Tackling hunger, disease and ‘internal security’: Official medical administration in colonial eastern India during the Second World War (Part II)

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NEGATIVE EFFECTS OF MILITARY MOBILIZATION ON CIVILIAN MEDICAL POLICY

The amount of time, effort and resources spent by the colonial authorities in targeting the civilian ‘priority groups’ meant, necessarily, that very little time could be spared to deal with the ‘general’ population. Senior officials had been aware of this problem, and as Theodore Gregory, the Permanent Economic Adviser to the Government of India had noted in January 1943, it was going to be impossible to arrange comprehensive rationing schemes even for the entire urban population. The result was that general distributive schemes could never be regularized despite the persistence of continued economic difficulties, with officials only managing to attend to severe local problems, often in a sketchy manner, due to the enduring shortage of material and official manpower resources.

The weaknesses of the official policy deployed amongst the ‘general’ civilian population were cruelly exposed as famine conditions progressed in Bengal and neighbouring provinces. During this period, food and medical aid could only be arranged for the poor, based or arriving, in the cities and selected district towns of eastern India. The Final Report of the Famine Enquiry Commission pointed out that the prominence given to the needs of the industrial workers caused a delay in the initiation of rationing measures for the poorer sections of the ‘non-productive’ civilian population. The Government of the United Provinces arranged schemes for the poorest 60% of the province’s urban population; the Bihar administration opened ‘poor shops’ where cheap food grains were sold to assist the ‘poorer classes’ in the district capitals, and Bengal, the focus of the famine, witnessed the establishment of ‘gruel kitchens’ and shops selling subsidized food in Calcutta and a few district capitals. Indeed, in 1945, the Famine Inquiry Commission reported in 1945 that apart from Greater Calcutta, only two other towns in Bengal—Chittagong and Kurseong—had seen a ‘true system of rationing’. The demands on the authorities in eastern India had been so great during 1943–44, that it had not been possible to implement schemes of controlled distribution even in Dhaka, a town with a population of more than 200,000 inhabitants.

The situation was allowed to deteriorate in rural areas to such an extent that in November 1943 Archibald Wavell, the Viceroy of India, ordered that the army be deployed to counter the effects of famine in the Bengal countryside. The scale of the crisis in rural Bengal was considered so great that a number of Indian voluntary agencies were allowed to undertake relief measures, even though it was recognized that many of them had what were considered to be doubtful political affiliations. Apart from the Indian Red Cross Society and the Friends Ambulance Unit, which worked in close collaboration with the civil medical establishment throughout the war, a number of private organizations became very active during the period of famine. These included the Bengal Relief Committee, the Marwari Relief Association, the Hindu Mahasabha, the Bengal Civil Protection Committee, the Bengal Muslim League Relief Committee and the Ramakrishna Mission. In fact, the responses to, and the enormity of the challenges faced during the Bengal famine underlines the biases of the official distributive strategies in eastern India. Indeed, the prospect of introducing special famine relief measures was given increasing importance in 1943, by senior policymakers within the Government of India and the General Headquarters (India) [GHQ (India)], as there was greater official nervousness that the ever-increasing number of refugees migrating towards the cities of eastern India presented potential strategic ‘internal security’ and public health risks. Relief camps in selected rural enclaves, well-connected to major cities and ports were presented as a solution, not merely because these could be easily provisioned but, interestingly, also because they offered the authorities the chance to keep the scale of suffering away from the attention of ‘impressionable city folk and the international and national press’. This, it was believed, would assist in avoiding further panic migrations, which often placed great pressure on militarily important modes of transport and lines of communication. Moreover, officials hoped that the camps, which tended to be located away from major military bases, would allow any outbreaks of disease to be contained locally. Since 1942, the movement of refugees had been considered a major strategic problem due to its capability to spread epidemic disease. Officials were especially worried about the spread of cholera, plague and smallpox. A new instrument, titled the ‘weekly epidemiological telegrams’, was introduced in April 1942 to keep an eye on the progress of these diseases in eastern India. The telegram, dated 24 April 1942, declared that ‘The Directors of Public Health send, in their weekly telegrams, only the total figures for their respective provinces for each of the diseases cholera, smallpox and plague; but, in view of the continuous flow of evacuees from Burma, the Directors of Public Health in Bengal and Assam are supplying, at our request, figures for districts in order to enable us to keep a watch on the progress of the epidemics.’

