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The Medicalisation of a Colonial Space: Sanatoria, Public Health, and the Political Geography of Darjeeling

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Abstract

This article interrogates the entangled histories of colonial medicine, spatial governance, and public health infrastructure in the Darjeeling Hills. It critically analyses how British colonial authorities deployed medical rationalities—particularly through the construction of sanatoria and health institutions—as instruments of imperial control and spatial reconfiguration. The medicalisation of Darjeeling, far from being a neutral or purely humanitarian endeavour, served to legitimise the consolidation of British authority in a strategically vital frontier region. Through a close reading of archival records, colonial gazetteers, and secondary literature, the study charts the transformation of Darjeeling from a peripheral frontier into a militarised cantonment and elite European hill station. It further examines the long-term implications of these interventions on postcolonial healthcare trajectories in the region. By foregrounding the intersections of biopolitics, empire, and geography, this study contributes to a deeper understanding of the colonial legacies embedded in the region's health infrastructure.

Keywords: Colonial medicine, biopolitics, Darjeeling Hills, sanatoria, spatial governance

1. Introduction: Sanatoria and the Colonial Medical Imagination

The establishment of sanatoria in Darjeeling offers a compelling entry point into the understanding of colonial medicine's spatial politics and the medicalisation of frontier geographies in British India. Far from being mere healthcare institutions, sanatoria in Darjeeling were instruments of imperial control and cultural hegemony, designed not only to treat disease but also to reinforce racial hierarchies and civilizational binaries between the coloniser and the colonised.

This introductory section unpacks the strategic imperatives that drove the transformation of Darjeeling into a cantonment town and elite hill station, structured around ideas of therapeutic landscapes and climatic determinism. The colonial state viewed the Indian plains as pestilential and degenerative to the European constitution. In contrast, the cooler, elevated terrains of the Himalayas were seen as sites of convalescence and physiological restoration, especially for British officials, soldiers, and their families.

The emergence of Darjeeling as a medicalised space must also be contextualised within the broader colonial framework of bio-politics and spatial governance. The selection of Darjeeling as a health resort intersected with colonial anxieties regarding tropical diseases, the productivity of imperial functionaries, and the legitimacy of empire itself. Colonial administrators and medical professionals co-produced a discourse in which the hills were not only healthier but also more governable and less rebellious than the plains, thus linking medical geography with political pacification.

Drawing upon archival resources and medical records, this section sets the stage for a deeper inquiry into how the British deployed health infrastructure as a tool of surveillance, segregation, and consolidation of power. Darjeeling's sanatoria were emblematic of the ways in which health care, urban planning, and imperial ideology came together to forge a colonial modernity in the eastern Himalayas. This article proceeds to trace these linkages through a detailed historical and spatial analysis of Darjeeling's evolution from a contested frontier to a regulated cantonment town central to the medical cartography of British India.

An analysis of the historical progression of the healthcare delivery system has been delineated in the following subsections to map the evolution of healthcare from the 1950s to the turn of the millennium.

2. Darjeeling: A Historical and Geopolitical Overview

*Darjyu Lyang,*or The *Land Of God'* or '*Heaven Earth*' is believed to have given Darjeeling (Darjiling, after the 1981 census), the northern most district of the Indian state of West Bengal, its name. It is also believed that the name is a corrupted form of *Dorjee ling* of the Lamaist religion, *'Dorjee'* the Celestial scepter of double-headed thunderbolt and *`ling'* or the land, and thus, literally means `the *land of the thunderbolt'* after the famous Buddhist monastery, which stood atop the observatory hill and was known by the same name.

Among the various frontier districts of India, Darjeeling in West Bengal has a particularly intricate history due to its connections with Sikkim, Nepal, and Bhutan. This complexity is further heightened by its proximity to international borders. Located in the eastern part of India, this region is bordered by Nepal to the west and Bhutan to the east. The northern border is formed by the river *Tista*, which separates it from the state of Sikkim. To the south, it shares borders with the districts of Jalpaiguri in West Bengal and Purnea in Bihar. The complexity of the boundary situation is evident when considering that, even as late as the 1950s, the issue of the narrow chickens neck remained largely unresolved. In contrast, the frontier boundaries in the North East were clearly demarcated with distinct lines separating India from Burma and India from East Pakistan (later Bangladesh). The borders of Nepal, Sikkim and Darjeeling converge at the peak of Phalut (3700m), creating a meeting point with a similar convergence at Rachela (3100m) between the subdivision of Kalimpong, Sikkim and Bhutan. From there, the river Jaldhaka flows down, dividing the countries of Bhutan and India. The District of Darjeeling is predominantly mountainous, with varying altitudes ranging from 132m at Sukna to 3700m at Phalut, excluding a portion of the Siliguiri subdivision. Access to Darjeeling is available from the southern part only, passing through the districts of Jalpaiguri, North Dinajpur, and Purnea district of Bihar, as well as the plains of Nepal across the river Mechi.

