workers, hospital equipment including bandages, surgical dressings, charpoys, beddings, warm clothing: '[A]ny help, in any form will go a long way to mitigate the sufferings of lakhs and lakhs of men, women and children who are flocking to Pakistan for help and succour.'.[563] For the doctors and nurses tirelessly working in the camps hospitals and dispensaries, Quaid-e-Azam himself had only one

[560] 'Note Dated 27 April 1948', in *Journey to Pakistan*, p. 65.
[561] Ibid., p. 66.
[562] 'Statement of Khwaja Akhtar Husain', in *Journey to Pakistan*, pp. 125-31.
[563] 'Medical Department's Appeal for Aid to Sick Refugees', *Pakistan Times*, 7 October 1947, in *Journey to Pakistan*, p. 264.

command: 'work more and more.'[564] The medical scope of the government was nevertheless limited by the evacuation of millions of trained Hindu and Sikh personnel to India, an absence that was felt keenly.[565] Many critically essential institutions like the country's major hospitals in Bengal and specialist institutions like the TB Sanatorium were entirely deprived of their expert staff and instructors.[566] Even the shortage of sweepers, which was seen as a cause for the dismal state of camp sanitation, was linked to the exodus of Hindus.[567]

At this time of need, the remaining health professionals were called on to serve to their utmost capacity while volunteers among the refugees themselves helped to ameliorate some of the loss of personnel.[568] Their actions provide some evidence of the implicit expectations and responsibilities of shared citizenship, which was critical in helping the state carry out its newfound obligations to receive and rehabilitate refugees. In the town of Panipat in Indian Punjab, where the migration crisis was in full swing by October 1947, cholera's impact was becoming more severe and malnutrition taking its toll as well. At this time, all the doctors had left the city. Retired Tehsildar of Panipat, Khwaja Akhtar Husain who migrated to Pakistan described, '[T]he only medical help available was a lady doctor, Sughra Begum, who had taken refuge in one of my houses in Mohalla Baghcha. But she too was helpless for want of medicines and cholera vaccine.'[569] The same was true in Ambala, where Muslim doctors in Ambala City and Ambala Cantonment were presumably willing to provide care and administer inoculations but could not for want of vaccines.[570] In the same way that Indian authorities were blamed for

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[564] 'Quaid-e-Azam visits Walton Camps: Refugees Urged to Work and Help Each Other', *Pakistan Times,* 7 November 1947, in *Journey to Pakistan,* p. 295.
[565] For a discussion of demographic changes with respect to literacy and occupation in Pakistan due to Partition, see Prashant Bharadwaj, Asim Ijaz Khwaja and Atif R. Mian, 'The Partition of India: Demographic Consequences', *Social Science Research Network*, 2009, pp. 1–41. <http://dx.doi.org/10.2139/ssrn.1294846>.
[566] NDC, 118/CF/51, Summary: Requirements of nurses and instructors at the time of Partition; 244/CF/49, Delegation to the 2nd Session of the Regional Committee of the World Health Organisation.
[567] 'Walton: Medical Conditions at the Camp – Opening of Maternity Section', *Pakistan Times*, 31 August 1947, in *Journey to Pakistan*, p. 239.
[568] 'Statement of Khwaja Akhtar Husain, Retired Tehsildar, Panipat, Distt. Karnal', in *Journey to Pakistan*, p. 131.
[569] Ibid.
[570] 'A Brief Report dated 4th October 1947 made by K.B. Malik Khuda Baksh', in *Journey to Pakistan*, p. 204.

obstructing the delivery of relief supplies to refugees in designated areas, Husain claimed that private practitioners that were sent out to provide medical relief to the Muslim sick in the camps were also obstructed 'till at last this social measure too had to be discontinued.'[571] The doctor was the last sacrosanct symbol of safety in a conflict in which all other rules of social conduct had seemingly descended into anarchy—their roles remained firm and their feats superhuman, prompting recognition in both official reports and personal memoirs.[572]

Doctors were not just actors in the drama of Partition, they were also witnesses. The best illustration of this role as witness is in the fictional short story 'Khol Do,' by Saadat Hassan Manto, considered one of the greatest writers in Pakistani history.[573] Manto wrote several works concerned with Partition, his writing famous for exposing the absurdity and comic tragedy of Partition and social norms in Pakistani society. In this shocking and wrenching short story, the title of which translates as 'Open It', Manto related the narrative of a man who has migrated from India to Pakistan, his wife murdered in India and his beautiful daughter separated from him. Initially, the man reaches out to young Muslim men volunteers, requesting their help in the search for his daughter. By the time they find her, her actions exhibit the trauma of a woman who has most certainly been raped, and the young Muslim men—her coreligionists and fellow citizens—are also implicated in raping and abusing her. She is later found by her father on a hospital bed, and he approaches her crying, fearing that she is dead. On his entrance into the hospital room the resident doctor emerges, also believing the body on the hospital bed to be dead, and utters to a hospital worker 'khol do'—*open it*—gesturing to a window. But upon hearing these words—*open it*—the young girl, in a state of near death, instinctively reaches down to pull down her pants and open her legs, an act that her father, jubilant at her being alive, does not notice but one which is fully understood by the doctor, who breaks out into a cold sweat at the realisation of the state of her condition. In the hospitals where doctors continuously saw the

[571] 'Statement of Khwaja Akhtar Husain', in *Journey to Pakistan*, p. 132.
[572] 'Dewan Bahader S.P. Singha's Appeal to Christian Nurses to Offer Services for Refugees: Pitiable Medical Conditions at Kasur Refugees Centre', *Pakistan Times*, 5 September 1947, in *Journey to Pakistan*, p. 250.
[573] *Manto: Selected Stories*, trans. by Aatish Taseer (Noida, U.P., 2011). [ebook]

'maimed and fiendishly wounded and acid-burnt' they became witnesses not only to the extent of violence but also the sheer depravity of it.[574]

Though physicians and their auxiliaries in the field were most directly involved in medical care, other groups were also actively involved in looking after the welfare of refugees. On one end of the spectrum were students, who had played a significant role in the galvanisation of the Pakistan movement in undivided India.[575] They once more raised the call for volunteer action in the service of the nation. In 1945, the Punjab Muslim Students Federation had worked to sell the idea of a Pakistan where state and society would ensure every social and economic need by doling out medicines, clothes, and other essential supplies to peasants.[576] In September of 1947 they raised an appeal for their new compatriots to collect clothes, utensils, and other material necessitates, and to help in the administration of camps, collection of food grains from villages, and protection of refugee properties.[577] The president of the Punjab Muslim Students Federation declared, 'The students have played a magnificent role in the struggle for achievement of Pakistan and it is my earnest hope that they will now be equally ready to strain every nerve in the gigantic task of alleviating the sufferings of hundreds of thousands of Muslims in distress.'[578] The students of King Edward Medical College volunteered their services as well at this time. With appeal upon appeal being made for more doctors, nurses and assistants, they were critical in helping stretch the capacity of Lahore's Mayo Hospital from its normal threshold of 800 beds to 4,500 beds within 3 months.[579] At the same time, students of Islamia College for Women in Lahore organised themselves into groups and visited patients at Mayo, distributing clothes and writing letters and broadcasting messages for the illiterate. Compulsory knitting and sewing of jerseys and sweaters for 40 minutes every day in their College was one way of

[574] 'Dewan Bahader S.P. Singha's Appeal to Christian Nurses', in *Journey to Pakistan*, p. 250.
[575] Mukhtar Zaman, *Students' Role in the Pakistan Movement* (Karachi, 1978).
[576] Jalal, *The Sole Spokesman*, p. 142.
[577] 'Zia-ul-Islam, President Punjab Muslim Students Federation Urges Students to Help in Rehabilitation of Refugees', *Pakistan Times*, 4 September 1947, in *Journey to Pakistan*, p. 247.
[578] Ibid.
[579] Talbot, *Pakistan: A Modern History*, (New York, 1998), p. 120.

preparing humanitarian supplies for the coming feared winter.[580] Students also helped in other more basic tasks that were nevertheless critical to the physical and mental well-being of refugees, such as when students belonging to the Lahore Islamia High School carried old men and women and children to shelter during periods of rain and flooding from Wagha camp.[581]

Women were asked to offer themselves up for service in the provision of relief to women and children refugees by the Director of Public Health of Punjab.[582] This gave women a greater opportunity to actively participate in public service whether by volunteering as auxiliary nurses or organising local groups to deliver clothing to patients in hospitals.[583] Female volunteers without medical credentials were able to play a more robust role in rehabilitation as opposed to relief, for example through the running of marriage bureaus for refugee girls and boys of marriageable age and maintaining lists of refugee women who could be employed as teachers, ayahs, and in other capacities.[584] Begum Liaquat Ali Khan, wife of the future prime minister, was the most visible actor in this regards, and would continue to spearhead women's voluntary work in the Pakistan of the 1950s and 60s. Government volunteers worked three eight-hour shifts 24 hours-a-day.[585]

Foreign agencies helped plug gaps in the humanitarian response though for the most part the international community overall was minimally involved.[586] By November the facilities at the Lahore hospitals had been increased drastically through domestic initiative, but foreign charitable organisations had also set up shop, with the British Red Cross Society establishing a hospital in Multan with 130 beds and at Rawalpindi with 40 beds. The greatest help from foreign health organisations however came in provision of medical staff. The Society of Friends and other

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[580] 'Students of Islamia College for Women Visiting the Mayo Hospital Daily for Distribution of Clothes to Sick Refugees', *Pakistan Times*, 30 October 1947, in *Journey to Pakistan*, p. 288.
[581] 'Walton: Improvement in Health and Administrative Conditions at the Camp', *Pakistan Times*, 9 October 1947, in *Journey to Pakistan*, p. 270.
[582] 'West Punjab Muslim League MLAs Discuss Refugees Relief Work', *Pakistan Times*, 31 August 1947, in *Journey to Pakistan*, p. 239.
[583] Pippa Virdee, 'Negotiating the Past: Journey Through Muslim Women's Experience of Partition and Resettlement in Pakistan', *Cultural and Social History*, 6/4 (2009), pp. 467-484.
[584] 'Relief Work by Punjab Muslim League Working Committee', *Pakistan Times*, 11 October 1947, in *Journey to Pakistan*, p. 277.
[585] 'Walton—The Shelter for the Shelterless', *Pakistan Times*, 23 October 1947, in *Journey to Pakistan*, p. 286.
[586] Khan, *The Great Partition*, p. 168.

organisations from the UK and USA provided medical units for service. Pakistan's diplomats, especially those in the UK, were charged with recruiting volunteer aid and were able to procure the services of eight doctors, four nurses and sixteen administrative officers, 'for the most part ex-army officers or civilians who have seen service in this sub-continent.' In October of 1947 the Pakistan High Commissioner in the UK appealed to British ex-colonial officials for help and offered to fly them (back) to the region to assist in aid operations, demonstrating not just the desperation of the Pakistanis but also the rapidity with which British staff had departed from the subcontinent.[587] This also portended Pakistan's subsequent efforts to shore up its supply of physicians and nurses by relying on the costly international market of trained specialists and medical personnel.[588]

By October, two months after independence, government health authorities finally took control over the totality of medical operations and surveillance. The Medical and Public Health Departments were consolidated into one unit, with daily meetings among the respective heads to issue orders and make policy on a 24-hour basis, and activities in a set of camps were placed under the direction of a single officer.[589] This consolidation of resources also enabled the dispatching of doctors, medical students (numerically the largest contingent), sanitary inspectors, lady health visitors, volunteer inoculators and an ambulance unit to meet foot convoys entering via Wagha crossing. In the camps, at Walton and Chinese barracks, another set of personnel was dispatched (again with medical students constituting the largest contingent) which included a large number of volunteer workers, among them women, at both sites of the border.[590] Significantly, the role of the students appears to have been so essential that the *Pakistan Times* declared that the Walton camps were being effectively looked after in a medical capacity by one IMS officer and 50 medical students.[591] While vigilance against cholera continued to be observed

[587] 'Note Dated 27 April 1948', in *Journey to Pakistan*, p. 65.
[588] NDC, 118/CF/51, Summary: Requirements of nurses and instructors at the time of Partition.
[589] 'Setting up of New Hospitals for the East Punjab Refugees', *Pakistan Times*, 10 October 1947, in *Journey to Pakistan*, p. 274.
[590] Ibid.
[591] 'Administrative Set Up of the Walton Camp', *Pakistan Times*, 11 October 1947, in *Journey to Pakistan*, p. 279.

and anti-malarial operations were undertaken with the spraying of DDT, the prevention of respiratory diseases like pneumonia became an increasing concern in advance of the approaching winter.[592]

The zeal and goodwill of volunteers could but make a small dent in the overwhelming trials faced by refugees. In a letter to the editor describing insanitary conditions at Walton, one concerned observer mentioned that a majority of the 25,000 people had complaints about mismanagement with regards to virtually every aspect of health administration: food supplies, sanitation and medical aid.[593] But the medical authorities had brought the mortality rates down significantly. The death rate had been 1 per 3,000 for those living in the centrally managed camps but it was brought down to 1 per 8,000 once no more fresh arrivals were taking place.[594] Without overstating the case of volunteerism in the development of national solidarity and identity, it can be said that civil society aid was certainly critical to meeting needs that were well beyond the state's capacity, even if we make no more than a passing mention of its ideological importance, for boosting morale—e.g. through mentions in the media—and in forging a new, short-term nationalist narrative that could temporarily paper over intense provincial and urban-rural divisions.

Mental Health, Work, and Citizenship

The communal aspect of Partition violence is well-studied, but few works have tried to grapple with its mental health consequences. Little has yet been published about the psychological history of Partition, though this topic has retained cultural resilience thanks to Manto's magnum opus *Toba Tek Singh*, which narrates the tale of inmates at a Lahore asylum who await transferral to India in exchange for Muslim psychiatric patients from India. Indian psychiatrists Sanjeev Jain and Alok Sarin have recently begun interrogating the prevalence of psychological problems and the place of psychiatry and mental health institutions amid the

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[592] 'Setting up of New Hospitals for the East Punjab Refugees', *Pakistan Times*, 10 October 1947, in *Journey to Pakistan*, p. 275.
[593] 'Walton Relief Camp: A Letter to Editore [sic] Reviewing its Conditions', in *Journey to Pakistan*, p. 231.
[594] 'Note Dated 27 April 1948', in *Journey to Pakistan*, p. 63.

communal violence of Partition.[595] Outside of the formal confines of the various asylums in the subcontinent, mental health of refugees was not discussed by government with the sole exception of its relevance to economic rehabilitation. Punjab Governor Francis Mudie warned, 'We have at present a very large number of people, who, unless something is done at once, appear likely to remain for an indefinite period in refugee camps with serious consequences not only to the economic position of the State *but also their own moral and earning power.*'[596] There was a fear of hopelessness among refugees that Mudie alluded to while pushing his emphasis on work and employment. 'What appears to me to be required is to recreate in the refugees interest in life and hope for the future. This can be done only by providing them with work, particularly work that they think will enable them to earn their own living and remake their homes in Pakistan.'[597] Therefore he argued, '[R]ehabilitation...must be approached from the moral and psychological side also. We are faced, unless immediate action is taken, with all the evil consequences of large scale unemployment.'[598]

In order to keep up the ethos of work, which was seen as tied up with morale, the Governor of Punjab suggested that refugees be enabled to garden and grow vegetables near the camps. Further proposals in this vein included special activities for various groups such as physical training and literacy lessons for boys and girls, home crafts for women, games and sports in addition to industrial training 'to enable those passing out of these schools to take a set of tools with them.'[599] This went with the optimistic policy that 'No one should be unemployed because, for instance, of lack of tools or the necessary capital to start a shop.'[600] Indeed, employment was considered to be 'particularly good for their bodily health and mental

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[595] Alok Sarin, Sarah Ghani and Sanjeev Jain, 'Bad Times and Sad Moods', in *Partition: The Long Shadow*, ed. by Urvashi Butalia (New Delhi, 2015), pp. 249–64
[596] 'A Note Dated 27 Jan. 1948 on Refugees Situation by R.F. Mudie, Governor, West Punjab', in *Journey to Pakistan*, p. 46.
[597] Ibid.
[598] Ibid.
[599] 'A Report Dated 31 Jan. 1948 on Refugees Camps, by R.F. Mudie, Governor, West Punjab', in *Journey to Pakistan*, pp. 51, 52, 64.
[600] Ibid., p. 51.

welfare.'[601] Nevertheless despite these encouragements towards restoring some normalcy to the lives of refugees, the administration of the camps simultaneously began to restrict movement with refugees not being allowed to receive food at any camp except the one to which they belonged, fraud being a predominant concern.[602]

Concern with the mental health of refugees and their productive capacity speaks to developing notions of citizenship in Pakistan and the recognizable political dangers of hosting millions of unsatisfied and unrooted individuals. In both India and Pakistan, the massive influx of different ethnic and economic groups who were reliant on the disbursement of public aid raised definitional questions: Who constituted a refugee, and under what circumstances did this identity change in the eyes of the state?[603] Under what conditions should the Government perceive its obligations to provide for these displaced persons? From the first, the prospective dependence of refugees on public hospitality as a consequence of the continuous provision of food and housing became a source of worry in light of the depreciating food supply in the country.[604] On 7 November, Quaid-e-Azam visiting the Walton camps directed the following message to refugees in Pakistan: 'No self-respecting person wishes to depend on the hospitality of others or beg from them. Refugees must help each other. They must work in whatever capacity they can thereby assisting the State in tackling the colossal refugees problem that Pakistan faces today.'[605] Later on, when visiting the camp kitchen he commented to the supervisors there, 'Make the refugees work. Do not let them nurse the idea that they are guests for all time.'[606] In a few months, the Minister in charge of refugee matters was advocating coercing refugees to work 'under threat of "no work no food".'[607] Of note, there were similar developments in India, where the Government's official narrative of Partition rehabilitation declared, 'It redounds to the eternal

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[601] BL, IOR/V/24/1723, Report on the working of the Punjab Mental Hospital Lahore, 1922-1946.
[602] 'Plan Dated 5 July 1948', in *Journey to Pakistan*, p. 85.
[603] For a discussion of the Indian context, see Sanjib Baruah, 'Partition and the Politics of Citizenship in Assam', in *Partition: The Long Shadow*, ed. by Urvashi Butalia (New Delhi, 2015), pp. 78–101.
[604] 'Note on Refugees Camps by Mian Muhammad Iftikhar-ud-Din, Minister for Refugees and Rehabilitation, West Punjab, 9 November 1947', in *Journey to Pakistan*, p. 26.
[605] 'Quaid-e-Azam Visits Walton Camps,' in *Journey to Pakistan*, p. 295.
[606] Ibid., p. 296.
[607] 'Note Dated 27 Jan. 1948', in *Journey to Pakistan*, p. 47.

credit of the displaced persons from West Pakistan (that) their toughness, their sturdy sense of self reliance, their pride...would not submit to the indignity of living on doles and charity...in this hour of supreme need.'[608]

A social contract was being developed informally in the rhetoric of these officials and its background was the travails of a financially strapped state on the brink of collapse. The figure of the refugee became the blank slate upon which the obligations of citizenship and the social contract were devised. Unsurprisingly, in the aftermath of the Partition crisis, perspectives on citizenship and being a refugee changed. Considering that 1 in every 10 Pakistanis was a migrant from India, the issue was bound to have a substantial influence on society's view of itself.[609] The Punjab refugee who had successfully 'rehabilitated' became an ideal type because he was resourceful, courageous and industrious and implicitly self-reliant.[610] But despite all the talk of liquidating camps and the repeated complaints about the burden of refugees, successful rehabilitation could not happen without direct involvement of government and civil society, e.g. through the creation of hiring quotas privileging refugees, the implementation of refugee taxes, and the granting of evacuee property to refugees.[611]

To understand why the refugee became such an ideological flashpoint, it is important to first understand that Pakistan's early days were overshadowed by the real threat of collapse and reincorporation into India. Though Quaid-e-Azam forcefully claimed on 31 August 1947, 'Pakistan is now a *fait accompli* and it can never be undone,' a British diplomatic memo dated 20th October 1947 acknowledged the precariousness of the country's continued existence,

> [I]t will be the policy of the Indian Government (or most of its members) whether by obstruction or core positive methods, to make it as difficult as possible for Pakistan to exist as a separate Dominion, in the hope that it will collapse within a measurable period of time….it is quite obvious in the main most of the present Indian Government, and

[608] U. Bhaskar Rao, *The Story of Rehabilitation* (New Delhi, 1967), p. 7, quoted in Ian Talbot, 'Punjabi Refugees' Rehabilitation and the Indian State: Discourses, Denials and Dissonances', *Modern Asian Studies*, 45/01 (2010), p. 110.
[609] 'Table Showing Muhajirs' Origins', in *Journey to Pakistan*, p. 119.
[610] Talbot, 'Punjabi Refugees' Rehabilitation and the Indian State', p. 110.
[611] Khan, *The Great Partition*, p. 171.

> almost certainly any Government that succeeds the present one, will do their utmost to undo Partition.[612]

The statement went on to admit, '[I]f this country [Britain] does not help Pakistan to some extent, its chance in the next few years of surviving seems poor. No other country is likely just now to assist it on a considerable scale.'[613]

In light of the fragility of the new nation-state, the new refugees were a grave social and economic threat—'the greatest, most difficult and most pressing of all Pakistan's nation-building problems'.[614] They also laid bare all the tensions inherent in the manner of Pakistan's political creation—by their search for safety and security in the Muslim majority state they gave real meaning to Pakistan's stated raison d'etre, and yet simultaneously with their physical vulnerabilities they stretched the capacities of the state beyond what it could bear. The migrants quite literally risked life and limb to seek safety in a state that was itself in danger of dying out. Thus the refugee crisis emanating from Partition became bound up with deep questions of national purpose and resilience. Not long after, public debates on the character of the refugee—his greed for alms and his laziness—by members of local and provincial governments allowed them to more easily justify revoking aid as they bemoaned the nuisance the refugee and his family posed, being homeless and unemployed, to cities like Karachi, Lahore, and Dacca. The development of an anti-refugee discourse, which will be discussed in the following chapter, not only made the removal of refugee rehabilitation from the national agenda more acceptable, but also laid the groundwork for future contestation of the right to be called a refugee, and all the attendant sympathies that went along with it. The term 'refugee' was not a fact; it was a loaded designation. The incomplete rehabilitation and settlement of refugees became a sore that would continue to fester from a political and public health standpoint.

Conclusion

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[612] UK National Archives [hereafter UK NA], DO 121/69, Analysis from British government on likely future relations between India and Pakistan, 20 Oct 1947.
[613] Ibid.
[614] NDC, 127/CF/48, Government of India (Second Amendment) Bill, 1948: Statement of Objects and Reasons.

The ethnically-motivated bloodshed and migration that arose as a result of the partition of the subcontinent while tragic and regrettable were neither unanticipated, nor actively avoided. In a February 1947 communiqué, the British government admitted to having deliberately abstained from publicly stating their choice between one or two successor states in India, and acknowledged that the price of avoiding giving in to either the Congress Party or Muslim League's demand was 'running risk that no settlement will be arrived at and that as date for our withdrawal draws near communal situation will deteriorate seriously.'[615] This still did not in any way delay the withdrawal of British officials and troops from India. Migration was seen as a logical outcome of partitioning the subcontinent into two religious majority states and Jinnah predicted that it would result in large movements of religious groups; his *hope* was that an effective, organized transfer of populations would be undertaken in the future by the then-established governments of Hindustan and Pakistan and the assurance of mutual goodwill could obviate the need for partitioning the Punjab and Bengal and their substantial religious minorities, as the Partition plan intended.[616]

While the violence of Partition is the focus of historical accounts of Pakistan's founding, recent studies on this topic have demonstrated that it encompassed more than high politics and violent tragedy, and that it was much more prolonged than the arrival to a new homeland.[617] What was arguably the most debilitating part of Partition for refugees, if not necessarily the most abrupt or dramatic, was the stay in the camps and on the streets—the depressing misery of dirty living quarters, cold winters, hunger, and sinking morale. Even the government spokesman at what was probably the best governed and most publicised camp at Walton acknowledged that of all the concerns plaguing refugee relief, 'sanitation was their main headache.'[618] This supports the conclusion that disease exacerbated the trials of Partition and the experience of the crisis

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[615] UK NA, FO 371/63520, Secretary of State's comments on India policy for British Ambassador in Washington, 19 Feb 1947.
[616] UK NA, FO 371/63533, Speech by Mohammad Ali Jinnah on the partition of Bengal and the Punjab, 4 May 1947.
[617] Ian Talbot and Gurharpal Singh, *The Partition of India* (Cambridge, 2008), see especially ch. 4.
[618] 'Administrative Set Up of the Walton Camp', *Pakistan Times*, 11 Oct 1947, in *Journey to Pakistan*, p. 278.

revolved extensively around issues of health and disease, for both the new government and its new citizens.

It is also worth noting that demographic changes that resulted from Partition were dramatic, although nowhere was it as cataclysmic a change as in Karachi where over half the city after Partition was composed of migrants from India.[619] In the Punjab districts the shifting composition of the population was also significant, with one in every four Punjabis being a *Muhajir*, or migrant.[620] On the flip side, an overwhelming number of the Muslim migrants came from one specific region, the Jullunder Division in East Punjab, and nearly 5.8 million of the total 7.2 total *Muhajirs* came from now-Indian Punjab.[621] The next biggest amount, around one million, came from the eastern end of the Indian colony, Assam, Bihar, Orissa, West Bengal etc, which considering the distance of migration seems quite remarkable.[622] The smallest proportion came from the South, Coorg, Madras, Mysore and the various southern states.[623] Undeniably, Partition populated Pakistan; that is, it populated those areas that would become the centres of political relevance and economic influence as well as sites of intractable social problems.[624]

The medical story of Partition should challenge the notion that this historical moment and its subsequent humanitarian crisis was short-lived and that it left behind only psychological and demographic structural changes. By focusing on the medical aspect, one is immediately made to realise that the process of becoming a refugee was far more prolonged and damaging and it challenged government authority, notions of citizenship, and state capacity for aid. As Gilmartin has noted, the historical experience of Partition has been used to depict '"the searing reality of the agony" of Partition violence, "the complexity of human emotions" in the face of loss, and the "sense of uprootedness" brought about by the Partition migrations. But there is virtually no attempt to integrate these perspectives into a larger narrative of the politics of

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[619] 'Table Showing Muhajirs' Origins', in *Journey to Pakistan*, p. 119.
[620] Ibid.
[621] Ibid., p. 117.
[622] Ibid.
[623] Ibid.
[624] See Talbot, 'A Tale of Two Cities' for extensive discussion of demographic changes in Punjab as well as political, economic, and social rebuilding in the aftermath of Partition comparing Pakistan and India.

partition.'[625] It is hoped that this chapter provides some corrective to that lacuna in Partition historiography and Pakistani history by shedding light on aspects of development of state authority, role of civil society, and notions of citizenship.

A focus on the experience of refugees and the official and nonofficial agents who attempted to aid them provides insight into the social dynamics of the political creation of Pakistan. As Talbot has noted with respect to the Indian state's narrative of refugee rehabilitation, '[I]t is in dealing with these unforeseen and unprecedented circumstances that the state receives its legitimization. Ultimately, it is not the refugees, but the state's representatives who are the heroes of the narrative.'[626] While the Pakistani state attempted to write a similar narrative, of goodwill and hard work amidst widespread deprivation, a closer analysis reveals the extreme handicaps in its efforts. The state's narrative of overcoming immense trials elided the fact that these trials had not actually been overcome and refugees continued to pose a political challenge and health hazard to themselves and others. Nevertheless, this was not for want of trying, particularly in the early days when special refugee taxes were implemented which stayed in force through the 1950s and Pakistani train travellers paid a 'refugee supplement' that was added to the cost of their railway ticket.[627]

For all their failures, Yasmin Khan writes, 'These state-sponsored efforts compared well with the apathetic approach of the British colonial state in the face of disaster.'[628] Conspicuously absent in this narrative are the British officials who mere months earlier ruled undivided India and who had played such a prominent role in the health and politics of the NWFP, Bengal and Punjab. As rule over India slipped through their fingers, they hastily departed with the exception of a few who stayed on in specific posts—especially in Pakistan—to advise the new government. But they had relinquished all control over the border and rejected all appeals for aid from the Government of Pakistan, even when requested to help stem communal

[625] Gilmartin, 'Partition, Pakistan, and South Asian History: In Search of a Narrative', *The Journal of Asian Studies*, 57/4 (1998), pp. 1068–95.
[626] Talbot, 'Punjab Refugees' Rehabilitation', p. 113.
[627] Khan, *The Great Partition*, p. 171.
[628] Ibid.

violence by arbitrating between the two states.[629] British Prime Minister Clement Attlee rejected Jinnah's petition to arbiter between India and Pakistan in order to reduce what he termed 'friction' between the two Dominions—an ill-fitting euphemism for the cataclysmic violence that had gripped the subcontinent.[630] The British Government's contribution to the alleviation of the circumstances arising from its departure amounted to a sum total of £20,000, given to the Red Cross for its initiative in undertaking medical humanitarian work in Pakistan.[631]

[629] UK NA, PREM 8/584, Telegram informing Commonwealth leaders of Attlee's response to requests from Jinnah for assistance in handling partition violence.
[630] Ibid.
[631] UK NA, DO 142/293, Letter to Rt. Hon Philip John Noel-Baker, M.P. Commonwealth Relations Office, from Treasury Chambers.

