MARGINALISED COMMUNITIES AND EPIDEMICS IN COLONIAL PUNJAB

Dr SASHA
Associate Professor
UILS, Panjab University
Chandigarh

Abstract

Epidemics provide a mirror into the way the state and the society deal with the marginalized groups. Punjab was affected recurrently with the outbreak of epidemics of smallpox, cholera, malaria and the plague which claimed millions of lives in the province. Since Punjab was an important province for the British due to its strategic location, agricultural production and being the chief recruiting ground for military, the British concentrated all their efforts to control and deal with the epidemics. In doing so, they did not pay attention to the social and religious susceptibilities of the people in general and the marginalized groups in particular. The marginalized groups not only faced greater incidence and mortality from the epidemics but also faced discrimination from the society and the British officials.

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The term marginalization in simple terms refers to social exclusion which occurs when certain sections of society are denied access to different areas of society. The marginalized groups do not belong to a particular demographic area. Marginialization can be a result of difference in ethnicity, gender, caste, class, socio-economic level and age. Marginalised people are those who are considered as a group of insignificant people belonging to a lower status. They face discrimination regularly due to their caste, race, religion, language and gender. The marginalized groups are generally at a disadvantage when it relates to access to education, employment and health care. As a result, they have limited opportunities as compared to other sections of society. They are socially, legally, politically and economically ignored. The Encyclopaedia of Public Health defines marginalized groups as “To be marginalized is to be placed in the margins, and thus

excluded from the privilege and power found at the centre." Marginalisation is demeaning for human beings as it results in discrimination which affects their dignity and physical and mental security. It often results in social, political and economic conflicts where the marginalized groups are targeted. They also have to struggle to acquire access to basic resources.

India has been a home to people belonging to different races, religions and castes right from the earliest times. It has been a multi-cultural, multi-racial and multi-religious country due to the arrival of Greeks, Kushans, Turks, Afghans, and Mongols amongst others, who came to India and settled in different areas of the country. Marginalisation in Indian society was an outcome of the caste system. Caste in India represents a social hierarchy ranked in terms of ritual purity where members of the higher caste share common identity. The lower castes are economically dependent on the higher castes due to which they are politically and socially subjugated and are denied access to basic facilities like education and health care. Economic disparities in agricultural and trading classes resulted in labourers and peddlers being denied access to basic facilities. Women have had a lower status as compared to men due to the patriarchal society. They do not have much control over the resources and their bodies. Early marriages and multiple childbirths seriously affect their health and nutritional status making them more prone to diseases. Under the British, marginalization increased manifold. They adopted the 'divide and rule policy' which created differences within the society. The British then used these differences for their political and economic gain and at the same time politicised these differences causing tensions and strife within the society. This was done by playing one religious group against other and by highlighting religious, linguistic and cultural differences. They extended favours to certain groups while totally ignoring other groups causing antagonism within different classes. The marginalized communities suffered at the hands of the British not only in normal times but even in crises situations like epidemics. Epidemics provide a mirror to study the vulnerability of the marginalized groups and how the societies deal with them.

Epidemics of malaria, cholera, smallpox and the plague affected colonial India recurrently in the nineteenth and the twentieth centuries. Malaria accounted for more than

forty million deaths while several million lives were lost in the smallpox epidemics.[1] Over ten million people succumbed to the plague during this time. The Punjab was amongst the worst affected province from the epidemics with high mortality rates. In this province, around fifty-one lakh people died from malaria; nine lakh perished in the smallpox epidemics, three lakh people died from cholera and twenty nine lakh people died from the plague which broke out at regular intervals with varied intensity. [2]These epidemics were not confined to a particular area of the province but affected all the districts with equal intensity. This posed a major challenge for the British. It may be pertinent to add that Punjab was the wheat basket of the British empire from where the grain was exported to feed the British army in different parts of the world. Also, Punjab provided a large number of soldiers to fight for the British army. The outbreak of epidemics not only caused large scale mortality but affected the livelihood of the people forcing them to migrate to other areas. It also affected the administrative machinery which was not geared up to deal with the epidemics. This in turn posed serious challenges for the economic and political stability of the empire.