3. Study Area

The study has been carried out in the 3 subdivisions of Darjeeling District: Darjeeling Sadar, Kalimpong and Kurseong. It includes both rural and urban areas.

MAP OF DARJEELING DISTRICT

Source: Author

MAP OF KALIMPONG DISTRICT

Source: Author

[Darjeeling district is located between 26° 31′ 05’’ and 26° 27’ 10” North latitude and between 80° 53’ 00” and 87° 59′ 30” East longitude occupies an area of 3,254.7 sq km (1200 sq miles) accounting for 3.68 percent of the total area of West Bengal. Three of the four sub-divisions that comprise the hilly region alone cover as area of 2320 sq.km. The Darjeeling- sub-division has an area of 935. 5. sq. km; Kurseong sub-division- 423 sq. km. and the largest Kalimpong sub-division 1,056. 5 sq. Kms. Out of 934.6sq km. area falling in the terai and plains, 837.4 sq. km is covered by Siliguri Civil sub- division.]

4. Political History of the Hills and Plains of Darjeeling

Darjeeling, much like Simla or Ooty, owes its existence to the British colonial imperial project. The development of hill stations in India was not a random occurrence. They were essentially European creations, as the British viewed India as a place of poor sanitation, illness, and unexpected fatalities. By the 18th century, they recognised the necessity of establishing hill stations to restore the health of Europeans (Metcalf, 1995, p. 171; Sarkar, 2006, pp. 231–245). The British noticed that the health and sprit of men improved dramatically during their sojourn in the hills. By the early decade of the 19th century, the British had felt the need of establishing a hill station in the vicinity of Calcutta since the sojourn in the hill stations of North India was both time consuming and costly (Bayley, 1836, p. 11). Not to mention, there was also a British consideration that is to intervene in the politics of Tibet under the guise of trade (Sen, 1989, p. 12).

The British government of India acquired the territories of the district of Darjeeling from two neighbouring states, Sikkim and Bhutan. Before Darjeeling became a hill station in 1835, it was originally a part of Sikkim. During the late 18th century to the early 19th century, Sikkim faced multiple invasions from the Gurkhas, who had gained control in Nepal. The British were drawn into the scene due to disruptions in the northern frontier. Between 1804 and 1812, the relationship between Nepal and the British gradually worsened along the frontier, leading to the declaration of war in November 1814 (O'Malley, 1907, p. 19). After an arduous campaign the British took possession of the whole country between the river Kali and Sutluj, which had been annexed by Nepal. The treaty of Segauli in 1816 finally settled British relation with Nepal (Moktan, 2004, p. 4). It gave the British direct contact of the Himalayan district of Kumaon and Garwal. The East India Company's relation with Sikkim may be traced to the Anglo- Nepalese war. Due to the strategic location of Sikkim the British had sought its help during the war. It included the hill regions east of the Mechi and part of the Terai between the Mechi and Tista rivers (Aitchison, 1929, p. 46). In the 18th century Sikkim was engaged in warfare with Bhutan and Nepal. The Raja of Sikkim Chador Namgyal (1700-1716) lost the territory to Bhutan in 1706, but re-conquered it by the closing decades of the 18th century (Sen, 1996). It was Nepal which overran Sikkim as far east as river Tista.