Chapter 7: Independence

> I wonder if you have ever thought that the system of medical relief handed over to us by the British was mostly designed to take care of the Government servants stationed at Headquarters and elsewhere. The community in general benefitted incidentally…Today we are the servants of a peoples [sic] Government and our responsibility towards people is the problem we have to handle.
>
> (Lt. Col. M. Jafar, Director General of Health)

Even before the government had established a physical presence within its borders, a narrative of nationhood had begun to be written detailing the damage wrought by Partition and the subsequent deprivation and struggle.[632] This exhaustive reportage of the disadvantages facing the nascent state was used to arouse a nationalist feeling and script a tale of success in harrowing circumstances. In the words of Jinnah, 'Never throughout history was a new state called upon to face such tremendous problem[s]. Never throughout history has a new state handled them with such competence and courage.'[633] Newspapers like the English daily *Dawn* played a large role in promoting this narrative, describing for readers the impoverished yet congenial atmosphere in the makeshift government offices in Karachi in 1947, where 'Cabinet ministers of Pakistan use packing cases as desks and crack jokes with painters who drip whitewash on them'.[634] As Yasmin Khan has written, 'the solidarity and camaraderie of the situation dissolved class differences and pulled new compatriots together, if only momentarily.'[635]

Unfortunately, historical accounts generally regard the first decade of independence to have been a profound failure of governance and to have been greatly responsible for the growth of authoritarian political tendencies which continue to plague the country to this day.[636] Jinnah had founded a nation, and given that nation a country, but that still left unfinished the painstaking task of developing representative political institutions and social cohesion. Ayesha Jalal has convincingly argued that the competition between Pakistan's linguistically and culturally diverse

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[632] National Archives of Pakistan [hereafter NAP], Serial no. 448, file 8-6/48-G, Office of the Director-General, Medical Services, History of Partition, 5 Jan 1948.
[633] M.A. Jinnah, *The Nation's Voice, Vol. VII: Launching the State and the End of the Journey (Aug. 1947 - Sept. 1948)*, ed. by Waheed Ahmad (Karachi, 2003), p. 243.
[634] Khan, *The Great Partition*, p. 120.
[635] Ibid.
[636] Talbot, *Pakistan: A New History*, pp. 47-74.

provinces (and groups within them) for scarce resources helped promote the predominance of non-elected institutions such as the civil bureaucracy and military over 'parties and politicians'.[637] Non-elected institutions were able to assume power due to their ability to elide and overrule domestic rivalries over national resources, and they maximised revenues for defence at the expense of social welfare.[638] The fact that these non-elected institutions carried within them the legacies of colonial inequalities in recruiting practices only served to further exacerbate the problems of integrating historically diverse socio-political groups under a unified nation-state.[639]

In this way, participatory democracy in Pakistan was damaged by pre-existing socio-political divisions—wherein centre was pitted against provinces, bureaucrats against politicians, resident populations against migrants, landowning elites against non-agriculturists.[640] These schismatic social tensions were further worsened by acute shortages of resources that arose in the immediate post-Partition period. The Pakistan of the 40s and 50s was a country of profuse shortages and deficits—in supplies, staff, institutions, and morale. Out of the entire administrative machinery the British had amassed in India, the Government of Pakistan had inherited 200 civil servants, 150,000 soldiers, and Rs. 200 million, the sum total of all the material resources with which it was to govern its errant provinces and administer approximately 360,000 square miles of territory.[641] It was evident from the outset that 'the pitiful inadequacy of the country's own financial resources,' which had left it unfit to build functioning administrations at the central and provincial levels, would be wholly inadequate to manage the crisis of Partition.[642] The violence and influx of landless migrants actually worsened existing food shortages and relations between provinces.

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[637] Ayesha Jalal, *The State of Martial Rule: The Origins of Pakistan's Political Economy of Defence* (Cambridge, 1990), p. 3.
[638] Ibid.
[639] Ibid.
[640] Talbot, *Pakistan: A New History*, p. 48; Jalal, *State of Martial Rule*, p. 207.
[641] Jalal, *State of Martial Rule*, pp. 32, 37.
[642] Office of the Economic Adviser, *Economy of Pakistan, 1950*, p. 403; Jalal, *State of Martial Rule*, p. 48.

Critically essential items were in short supply and this not only impacted human health but became a source of festering domestic rivalries. This chapter will illuminate resource shortages in Pakistan in the period from 1947 to 1958 and explore three major public health issues that affected various parts of the country after independence: the water problem in Karachi, the food shortages in non-food producing provinces, and the woeful insufficiency of medical resources in the rural areas of the country. Using these three brief case studies, I will trace out government response to these challenges in the localities, in the provinces, and at the Centre. I will demonstrate how resource shortages exacerbated social divisions and promoted illiberal political rhetoric in independent Pakistan in light of our understanding of the failure of parliamentary governance and subsequent imposition of military rule in the country.

In light of the existential danger faced by the country owing to its war with India, the humanitarian and financial crises created an atmosphere of emergency which justified increasingly hostile responses to domestic grievances over the distribution of economic resources. Though the political infighting that was ongoing during this period could be characterised as a struggle to determine the balance of power between various groups in an as-yet unformed political structure, couched within this struggle were the competing demands of these social groups for a larger share of severely limited national resources. Tensions between distinct social groups over scarce resources evolved from their local contexts into the national arena, exacerbating political divisions between provinces. In this way, resource shortages and the resultant conflicts disrupted the functioning of political institutions at the interprovincial level in Pakistan.

Karachi's Water Crisis

When Lord Mountbatten, the last Viceroy of India, commented that the Government of Pakistan would be spending its first few years housed in a 'tent', he had inadvertently prophesied the fate of millions of Pakistanis who arrived in the country after Partition, many of whom settled in the capital city of Karachi.[643] A census of Karachi's population a couple of years after

[643] Jalal, *State of Martial Rule*, p. 29.

independence revealed the presence of 120,000 refugees living without any sort of proper shelter in the nation's capital. 5,000 families made their homes on pavements and footpaths, 4,000 families had resorted to squatting in the city's school buildings, and 15,000 families found shelter in improvised huts.[644] In a country where only three million people had access to clean water in 1947, these families and individuals without permanent dwellings were most at risk from insanitary and inadequate water supplies and most in need of structural support to access basic necessities such as housing, food and clean water.[645] Instead, they came to bear much of the blame for the capital's failures to provide clean water to its permanently-housed residents and to its nascent industry.

The water problem reveals the reality of makeshift arrangements and bitter fights over resources in the nation's capital and throws distinctions between different socio-economic and geographic groups into stark relief. The Karachi water supply was hopelessly inadequate for a city that had more than doubled its population seemingly overnight. Efforts to stem the movement of refugees into Karachi were guaranteed to come to nought 'as long as Karachi offers any employment' even though essential amenities including water, drainage, sewage, and electricity were 'at a breaking point'.[646] Within a month of Partition, the problem of providing water to the inhabitants of Karachi had been sufficiently recognised, and a plan had been put in place to increase the water supply from the Indus into Haleji Lake by building additional canals, and from there increasing the number of plants which pumped the water from the lake into the city. The entirety of this plan required materials that simply did not exist within the country. By February 1949, the problem had grown so acute that it was decided to install pontoons—a low-cost measure to extract water from near the surface of the lake—to provide an immediate supply

644 Office of the Economic Adviser, *Economy of Pakistan, 1950*, pp. 400-1.
645 Pakistan Planning Board, *The First Five Year Plan, 1955-60. Draft.* (Karachi, 1956), p. 609.
646 NDC, 148/CF/50, Note for the meeting of Ministers of Finance, Refugees, Industries and Health and Workers regarding Rehabilitation of New Refugees; Mahmud Husaid, Ministry of Finance to Khwaja Shahabuddin, Minister for Interior, 14 Sep 1950.

of three million gallons of drinkable water per day, which was respectable but completely insufficient for a city that needed an additional 10 million.[647]

A permanent increase in the water supply could only be achieved slowly and incrementally, the pace at which materials could be imported from overseas, a process that would take until 1955.[648] Immediately, however, Karachi's active Municipal Corporation was concerned with safeguarding the purity of its existing water supply.[649] In 1953, a critical report appeared in the press regarding the impure water supply of the city, a matter which caused 'great anxiety' and which provoked the Cabinet to demand a response from the Ministry of Health and Works.[650] A committee composed of municipal administration officials charged with investigating the matter found the presence of refugee huts near water mains in the city to be the source of pollution.[651] The committee maintained that its reservoirs were being sufficiently chlorinated and that they had 'saved the citizens of Karachi from serious epidemics', but the conduits that distributed water throughout the city were vulnerable, especially during rains when refugees living nearby dumped night soil and other refuse on or near the mains.[652] It was noted that the Director-General of Health (DGH) had long advocated to the Chief Commissioner of Karachi to proceed with the removal of refugee huts. The Chief Commissioner could only reply that 'he was fully conscious of the danger involved in allowing these refugees to stay where they were but he could not do anything in the matter as Government would not allow the eviction of refugees without providing them with alternative accommodation.'[653]

The makeshift living arrangements of Karachi's refugees were not only a sanitary problem—they soon became a social nuisance with highly charged political and legal implications. From the city's rising rate of thefts to its illicit drug trade, 'full blame' for these

[647] NDC, 210/CF/50, Measures to augment the existing water supply of Karachi, 9 Sep 1950.
[648] NDC, 18/CF/49, Fortnight Summaries of the Ministry of Food, Agriculture and Health: Summary for the fortnight ending 15 June 1949.
[649] NDC, 18/CF/49, Fortnightly Summaries: Summary for the fortnight ending 30 June 1949.
[650] NDC, 179/CF/53, Report on the causes of contamination of drinking water in Karachi, 7 July 1953.
[651] Ibid.
[652] Ibid.
[653] Ibid.

criminal activities was laid at the feet of refugees 'who, it was stated, were solely responsible' despite lack of available statistics to support this claim.[654] Letters to the editor published in *Dawn* chronicle complaints by Pakistani citizens of the nuisance posed by squatters—likely some of Karachi's 5,000 refugee families who made their home on the city's pavements according to the 1950 Census[655]—who dared to fill the sidewalks around residential flats in the federal capital during the day, carry on their trade into the night, and then indulged late into the night in 'merry-making'.[656] 'One by one they have occupied all open spaces in and around the city,' and this was no understatement.[657] From railway stations to industrial waste sites to government buildings under construction, Karachi drowned in the unstoppable flow of migrants. As a consequence of their unorthodox living arrangements, refugees were continuously implicated in making Karachi an unpleasant place for salaried government employees to live in.[658] Visitors to the city proclaimed bluntly, 'Karachi Stinks.'[659] 'Garbage heaps and stagnant pools of stinking water are on the increase in the city, specially in open spaces occupied by refugees,' though even middle-class colonies suffered from lack of sewage and drainage systems.[660]

This put pressure on the national, provincial, and municipal governments to take action, either to provide relief to the homeless individuals or to forcibly evict them from places they did not belong.[661] According to *Dawn,* while the alternate housing offered to refugees who were squatting in government buildings had steady water supply and sanitary facilities and was close to where they were already squatting, the refugees 'do not appear to be in a reasonable mood'.[662] The Ministry of Health put pressure variously on the Ministry of Interior, the Ministry of Refugees, and the Karachi Municipal Government to evict refugees from areas in Karachi they

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[654] 'Letters to the Editor: Illicit Drug Traffic', *Dawn*, 28 Dec 1950.
[655] Office of the Economic Adviser, *Economy of Pakistan, 1950*, pp. 400-401.
[656] 'Letter to the Editor: Karachi Noise', 3 Nov 1950, *Dawn*.
[657] NDC, 148/CF/50, Khwaja Shahabuddin to Muhammad Zafrullah Khan, Minister for Foreign Affairs, 12 June 1950.
[658] 'Letter to the Editor: Karachi Noise', 3 Nov 1950, *Dawn*.
[659] NDC, 148/CF/50, Karachi Stinks.
[660] Ibid.
[661] 'Editorial: Squatters', *Dawn*, 1 Oct 1950, p. 7.
[662] Ibid.

were not legally authorised to occupy but for years was met with continued intransigence.[663] Government's internal divisions regarding the best approach towards the refugees was further complicated by the developing divisions amongst refugees themselves. Foremost, there was the distinction between 'official' and 'non-official' refugees, who were not Government-affiliated. With the passage of time, a further distinction developed between earlier and later groups of refugees. The former were those who 'thanks to their own individual pluck or to the help afforded them' by private and government groups had become well-settled by 1950; the latter, who numbered in the thousands in Karachi, 'should give cause for anxiety' as they consisted of those who 'cannot take to honest living' and who 'refused to be dispersed'.[664] According to the editors of *Dawn*, 'This is as much due to their inherent preference for the precarious present to the uncertain future' as to the lack of Government 'planning and firmness' in carrying out their removal.[665]

Advocates for refugees blamed not the refugees but the stalled pace of rehabilitation. As early as June of 1950, officials within the national government raised the alarm that 'the rehabilitation of thousands of refugees who are already in our midst has now practically come to a dead end'.[666] According to the Minister of the Interior, 'The [Sind] Provincial Government…have become indifferent to the fate of the unsettled refugees. They even stopped giving the dole to the destitute refugees many of whom are practically on the verge of starvation,' while the Central Government 'have not spent anything on the rehabilitation of refugees in Karachi.'[667] The developing antipathy to the deplorable state of housing for refugees is indicated by the municipal government's response to making arrangements for homeless refugees in 1953 who obstructed a site that had been chosen for road-building. The Chief Commissioner instructed the Chief Engineer to temporarily shift the refugee huts elsewhere but

[663] NDC, 179/CF/53, Contamination of drinking water in Karachi; 264/CF/49, Fortnightly Summaries: Summary for period ending 30 Nov 1949.
[664] 'Editorial: New Taxes', *Dawn*, 13 Oct 1950.
[665] Ibid.
[666] NDC, 148/CF/50, Khwaja Shahabuddin to Muhammad Zafrullah Khan, 12 June 1950.
[667] Ibid.

once the roads were complete, they would be allowed to resume living by the road-side.[668] In East Pakistan, which also saw a late wave of migration in 1950 from West Bengal in India, the provincial government was castigated for being 'singularly negligent in the provision of accommodation to refugees' due to its focus on rehabilitating Government refugees while doing nothing for non-Government ones.[669] The Minister of Refugees and Rehabilitation too attempted to arouse attention to the housing situation of refugees, writing to the Cabinet, 'So long as the refugees are living in the present circumstances they not only are subject to all kinds of influence but their grievances and frustration are also genuine and almost intolerable.'[670]

Keeping Karachi clean while dealing with the refugee problem was thus politically vexing and evidently intractable. This was a worsening problem, particularly in light of expanding industrial interests which were expelling offensive fumes and refuse into their living areas.[671] Such social realities were the logical extension of the kind of economic logic being promoted by bureaucrats like Archibald Rowlands—a colonial era civil servant who stayed on to advise the independent government—who suggested that what Pakistan needed to become economically self-sufficient was to build an industrial base around its agricultural commodities, 'not social welfare schemes requiring large capital outlays.'[672]

Though the problem of pollution was attributed to refugees, the state of the water distribution system in Karachi was a structural problem resulting from the lack of repairs and maintenance in municipal as well as private water supply systems. The committee inquiring into the contamination of Karachi's water supply had actually found that distribution water mains crossed over sewers at about 30 places in the city; within private houses, underground and overhead water storages were not being properly maintained or cleaned, and when they malfunctioned, residents continued to draw water from them with makeshift means. The lack of

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[668] NDC, 43/CF/56, Office Memorandum, Ministry of Labour, 1953: Construction of Roads.
[669] 'Parliamentary Process', *Dawn*, 13 Oct 1950.
[670] NDC, 7/CF/53, Ministry of Refugees and Rehabilitation to Cabinet, 8 Jan 1953.
[671] NDC, 18/CF/49, Fortnightly Summaries: Summary for fortnight ending 15 June 1949; 264/CF/49, Fortnightly Summaries: Summary for fortnight ending 30 Sep 1949.
[672] Jalal, *State of Martial Rule*, p. 65.

repairs in houses drew attention to the fact that many tenants were occupying evacuee property—i.e., property left behind by Hindu or Sikh refugees to India—and therefore would not have exercised previous ownership or been aware of all their resultant obligations upon the property.[673]

Called to action, the Ministry of Health sought to tackle the immediate problem of insanitary water supply in two ways. The first method was increased distribution of chlorination supplies; however, this was accompanied by an anti-refugee policy which advocated wire fencing boundaries between refugee colonies and water conduit lines that distributed water throughout the city.[674] The Ministry of Health produced posters and films hoping to educate citizens in Karachi on the importance of drinking clean water. This futility of such an approach is indicated by the observation of a correspondent who visited Rohri railway station in Karachi in 1950 and reported, 'Passengers getting down…find it difficult to breathe because of the stink. Huddled together lie hundreds of refugees at each end of the railway platform. They find it difficult to get water even for their most urgent needs.'[675] As Hatim Alavi, who had served for a time as mayor of Karachi, wrote, '[N]early three-fourths of the citizens of Karachi reside in such squalor in the midst of unhygienic and overcrowded tenements. How can these citizens remain healthy when both their vitals and drinking water are disorganized, and in some areas not even assured?'[676]

Thus, a situation developed in Karachi wherein sanitation and removal of nuisances came at the expense of refugee welfare and health. This was part and parcel of a worsening attitude towards refugee rehabilitation. In a 1950 conference that brought together Pakistan's Governor-General, Prime Minister, Governors, and Chief Ministers, the Governor of Sind openly

[673] NDC, 179/CF/53, Investigation about the contamination of water supply in Karachi and action taken in this connection so far, 7 July 1953.
[674] Ibid.
[675] NDC, 148/CF/50, Correspondent of Civil & Military Gazette on condition of new refugees in certain parts of Sind.
[676] Hakim Mohammed Said, Hamdard National Foundation, Institute of Health and Tibbi Research, *Proceedings, Health of the Nation Conference, 1971* (Karachi, 1971) pp. 49-50.

admitted that he 'found the refugees most rude and ungrateful people.'[677] For all the patriotism that the horror of Partition aroused, the bitter fights over housing and frustrations over sanitary derangements resulting from refugees living arrangements revealed deepening divisions. Writing in 1950, Mir Laik Ali, the advisor to the Ministry of Defence, noted, 'The divergent views held by the refugees and the Ansars as regards their claims over Pakistan have further widened the gulf between the two sections of the people.'[678] This had clear political consequences, as the widening rift and the increasing frustration of refugees worried the Pakistan Government, demonstrating that this was a matter of both social and political capital. Urging the refugees to be self-supporting, Prime Minister Liaquat Ali Khan appealed to them 'not to take part in politics at present because, he said, politics was bound to divert their attention from life's other urgent problems.'[679] Indeed, the residential requirements of voting laws effectively disenfranchised refugees, lending a political twist to the observation of Karachi's refugees who 'think it sheer waste of breath even to complain openly against the general apathy.'[680]

Feeding the Nation

Another source of political division was the rivalry between Centre and provinces. A major problem in this regard was that of food shortages. The first food shortage in Pakistan lasted from August 1947 to April 1949, and was a result of two catastrophes: (1) the Partition crisis which depleted the surplus stores of the country and resulted in the dislocation of economic life in the Punjab, and (2) the legacy of the Bengal famine of 1943 which had left that region in a severely deficit situation.[681] Severe rationing was imposed across the country, from Peshawar to Karachi to Chittagong; by January of 1949 the breakdown of the rationing system in Punjab seemed imminent in light of prolific black-marketeering. This was only narrowly avoided by direct negotiations with Russia for the speedy import of 124,000 tons of wheat, which enabled in

[677] NDC, 172/CF/51, Conference of the Provincial Governors and Chief Ministers, 4 to 9 April 1952.
[678] NDC, 148/CF/50, Rehabilitation of New Refugees.
[679] 'PM advises refugees to be self-supporting', *Dawn*, 4 Nov 1950, p. 1.
[680] NDC, 145/CF/49, Report of Elections Inquiry Committee, 6 May 1949.
[681] NDC, 18/CF/49, Desirability or otherwise of decontrolling movement of wheat and other foodgrains in Western Pakistan.

Karachi the atta ration to be raised from 2.5 to 3 chattaks per head per day—enough to make three chapatis—which was still staggeringly small compared to the average estimated chattak ration per diem for the average adult male in India of between 12 and 14 chattaks.[682] Additional supplies came courtesy of Canada and Australia, along with rice from Burma. Karachi, being the destination of international food imports, became invaluable as the port that was feeding Bengal and other food deficit areas.[683]

By February 1949, the food position had been secured through the importation of food grains, and the prospect of West Pakistan's self-sufficiency for the upcoming harvest was good, which led to hoarders letting out their stocks and food prices falling.[684] But not long after, another food crisis hit the country. The areas of food surpluses and shortages again fell along predictable lines. This time, the Punjab had brought in a serious surplus which was to be earmarked for Kashmiri refugees, Karachi refugees, Baluchistan, NWFP's tribal areas, and East Pakistan. But when time came to collect the surpluses, the Punjab, even with stringent anti-hoarding provisions in force, was not able to or was not willing to procure enough of the surplus. The problem was so acute that the Punjab Government was not able to feed even the non-producing populations of large towns within its own borders like Lahore and Rawalpindi.[685]

The Punjab had been charged with feeding most of the country—its two wings as well as the Army.[686] Foreign imports were critical to removing some of the pressure placed on this province in carrying out its obligations to procure the necessary food crop quotas and, more importantly, in combatting rampant, destabilizing hoarding and black-marketeering. To appreciate the political significance of this problem, it is relevant to consider that when martial law was declared in Pakistan in 1958, one of the first directives ordered by martial law administrator Field Marshal Ayub Khan was with regards to preventing black-marketeering and

[682] NDC, 18/CF/49, Summary for the fortnight ending 16 Jan 1949; IOR/V/25/800/8 C.B. Barry, Rates of Food Consumption by Zamindars in the Tallagan Tahsil of the Attock District, 1925, p. 3.
[683] NDC, 18/CF/49, Summary for the fortnight ending 16 Jan 1949.
[684] NDC, 18/CF/49, Summary for the fortnight ending 28 Feb 1949.
[685] NDC, 172/CF/51, Conference of Provincial Governors and Chief Ministers, 21 July 1951.
[686] Ibid.

enforcing food distribution policy across the country. News authorities were directed to inform the public of the severe consequences of defying the military government in the matter of procurement of food supplies. 'Punishments were announced for selling stale food, hoarding of essential commodities…Price lists were issued by the [Muslim League] authorities declaring punishments for overcharging.'[687] Thus, Punjabi politicians' refusal or inability to provide food aid to needy populations in the country was a matter of protecting the interests of their own province in light of the potentially catastrophic public fallout that threatened to result from untenable prices and the resultant hoarding and black-marketeering of scarce foodstuffs. They were unwilling to put the needs of their own population in danger for the needs of East Bengalis.[688]

The discordance between Pakistan's constituent provinces in the matter of food policy was a historical problem. Even as they were fighting to make Pakistan a reality, Muslim League politicians expressed grave concern over the ability of the Muslim-majority provinces of British India to help prevent starvation among their brethren. M.A. Ispahani, a leading figure in the Muslim League and a close friend of Jinnah, wrote to the latter in 1943 during the Bengal Famine crisis, decrying the politics that had produced such an imbalanced situation,

> The present relationship existing between the two provinces of Bengal and Punjab is one to cause ridicule as both these provinces are included in the area of Pakistan, and yet one section is starving while the other is holding on to foodstuffs for higher prices…Already, our Pakistan areas are not so strong as to give a decisive fight to Hindustan. If there is going to be a zonal Pakistan with a typically different policy in vital matters which are confronting us today, like food and death due to starvation, it certainly does not help a clear-thinking man to accept the possibility of Pakistan. [689]

Ispahani had only one solution to the problem—the unity of Pakistan could not be saved 'unless remedied by the Quaid-e-Azam to whom the whole of Muslim India today looks forward to give the lead on such fundamental questions.' Unfortunately, Jinnah died in September of 1948 from tuberculosis, approximately one year after Pakistan's birth. As the *New York Times* noted in its

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[687] 'Flashback: The Martial Law of 1958, *Dawn*, 8 Oct 2011 <http://www.dawn.com/news/664894/flashback-the-martial-law-of-1958> [accessed 7 July 2014].
[688] NDC, 172/CF/51, Conference of Provincial Governors and Chief Ministers, 21 July 1951.
[689] 'No. 28, M.A. Ispahani to M.A. Jinnah, F. 310/30, 23 Oct 1943', in Zaidi, *Quest for Political Settlement in India*.

obituary of the Quaid-e-Azam, 'It is not clear who will replace him, or, indeed, if he can be replaced.'[690]

The subsequent food crises in 1951 cemented the pre-existing rancour between those areas and people that had access to supplies and were frequently hoarding, and the needs of populations—most prominent among them being non-rehabilitated refugees and East Bengalis—that were being denied the means to meet their nutritional needs by their compatriots.[691] Eventually the provinces became hesitant to openly declare their actual position to the Central Government. The Minister of Food & Agriculture noted, '[O]ut of caution the Provinces are becoming hoarders of grain like individuals. Similarly, the deficit Provinces were, out of caution, putting up their demands higher than they should.'[692] For its part, the Central Government was castigated for taking an inactive domestic role. It had neglected to promote programs to increase food production after Partition. 'Instead, they had been boasting too much about Pakistan's surplus of food,' complained provincial officials from Baluchistan. 'The knowledge that Pakistan was surplus in food had also contributed to the diversion of land to cash crops. The fact is that Pakistan's surplus in wheat is only 2% which can easily be wiped out by floods, droughts, etc.'[693]

Unable to improve the domestic food situation, the Central Government tried to resist turning outward for relief, claiming, 'Importing of foodgrains from foreign countries is very undesirable, from the point of view of the general economic prestige and reputation of Pakistan.'[694] The Punjab remained unsympathetic to this line of argument. Its Governor stated bluntly, '[P]restige should not stop Pakistan from importing food if it was considered necessary, as otherwise the position would be exploited by subversive elements. There would be genuine and great discontent.' To the question of economic reputation, he argued, 'We could explain the imports to the world by telling them that the present was an abnormal year for Pakistan,' thus obviating the impression that Pakistan was becoming dependent on external aid.[695] Even if

[690] 'The Death of Jinnah', *New York Times*, 13 Sep 1948.
[691] NDC, 172/CF/51, Conference of Provincial Governors and Chief Ministers, 21 July 1951.
[692] Ibid.
[693] Ibid.
[694] Ibid.
[695] Ibid.

Pakistan wanted to import help from abroad, its possible donors, which included Australia, USA, and Canada, were all showing a pessimistic outlook. Furthermore, across the border India was also facing a massive food shortage, one in which the United States had already provided some measure of relief aid with a large wheat loan.[696] The food crises facing Pakistan and India would become a major international issue by the 1960s, as will be discussed in the next chapter.

The food crisis was thus more than a matter of public nutrition; it was a political issue that had the potential to affect the state's image in the community of nations and worsen interprovincial relations. Even when the food situation stabilized, the Minister for Food wrote, '[T]he experience of two years' deficits had shaken confidence' leading surplus provinces to continue to remain shy in declaring surpluses—which indicates that even in times of plenty the provinces had become distrustful of one another.[697] Not only was there distrust between the constituent elements of Pakistan's political system, but there was also a hierarchical battle between different levels of government where 'the Centre blamed the Provinces and vice versa.'[698] The Provinces demonstrated outright hostility against the Centre's efforts to nationalise policy in matters relating to health and welfare.[699] In order to combat high price of foodstuffs, the Central Government contemplated seizing control of the movement of food grains in the western wing of the country. But the Provinces so concerned threatened the Centre with financial liability for unsold provincial grain stocks and with oblique support for smuggling if the Centre were to act against provincial interests.[700] They demanded the right to control the movement of grains as they saw fit and even to have freedom to negotiate with foreign governments.

The rhetoric of provincial officials indicates that they were most worried about the economic condition of their own areas, even when the condition of the food economy in the

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[696] United States Department of State. Office of the Historian, *Foreign Relations of the United States, 1951, Asia and the Pacific, Volume VI, Part 2*, ed. by Frederick Aandahl (Washington, 1977), Document 427.
[697] NDC, 18/CF/49, Decontrolling movement of wheat and other foodgrains.
[698] NDC, 172/CF/51, Conference of Provincial Governors and Chief Ministers, 21 July 1951.
[699] Jalal, *State of Martial Rule*, p. 75. As Jalal writes, 'Within a year of Pakistan's creation, unbeknown to itself, the central government had mobilised all manner of opposition to its policies.'
[700] NDC, 172/CF/51, Conference of Provincial Governors and Chief Ministers, 21 July 1951.

country as a whole required direct assistance to the deficit areas through the coordination of the Central authorities.[701] These regional authorities perceived themselves as autonomous polities and not as members of a national governing coalition. The particular interests of these administrations brought them into conflict with the state's interests as a whole and their need to maintain their autonomy even turned them against the interests of their own constituents, including the cultivators and consumers. This provoked a counter-response from those who were opposed to the provinces' self-interested position. In a strong editorial concerning the country's food policy, the *Dawn* newspaper affirmed the domestic sovereignty of the Central Government. It was not only important for the public welfare, but a matter of political principle that the national government retain the authority to control food supply into and within the country. 'In a country like Pakistan which has deficit as well as surplus areas, chaos will be the result if the food policy is not controlled by the Central Government…Even countries with dependable surpluses have not thought it wise to remove State control which is an accepted policy the world over.'[702] Furthermore, the Centre had a role to play in upholding the public interest against the provinces. If the provincial governments' demands were acceded to, '[i]t will be a signal for the big zamindars and grain dealers to hoard stocks and create an artificial scarcity in the country.'

The 1950s bore witness to the 'centrifugal' forces within Pakistan's Government as provincial opposition and security concerns provoked increasing control by the bureaucracy and military over various matters of policy, helped by external aid.[703] But centralisation did not happen without a fight from the provinces. The expectations engendered by the 1940 Lahore Resolution with respect to provincial autonomy and the historical experience of self-administration along ethno-linguistic lines that these provinces had under British rule provided the impetus for resistance to these centralising tendencies.[704] This is best evidenced by the unanimous opposition of the provinces to a Central Government proposal to establish a Central

[701] NDC, 18/CF/49, Decontrolling movement of wheat and other foodgrains.
[702] 'Editorial: Centre's Food Policy', *Dawn*, 27 Sep 1950.
[703] Talbot, *Pakistan: A New History*, p. 49.
[704] Jaffrelot, *The Pakistan Paradox: Instability and Resilience*, (Oxford, 2015), p. 7.