The British considered the outbreak of the epidemics as a crises situation. They made use of the administrative machinery with great rigour to curtail the spread of the epidemics. This was done to safeguard their political and economic interests as well as to protect their officials and their families. While implementing the measures, the British disregarded the religious and personal sensibilities of the people. The prevailing social customs were violated, privacies were invaded and people were forcibly handled. Since the causal agents of the diseases were not known for a long time, the native population was targeted and considered to be the main agency of causing as well as spreading the diseases. The natives, specially the marginalized groups bore the brunt of the epidemics. Not only were they at a greater risk of contracting the disease, they were considered as primary agents for the disease. Consequently, they were dealt with suspicion by the

[1] David Arnold, Colonizing the Body : *State Medicine and Epidemic Disease in the Nineteenth Century India*, Oxford University Press, New Delhi, 1993. P 164, 201.
[2] *Census of India, 1921*, Volume XV for Punjab and Delhi, Civil and Military Gazette Press, Lahore, 1923. pp 10-12.

British and were attacked by the natives. No social regard was shown to them and they suffered both socially and economically.

Various works have dealt with the outbreak of epidemics both in colonial India and the colonial Punjab. David Arnold (1993) studies the outbreak of the three epidemics of smallpox, cholera and the plague highlighting their spread, mortality and handling by the British. He shows how the outbreak of epidemics helped in the acceptance of western medicine by the natives. In another work, he studies the relationship between Indian and Western medicine and the two directional cultural exchanges between these systems. Terence Ranger and Paul Slack (1995) give an account of the outbreak, spread and handling of different epidemics in various parts of the world and their influence on prevailing ideologies. Atsuko Naonos work (2009) deals with the outbreak treatment of smallpox in Burma. Chinmay Tumbe in *The Age of Pandemics* (2020) gives a detailed account of the cholera, plague and influenza pandemics. He considers the nineteenth and the twentieth centuries as the age of pandemics which was marked by large scale mortality and destruction and how people handled these epidemics. He mentions that we can learn lessons from the past epidemics to deal with contemporary disasters like Covid-19. Madhu Singh in *Outbreaks: An Indian Pandemic Reader* (2021) studies the impact of epidemics in colonial India as well as the impact of the first wave of Covid-19. David Arnold in *Pandemic India* (2022) gives an account of the outbreak and devastation caused by the pandemics in colonial India. It also compares the outbreak of cholera, plague and influenza with Covid-19. These works confine themselves to the outbreak and handling of the epidemics along with the response of the society to the epidemics. The impact of epidemics on the marginalised groups has not received attention of the historians.

I

As mentioned earlier, the Punjab was one of the worst affected provinces in India. From 1850 to 1947, twenty- five districts of Punjab were affected by fifteen major epidemic outbreaks of malaria. These claimed more than fifty lakh lives and severely impacted the economy of the region. Around twenty-two lakh people died in the worst affected districts of Hissar, Rohtak, Delhi, Karnal, Gurgaon, Jalandhar, Lahore, Amritsar,

Ferozepur and Gujranwala. Another twelve lakh people succumbed to the disease in the districts of Sialkot, Gurdaspur, Ambala, Gujrat, Jhelum, Rawalpindi and Hoshiarpur. The north-western dry area and the Himalayan region had relatively fewer deaths.[3] The influenza epidemic of 1918 claimed almost nine lakh lives in the Punjab affecting all the districts. The districts of Gurgaon, Rohtak, Karnal and Hissar in the present day Haryana were worst affected.[4]

Nine major epidemics of smallpox broke out in the province affecting twenty-seven districts and claiming almost nine lakh lives. The districts in the north-western and south-eastern areas were worst affected by the epidemic. Cholera on the other hand affected almost all the districts and claimed more than two lakh lives.[5] The plague was the most dreaded epidemic which broke out recurrently in the province with varied intensity. It started from the districts of Jalandhar and Hoshiarpur and soon spread to other areas. It claimed more than thirty lakh lives from 1897 to 1919 in the province affecting twenty-six districts.[6]

One of the major reasons for the severity of the epidemics was the lack of understanding of the causal agent of the disease. The British were struggling and carrying out various experiments to understand the etiology and the treatment of the diseases. This prevented the effective handling and treatment of the epidemics. The British were hesitant to acknowledge that various policies and programmes like the process of canalisation and colonisation or the building of railways contributed to the spread of the diseases.[7] Instead, in order to justify their rule, they attribute the diseases to certain sections of the native population. In doing so, it was the marginalised sections who suffered the most.