In fact, the ability of migrants escaping famine conditions to spread ‘disease and distress’ amongst both military personnel and ‘priority’ civilians bared the dangers of adopting audience-specific medical and public health policies in eastern India. The
predominant policy ever since the outbreak of the war had been to strengthen the military medical establishment at the expense of the civilian sector. This affected all branches of Indian medicine, both public and private, especially when it became apparent that the Indian Medical Service (IMS) and the Indian Medical Department (IMD) were not going to be able to fulfill the military's requirements. The result was the recruitment of a number of 'special categories' of medical officers, which included, among other things, the recruitment of European doctors in India and Britain (October 1940), the transfer of assistant-surgeons in the IMD to the IMS under the emergency commissioning scheme (June 1941), the introduction of medical graduates in state-managed and company-managed railways (October 1941), the employment of specialists on special terms (January 1942), the introduction of women medical practitioners (January 1942) and the transfer of civilian antimalaria officers to military duty (February 1942). The enduring shortages of medical personnel finally forced the authorities to draw on medical licentiates, operating among civilian establishments, in 1943. This forced the creation of a completely new medical service within the army, allowing 'inferior' medical qualifications to be accommodated. This body, the Indian Army Medical Corps, pulled more practitioners out of the civilian medical services, thereby weakening it further.22,23

In the context of the Bengal famine and the epidemics that attended it, these infrastructural trends created a situation where the civilian medical services in eastern India proved unequal to the task of organizing an appropriate response. This forced the various military medical corps to buttress the civilian infrastructure in various ways. At one level, the military was forced to take a direct role in medical relief, with troops and specialized medical units being given orders and resources to arrange comprehensive relief schemes.24 At another, they helped the civilian medical units to be provisioned and run more effectively, with dramatic consequences. In November 1943, the military authorities released an IMS officer, so that he could take over the duties of a Director of Public Health. He was followed, in the first half of 1944, by seven other colleagues, into the Bengal Medical Services. By 15 November 1944, this military assistance had allowed the civilian authorities to open 582 new hospitals, 195 mobile medical units and 1352 'satellite medical centres'. Three types of hospitals were set up: those with 100 beds, 50 beds and 20 beds. The first two categories could be expanded in multiples of 100 and 50, respectively, and were put under the control of the district civil surgeon. The 20-bed units, in comparison, were attached to district outdoor dispensaries, while the 'satellite centres' were outdoor clinics situated within five miles of the local dispensary, and housed in verandas or rooms lent by owners of houses or under trees in the dry season. They, like the mobile units, were placed under the control of the local civil surgeon, whose work was supervised by military officials. Three hundred and fifty-six civilian doctors were involved in this exercise (excluding the Burma Medical Officers and two temporary assistant-surgeons brought in from the Central Provinces), and were supported by 2852 nursing staff in treating 229 253 hospital patients (24 551 of these were treated in Calcutta and 203 702 in mofussil towns).25 However, a combination of factors, especially the requirements of the Allied army based in the front, the continuing shortage of medical manpower and an easing of epidemics connected to the famine conditions in Bengal, caused the special antifamine measures to be withdrawn by May 1944, to the great consternation of many district officials and aid-recipients in the province.16

Strikingly, officials remained aware that Bengal, being the main focus of the famine conditions, was luckier than the other provinces in the region in receiving military assistance to tackle a crisis that was threatening to disrupt administrative functioning. Although districts in Assam, Bihar, Eastern United Provinces and Orissa had suffered greatly from a host of severe epidemics, the official efforts to tackle the problems in Bengal by moving food stocks from these provinces did not bring in any appreciable military assistance. While food distribution and public health measures in the towns and villages near military encampments or battlefronts in Assam, Bihar, Orissa and United Provinces were ratified by the civilian and military officials, vast areas of rural eastern India were denied any lasting state-sponsored distributive schemes. A good example of this is provided by the distribution of antimalarial measures, especially the latest technologies and techniques, among civilians. The spraying of DDT (widely considered to be a miracle chemical at the time) and pyrethrum tended to be organized in centres in and near troop encampments, while the other technique of using 'Paris Green' was generally continued elsewhere. Similarly, mepacrine, the new synthetic antimalarial drug was almost completely monopolized for military use and only shared with very specific civilian groups such as the labour employed in strategic projects and mines.26,27 Even though attempts were sometimes made by the British and Indian officials attached to local civilian administrations to redress some of these difficulties by the general distribution of released hoards of food and medicine, such efforts tended to remain spasmodic due to various reasons. Prominent among these were the ability of the military authorities' to keep an eye out for such 'insubordination', the Central Government's continued willingness to order punishments on the basis of the army's reports and, not least, the continuing shortages of all manner of civilian administrative staff.2