Medical Service in 1949.[705] The Sind Government wrote, 'The very existence of a Central Medical Service announces dependence of the Provinces—which are otherwise autonomous on the Centre to man their Health services.' It went on to say, 'the acceptance of the principle of Provincial autonomy militates against creation of a service, the ultimate control over certain members whereof lies outside the jurisdiction of the Provincial Government.' The Punjabis expressed a similar position: '[T]he proposed constitution of Pakistan Central Medical Service is a trespass on the already established autonomous position of the Provinces.' It is difficult to avoid the comparison with Bengal in 1919 when local politicians rebuked the Presidency Government for attempting to establish central control over sanitary policy in the localities 'in these days when they are granting more power to the people in the matter of self-government.'[706] The importance of historical experience is borne out by similar trends in India where provincial health authorities also 'jealously guarded their responsibility for running their own public health and medical strategies'.[707] Yet in both nations, the national governments in distinct ways eventually established their control over health policy-making in the localities.[708]

The development of a dissonance between the interests of provincial governments and of their citizens in addition to the existing divide between Centre and provinces laid the stage for repressive policies that would soon follow within Pakistan as unrest grew. In Bengal, where the situation was critical already by 1951, the Minister for Finance noted that local Muslim Leaguers had already taken to calling 'the last 5 years as years of repressive alien rule.'[709] Central and Provincial ministers were beginning to worry that, 'Unless prices were brought down and the standard of living raised, the people would be thrown towards communism.'[710] The spread and depth of communist activities and sympathies in the various provinces was a matter of great

[705] NDC, 28/CF/49, Statement of replies received from the Provincial Governments regarding the formation of Pakistan Central Medical Services.
[706] IOR/P/10983, Opinion Of Babu Hem Chandra Ray Chaudhury.
[707] Bhattacharya, *Expunging Variola*, p. 17.
[708] Ibid., p. 38; Government of Pakistan, *Report of the Director General Health on the Activities of Health Division, 1960-65* (Rawalpindi, 1968), p. 1.
[709] NDC, 172/CF/51, Conference of the Provincial Governors and Chief Ministers held on 4th to 9th April 1952.
[710] Ibid.

concern and was twinned with the issue of agitation over famine conditions in Bengal as well as high food prices across the country.[711]

Clearly, food and nutrition were health-related issues which due to the dynamics of food production and distribution had great ramifications for political stability and power relations in independent Pakistan. This was further exacerbated by the explosion of urban, uprooted populations with no connection to land through personal ownership or through kinship networks.[712] The problem of refugees also significantly contributed to this reality. Refugees fortunate enough to get land grants were given small holdings in proportion to what they may have left behind, and such a system was not suited to meet the large social need for increased foodgrain production.[713] But beyond those refugees that were landed, it is important to acknowledge that, according to the Pakistan Census, at the time of the 1951 food crisis, half of the population of major cities in Pakistan, which were dependent on food allocations, was composed of refugees.[714] The overarching problems relating to refugees and nutrition were acknowledged by Pakistani leaders to be the two main concerns of government throughout the '40s and '50s.[715] Nevertheless, they continued to come under intense criticism by politicians and fellow citizens and function as scapegoats for national problems.

In response to perceived seditious behaviours by government servants, labourers, and refugees, etc., the Governor of Sind proposed a constitution making Pakistan a 'Democracy-cum-Fascism'. According to him, 'Anti-State activities under the garb of democracy must not be tolerated.'[716] In advocating such a position, the Honourable Governor of Sind was not alone. The Governor of NWFP too felt that the state was not doing enough against those willing to challenge it. 'In Pakistan anti-State activity was being frequently cloaked as merely anti-Government

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[711] Ibid.
[712] Ibid.
[713] Ibid.
[714] Arif Hasan and Masooma Mohib, *Reporting on 'Slums': A Case Study of Karachi, Pakistan*, UNHSP Global Report 2003 (London, 2003), p. 1.
[715] NDC, 127/CF/48, Government of India (Second Amendment) Bill, 1948: Statement of Objects and Reasons.
[716] NDC, 172/CF/51, Conference of the Provincial Governors and Chief Ministers held on 4th to 9th April 1952.

activity. It should not be spared on that account. The food situation was also being exploited by anti-State elements.' Other ministers argued that the developing agitation over food prices and availability reflected the fact that Pakistanis were not ready to exercise the responsibility of sovereign nationhood:

> Pakistan was following Britain's example of allowing freedom of speech which was a well-recognised canon of democracy even though the conditions of the people were different. He [the Minister of East Bengal] could not advocate freedom of speech for our people who, generally speaking, did not have a sense of responsibility. They abused Ministers in dirty language and spoke all manner of lies.[717]

Rather than pointing to sedition and communism as the causes of unrest, the Finance Minister stated, 'The anti-Centre feeling in any Province ultimately boiled down to this, that sufficient money was not being spent on development in that Province.' Foreign Minister of Pakistan Chaudhry Zafrullah Khan also attempted to clarify that conditions of starvation and poverty were responsible for unrest. He warned, 'A hungry man is a desperate man and human nature cannot be ignored.'[718] But in this period of limited options and even more limited imagination, it seems that rather than ameliorating the underlying food problem by improving distribution, Pakistani politicians decided instead to strategise to eliminate dissent among the populace. This was made more complicated by the fact that in many instances, Provincial officials developing such repressive policies were in fact administrators sent from the Centre to solidify control in the provinces.[719]

In the name of fighting 'anti-Centre feeling', severe measures were put forward to limit political agitation over high food prices and insufficient supply by 1952. The NWFP Government had been able to successfully tackle this by prohibiting free association and the expression of opposition, as well as the clamping down of free movement in the border regions—a move that hearkened to the policies of the British government in the province which had been in force not more than five years prior. 'This exemplified compromise between democratic action and fascist action, which was necessary for Pakistan as its people had not yet become fully responsible,'

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[717] Ibid.
[718] Ibid.
[719] Jalal, *State of Martial Rule*, p. 75.

stated the NWFP's governor.[720] The Minister for Commerce had a different strategy based on his recent tour of East Bengal. 'Though there was the salt and jute crises, his appeal to Islam, Islamic socialism and democracy and the oneness of Pakistan succeeded in winning the support of the people.'[721] Government officials and politicians also seemed keen to paper over the problem of food scarcity and food insecurity by shuffling it together with other grievances, which included criticisms over delays in the framing of the Constitution and the handling of the language issue between Urdu and Bengali, and then dismissing them all out of hand as illegitimate.[722] The multiple problems of refugee rehabilitation, food supplies, housing, defence and finance required economic investment and strong, well-administered programs. Instead, political divisiveness only worsened, a 'large cancer neither destroyed nor dormant' which all along was 'growing toward an eruption.'

Lastly, it is worth exploring how the problem of scarcity exacerbated by internal divisions and fear of economic insecurity impacted national morale. Not long after independence, the perceived economic danger facing the country led the Refugees Minister to suggest amendments to the existing Government of India Act—which formed the basis of rule in Pakistan—whereby local government authority could be superseded in the event that 'a grave emergency exists whereby the security or economic life of Pakistan…is threatened whether by war or internal disturbance arising out of the exchange of population between Pakistan and India.'[723] This was in addition to the disorder already festering in the nation's capital due to the influx of refugees, with regards to which Government was forced to admit, 'We are now placed in a precarious or dangerous position as far as law and order, sanitation and health…is concerned, not to speak of the bitterness and sense of injury that has been engendered among the masses.'[724] Within five years, pride in the nation's initial survival after Partition had already

[720] NDC, 172/CF/51, Conference of the Provincial Governors and Chief Ministers held on 4th to 9th April 1952.
[721] Ibid.
[722] Talbot, *Pakistan: A Modern History*, pp. 69-70.
[723] NDC, 127/CF/48, Note on constitutional amendments needed to enable the Centre to control refugee administration in provinces.
[724] NDC, 148/CF/50, Rehabilitation of new refugees.

given way to a grim acceptance of the continuing existential threat from economic insecurity and internal discord.

Medical Supplies and Aid

With some measure of stability having been attained by the 1950s, attention subsequently turned to establishing some plan for the development of the country.[725] However, it would soon become apparent that the dislocation caused by independence had largely gutted the healthcare infrastructure. The evacuation of Hindus and Sikhs, while crippling the civil administration and depleting its stock of traders, bankers, industrialists, and technocrats, also deprived the country of three-quarters of its pre-partition medical and public health personnel according to the Government of Pakistan.[726] Habibullah Bahar, a member of the Committee which organized the second All-Pakistan Health Conference, described the situation thus: 'Can you conceive of any hospital without any medical officer, compounder or nurse?…This was the state of affairs on the day we took up the reins of administration here.'[727] After having agitated successfully for a separate homeland of their own, Pakistanis found themselves in the difficult situation of possibly being worse off than they were before independence from Britain. Meanwhile, the endemic diseases of the subcontinent such as malaria and tuberculosis continued to wreak havoc on the population unabated.[728] The bureaucrats responsible for economic planning were convinced that without trained workers, there would be little understanding of the challenges the country faced in all these aspects of health and well-being.[729] Out of all the problems related to public health in independent Pakistan, policymakers were convinced 'the first and most important…is the shortage of technical personnel.' In this, they echoed the wisdom of their British predecessors who had advocated much the same a few decades prior.

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[725] Government of Pakistan, *Report of the Director General, 1960-65*, p. viii.
[726] Office of the Economic Adviser, *Economy of Pakistan, 1950*, p. 390.
[727] Government of Pakistan, *Summary of the Proceedings of the All-Pakistan Health Conference, 8-10 Jan, 1951*, p. 6.
[728] Ibid., p. 15.
[729] NDC, 244/CF/49, Report of proceedings of the Second Session of the Regional Committee for the Eastern Mediterranean.

Making do with 3,500 doctors, 15,000 hospital beds, and 1 medical school was not acceptable for a nation of 76 million.[730] These numbers hid insidious disparities within the different regions of the country. With respect to strength in personnel, the Punjab had 1 doctor to 15,000 people while in East Bengal it was 1 doctor per 103,000.[731] The Planning Board put together in 1953 was charged with implementing the five-year economic programme 'to develop the resources of the country as rapidly as possible,' including in the sphere of health.[732] By December 1954, though the Board reported humble gains in increasing the country's medical infrastructure, half the posts in government health departments were still vacant.[733] The number of nurses—'even more inadequate than the number of doctors'—was only 1,600 in 1954.[734] At the time of the drafting of the plan, investigation revealed that less than half of posts in nursing schools were filled, out of which half of the students dropped out during their schooling, and of the remaining only a third actually ended up successfully qualifying. In explaining the shortfalls in nursing applicants, the drafters of the Plan noted, 'There seem to be two major reasons for this situation: the limited number of educated girls available, and misgivings in the minds of some parents about the social conditions in which nurses live.'[735] Though migrants to Pakistan happened to be vastly more educated than resident Pakistanis, they also overwhelmingly concentrated in cities in West Pakistan; 91% of the literate population of Karachi consisted of migrants and an astonishing 50% of migrants to Pakistan with higher degrees moved to Karachi.[736] Pakistan thus suffered not only from a pervasive lack of necessary resources, it continued to be plagued by an unhealthy imbalance between urban and rural.

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[730] Pakistan. Planning Board, *The First Five Year Plan, 1955-60*, p. 609.
[731] Government of Pakistan. Ministry of Health and Works, *Summary of the Proceedings of the Second All Pakistan Health Conference* (Karachi, 1951), p. 13
[732] Pakistan. Planning Board, *The First Five Year Plan, 1955-60*, p. 1.
[733] Ibid., p. 609.
[734] Ibid., p. 614.
[735] Ibid.
[736] Prashant Bharadwaj, Asim Ijaz Khwaja and Atif R. Mian, 'The Partition of India: Demographic Consequences', *Social Science Research Network*, 2009, 1–41 <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1294846> [accessed 19 July 2016], pp. 3, 10.

The planners, though suffering from a lack of information about the country's resources, also expressed enthusiasm for preventative measures, with the highest priority accorded to malaria eradication and tuberculosis control programs.[737] Though Pakistan was predominantly agricultural, it was also a rapidly urbanizing country. Deficiencies in nutrition, housing, and economic circumstances, some of which were partly attributable to Partition, left an estimated number of 750,000 open cases of tuberculosis in the country.[738] These cases were responsible for roughly 200,000 annual deaths.[739]At the same time, malaria continued to be a national scourge, incapacitating millions at the peak of the agricultural season and was responsible for nearly 125,000 deaths each year.[740] It was described by one minister as 'our enemy No. 1' which in addition to its mortality risk, 'also saps the vitality of our people.'[741] His comments were remarkably similar to the sentiments expressed by the authorities in India's Uttar Pradesh who with respect to the scourge of malaria in their borders also stated, 'Malaria is our Enemy No. 1; it is not only responsible for causing a large number of deaths but it also weakens and emaciates those who suffer from it even though they may not die.'[742] While malaria had been a common problem before Partition in the future India and Pakistan areas, the similarities did not end there as both nations were able to implement national malaria eradication programmes buoyed by the promises of DDT and the help of international funding.

The prominence of malaria and TB control programmes on the national health agenda also alludes to the developing importance of the international context on the formulation of domestic health policy. The international focus on these diseases of decolonised nations was a consequence of the types of advances that had taken place in the practice of international health up to this point.[743] The efforts of colonial powers and the rise of international bodies such as the League of Nations and the Rockefeller Foundation had brought about a network of international

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[737] Pakistan. Planning Board, *The First Five Year Plan, 1955-60*, p. 615.
[738] Ibid., p. 481
[739] Government of Pakistan, *Second All-Pakistan Health Conference*, p. 16.
[740] Ibid, pp. 8; 15.
[741] Ibid., p. 8.
[742] Bhattacharya, *Expunging Variola*, p. 39.
[743] *Decolonizing International Health*, pp. 2-3.

expertise and techniques and technologies for implementing improvements in global public health prior to WWII.[744] 'At the moment when nationalists across Asia took over colonial states, a wide set of technologies for the government of the population were freely available for adoption and adaptation,' writes Sunil Amrith who has studied international health in postcolonial contexts. '[T]he WHO offered targeted interventions as a simple tool of "technical assistance"…using BCG vaccination against tuberculosis, penicillin against the disfiguring yaws, and DDT against malaria…to activate new forms of technical expertise.'[745] Expert committees were established to provide scientific guidance to member nations in the planning of eradication programs and countries like Pakistan were further enveloped in these programs through the provision of training fellowships. A Malaria Control Demonstration Team from the World Health Organisation (WHO) was invited to tour East Bengal in 1948, which provided stimulus for a national programme for malaria research and eradication in Pakistan.[746]

While international funds provided great impetus for new epidemic control projects, domestically it became a *de facto* policy to invest in improving and bolstering existing institutions rather than building new ones. While investing in current infrastructure was a conscious decision resulting from the acute scarcity of financial resources and political will, it was also exacerbated by two concomitant trends: the tendency of leading figures in the administration to take the helm of the scarce few medical institutions such as the Jinnah Central Hospital or the Fatima Jinnah Medical College for Women so that such institutions were privileged with regards to government patronage, and the practice of addressing the scarcity of trained doctors by sending them for training abroad.[747] When they returned from countries such as the US, Australia, and the UK with specialist skills, these trained professionals often could only practice their newfound skills in institutions with facilities offering specialist services or

[744] Mark Harrison, 'A Global Perspective: Reframing the History of Health, Medicine, and Disease', *Bulletin of the History of Medicine*, 89/4 (2015), pp. 639-689.
[745] Ibid.
[746] Government of Pakistan, *Second All-Pakistan Health Conference*, pp. 8-9; *Report of Director General Health for the period 1947-51* (Karachi, 1958), p. 23.
[747] NDC, 18/CF/49, Summary for fortnight ending 30 April 1949; Government of Pakistan, *Second All-Pakistan Health Conference*, pp. 19-21.

where such capabilities could readily be built up.[748] They did not have a place in the rural villages where dispensaries were suffering for lack of trained physicians to supervise many of them.[749] This dilemma recalls the observation made by W.S. Carter regarding the social discordance between the qualifications of MBBS graduates in British Punjab and the needs of rural health.

Though the dire shortage of medical practitioners cropped up in the media from time to time, according to officials in the Defence Ministry, 'The gravity of this shortage, both as regards quality and as regards quantity is…not generally realised.'[750][751] The Pakistan Army, though it enjoyed a disproportionate amount of national resources and had heavily recruited medical officers from abroad, still remained 50% short of its staff needs in 1950.[752] The position in the civil departments was at least as bad—in Punjab, 207 of 580 dispensaries were without qualified medical officers.[753] The entire country had 3,500 doctors, but the vast majority—nearly three-quarters—were medical licentiates and were considered to have a lower level of professional knowledge compared to the internationally recognised MBBS graduates.[754] The Bhore Committee, which had been appointed to look into the matter of health development in India towards the end of colonial rule, had set a target ratio of 1 doctor per 1,000 people which was adopted by both Pakistan and India. Regarding the ability of existing medical colleges and schools to produce enough doctors to meet this target, a Defence Ministry official cynically calculated, '[A]t the present rate, it would take these schools and colleges over a century and a half to give us the 1:1,000 ratio; provided in the meantime no doctor dies, and our population does not increase.'[755] In a statement that reflected the general state of civil-military relations in Pakistan in the 1950s, the Defence Ministry delegation offered the following indictment of planning in the health sector:

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[748] NDC, 18/CF/49, Summary for fortnight ending 30 June 1949.
[749] Said, *Health of the Nation Conference*, p. 47.
[750] 'Editorial: Conscription of Doctors,' *Dawn*, 22 Nov 1950; Said, *Health of Nation Conference*, p. 38
[751] Said, *Health of Nation Conference*, p. 38
[752] 'Editorial: Conscription of Doctors,' *Dawn*, 22 Nov 1950.
[753] Government of Pakistan, *Report of the Director General Health, 1947-51*, p. 13.
[754] Said, *Health of Nation Conference*, p. 39
[755] Ibid.

> The Medical Services of the Armed Forces have had to shoulder heavy civil commitments repeatedly. At the very start the Army had to help in a big way, in the care and hospitalisation of the wounded and sick refugees from India. We had to do the same later with regard to the Kashmir refugees. The large commitment has continued for nearly two years, and is still being discharged by us. The Civil medical arrangements in Kashmir, and now in Gilgit and Northern Areas, have also been organised, manned, and supplied by us…The Civil side whenever approached, expressed its inability to do the needful.
> …If the position is ever reversed, and the Armed Forces are faced with a Military emergency amounting to war, the Civil Medical side is not organised in a manner to render prompt and adequate assistance…If their personnel are not to disappear in chaos the Civilian Medical Services in their own interest will have to come under military control.[756]

The Army's frank ultimatum was a harbinger of things to come—its hegemonic tendencies would find their full expression in the declaration of martial law seven years later. Expressing a similar sentiment with respect to the inefficiency of civilian administration, Ayub Khan justified his overthrow of the civilian government in Pakistan by claiming, 'Whether the army liked it or not it would get embroiled, because in the final analysis it would become a question of maintaining some semblance of law and order.'[757]

The problems with regards to unstaffed dispensaries prompted the Centre to pass a bill enforcing compulsory government service by medical graduates under the age of 32 for a period of three years.[758] Though there was an underlying scarcity of medical doctors, the exacerbating problem in Pakistan, as in India, was the tendency of medical graduates to go into practice in urban areas while 'villages, which constitute the real country, are neglected.'[759] But whereas in India, little could be done after independence in light of the Central Government's prioritisation of industrial development to the neglect of rural healthcare, in Pakistan legislative intervention was attempted to redistribute medical resources across the nation.[760] There was opposition from medical graduates themselves to the terms of the Bill.[761] There is some evidence to support the idea that in the public perception, physicians were seen as acting in their self-interest in the face

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[756] Government of Pakistan, *Second All-Pakistan Health Conference*, p. 41.
[757] Mohammad Ayub Khan, *Friends Not Masters: A Political Autobiography* (Oxford, 1967), p. 70.
[758] 'Compulsory service by doctors under 32: Bill passed,' *Dawn*, 29 Nov 1950.
[759] Ibid.; Bhattacharya, *Expunging Variola*, p. 22.
[760] Bhattacharya, *Expunging Variola*, p. 25; 'Editorial: Conscription of doctors', *Dawn*, 22 Nov 1950.
[761] 'Conscription Bill: Medical students' memorandum', *Dawn*, 9 Dec 1950

of so much misery from disease. An editorial in *Dawn* commenting on the passage of the conscription bill remarked, 'In the country's present need and temper doctors cannot be expected to live solely for themselves as money-making agents.'[762] The DGH himself admitted, 'I am afraid we have lately acquired a bad name. People have come to think of us as a class which cares more for money.'[763]

The compulsory medical service bill also draws attention to the conception of citizenship and responsibility in this decolonized state. The *Dawn* editorial stated,

> [A]lthough not much has yet been done to improve public health, the demand for medical relief is increasing and growing louder. …The State, which incurs no small expense in providing for [doctors'] education and training, can rightly expect and demand that they shall contribute their share and worthly too, to the improvement of health conditions and to the alleviation of physical misery among the masses.[764]

The statement here refers to a mutual obligation between citizens rather than benevolence towards imperial subjects inspired by a sense of *noblesse oblige*. It speaks to a neighbourly demand rooted in entitlement rather than a request rooted in dependence. Thus, the Director-General Health, Lt. Col. Jafar described the differing expectations of physicians' duty under a colonial government versus under a 'peoples' Government': in both, physicians work on behalf of Government, however, in the former, the principal dependents of the State are the civil servants and soldiers sent on behalf of the imperial authority, and in the latter, it is the masses whose welfare is—or ought to be—the responsibility of the State.[765]

This concern over the shortage of medical practitioners also raised the 'vexed problem' of ascertaining the validity of indigenous medical systems in the eyes of government bodies [766] There were steady efforts by the medical profession through organized councils to establish laws against quackery and limit the use of medical terms by non-licensed practitioners and to have individuals prosecuted actively under these laws. But the desperate need to provide some measures for health provision in the rural areas manifested in the proposal for the Non-Allopathic

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[762] 'Editorial: Conscription of doctors', *Dawn*, 22 Nov 1950.
[763] Said, *Health of the Nation Conference*, p. 26.
[764] 'Editorial: Conscription of doctors', *Dawn*, 22 Nov 1950.
[765] Government of Pakistan, *Second All-Pakistan Health Conference*, p. 26.
[766] 'Compulsory service by doctors under 32: Bill passed,' *Dawn*, 29 Nov 1950.

Medical Practitioners Bill in 1953.[767] Though the name of the bill underscored the Central Government's clear partiality for the growing system of allopathic medicine in the country, western medicine could hardly be said to have displaced indigenous medical systems particularly in the rural areas where 90% of the population lived.[768]

The proceedings of the second All-Pakistan Health Conference candidly note that Government could not avoid taking action on the position of *Unani, Ayurveda* and homeopathy in the country. 'Since the establishment of Pakistan there has been pressure from many quarters in favour of according State recognition to these systems of medicine and to control teaching and practice of these systems.'[769] In fact, pressure had been building even before the establishment of Pakistan, as *hakims* and students of *Unani* had insisted on a privileged status for their profession in the future Muslim state in their letters to the Quaid-e-Azam.[770] To take up the question of recognition of these systems, a committee was appointed consisting of allopathic practitioners as well as the Director-General of Health and was tasked with debating evidence taken from representatives from the Unani and Ayurveda Conference, the Homeopathy Association, and the Unani Conference. The committee stated its unanimous opinion that these systems should not be given State recognition.[771] However, an important consideration in favour of granting governmental recognition to these practitioners was the preoccupation of the medical profession in Pakistan with the menace of quackery.[772] Thus, in considering the question of non-allopathic practitioners' place in the health system, the committee was of the belief that legislation would allow the government to regulate their ability to practice and their training.[773] In this, the

[767] NDC, 68/CF/53, Non-Allopathic Medical Practitioners Bill, 1953.
[768] Government of Pakistan, *Second All-Pakistan Health Conference*, p. 25.
[769] Ibid., p. 96-7
[770] No. 368, Hakim Masud Ahmed to M.A. Jinnah, F. 905/24, 20 May 1944; No. 87 Ahmed Husain to M.A. Jinnah, SHC, Madras I/41, 29 August 1944, in Zaidi, *Consolidating the Muslim League for the Final Struggle*. Husain sent a copy of his book Principles of Unani Medicine to Jinnah and wrote, 'Ayurveda finds a place in the national life of the Hindus whereas unani failed to progress due to neglect of Musalmans…if you are sufficiently convinced that unani, as science and art of healing, can still serve the people, you may include revival and encouragement of unani in the reconstruction programme of the League.'
[771] Government of Pakistan, *Second All-Pakistan Health Conference*, p. 33.
[772] 'Quacks on trial', *Dawn*, 21 Sept 1950, 1950.
[773] Government of Pakistan, *Second All-Pakistan Health Conference*, p. 33.

Pakistani delegation was influenced by the example of India, where the recognition of indigenous medical systems seems to have arisen from the recognition that a government ruling on the matter would enhance the capacity for control and regulation over practitioners and at the same time would provide the authorities a source of properly qualified men for use in a national emergency, if the Government was willing to consider such a measure.[774]

This committee investigation eventually became the basis for the Non-Allopathic Practitioners' Registration Bill which was moved for consideration to the National Assembly in 1953.[775] The subsequent trials of this legislation provide a pithy but accurate look at the travails of governance in independent Pakistan: the Bill reached the last stage before passage in 1953, at which point the National Assembly was dissolved—'and with the chaff the grain was milled,' according to retired Secretary of Health for the Government of Pakistan, Hashim Raza.[776] In 1957 the Bill was again presented to the second Constituent Assembly, but foundered again, this time in the face of a political revolution and military coup in October of 1958.[777] In the meantime, *Unani* and *Ayurveda* and homeopathy institutions remained deprived of official Government support. Whether the problem of quackery was ameliorated to an appreciable degree is difficult to ascertain. But like analogous problems of spurious and illegal manufacture and sale of drugs and adulterated foods, it was the by-product of severe shortages in the country as well as political and social rivalries, in this case between the medical establishment and practitioners of *unani tibb*.[778] The problem of quackery was not alleviated, but rather became one of a host of scarcity-induced phenomena in Pakistan, which included increase in sale of spurious and illegal drugs and proliferation of adulterated foodstuffs. Rivalries and group interests continued to prevent agreement on common measures to alleviate resource and personnel shortages in medicine.

Conclusion

[774] Ibid., p. 105.
[775] NDC, 68/CF/53, Non-Allopathic Medical Practitioners Bill, 1953.
[776] Said, *Health of Nation conference*, p. 47.
[777] Ibid.
[778] Government of Pakistan, *Second All-Pakistan Health Conference*, p. 34

The national and provincial leaders of Pakistan were faced with the profoundly difficult task of building a functional state and economy out of an edifice that was first divided by violence and then gutted by the abrupt exodus of trained personnel and civil servants. Men unused to the responsibility of governing a republic assumed power in the long shadow of Partition. The economic and social dislocation experienced by certain regions and portions of the population put pressures on the country at large to find ways to cope as needs quickly outstripped local resources. Efforts to ameliorate miserable conditions with regards to the availability of basic necessities—food, water, medicines—in local contexts came up against overt inequalities between different groups at the regional and national levels with regards to access to material resources and political representation. The fault lines persisted across diverse domains of national life, e.g. between longer-term residents and more recent newcomers in major cities, between food producing and non-producing provinces, between urban and rural areas, and between army and civilian. These inequalities were often inherited from the colonial period, but they persisted in the absence of an alternative vision for more inclusive arrangements of economic and social relations between the various civil groups in independent Pakistan. Faced with simmering unrest among the populace, provincial and central politicians responded with illiberal rhetoric and divisive tactics.

This chapter attempted to understand how the function and dysfunction of politics, economy, and society in Pakistan during the volatile years after Partition was impacted by developments in the spheres of health and environmental sanitation. The discussion in this chapter also relates to certain broader themes in the study of colonial and postcolonial South Asia. For example, we can better appreciate the importance of access to resources as a critical factor enabling shortages as opposed to the simpler excuse given regarding widespread deprivation in an admittedly poor, postcolonial state.[779] This recalls Amartya Sen's 'entitlement

[779] Akbar S. Ahmed, *Jinnah, Pakistan and Islamic Identity: The Search for Saladin* (Karachi, 1997), p. 204. Regarding Pakistan's economic potential on independence, political economist Akbar S. Ahmed has written, 'Even if Pakistan did not have the big imperial cities and higher level of development that India possessed, the resources were available for a strong economy to form the basis of a stable society.' Ahmed asserts that the failure to do so was due to lack of faith in leadership and the trauma of Pakistan's creation which created an atmosphere of insecurity leading society at large to seek respite in short-term solutions.

approach' to studying poverty and famines; using historical case studies of famines, including the Bengal Famine of 1943 which was discussed briefly in this chapter, the Nobel Prize-winning economist has found that deprivation relates not only to the mere unavailability of resources, as is conventionally believed, but also to 'the ability of people to command food through the legal means available in the society, including the use of production possibilities, trade opportunities, entitlements vis-à-vis the state, and other methods of acquiring food.'[780] In each one of the case studies discussed in this chapter, certain portions of the public were bereft of critical resources. It is crucial to note that in each case, blame was laid not at the feet of economic misfortune but at the behaviour of other individuals and groups within the country. The failure to ameliorate deficits in supplies of water, foods, and medical personnel reveals a prevailing tendency towards competition, not cooperation. Combined with the instability of creating a new state apparatus and the subsequent jockeying for power, this jealousy over resources resulted in policies that privileged some needs over others.

The public health crises also shed light on how the political legacy of colonialism may have adversely impacted state-building in Pakistan. The division of economic power and loyalty between Centre and Provinces and bureaucrats and politicians resulting from the struggles of political reform and diarchy arguably exacerbated the economic disaster.[781] Decades spent fighting for provincial autonomy and building up provincial spheres of influence against the Central Government during the colonial period left a legacy in Pakistan where 'Provincial officers have tended to look to the Provincial Minister and higher Provincial officials…rather than to the Central Government and its officers.'[782] But the crises that existed in local settings required cooperation and national coordination.[783] Demonstrated provincial inadequacies in the face of these crises prompted the Centre to try and take control; this ultimately reached its logical conclusion in the complete concentration of political decision-making at the Centre by the Army

[780] Sen, *Poverty and Famines: An Essay on Entitlements and Deprivation*, (New York, 1982), p. 154.
[781] NDC, 127/CF/48, Note on constitutional amendments.
[782] Ibid.
[783] NDC, 127/CF/48, Government of India (Second Amendment) Act, 1948: Statement of Objects and Reasons.

some years later. Institutions with greater command over resources and resource distribution appeared to have been in a position to overrule institutions less capable in that regard.

