Public Health and Epidemics in Madras: Cholera, Plague, and Urban Response

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Introduction

This book examines how a growing port city confronted the recurrent shocks of epidemic disease and, in doing so, remade itself. Framed by cholera and plague but attentive to the wider ecology of illness, Public Health and Epidemics in Madras: Cholera, Plague, and Urban Response traces the entanglement of medical thinking, municipal reform, and everyday life. It argues that health emergencies did not merely interrupt urban routine; they catalyzed infrastructural innovations, reconfigured political authority, and exposed the social hierarchies that structured risk and relief.

Madras, situated at the hinge between sea lanes and inland trade routes, was a node of intense circulation—of people, water, goods, and microbes. Epidemics exploited these mobilities, but so did responses to them. From wells, tanks, and standpipes to drains, scavenging depots, and quarantine stations, public works emerged as both medical instruments and political statements. The “sanitary idea” migrated from imperial reports to municipal committees and, finally, to the street-level practices of sweepers, nurses, and householders whose labor sustained the city’s fragile health.

The book foregrounds this layered labor of public health. It highlights the clerks and statisticians who transformed mortality into charts; the conservancy workers who converted policy into cleanable surfaces; the dock officials and police who enforced quarantine; and the midwives, temple attendants, and bazaar practitioners who negotiated between official medicine and vernacular care. Together, their actions produced a patchwork infrastructure that was at once technical and moral, scientific and social. Crises revealed its seams: cholera traced the politics of water; plague dramatized the surveillance of bodies and homes; and influenza exposed the limits of institutional capacity and the indispensability of community networks.

Equally central is the book’s attention to debate and dissent. Epidemics pressed newspapers, civic associations, and neighborhood councils into vigorous argument about causation and cure, rights and responsibilities, expenditure and equity. Controversies over compulsory measures, slum “improvement,” and the siting of hospitals were not merely technical disputes; they were moments when residents contested who counted as a public and what a city owed its people. By following these arguments across languages and forums, the chapters show how health policy became a crucible for urban citizenship.

Methodologically, the study draws on municipal minutes, engineering plans, medical department records, newspapers, and oral histories to reconstruct how policy traveled from committee rooms to crowded lanes. Rather than treating colonial medicine as a monolith, it traces the frictions among administrators, engineers, laboratory scientists,

and local practitioners, and it reads official documents alongside the practical knowledge embedded in labor routines and household strategies. This approach reveals a city governed as much by infrastructures and routines as by laws and edicts.

Although rooted in a specific time and place, the questions animating this book speak broadly to urban governance in the Global South and beyond. How do cities steward water and waste as matters of both biology and politics? What forms of authority—and resistance—emerge when disease management collides with everyday survival? Which investments endure after the sirens of emergency fade, and which reproduce old inequalities under the banner of reform? For historians of medicine, the narrative offers a grounded account of how scientific ideas are domesticated by institutions. For policymakers and planners, it distills lessons about equity, participation, and the slow, unglamorous work that makes public health possible.

The chapters that follow move from epidemiological diagnosis to infrastructural design, from legal frameworks to neighborhood experience, and from colonial experiment to postcolonial legacy. They show how cholera and plague were not only biological events but also civic dramas, reshaping the city’s built environment and political imagination. In doing so, the book invites readers to see epidemic response not as a sequence of one-off measures but as an ongoing negotiation over the material and moral terms of urban life.

CHAPTER ONE: Ports, Presidencies, and Public Health: Madras as a Maritime Gateway

Madras, now known as Chennai, occupies a significant place in the annals of public health history, largely due to its strategic location as a bustling port city on the Coromandel Coast of the Bay of Bengal. Established in 1639 by the English East India Company, it swiftly evolved from a modest fishing village into a formidable trading post, eventually becoming the capital of the Madras Presidency, one of the three major administrative divisions of British India. Its maritime identity was not merely a matter of economic prosperity; it profoundly shaped the city's demographic landscape, its environmental vulnerabilities, and ultimately, its unique struggles with epidemic diseases.