CONCLUDING COMMENTS

An examination of the modes of distribution of food and medical aid, which remained an important component of the official propaganda policies in eastern India between 1942 and 1945, allows important insights into the strategies of the wartime colonial state, the role of its indigenous employees and the reactions of the civilians. From 1942 onwards, the scale of the Japanese threat and economic dislocation in eastern India, both of which caught the colonial state unawares, forced a series of panicky responses. These were intended, ultimately, only to allow the smooth mobilization of the war-effort at the expense of all other competing administrative concerns. However, it was soon obvious to the bureaucrats in New Delhi and the provinces, as well as the GHQ (India), that the disruption caused by these short-term policies—and the political capital being made out of their effects—would necessarily lead to a situation where major constitutional concessions, leading to the dissolution of the Raj, would be unavoidable.28

The various propaganda schemes deployed by the Government of India between 1942 and 1945 were never intended to win the unwavering support of the civilian audiences targeted. In the context of the great economic difficulties being experienced in eastern India, the policy was always one of offering the carrot without ever removing the stick out of view. This is clearly revealed in the relationship between the Government of India and the various 'priority' groups. In the case of the junior employees of various central and provincial services, for instance, their support for the war-effort was effectively controlled by centrally-financed salary increases, subsidized or free food, medical aid and, not least, the warning that these could be withdrawn—with
dangerous consequences—at a moment’s notice.29 Similarly, members of the labour force used in military works and the ‘war industries’ were constantly reminded that the continuation of their bonuses and free or subsidized rations was dependent on the completion of their contractual terms. That the resultant ‘loyalty’ to the war-effort would be necessarily solicitous was obvious to most officials.16

While the Government of India was able to pursue the seemingly paradoxical, albeit effective, policy of ensuring the mobilization of the war effort through the deployment of special aid schemes and threats of their withdrawal, its hold over rural administration was fatally weakened in a number of ways. For instance, a wide variety of official communications underlined the fact that the authorities’ wartime priorities had caused great economic and social distress amongst the ‘general’ civilian population, which had been translated into political discontent. While the inhabitants of the bigger urban centres in eastern India, which tended to house big military bases, were relatively well provisioned, civilians based in the smaller mofussil towns and ‘non-strategic’ villages were generally left to their own devices to fend with the vagaries of an unstable economy. Moreover, the crisis in rural eastern India in 1943 was accentuated by the official decision to feed the region’s cities and urban centres at the expense of its villages.30 In provinces such as Assam, Orissa, Bihar and the princely states surrounding it, such policies resulted in localized famines.31 The province of Orissa and the princely state of Travancore, in southern India, were affected by famine conditions which were accompanied by severe epidemics of malaria, cholera and smallpox.32 The creation of rather serious famine conditions in Bihar32 was regularly noted in military intelligence reports. One such report mentioned that the inhabitants of some villages in Bihar had not tasted rice for months, causing them to revert to eating edible bulbs and pulses ordinarily used to feed cattle.33 Military intelligence would also regularly point out that both East Bengal and Assam were seriously affected by famine conditions. Indeed, the levels of starvation in these regions was high enough to encourage suicide, prostitution and child selling. The army complained that ‘hundreds of deaths’ in villages surrounding the military camps was making the Indian soldiers apprehensive about the effects of shortages upon their families.34 It is often forgotten that parts of Bombay, the Central Provinces and Berar and Hyderabad state suffered from serious food shortages as well. In Bombay, for instance, a state of scarcity was declared in all the villages of Athani and Paragad talukas in Belgaum district, in early 1943 (the declaration was cancelled on 1 October 1943). Scarcity was also declared in Karmala, Madha, Pandharpur, Sangola and Malsiras talukas of Sholapur district from 9 February 1942 which was extended to the Sholapur taluka from 18 January 1943 (the declarations were only withdrawn in January 1944). Famine was also declared in Bijapur district in 1942 and caused a large migration from the area (calculated at one-eighth of the district population). Scarcity relief works—in the form of stone quarries, metal breaking units, tank and road building schemes—were started to tackle the situation and by the end of July 1943 it was reported that more than 90,000 labourers were involved. Moreover, 23 kitchens were opened to feed about 18,000 destitutes.35 There was also a corresponding fall in general health standards, which was underscored by a series of epidemics that hit the region between 1943 and 1945.36-38 One report referring to the fall in morbidity from malaria in the Raniganj area pointed out that ‘available statistics of malaria morbidity have shown a steady decline in Raniganj coalfields since 1944. This reduction is more real than apparent as no such corresponding reduction is manifest in the rural areas of the neighbourhood.’28 Such views were by no means isolated.2,16