Nepal had to face another enemy the British whose expansion in the east led to border skirmishes between them and this eventually led to the Anglo-Nepal war of 1814 which was concluded by the Treaty of Segauli on the 2nd of December 1815 whereby Nepal ceded to the East India Company all its Sikkimese territories. By the treaty of Titalya of 10th February 1817, the whole country between the river Mechi and the Tista (a vast tract of 4000 sq miles) was restored to Sikkim, and the sovereignty of the Raja of Sikkim was guaranteed by the Company. By this treaty the Company assumed the position of 'paramount power' in Sikkim (O'Brian, 1878, p. 12). According to article two of the Titaliya treaty Sikkim Raja agreed for himself and his successors to abstain from any act of aggression or hostility against the Gurkhas or any other state (O'Brian, 1878, p. 12). By the article three of the above treaty Sikkim Raja agreed that he will refer to the arbitration of the British Government any disputes or questions that might arise between his subject and those of Nepal, or any other neighboring state, and abide by the decision of the British Government (O'Brian, 1878, p. 12). In 1828, disputes between Nepal and Sikkim led to arbitration of the British Government who ordered Captain Lloyd and Mr. J.W Grant the Commercial Resident at Malda, an enthusiastic explorer of the Himalayan foothills to bring about a settlement (Hosten, 1930). In February 1829 Lloyd was impressed by Darjeeling for the purpose of a sanatorium (O'Malley, 1907, pp. 5–9). He urged the British Government to secure possession of such a strategically located place, commanding the doorway to the neighboring countries of Nepal and Bhutan. For the nearest road to Lasha from the British

territory lay through Darjeeling (Sen, 1989, p. 23). His views were supported by Captain Herbert, the Deputy Surveyor-general deputed by the Government. On the basis of their reports the Court of Directors approved of the project of having a sanitarium for invalids. Governor- General William Bentinck ordered Major Lloyd to open negotiation on 23rd of January 1835, offering land or money (Pin, *Darjeeling Letters*, p. 89) and making the Raja understand that the British only wanted Darjeeling for sanitarium.

The Raja of Sikkim had a list of demands. He asked for an extension of the western boundary of Sikkim. The tax collector who owed him money was to be handed over to Sikkim and thirdly he asked Debgong.[1] The Government of India Did not like the nature of the demands made by the Raja of Sikkim and asked Lloyd to stop negotiations but the Government was surprised that Major Lloyd did not follow the order and instead informed them that he was in possession of the deed of grant of Darjeeling. The English version of the Deed of Grants as found in the District Gazetteers by A.J .Dash as follows:

> *"the Governor General having expressed his desire for the possession of the hill of Darjeeling on account of its cool climate, for the purpose of enabling the servants of his Government, suffering from sickness, to avail themselves of its advantages, I, the Sikkimputtee Rajah, out of friendship for the said Governor general, hereby present Darjeeling to the East India Company, that is all the land South of the Great Rangit river, east of Balasun, Kahail and Little Rangit rivers and west of Rungno (Tista) and Mahanadi rivers." (Dash, 1947, pp. 37–38)*

The British took over Darjeeling in August 1835. In December 1836 Lloyd and Chapman were sent for a year to make a report on Darjeeling and General Lloyd was made the Local Agent dealing with application for land plots (Hosten, 1930, p. 107). The settlement in Darjeeling grew from a few huts in 1836 to 70 locations by 1840 (O'Malley, 1907, p. 22). Relationship between the Company and Sikkim deteriorated as Sikkim lost its rights over the Lepchas settling as British subjects in Darjeeling.

In November 1849, Sir Joseph Dalton Hooker and Dr. Campbell, the Superintendent, were unexpectedly taken captive while travelling in Sikkim with the consent of both the Raja and the British Government (O'Malley, 1907, p. 24). The Dewan of Sikkim sought to exert pressure on Dr. Campbell to surrender all fugitives and individuals in bondage from Sikkim. The Sikkimese Government had no choice but to release the British prisoners without any conditions on 24th December 1849. The grant of Rs. 6000 per annum to Sikkim, which had been previously agreed upon, was abruptly withdrawn by the British. Additionally, the Sikkimese terai was occupied by them. This Darjeeling, encompassing an area of 640 square miles, was incorporated into British India (O'Malley, 1907, p. 24). Sikkim asserted its ownership of the land located north of the Raman River and west of the Great Rangeet River. Sikkim suffered a defeat and, as per the treaty of 28th March 1861, was compelled to provide compensation for the damages suffered by the locals who were affected by the actions of the Raja's forces and the British troops. The treaty was comprised of 23 articles. These agreements resolved all border conflicts between British Darjeeling and Sikkim, ensuring unrestricted trade for British subjects along the Sikkim borders (O'Malley, 1907, p. 24).