Another important theme relates to the failure of nationalism. Prior to his death, Jinnah had warned of the curse of provincialism.[784] However, this vice remained an enduring part of Pakistan's political experience, best exemplified by the 1971 civil war and secession of East Pakistan resulting in the independence of Bangladesh. In his 1985 article exploring the failure to build an inclusive nationalism in Pakistan prior to the civil war, historian Philip Oldenburg cited a passage from Indian novelist Salman Rushdie which characterised Pakistan thus: 'Pakistan, the peeling, fragmenting palimpsest, increasingly at war with itself, may be described as a failure of the dreaming mind…[P]erhaps the place was just insufficiently imagined.'[785] Jinnah's warning of the distracting lure of local attachments over national interests and Rushdie's evocation of the subjective social experience of failed nationhood are relevant to the ideas discussed in the present chapter because they embody the political and social ramifications of economic inequality and dislocation. Though the social divisions that were at play in the post-independence period also existed in the pre-independence period, the failure to sufficiently re-imagine political relations and implement a new system of social relations to replace the old one became an existential hazard largely because of the scarcity of resources. As profuse shortages overwhelmed the promises of independence and national politics continued to remain divisive, the Government of Pakistan sought to elide the domestic economic and administrative discord by wholeheartedly pursuing an active policy of seeking economic aid abroad.

[784] Jinnah, *The Nation's Voice, Vol. VII*, p. 252.
[785] Philip Oldenburg, '"A Place Insufficiently Imagined": Language, Belief, and the Pakistan Crisis of 1971', *The Journal of Asian Studies*, 44/4 (1985), pp. 711–33.

Chapter 8: The Development of Underdevelopment

> As if undergoing a penance for severing ourselves from our glorious past and chastised for having turned a blind eye to our own culture and civilization, we in Pakistan are relegated to stand in the queue of under-developed nations. Bereft of our past distinction and honour, we are knocking at doors for alms. Imagine the zenith of our past, and this abysmal present.
>
> (Hakim Mohammad Said, *Health of the Nation Conference*)

> Finally I appeal to our rich Uncle Sam to send us Streptomycin at a much cheaper rate. An average citizen of Pakistan cannot spend two dollars for a one-gram bottle of Streptomycin.[786]

One month after Pakistan's independence, American photographer Margaret Bourke-White visited Karachi to interview the Quaid-e-Azam, who after having manoeuvred Pakistan into existence now occupied the post of Governor-General. In her reminiscences published in 1949, she gave free rein to her personal scepticism of the endeavour to create Pakistan. Candid about her unease at Mohammed Ali Jinnah's apparent triumphant demeanour, she notes of the interview in her memoir, 'I wondered how much thought he gave to the human cost…I hoped he had a constructive plan for the seventy million citizens of Pakistan.' She was troubled, perhaps angered, by Jinnah's inability or refusal to articulate a precise plan for building a modern, secular state and ensuring its continued survival which would justify the untold lives which had been sacrificed for its creation. Frustrated by Jinnah's vague posturing, she pressed him for concrete answers: 'What plans did he have for the industrial development of the country? Did he hope to enlist technical or financial assistance from America?'[787]

Her questions indicate that immediately after the birth of Pakistan, the issue of reliance on foreign aid had been raised as a means to keep the new state afloat. Bourke-White was not the only one who considered the matter of securing foreign aid to be one of the most pressing for the independence state. Optimistic, and rightly so, about Pakistan's geographical importance in light of the geopolitics of the time, several government officials expressed to her their confidence in

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[786] NDC, 168/CF/49, 'Riaz Ali Shah, 2nd Commonwealth and Empire Health and Tuberculosis Conference'.
[787] Margaret Bourke-White, *Halfway to Freedom; a Report on the New India in the Words and Photographs of Margaret Bourke-White.* (New York, 1949), p. 92.

being able to bank on America's interest in their country considering its proximity to the Soviet Union. 'This hope of tapping the U.S. Treasury was voiced so persistently,' Bourke-White wrote afterwards, 'that one wondered whether the purpose was to bolster the world against Bolshevism or to bolster Pakistan's own uncertain position as a new political entity.'[788] In subsequent years, Pakistan's leaders entered bilateral and multilateral military and economic cooperation agreements that ensured the flow of capital into the country in return for assisting its international partners in carrying out certain foreign policy objectives.[789] By 1956, when a new Prime Minister, Huseyn Suhrawardy, came into power and aggressively pursued a security and military alliance with the US, it was evident to observers that, '[F]oreign policy has become, since the new cabinet took power, one of the prominent issues in the struggles…between all different parties and organizations.'[790]

From the 1950s onwards, foreign aid was one of the most critical elements of Pakistan's economic policy and political trajectory. This chapter will analyse Pakistan's foreign policy to see how resources shortages after independence and the need for foreign medical aid illuminate Pakistan's developing relationships with the wide world and its role in the global community arising out of its domestic difficulties. For Pakistan, its historical reliance on foreign aid has had a profound impact on its development as a nation-state.[791] This aid relationship has had great ramifications for domestic public health policy, medical expertise and technologies, and health access, and though these relationships arose in the Islamic republic's earliest days, they have remained enduring to this day. In understanding Pakistan's reliance on foreign aid, it is helpful to briefly consider expectations of independent statehood and how they clashed with the realities of decolonisation, and how this disjunction paved the way for reliance on developed world

[788] Ibid., p. 93.
[789] Shuja Nawaz, *Crossed Swords: Pakistan, Its Army, and the Wars within* (Oxford, 2008), pp. 92-121.
[790] Wilson Center Digital Archive, PRC FMA 105-00779-04, 25-28, 'Cable from the Chinese Embassy in Pakistan, "Pakistan's Parliamentary Debate About Foreign Policy", October 11, 1956' <http://digitalarchive.wilsoncenter.org/document/114887>.
[791] S. Akbar Zaidi, 'Who Benefits from US Aid to Pakistan?', *Economic and Political Weekly*, 46/32 (2011), pp. 7–8.

assistance for public health and social welfare and subsequently produced a self-perception of underdevelopment.

The relationship between developed and developing countries based on the provision of aid in return for the pursuance of certain strategies for economic growth and support for developed world blocs was not a natural, immediate consequence of the process of decolonization. The rise of movements for self-determination in colonial territories in the twentieth century was based in part on the desire for sovereignty, and the material framework within which this had come to be realized was, by historical convention, the state.[792] This idea became a compelling argument for freedom from imperial rule and fuelled the demand for independent statehood by colonised peoples.[793] It propelled the fight by a growing number of groups who proclaimed their nationhood—as Jinnah did on behalf of the Muslims of India—for independent statehood. These groups' justification for claiming this right was to have a polity that might serve their interests and achieve economic and social prosperity for them, not for foreign invaders or settlers. Indeed, as discussed in earlier chapters, inappropriate intervention in matters of local health by the British colonial state was as likely to be a source of grievance among Indians as was neglect of the same. Clamouring for independence, would-be nationalists asserted 'that *they* could care for the welfare of "their" populations better than alien colonial governments'.[794]

The ability to determine the ideal political, economic, and social arrangements for public life in one's own sovereign state had been a core reason for undertaking the project of self-

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[792] Partha Chatterjee, 'Whose Imagined Community?', in *Mapping the Nation*, ed. by Gopal Balakrishnan (London, 2012), pp. 216-7. Chatterjee has written extensively on the distinct yet intertwined material and spiritual domains of Asian and African nationalisms in the course of refuting the notion that anticolonial nationalism was entirely derived from Western experience of state-building. He writes that European and American nationalisms had provided the inspiration for the material underpinnings of postcolonial state formation—'the domain of the "outside", of the economy and of statecraft, of science and technology, a domain where the West had proved its superiority and the East had succumbed'. However, another domain of Asian and African nationalisms—indeed for Chatterjee the most powerful and creative aspect of anticolonial nationalism—has been the development of a communal spiritual culture that is decidedly non-Western and wherein the sovereignty of the nation is brought into being.

[793] David Williams, 'Aid and Sovereignty: Quasi-States and the International Financial Institutions', *Review of International Studies*, 26/04 (2000), p. 562

[794] Amrith, *Decolonizing International Health*, p. 10.

determination in Pakistan as well, and the desire was no less acute once independence had actually been achieved. Notwithstanding the minimalist stance of the Muslim League's pre-Partition economic plan with respect to the provision of social welfare by the state, the authors of the country's First Five-Year-Plan fully recognised, 'With the attainment of independence, and the establishment of Pakistan it was natural that hopes should arise of an improvement in the ways of life of the people.'[795] As former colonies assumed their place within the community of nation-states, they also assumed responsibility for ensuring 'national welfare', which also entailed attention to population health.[796] Sunil Amrith has documented how independence in previously-colonised states was followed by the demand for state-run health services. 'Health,' Amrith writes, 'became a part of the broader promise that gripped large parts of the world after 1945: the promise of "development".'[797] This expectation became so pervasive that even poor and economically underdeveloped states became obligated to develop national development and welfare programmes.[798] As Pakistan's first generation of economic planners acknowledged in 1956, 'A democratic and responsive national government could not wait for economic conditions to improve before undertaking the amelioration of their social conditions of life.'[799]

However, the reality that became apparent upon the assumption of independence was that the need to ensure national welfare was at cross-purposes with the desire to throw off all vestiges of imperial control.[800] The obligation to provide for the public welfare propelled requests for help from donors within the international community. The latter were eager to bestow money, but for the pursuance of *specific* strategies for development. On the one hand, having thrown off the yoke of Western imperialism, these decolonised, independent states desired a retraction of interference in the determination of their economic and social goals by the West. On the other hand, by adopting the conventions of modern statehood *from* the West, these states had bound

[795] Pakistan Planning Board, *The First Five Year Plan, 1955-60*, p. 609.
[796] George M. Thomas and Pat Lauderdale, 'State Authority and National Welfare Programs in the World System Context', *Sociological Forum*, 3/3 (1988), p. 388; Porter, 'History of Public Health', p. 15.
[797] Amrith, *Decolonizing International Health*, p. 2.
[798] Williams, 'Aid and Sovereignty', p. 565
[799] Pakistan Planning Board, *The First Five Year Plan, 1955-60*, p. 609.
[800] 'Colonialism must end', *Dawn*, 22 Oct 1950.

themselves to fulfilling social obligations in a manner that necessitated further economic dependence on the West.[801] The resulting ambivalence is reflected in the reaction of developing states to foreign development programmes, as exemplified by the response of Asian states to the Commonwealth Colombo Plan. In the words of one contemporary observer, 'Some Asians will see in it only the hand of British imperialism, especially as it is not aimed at developing national self-sufficiency…[and] will inevitably cry "exploitation," even though Asians helped draft the Plan.'[802] Keeping these developments in mind, this chapter will demonstrate how technical aid in the field of health served as a critical element in the strategic relationship between an under-developed country like Pakistan and the wealthy donors it sought, such as the USA, and the manner in which Pakistani administrators co-opted and challenged the priorities of international development discourses to demand aid to ameliorate shortages with respect to health resources.

How Foreign Aid Became Technical Aid

Pakistan's need for foreign aid was rooted in events that took place before it even came into existence. Because of the stance taken by the British authorities negotiating the transfer of power, India was able to retain supervisory control over those financial resources of the subcontinent which remained to be distributed upon independence.[803] Despite being a sovereign state that was owed its rightful share of all-India's financial resources for the contribution its provinces had made to the economy of colonial India and to Britain's coffers during the Second World War, Pakistan was dependent on India for its financial survival upon independence. To add to the indignity, a few months after Partition, Pakistan was embroiled in a war with its hostile creditor, which also held Pakistan's share of military supplies.[804] Having inherited a

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[801] Sharad Chari, Stuart Corbridge, 'Promethean Visions: Introduction to Part Four', in *The Development Reader* (London, 2008), p. 126. Chari and Corbridge paraphrase Nils Gilman in describing the essential social activities of modern states as promoted by post-war modernisation theory to include 'industrialisation, state-provided welfare, a consensual model of social organisation based around limited class differences, and a high regard for science and expertise as guides to good government.'

[802] Charles S. Blackton, 'The Colombo Plan', *Far Eastern Survey*, 20/3 (1951), p. 31. A Dawn editorial from 1950 noted that Pakistan (and Indian) intellectuals and journalists were vocally opposed to American activities in their countries, and yet both countries were actively seeking aid from the US. 'Editorial: A matter of attitude', *Dawn*, 29 Oct 1950.

[803] Jalal, *State of Martial Rule*, pp. 26-7.

[804] Ibid.

ready-made bureaucratic infrastructure from the British Raj, India could wait out Pakistan's demands for its share of all-India assets while the latter came closer and closer to oblivion.

The only other source of funds that Pakistan could call upon were the sterling balances the British Government owed to its former colony from the money borrowed to finance the World War II effort; unfortunately, agreement over the method and timing for disbursing these was not reached for a long time.[805] Though loans and grants were requested from the United Kingdom, Jalal writes, 'No one in London was prepared to extend credit to a country that seemed such a poor economic bet.'[806] Naturally, relations between Britain and its former colony suffered as a result. Describing a meeting between representatives of the two nations, a Commonwealth Relations Office (CRO) memo noted how the Pakistani diplomat 'recounted at length the familiar complaints of Pakistan against the United Kingdom,' while his counterpart 'wondered whether Pakistan really appreciated just how much had been done for her.'[807]

This sense of being alienated by Britain bled over into the sphere of health. At the instigation of the CRO, which oversaw Britain's relations with the former territories, a team from the British Red Cross (Britcross) had been sent at the end of 1947 to provide medical relief aid to Partition refugees in Pakistan. The renewed fighting in Kashmir in 1949 created a continuing need for Britcross aid for refugees. The help provided by the British Government to this charitable effort was so nominal as to provoke the Chairman of the Executive Committee of the Britcross to complain, '[I]in spite of the fact that the British Government asked us to do this work, the contribution that it made towards the cost was very small and…a great disappointment to us.'[808] The head of the CRO himself made a plea to the UK government to give financial help so as to allow the medical personnel to continue their critical and highly regarded work in Pakistan. He argued that the dearth of medical and nursing staff in Pakistan as well as the universal praise of the work by the Britcross demonstrated that continued support by the British

[805] Jalal, *State of Martial Rule*, p. 47.
[806] Ibid., p. 45.
[807] UK NA, DO 142/180, Note of the Discussion Between Lord Addison and the High Commissioner for Pakistan, 14 Sep 1949.
[808] UK NA, DO 142/293, Draft Letter to Sir Stafford Cripps, 4 Feb 1949.

Government would, at this point, prove very valuable from a foreign relations standpoint. The Britcross's work had been 'a valuable example of Commonwealth fellow feeling which may lose much of its value, in Pakistani opinion, if it is withdrawn while there is still urgent work for it to do.'[809] The letter he received in response from the Treasury stated, 'The UK could hardly be charged with failure to make contributions where there is a refugee problem which is of an international character or too large for the Government directly concerned.'[810] Despite asserting its 'full understanding of the almost impossible burdens placed on the two new Dominion Governments at the very outset of their career', the UK government assumed the position that with the independence of Pakistan and India the residual problems of the subcontinent were no longest its responsibility, but the responsibility of these new governments alone and of the international community if it was willing to help.[811]

Eventually, however, the British came to realize that '[a] militarily and politically weak Pakistan might endanger Britain's long-term strategic interests in South Asia, and also in South-East Asia and the Middle East'.[812] Eager to retain a foothold in the area for itself and its allies, Britain realised that financially desperate Pakistan seemed the logical entry point.[813] The only question was '"what inducements, material, financial, or political" Britain could offer "to persuade them to do what we wanted"'.[814] British policymakers acknowledged that 'the cry that sterling releases are a real contribution on our part is beginning to sound a little thin' and that 'a gesture on our part might be wise.'[815] They found one ideal outlet in the Colombo Plan. It was hailed as 'one of the most ambitious programs' for 'the voluntary assumption by economically advanced nations of increased responsibility for the development of technologically backward areas.'[816] The Colombo Plan reflected the strategic interests of the developed countries in the

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[809] Ibid.
[810] UK NA, DO 142/293, Treasury Chambers to Commonwealth Relations Office, 16 Feb 1949.
[811] UK NA, PREM 8/584, Telegram informing Commonwealth leaders of Attlee's response to requests from Jinnah for assistance in handling partition violence, 20 Sept 1947.
[812] Jalal, *State of Martial Rule*, p. 52.
[813] Ibid.
[814] Ibid., p. 53.
[815] UK NA, DO 35/2724, General review of the Colombo Plan, 1951.
[816] Blackton, 'The Colombo Plan,' p. 27.

formerly colonised countries as well as developmental priorities of the newly-independent Commonwealth nations as it ostensibly aimed to launch 'a comprehensive attack upon the problems of poverty and under-development.'[817] Financing for the proposal relied on Commonwealth donors, but foreign funds were heavily recruited.[818] As the drafters of the proposal put it, 'the Plan as a whole could hardly be carried out without United States funds.'[819]

With a far less taxing expectation of assistance, Britain now seemed to take easily and strongly to the ideological importance of its role as an expected aid giver.[820] While money and goods were in short supply, technical aid was 'well under way and more technical assistance is being offered than is being accepted.'[821] Technical aid involved provision of expertise for planning in economic and social sectors. It covered training of personnel from under-developed countries in the 'more highly developed countries', provision of experts from developed countries to under-developed countries to assist in economic and infrastructural planning, and establishment of training institutes in the latter countries.[822] These being resources that Britain had in surplus, policymakers affiliated with Commonwealth affairs argued that 'it would be wise to bring economic development increasingly into the field of technical assistance.'[823] Policymakers in other developed nations voiced similar sentiments; in the US, President Harry Truman noted in his Inaugural Address in 1949: 'The material resources we can afford to use in the assistance of other peoples are limited. But our imponderable resources in technical knowledge are constantly growing and are inexhaustible.'[824]

Thus, technical aid became a preferred method of aid early on as it enabled former imperial powers to retain influence over their former colonies. With respect to technical cooperation schemes like the Colombo Plan, though it was acknowledged that they were

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[817] Ibid., p. 28.
[818] UK NA, DO 35/2724, General review of the Colombo Plan, 1951.
[819] Blackton, 'The Colombo Plan', p. 30.
[820] UK NA, OD 29/55, W.T.A. Cox to H.N. Roffey, Ministry of Health, International Division, 24 June 1966.
[821] UK NA, DO 35/2724, General review of the Colombo Plan, 1951.
[822] UK NA, DO 35/2714, Advisory Council on Scientific Policy, Fourth Annual Report (1950-1951).
[823] UK NA, DO 35/2724, General review of the Colombo Plan, 1951.
[824] Packard, 'Malaria Dreams,' p. 289.

developed with the input of newly independent states, nevertheless it was also evident at the time 'that some direction has come from the able officials of a British Empire still concerned with retaining markets, gaining allies, maintaining world order, and pursuing diplomatic advantage.'[825] Without having to make costly financial donations for the development of former colonies, '[s]uccessful operation of the Plan would help the United Kingdom to retain its position of *primus inter pares* in the Commonwealth'.[826] Writing of the importance of furthering development activities in India, Pakistan, and Ceylon even in the face of resistance on the part of these countries, officials within the British Government acknowledged that 'it is in our own interests to remove that inertia…but largely for selfish rather than altruistic reasons. On strategic, political and commercial grounds, we wish to maintain our position in the area.'[827]

Significantly, the provision of technical aid to developing countries was made possible by the legacy of developments in international health up to the Second World War and the developing view that health interventions were a distinct but important corollary to the economic and social improvement of the Third World.[828] The mid-1940s were rife with technological developments in medicine which made it possible 'to imagine that the control of infectious disease might be a realistic prospect in large parts of the world.'[829] The same outlook underpinned post-WWII development efforts, which offered rapid economic growth and social change as a salvo for the mass poverty and other social pathologies of the Third World.[830] Technical and scientific matters lent themselves to international cooperation with developing countries like Pakistan. These countries provided the desired environments for bringing to fruition the developing technical expertise of new medical and public health modalities arising

[825] Blackton, 'The Colombo Plan,' p. 31.
[826] Ibid., p. 30.
[827] UK NA, DO 35/2724, General review of the Colombo Plan, 1951.
[828] Chari and Corbridge, 'Promethean Visions', p. 125; Randall M. Packard and Peter J. Brown, 'Rethinking Health, Development, and Malaria: Historicizing a Cultural Model in International Health', *Medical Anthropology*, 17/3 (1997), pp. 181, 188.
[829] Packard and Brown, 'Rethinking Health, Development, and Malaria', p. 185; Amrith, *Decolonizing International Health*, p. 2.
[830] Chari and Corbridge, 'Promethean Visions', p. 125.

out of the West, particularly when the use of these technologies complemented local initiatives in the newly independent nations.[831]

The enumeration of diseases and populations by colonial powers in parts of Asia and Africa had internationalized these areas to global expertise and made them hospitable for the technical advisors and schemes that would come to form an integral aspect of post-war foreign aid.[832] The responsibility of new nations like Pakistan to inaugurate economic and social development within their borders made that expertise relevant and necessary. As explained by Pakistan's chief health bureaucrat, 'The emphasis today is on what they call social medicine and which means the study of the occurrence and prevalence of diseases in the various social and economic groups, the influence of social and economic factors upon health and disease, the methods of providing adequate health care both curative and preventive, to all the population.'[833] The resources needed develop this knowledge was outside Pakistan's financial and professional capacities, and so it turned to Western and multilateral organisations, signifying an implicit faith in the expertise of external organisations in Pakistan's domestic problems. For example, in 1949, the Government of Pakistan resolved to approach the Carnegie and Rockefeller Foundations and the United Nations to request them to undertake socioeconomic surveys of its population and to investigate and analyse the scope of its refugee rehabilitation problem, respectively.[834] At the same time, international health organisations had a prominent hand in raising global expectations of public health and were eager to provide material aid in the form of malariologists, doctors, DDT, antibiotics, and vaccines to meet these rising expectations.[835]

International health aid could also be a politically strategic enterprise on the part of both donor and recipient. The technological optimism resulting from early successes in some public health programmes in combination with the political objectives of superpowers like the United

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[831] Harrison, 'Reframing the History of Health, Medicine, and Disease', p. 671.
[832] Ibid., p. 672.
[833] Government of Pakistan, *Second All Pakistan Health Conference*, p. 24.
[834] NDC, 21/CF/50, Ministry of Refugee and Rehabilitation, Fortnightly Report for fortnight ending 15 Apr 1950.
[835] Amrith, *Decolonizing International Health*, p. 2.

States and the Soviet Union produced material assistance to health campaigns in many newly independent states, with the hopes that this would improve relations with countries regarded as ideological battlegrounds.[836] At the same time, it is clear that Pakistan lobbied hard to qualify as the beneficiary of such politically-motivated aid.[837] A directive sent in 1953 from the Deputy Secretary to the Government of Pakistan to its various ministries, including the Ministry of Foreign Affairs and Ministry of Information, laid out a systematic method of mobilizing foreign public opinion to persuade 'friendly countries' to provide food aid to Pakistan.[838] The missive directed that the concerned ministries should '[e]mphasise that Pakistan is a major bulwark against Communism in this part of Asia.'[839] It further instructed, 'Bring out the fact that (i) at one point West Pakistan is separated from USSR territory by a land strip of only 18 miles…and (ii) East Pakistan is contiguous to Burma, which country is already a hot bed of Communist infiltration and strife.'[840] Simultaneously, Pakistani newspapers carried front page coverage during the 1950s of American adventures in the Far East, quoting diplomats and foreign news agencies that critiqued America's misplaced intervention in Korea and argued instead that Pakistan was far more worthy of American aid in the struggle against communism.[841]

These various considerations informing the relationship between developed and developing countries with respect to public health can be illustrated using the example of malaria. DDT, discovered, in 1939, was an example *par excellence* of the impact of technological developments on the reframing of global public health priorities. The dramatic results in controlling mosquito vectors responsible for spreading malaria were such that in 1947 the WHO's Expert Committee on malaria declared, '[I]t is now possible to attain a degree of practical malaria control, and even of malaria eradication, impossible 15 years ago.'[842] In contrast to this newfound "technological optimism", during earlier periods there was a greater degree of

[836] Harrison, 'Reframing the History of Health, Medicine, and Disease', pp. 671-2.
[837] 'Ispahani: "Problem of Asia more important than that of Europe"', *Dawn*, 6 Nov 1950.
[838] NDC, 48/CF/53, Publicity Regarding Food Situation: Directive, 17 Apr 1953.
[839] Ibid.
[840] Ibid.
[841] '"Pakistan will fight all aggression": Parliament approves stand on Korea', *Dawn*, 12 Oct 1950, p. 1.
[842] Socrates Litsios, 'Malaria Control, the Cold War, and the Postwar Reorganization of International Assistance', *Medical Anthropology*, 17/3 (1997), p. 258.

international ambivalence regarding the most effective approach to the problem of malaria. As discussed earlier with respect to public health in colonial Bengal, debates over the causes of malaria were prominent in regions of malaria endemicity. They were also prominent in international settings such as the League of Nations, where the Malaria Commission in the 1920s played host to debates between western malariologists over whether vector control or rural social uplift was the most effective approach to malaria control.[843] Randall Packard, who has written extensively on the history of malaria, notes that the dramatic results achieved with DDT contributed to the conceptual and institutional separation of malaria control from rural uplift.[844]

The visions of post-war malaria eradication were built on the foundations of a longstanding engagement by western stakeholders with the malaria problem in tropical regions. Under colonial rule, malaria had been naturalised as a by-product of the pathologic environments and climactic conditions of the tropical colonies.[845] Colonial reports had long been citing meteorological conditions and breeding capacities of mosquito vectors in the hopes of tackling the menace of malaria in their colonies, while parts of the local populations had fixated on the problem of impoverishment and failure of colonial economic policies as the cause of malaria epidemics.[846] According to Packard and Peter Brown, the naturalisation of malaria as a by-product of the tropical environment subsequently allowed stakeholders in international health 'to concentrate on mosquitoes and not be concerned with thorny problems of poverty and inequalities in the distribution of land and capital resources', an approach that benefited from the emergence of DDT.[847] Another historical element that informed post-war malaria control was the strong economic logic that had underpinned colonialist approaches to malaria, which had been

[843] Kalinga Tudor Silva, '"Public Health" for Whose Benefit? Multiple Discourses on Malaria in Sri Lanka', *Medical Anthropology*, 17/3 (1997), pp. 195–214; Packard and Brown, 'Rethinking Malaria', p. 184.
[844] Packard and Brown, 'Rethinking Health, Development, Malaria', p. 185.
[845] Ibid., p. 187.
[846] Ibid. The situation in India, as well as the example of C.A. Bentley who was one of the earliest to expose the link between rise in malaria in certain regions and socioeconomic conditions, demonstrate that this binary was not strictly true. Indeed, Bentley had drawn attention to the role played by agrarian decline in the malaria problem, and concluded that development policies were responsible for decreased cultivation and creating situations for malaria endemicity in Western Bengal. See Klein, 'Malaria and Mortality in Bengal', p. 159.
[847] 'Rethinking Health, Development, Malaria', p. 187.

preferentially directed towards plantation and industrial workers whose labour was integral to colonial revenues.[848] In the post-war era, this economic concern remained predominant. Packard quotes the famous American Secretary of State George Marshall who stated in a 1948 address to the Fourth International Congress of Tropical Diseases and Malaria:

> [The tropical regions] produce large quantities of materials required by the industrial areas of the temperate zones, but the potential of the tropics largely remains to be developed. The tropical countries do import industrial products, but the market is only a fraction of what it should be…Little imagination is required to visualize the great increase in the production of food and raw materials, the stimulus to world trade… that would result from the conquest of tropical disease.[849]

In this manner, pre-existing concerns and relationships were revitalized as a consequence of new technologies and new formulations of the economic problems of Asia. Of course, there were also novel developments such as the recognition of a concomitant problem of global food scarcity that lent a new urgency to the malaria issue. Food scarcity grew during WWII and emerged by its end as a preeminent international crisis.[850] In 1947, malaria was cited by the US representative to the WHO Interim Commission as 'a direct and important contributing cause of the current world food shortage'.[851] This led directly to the formation of a joint project between the Food and Agriculture Organization (FAO) of the United Nations and the WHO to launch a malaria demonstration programmes in certain key food-producing areas and assess the impact on production. Added to this was the postwar Cold War environment in which the hearts and minds of millions of newly liberated people became the battleground for competing ideologies, which led to malaria programmes being deployed by Western nations to prevent communist expansion, as was done by the US in Vietnam and Thailand.[852] Packard and Brown note that while integrated programs aiming at social uplift and economic improvement could be seen as statist by Western donors, as matters better left up to the market, the need for immediate intervention to

[848] Packard, 'Malaria Dreams', p. 281.
[849] Ibid., p. 282.
[850] Socrates Litsios, 'Malaria Control, the Cold War, and the Postwar Reorganization of International Assistance', *Medical Anthropology*, 17/3 (1997), p. 259.
[851] Ibid.
[852] Packard, 'Malaria Dreams', p. 283.

attain local goodwill privileged the use of technologies like DDT—quick, cheap, and politically optimal.[853]

This formed the international backdrop to the global campaign for malaria eradication. Newly independent countries like Pakistan seeking help in tackling the problem of malaria within their borders thus found themselves subsumed into a web of pre-existing international relationships and prevailing wisdom regarding malaria. In addition to the strategy of vector control as the primary method of malaria control and eradication programmes, which brought intensive DDT-spraying to Pakistan, the connection between food and malaria and the formation of a formal FAO-WHO alliance also directly impacted the country, particularly eastern Pakistan. Not only was Bengal a region of malaria endemicity, but the eastern half of Bengal, which Pakistan had inherited, had seen rising rates of malaria over the twentieth century even as the western regions improved comparatively.[854] The growing malaria problem afflicting these regions was such that in 1946, nearly 200,000 deaths had been officially recorded due to malaria.[855] Moreover, this same region had suffered the ravages of famine during the 1940s. These legacies Pakistan inherited on independence, and the aftermath impacted the new country as a whole in terms of chronic food shortages. The global anxiety over rising population rates amidst chronic food shortages and the proximity of Pakistan to the USSR further made this populous, food-producing nation an ideal scientific and political test site for the study of the relationship between malaria morbidity and mortality and crop cultivation and production funded by Western monies.

