International Journal for Multidisciplinary Research (IJFMR)
E-ISSN: 2582-2160 ● Website: www.ijfmr.com ● Email: editor@ijfmr.com

Caste, Cleanliness, and Control: Epidemics and the Politics of Public Health in Colonial Kerala

Himanshu Pandey

Pondicherry University, India

Abstract:
This paper explores how caste and social hierarchy affected public health in colonial Kerala, and how health policies also reinforced those hierarchies. Using archival materials such as *Travancore Administration Reports*, *Malabar District Health Reports*, missionary hospital records, and local newspapers, the study looks at public health measures like quarantine, sanitation campaigns, vaccination programs, and burial rules. It argues that these measures, although presented as scientific and neutral, often reflected caste-based ideas of purity and pollution. This influenced who received care and how people followed health rules. By studying epidemics such as cholera, plague, and the 1918 influenza, the paper shows that epidemic control was not just about medicine but also about social power and control. The findings suggest that state health policies and local customs shaped each other, making some caste groups more vulnerable to disease than others. Overall, the study highlights how modern public health in colonial Kerala was closely linked to social inequality and cultural beliefs.

Keywords: caste, colonial Kerala, epidemics, public health, sanitation, social hierarchy, cholera, influenza, plague, medical history

Introduction:

Tracing back the historical roots of health inequities in Kerala goes along with the positioning of public health within the societal and cultural structures of the area. The state of Kerala has made remarkable advancements in health, economic, and social development; however, the questions about the degree to which these advances resulted in equal healthoutcomes still linger. Researches working on modern Kerala have found out that disparities in morbidity and mortality are still very much present, particularly with respect to caste and gender (Borooah, 2010; Sen & Iyer, 2012). Though the state is often celebrated for its high human development indicators, lower social groups and women still face the highest risk of diseases, the worst access to treatment, and the highest rates of death (Ghosh, 2011; Kumar et al., 2010; Sen et al., 2002). These outcomes validate the argument regarding the strong power of social institutions and cultural practices which are able to determine health situations.

The colonial era saw public health measures becoming more and more associated with caste and cleanliness, which in turn reflected the prevailing norms of social control. The accurrence of diseases such as cholera plague, and the 1918 flu pandemic broght about state regulations and control, which comprehended actions such as isolation, health regulations, and vaccinations. Yet, the measures were marketed as impartial medical and bureaucratic procedures, but they were largely affected by social hierarchy with the first privilege in the provision of treatment given to the higher-status groups while lower-status groups were entirely watched and separated. It is revealed through missionary and colonial

administrative documents from the Travancore and Malabar districts that the management of the epidemic was a medical treatment site as well as posting of social norms among the or even the media that facilitated existing hierarchies of pollution and purity (Travancore Administration Reports; Sanitary Commissioner's Reports).

In this regard, the colonial public health history of Kerala is cast in the light of the wider debates on the social determinants of health. Following intersectionality models, the research investigates how caste and gender were intertwined with, and at the same time, influenced by structural factors, like the colonial government, its policies, economic growth, and the availability of medical services, in determining the degree of susceptibility of different population groups during epidemics (Sen et al., 2009; Sen & Östlin, 2008). It also addresses the historiographical omissions pointed out in the studies conducted in South India where the emphasis is typically on state policy or epidemiology and social stratification is overlooked or analyzed superficially. The paper, which primarily amphasizes the politics of cleanliness, caste, and control, is focused to unveil the fact that colonial public health interventions did not just tolerate but also promoted the establishment of social hierarchies in the context of disease management. In the end, this research offers a more multi-faceted view of the health history of Kerala, showing that high health indicators did not necessarily lead to social equality and the various forms of discrimination related to caste and gender that were factors in health outcomes have left their mark as part of the problem.

Theoretical Framework: The demographic and health transitions of societies often present a contradictory situation whereby the increase in life expectancy goes hand in hand with the rise in self-reported illness. An example here is Kerala which is a state with a relatively longer life expectancy that shows a greater incidence of illness while states such as Bihar that are less in longevity report better health (Sen, 2002). This situation requires an explanation concerning the interpretation of morbidity: is it that higher self-reported morbidity necessarily results in poorer health or are these patterns mediated by other cultural, social, and structural factors? Das (2007) points out that the contexts of the ill health experiences are very much different, thus suggesting that health indicators that are commonly used would not always be able to capture everyday pains and sufferings.