The problem, as it unfolded for the colonial authorities, especially the local administration, arose from the fact that such official inactivity attracted a variety of tenacious critics. The middle classes, especially the poorer groups who were dependent on fixed salaries, remained active throughout the war and would often tap into the anti-government agitations being carried out by other sections of rural society, especially the poor agricultural labour, badly affected by the acute shortages.6,39 And yet, the reactions of civilian groups towards the special official medical initiatives underlined the complexity of colonial social and political relations. Military medical intervention was, for instance, welcomed by the poorest sections of the civilian population in eastern India in mid-1943, as the dissemination of official aid set aside for the so-called ‘non-priority’ sections had been constrained by political and communal squabbles, ultimately harming the interests of the groups most in need of assistance.40 Aid meant for general distribution would often be denied to the poorest elements of the rural population and instead be targeted by the subordinate civil services to the relatively well-off, but vocal rural middle classes or landed agriculturists.16 The situation in Bengal was only stabilized by the introduction of large-scale military intervention in famine relief operations, where army officers were given the power to direct food and health measures amongst the worst affected sections of the rural poor, often in special refugee camps outside local bureaucratic control.13 Thus, notwithstanding the basic strategic and political underpinnings of such military medical policy, it is difficult to deny that certain marginalized sections of South Asian society benefited from these special wartime measures. The acceptance, and indeed, the popularity of these schemes is highlighted by the vociferous protests that accompanied the withdrawal of these measures in 1944.16

It is also useful to point out here that while the acceptance of food, domestic fuels and cloth was relatively easy to ensure amongst civilian recipients, the official experience of targeting medical aid was more complex. Although civilian labourers drafted into wartime projects in Assam and Burma tended to accept preventive medical measures such as smallpox vaccination easily, as these were made mandatory for their recruitment, the dissemination of ‘western’ medicines in other contexts proved more difficult. While the scope of ‘western’ medical science had been successfully expanded in India during the 1930s and 1940s, notably through the incorporation of locally prominent vaids and hakims into the colonial medical establishment and by the introduction of the scheme of subsidizing medical practitioners in rural areas, some preventive practices, like vaccination and inoculation regimes, continued to be difficult to introduce. The challenges faced in this regard are highlighted by the difficulties experienced during efforts to vaccinate patients in famine camps, where the primary malady tended to be malnourishment: the issue was finally tackled by tying up the free distribution of food and cloth with the acceptance of vaccination.13 However, civilian attitudes towards epidemic measures turned out to be strikingly different, with people generally becoming more willing to accept both preventive strategies and oral prophylactics in such episodes. The wartime colonial medical authorities were thus faced with an apparently irresolvable situation, where they were criticized for introducing preventive medical measures in some contexts and castigated for not providing vaccines and prophylactics to counter epidemics in others.
To conclude, this general state of affairs, where the demand for access to medical facilities of all descriptions would shoot up during severe outbreaks of disease, was, of course, becoming increasingly apparent through the course of the twentieth century, and needs to be investigated by historians of medicine in much greater detail than has as yet been attempted. Indeed, the great variety of South Asian responses to official medical initiatives between 1900 and 1947—so often regarded as being ‘western’ in character, despite the existence of numerous officially-sponsored practitioners of indigenous systems of medicine—has to be ultimately assessed through a more nuanced understanding of the often contradictory effects of class, caste and religious considerations. State medicine in South Asia was, and has continued to be, responsive to such social determinants not only due to their influence on patient attitudes, but also as a result of their ability to shape official attitudes at different levels of administration. This in turn, has had the effect of determining access to public health benefits and curative care. It is in this context that a careful assessment of the role played by the indigenous agent attached to the public health and medical departments of the British colonial state in South Asia is required. This would help historians of medicine and other social scientists to effectively identify and understand the complex factors shaping the structure of, the resistance to and/or the popularity of particular colonial medical campaigns and establishments.

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