Pakistan lost no time in throwing its hat in the ring as a possible demonstration site for the FAO-WHO programme, its enthusiasm largely borne out of need. In the estimation of its Health Ministry, '[O]wing to lack of funds, trained personnel etc. Pakistan was not in a position

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[853] Packard and Brown, 'Rethinking Health, Development, and Malaria', p. 186.
[854] Fever indices and malaria deaths in the eastern districts of Dacca, Rajshahi, Chittagong, and the Presidency district were kindly provided by Prof. Mark Harrison from the Bengal Public Health Reports for the years 1921-40. While mortality from malaria improved for the most part over these years, with the exception of Chittagong where it was already low, fever indices were on the rise. This was in contrast to the western districts where malaria rates fell over this period.
[855] Ibid.

to give medical relief to more than 10 per cent of its population.' The FAO-WHO project team ultimately did select East Pakistan as a test site in 1949 and began its work in Mymensigh district, in the town of Gauripur. While thankful for its work, Pakistan's Health Minister Habibullah Bahar, who hailed from East Pakistan, complained to the WHO that the methods employed by the agency 'were rather an expensive proposition' and 'not likely to fit in with the economic level of the population'. At a cost of Rs. 1 per head for DDT spraying in the area, it was in fact 'an impossible proposition and could not be applied to the rest of the province'.[856] In light of the economic burden of sustaining anti-malarial operations, further requests were made for aid for the establishment of a Malaria Institute, assistance in the establishment of factory for DDT manufacture, and provision a malaria research team for West Pakistan.[857]

Planning and securing this type of aid, which included medical expertise and equipment, became the primary contribution of Pakistan's Health Ministry to medical and public health activities in the country. The provincial governments were in charge of providing the implements of curative medical relief through building hospitals, training nurses, staffing and maintaining dispensaries, and selecting candidates for medical training.[858] The local governments of municipalities, district boards, and village panchayats were tasked with the provision of preventative health including control of infectious diseases through vaccinations and inoculations, regulation of housing, control of food and water supplies, drainage, and abatement of nuisances.[859] But it was the Central Government that had the wherewithal as well as diplomatic standing to seek international support for designing and financing these medical and public health efforts in the first place.[860] Its codified responsibilities included funding of research and technical training, post-graduate medical education, prevention of infectious diseases, and 'deals with international agencies'.[861] This limited description gives little indication of the broad

[856] NDC, 244/CF/49, Report on the proceedings of the Second Session for the Eastern Mediterranean, 12 Oct 1949.
[857] Ibid.
[858] Government of Pakistan, *Report of the Director General Health, 1960-65*, p. 1.
[859] Government of Pakistan, *Report of the Director General Health, 1947-51*, p. 2.
[860] NDC, 190/CF/54, WHO Regional Sub-Committee: Participation of Pakistan.
[861] Ibid., p. 1.

range of health matters tackled by the Central Government. The Director-General of Health lobbied for seats in developed world educational institutions and specialty training institutes for eligible Pakistanis and for experts or equipment that the country could not locally produce, such as BCG vaccines, DDT manufacturing facilities, cholera research laboratories, and malaria demonstration teams.[862] By 1965, the foremost duty of the Central Government with respect to health was defined as its dealings and agreements with other countries and international organisations.[863] Recounting the attitude of delegates at a Commonwealth Consultative Committee meeting on the question of technical assistance, the UK High Commissioner in Ceylon described Pakistan as 'determined to squeeze [out] the last penny she can.'[864] In this way, technical aid had come to be an important element in the strategic relationship between an eager, under-developed country like Pakistan and the wealthy donors it sought. The domain of public health became an important arbiter of that relationship.

Medical education was one of the most critical item for which Pakistan would seek collaboration and advice from other member states. The Government of Pakistan 'accorded the highest priority to the training of personnel.'[865] With the massive shortage of educational institutions within Pakistan, arrangements for seats in medical schools and training for health workers and health professionals were made with countries like Australia, New Zealand, Canada, and the United States.[866] Though international health campaigns such as against malaria and cholera were focused on a targeted assault on disease-causing parasites by teams of field workers, Pakistan's national health policy was built on the notion that 'without trained personnel it was impossible to plan any assault on disease.'[867] This reflects the extreme shortage of trained medical and public health personnel within the country as well as the legacy of colonial

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[862] NDC, 118/CF/51, Deputation of Major-General S.M.A. Faruki to attend the XIII International Congress of Military Medicine and Pharmacy at Paris; 244/CF/49, Report of proceedings of the Second Session of the Regional Committee for the Eastern Mediterranean.
[863] Government of Pakistan, *Report of the Director General Health, 1960-65*, p. 1.
[864] UK NA, DO 142/213, 'Report for Commonwealth Consultative Committee on establishment of a Technical Assistance Bureau in Colombo
[865] NDC, 244/CF/49, Report of proceedings of the Second Session of the Regional Committee for the Eastern Mediterranean.
[866] Government of Pakistan, *Report of the Director General Health, 1960-65*, p. 1.
[867] NDC, 244/CF/49, Report of proceedings of the Second Session of the Regional Committee for the Eastern Mediterranean.

discourses around public health, and the principle upheld by colonial public health officers that it was through the appointment of trained workers in local settings that public health efforts could be advanced. It also reflects the bureaucratic biases of colonial forms of rule and the immense impact of diarchy on the structure and functions of health policy in independent Pakistan. The Director General of Health of Pakistan initially worked alongside the Health Minister though by 1965 policy at the Centre and in East and West Pakistan was determined by the Health Department solely under the aegis of civil service officers.[868] Unsurprisingly, trained officials brought up in the British tradition remained convinced that only through training more officials could the shortages that limited Pakistan's capacity to provide social services to its citizens be ameliorated.

Following from the malaria expedition, Pakistan became a site for international health fieldwork in the implementation of new kinds of public health measures and affordable techniques to eradicate preventable diseases. In East Pakistan, the WHO again sent a team in 1949 to study the conditions which exacerbated the prevalence of cholera.[869] The WHO, UNICEF, and the Foreign Operations Administration of the US were all called on in 1951 to help create a comprehensive scheme for the provision of preventative and curative services to rural communities in Pakistan where 85 percent of the country's population resided.[870] For their part, instead of incorporating foreign aided programmes into the Central Government's portfolio, Pakistani officials came to see Non-Governmental Organizations (NGOs) and foreign governments as surrogates. Partly this was because, as discussed earlier with respect to malaria, the demonstration programmes and institutes set up by international agencies were too expensive for Pakistan to continue on its own after funds dried up. However, no complementary programmes or activities were proposed for those issues for which other NGOs had established plans, facilities and resources. Foreign aid was requested across all sectors of national public

[868] Government of Pakistan, *Report of the Director General Health, 1947-51*, p.1; *Report of the Director General Health, 1960-65*, p. 1.
[869] NDC, 244/CF/49, Report of proceedings of the Second Session of the Regional Committee for the Eastern Mediterranean.
[870] Government of Pakistan, *Report of the Director General Health, 1960-65*, p. 2.

health, from engineering of sewage and drainage schemes to training of *dais* and nurses to surveys of cholera and venereal diseases.[871]

Health aid was envisioned by Pakistan's diplomats and leaders to be a cooperative enterprise, morally incumbent upon developed nations in light of the globalised dangers of an interconnected world. This is aptly reflected with reference to the example of tuberculosis as described by Pakistan's TB expert Riaz Ali Shah at a Commonwealth conference on combatting tuberculosis in 1955,

> [T]he tubercle bacillus was a universal enemy at perpetual war with mankind. The front line in this war, as in every war, existed where the enemy was the thickest and strongest. This means that the front line in our fight against tuberculosis should be in backward and poor countries such as Pakistan. As the world is fast becoming smaller and smaller and intercourse between countries is increasing, no nation can sit safely behind its borders and feel that what happens to the rest of the world is not its concern.[872]

This was the same logic underpinning developmentism and the justification for intervention in the economic development of poorer countries. It was increasingly being recognised that the development of the 'underdeveloped world' was critical for the economic health of the industrialized world, and the same was true with respect to disease and nutrition in a world threatened by overpopulation, hunger, and communism.[873]

Problems of Aid

There were tensions and abuses that arose from the funnelling of technical aid to Pakistan. In light of the division of responsibility between Centre and province, collaboration with NGOs resulted in a fragmentation of authority and obscured oversight. An inquiry into the position and supply of drugs and medicines in Pakistan in 1956 seems to have been spurred largely by abuses of this kind, with unwarranted requests for foreign aid being made without the Central Government's knowledge by East Bengal.[874] For example, in 1956 the representative of

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[871] NDC, 17/CF/52, Fortnightly report for period ending 30 Nov 1952; 244/CF/49, Report of proceedings of the Second Session of the Regional Committee for the Eastern Mediterranean.
[872] NDC, 147/CF/55, Pakistan's Participation in the IV Commonwealth Health and Tuberculosis Conference: Appendix.
[873] Packard, 'Malaria Dreams', p. 284.
[874] NDC, 321/CF/56, Summary for Cabinet regarding stock position of vaccine, sera drugs and medicine in East Pakistan.

the US Government's International Cooperation Administration (precursor to US Agency for International Development) was contacted by the Government of East Pakistan for assistance in obtaining medicines and drugs costing Rs. 1.66 million.[875] Because this agency's partnership was directly with the Central Government, its representative informed the oblivious Ministry of Economic Affairs as well as the Ministry of Health, demanding that they procure the necessary supply themselves. The UNICEF Mission Chief received a similar request from the provincial government in Dacca.[876] The significance of allowing foreign governments and multilateral organisations to serve as surrogates in the matter of health—one of the most intimate links between state and citizen—is not to be discounted. As one noted Indian malariologist pointed out with respect to malaria eradication activities 'No service establishes contact with every individual home at least twice a year as the DDT service does unless it be the collection of taxes.'[877] Thus, public health programmes provided an immense opportunity for gathering information about and intervening in local communities in these regions.

As a developing country which came into existence with few internal resources to support health services, Pakistan by necessity outsourced a lot of activities such as medical education, drug and medicine supply, and expertise provision to other more developed countries and regional bodies. Nevertheless, the fact that East Pakistan was a site for many of these internationally-sourced programmes, beginning with malaria but eventually coming to encompass cholera, maternal and child health, medical education, sewage, drainage, vaccines, and flood relief, indicates the willingness of the state to cede control to foreign organisations over an area which was plagued with comparatively higher incidences of smallpox, cholera, and malaria compared to West Pakistan, was economically disadvantaged compared to West Pakistan, and was consistently at the mercy of the food surplus provinces in West Pakistan.[878] Furthermore, the use of international aid prompts the question of how it was implemented and

[875] Ibid.
[876] Ibid.
[877] Packard, 'Malaria Dreams', p. 283.
[878] NDC, 28/CF/56, Fortnightly Summaries on the activities of Ministry of Health from Jan 1956 to Jan 1957; Government of Pakistan, *Report of the Director General Health, 1947-51*, pp. 15, 24; Talbot, *Pakistan: A New History*, p. 70.

who actually benefited from these interventions. Malaria and cholera control programmes were intended to increase the food and crop-producing and exporting capacities of East Pakistan. However as Ian Talbot has noted, foreign exchange earned by increasing East Bengal jute exports, for example, were subsequently used for development projects in West Pakistan, leading to charges of 'internal colonialism'.[879] In light of the political distance of East Pakistan from the national capital in Karachi and the subsequent charges of political repression and socioeconomic neglect that would be flung at the national government by Bengalis, the continuing absence of the Pakistani state in alleviating inter-regional socioeconomic disparities or personally discharging its obligations towards ensuring public welfare in this region was ominous. By contrast, the fact that international organisations, while underplaying the socioeconomic causes of ill-health, could swoop in to kill mosquitoes and thereby liberate 'poor malarious people' from their diseased environment had a particularly ennobling effect on their efforts.[880]

Another controversial part of the effort to sustain Western interest was the Government of Pakistan's strategy of portraying their hungry and poverty-stricken citizens as a potential threat to the West in effort to attract aid. The idea that millions of newly independent Asian people were a danger to global peace had been codified in the Colombo Plan, which was itself described as 'a concerted attack on the problems created by Asian poverty and Asian nationalism.'[881] Pakistanis did not shy away from co-opting this rhetoric for its own ends. While the US was marshalling aid to Europe, Pakistan's diplomats argued at the UN and elsewhere that if preventing the spread of communism and agitation due to hunger and poverty was the aim of US aid, then it was being misspent in Europe when it would be more appropriate in Asia. 'There is no better ally of disruption than poverty and ignorance and there are heaps of that in Asia.'[882] There was certainly a real fear within the ruling Muslim League party with respect to growing

[879] Talbot, *Pakistan: A New History*, p. 70.
[880] Packard and Brown, 'Rethinking Health, Development, and Malaria', p. 187.
[881] Blackton, 'The Colombo Plan', p. 28.
[882] UK NA, DO 142/178, Discussions between US and UK on development of India and Pakistan.

domestic communist sympathies by 1951.[883] Nevertheless, presenting Asian poverty and 'backwardness' as a threat to world peace was a deliberate strategy pursued with an eye to increasing foreign investment. In a visit to Washington, DC in 1957, Prime Minister Suhrawardy bluntly stated, '[T]he United States *should* not withhold food grains from Pakistan if it wished to see Pakistan avoid starvation, revolution, inflation and chaos.'[884] Suhrawardy's oblique referral to the threat of communist revolution in Pakistan in the absence of food aid from the developed world is emblematic of the politics of international health aid in the post-WWII period and Pakistan's role in this dynamic. Effectively, the Pakistani government's representatives allied their country's fortunes with a persistent colonial logic, reinforcing the pathologisation of the tropical environment as a site of endemic poverty, disease, and undernutrition, and therefore in dire need of outside intervention and funding. As Sunil Amrith notes, a similar strategy was employed by Jawarhalal Nehru in India as he capitalised on the legacy of European fears of India as a source of contagion—'as an epidemiological heart of darkness'—to justify greater priority for India in the agendas of international health organisations.[885]

The Development of Underdevelopment

Initially, when Pakistan was conducting its relations abroad in light of the urgent need for foreign aid, Europe itself was emerging from crisis. This was a unique moment which preceded the well-entrenched dependency that eventually arose between Pakistan and developed nations afterwards. In 1948, Pakistan's Director-General for Health, Lt.-Col. M. Jafar attended the International Red Cross's conference in Stockholm, Sweden seeking aid for Partition refugees.[886] The purpose of this meeting and of various others hosted by transnational organisations during this time was to deal with the dislocation and humanitarian needs arising

[883] NDC, 172/CF/51, Conference of the Provincial Governors and Chief Ministers held on 4th to 9th April 1952.
[884] United States Department of State. Office of the Historian, *Foreign Relations of the United States, 1955–1957, South Asia, Volume VIII*, ed. by John P. Glennon (Washington, 1987), Document 221. emphasis added.
[885] Amrith, 'Political Culture of Health in India,' p. 117.
[886] NDC, 227/CF/48, Delegation to the International Red Cross Conference, Summary for the Cabinet, Aug 1948.

from World War II.[887] When Pakistan's representatives stepped into these venues seeking ideas and resources for rebuilding, they did so seeing themselves as equal partners, because they remembered themselves as participants in that war. Indeed, even during the war itself, M.A. Ispahani of the Bengal Muslim League had written to Jinnah asking him to seek relief from Europe and America for famine-stricken Bengal which was an ally in the war effort:

> Cannot you draw the attention of Churchill and Roosevelt to the urgency of Bengal's need? Cannot you demand immediate relief? Bengal has become the first line of defence against the Jap[anese]. It is the bounden duty of the United Nations to come to her aid. They *should* bring rice and wheat from the U.S.A., Brazil, Canada and Australia who have more than they require.[888]

Jafar recorded his surprise at hearing in the Refugee Children Committee discussions of only the refugee children of Europe. '[T]he problem of rehabilitation of refugees was not confined only to Europe but existed in other parts of the world, like Pakistan, India, China and Palestine,' he sought to remind his fellow attendees. When asked about what kind of aid Pakistan would benefit from, Jafar responded, 'The need is great, not so much for food etc., but for trained social workers, who could train our people to help themselves.' He went on to say, 'It is my earnest hope that Radda Barnen [Swedish branch of Save the Children] will come to the help of my people as they have done so successfully the suffering children of Europe.' In conveying Pakistan's need it appears he did so not from a sense of his country's relative poverty or backwardness in relation to the nations of Europe, but rather from a shared appreciation of the burdens of (re)building in the aftermath of a crisis. There was something about the immediacy of the war, in which Asians and Europeans and Americans had all taken part, and the unexpected spontaneity of the humanitarian crisis of Partition that allowed Pakistan to momentarily consider itself a nation building up from crisis, rather than a poor country fundamentally different from the developed nations in its foreseeable trajectory. The idea seems not to have caught on yet that there was some particular vision of development to which the country was beholden.[889]

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[887] Ibid.
[888] Zaidi, *Quest for Political Settlement*, Document 6.
[889] NDC, 227/CF/48, Delegation to the International Red Cross Conference, Summary for the Cabinet, Aug 1948.

Though pessimism about the country's existing economic prospects was evident early on, their *chronicity* was by no means a given. This may well have arisen from a fundamental ignorance of the socioeconomic position of the country. Basic information was lacking in the field of human health. For example, the Ministry of Health did not have clear information on domestic rates of tuberculosis incidence and mortality, despite it being generally considered one of the biggest killers of Pakistanis.[890] In the midst of this extensive lack of information, the country's economic planners envisioned making great strides in the field of scientific and technological advancement. Their pronouncements give the impression of an inexperienced government that vacillated between the sombre realities forced on it by the experience of Partition and the excitement of overwhelming possibilities for a brand new country. 'Inasmuch as organized research on a large scale is new to us, we have the advantage of being able to set the standards high at the outset,' the architects of the First Five-Year-Plan wrote of their grand ambitions for developing the country's scientific research capacity.[891] They envisioned the development of a network of laboratories branching out from a centre in the capital in Karachi and establishment of research stipends and foreign study scholarships in universities, laying emphasis on atomic research.[892] The Board displayed a keen interest in promoting research in the pure sciences (as opposed to applied sciences), and proclaimed, 'There is no reason why Pakistan should pass through all the technological stages which have been witnessed in advanced countries.'[893] By telling contrast, Pakistan's Second Five-Year-Plan, unveiled in 1960, unambiguously acknowledged acceptance of the step-wise growth philosophy for developing nations dictated by modernisation theory.[894] The First Five-Year-Plan's Board wrote optimistically with respect to technical progress in 1953, 'We have the advantage of being able to set the standards high at the outset.' In a matter of years their attitude was derided by the

[890] Government of Pakistan, *Report of the Director General Health, 1947-51*, p. 34.
[891] *First Five Year Plan*, p. 443.
[892] Ibid., 439.
[893] Ibid.
[894] Pakistan Institute of Development Economics, 'Pakistan's Second Five-Year Plan (1960-65)', *Economic Digest*, 3/3 (1960), p. 67.

architect of the Second Five-Year Plan as 'a callous waste of money for a poor society.'[895] According to Pakistan's Chief Economist who helped devise the Second Plan:

> It is well to remember the lessons of history and the implications of growth philosophy. During the Industrial Revolution, no one gave much thought to the emergence of slums, the prevalence of bad sanitary conditions, and the need for social security benefits…But the underdeveloped countries today find themselves in a world of national health services, social security benefits, sanitary housing conditions.[896]

The way in which the need for foreign aid and the discourse of development came to inform domestic conceptions of Pakistan as backwards, as an 'underdeveloped' state, can be illustrated using the case study of tuberculosis in Pakistan. Riaz Ali Shah, a TB expert from King Edward Medical College in Lahore, represented British India and Pakistan in multiple annual conferences of the British Empire and Commonwealth nations on tuberculosis and his reports provide a thoughtful rumination on the relationship between disease, "backwardness", and development.[897] TB provides an ideal metaphor for development because during this period, health experts active in the WHO and international health community did indeed use stages of TB control as a measure of the developmental status of nations. As TB expert J.B. McDougall noted in 1952, 'Tuberculosis mortality-rates, with all their defects, still remain the broad criteria which enable us to place countries in some sort of order in the scale of international comparisons.'[898]

Tuberculosis had become an important item on the agenda of post-war international health. The WHO expert committee on tuberculosis which met in 1949 turned its focus to control of tuberculosis in those countries with 'undeveloped and underdeveloped programmes'.[899] Pakistan's health diplomats attempted to further limit the focus within this domain to the

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[895] Haq, *The Strategy of Economic Planning,* p. 36.
[896] Ibid., p. 35.
[897] NDC, 147/CF/55, Pakistan's Participation in the IV Commonwealth Health and Tuberculosis Conference.
[898] J. B. McDougall, 'Epidemiological Factors in Tuberculosis Control', *Bulletin of the World Health Organization*, 7/2 (1952), p. 111.
[899] World Health Organization, WHA3.61, Expert Committee on Tuberculosis: report on the fourth session, 1950 <http://apps.who.int/iris/handle/10665/86301> [accessed 7 July 2014].

underdeveloped countries that lacked established TB control programmes.[900] They drew attention to their impoverished economy, quoting preferentially from other experts who advocated directed greater energy towards 'the less favorably situated parts of the world.'[901] Much as diplomats drove home the point that American dollars ought to be spent in reducing Asian poverty, Shah too proclaimed vociferously, '[T]he front line in our fight against tuberculosis should be in backward and poor countries such as Pakistan.'[902] He reinforced the idea of his country's backwardness with respect to tuberculosis control to demand that these international organisations provide material help 'by sending more units for B.C.G. vaccination, by sending or selling cheaply mobile X-ray units and by sending experts to advise us as to how best to spend and stretch our rupees.'[903] In India, Nehru too used the notion of backwardness to justify international investment in public health works in poorer countries especially. Amrith notes that at the first meeting of the WHO's south-east Asian regional committee, India's leader declared, 'India attaches the greatest importance to the work of the WHO, more especially from the point of view of south-east Asia, which was very backward in health conditions.'[904] He was demanding greater attention to the needs of his region in light of the fact that at this time 'world organisations directed their activities more towards the problems of Europe and America.'[905]

Shah affirmed that nearly all the papers at the 1955 Commonwealth TB Conference treated the relative intensity of the disease prevailing in different areas of the world as being related to economic and social progress, and not related to racial or ecological considerations. According to Shah, as a consequence of the socioeconomic disparity between different regions, '[w]e have, therefore, one set of problems in the technically well-developed countries and a quite different set of problems in the technically under-developed countries,' and this was because the

[900] NDC, 168/CF/49, Participation in the 2nd Commonwealth and Empire Health and Tuberculosis Conference, 1949.
[901] Ibid.
[902] Ibid.
[903] Ibid.
[904] Amrith, 'Political Culture of Health in India', p. 117.
[905] Ibid.

material disparities between the two.[906] This indicated that backwardness was not a sign of delinquency or racial difference or ecological or demographic pressures, but that it was economic poverty that limited social progress.

Shah provided a genealogy of Pakistan's developmental milestones with reference to the stages of tuberculosis incidence and prevention. The discernible development of a nation was perceived to happen as it advanced with regards to the battle against tuberculosis, beginning when 'it first sees tuberculosis at every corner, in every street, in its markets and bazaars.'[907] Eastern countries were at that stage where the high incidence of TB was clearly visible, even if its full account had not been taken. Shah affirmed that this was the state of the disease's endemicity in Pakistan. He wrote,

> [D]uring the past fifteen years when I have been in charge of one of the largest tuberculosis institutions in the Indo-Pakistan subcontinent at Lahore...inspite of the very little that has been done so far to control tuberculosis or to improve the economic condition of the people, the disease has changed. No longer is it a common sight to see hordes of coughing, spitting, emaciated, living corpses sitting, lying or crawling outside the clinis [sic]. In the wards the majority of patients now look remarkably healthy in contrast to the picture obtained fifteen years ago.[908]

He concluded therefore that Pakistan was coming out of a protracted epidemic wave. The next stage of advancement was defined by the ability to seek out and identify cases for isolation and treatment and the last stage was the tackling of primary infections to completely rid the community of the scourge.[909] In all nations, the evolution of the disease and the evolution of measures to combat it would be a sequential process; ascertaining where in the process of controlling TB a nation was at a particular time was the benchmark of its development. But, critically, since backwardness was a matter of a nation's capacity to enumerate and combat the incidence of tuberculosis, poverty was huge force of stagnation and therefore the cause of under-development. In this respect, tuberculosis was different from malaria, which was tied to the tropical environment. TB was a disease that demonstrated that development was a matter of

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[906] NDC, 168/CF/49, Participation in the 2nd Commonwealth and Empire Health and Tuberculosis Conference, 1949.
[907] NDC, 147/CF/55, Pakistan's Participation in the IV Commonwealth Health and Tuberculosis Conference.
[908] Ibid.
[909] Ibid.

economic resources and could be achievable in the same manner as it was in the West. It is remarkable the degree to which this conceptualisation mirrored the ideas of modernisation theory which was also ascendant at this time.

By 1955, the rhetoric of the international community had come to parallel Shah's own preferential use of terms such as 'backward' or 'underdeveloped' in describing the trajectory of health development in countries like Pakistan. Discussions in that year's Commonwealth Conference on TB devoted a whole programme to discussing the various stages that countries went through in their capacities to tackle the problem of tuberculosis.[910] Shah co-opted this paradigm, reporting, '[T]uberculosis is found wherever civilised human beings are found...There are still some pockets of people on this earth whom civilisation has not touched, but they are fast vanishing.'[911] He situated Pakistan in this trajectory of civilisation: 'Fifty years ago, in Europe the tuberculosis position was identical to that of Pakistan today.'[912] With this, he was re-treading the path carved out by European physicians and researchers in the early 20th century who upon finding relatively higher tuberculin-positive results among adults in areas with higher levels of 'civilisation'—as determined by predefined markers of social and economic development—had developed the modern idea that 'tuberculisation was a marker of civilization.'[913] These ideas of disease and development were significant in light of the importance given to TB campaigns in newly independent nations. During the 1950s and 60s, mass campaigns to eradicate tuberculosis became a global phenomenon, especially with the development of the BCG vaccine, featuring in the national health plans of many other developing countries along with malaria, including in Pakistan and in nearby India, which was one of the first to host such a programme.[914]

Conclusion

[910] Ibid.
[911] Ibid.
[912] Ibid.
[913] Mark Harrison and Michael Worboys, 'A Disease of Civilisation: Tuberculosis in Britain, Africa and India, 1900-39,' in Worboys and Larks (eds.), *Migrants, Minorities and Health*, (London, 1997), pp. 99; 103.
[914] Christian W. McMillen and Niels Brimnes, 'Medical Modernization and Medical Nationalism: Resistance to Mass Tuberculosis Vaccination in Postcolonial India, 1948–1955', *Comparative Studies in Society and History*, 52/01 (2009), pp. 181-2.

It is important to analyse the terminology around disease and backwardness in Pakistan because the choice of wording gives indication of how authorities saw the problem of disease within their borders and how they viewed their ability to combat it. Such a discussion also grounds articulations of development by describing to us what that meant in practical ways for policymakers and citizens. In this case, it shows that Pakistan had a responsibility to achieve certain metrics of development arising out of a new global standard of expectations, which its health bureaucrats grappled with. At the same time, other nations had a responsibility to acknowledge their stake in enabling and ensuring that development, especially by providing funds which would enable the underdeveloped state to step out of the cycle of poverty that prevented it from advancing to the active stages of disease eradication. The Health Ministry in all global forums in which its representatives sought aid seemed intent on maximising the use of offered services and justified their claims on this aid by highlighting their country's "backwardness".[915]

Ultimately, however, the discourse around development and the particular relationships within international health that were forged in Pakistan's early years impacted the subsequent trajectory of the country, both politically and in the realm of public health. The history of public health policy in Pakistan during this period can help explain how a postcolonial state eager to provide resources for public welfare became embedded in the post-WWII international discourse of modernisation and development. It shows how a nation conceiving of itself as resource-poor pursued international relationships that reinforced its place and priorities as a 'Third World' or 'under-developed' state. The exchange of health information and resources between countries like Pakistan and their aid partners informed the kinds of Third World pathologies—physiological, behavioural, and environmental—that were eventually identified and targeted for intervention by international aid. It led to Pakistan's concerted involvement during the 1960s in the global population control movement, one of the most prominent and politically charged international health campaigns in modern history. It enabled a military government to undertake

[915] NDC, 244/CF/49, Report of proceedings of the Second Session of the Regional Committee for the Eastern Mediterranean.

one of the most wide-ranging interventions in Pakistani society in the country's history, forever changing the landscape of politics and health in Pakistan.

Chapter 9: Family Planning

> The human and psychological side of development must go hand in hand with the economic development. Non-compliance with this will result either in failure of the development process to take and become self-generating or creation of a menace to freedom. What it amounts to is that people have to develop themselves before they can change their physical environment.
>
> What we need is a pill, and you could make people eat it, and that would be the end of his activities—the husband's. That's the sort of thing I'd like to see.
>
> (Field Marshal Mohammad Ayub Khan)

On October 4, 1958, the *Pakistan Times* newspaper published the following unflattering description of the process of parliamentary government in Pakistan: 'The newly-selected Ministers eagerly mount their hobby horses, fly high up; they feast on the lights, take in the music. Then, the ramshackle structure comes to a creaking halt. We see a scramble for the next ride; some are dragged off their seats, some cling on.'[916] Even as the functioning of government had become effectively paralyzed, '[t]he ministerial merry-go-round goes on and on.' Three days later, the President of Pakistan, Iskander Mirza, declared martial law in the country, abrogated the constitution, and dismissed the Constituent Assembly, the elected, legislative branch of government. Exactly twenty days later, the Sandhurst-educated head of the Pakistan Army, Field Marshal Mohammad Ayub Khan took the reins of power in a bloodless coup, the first in Pakistan's history, and remained President of Pakistan for 11 years. The experiences of that era did not prove fleeting; Pakistan experienced two more outbreaks of military rule, the most recent period of military rule ending only in 2008.