To decipher these elements, the present study applies the cultural inflation of morbidity theoretical framework proposed by Johansson (1991). This standpoint does not only classify morbidity as a biological reality, but also as a cultural and institutional process influencing its acknowledgment, reporting, and treatment together with the biological truth. As per johansson (1991: 53), the advent of medical knowledge, diagnostic technologies, institutional arrangements for illness management, and society-set health thresholds all can contribute to the rise in given morbidity. The framework accentuates three dimensions incidence of morbidity, its duration, and prevalence of co-morbidity. The framework brings out three dimensions: the incidence of morbidity, its length, and the prevalence of co-morbidity. Rise in disease diagnosis and treatment has led to non-infectious and chronic diseases being the primary sources of morbidity, which in turn, prolong the sickness and boost the reported prevalence while death rate is decreasing. Another important factor along with economic development is that of policy interventions which is the primary reason for people in the community to have access to medical care and thus resulting in increased private health expenditure (Johansson, 1991).

This exact framework significantly aids to uncover inequities in health status between different social categories and genders. According to Johansson, the health continuum has two "break points": he sick self-perception and the threshold for professional medical care. The differences in these break points are typical for social groups. It is like that poor communities would consider their state of health to be sick

only when it is very severe and they would seek doctors' assistance almost at the point of Death due to a lack of money. women's health issues in the least developed countries are similar; they may only see a doctor when their illness is very serious already which, indeed, is a reflection of the socially dictated practices of health behavior among the different genders (halliburton, 1998). However, these break points are shaped to some extent by cultural factors and are also influenced by the structural elements such as household income, access to health care, and health policies which highlight the complex interaction between social stratification, gender, and health that determines morbidity patterns in Kerala (Lieten, 2002; Sen et al., 2002).

Why Kerala: The health scenario in Kerala is characterized by a complex situation with a combination of low and high mortality rates, alongside low birth rates, long life expectancy and on the other hand, high morbidity rates, and a shift in disease pattern from acute to chronic (Panikkar & Soman, 1984; Kunhikannan & Aravindan, 2000; Navaneetham et al., 2009). The factors like colonial health policies, missionary activities, social reform movements and caste associations played a significant role in making modern medicine popular through vaccination, education, and sanitation (Menon, 1995; Kooiman, 1989; Kabir & Krishnan, 1996). With the independence of India, the demand for health services and literacy revolution took place which consequently led to the expansion of government health services first and then private ones later (Kutty, 2000; Lieten, 2002). The basic indicators of caste and gender inequality point towards being very low, but micro-level evidence shows that lower social groups and Women undergo higher morbidity. borrowing from johansson's (1991) cultural inflation of morbidity, historical and social factors might have moved the "break points" of the health continuum—sickness perception and care seeking—much farther away from death especially for women and marginalized castes (Halliburton, 1998). Such health patterns indicate that the long-standing inequalities in morbidity still persist despite the great health achievements in Kerala.

Methodology: This research paper makes use of a historical-analytical method to analyze the relationship among caste, gender, and public health in the colonization of Kerala. Primary sources are the most important part of the study, which include the reports of the administrations of Travancore and Cochin, health reports of the Malabar district, reports of the sanitary commissioner, records of missionary hospitals, and letters exchanged between the colonial officials and the native rulers. These documents offer a thorough picture of the handling of the epidemics, vaccination campaigns, sanitation measures, and the execution of health policies, indicating the manner in which social hierarchies affected the access to care and the compliance with the public-health interventions.

The newspapers published in the local languages, for example, Malayala Manorama and Nasrani Deepika are the sources which mirror local views on epidemics and hygiene thereby drawing attention to the reactions of the community and the cultural explanations of sickness. The records of missionaries and literature dealing with social reforms are consulted to track the movement of health knowledge from the higher to the lower caste and male to female groups. Some of secondary sources like the scholarly monographs, journal articles, and previous thesis on The health history of kerala and caste dynamics not only provide the necessary contextual understanding but also the historiographical positioning.