The very genesis of Madras was intertwined with trade. The East India Company sought secure strongholds on the Indian coast to expand its trade in textiles and spices. The site of Madrasapatnam, a fishing village, offered strategic benefits due to its proximity to inland cotton markets and vital sea routes. This early commercial interest attracted a diverse influx of people, including Armenian, Portuguese, and various Indian traders, contributing to the city's rapid growth and making it a commercial capital. By the 18th century, Madras was already competing with Bombay and Calcutta in terms of trade volume.

However, the geographical advantages that facilitated trade also presented significant public health challenges. The Coromandel Coast, while ideal for maritime access, directly faced the open sea, making it susceptible to the full fury of monsoons and cyclones. Unlike the relatively calm harbors of Bombay or Calcutta, Madras faced a notorious surf, which made docking treacherous in its early days. Ships often had to anchor two miles offshore, with goods and passengers ferried to the beach by masula boats and catamarans through the rough waves. This arduous process not only led to the loss of a significant portion of merchandise but also highlighted the lack of robust infrastructure to manage the flow of people and goods, creating potential vectors for disease transmission.

The establishment of Fort St. George in 1640 marked the beginning of a fortified settlement, attracting more European and other traders, and leading to significant urban expansion throughout the 17th and 18th centuries. By 1646, the settlement's population had swelled to 19,000, not including the Portuguese and Dutch populations in their respective forts. This burgeoning population, coupled with the inherent difficulties of its coastal environment, meant that Madras was a city constantly grappling with rudimentary sanitation in the face of rapid growth and high mobility.

The British colonial administration, particularly the East India Company, recognized the need for some form of medical services, primarily for their troops and European civilians. In 1664, the first British hospital in India was established at Fort St. George, initially to cater to sick soldiers. By 1785, medical departments were formally set up in the Bengal, Madras, and Bombay presidencies, looking after both military personnel and British civilians. These early efforts laid the groundwork for a more structured approach to health, albeit one initially focused on the colonial elite.

However, the concerns for public health slowly began to encompass the Indian population, particularly the laboring and service-providing classes, by the 1860s. This shift was often driven by a pragmatic desire to prevent the spread of diseases from the local population to colonial employees. The establishment of the Subordinate Medical Service (SMS) in Madras in 1812 was an early step towards providing medical training to Indians. While initially composed of non-commissioned European medical personnel, the Native Medical Institution was set up in 1822 to train Indians for the SMS, albeit briefly. This early medical infrastructure, though nascent, was crucial in the eventual battle against epidemics.

The tropical monsoon climate of Madras (now Chennai) also played a critical role in shaping its public health challenges. The city receives a significant portion of its annual rainfall from the northeast monsoon between October and December. While vital for water storage and agriculture, these monsoons often brought intense rainfall, exceeding the city's drainage and storage capacity, leading to widespread flooding and waterlogging. Such conditions were, and continue to be, breeding grounds for mosquitoes, contributing to outbreaks of vector-borne diseases like malaria and dengue.

Moreover, the mixing of overflowing sewage with floodwaters created serious sanitation and health hazards, leading to a surge in waterborne diseases such as cholera, typhoid, and gastroenteritis during the monsoon season. Cholera, in particular, was endemic to Madras and the broader coastal regions of Tamil Nadu, with incidence often peaking during the rainy months of October and November. The very environmental conditions that defined Madras as a maritime gateway also rendered it acutely vulnerable to the spread of infectious diseases.

Despite these challenges, the city continued to grow and thrive as a center for trade, administration, and eventually, education and culture. The development of a proper harbor in Madras in the late 19th and early 20th centuries, with official operations beginning in 1881, further solidified its position as a major port. This ongoing development, however, placed continuous pressure on the existing infrastructure and sanitation systems, setting the stage for the major public health crises that would define much of its colonial history.

The story of public health in Madras is thus not merely a tale of medical interventions but a complex narrative interwoven with its identity as a maritime hub, its colonial governance, and its unique environmental predispositions. The constant movement of people and goods, the challenges posed by its geography and climate, and the evolving nature of colonial administration all contributed to the specific patterns of disease and the responses developed to combat them. These foundational elements would continue to influence the city's public health landscape for generations to come.

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