

Soldiers, Surgeons and the Campaigns to Combat Sexually Transmitted Diseases in Colonial India, 1805–1860

DOUGLAS M PEERS*

Officers in the military and medical establishments of colonial India agreed that preserving the health of European troops in India must be one of their highest priorities for, without an adequate supply of healthy Europeans at hand, British rule might be jeopardized. Periodic mutinies and other manifestations of discontent amongst the sepoys reminded Europeans that they could not take sepoy loyalty for granted. Events in 1857 would confirm what many officers were already insisting upon at the beginning of the nineteenth century: a large reserve of European soldiers was needed to keep the sepoys in check. But Europeans were much more likely than sepoys to become casualty statistics: data from 1836 confirmed that European soldiers were more than twice as likely to be hospitalized as Indian sepoys.¹ The situation was much the same twelve years later when troop returns from 1848 for the Bengal army listed 847 deaths from among the 15,558 Europeans on strength, but only 1,065 deaths from among the more than 100,000 sepoys.² Therefore the British directed a good deal of attention to those diseases thought most threatening to the European rank and file, particularly cholera, malaria, and dysentery. This being the case, it is not surprising that these diseases have been the subject of some very important recent works on the history of colonial medicine.³ Yet if we extend our

*Professor Douglas M Peers, Department of History, University of Calgary, 2500 University Drive N.W., Alberta, Canada T2N 1N4.

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¹ Data compiled from charts in the 'The health of the army', *Q. J. Calcutta med. phys. Soc.*, 1837, 4: 684–93.

² Oriental and India Office Collections [hereafter OIOC], 'Health of European troops in Bengal, 1848', E/4/808.

³ The dynamic interplay between medical thought and imperial imperatives in India has been the subject of several recent works. David Arnold, *Colonizing the body: state medicine and epidemic disease in nineteenth-century India*, Berkeley, University of California Press, 1993; Poonam Bala, *Imperialism and medicine in Bengal: a socio-historical perspective*, New Delhi, Sage, 1991; Philip Curtin, *Death by migration*, Cambridge University Press, 1989; and Mark Harrison, *Public health in British India: Anglo-Indian preventive medicine, 1859–1914*, Cambridge University Press, 1994. However, much more is known about late nineteenth-century imperial medicine than its early nineteenth-century counterparts, a point acknowledged in David Arnold, 'Social crisis and epidemic disease in the famines of nineteenth-century India', *Soc. Hist. Med.*, 1993, 6: 385–404, p. 385. Arnold has also assessed in broad terms the history of venereal diseases in India in 'Sexually transmitted diseases in nineteenth and twentieth century India', *Genitourin. Med.*, 1993, 69: 3–8.

gaze beyond the army's mortality rates, and take morbidity into account, we find that sexually-transmitted diseases (syphilis, gonorrhoea, and a range of undiagnosed penile chancres) were constantly threatening to deprive the British of many of their rank and file. With upwards of 30 per cent of the European soldiers in India in hospital with venereal complaints at any time, a reduction in venereal diseases became a strategic as well as a medical imperative. Regimental hospitals of the Bengal army in the 1820s and 1830s treated approximately 2,400 venereal cases each year, and this was in an army which had an average establishment of only about 8,500 Europeans. Hence, venereal diseases became a strategic as well as a medical imperative.⁴ Moreover, medical and military spokesmen often pointed to the correlation between venereal diseases and other health and discipline problems. Troops searching for sexual gratification were lured away from the safe confines of the barracks where the military could exert some control over them and into local communities where the army's powers of surveillance were greatly circumscribed. There, soldiers were exposed to a range of temptations threatening to military discipline as well as to the troops' own physical well-being.