In the decades since his reign, Ayub Khan has acquired a reputation as a benevolent dictator, one who used his undemocratic powers in the service of socioeconomic progress, with varying successes.[917] At the time, his ambitions, his seizure of power, and his style of governance led to him being sarcastically referred to by his opponents as 'Ayubshahi'—King Ayub.[918]

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[916] Khalid Bin Sayeed, 'Collapse of Parliamentary Democracy in Pakistan', *Middle East Journal*, 13/4 (1959), p. 400.
[917] Ayesha Khan, 'Policy-Making in Pakistan's Population Programme', 11/1 (1996), p. 32; Shuja Nawaz, *Crossed Swords: Pakistan, Its Army, and the Wars within* (Karachi, 2008), p. 244.
[918] Ayesha Jalal, *Struggle for Pakistan*, p. 106.

Nevertheless, Ayub's reign in Pakistan was presented as 'the decade of reforms and development', and is still nostalgically remembered as such.[919] Many international and domestic political commentators who were cautiously in favour of the coup at the time concluded, 'Ayub's regime may have been undemocratic, increasingly corrupt, and beholden to the United States but it also ended a decade of inactivity, democratic failure, and zero "development".'[920] Or as lay Pakistanis who lived through his reign put it: 'At least he did something.'[921] Under the aegis of this military moderniser, major development programmes were freed from the 'day to day bickering of the politicians'.[922] It was said of Ayub's Cabinet, '[B]esides the Generals, there are men of first-rate technical and administrative ability.'[923] This presumed technical and administrative competence became a powerful trope that served to elevate the prestige of the armed forces. As one Western commentator noted, 'The government and politicians were despised. In contrast, the army gained prestige. *For the army was conspicuously efficient*.'[924] The contention that the Army's efficiency makes it superior to elected politicians for governing the country has arguably enabled the military to commandeer a disproportionate degree of national resources towards defence and military welfare.[925]

The significant role played by the military in domestic politics has been one of the most important aspects of governance in Pakistan.[926] Yet few studies have attempted to study the Ayub era in detail, and no attempts have been made to explore the social impact of military rule in under his leadership.[927] Ayub's political goals and his self-professed commitment to scientific

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[919] Naveeda Khan, 'Future Imbued Movement: Ayub Khan's Legacy for Pakistan,' unpublished manuscript, Johns Hopkins University, 2009, pp. 1-38; Altaf Gauhar, *Ayub Khan: Pakistan's First Military Ruler* (Lahore, 1998).
[920] Markus Daechsel, 'Sovereignty, Governmentality and Development in Ayub's Pakistan: The Case of Korangi Township', Modern Asian *Studies*, 45/01 (2011), p. 132.
[921] Khan, 'Future Imbued Movement,' p. 3.
[922] Albert Gorvine, 'The Civil Service under the Revolutionary Government in Pakistan', *Middle East Journal*, 19/3 (1965), p. 325.
[923] Sayeed, 'Collapse of Parliamentary Democracy in Pakistan', p. 405.
[924] Guy Wint, 'The 1958 Revolution in Pakistan,' (*St. Antony's Papers*, 1960), pp. 76-7 qtd. in Samuel Edward Finer, *The Man on Horseback: The Role of the Military in Politics*, (New Brunswick, 2009), p. 82. Italics added.
[925] Tariq Ali, 'The Colour Khaki', *New Left Review*, 19 (2003), p. 13.
[926] Farzana Shaikh, 'Pakistan between Allah and Army', *International Affairs*, 76/2 (2000), pp. 325–32.
[927] There is a preponderance of works on the historical and contemporary role of defence and the military in politics in Pakistan. Some of the most salient are: Nawaz, *Crossed Swords*; Jalal, *State of Martial Rule*;

planning and economic growth greatly impacted population health in Pakistan. Health care in the country in the 1960s was characterized by an emphasis on research, planning, and development—the trifecta underlying Ayub's vision of strong, enlightened, scientifically sound, and progress-oriented governance for the whole country. This era saw the establishment of national disease eradication programmes aimed at malaria, cholera, smallpox, tuberculosis, and other threats to economic productivity such as hunger and population growth. External expertise and funding provided the blueprint and fuel for increasingly sophisticated and ambitious health goals for the country. Researchers, vaccinators, doctors, and *dais* administered surveys, injections, pills, and Intrauterine Devices (IUDs) in an ambitious attempt to eradicate the two major causes of human misery—poverty and disease. Meanwhile, Pakistan came to play an increasingly prominent role as a testing ground for demographic data collection and disease and population control in the developing world.

These ideologies and efforts were most strongly channelled towards the inauguration and implementation of a national family planning programme in Pakistan aimed at reducing the national population growth rate. As Ayesha Khan has explained in her brief overview of the trajectory family planning efforts in Pakistan, the strong leadership role assumed by the President of Pakistan and the inordinate role played by international actors in the 1960s 'brought a level of credibility and publicity to family planning which has never been achieved again since.'[928] The family planning programme therefore provides an important case study of the priorities and policies of the military government in the sphere of health. A detailed analysis of this and other major public health programmes in the 1960s shows that while public health policy in the era of military rule was centralised under a small corpus of non-elected officials at the national level, the funding and operation of domestic health priorities was in fact being increasingly determined by international actors, including foreign governments. Furthermore, the use of financial

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Ayesha Siddiqa, *Military Inc.: Inside Pakistan's Military Economy* (London, 2007). Yet as Ian Talbot notes, no significant analysis of Ayub's rule has been published since Lawrence Ziring's *The Ayub Khan Era* (Syracuse, 1971).

[928] Khan, 'Policy-Making in Pakistan's Population Programme', p. 33; Shahid Javed Burki, 'Population as an Asset', *The Express Tribune* (5 May 2014) <http://tribune.com.pk/story/704142/population-as-an-asset/> [accessed 7 September 2016].

incentives and political coercion to enforce behavioural change challenges prevailing notions of military efficiency and scientific planning in the sphere of public health and reveals the persistent difficulties of the state in making its health priorities relevant in the politically aloof rural areas.

Major Trends in Public Health: Cholera and Malaria

The period between 1959 and 1968 saw heightened government activity in the social sector, with the increase in activity coinciding with the stimulus provided by the nation's Second Five-Year Plan for economic development covering the years 1960-65. The cornerstone of the new health policy became a core set of top-down programmes focusing on the eradication of specific disease and promotion of certain health behaviours; these programmes grew out of pre-existing partnerships with international health stakeholders such as the WHO and UNICEF but also from new alliances with regional blocs.[929] The programmes encompassed malaria eradication, cholera research and control, smallpox control, nutrition research, rural health programs, and family planning.[930]

These initiatives shared some cardinal features. There was a great dependence on international design and planning, making countries such as Pakistan a laboratory for experiments and field studies in the scientific and political problems of Third World nations. Diplomatic forums became a preferred venue for the exchange of development aid and expertise between governments and philanthropic organizations. They provided the milieu in which demographers, scientists, economists, clinicians, diplomats, and donors devised comprehensive disease eradication programmes reflecting international priorities in social and economic development.[931] These programmes utilised available technologies to target specific diseases, obviating the need to create functioning health systems.[932] The examples of cholera and malaria provide two notable examples of these developing trends in Pakistani public health programmes.

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[929] Sunil Amrith, *Decolonizing International Health*; Paul Weindling, 'From Disease Prevention to Population Control: The Realignment of Rockefeller Foundation Policies 1920s–1950s', in *American Foundations and the Coproduction of World Order in the Twentieth Century*, ed. by John Krige and Helke Rausch (Germany, 2012), pp. 125–45.
[930] Government of Pakistan, *Report of the Director General Health, 1960-65*, p. viii.
[931] Randall Packard, '"Roll Back Malaria, Roll in Development"? Reassessing the Economic Burden of Malaria', *Population and Development Review*, 35/1 (2009), p. 60.
[932] James L.A. Webb, Jr., *The Long Struggle Against Malaria in Africa*, (New York, 2014), p. 69.

Cholera, endemic in certain areas of the subcontinent, flared up again in West Pakistan in 1958, coincidentally the year of Ayub's coup. Pakistan at this time was a new member of the Southeast Asia Treaty Organization (SEATO)—an organisation dedicated to preventing communism from gaining ground in the region. As a consequence of its timely epidemic and its geopolitical relationship with the US through SEATO, Pakistan was able to garner epidemiological interest from United States' National Institutes of Health (NIH) leading to the establishment of a research and technical aid programme for cholera and the creation of a Cholera Research Lab (CRL) fully funded by the NIH. 'Eminent scientists of international repute have been assigned to the Laboratory' reported the DGH demonstrating that the US and 'other friendly' countries such as the UK and Australia provided a research laboratory for developed world researchers.[933] In the period under study, there was a significant reduction of case-fatality ratios from cholera, from a low of 65.73% during the post-independence decade to 19.35% at the end of Ayub's reign with the advent of oral rehydration therapy.[934]

The Malaria Eradication Programme (MEP) provides further illumination of international involvement in public health in Pakistan. The MEP was a mass eradication campaign that spanned both wings of the country and aimed to cover millions. As Randall Packard has shown, one of the important justifications given for promoting malaria research and eradication in the developing world in the early 20th century was that this disease hindered economic advancement at the national level.[935] In Pakistan, malaria was implicated not only in labour absenteeism and national economic productivity, but also in the country's contribution to the global food supply, as indicated in the following comment from the country's top health officer:

> [V]ast agricultural fields used to remain uncultivated due to absenteeism and loss of man-days. Timely sowing and harvesting was a great problem. This had affected seriously the agricultural output of the country. Labour population of industries mainly come from rural areas where they are exposed to malaria infection which caused considerable drop of production in this field as well…and also in the gigantic

[933] Government of Pakistan, *Annual Report of the Director General Health, July 1969-June 1970* (Rawalpindi, 1971), pp. 21, 23.
[934] Ibid., p. 21
[935] Packard, '"Roll Back Malaria, Roll in Development,"' p. 57.

> construction projects requiring aggregation of labour which had a far reaching effect on socio-economic condition of the country.[936]

The problem of malaria was also fraught with international political consequences with respect to Western and Third World elites' anxieties about the danger posed by Third World populations.[937] The liberation of large swathes of the globe from colonial domination had given rise to anxieties about a 'hungry and volatile "Third World".[938] This existential fear was paired with a prejudiced view of the wretched and miserable state of life in the Third World: 'Although Asia hungered for progress and power, it was a place of pain and pathos, unable to feed its people not because there was insufficient land but because it lacked efficient methods of cultivation and distribution.'[939]

The US and WHO had a major stake in the Pakistani malaria program since their resources were providing the material impetus for the program.[940] Consequently, their demands became unyielding: '[A] M.E.P. is a major program of national interest and an emergency one. It, therefore, needs the active and unstinted cooperation of all government departments. If a government is not aware of these needs, it should refrain from attempts at eradicating malaria or be prepared to fail in the attempt.'[941] The DGH Pakistan wrote,

> [T]he international agencies, *viz.* WHO and US AID before committing their assistance for the Scheme had obtained assurance from the Government of Pakistan that firstly the Plan of Scheme prepared in collaboration with WHO would be implemented without any material change [and] uniform thoroughness [sic] in implementation is achieved in both wings of the country.[942]

On the basis of this assurance, '[c]onsiderable powers on personnel and finances were vested in the Central Board.'[943] This strengthening of federal powers through the implementation of a national malaria programme also occurred in India. Though the DDT programme enjoyed

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[936] Government of Pakistan, *Annual Report of the Director General Health, 1970-71* (Rawalpindi, 1972), p. 16; *Annual Report of the Director General Health, 1966-67*, p. 41.
[937] Cullather, *The Hungry World: America's Cold War Battle against Poverty in Asia* (Cambridge, MA, 2010), p. 2.
[938] Matthew Connelly, *Fatal Misconception: The Struggle to Control World Population* (Cambridge, MA, 2008), pp. 474, 476.
[939] Cullather, *The Hungry World*, p. 2.
[940] USAID, PDABJ108, Capital Assistance Paper: Pakistan, Malaria Eradication Program <http://pdf.usaid.gov/pdf_docs/pdabj108.pdf> [accessed 7 May 2014].
[941] Ibid.
[942] Government of Pakistan, *Annual report of the Director General of Health, 1966-67*, p. 30.
[943] Ibid.

immense successes, eventually the weakness of the health infrastructure as well as the culture of apathy and neglect caught up with the planners.[944]

For the MEP to be successful, it required deep surveillance, accurate and speedy enumeration, and transnational coordination.[945] It brought government health workers to the doors of rural residents, with millions of Pakistanis in both wings of the country having their blood microscopically investigated for the presence of the malaria parasite.[946] From the outset, the MEP encountered hostility in West Pakistan. The provincial authorities requested that the scheme be modified based on the understanding that they did not have enough personnel to visit every household per the fortnightly requirement of the WHO program, while also realizing that funds were being diverted from other local health schemes, including the establishment of health centres which were considered necessary for consolidating the gains from the eradication program. Simultaneously, the programme's costs were rising as DDT resistance began to develop.[947]

Nevertheless, great gains were made in Pakistan, as rates of malaria declined.[948] Following the DDT spraying campaign in East Bengal, a 15% increase in rice harvest was reported, providing support to economic rationales for malaria programmes.[949] Such was the case in other developing states, including Indonesia where the protection of one million people by antimalarial operations led to increases in production of rice and export of rubber and palm oil. The Deputy Director of the US Technical Cooperation Assistance mission to Indonesia declared, 'In areas where DDT-house-spraying activities have been carried out, once-idle rice fields have been brought back under cultivation and new rice fields opened up.'[950]

The programme was an apt illustration of the workings of international frameworks of collaboration between developing countries and international aid-providing organizations and the

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[944] Amrith, 'Political Culture of Health in India,' pp. 117-9.
[945] USAID, PD.ABJ-108, Capital Assistance Paper: Pakistan, Malaria Eradication Program.
[946] Ibid.
[947] Ibid.
[948] Government of Pakistan, *Annual Report of the Director General Health, 1966-67*, p. 43
[949] Packard, '"Roll Back Malaria, Roll in Development,"' p. 59.
[950] Ibid., p. 60.

economic logic these collaborations. However, by the mid-1960s, the United States had ceased to continue funding MEPs in light of dubious evidence that malaria eradication was actually responsible for economic gains.[951] Instead, the new cause célèbre became family planning. Critics of disease eradication programmes had long warned that decreasing deaths from disease would worsen overpopulation and lead to more famines and unrest. When USAID, the largest funder of malaria eradication programmes worldwide, cut back funding for the MEP, it did so in order to funnel resources towards family planning.[952] Other international actors, such as the Food and Agriculture Organization of the United Nations (FAO) also left aside disease eradication as a means of promoting agricultural productivity and instead focused on encouraging use of green revolution technologies towards enhanced crop production.[953]

Family Planning

The articulation of a population crisis in the 1960s cannot fail to feature prominently in a discussion of post-war development and modernisation efforts in Pakistan. Discussions of the population problem were bound up in Western and Third World elite anxieties about developing world populations as well as faith in the promises of technology as noted by Matthew Connelly and Nick Cullather in their histories of the developed world's preoccupation with the population question and food production leading up to the Cold War.[954] Connelly notes that Britons and Americans involved in international family planning efforts had often participated first in national family planning efforts in their home countries, which has been demonstrated by Annika Berg and Sunniva Engh with respect to Swedish family planning experts whose international work in family planning in India, Sri Lanka, and Pakistan was a continuation of their domestic efforts.[955]

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[951] Randall M. Packard, 'Malaria Dreams: Postwar Visions of Health and Development in the Third World', *Medical Anthropology*, 17/3 (1997), p. 284.
[952] Ibid., pp. 286-7.
[953] Ibid., p. 287.
[954] Connelly, *Fatal Misconception*; Cullather, *The Hungry World*.
[955] Annika Berg, 'A Suitable Country: The Relationship between Sweden's Interwar Population Policy and Family Planning in Postindependence India,' *Berichte Zur Wissenschaftsgeschichte*, vol. 33, no. 3 (2010), p. 299; Sunniva Engh, *Population Control in the 20th Century: Scandinavian Aid to the Indian Family Planning Programme* (doctoral dissertation, Oxford University 2005), chaps. 4–5.

With respect to the history of family planning and population control in South Asia, David Arnold has analysed official colonial attitudes toward issues of reproduction and population within the Indian Civil Service and Indian Medical Service, finding a shift in thinking in the 1920s as public health officials began to note a 'population problem' for India.[956] Rahul Nair adds that the focus on India's population problem stemmed from concern regarding India's high rates of infant and maternal mortality. As Paul Paustian noted in 1931 with respect to rural Punjab, 'The unsanitary conditions necessitate a heavy birth-rate, and a heavy birth-rate, owing to the risks run at each birth, causes a heavy death rate among women.'[957] Significantly, the focus on the population problem was tied to the desire of colonial officials to maintain centralised control over health policy in the context of constitutional devolution of power, an issue discussed in chapter four. The population issue would highlight the importance of coordinating public health on an all-India basis.[958] Nair writes of their failed efforts, 'Ironically, it would be in an independent India that the central Health ministry would achieve its most prominent and distinguishing role in the formulation and coordination of population control under the rubric of family planning for the entire nation.'[959] This would also be the case for Pakistan.

The history of western efforts towards fertility control in South Asia date from the colonial period when Margaret Sanger's birth control efforts found their way to clinics in India where locals, especially upper-caste Hindus, absorbed discussions of fertility regulation as related to eugenics. In advance of independence, the Congress Party's National Planning Committee produced recommendations calling for selective sterilisation of certain groups. This legacy explains why independent India took the lead in implementing population control measures, being the first country to obtain family planning advice from the WHO and inviting the first field study by the UN Population Commission. Its earliest leaders, including Nehru,

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[956] Arnold, 'Official Attitudes to Population, Birth Control, and Reproductive Health, 1926– 1946', in *Reproductive Health in India: History, Politics, Controversies*, ed. by Sarah Hodges (New Delhi, 2006), 22–50.
[957] Paustian, *Canal Irrigation in the Punjab*, p. 100.
[958] Rahul Nair, 'The Construction of a "Population Problem" in Colonial India 1919–1947', *The Journal of Imperial and Commonwealth History*, 39/2 (2011), pp. 227–47.
[959] Ibid, p. 241.

openly favoured birth control and measures to limit the excessive population.[960] Amrith notes that there was historical momentum behind postwar population control programmes in India and to a lesser degree in South Asia at large because 'there had long been a constituency of administrators and activists interested in birth control and who perceived population growth as a threat to national welfare.'[961]

Pakistan by contrast does not appear to have experienced a similar type of transition from pre-independence family planning discourses/efforts to post-independence national programme. Family planning efforts in Pakistan were rooted in a small home-grown initiative that arose in the early 1950s directed towards urban women as demonstrated by the location of the clinics in major cities before American backers entered the scene. This initiative was the product of efforts by elite women in Pakistani society, wives of politicians as well as prominent lawyers and businessmen.[962] The most influential personality in this regards was Begum Saeeda Waheed, the wife of a Lahore businessman who purportedly became an advocate of birth control after her maid died attempting to abort a fourth pregnancy.[963] There was a shared similarity in this respect with the landscape of family planning in India, where prominent public-private networks of individuals also formed the basis of support for family planning organisations.[964] For Begum Saeeda, 'The original logic for beginning the work was simply the shock of discovering that a woman should have to risk taking her life to control her own fertility'.[965] The records of the Population Council add a different explanation, noting, 'In 1952 particular concern for the misery caused by too frequent childbearing among families of the refugee colonies resulted in the organizing of family planning services in Karachi, Lahore and Dacca'.[966] The Family Planning

[960] Matthew Connelly, 'Population Control in India: Prologue to the Emergency Period', *Population and Development Review*, 32/4 (2006), pp. 631-2.
[961] Amrith, *Decolonizing International Health*, p. 173.
[962] Khan, 'Policy-Making in Pakistan's Population Programme', p. 31; Population Council [hereafter PC], Acc 1, box 24, fo 361, Pakistan, 1954-1958: WPM Notes, Conference with Family Planning Association Personnel, 30 Apr 1958.
[963] Dawn, <http://www.dawn.com/news/705319/profile-purposefully-active>; A. Khan, 1996, p. 31
[964] Connelly, 'Population Control in India,' p. 644.
[965] Khan, 'Policy-Making in Pakistan's Population Programme', p. 31.
[966] PC, Acc 2, box, 130 fo 1252, Dr. J. Gilbert Hardee: Pakistan Country Profile, May 1969.

Association (FPA)'s family planning clinics in Karachi tended to attract low middle class clientele, much like in the US.[967] Eventually, family planning would evolve from its middle class orientation as it gained international patronage, becoming more strongly intertwined with antipoverty efforts aimed at reducing the number of births to poor families, which in Pakistan were presumed to be located in rural areas, as compared with the US where family planning in the public health context was aimed at urban areas and African American communities.[968]

W. Parker Mauldin, a representative of the Population Council of New York (PC) who eventually came to manage much of the collaboration in family planning between Pakistan and the US, wrote to Begum Saeeda personally when he made plans to visit Lahore in 1958 as well as the wife of one-time Governor of East Pakistan and later Prime Minister Firoz Khan Noon, Begum Viqar-un-Nisa Noon, who visited the headquarters of the Population Council in New York in March of 1957. At the time Begum Viqar un Nissa described attitudes towards family planning in the country as follows: '[T]here has been no religious opposition voiced to these family planning clinics although, of course, there is a cultural opposition to them in the sense that a typical attitude is "it is Allah's will".'[969] The activities of the FPA were modest, their chief clinic 'located in a somewhat inaccessible area, inaccessible to the masses.' This and six other clinics were open for a few hours in the morning rendering free services and by appointment in the evenings for paying customers with two female doctors whose primary operations consisted of fitting diaphragms and giving foam tablets.[970]

The Population Council's interest in Pakistan stemmed from a desire to undertake demographic and statistical research that would determine knowledge of and attitudes towards family planning among people in Pakistan as part of its broader preoccupation with the

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[967] PC, Acc 2, box 139, fo 1320, Dr. Samuel M. Wishik, Reports, 1963-1965: Quarterly Report to Population Council for Period Oct 15-Dec 31, 1963, p. 11.
[968] Jennifer Nelson, '"Breaking the Chain of Poverty": Family Planning, Community Involvement, and the Population Council-Office of Economic Opportunity Alliance',*Journal of the History of Medicine and Allied Sciences*, 69/1 (2012), pp. 101–34.
[969] PC, Acc 1, box 24, fo 360, Pakistan, 1954-1958: WPM to FO, 28 Mar 1957, Subject: Visit of Lady Noon of Pakistan to The Population Council March 26, 1957.
[970] PC, Acc 1, box 24, fo 360, Pakistan, 1954-1958: WPM Notes, Conference with Family Planning Association Personnel.

population crisis in lesser developed countries.[971] Mauldin had ample help on the ground as the population control movement spread via a web of personal and professional links from New York to Islamabad based on a bedrock of pre-existing technical aid partnerships. Writing to Mauldin in 1958, a Pakistan-based official from the International Co-operation Administration (ICA), a USAID precursor that disseminated technical aid on behalf of the US to Pakistan, noted optimistically, 'Your visit to Pakistan should help to stir up the kind of interest in demographic research that some of us in Pakistan are trying to stir up.'[972] He referred Mauldin to officials in the University of Punjab's Institute of Statistics, at the Health Directorate and the Population Census Office, as well as the Central Statistical Office who were interested in questions of demography, almost all of them exclusively statisticians. A prominent role was also played by M.L. Qureshi, Chief Economist of the Planning Board, who met with Mauldin to discuss the lack of national data or ongoing research in Pakistan on rates of population growth, which later spawned a seminar on economic development and family planning in Karachi in 1959 in collaboration with the Pakistan Institute of Development Economics and the Population Council.[973]

These were the origins of family planning and population control activities in Pakistan, which were promoted and expanded by the Population Council of New York through creating links between important stakeholders in Pakistan's inner circle of government and society. However, the political impetus for the establishment of a formal national program for family planning actually came with the rise to power of Ayub Khan. In 1961, on a state visit to the US, President Ayub held a frank discussion about Pakistan's overpopulation problem with journalists at the National Press Club, remarking that 'unless there was population control in his country of

[971] PC, Acc 1, box 24, fo 360, Mauldin to Lady Noon, 8 July 1958. For history of the Population Council, see Judith Nagelberg, 'Promoting Population Policy: The Activities of the Rockefeller Foundation, the Ford Foundation and the Population Council 1959-1966', PhD thesis, Columbia University, NY, 1985. The following are primary accounts: Oscar Harkavy, *Curbing Population Growth: An Insider's Perspective on the Population Movement* (New York, 1995); Frank W. Notestein, 'The Population Council and the Demographic Crisis of the Less Developed World', *Demography*, 5 (1968), pp. 553–60.
[972] PC, Acc 1, box 24, fo 360, Roe Goodman to W. Parker Mauldin, 16 Apr 1958.
[973] PC, Acc 2, box 24, Folder 360, Mauldin to M.L. Qureshi, 25 July 1958; M. L Qureshi, *Population Growth and Economic Development with Special Reference to Pakistan* (Karachi, 1960).

94 million, economic aid and development funds would be eaten up by population growth rather than contribute to higher living standards.'[974] Mindful of the country's needs and deficits, Ayub laid much rhetorical emphasis on the scientific basis of development and set about reforming administration, research, academia, and agriculture in Pakistan. His establishment of a Scientific Commission was one of the first orders of business of his regime in 1959; its terms of reference were to develop facilities for 'the utilisation of the results of research in a way which would contribute to the development of the country.'[975] This demonstrates that the transformation of the international population control cause from rhetoric to reality could not have taken place without the firm commitment of Third World leaders like Ayub. While the United States provided more than half of all international aid between 1968 and 1976, it was countries like Pakistan that chose to accept that foreign aid on the condition of implementing family planning programs.[976] Writing about the role of indigenous elites in the population control movement in Third World countries, Connelly writes, 'They took pride in exercising leadership in a population crisis they considered more grave than the Cold War.'[977] Indeed, the departure of imperialists had left a problematic void of central authority in states like Pakistan. Into this newly emergent void stepped strongmen like Ayub who filled a critical niche in his country when it came to large scale programs for development. As one international newspaper put it, 'Today Ayub is just as absolute a dictator as is Francisco Franco in Spain or Benito Mussolini ever as in Italy. And, just as Mussolini became famous for at least making the trains run on time, Ayub is cleaning up the city of Karachi.'[978]

Leadership and Conflict

Initially under the new military government, population growth did not feature prominently as a crisis. According to Lee Bean of the Population Council, this was due to the time it took for Government planners to accept the alarming population growth rate of over 3%

[974] 'Pakistan head asks for aid in birth control', *Ottawa Citizen*, 13 Jul 1961.
[975] Government of Pakistan. Ministry of Industries, 'Report of the Scientific Commission of Pakistan', *Minerva*, 1/1 (1962), p. 75.
[976] Connelly, *Fatal Misconception*, p. 480
[977] Ibid., p. 481
[978] 'President Ayub keeps firm grip on Pakistan', *The Bulletin*, 7 Deb 1959.

per year.[979] Foreign, non-state actors operating in Pakistan were instrumental in convincing the top-level leadership in the country that family planning ought to be an actionable item in Pakistan's domestic program of development. These advisors, such as the ones from the Harvard Advisory Group (HAG), were strong advocates for state intervention in the economy and enjoyed the favour of the Pakistani President.[980] Ayub would go on to become a vocal advocate of family planning efforts, and described the spectre of overpopulation in blunt terms in public forums and speeches. He warned, 'If our population continues to increase at the present rate it will ultimately lead to a standard of living which will be little better than that of animals.'[981] For this frankness, he was lauded by observers in the US and elsewhere who expressed admiration for this dictator for 'persuading his Moslem countrymen to overcome their religious scruples and accept birth control'.[982] They agreed that the nascent family planning programme 'owes a great deal to the strong lead and backing of the president.'[983]

Government's role, encouraged by philanthropic organizations, was to give sanction and administrative support for deeper penetration and implementation of family planning in Pakistan society as a method of population control on a large scale in the country. Researchers from the US and their partners were tasked with developing and applying methodologies from the social sciences to gather data on family planning and population growth in the country and to develop strategies to promote take-up of family planning ideas and methods. Family planning (FP) agents who delivered the actual services and collected data on the ground, such as physicians, lady health workers, and *dais*, were driven by career interests as well as monetary incentives.[984] This design was ultimately implicated in producing a fractured programme with multiple and competing motives and aims.

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[979] PC, Acc 2, Box 128, fo 1216, Dr. Lee L. Bean: End of Tour Report, Bean to JCC.
[980] Nausheen
[981] 'For Population Control, *The Pittsburgh Press*, 22 Apr 1963.
[982] 'Nation's President Cited: Pakistan Effort to Boost Birth Control is Praised', *Toledo Blade*, 8 Sept 1968.
[983] Ibid.
[984] PC, Acc 2, Box 138, fo 1305, A.P. Satterthwaite 1971: Observations arising from the Pakistan experience.

On the ground, the programme was rooted in research originating in university pilot research projects in East and West Pakistan carried out by the University of California School of Public Health and the Johns Hopkins University School of Hygiene, respectively, in health education and motivation as well as rural family planning activities. Foreign advisors sent on behalf of the Ford and Population Council were not content with merely promoting family planning. Rather, they wanted to understand it as a social problem and a political one as well. Population Council representatives were interested in questions such as: 'How does a Government do a family planning program, since family planning clearly deals with strictly personal decisions?'; 'How do we get a government organization for family planning staffed and trained?'; 'How do we get medical answers?'; 'How do we get the sociological answers?'[985] The benchmarks for progress reflected these open-ended inquiries as they sought to measure whether the purposes of the programme had been accepted by key local people, whether suitable legal bases existed, what the professional qualifications of staff were and their standing in the local community, the feasibility of long term institutional plans, and lastly, concrete results in economic or other terms. Moreover, they were interested in locating where the "talent" for this sort of work could be found in Pakistani society—the academics and researchers and training supervisors—and how to cultivate it, attract it, and enable it to achieve program purposes.[986] Knowledge of Pakistan, not just the national fertility rate and population numbers but also the state of the educational system and the country's linguistic diversity among other features, was paramount, and this too drove research priorities.