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[3] *Report on the Administration of the Punjab and its Dependencies*, Punjab Government Civil Secretariat Press, Lahore, 1879. pp 43-44.
[4] *Census of India, 1921*, Volume XV for Punjab and Delhi, Civil and Military Gazette Press, Lahore, 1923. pp 10-12.
[5] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, December 1887, Serial Number 24, pp 131-36.
[6] Major F Norman White, *Twenty Years of the Plague in India*, Calcutta Government Press, 1919, pp16-18.
[7] Himadri Bannerjee, *Agrarian Society of the Punjab, 1849-1901*, Manohar Publications, New Delhi, 1982, pp 27-32.

People belonging to low socio- economic groups, low castes, and women were considered as causal agents and chief carriers of the diseases. For instance, the poor and the low castes who lived in 'ill ventilated and tiny hutments' were believed to be causal agents of fever in Peshawar and Rawalpindi.[8] In another instance, the Kashmiri shawl traders were considered to have caused the outbreak of fever epidemic in Amritsar in 1880s. The labourers who were clothed insufficiently were believed to have caused the epidemic in 1882.[9] In the villages of Gurdaspur district, the British considered that the low caste people who looked 'emanciated' caused the fever outbreak.[10] Even for cholera outbreaks, certain marginalised groups were targeted. The poor Kashmiri Mohammedans were again targeted to have caused the disease outbreak in Amritsar. In certain areas, the people who earned their livelihood through begging were held responsible for the outbreak of cholera.[11]

The marginalised groups were also considered as the carriers of diseases. It was believed that the cholera outbreak of 1872 was caused by a Mohammedan who came from Lahore to Gujrat. The cholera outbreak in 1875 in Shimla was attributed to a wandering mendicant.[12] At Murree, it was believed that cholera outbreaks were caused by the coolies and servants who had come there and brought the infection with them. The Kashmiri Mohammedans were considered to have infected Hazara and Peshawar with cholera.[13] Labourers were considered as carriers of cholera infection in Sakroti. The outbreak of the plague at Bhajjal was attributed to butchers while at Lodipur and

[8] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, February 1884, Serial Number 17, p 10.
[9] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, August 1882, Serial Number 14, p 62.
[10] *Gazetteer of Gurdaspur District, 1891-92*, pp16-17.
[11] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, February 1884, Serial Number 17, p 12.
[12] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, October 1875, Serial Number 7, p 74.
[13] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, December 1879, Serial Number 11, p 102.

Musapur, it was attributed to Chamars.[14] The influenza epidemic of 1918 was believed to have been caused by Bhabras, a group of Jains who came to Sialkot from Bombay.[15]

People belonging to certain castes and occupational groups were considered as the carriers of the plague. The barbers (Nais) and the leather workers (Chamars) were considered to carry the infection from one place to another. The infection at Simal Mazra and Deron was believed to have been spread by Muslim fakirs. The untouchables or the Doms were considered to spread the infection by taking the clothing of the dead from one place to another.[16] It was believed that the plague was spread by women as they sat near the dead bodies of the plague victims or slept on the floors during mourning. Also, they carried the infection with them as they touched the open buboes with their clothes.[17] The following table shows the outbreak of the plague in various villages in Banga circle being attributed to the marginalised groups.

Table 1.1: Plague Infection Attributed to Certain Socio-Economic Classes

Name of the Village	**Socio-Economic Occupational Groups**
Khan Khanan	Tarkhan
Sirhal Qazian	Mohammedans, Qazis
Mallupota	Jains and Arains
Gunachaour	Mohammedans
Balon	Gujjars
Mahla Gohla	Chamars
Sahi Kalan	Arains
Masani	Muhammedans, Arains
Saih Khurd	Gujjars
Heeon	Mohammedans

[14] Major E. Inglis, *Report on the Outbreak of the Plague in Jullundur and Hoshiarpur Districts 1877-98*, Punjab Government Press, Lahore, 1898. P6.
[15] *Gazetteer of Sialkot District, 1920*, p32.
[16] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, January 1901, Serial Number 69-70, p2.
[17] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, July 1912, Serial Number 51-53, p1.

Langeri	Arains
Lalpur	Chamars
Dhandua	Marasis
Mukandpur	Chamars
Malah	Chamars
Pharala	Chamars
Mazari	Jhiwars
Tahirpur	Telis

Source: *Report on the Outbreak of the Plague in Jullundur and Hoshiarpur Districts 1897-98*.