This paper will examine early nineteenth-century debates in India over how best to combat venereal afflictions in the British and Company armies. In the absence of an effective clinical treatment for these diseases, prevention seemed the only course of action. However, owing to contemporary ideas of masculinity as well as the constructions of Indian society that were then taking shape, the obvious route of intervening directly in the soldiers' sexual activity was never thought to be a viable option save by a few medical and military officers. The rest were convinced that their soldiers were not only personally incapable of curbing their sexual desires, but also that any attempt by their officers to do so for them might undermine their heterosexuality which the army prized so highly. Masculinity had become an important prism through which colonial societies could be observed and ranked. The difference between the conquering European and conquered Indian were often presented in starkly gendered terms. The manliness of the European conqueror was set against the fickle and effeminate Indian male.⁵ Although not all Indian males were typecast the same (the Bengalis for example were singled out as the most effeminate, while Sikhs were credited with being more masculine), a clear line was laid down between Europeans and Indians. To maintain such a hierarchy required that nothing be done that could raise uncertainties about the European male and so the soldier was left alone.

It is no surprise that attention then turned to those viewed as the principal carriers of the disease—the prostitutes of the cantonment.⁶ Various schemes of mandatory inspection

⁴ I need at this point to make an important disclaimer. Venereal diseases will be used here in its nineteenth-century sense, that is as a generic term for those diseases which contemporaries primarily identified on the grounds of their being sexually transmitted. These would include what today we would identify as syphilis, gonorrhoea and a range of penile chancres. By way of comparison, rates of venereal diseases in the United States army at this time were much lower, averaging around 6 per cent between 1829 and 1838 and only rising to 7 per cent in the 1840s. Edward M Coffman, *The old army: a portrait of the American army in peacetime*,

1784–1898, New York, Oxford University Press, 1986, p. 191.

⁵ The relationship between masculinity and imperialism in India is the subject of Mrinalini Sinha, *Colonial masculinity: the 'manly Englishman' and the 'effeminate Bengali' in the late nineteenth century*, Manchester University Press, 1995.

⁶ It is much to be regretted that all my diggings in the archives have failed so far to recover the voices of those Indian women affected by policies aimed at combating venereal disease, at least for the first half of the nineteenth century. I can only hope that further research will fill in this lacunae.

accompanied by the enforced treatment of those labelled as diseased were devised, frequently critiqued, sometimes rejected, and often modified in India between 1805 and 1860, and these would serve as the prototypes for the more famous Contagious Diseases Acts of the later nineteenth century.⁷ Between 1805 and 1833, lock hospitals for the forcible confinement of women suspected of venereal infection were established at most cantonments, in which were housed the some 26,000 European soldiers normally stationed in India. Interestingly, and in contrast to the situation later in the century, their introduction did not cause much debate. Support for lock hospitals was initially greatest amongst army officers, who sought to stem the flow of soldiers seeking medical treatment for venereal infections. By the 1830s, military officers were joined by many surgeons who had also come to view the lock hospital as a necessary and possibly unique solution to the problem of venereal diseases. Yet in 1833 the system of lock hospitals, which had hitherto enjoyed wide support from the Anglo-Indian military, medical and civilian communities in India, as well as from the East India Company's Court of Directors in London, suddenly came under attack from the Governor General. William Bentinck (Governor General 1828–1835), armed with a lengthy condemnation of lock hospitals written for him by the Inspector General of His Majesty's Hospitals in Bengal, ordered their closure. This directive triggered a great deal of discussion, much of it quite acrimonious, and it is from these debates that we can begin to reconstruct some of the military, medical and moral agendas, and their transformations, which so powerfully shaped colonial rule in India. British medical and military officers in India were white, male and middle- if not upper-class; gender and race set them apart from the Indian prostitutes, while class distinguished them from the rank and file. Consequently, questions of race, gender and class all came into play whenever the army looked to control venereal diseases within its ranks.