This investigation employs qualitative content analysis to determine the themes which continue repeating and are related to caste, cleanliness, and control in the epidemic response, and it also has a look at the cultural construction of morbidity. The study uncovers the different access to health care and public health compliance discrepancies by using the idea of Johansson (1991) cultural inflation of morbidity which is based on the "break points" of perceiving illness and professional help seeking.

The study accordingly adopts an intersectional analysis to see the mediating role of caste and gender in these processes as the opposite side of the social determinants of health outcomes. The methodology helps develop a good understanding of the colonial health policies, social norms, and cultural perceptions that had deeply influenced and even shaped the epidemiological landscape of Kerala through a combination of archival research, textual analysis, and theoretical interpretation, with the constant and underlying factor of caste and gender affecting the distribution of health inequalities.

Findings: Kerala's existing demographic and health data have been scrutinized and analyzed revealing a multi-faceted scenario of health results which comprises both the remarkable and the unequal aspects of the population's health. The State of Kerala has an exceptionally good public health situation consisting of low mortality, including among infants and mothers, and small family sizes as well as high life expectancy besides significant-eepidemiological transitions where chronic and non-communicable diseases hold the lion's share of morbidity and mortality (Panikkar & Soman, 1984; Kunhikannan & Aravindan, 2000). Nevertheless, the historic and secondary data point to the fact that the geographical locations of illnesses and inequities in health are greatly determined by the caste system, gender and economic conditions.

Statistics based on the caste system indicate that the disadvantaged segments of society, mainly the Scheduled Castes (SCs) and Other Backward Classes (OBCs), are suffering from both incidence and severity of diseases the most. They have more cases of diseases associated with symptoms like musculoskeletal pain, headaches, and some birth-related or neurological diseases (Johansson, 1991). This phenomenon can be considered as an example of "cultural inflation of morbidity", where socio-cultural factors influence the perception of illness and health-seeking behavior as well. On the contrary, the socially and economically better-off families, such as the Brahmins and upper-caste groups, have a low incidence of diseases but a high prevalence of lifestyle-related chronic diseases, indicating different health risks connected with their occupational patterns and consumption habits.

Nonetheless, gender disparities are glaring. In general, Women experience more health issues than the men do in a different conditions, such as heart disease, musculoskeletal disorders, and hypertension (Halliburton, 1998). According to an intersectional perspective, health disparities primarily affect poor caste women, especially SC women. This condition is made worse by poverty, poor diet, and male-oriented health practices. Changes in the past have improved everyone's health, but they did not fully remove the obstacles faced by women and people from lower castes (Scaria, 2008; Sen et al., 2002).

Overall, the amalgamation of epidemiological, demographic, and historical data shows that systemic injustices coexist with the health of Kerala's accomplishments. Social structures and cultural norms continue to mediate health outcomes, As evidence of the incidence of morbidity, disease patterns, and unequal access to care. This supports the need for policy and intervention frameworks that take gender and caste disparities into consideration.

Summary and Conclusions: The current research demonstrates the fact that even though Kerala's low infant and maternal mortality, high life expectancy, reduced fertility, and other health indicators indicate the topmost developments, still the patterns of inequity based on caste and gender are the major determinants of health outcomes. The analyses of secondary data portray a vivid picture of the social gradient, higher morbidity and vulnerability being the lot of Scheduled Castes, Other Backward Communities, and a few Christian sub-groups, whereas upper caste and economically well-off groups show lower disease incidence but higher prevalence of lifestyle-related chronic conditions at the same time. There is a gender gap in health issues, with women reporting more health problems than men. This

is especially Right for non-communicable diseases like hypertension, osteoarthritis, and cardiovascular diseases. An intersectional view shows that women from marginalised castes face the worst health disparities, highlighting how caste and gender affect health outcomes.