The above table shows how the outbreak of the plague was attributed to certain social and economic groups in the initial years of the outbreak of the disease. In the initial years of the plague from 1897-98, human beings were considered to have caused the infection in twenty- two out of twenty-five villages in Jalandhar and Hoshiarpur Districts. Out of these, the people belonging to lower socio-economic occupational groups were considered to have infected eighteen villages.[18] This targeting of the marginalised groups continued till it was discovered that the fleas caused the infection which spread from one area to another by the rats.

II

Not only did the marginalised groups bear the brunt of being stigmatised for being the causal agents and carriers of the epidemics, they also suffered more from the outbreak of the diseases. It was seen that there was a higher incidence of disease amongst them as compared to the other sections of the society. Women suffered more from the epidemics as compared to men.

Table 1.2: Comparative death rates in males and females due to different epidemics from 1901 to 1920

Disease	**Mortality Rates in Males (1901-1920)**	**Mortality Rates in Females (1901-1920)**

[18] Major E. Inglis, *Report on the Outbreak of the Plague in Jullundur and Hoshiarpur Districts 1877-98*, Punjab Government Press, Lahore, 1898. P6.

Cholera	0.4	0.6
Smallpox	1.0	1.1
Plague	11.7	15.1
Fevers	42.5	47.9

Source: *Census of India 1921, Volume XV For Punjab and Delhi*. P61

The average mortality rates of men per mille in the Punjab from cholera was 0.4 while for women it was 0.6. The difference in the mortality rates in males and females was more pronounced in the case of fevers including malaria and the plague. This was largely due to the fact that the patriarchal set up exposed women more to infection as they were expected to take care and nurse the sick. The men also had full control over financial and social matters including providing access to medical facilities. The social customs like purdah and questions of honour also prevented the women from gaining access to medical facilities. Lesser number of women benefited from plague inoculation or smallpox vaccination. For instance, only about thirty eight per cent of women in Hoshiarpur district got themselves inoculated. Only about thirty-five per cent of the women went to hospitals and dispensaries to get themselves treated as compared to seventy-five per cent males.[19] This increased incidence of disease was also seen during the influenza epidemic where the prevalence of the disease amongst women was higher by twelve per cent as compared to men.[20]

It was also seen that the Mohammedans who formed the relatively poorer sections of population suffered more during the outbreak of malaria epidemics. In the three most severe epidemics of 1881, 1892 1nd 1908 there was higher incidence of malaria amongst the Kashmiri shawl weavers. [21]This was due to the fact that they were adversely affected by the decline in the shawl industry which affected their economic status and consequently their nutritional status and immunity. They lived in small, ill ventilated and

[19] Captain E. Wilkinson, *Report on Inoculation in Jullundur and Hoshiarpur Districts of Punjab, October 1899-September 1900,* Punjab Government Press, Lahore, 1901. Pp vi-vii.
[20] *Census of India, 1921,* Volume XV for Punjab and Delhi. P 61.
[21] Major S. R. Christophers, *Malaria in the Punjab*, Government Printing, Calcutta, 1911.p105

damp units on the outskirts of villages and towns which made them susceptible to the disease.

Table 1.3: Mortality from malaria in Mohammedans and Hindus

Years	Mortality among Mohammedans	Mortality among Hindus
1881	407.4	243.8
1892	139.5	100.4
1908	260.6	157.0

Source: Major S.R. Christophers, *Malaria in the Punjab*. P 105.

Amongst the Hindus, it were the lower classes and people belonging to lower occupational categories who suffered more. In Amritsar, amongst the total number of higher caste Khatris and Brahmans, only forty-six per cent of the people got infected while it was as high as 78.9 per cent amongst the sweepers. The marginalised groups lived in unhygienic conditions with poor drainage and close to water logged areas which made them more susceptible to disease.[22] Also they worked in open areas which exposed them more to mosquitoes. This combined with denial of access to medical facilities increased their chances of getting infected. Similar pattern was observed in other areas including Delhi as is evident from the table below.

Table 1.4: Mortality from Malaria in different social groups of Hindus

City/ Town	Upper Castes Brahmans, Khatris (In per cent)	Lower Castes Chamars and Sweepers (In per cent)	Occupational Groups Lohar, Dhobi, Teli (In per cent)
Amritsar	46	78.9	73
Delhi	40	82	70
Palwal	79.2	90	83.4
Gujrat	38.5	47.7	67

Source: Major S.R. Christophers, *Malaria in the Punjab*. P 106.