Detection and Diagnosis of the Problem

Venereal diseases and the British army of the nineteenth century were for many contemporaries almost synonymous. It was an army of mostly single males who were signed up for stretches of up to twenty years in a society which placed great stress on the assertion of masculine traits, and which had few recreational outlets beyond the bottle or

⁷ There is extensive literature available on the Contagious Diseases Acts, particularly on their origins in and impact on Britain itself. See, for example, F B Smith, 'Ethics and disease in the later nineteenth century: the Contagious Diseases Acts', *Hist. Stud.*, 1971, 15: 118–35; *idem*, 'The Contagious Diseases Acts reconsidered', *Soc. Hist. Med.*, 1990, 3: 197–215; Judith R Walkowitz, *Prostitution and Victorian society: women, class, and the state*, Cambridge University Press, 1980; Paul Werth, 'Through the prism of prostitution: state, society and power', *Soc. Hist.*, 1993, 19: 1–15. Some of the more noteworthy studies that deal with India, though most treat the period after 1860, include: Philippa Levine, 'Venereal disease, prostitution, and the politics of empire: the case of British India', *J. Hist. Sexuality*, 1993–4, 4: 579–602; *idem*, 'Re-reading the eighteen-nineties: venereal disease as "constitutional

crisis" in Britain and British India', *J. Asian Stud.*, 1996, 55: 585–612; Miles Ogborn, 'Law and discipline in nineteenth century English state formation: the Contagious Diseases Acts of 1864, 1866, and 1869', *J. hist. Sociol.*, 1993, 6: 28–55; Kenneth Ballhatchet, *Race, sex and class under the Raj: imperial attitudes and policies and their critics, 1793–1905*, London, Weidenfeld and Nicolson, 1980; Antoinette Burton, *Burdens of history: British feminists, Indian women, and imperial culture, 1865–1915*, Chapel Hill, University of North Carolina Press, 1994; Arnold P Kaminsky, 'Morality legislation and British troops in late nineteenth-century India', *Mil. Aff.*, 1979, 43: 78–83; and Judy Whitehead, 'Bodies clean and unclean: prostitution, sanitary legislation, and respectable femininity in colonial North India', *Gender Hist.*, 1995, 7: 41–63.

the brothel. Therefore, it is no surprise to find that venereal diseases featured so prominently in the army's medical records, or that the surgeons and officers directed so much energy to finding ways of alleviating, if not eradicating, the problem. The situation was thought to be even worse in India. It was estimated by some that venereal cases were more numerous there than in the other stations of the British army—one surgeon pronounced that “more cases often occur in one regiment in the east than in the whole of the West Indies command.”⁸ Another surgeon, reminiscing about his time in India, claimed that “for many years of my life, I was in the habit of seeing at least from ten to twenty venereal cases daily.”⁹

While it is impossible to give precise figures for the number of European soldiers and officers and Indian sepoy who were afflicted with sexually transmitted diseases, the available data establish beyond a doubt that a good number of European soldiers, perhaps as many as 50 per cent in some locations or some regiments, passed through military hospitals seeking treatment for what were believed to be venereal complaints. Statistics compiled in 1834, which though incomplete are amongst the best available, indicate that for the Bengal army as a whole, the proportion of venereal cases to total strength ranged between 30 per cent in 1827 and 16 per cent in 1833. Here we must remember that there were significant differences between regiments depending on where they were stationed, and from whom they were recruited. Those regiments in which temperance societies had gained ground, and where drunkenness had ceased to be a major problem, also had lower rates of venereal infection. Then there were others in which nearly half the soldiers were infected at one time or another. Surgeon MacKinnon's records for H.M. 21 Regiment when stationed at Dinapur indicate that there were 473 cases of venereal disease in 1840 out of a total strength of 763.¹⁰ While some soldiers would be counted two or three times in this list, the fact that nearly half the regiment contracted venereal complaints indicates just how widespread these diseases were.

European officers and Indian sepoy do not appear to have been infected to anything like the same degree, though, as will be discussed later, there were more opportunities and more incentives for officers and sepoy to seek treatment elsewhere. However, even if we include these points in our calculations of relative degrees of venereal infection amongst the various components of the colonial forces in India, the European soldiers (for reasons which I will elaborate later) still top the charts. Consequently, venereal diseases in nineteenth-century India were seen as primarily affecting the European male rank and file of the British regular and East India Company armies.