This comprehensive approach to researching and developing a family planning programme was a result of the fact that Pakistan's family planning programme was a pilot study of sorts, a field test in which family planning enthusiasts could ascertain the means through which individuals in a primarily agricultural and underdeveloped Muslim society with little civic consciousness could be persuaded to take up family planning methods. As Warren Robinson

[985] PC, Acc 2, Box 132; fo 1267, Medical Social Research Project, Dr. John C. Cobb: Diary Notes, 1960-1964.
[986] PC, Acc 2, box 135, fo 1286, Report on the Use of Fellowships, June 1966.

remarked in *Eugenics Quarterly* in 1966, '[T]he family planning scheme in Pakistan represents a good test of whether family planning can take hold in a situation in which the setting is basically adverse.'[987] The scheme would have to address obstacles presented by conditions of high illiteracy, unfavorable levels of unemployment and under-employment, and the low per capita income typical of an agrarian society.[988] Ultimately, however, it was the perfect study setting for family planning researchers because it contained the high-level administrative and political support needed to allow these researchers the necessary privileges and resources to undertake their work.[989]

By contrast, the President and the Planning Commission considered the issue of fertility to be almost solely an economic issue, i.e., a barrier to economic development. For the President and his subordinates, the primary concern was to effect the reduction of the population growth rate in the shortest time possible to salvage the gains made through economic aid for development and ensure the political futures of those involved. As far as Ayub himself was concerned, all he required was a supply of 'the injection, pill or whatever' from international donors and the means to distribute it in the villages of Pakistan.[990] Enver Adil, under whom the National Family Planning Commission was established and who became the Secretary (later Commissioner) for Family Planning, openly acknowledged when he first took up the post that 'he knew nothing about Family Planning and would need help from the experts'.[991] But as he had been appointed to the post by the President, his future prospects hinged upon his performance in the role. Adil had the power to decisions which would dictate the priorities of the program, such as appointments to key administrative and research posts, but often did so without regard to the

[987] Warren C. Robinson, 'Pakistan's New National Family Planning Experiment', *Eugenics Quarterly*, 13/4 (1966), p. 323.
[988] PC, Acc 2, Box 131, folder 1253, Harvard Advisory Group: Agreement, 1960-1961.
[989] Notably, while the absence of these very destabilising factors had made India in contrast to Pakistan a more desirable focus of international health efforts, it also made the latter on occasion a more interesting and complex case study for health. See Amrith, *Decolonizing International Health*, p. 14.
[990] 'Pakistan head asks for aid in birth control', *Ottawa Citizen*. PC, Acc 2, Box 139, folder 1319, Wishik to Parker Mauldin, 11 Sept 1964
[991] PC, Acc 2, box 139 fo 1319, Wishik to Parker Mauldin, 11 Sept 1964.

'principles' of family planning.[992] A mere two years after his appointment Adil admitted, 'I'm fed up', and claimed that he was 'ready to leave F.P. when the President appoints him to another position.'[993] One Pakistani official ordered to assume the position of provincial Family Planning Director in July 1965 admitted to a PC advisor that his own attitude on the topic of family planning was that 'man is a rational human being who needs to use restraint,' explaining that he himself had practiced family planning through 'natural methods' and had only had two children; his views on the use of 'foam and all those things' and other contraceptives was that they could be dangerous to a woman's health.[994] Such incidents led one visiting researcher to write, '[I]t is only a very few thinking people in the planning commission and in the President's cabinet who really are convinced of the need for a vigorous and effective family planning program...Evidence of a strong negative undercurrent in the Ministry of Health is everywhere to be seen.'[995] Others such as Haldore Hanson concluded, 'It seems plain that this plan is just a gesture to satisfy higher ups.'[996]

'The focal points of the program are the two indices of couple years protection and births prevented. These are cited continuously and are the keys to judging the progress of the program at all levels,' noted Lee Bean of the PC in his End-of-Tour report.[997] Summarizing the issue of utilising data-driven measures to demonstrate rapid programme growth, Bean wrote,

> Mr. Adil accepts [the indices] as valid concepts...these concepts have some validity but if they are immediately interpreted as births prevented by program action someone is kidding himself...the Secretary of Family Planning should be cautioned about their meaning and interpretation. At the present time he seems unwilling to accept suggestions.[998]

Inevitably, such divergent expectations were a cause of great frustration to foreign advisors in Pakistan. Dr. Samuel Wishik's experience with the ambivalence he saw in Pakistan towards the principles of family planning moved him to write, 'The prospect for much to be achieved in

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[992] Ibid.
[993] PC, Acc 2, box 135, fo 1286, Final Report-December 15, 1966.
[994] PC, Acc 2, box 135 fo 1285, Background Notes on Personalities.
[995] PC, Acc 2, box 132, folder 1267, Cobb: Diary Notes, 1960-1964, p. 2.
[996] PC, Acc 2, box 130, fo 1243, Hansen Haldore to Frank Notestein, 9 Dec 1963.
[997] PC, Acc 2, box 128, folder 1216, Bean, End of Tour Report.
[998] Ibid.

almost any field in Pakistan is not bright. The country does not seem to able to meet the problems it faces.'[999] J.C. Cobb wrote of the efforts of the health administration to support family planning, '[T]he Health Directorate does not really care whether the Family Planning program works or not.'[1000] Elaborating further, he explained,

> Why am I so pessimistic about the Pakistan Health Department? I could fill pages of fantastic stories of intrigue, corruption, back-biting, and delinquency by the middle and top-level officers in West Pakistan. They spend so much time on these activities, trying to deprecate some other person who might possibly be a competitor for some better post some day, trying to get their own salary raised, trying to squeeze somebody for whom a favor has been done, arranging deals under the table and kick-backs, and trying to straighten out impossible snarls of red tape by creating more, that almost nothing gets accomplished.[1001]

PC representatives emphasized the education and training of workers because they believed change of cultural attitudes and persuasion to be the foundation for sustained take-up of FP.[1002] This strategy was not shared by the Secretary of Family Planning who was of the opinion that 'most training (more than a few days) is a waste of time.'[1003] Rather than a sign of mere apathy, this attitude can be attributed to other factors, one of which was that the prospect of educating and training workers and then relying on them to educate yet more villagers would not have aligned with the Government's focus on speed and immediate results.[1004] The other reason was that these administrative officials, many of whom were male, were convinced that without reaching out to men, the programme had no hope of succeeding in educating and persuading villagers.[1005] The use of *dais*, traditional midwives, was made difficult by the fact that the *dai* was always female and of low class/caste.[1006] There was also the underlying tendency among elite Pakistanis involved in the programme to patronisingly assume the habits, ideas, and responses of other classes of Pakistanis, including rural communities. A study done through

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[999] PC, Acc 2, box 138, fo 1320, Dr. Samuel M. Wishik's third "quarterly" report on Family Planning in Pakistan, April 18, 1964-August 31, 1964.
[1000] PC, Acc 2, box 132, folder 1267, Cobb: Diary Notes, 1960-1964, pp.3-4.
[1001] Ibid., p. 6.
[1002] PC, Acc 2, box 136, fo 1295, Karlin: A Discussion Paper for TcRI Directors.
[1003] PC, Acc 2, box 139 folder 1319, Wishik to Mauldin, 26 Dec 1964.
[1004] PC, Acc 2, box 139, folder 1319, Wishik to Parker Mauldin, 11 Sept 1964.
[1005] PC, Acc 2, box 135 fo 1285, Background Notes on Personalities.
[1006] PC, Acc 2, box 127, folder 1210, Anderson, Section II, p. 2.

Radio Pakistan in 1963 constituted the first attempt to formally catalogue public opinions on family planning, in spite of groundless assumptions expressed by Government officials that the rural classes would not countenance frank discussion of family planning.[1007]

Another telling difference between the Government's attitude and the PC's approach was the attitude towards physicians. Government decided to operate outside the formal health infrastructure for the sake of expediency and so alienated physicians, but the PC actively sought their aid. 'Those of us working in Family Planning in Pakistan find a great deal of apathy among the doctors with respect to Family Planning. We also find a real lack of knowledge about contraception,' wrote Morris Dixon in a letter requesting the help of the British Medical Director of the Family Planning Association in reaching out to the Pakistani and British Medical Associations.[1008] The message he wanted to impart to these professional bodies was antithetical to the Government's, that family planning a matter of health, and only secondarily related to economic growth of the country.[1009] The only effort to ascertain the opinions of medical professionals on family planning in Pakistan was a questionnaire study of medical graduates by the newly-established National Research Institute of Family Planning (NRIFP), which found that despite lack of knowledge amongst this demographic about family planning due to the lack of medical training in family planning, a majority 'believe that it is one of the responsibilities of the medical profession to assume leadership in promotion of family planning in Pakistan.' [1010] However, only one-third opined that physicians ought to provide family planning advice on request.

One of the problems that arose was the 'ignorance concerning appropriate research methodology and research problems in Pakistan' amongst the senior Pakistani personnel.[1011] Many appointments at the NRIFP, the central research institution for family planning in the

[1007] PC, Acc 2, box 127, folder 1211, Research Proposal for the Testing of Boundaries of Frankness Permissible though Radio Broadcasting.
[1008] PC, Acc 2, box 135 fo 1286, Dixon to Sir Theodore Fox, 15 July 1966.
[1009] Ibid.
[1010] PC, Acc 2, box 138 folder 1305, Medical Aspects of the Pakistan Family Planning Program, 8 Jan 1971, p. 14.
[1011] PC, Acc 2, box 128, folder 1216, Bean, End of Tour Report: section on education in Pakistan.

country, went unfilled for long periods while the head of Family Planning operations openly expressed his disinterest in research.[1012] Exasperation with the programme's leadership was evident, particularly with regards to Adil who 'seems to consider himself in a buyer's market, with Sweden, Ford and AID competing to give him whatever he wants…[and] would like foreign aid to buy a fleet of jeeps and all his contraceptive supplies.' PC officials adamantly stated that 'the role of the Ford Foundation, in any speed-up program by the Government, is not to finance the jeeps and contraceptive materials, but to help the Government find experimental answers, and manuals of operation, for each type of operation contemplated.' The problem was related to disciplinary backgrounds. Aftab Ahmad Khan, who was involved in various facets of planning programs in Pakistan, argued, '[T]he staff of the central planning-agency should include some highly qualified sociologists…Planning in Pakistan has been too much the work of economists and administrators.'[1013] Instead, civil service officers and military officials, whose priorities were national economic development and procedural efficiency, were placed at the helm of a lengthy research study that they wanted to use instead as the basis for a national family planning programme.

These tensions were compounded by the fact that the Central Government was beginning to lose domestic authority over malcontent regions, particularly East Pakistan, which would break away in a few years to form Bangladesh. Despairing of the ambition to turn the NRIFP into a Pakistani version of the American NIH, Hanson wrote, 'This parallel would [be] valid if Pakistan were not in the midst of a major drive to decentralize authority, and East Pakistan were not in a state of administrative rebellion bordering on the Richmond-Washington period.'[1014] The resurgence of Centre-Province tensions was palpable following a directive in June 1962 to provincialise health once more, and as Hanson noted, 'Naturally, this makes Provincial officers more and more defiant about any effort of a Central Ministry or Directorate to tell them what to

[1012] PC, Acc 2, box 139, folder 1319, Wishik to W. Parker Mauldin, 26 Dec 1964.
[1013] Aftab Ahmad Khan, 'Review: On Planning in Pakistan', *The Pakistan Development Review*, 4/1 (1964), p. 119.
[1014] PC, Accession 2, Foreign Correspondence, Box 130, fo 1243, Haldore Hanson to Frank Notestein, 23 Sept 1963.

do.' Because this tension threatened to affect family planning efforts, the relationship between the Government of Pakistan and the Population Council quickly came to be seen by representatives of the PC as 'an awkward relationship that is handicapping our ability to deal directly and sympathetically with the provincial level, where all training and activity is taking place...and where action plans now originate.'[1015] The PC's role in project planning and its support of local researchers meant it was well-placed to exploit the resulting political and administrative chaos. As Cobb noted,

> We probably get more well qualified Pakistani professionals every year as immigrants than we send to Pakistan. Many of them get started on this road to migration through a foreign training fellowship. This turns out to be a way of skimming off the cream of Pakistani talent. No one can blame them for migrating when they get an opportunity. The professional life of an intellectual or thinking professional here is comparatively degrading, unrewarding, and frustrating.[1016]

The willingness to engage Pakistanis at all levels of the family planning programme through training sessions and fellowships and research activities allowed PC officials like Parker Mauldin and Adelaine Satterthwaite to gain a familiarity with these individuals especially in light of Government ambivalence towards nurturing domestic human capital and outsourcing program implementation to foreign advisors.[1017] In addition to their influence on programme staff, PC officials also attempted to challenge social norms in the country. The training programmes and educational tools being developed through social and demographic research sought to promote the idea of smaller families in Pakistan's villages by refuting deeply held ideas about health and sickness, morality, intimacy, economic security, and familial decision-making.[1018] This privileged access to health information and health habits of the people were risky on the part of a government whose own authority was highly circumscribed and being openly challenged domestically. Profiling Ayub Khan in 1959, an American newspaper wrote, '[M]any in rural areas do not even know the name of their strongman leader, Gen. Ayub Khan.'[1019] After about 3

[1015] PC, Acc 2, box 130, folder 1244, Ford Foundation: Haldore Hanson, 1967.
[1016] PC, Acc 2, box 132, folder 1267, Cobb: Diary Notes, 1960-1964, p. 1.
[1017] PC, Acc 2, box 127, folder 1210, Mauldin to Farhat Yusuf, 21 Oct 1965; box 138, folder 1311, Adaline Satterthwaite Diary Notes, 17 Jul 1971.
[1018] PC, Acc 2, box 139, folder 1321, Training Materials, Wishik, p. 139.
[1019] 'Pakistani strongman rule solves urgent problems but many remain', *Eugene Register-Guard*, 9 Oct 1959.

years of a dedicated Family Planning programme, international observers estimated that it had resulted in about half of Pakistan's people having 'knowledge of the existence and functions of family planning clinics'. In fact, by 1968 awareness of Ayub's family planning ambitions was such that large mobs protesting Ayub's rule would attack signboards advocating family planning as a sign of their opposition to the national government and its associated activities.[1020]

Programme Implementation and Local Challenges

Despite the immense administrative challenges involved in family planning research in Pakistan, the knowledge gained from small-scale studies on family planning were incorporated into a comprehensive Family Planning programme under the Third Five-Year Plan which began in 1965. Whereas international and national political developments marred the planning of this programme at the macro-level, at the micro-level family planning was essentially about the person-to-person dissemination of the message and techniques of family planning at the hands of *dais*, lady health workers, and physicians. The Family Planning programme emphasised the use of the IUD as the principal contraceptive method, the use of the *dai* as the primary agent for publicizing family planning in villages—with male officials recruited to talk with husbands and 'legitimizing' the idea of family planning— and small shop-keepers and chemists as agents to distribute conventional contraceptives, and family planning outreach to rural areas rather than expecting those women to travel to urban clinics.[1021] The goal was to reduce the population growth rate from 50 per thousand to 45 per thousand, though these estimates were based on faulty figures, and ultimately to prevent the national population growth rate from exceeding 3% per year from its estimated 2.8% to stave off a rise in population consequent to falling mortality from disease in the country.[1022]

The challenge to making family planning accessible to its target population was that the *dai* was usually of the lowest caste or social class even though she provided an important link between family planning services and the public. '[W]hen a dai sallies forth to talk to a group of

[1020] 'Long-smouldering dissatisfaction with Ayub is deeper than realized', *The Morning Record*, 23 Dec 1968.
[1021] PC, Acc 2, box 130, folder 1252, Hardee, Pakistan: country profile, p. 25.
[1022] Ibid, p. 4.

women about family planning she has two strikes against her,' noted Lewis S. Anderson—the first was her gender and the second was her social status. It became the belief of visiting family planning advocates that these obstacles would not prevent dais from being effective as long as they were well-supported by their immediate superiors.[1023] The use of an untrained, unofficial health worker was befitting a programme that operated outside of the confines of health administration and without the support of the medical profession, yet elements of the domestic health system were incorporated into the Family Planning programme. An example of this was the Lady Family Planning Visitors (LFPVs). This was a cadre of workers modelled on the Lady Health Visitors (LHVs) that were trained to fill the gap left by an inadequate number of physicians to treat the Pakistani population. The LFPVs were trained in inserting IUDs and screening out easily identifiable abnormalities that would exclude candidacy for IUD insertion.[1024] LFPVs were estimated by a Deputy Director of the Provincial Family Planning Board office to have inserted 80% of the IUDs in East Pakistan.[1025] In West Pakistan, it was the LHVs who took on a prominent role in family planning work, being already seriously engaged in maternal and child health through their provision of pre-natal health services which were used as a platform to promote family planning methods.[1026] The LHV programme was have been heavily supported by international aid programs, including USAID, WHO, and the Peace Corps, with the intent being to improve the standards and prestige of auxiliary medical staff and to train professionals and non-professionals to work jointly in rural health.[1027] However, there were challenges to gaining the approval and acceptance of Pakistani physicians for these staff because of their unequal social status.[1028]

The primary challenge of rural health besides the inadequacy of resources was the neglect to which it was subject without sustained supervision. 'So much depends on supervision,'

[1023] PC, Acc 2, box 127, fo 1210, Anderson, p. 2-3.
[1024] Ibid., p. 3,
[1025] Ibid., p. 7.
[1026] Ibid., Section II, p. 2.
[1027] PC, Acc 2, box 127, fo 1209, U.S. assistance in scientific and technological field; Ibid., p. 1.
[1028] PC, Acc 2, box 127, fo 1210, Anderson, p. 4.

wrote Anderson emphatically. This was exacerbated by the "produce or perish" culture of the programme and the prevailing sense of urgency, which put pressure on staff working at the grass-root level to produce results.[1029] This inevitably led to falsification of data and negligence of duties. There was no shortage of allegations of corruption. '[C]orruption has become rampant [sic] and growing in leaps and bounds in the Family Planning field programme—a programme which had earned enviable reputation at the beginning both at home and abroad,' wrote the Principal of the Family Planning training-cum-research institute in Rajshahi. 'The reputations of being corrupt of Family Planning officers and other personnels engaged at district and thana levels have been the talk of the day among the public.' Fees were being fraudulently collected for fictitious clients, without actually conducting the quoted procedures or by re-inserting IUDs or repeating vasectomies. In some cases, this was the result of misconduct by physicians. Other times the deception was carried out by the patients. And not infrequently, both agents responsible for referring patients and villagers eager to pocket incentive money would collude and provide the appropriate history needed to qualify as candidates for family planning services, after which the incentive money would be split between the patient and agent.[1030]

Opposition

While family planning efforts in Pakistan, as in India, were directed towards rural populations, peasants and their families, opposition to or disapproval of the programme was present among many diverse demographics.[1031] As Haldore Hanson noted, 'There are frequent comments about the opposition within the Secretariat, within the medical profession and among educated people in the country,' which he attributed to ignorance and not religious qualms.[1032] There were also important socioeconomic influences on family planning attitudes. Children were viewed as an economic asset and assurance of future security and a sign of marital fidelity.[1033]

[1029] Ibid., p. 2-3.
[1030] PC, Acc 2, box 127, folder 1212, Corrupt practices in the Family Planning Program. Equally sordid tales afflicted the running of the Indian population control program. See Connelly, 'Population Control in India,' p. 657-9.
[1031] Connelly, 'Population Control in India,' p. 661.
[1032] PC, Acc 2, box 130, fo 1243, Hansen Haldore to Frank Notestein, 23 Sept 1963.
[1033] PC, Acc 2, box 139, fo 1321, Wishik: Reports, 1965, Training Materials, p. 142.

There was also recognition of the inability of married couples to make decisions unilaterally within the joint family system prevailing in rural communities.[1034] Religious opposition where it did erupt was usually entwined with multiple other motives, such as the impression that the state's strong-handedness with respect to enforcing family planning ignored the importance of moral discipline, to say nothing of the 'implied external coercion' of family planning.[1035] Furthermore, '[s]ince Ayub's Muslim League strongly supported family planning, it was therefore politically expedient to oppose the government Family Planning program.'[1036]

The Ford Foundation found that when it tried to extend the family planning program in East Pakistan, for example, it was easier to do so in places where cooperative societies existed which had incorporated local imams into their infrastructure, in contrast to areas where no other infrastructure for supporting development plans existed and where Family Planning programs were subsequently shuttered due to opposition from local religious leaders.[1037] In West Pakistan, Sind became the centre of opposition due to a sustained campaign of rumours which was particularly virulent in Karachi's migrant colonies.[1038] Vasectomies became a critical flashpoint as evident from reports in the *Dawn* newspaper. 'In the ignorant and backward rural areas of Tharparkar and Sanghar districts, disruptive elements first spread a rumour that sterilisation led to impotency and was harmful to health.'[1039] In East Pakistan, vasectomies had become a small but rapidly expanding part of the family planning program, though it was unclear whether this was because of cultural acceptance. The success of this campaign had led to efforts to expand it in West Pakistan where it appears to have met with vocal resistance.[1040]

These rumours seemed to lay in the belief or popular fiction that children were being given sterilizing drugs/operations without consent. It was considered necessary to have the Directorate of Education of Karachi inform all heads of institutions that vasectomy was not being

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[1034] Ibid.
[1035] PC, Acc 2, box, 130 fo 1252, Hardee: Pakistan Country Profile.
[1036] Ibid.
[1037] Ford Directors conference, p. 9
[1038] PC, Acc 2, box 127, folder 1211, Qureshi to Fendal, 9 Aug 1968.
[1039] PC, Acc 2, box 127, fo 1211, Dawn: Vasectomy is not performed on children.
[1040] PC, Acc 2, box 127, folder 1210, Anderson, p. 4; box 127, fo 1211, Qureshi to Fendal, 9 Aug 1968.

performed on children and that FP officials had never visited any educational institutions towards this purpose. The Tehsil (subdistrict) Council, Karachi had to issue an appeal to parents not to stop their children from attending schools.[1041]

The rumours eventually progressed to violence. A family planning contingent was attacked and stoned in the Golimar slum of Karachi as well as a girls' school in Lyari, another Karachi slum area (both areas were settled by refugees in the aftermath of Partition). The attach was apparently rooted in rumours that local family planning officials were performing vasectomies on female students. In a plea to the citizens of Karachi, the Deputy Commissioner encouraged the public to turn in any persons found spreading rumours that 'family planning treatment was being given to people forcibly or by fraud' to the police 'as a national duty'. The campaign of rumours was framed as 'the attempts of antisocial elements and mischief-mongers to undo the efforts for economic prosperity of President Ayub's Government.'[1042] Government attempted to suppress these seditious rumours through arrests, which were considered necessary to prevent 'the mischievous elements' who were 'out to capitalise on the ignorance of the common man' as well as 'poisoning the highly impressionable minds of the children'.[1043]

Some perceptive individuals within the Family Planning administration recognised the underlying issue to be about consent. A *Dawn* editorial noted that the fear of being coerced was inflamed by 'the spreading of false rumours regarding the programme—rumours that so scare the uneducated that they even refrain from taking the normal medical aid and advice in common cases of illness for the fear of being forced or tricked by the doctors into sterility.'[1044] The Director-General of the Family Planning Council had to assure reporters that vasectomy was performed only on consenting adult males, married with at least two living children. '"We take this in writing from each person and also ask them if they understand the significance and consequences of the operation."'[1045] The Pakistan Medical Association (PMA) meanwhile was

[1041] PC, Acc 2, box 127, folder 1211, Dawn: Citizens asked not to pay heed to rumours, 2 Aug 1968.
[1042] Ibid.
[1043] Ibid., Anti-family planning propaganda dying down in Hyderabad; People urged not to heed to malicious propaganda.
[1044] PC, Acc 2, box 127, folder 1211, Dawn: Citizens asked not to pay heed to rumours, 2 Aug 1968.
[1045] Ibid.

forced to publicly denounce any doctors found indulging in 'unethical practice of forcible sterilization or sterilization without consent in writing' because of the situation created by rumours which implicated doctors. It was noted that, '[T]he scare had in some cases risen to such an extent that doctors in some locations had found it difficult to give cholera, or malaria injections.'[1046] While medical professionals had not raised any organized resistance to the Family Planning program, this provided an opportunity to express their annoyance with the political decision to separate family planning services from the provision of general health services in the context of routine patient care, as well as the authoritarian and nontransparent nature of the programme.[1047]

The role of rumour in Pakistani society and politics has received much attention recently with respect to contemporary political events.[1048] The ubiquity of conspiracy theories and paranoia in Pakistan has led many international and domestic observers to disparagingly note the predilection of the Pakistani masses to concocting dramatic theories to explain political events in their unstable country. But in fact, the prevalence of such discourses draws attention to the psychological dimension of development and the political significance of rumours, thereby shedding light on the distrustful relationship between state and citizenry in Pakistan during Ayub's time. In her book *Speaking with Vampires: Rumor and History in Colonial Africa*, Luise White has discussed the function of rumour as terrains of alternative theories of cause and effect, a site where people seeks to debate the truth about events, diseases, polities and corporations. Rumours contain genealogies of local concerns and historical fixations. Humeira Iqtidar has made a novel contribution to unpacking the importance of rumour in Pakistani society and politics, suggesting that rumour has historically served as an important means of social discourse

[1046] Ibid., PMA's warning to doctors, 1 Aug 1968.
[1047] PC, Acc 2, box 130, fo 1252, Hardee: Pakistan Country Profile.
[1048] Julie McCarthy, 'Conspiracy Theories "Stamped in DNA" of Pakistanis' *NPR*, 24 Dec 2009, <http://www.npr.org/templates/story/story.php?storyId=121880229> [accessed 13 March 2016]; Nurith Aizenman, 'Polio's Surge in Pakistan: Are Parents Part of the Problem?' *NPR*, 30 July 2014 <http://www.npr.org/sections/goatsandsoda/2014/07/30/336382581/polios-surge-in-pakistan-are-parents-part-of-the-problem> [accessed 13 March 2016]; 'Conspiracy of the Masses', *The Economist*, 13 May 2011 <http://www.economist.com/blogs/banyan/2011/05/what_pakistanis_think> [accessed 13 March 2016].

for deciphering political, economic, and social realities in the absence of information. Viewed through this lens, the historical campaign of rumours against family planning in Ayub's Pakistan can be seen as an active public discourse attempting to deciper the motives of political authorities in the absence of concrete information about government activities and lack of democratic participation under military rule.

Results of the Family Planning Programme

In the middle of 1969, Pakistan's newly assigned PC liaison Adelaine 'Penny' Satterthwaite remarked, 'Exciting things are happened here in Pakistan. The future is wide open before us.'[1049] By the end of that year, the PC was being urged to withdraw its operations by stakeholders in the US, barring a strong request from the Government of Pakistan.[1050] Two years later, Satterthwaite described Pakistan in her diary as a 'sinking ship,' noting the numbers of Pakistani family planning programme participants—researchers, academics, physicians—who were anxious to leave the country and seek opportunities abroad as the country disintegrated.[1051] By this point, the shortcomings of the program had become clear. A population policy made on economic grounds could not guarantee social acceptance by either the professional elite or the common man in the form of family planning. Satterthwaite pointed out that it was inherently dangerous to make such a policy with high level support and policy statements when no broad-based support existed in the country. In line with this, it was evident that family planning 'cannot be bought by monetary incentives and program efficiency ensured by targets.' The Pakistani experience made it evident that without education, there could not be acceptance and sustained progress which was necessary to ultimately curb the population growth rate.[1052]

Education and persuasion were curbed by the limits of discourse, which stifled the progress of the program. Apart from deeply embedded ideas among Pakistani officials about the

[1049] PC, Acc 2, box 137, fo 1303, Adaline P. (Penny) Satterthwaite, 1969 July-December, letter dated July 1969
[1050] PC, Acc 2, box 127, fo 1212, Fendall to Mauldin, 30 Dec 1969.
[1051] PC, Acc 2, box 138, fo 1305, Observations arising from the Pakistan experience, A.P. Satterthwaite 1971.
[1052] Ibid..

supposed prudishness of rural society, there were other forms of passive censorship. PC representatives noted that in Pakistan, 'program leaders consider evaluation a threat to their political survival' which made it difficult to have frank discussion of obstacles and methods of improvement because critical comments were perceived as a threat.[1053] Supervision was equated with inspection. Moreover, for foreigners and lay participants, it was difficult to argue with the civil service officers who were characterised informally as 'tin-gods'.[1054] There was a multiplicity of research and evaluation units with mixed affiliations and funding situations which fragmented the programme and led to competing ideas regarding implementation. Indeed, the shared commitment between foreign partners and domestic actors to family planning at the international-national level as a policy priority was in marked contrast to tensions at more local levels regarding program implementation. The top-down dissemination of the programme's objectives through the governmental bureaucracy existed uneasily alongside the more ambiguous responsibilities of PC advisors who had competing loyalties to the institutions who employed them, the Central Government liaisons who provided the authority for the programme's implementation, and the on-the-ground workers who helped collect the data needed for research, training, and networking.