[22] Major S. R. Christophers, *Malaria in the Punjab*, Government Printing, Calcutta, 1911.pp106-08

A similar pattern of higher incidence of disease amongst the marginalised groups was seen during the outbreaks of the plague epidemics and influenza. In a case study of forty eight villages in Punjab during the initial outbreak of the plague epidemic, it was seen that in 33 villages, the disease was largely prevalent amongst the marginalised groups of Chamars, Mohammedans, Chhimbas, Telis, Jhiwars, Gujjars and sweepers with only a few cases of the disease in Khatris and Brahmans.[23] Even during the outbreak of the influenza epidemic which occurred two decades later, it was seen that the mortality amongst the low caste Hindus was 5.5 times the upper castes and 7.5 times the Europeans.[24] The prevalent social customs, social and racial prejudices affected the general health of these groups which made them vulnerable to the disease. Also, the British utilised the services of the lower castes to contain the diseases which exposed them to infection causing larger incidence of diseases amongst them.

III

In the nineteenth and the early twentieth centuries, the causal agents of the epidemics were unknown. In order to contain the spread of the diseases, the British laid emphasis on stopping all communication between the infected and the uninfected persons. Those suffering from fevers were segregated and kept under observation. By the third quarter of the nineteenth century, emphasis was laid on disinfection. The dwelling units of the infected were disinfected, walls were scrapped and white washed and leeping of floors was carried out along with fumigation. To carry out the work of disinfection and whitewashing, the services of the lower castes like the coolies and chamars were utilised.[25] This increased their exposure to the disease.

To reduce the intensity of smallpox, variolation was carried out. This procedure involved inserting the mixture of dry crusts of pustules and rice grains in a wound made near the thumb and inducing the disease in a less virulent form. This procedure was carried out by

[23] Major E. Inglis, *Report on the Outbreak of the Plague in Jullundur and Hoshiarpur Districts 1877-98*, Punjab Government Press, Lahore, 1898. Pp76-85.
[24] I.D. Mills, Influenza pandemic in India 1918-19, *IESHR*, Volume23, Number1, 1986, Sage Publications, Delhi.
[25] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, August 1881, Serial Number 13, pp616-23.

the Sayyid Muslims and Barbers among the Hindus.[26] By the 1870s, variolation got replaced by vaccination. To start with arm to arm vaccination was carried out. In this, children often belonging to lower castes were vaccinated and on the eighth day, those with good lymph vesicles were chosen as vaccinifers. People were then vaccinated from the lymph taken from the low caste vaccinifer child. This continued till it got replaced by calf lymph vaccine.[27]

To contain cholera, the British relied on the use of cordons. The infected areas were cordoned off to protect the uninfected areas. The infected persons were segregated in open areas. Thereafter, infected houses were fumigated and whitewashed. Personal belongings including clothes and articles of the infected persons were washed and boiled to disinfect them. This work of whitewashing and disinfection was once again left to the sweepers and the coolies.[28]

The British relied on cordoning off the infected areas to prevent the spread of the plague. A cordon was put around the infected area to prevent any communication with the unaffected area. The inhabitants of the infected villages were asked to vacate their houses and move into the temporary camps with their essential belongings which were set up on the outskirts of the villages. Meanwhile, the houses were disinfected and white washed. The Chamars and the coolies were required to disinfect the walls, ceiling and the floors with phenyl solution. Furniture and other articles which were left behind were also disinfected by the chamars. To start with, temporary sheds were provided by the British for evacuation.[29] In 1907, the village headmen were asked to provide temporary huts for their villages which they were unable to do due to insufficient funds. Those who were well off like the zamindars were able to make their own shelters while those belonging to lower economic status and outcastes were unable to do so. As a result, they took shelter

[26] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, October 1873, Serial Number 5, p815.
[27] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, January 1903, Serial Number 60, p127.
[28] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, May 1886, Serial Number 21, p73.
[29] Major E. Inglis, *Report on the Outbreak of the Plague in Jullundur and Hoshiarpur Districts 1877-98*, Punjab Government Press, Lahore, 1898. Pp7-45.

under the trees in sweltering heat. The services of other marginalised groups were utilised by the British in the isolation and segregation camps exposing them to infection.[30] For instance, the Bhishtis or the water carriers were asked to provide water in the camps while the Dais were to provide food to women.[31]