A caveat is, however, in order here. Extreme caution is needed when using contemporary estimates of the numbers of infected soldiers. Incomplete runs of figures, discrepancies in the listing of diseases, the inability to diagnose the various venereal diseases, and finally the likelihood that many sufferers sought alternative cures and generally evaded the surgeon's gaze, mean that the exact number of men infected can never be known with any certainty. One contemporary surgeon summed up the

⁸ John Clark, 'Report on syphilis in H.M. Light Dragoons', *Madras q. med. J.*, 1839, 1: 370–410, p. 385.

⁹ George Ballingall, *Practical observations on fever, dysentery, and liver complaints . . . to which is annexed an essay on syphilis*, 2nd ed., Edinburgh,

Adam Black, 1823, p. 127.

¹⁰ Kenneth MacKinnon, *A treatise on public health, climate, hygiene and prevailing diseases of Bengal and the North-West Provinces*, Cawnpore, Cawnpore Press, 1848, appendix.

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predicament of medical officers as follows: “The diseases of the genital parts are the most difficult of any to investigate, from the tendency in almost all our patients to deceive, covering themselves with a fig leaf of deceit and quibbling, and attempting to mislead.”¹¹

The figures that I have given for the European rank and file are likely to be on the low side, as there is evidence to suggest that many European soldiers suffering from venereal diseases evaded scrutiny, particularly in the first half of the nineteenth century when regular health inspections were not systematically carried out. In the absence of such surveillance, and considering the treatments often used, it is not surprising that many European soldiers chose to avoid the surgeon. Mercurial treatments for venereal disease were especially loathed, given reports that mercury was administered according to the “quantity of saliva discharged, the teeth and sometimes parts of the jaw bone falling into the spittoon.”¹² Financial considerations were another disincentive to seek medical help from cantonment hospitals; soldiers were no longer eligible to receive *batta* (bonus pay for field service) and were subject to various deductions from their pay.¹³ They could also be tempted by lay practitioners within their barracks, and by the survival of folk traditions and medical quackery. Unfortunately, there are only oblique references to this alternative world of medicine, though one soldier’s diaries from this period contain some fascinating remedies for various maladies, including enemas and poultices for venereal diseases.¹⁴

The reliability of the figures for infected soldiers which are available to us is further undermined by contemporary difficulties in correctly diagnosing venereal complaints, and in listing them according to a commonly accepted nosology. This is clearly seen in the absence of any standardized form for reporting venereal complaints. We must remember that the treponema pathogen responsible for syphilis was not identified until 1905, and even in the 1880s some surgeons were still arguing about whether gonorrhoea and syphilis were variants of the same disease, or completely unrelated; and as late as 1898, surgeons were having problems distinguishing between gonorrhoea and urethritis.¹⁵ In the early nineteenth century, the uncertainty was even greater, particularly before the 1838 publication of Philippe Ricord’s influential *Traité pratique sur les maladies vénériennes*.¹⁶ Ricord’s nosology clearly delineated between syphilis and gonorrhoea and also set out the three separate stages in syphilitic infection, but not all surgeons subscribed to these theories. The Madras surgeon John Clark and many others followed the eminent surgeon John Hunter in arguing that gonorrhoea was merely a variant of syphilis.¹⁷ This belief that syphilis and gonorrhoea were manifestations of the same disease was particularly well entrenched in the army; and its advocates rested their case on such seemingly persuasive observations as: “every surgeon knows that two men may have connection with the same woman, and one be infected with syphilis and the other with gonorrhoea”.¹⁸ Even those surgeons who did differentiate between syphilis, gonorrhoea, bubos, and a range of penile ulcers and rashes frequently lumped them all together in their medical returns under the generic heading of “venereal diseases”.

¹¹ Clark, *op. cit.*, note 8 above, p. 389.

¹² MacKinnon, *op. cit.*, note 10 above, p. 8.

¹³ Dr Archibald Shanks, ‘Report of H.M. 55th Foot’, *Madras q. med. J.*, 1839, 1: 237–68, p. 263.