Another flaw that doomed the programme was the overemphasis on IUD insertions. Ayub had certain ideas about how he wanted the program to proceed, the most stubborn of which was the use of IUDs. The PC advisor in Pakistan, Dr. Samuel Wishik wrote after his first meeting with the head of the National Family Planning Commission, Enver Adil,

> [The President] is determined to institute a widespread IUD program in the villages. He knows that this cannot be done with the available professional or near-professional resources of the Nation...that it is unlikely that an organization can be set up quickly with thousands of workers...President Ayub is determined to have IUD insertions done by village dais.[1055]

Wishik strongly objected on ethical grounds to putting such a procedure in the hands of *dais* who could not reasonably be trained to the appropriate level. His wife astutely remarked, 'One can

[1053] Ibid.
[1054] Ibid.
[1055] PC, Acc 2, box 139, fo 1319, Wishik to Parker Mauldin, 11 Sept 1964.

say that the Pakistani woman has nothing now, and perhaps insertion by the dai, upon whom she relies for all deliveries no matter how complicated, is better than nothing.'[1056] Yet she agreed with Wishik's view that the policy was 'tantamount to murder.' There was pressure on Family Planning officers to 'herd women in for IUD' making the program 'little short of coercion.'[1057] Unsurprisingly, continuation rates were disappointing because without acceptance of the goals of family planning, people could be little induced to put up with the discomfort of IUDs. The lessons learned led to some efforts at shifting the focus from gaining acceptors to promoting continuing adherence by employing literate field workers who could follow up with couples maintained on contraceptives once every three months.[1058] This was symbolic with respect to the failures of the national government to gain widespread support for its development programme across the country and the decision to consolidate gains where support was already evident.

Lastly, the programme's leadership had pursued a policy that alienated medical personnel. The divorce of the family planning programme from the normal administration of the health department for its own effective running meant that it fell afoul of the support of the medical establishment. As well, the absence of efforts to integrate the family planning campaign into medical education meant that there was little prospect for integration between community-based family planning services and clinical-medical practice in the near future. Because the success of the programme was thought to depend on the distribution of supplies and motivation/education of the people, the attitude taken by government was that 'family planning is essentially an administrative and not a clinical programme.' Consequently, it was the case that a sizeable minority of future medical professionals surveyed in the 1960s considered no argument valid to support contraceptive use and family planning and less than half had 'modest knowledge' of the aspects of population growth and family planning.[1059]

[1056] Ibid.
[1057] PC, Acc 2, box 135, fo 1285, Background Notes on Personalities; box 138, fo 1305, Observations arising from the Pakistan experience, A.P. Satterthwaite 1971.
[1058] PC, Acc 2, box 138, fo 1305, Observations arising from the Pakistan experience, A.P. Satterthwaite 1971.
[1059] Ibid., Medical Aspects of the Pakistan Family Planning Program, p. 14, 8 Jan 1971.

Ultimately, the results produced by the programme were mixed. From 1960-1965, some 15 million rupees were spent to provide services, train personnel, and undertake research, which produced remarkable results with respect to the extension of government services across the country with over one thousand health centres being established.[1060] The national Family Planning programme which was established in 1965 sought to provide family planning services to 20 million citizens and reduce the birth rate from 50 per thousand to 45 per thousand in five years by spending over 284 million rupees.[1061] The programme was initially judged by international observers to have succeeded 'so much better than the Indian programme right next door'.[1062] However, it came to an abrupt end in 1969 as the leadership of the programme and the country changed and the lack of adequate or reliable data made it impossible to actually calculate the effectiveness of the programme and whether the population growth rate had been affected. In the process however, it did extend the message of family planning to about 4/5 of the country's population and made the Family Planning programme the third largest employer in Pakistan after the Army and the Railroad departments with nearly 90,000 personnel.[1063]

Conclusion

At the time of the seminar on population problems in 1959, which spurred the development of a national family planning policy, the Government of Pakistan was developing its Second Five-Year-Plan.[1064] The Finance Minister remarked at the seminar to the foreign participants in attendance, 'We want to introduce and implement a scientific programme, and I do hope that you will kindly study our problems and advise our planners in the light of your rich experience gained through trial and error in your countries.'[1065] Through the invitation of foreign expertise in forums such as this to devise strategies for national economic improvement, Pakistan

[1060] Warren C. Robinson, 'Family Planning in Pakistan 1955-1977: A Review', *The Pakistan Development Review*, 17/2 (1978), pp. 233–47.
[1061] Ibid; PC, Acc 2, box, 130 fo 1252, Hardee: Pakistan Country Profile.
[1062] Robinson, 'Family Planning in Pakistan', p. 236.
[1063] L.L. Bean and A.D. Bhatti, 'Three Years of Pakistan's New National Family-Planning Programme', *Pakistan Development Review*, 9/1 (1969), pp. 35–57.
[1064] PC, Acc 2, box, 130 fo 1252, Hardee: Pakistan Country Profile.
[1065] Ibid.

and its neighbour to the east became sites of international experiments on development and the sociological and economic determinants of health.

The intellectual basis for these ambitious development programs was the application of methods of social science for international improvement. As early as 1922, Herbert Hoover, later American president, had articulated a model for social progress as in-charge for Belgium relief whereby 'techniques of social optimization' such as demographic standardization and market research and dietetics, would harmonize precariously balanced aspects like wages, production, labor, health, consumption.[1066] As a result of the use of sociological methodologies, not only was information being collected by Pakistan's governing officials about the attitudes of social groups and the numbers of people in the country and their distribution and their behaviours, but this knowledge about Pakistan was being opened up to the world.[1067] By 1965, there were approximately 1,000 advisors in the country paid by various aid agencies and national governments and philanthropic organizations; another 1,000 were paid by Pakistan using loans. Many other foreign advisors were in Pakistan as a consequence of the agreements that were made with the aid-agencies which stated 'in effect, if you don't take our consultants, we won't give you the loan or grant.'[1068] The resulting aid projects utilised the strength of state authority to intervene in the intimate lives of people—where state authority was weak, the programmes suffered as a result. The endeavour to restore the 'lost' balance between unreliable food supply and a rapidly growing population 'authorized, even mandated, official intrusion into the most intimate of personal decisions,' writes Cullater of the population control and family planning programmes.[1069] 'Crucial choices about food and famine became internationalized and removed from local political control, while Asians, at the moment of their emancipation, ceased to be colonial subjects only to become developmental subjects, mobilized, sterilized, and enlightened by foreign experts.'[1070]

[1066] Cullather, *The Hungry World*, p. 23.
[1067] Lawrence W. Green and Yasmin Azra Jan, 'Review: Family-Planning Knowledge and Attitude Surveys in Pakistan', *The Pakistan Development Review*, 4 (1964), p. 332.
[1068] PC, Acc 2, box 130 fo 1244, Memorandum from Hanson to Frank J Miller, 7 Oct 1965.
[1069] Cullather, *The Hungry World*, p. 7.
[1070] Ibid., p. 8.

Strongmen like Ayub were the vector by which foreign development projects were instituted in the Third World. Ironically, he would later go on to bitterly decry the very allies who bolstered his rule, stating,

> [F]oreign powers...do not hesitate to make mischief wherever it suits them. The Russians used to be accused of such practices, but the Americans have now surpassed them. Their CIA has worldwide tentacles and pursue their dirty work relentlessly. Their efforts are concentrated on *keeping the rulers of the country* in their pocket. They demand complete submission to their will although the leaders may not be able to carry his people on such policies and geographical situations may not allow it.[1071]

At the macroscopic level, initiatives such as the family planning programs sometimes turned Third World states into a medium for enforcement of international health interests. On a microscopic level, the interaction between foreign experts and local officials had the potential to create ill-will that doomed the prospects of such partnerships from the start. The result was 'an endless series of little and big frustrations resulting partly from differences in culture...and partly from the natural jealousy and hostility which arises when somebody else comes in and does what local people were not able to do because of lack of know-how, or money, or government support--all of which may be easier for a foreigner to get.'[1072] Speaking from his extensive experience with international aid programmes while serving as the economic advisor to Ayub, Mahbub-ul-Haq cynically noted that the process of development led only to the development of dependence on foreign expertise for the creation of things that poor countries did not need, and a lack of expertise for the things they did need.[1073]

In articulating his view on development, Ayub wrote, 'Some economists consider economic development as essentially the accumulation of capital. This is important but the real core of the problem is what happens in men's minds, especially in their habits and organization for working together.' For Ayub, development was all-encompassing:

> [A] whole complex of interdependent changes manifested simultaneously in the physical environment, new roads, building, harbours, machines, implements, chemicals; in the form of association by which men live and work, growth of cities, changes in

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[1071] Mohammad Ayub Khan, *Diaries of Field Marshal Mohammad Ayub Khan: 1966-1972*, ed. by Craig Baxter (Oxford, 2007), p. 392.
[1072] PC, Acc 2, box 132, folder 1267, Cobb: Diary Notes, p. 2.
[1073] Ward Morehouse, 'Confronting a Four-Dimensional Problem: Science, Technology, Society, and Tradition in India and Pakistan', *Technology and Culture*, 8/3 (1967), p. 369.

> government, factory organizations, business corporation, banking, readjustment in land tenure, family practices, even religion.[1074]

For Ayub, 'The human and psychological side of development must go hand in hand with the economic development. Non-compliance with this will result either in failure of the development process to take and become self-generating or creation of a menace to freedom. What it amounts to is that people have to develop themselves before they can change their physical environment.'[1075] Thus, development in the ideal ultimately aimed at the development of the individual, to extricate him from his older loyalties 'to dynasty, religion, tribe, region, localities' which still formed 'the principal appeal' to the erstwhile citizens of Pakistan, and to develop his loyalty to the state.[1076] The new politics of development required the cooperation of the individual to the terms of socioeconomic development in order to save the nation from underdevelopment. Family planning and population control programs were uniquely placed to bring this individualistic aspect of postwar economic development to fore. "'To cut the death rate, you could wipe out malaria by massive spraying or you could wipe out other disease through mass methods,"' Ayub noted, "'But for birth control you have to approach every individual. You may find that if the wife is agreeable, the husband isn't.'"[1077]

Yet what is evident in the actual implementation of the Family Planning program is that the focus on incentivising take up of family planning ended up overshadowing efforts to educate the public to accept its benefits. It was in fact Ayub and his subordinates who were responsible. During his tour of the US, he bluntly stated, 'What we need is a pill, and you could make people eat it, and that would be the end of his activities—the husband's. That's the sort of thing I'd like to see.'[1078] Absent any attention to the psychological aspect of development, which was the result of the Pakistani Government's emphasis on increased number of procedures rather than do the painstaking work of developing training and educational activities, the family planning campaign

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[1074] Khan, *Diaries*, p. 322.
[1075] Ibid.
[1076] Ibid., p. 392.
[1077] 'Pakistan head asks for aid in birth control', *Ottawa Citizen*.
[1078] Ibid.

became liable to subversion by a sufficiently compelling counter-narrative, and was only as strong and viable as the regime that enforced it.

The top-down enforcement of unfamiliar reproductive practices within Pakistani society based on foreign development priorities highlighted the political and social divide between the westernised elite who accepted the terms of international aid and the populations that were to be the targets of development plans funded by that aid.[1079] Indeed, as befitting a military dictator who abolished participatory democracy for a time in Pakistan, Ayub believed that in underdeveloped states where political legitimacy and consensus was lacking, democratic politics 'have a strong pull for division and disintegration.' Therefore, in such conditions, law-making through means of debate 'cannot hope for acceptance and loyalty from the people.' The only way forward was 'enforcement by a few of the westernised elite.' The resulting conflict provided a space into which opposition elements could step in and reframe government intentions towards the people. The acceptance of opposition discourse was interpreted by western researchers and the westernised elite as a sign of the ignorance and illiteracy of the masses, rather than a sign of the Government's failure to link itself to its citizens or to local political authorities in a way that it could makes its goals heard and legitimised by public support.

With its forays into family planning and community health programs, the modern Pakistan state sought to gain physical authority over the populace and transform development into a moral obligation. Prior to the development of the family planning programme, PC officials assessed, 'Administration of health in Pakistan is weaker than any other department of Government.'[1080] It was through the organisation of family planning activities outside the existing administrative structure that headway was made.[1081] Indian political elites too were eager to enlist international aid for family planning and they also attempted to make it a priority despite the apathy of the populace.[1082] Amrith notes that embedded in this commitment to public health

[1079] Connelly discusses this phenomenon with respect to Indian family planning advocates. See 'Population Control in India', p. 662.
[1080] PC, Acc 2, box 130, fo 1243, Haldore Hanson to Frank Notestein, 9 Sep 1963.
[1081] Ibid.
[1082] Connelly, 'Population Control in India,' p. 662.

was also a desire to centralise authority and thereby being able to control economic production and human reproduction.[1083] In Pakistan too, the family planning program was used to further entrench the centralised authority of the President. Ultimately, however, in the cause of centralising authority over the country, these efforts to penetrate into rural society and exert control of the body of the people ended up bringing these populations under greater control of international ideas about health and development. A history of the family planning programme further reveals the critical role played by social incentives and political coercion in making the programme a priority in a politically aloof rural environment. It demonstrates the disconnect between the aims of national governments with respect to producing rapid declines in population growth rates and the methods of foreign experts and researchers who envisioned slower but more sustainable changes.

Family planning was one of many development goals, but it was unique because of the sheer size of the programme. '[T]he Government is giving it unquestioned priority, co-equal to the military budget, and has assigned the key advisory roles to Ford Foundation projects,' explained Haldore Hanson.[1084] This would not have been possible without the existence of contraceptive technologies that promised more effective methods than personal motivation and restraint for reducing fertility, and which became the favoured method of family planning from both the donor and recipient perspective.[1085] The achievements of the program are therefore notable, despite the apathy that existed throughout much of the administrative chain and despite the very low percentage of women in the country (6%) using any form of contraception after three years of the program.[1086] The sheer size and visibility of the programme domestically and

[1083] Amrith, 'Political Culture of Health in India,' p. 120.
[1084] PC, Acc 2, box 130 fo 1244, Memorandum from Hanson to Frank J Miller, 7 October 1965.
[1085] PC, Acc 2, box 138, fo 1305, Medical Aspects of the Pakistan Family Planning Program, 8 Jan 1971. With respect to widespread availability of contraceptives as a strategy to expand uptake of family planning, Warren Robinson notes that USAID, which was responsible for the idea of inundating the country with contraceptives, saw to it that large quanities were supplies to Pakistan while the Pakistani leadership decided to make contraceptive distribution a cornerstone of family planning policy. Robinson, 'Family Planning in Pakistan', p. 242. By contrast, personal restraint and the rhythm method were the preferred tools of family planning efforts by Swedish groups operating in South Asia. See Berg, 'A Suitable Country,' pp. 297-320.
[1086] Khan, 'Policy-Making in Pakistan's Population Programme,' p. 34.

internationally was remarkable. Robinson writes, 'The Pakistan programme received considerable attention abroad and a steady stream of visitors came to see at first hand what was called by some as an administrative 'model' of how to build a family planning programme.'[1087] Lee Bean described its domestic impact as follows upon the completion of his tour of Pakistan on behalf of the PC:

> It is impossible for a sociologist or a demographer to be in Pakistan for any period of time without becoming actively interested in the program. The problem of population growth is critical; it's obvious that it is something with which the Government is trying to cope. A person would have to be both blind and deaf to miss the family planning program in Pakistan. It's there; it's active; it's overt and sometimes forceful. To any observer the program must be viewed as important and very impressive.[1088]

The developments in health discussed in this chapter represent the coming to fruition of many of the policies set in motion with the end of colonial rule. Pakistan, as a former part of undivided British India, was deeply entrenched in the existing system of production of knowledge about the tropical world.[1089] This historical legacy was used as a means to attract continuing interest and investment in health programs in this region by international health stakeholders. Simultaneously, early decisions made by the leaders of independent Pakistan had wedded the fortunes and governing priorities of the country's constituent provinces to increasingly removed authorities, particularly with increasing centralisation which left the provinces impotent to challenge the Central Government's growing reliance on international technical aid for health. In light of pre-existing maldistribution of resources between provinces as well as the relatively weak penetration of the Central Government's influence over the country's populace, the involvement of foreign aid groups and their provision of critical services such as maternity and child care or vaccines replaced many functions of the national government in the realm of public health, most problematically in Bengal. In some ways, this subverted the promise of independence, specifically the desire for decentralisation and respect for local autonomy in the matter of health as had once been advocated for by nationalists in India from the Frontier to Bengal. The sovereignty of Pakistan and the autonomy of its provinces in the sphere of health

[1087] Robinson, 'Family Planning in Pakistan', p. 236.
[1088] PC, Acc 2, box 128, folder 1216, Bean: End of Tour Report.
[1089] Amrith, 'Political Culture of Health in India,' p. 117.

and sanitation had once prompted bitter fights with the colonial authorities and their successors at the Centre. Now, Pakistan and its constituent Provinces witnessed the influx of aid-organisations and development experts from foreign governments redesigning the country's cities, its economic policy, its hospitals and clinics, and eventually, its ideal family structure at the behest of an autocratic ruler. Plans in the sphere of health were less related to the nature of endemic and epidemic disease and more to the nature of international relations. The military government apparatus—to which the historical literature has attributed the description of being a strong, active, and disciplinarian entity—had in fact completed the process set in motion by its predecessors with respect to ceding sovereignty over the health of its people to international vogues in academia and philanthropy.

Conclusion

This thesis has provided the first history of medicine in modern-day Pakistan. The purpose of undertaking such a survey was to investigate how political developments in the country prior to independence and after have impacted the health of the populace, and what discourses around health and the nature of health interventions reveal about the priorities and functioning of governments in this region during the period under study. To fulfil this objective, I provided an overview of the varied landscape of health across different political boundaries in British India and independent Pakistan with analyses of specific case studies of health interventions in each administrative context. These case studies were selected in an attempt to understand the nature and impact of major political developments in late colonial India and independent Pakistan on the nature of health policy and public health interventions.

In writing a history of medicine of the vast territories that constituted colonial India and Pakistan, it as an immense challenge to try and comprehend in limited space (1) the various diseases and environmental influences which impacted the populations of this area (2) the diverse political and social habits of the hundreds of millions of these populations; (3) and the intentions and policies of the numerous entities that have attempted to govern the people of these territories at national, regional, and local levels. In order to make that task more manageable and more meaningful, the approach here has been to focus on specific case studies that can illustrate major national and regional developments in state politics and governance over time. In the case of this thesis, these developments have been such as provoked public discourse at the time they occurred, were reasonably well-documented in archival sources, and/or which have proved enduring in the political historiography of colonial India and Pakistan.

In my analysis I began with the colonial territories of the north-west frontier, the Punjab, and Bengal during the time of governance reforms in the 20th century. I showed that from the 1920s to 1940s, control over health and welfare in colonial India had become a symbol of political power and governmental responsibility, and therefore became a flashpoint in the struggle for self-government by the provinces of India. When Pakistan inherited some of these provinces in 1947, it unfortunately also inherited their interprovincial rivalries and endemic

diseases; the atmosphere of competition between these provinces worsened due to the loss of institutions, expertise, and resources with Partition as well as the concomitant addition of so many needy refugees. This provoked a reversion to centralised state control over health and dependence on international aid. This drive towards more consolidated and streamlined control over the country's functioning culminated in the seizure of power by the military, which utilised this state of affairs as well as its international strategic alliances to implement and fund ambitious national programmes for health.

The nature of these developments provides an opportunity to delve into complex themes relating to governance over a period of time that saw dramatic changes in political structures. Developments in public health demonstrate the uses of governmental power within society and illustrate themes of control, division, and social change.

Control

Asserting and maintaining control—over populations, territories, and political privileges—was a vital dimension of government health policy. Policy with respect to health was not necessarily always driven by larger political concerns, though it did often parallel the state's ambitions of control over a territory of segment of society. In this respect, the trajectory of health policy also gives opportunity to examine the concomitant struggle for sovereignty by those groups and institutions that militated against the reigning government's desire to maintain political control.

This was nowhere as acutely demonstrated as on the North-Western Frontier, where the purpose of the Government of India's medical institutions, camps, and campaigns was to 'convert' the local population, which was only precariously under its control, to the side of the British. Medical care was one of the few elements of government intervention in this region which was accepted without hostility and suspicion, and was consequently used to win 'hearts and minds'.[1090] Though the Punjab was a region with a markedly different geographic and

[1090] A phrase first used by Robert Sandeman who advocated a system of military occupation alongside investment in welfare activities, such as schools and hospitals, to extend Britain's imperial influence in the restive western frontier. See Christian Tripodi, '"Good for one but not the other".

historical relationship to imperial power, here too ambitions of control were evident, but were calibrated to a land that had already been conquered and where imperial rule now sought to solidify itself rather than find purchase. Here, British politics and infrastructural planning had already dramatically altered the landscape of the region. Consequently, the sanitary 're-engineering' of the local landscape was aimed at reifying the hierarchy of colonial power and race relations as well as norms of western medical practice, and bringing sanitary control and behavioural change to the new villages that would be created in the lands watered by British-built canals. Bengal again was situated far differently—it was not constitutionally autonomous like the frontier where British rule was precarious, yet also not a loyal bedrock like the Punjab where British rule was absolute. Here, in the hotbed of nationalist agitation, the prevailing theme was that control over health signified control over the right to govern and as such gave the holder the right to dictate how social funds should be allocated and to determine the best mode for achieving health and sanitation. The right to deploy health interventions for the good of the people, indeed to decide what was good for them, was being wrested from the British government of the Presidency by Indians in local government in the context of large-scale devolution of power.

Many writers on the history of medicine in colonial India have discussed the slow progress of sanitary reform in the region and the culpability of the colonial government versus the public in this. Yet as Roger Jeffrey and Mark Harrison have pointed out, practical constraints hindered the straightforward application of sanitary logic.[1091] Though public health officials sought to remedy the lack of adequate or appropriate attention being paid by local bodies to anti-epidemic operations and issues of adequate water-supply, they were hampered by the outcry over government attempts to retain any centralised control over transferred subjects—which included health—even if centralised control may have been the only means to legislate the changes necessary to bring about dramatic improvements.

[1091] Harrison, *Public Health in British India*, pp. 233-4.

With respect to acquiring and maintaining control, there was a different logic when it came to state-driven public health in the postcolonial era. In independent Pakistan, epidemic control measures directly paralleled the nascent government's increasing authority over the state's borders and were one of the earliest signs of the establishment of a functioning state. However, the sovereignty of the people was no longer in question from a foreign, non-elected power, and so successive governments seemed comfortable with dispensing with as much of their privileges to control health as did not fit expediently into the financial burdens of governance, and thus allowed international organizations and states to commandeer the nation's health policy and financial resources. This proved to be dangerous with respect to East Pakistan in the 1960s. The expertise of outsiders, who built research institutions, funded extensive demographic surveys of East and West Pakistan, and lent seats in their educational institutions to Pakistani students, was not evidently considered a challenge to the political autonomy of the people, as it had been when direct political control was exercised over the subcontinent by the British Government. At that time, any indication that the British Government was attempting to retain control of sanitary policy in the hands of non-elected officials raised such a hue and cry, as was most notable in Bengal. Health aid had become an accepted part of the new order of relations between western, former colonial powers and their erstwhile territories, with the understanding that the principle of political self-determination was to be respected.[1092] Equally importantly, however, this reflects the fact that international priorities in health were not seen for the most part as the legacy of coercive imperialism, but rather as a mix of developed world interests and developing world needs. Moreover, officials within Pakistan clearly exercised their capacity to frustrate or pervert the original designs of these health programs for their domestic use in the end.

In marked contrast to concession of international control over domestic health policy, internal struggles continued unabated over the right to determine domestic health policy, demonstrating that this was an arena where political struggles were rife as well. The right to

[1092] 'Colonialism must end', *Dawn*, 22 Oct 1950.

determine the affairs of the provinces was a persistent issue, and at multiple times this issue spilled over into the arena of health. The provinces of Pakistan hotly contested the Centre's decisions with respect to food policy and refused to accept a central medical authority to coordinate medical policy throughout the country. They also challenged the national medical schemes imposed on the country with international support.

Division

Another important aspect of governance that becomes apparent is the types of divisions that existed within society with respect to access to political entitlements, most notably the right to govern one's health or be the willing beneficiary of health interventions.

There was a marked inequality in the access of different social groups to the implements of health that evolved throughout the colonial and postcolonial period. Even as the welfare state which ensured a baseline level of care to all became the norm in certain industrialised states, in colonial India and later Pakistan certain groups remained for various reasons relatively less privileged with respect to state patronage. One of the most persistent examples of this was the imbalance between food-surplus and food-deficit areas within the Muslim-majority provinces and later within Pakistan. Another was the legacy of British influence-building and hospital medicine in India which had privileged urban health relative to rural—the problems of rural India were at times too vast for the limited structure of the colonial edifice to withstand. This remained the case in independent Pakistan, where rural health institutions suffered for want of any personnel to work in them. Another marked inequality can be noted with reference to the status of refugees in relation to older residents of the Pakistan areas. The *Dawn* newspaper noted of the problem of homelessness in Karachi, 'Both the Government as well as the public cannot but sympathise with the homeless, but at the same time, the Government have a duty as regards completing the building programme which is in hand and also as regards the maintenance of the city's health.'[1093] This demonstrates that the industrial concerns and the sanitary needs of the

[1093] 'Editorial: Squatters', *Dawn*, 1 Oct 1950.

city's preferred residents silenced the needs of refugee health, but alongside this, the political needs of refugees were also silenced.

The most profound and resilient division in the subcontinent during the period under study were between local governments and regional/national governments. This intergovernmental conflict was a consequence of the bitter struggle for political autonomy by Indians against the decision-making power of higher levels of government, and was exacerbated by rivalries among the Muslim majority provinces for political and economic capital throughout the period under study. The political habits that had been honed during the colonial period seem to have persisted over time. They led to a repudiation of any central involvement in provincial matters relating to health and well-being, even though at times provincial authorities decried the Centre's unwillingness to take responsibility for the welfare of the people, e.g. in the settled districts of the NWFP during colonial rule and in Punjab after independence when the burden of refugees and food production became excessive. In such a political context, health policy became a flashpoint—the inability of those in local government to make the required decisions for health promoted arguments for centralised control and national coordination. This was true in colonial provinces with respect to anti-epidemic and sanitary works, and in independent Pakistan with respect to food and family planning. A major difference was that whereas the British government at the twilight of its rule in India the colonial government did not have the political will or support necessary to revert to centralised rule, in independent Pakistan the needs of efficient governance in the face of economic and political hardship as well as other factors promoted increasing centralisation.

The Civilising Impulse

Beyond the economic and social logistics of rule, there was an important and unique aspect colouring the implementation of political will in this era, and that was the civilising impulse. This has been discussed in the literature on colonial public health. However, in independent Pakistan, efforts with respect to health were also marked by a similar ambition to use health at the state level to improve the social habits of the people and also their fitness for self-rule. In the latter case, though, it was termed 'development'.

One of the objectives of colonial rule had been to reshape the civic character of Indians who had been placed under the charge of a civilising power which attempted to rescue them from the tyranny of tradition. It was with pride that the Settlement Officer for the Chenab Colony in Punjab reported that as a result of the sanitary regulations in the canal colonies, 'The standard of comfort has obviously risen and it is clear from the pride which the majority exhibit in their well-planned and clearly villages that their ideas of sanitation have advanced far beyond those still obtaining in the districts from which they came.'[1094] This was also one of the subsidiary purposes of western hospital medicine in India, wherein Indians learned not only the norms of convalescence and quarantine, but also of social hierarchies. These hierarchies developed as patients who were separated and treated differently on the basis of their race or religion or caste, and as health professionals who were made the beneficiaries of different privileges based on their standing within the hierarchy of the British educational and appointment system. Though hospital medicine was limited to urban centres while the population of the areas under study was largely rural, its norms had clearly infiltrated the civic consciousness by the time the British had departed India. Letters and editorials in Pakistani newspapers promoted the importance of institution-based medical care, whether in dispensaries or hospitals, as a centerpiece of health policy while also carrying lessons about the proper behaviour that was to be displayed within hospitals and also establishing clear hierarchies of knowledge between different health systems. Furthermore, much as the writings of British bureaucrats revealed a belief that sanitation was an expression of individual character, so too in the postcolonial period we see poor sanitation being associated with lack of character, most clearly with respect to refugees who were considered to be dependent on public welfare, prone to vagrancy, homelessness and largely responsible for pollution of municipal water supplies.

The family planning programme which took off in the 1960s was probably the most ambitious successor to the civilising ethos of the colonial era. Its international proponents openly acknowledged their desire to transform the peasantry of the subcontinent from being beholden to

[1094] BL, IOR/V/26/315/1, Report of the Canal Colonies Committee.

the lures of communism to thriving in their agriculturist economies, with western aid helping entrench these economies within the anti-communist bloc. Moreover, as Ayub Khan openly admitted, he saw in his pursuit of family planning the means of enforcing greater enlightenment for the masses in social and health behaviours related to fertility through acceptance of modern methods of family planning and thereby also opening themselves up to modern modes of governance, through moving past the ties of caste, kin, and tribe towards greater obedience to the state. This was similar to the rhetoric of British officials in Punjab for example, who believed that the canal colonies as designed by British engineers would help to create an agriculturist class that would be the bedrock of British rule in India by transforming their landscape and their behaviour, and thereby their relationship with the colonial regime.

Governance and Medicine

Issues of politics were and have remained tightly bound up with health, even as the style of politics changed in the subcontinent. The importance of health was not merely restricted to the budgetary importance of health programmes, as is often the way public health is presented in politics. Political aims determined the uses of health, the style of medical interventions proposed, and the dissemination of medical, sanitary and welfare activities within society at large.

For the study of the history of Pakistan from its emergence from colonial rule to its political transformations in the decades since, it is edifying to note the way in which the state's impact in society changed as the character of government and social milieus changed. Health, with its access to the intimate sphere of human activities has provided an ideal means to assess these changes. The analysis of health interventions has revealed that struggles for political control between competing political institutions have animated the political history of the Pakistan territories over the 20th century. It also demonstrates that the political, economic, and social diversity of the subcontinent, while adding to the richness of its character, have also been at the root of serious divides between social groups and political institutions, and have thus informed some of the most significant political transformations in the political history of this region over the 20th century—the Government of India Acts of 1919 and 1935, the independence of India and Pakistan, the dysfunction and failure of democratic, parliamentary governance in

early Pakistan, and the rise of Pakistan's first military government. Through health, we can ascertain the social significance of these political changes—ultimately they determined the ability of different groups to maintain autonomy and to access the resources necessary to have adequate food, shelter, and medical care as a subject or citizen of the state.

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