Restrictions were also imposed on the movement of passengers. Those travelling by trains were medically inspected at various inspection posts. Preferential treatment was meted out to the passengers travelling in first class as they were examined in their compartments. [32]The lower socio-economic groups travelled in the third class and were medically examined at the platforms. They were asked to disrobe publicly and were then physically examined. Even women were examined by male medical officers on the platforms which were sometimes screened off.[33] Although the British mentioned that Dais would look after the requirements of the women, the actual situation was different. There was no Dai to look after women in Ambala. At several places, women were examined along with men by hospital assistants and medical officers for the signs of the plague.[34] The medical officers forced them to uncover their faces and the doctors searched for buboes in the armpits and groin of women in the open. Plague inoculations were carried out by male doctors hurting the social susceptibilities of women.[35]

Although the British propagated the use of vaccination to curtail the spread of smallpox, it was carried out in a manner which hurt the sentiments of various people. The women had to walk long distances to get vaccinated from male vaccinators whose touch was considered 'polluting.' There are numerous instances of male vaccinators and hospital assistants forcibly dragging out women from their homes and being taken for

[30] *The Tribune*, March 24, 1904.pp2-3.
[31] Major E. Inglis, *Report on the Outbreak of the Plague in Jullundur and Hoshiarpur Districts 1877-98*, Punjab Government Press, Lahore, 1898. Pp22-45.
[32]*Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, August 1898, Serial Number 172-B, p1.
[33] Major E. Inglis, *Report on the Outbreak of the Plague in Jullundur and Hoshiarpur Districts 1877-98*, Punjab Government Press, Lahore, 1898. Pp45-47.
[34] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, May 1898, Serial Number 16-51B, p5.
[35] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, January 1898, Serial Number 45, p20.

vaccination.[36] Sometimes, they had to travel for several days to see their child being tortured while lymph was extracted from his arm. When house to house vaccination was started, the vaccinators often came when the women were alone and it was perceived as invasion of privacy. It was also reported that very often the women were molested.[37]

The marginalised groups faced greater hardships during the evacuation measures. In the villages of Gundial and Ali Mardan where there were shortages of huts, the marginalised groups were forced to live under the shelter of trees.[38] In the plague camps, wherever there was a shortage of provisions, the lower castes were deprived of the essential commodities.[39] The marginalised also faced economic hardships. Agriculture was severely affected by segregation and evacuation. The peasants suffered due to decline in agricultural produce and no remission in land revenue was provided to them.[40] Those who grew crops like fruits and sugarcane which required to be processed or sold immediately were worst affected as they were unable to sell their crop due to cordons. [41]The daily wage labour or the kamins were deprived of their means of livelihood. Others like pedlars who sold their goods from village to village also lost their livelihood as they were unable to go to other areas due to cordons.[42] In Garhshankar, the weavers or Julahas suffered as they could not take their goods to the markets. Small traders who sold goods of daily use faced hardships as their shops were forcibly closed.[43] A large number of agricultural labourers and small traders migrated to less infected areas which severely affected their livelihood.[44]

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[36] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, February 1881, Serial Number 13, p83.
[37] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, December 1884, Serial Number 18, p140.
[38] *The Tribune*, May 4, pp3-5.
[39] *The Tribune*, April 27, 1901, p2.
[40] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, June 1898, Serial Number 149, p2.
[41] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, August 1898, Serial Number 204, p83.
[42] *The Tribune*, April 27, 1901, p2.
[43] *Punjab Government Civil Secretariat Proceedings, Home : Medical and Sanitary*, April 1898, Serial Number 279-B, pp1-2.
[44] *The Tribune*, February 22, 1902, p5.

Epidemics represents a crises situation in which the state exhibits alarming response. Epidemics do not affect different sections of people equally. It is during such crises situations that the marginalised groups are at a greater disadvantage. They suffer not only at the hands of the local population but from the state as well. In the colonial Punjab, they bore the brunt of the administration as they were employed by the state to carry out the measures to prevent and treat the epidemics which exposed them to the disease. The caste prejudices along with patriarchal society prevented their access to medical resources thereby making them more vulnerable to diseases. The epidemics had an unequal impact on different sections of the society. The disruption of work did not affect the people in a similar manner. The marginalised groups feared to go to the medical institutions which increased the incidence and mortality from the diseases. It was during the outbreak and handling of epidemics that the social and economic disadvantage of the marginalised groups came to the forefront.

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