It is worth mentioning that while the area was initially ceded for health reasons, it later proved to be economically promising for the British. As a result, it is worth noting that tea plantation on an experimental

[1] Political consultation, 6th April, 1935 Numbers 100 and 102. Dabgong was a small territory formerly belonged to the Raja of Sikkim and later it was under the British protection. During the negotiations with Major Lloyd and the Raja of Sikkim, the Raja demanded Debgong in exchange of Darjeeling.

basis began as early as 1840, which was actually before the establishment of a sanatorium. By 1860, the tea industry had already experienced significant growth, while the first-ever Eden sanatorium was established in 1883, followed by the Jubilee sanatorium in 1887. It would be imprudent to overlook the colonial ambitions in the development of Darjeeling as a prominent hill city. While health considerations may have played a significant role in its acquisition, the primary motive behind the colonial rule was undoubtedly trade and commerce. Therefore, it is appropriate to discuss how these two intentions, the perceived necessity and the desire for physical comfort, have worked together to facilitate the development of Darjeeling as a prominent hill city during the colonial era in India.

Relationship with Sikkim was drawn out but the British still had to deal with the neighboring kingdom of Bhutan. The Bhutanese were engaged in aggressive attack on the frontier causing disturbances (Singh, 1972). In fact in 1862, British troops had to be mobilized at Dinapore in preparation of the Bhutanese attack. In 1863 Sir Ashley Eden the British envoy was sent to the Bhutan durbar, to demand restoration of the plundered territories but he was forced to sign a document by which the Bhutan Duars, on the Assam frontier was surrendered by the British (Surgeon, 1866, p. 407). In order to re-annex the Bengal Duars the British sent an army in 1865 which conquered the territory and the humiliating treaty signed by Sir Ashley Eden was cancelled (Surgeon, 1866, pp. 163–164). Instead a new treaty called treaty of Sinchula was signed on November 11th, 1865, by which Bhutan Duars was ceded to the British in return for an annual subsidy (White, 1971, p. 281). In 1866 a strip of hill territory of 486 square miles, which was annexed from Bhutan by the treaty of Sinchula, had been added to the district of Darjeeling (Sen, 1989, p. 16). This area was made Kalimpong Sub- Division subsequently. Thus in 1866, the Darjeeling district consisted of two subdivisions only namely, Darjeeling and Kalimpong. In 1891, the Kurseong subdivision was formed from Sadar Sub-division (Sen, 1989, p. 16). It was on 14th February 2017 Kalimpong Sub- Division was carved from Darjeeling District and Kalimpong district was formed.

5. Administrative Reorganisation of Darjeeling District

Although historically Darjeeling was a part of the sovereign state of Sikkim, it is now a District of the state of West Bengal and thus remains separated by a politically demarcated boundary. The district has retained its geographical dimensions since 1886 but administrative placements kept on changing. The Darjeeling District was included in the Rajashahi Division until October 1905 when, as a result of the partition of Bengal, it was transferred to the Bhagalpur Division. With the re-arrangement of the provinces it was retransferred to the Rajashahi Division in March 1912.

Darjeeling hill areas belonged to the Non-Regulation scheme before 1861. It was brought under general regulation system for a short period of 1861-1870. The administrative arrangement for the district, considered as less advanced district was placed under the Governor-General from 1870 to 1874. Soon Darjeeling was brought within the purview of the Laws Local Extent Act 1874 also known as the Scheduled District Act. The Act provided that in the listed districts the normal legislation and jurisdiction were in force only in part or with modifications if necessary of any enactment in force at the time in any part of British India. Darjeeling District was Scheduled Area and hence outside the purview of laws applicable to the areas not coming under the Act. The administrative arrangement provided for remained unaltered for quite a long period.