The ongoing differences can be traced back to the structure and socio-economic aspects of society. Macro-economic policies, which included privatization of health services and the imposition of out-of-pocket payments have had a negative impact on vulnerable groups and also women and lower-caste groups continue to face limitations imposed by the social norms that discriminate against them, which are primarily in the area of the basic needs: food, education, and economic resources (Sen et al., 2002; Banerjee & Krishnaraj, 2004). Health insurance programs funded by the government serve as a partial alleviation, but their usefulness is determined by accurate targeting and the implementation being open to all.

In general, the research points out that Kerala's success in conventional health indicators does not necessarily lead to equal health outcomes. In order to eliminate the remaining inequities, policy interventions should use a multipronged strategy that incorporates caste, gender, socio-economic status, and access to resources. In addition, it is necessary to conduct further studies to determine the relative strength of these factors, to evaluate the long-term impact of macroeconomic policies, and to think of ways that can eliminate the divide between remarkable health achievements and equitable health outcomes for all social groups.

References:

1. Banerjee, N., & Krishnaraj, M. (2004). Sieving Budgets for Gender. *Economic & Political Weekly, 39*(44), 4788–4791.
2. Bhandari, L., Berman, P., & Ahuja, R. (2010). The Impoverishing Effect of Health Care Payments in India: New Methodology and Findings. *Economic & Political Weekly, 45*(16), 65–71.
3. Borooah, V. (2010). *Inequality in Health Outcomes in India.* Munich: Personal RePEc Archives. Retrieved from http://mpra.ub.uni-muenchen.de/19832/
4. Census of India. (2011). Retrieved from www.censusindia.gov.in
5. Centre for Development Studies. (1975). *Poverty, Unemployment and Development Policy: A Case Study of Selected Issues with Reference to Kerala.* Thiruvananthapuram: CDS.
6. Chakraborty, A. (2005). Kerala's Changing Development Narratives. *Economic & Political Weekly, 40*(6), 541–547.
7. Das, V. (2007). *Life and Words: Violence and the Descent into the Ordinary.* Berkeley: University of California Press.
8. Das, V. (2015). *Affliction, Health, Disease, Poverty.* New York: Fordham University Press.
9. Economic Review. (2012). Retrieved from www.kerala.gov.in
10. Frankie, R. W., & Chasin, B. H. (1999). Is the Kerala Model Sustainable? Lessons from the Past: Prospects for the Future. In M. A. Oommen (Ed.), *Rethinking Development: Kerala's Development Experience* (pp. 118–148). New Delhi: Concept.
11. Garg, C. C., & Karan, A. K. (2009). Reducing Out-of-pocket Expenditures to Reduce Poverty: A Disaggregated Analysis at Rural-Urban and State Level in India. *Health Policy and Planning, 24*(2), 116–128.
12. Ghosh, S. (2011). Catastrophic Payments and Impoverishment Due to Out-of-Pocket Health Spending. *Economic & Political Weekly, 46*(47), 63–70.