The Government of India, in its proposals under Section 52-A(2) forwarded to the secretary of State, divided the backward areas into two classes: (i) “Those wholly excluded” and (ii) “Those in which the scheme should be introduced with modification. By the Government of India Act of 1919, Darjeeling was

declared as a backward tract. The administration of the district was not subject to vote of the Legislature. Darjeeling remained as a Backward Tract till the passing of the Government of India Act 1935 which declared the district as a partially excluded area and remained as partially excluded area till the end of the British rule. Thus an Act either of the federal legislature or the provincial legislature would not extend to the partially excluded area, unless the Governor of the province would give his assent to the applications as he thought necessary. The governor could also make regulations for such area for peace and good government. In the case of partially excluded area, the Governor had to consult the council of ministers. Thus, Darjeeling became a partially excluded area within the Province of Bengal. Therefore, between 1835 and 1947, Darjeeling area was under the British Rule. During this period the British never allowed the district to come within the national mainstream, and within the purview of general administration (Dhar, 1998, pp. 184–185).

6. The Sway of the Raj and Modern Medicine: Medicalisation of a Colonial Space

It is crucial to consider the broader historical, social, and economic context of South Asia when examining the health care system during the Raj (Chakraborty, 2022, pp. 9–25). Understanding the extent of the medical evangelization effort requires recognising the interconnection between the ideas and practices of medicine and the mechanisms of exploration and control employed by the colonial state. This effort involved numerous organisations (Arnold, 1993, p. 105). Initially, only colonial administrators, military personnel, and the numerous labourers who ventured into the mountainous frontiers of the northeastern borderlands had the privilege of accessing western medicine and health services. The colonial documents records the slow wave of 'medicalisation' (Zola, 2007/1972; Conrad, 2007) and taming of the Raj's once-'wild tribes' on the Raj's eastern frontiers. Medicalisation and health services were prioritised with the intention of transforming the formerly rebellious tribes into submissive Imperial subjects (Chakraborty, 2021, pp. 66–96).

6.1 The History of the Hospitals in Darjeeling

The hill station of Darjeeling and the surrounding plantations showcased distinctive spatial and political structures as colonial enclaves. The development of medical and sanitary programmes in these areas was driven by their crucial role in the colonial economy and implemented with a focused and strategic approach. The establishment of Darjeeling as a hill station not only facilitated the colonisation of neighbouring areas but also received active encouragement from the government for the development of plantation enclaves. This transformation had significant impacts on the ecology, demography, and economy of the entire region. In addition, the region gained significant recognition in the medical community of colonial India. This recognition was primarily due to its unique disease environment and, later on, the demand for Tropical Medicine research driven by the plantations and the hill station (Bhattacharya, 2012).

The establishment of hill stations, which resembled the English homeland, played a crucial role in the colonial strategy to adapt and thrive in tropical regions. 19th-century colonial medical discourse often discussed the perceived unhealthiness of the plains, particularly in Bengal. Mountains were depicted as a contrasting sanctuary. Prior to the 1830s, theories on acclimatisation were characterised by optimism and a wide range of perspectives. These theories advocated for adapting to Indian dietary habits and clothing, which included practices such as seeking cooler environments during the summer, influenced by Mughal customs (Harrison, 1999, p. 52).

Hill stations, such as Darjeeling, were established not only for health reasons but also to maintain a physical and metaphorical distance between rulers and the ruled (Kennedy, 1996). The choice of station locations, far from the bustling Indian populations in the plains, was deliberate. The British further emphasised this spatial separation through the architectural and social elements of their life in India.

Darjeeling, which J.D. Herbert identified as a potential sanatorium, was highly recommended for its pleasant cold climate, particularly well-suited for European troops. It was believed that the elevation of 6000 feet in Darjeeling would prevent fever and ague, making the region free from these diseases. The decision to select Darjeeling over other locations was influenced by its high elevation, which offers protection against common diseases. The narrative woven around Darjeeling consistently highlighted its therapeutic qualities, ascribing the region's air to remarkable recoveries.

The depiction of Darjeeling as a haven of rejuvenating mountains has been consistently highlighted in medical and tourist literature. The portrayal depicted Darjeeling as a health resort contrasting with the unwholesome lowlands, with an implicit belief in the separate status of the local population and foreigners (primarily Europeans). The mountains were depicted as invigorating for the robust, energetic, strong English constitution, in contrast to the draining effects of the tropical plains.

By 1839, the establishment of Darjeeling as a hill station had a significant impact on the tone of medical discourse. Testimonies highlighted the difference in constitutions between natives and non-natives, portraying the cold mountain air as advantageous for non-natives, especially the English. The rhetoric continued, linking any prevalent diseases in the mountains to contraction in the plains.