13. Halliburton, M. (1998). Suicide: A Paradox of Development in Kerala. *Economic & Political Weekly, 33*(36/37), 2341–2345.
14. Halliburton, M. (2003). The Importance of a Pleasant Process of Treatment: Lessons from South India. *Culture, Medicine and Psychiatry, 27*(2), 161–186.
15. Jeffrey, R. (1992). *Politics, Women and Well-being: How Kerala Became a Model.* New Delhi: Oxford University Press.
16. Johansson, S. R. (1991). The Health Transition: The Cultural Inflation of Morbidity during the Decline of Mortality. *Health Transition Review, 1*(1), 39–68.
17. Kabir, M., & Krishnan, T. N. (1996). Social Intermediation and Health Changes: Lessons from Kerala. In M. Dasgupta, T. N. Krishnan & L. C. Chen (Eds.), *Health, Poverty and Development in India* (pp. 239–269). New Delhi: Oxford University Press.
18. Kannan, K. P. (2005). Kerala's Turnaround in Growth: Role of Social Development, Remittances and Reform. *Economic & Political Weekly, 40*(6), 548–554.
19. Kleinman, A. (1988). *The Illness Narratives: Suffering, Healing and the Human Condition.* New York: Basic Books.
20. Kooiman, D. (1989). *Conversion and Social Equality in India: The London Missionary Society in South Travancore in the Late 19th Century.* New Delhi: Manohar.
21. Krishnan, T. N. (1976). Demographic Transition in Kerala: Facts and Factors. *Economic & Political Weekly, 11*(31/33), 1203–1224.
22. Kumar, S. A. K., Acharya, A., Nagaraj, N., Baru, R., & Acharya, S. (2010). Inequities in Access to Health Services in India: Caste, Class and Region. *Economic & Political Weekly, 45*(38), 49–58.
23. Kunhikannan, T. P., & Aravindan, K. P. (2000). *Changes in the Health Status of Kerala 1987–1997.* Discussion Paper No. 20. Trivandrum: Centre for Development Studies.
24. Kutty, R. V. (2000). Historical Analysis of the Development of Health Care Facilities in Kerala State, India. *Health Policy and Planning, 15*(1), 103–109.
25. Lieten, G. K. (2002). Human Development in Kerala: Structure and Agency in History. *Economic & Political Weekly, 37*(16), 1539–1544.
26. Menon, A. C. (1995 [1911]). *The Cochin State Manual.* Thiruvananthapuram: Kerala Gazetteers Department.
27. Navaneetham, K., Kabir, M., & Krishnakumar, C. S. (2009). Morbidity Pattern in Kerala: Levels and Determinants. Working Paper No. 411. Trivandrum: Centre for Development Studies.
28. Panikkar, P. G. K., & Soman, C. R. (1984). *Health Status of Kerala: The Paradox of Economic Backwardness and Health Development.* Trivandrum: Centre for Development Studies.
29. Parayil, G. (2000). Introduction: Is Kerala's Development Experience a Model? In G. Parayil (Ed.), *Kerala: The Development Experience: Reflections on Sustainability and Replicability* (pp. 1–4). London: Zed Books.
30. Scaria, S. (2008). *Developmental Trajectories of a Kerala Village: Land, Education, Health and Women in Wadakkancherry.* Unpublished PhD Dissertation, University of Hyderabad.
31. Scaria, S. (2010). Changes in Land Relations: The Political Economy of Land Reforms in a Kerala Village. *Economic & Political Weekly, 45*(26/27), 191–198.
32. Sen, A. (2002). Health: Perception versus Observation: Self-reported Morbidity Has Severe Limitations and Can Be Extremely Misleading. *British Medical Journal, 324*(7342), 860–861.

33. Sen, G. (1992). Social Needs and Public Accountability: The Case of Kerala. In M. Wuyts, M. Mackintosh & T. Hewitt (Eds.), *Development Policy and Public Action* (pp. 253–277). Oxford: Oxford University Press.
34. Sen, G., & Iyer, A. (2012). Who Gains, Who Loses and How: Leveraging Gender and Class Intersections to Secure Health Entitlements. *Social Science and Medicine, 74*(11), 1802–1811.
35. Sen, G., Iyer, A., & George, A. (2002). Structural Reforms and Health Equity: A Comparison of NSS Surveys, 1986–87 and 1995–96. *Economic & Political Weekly, 37*(14), 1342–1352.
36. Sen, G., Iyer, A., & Mukherjee, C. (2009). A Methodology to Analyse the Intersections of Social Inequalities in Health. *Journal of Human Development and Capabilities, 10*(3), 397–415.
37. Sen, G., & Östlin, P. (2008). Gender Inequity in Health: Why It Exists and How We Can Change It. *Global Public Health, 3*(Suppl. 1), 1–12.
38. Tharamangalam, J. (1998). The Perils of Social Development without Economic Growth: The Development Debacle of Kerala, India. *Bulletin of Concerned Asian Scholars, 30*(1), 23–34.
39. Williams, D. R., Mohammed, S. A., Leavell, J., & Collins, C. (2010). Race, Socio-economic Status and Health: Complexities, Ongoing Challenges and Research Opportunities. *Annals of the New York Academy of Sciences, 1186*, 69–101.