Darjeeling, during its early development, established the atmosphere for a discussion where the sanatorium was contrasted with the perceived unhealthiness of the plains. The mountains were presented as a way to revive the English constitution, highlighting the blissful and organic nature of physical effort. The discussion continued for the following century, with Darjeeling being recognised as a destination where European individuals could recuperate from illnesses acquired in the tropical lowlands.

In the town of Darjeeling, three renowned medical institutions were instrumental in delivering healthcare services to both the European and local populations. These institutions included the Eden Sanitarium for Europeans, the Lowis Jubilee Sanitarium for locals, and the Victoria Memorial Dispensary, which served both locals and Europeans (O'Malley, 1907).

The Eden Sanitarium, inaugurated in 1883, was named after Sir Ashley Eden, the then Lieutenant Governor of Bengal. It served as a recovery home for European patients from tea gardens and the plains who required treatment in a cool climate. The institution, partially charitable, provided accommodation, care, and attention to patients. While some cots were offered free of charge, others were available at a daily rate of Rs. 3, excluding maintenance costs. The annual admission ranged from 450 to 500, and by 1905, over 60 operations were conducted annually. The Lowis Jubilee Sanitarium, later known as the Luis Jubilee Complex, opened in 1887 to commemorate Queen Victoria's Jubilee. Maharaja Gobind Lal Roy's donation of Rs. 90,000 facilitated its establishment for the benefit of Indians without a hill resort (O'Malley, 1907). Divided into Hindu and general departments, the sanitarium admitted around 650 patients annually, with an annual maintenance cost of approximately Rs. 25,000. The Victoria Memorial Dispensary, functioning as the Darjeeling Municipal hospital, treated more than 10,000 patients and performed 389 operations in 1905. With 45 beds, it included a cottage hospital, an infectious diseases hospital, and an operating room. Numerous charitable dispensaries were scattered across the district, including those in Kurseong, Kalimpong, Pedong, Pankhabari, Siliguri, Baghdogra, Kharibari, Naksalbari, Phansidewa, and Sombari Hat. Several missionary efforts greatly improved healthcare services. The

hospital at Kalimpong, supported by the state and overseen by the Church of Scotland Mission, had a capacity of 26 beds. In addition, the mission ran dispensaries in Nimbong and Kizom, offering medical assistance to thousands of people every year. Sukhiapokhri has been hosting an independent medical mission, providing treatment to more than 10,000 people every year. The treatment is offered either at the dispensary or during missionary tours. The Church of Scotland made a significant impact on healthcare services, ensuring widespread coverage throughout the region (O'Malley, 1907).

Conclusion: Legacies of Colonial Health Governance

The case of Darjeeling demonstrates how colonial medicine was never a neutral or purely humanitarian enterprise, but a deeply political and spatial project embedded within the structures of empire. The sanatoria built in the hills were emblematic of the colonial regime's attempt to reconfigure health as a terrain of control—spatial, racial, and institutional. These institutions did not merely address health crises but played a vital role in legitimising imperial presence, reinforcing social hierarchies, and mapping colonial authority onto the physical landscape (Arnold, 1993; Sen, 2006).

The strategic elevation of Darjeeling as a site for convalescence and governance was not incidental. The region's temperate climate and geographic location were appropriated to build a medical sanctuary that served imperial objectives. Through infrastructural investments in sanatoria, dispensaries, and cantonment hospitals, the British produced a sanitised, governable space distinct from the 'tropical chaos' of the plains (King, 1976). These efforts, couched in the language of public health, also entrenched spatial and racial segregation, as evident in the differentiated facilities for Europeans and Indians.

Furthermore, the intertwining of plantation economies and medical infrastructure underscores how health governance was aligned with capitalist exploitation. The medicalisation of tea estates was driven less by concern for worker welfare and more by the imperative to sustain productivity (Chatterjee, 1999). Missionary and charitable institutions supplemented state efforts, though their presence often entailed parallel projects of cultural assimilation and religious conversion (Baral, 2010).

Even after independence, the legacies of this colonial health geography persist. Disparities in access, uneven distribution of healthcare facilities, and the centralisation of services in urban cores reflect the long shadow of imperial planning. Thus, understanding the formation of sanatoria in Darjeeling allows us to trace the imprints of colonialism on contemporary health systems, spatial hierarchies, and governance practices in the region.

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