¹⁴ National Library of Scotland (hereafter NLS), Diary of Private John Charles Brown, endpapers, MS 15393.

¹⁵ F B Smith, *The people’s health, 1830–1910*,

London, Weidenfeld and Nicolson, 1990, p. 294.

¹⁶ Walkowitz, *op. cit.*, note 7 above, p. 50.

¹⁷ Clark, *op. cit.*, note 8 above, p. 388. See also the exchange in: (anon.), ‘Identity of syphilis and gonorrhoea’, *Q. J. Calcutta med. phys. Soc.*, 1837, 1: 207–8.

¹⁸ *Ibid.*, p. 207.

Consequently, many surgeons, deprived of a sound clinical understanding of the source of these diseases, had to work instead from what were commonly accepted to be their outward symptoms. Yet accurate diagnosis was frustrated in the case of syphilis, for it is a disease which is capable of manifesting itself, particularly in the secondary and tertiary phases, in all parts of the body. Moreover, some of the symptoms of syphilis were similar to those associated with other diseases. Diagnosis was rendered even more difficult when dealing with female patients, for the symptoms were not so readily apparent to the eye, and British surgeons were more reluctant than their continental counterparts to adopt the speculum.¹⁹

Yet notwithstanding these shortcomings in the archival record, we can establish some patterns. Levels of infection were not only higher for the European rank and file than they were for the officers or the sepoy, but there was also considerable variation by station. In the first half of the nineteenth century, hill stations, for example, tended to be less affected by venereal diseases than did nearby cantonments on the plains. This has been attributed to the smaller numbers of prostitutes in such places, the isolation of these stations from large urban centres, and the greater ease with which individuals could be policed. Also, it would appear that the army tried to prevent soldiers infected with a venereal disease from being sent to a hill station.²⁰ Medical priorities took precedence in such places because they had initially been established as sanatoria, and a much greater range of regulatory powers had consequently been made available to local authorities.²¹ Statistics from some of the major garrisons astride the Ganges River tell a different story. Between January 1833 and June 1837, the artillery hospital at Meerut, a major station on the plains, registered 279 admissions per thousand for syphilis and a further 166 admissions per thousand for gonorrhoea.²²

Sepoys of the Indian army, in contrast to the European rank and file, were far less likely to be treated in hospital for venereal infection. In the 1840s, a survey of European troops in the Madras Presidency found that they were more than twice as likely to be treated for venereal disease than were the sepoy.²³ The level of incidence was even less within the sepoy regiments of the Bengal and Bombay armies; a surgeon with a regiment of native infantry in the latter related that “scarcely a case of syphilis came under my notice during the past year”. He went on to suggest some possible reasons for this, notably that far more sepoy than Europeans were married, that they were reluctant to seek out western medical attention, and that they were less susceptible to venereal infections.²⁴ The first two reasons are in themselves convincing, and are likely to account at least partially for the different rates of infection in soldiers and sepoy. The third reason he gives, that the sepoy have some type of acquired or heightened immunity to venereal infections, is indicative of the extent to which racist and environmental thinking was impinging on colonial medicine.

¹⁹ T J Wyke, ‘Hospital facilities for, and diagnosis and treatment of, venereal disease in England, 1800–1870’, *Br. J. venereal Dis.*, 1973, 49: 78–85, p. 84.

²⁰ Dane Kennedy, *The magic mountains: hill stations and the British Raj*, Berkeley, University of California Press, 1996, p. 26.

²¹ Scottish Record Office, Lieut. Col. Congreve to Quartermaster General’s Office, 17 Nov. 1847, GD45/6/378.

²² John Murray, *On the topography of Meerutt*, Calcutta, Huttman, 1839, p. 17.

²³ ‘Report on the sickness and mortality of troops in the Madras presidency’, *J. statist. Soc. Lond.*, 1840, 3: 113–42, p. 140.

²⁴ J R Miller, ‘Annual report of the 23rd Regt. N.L.I.’, *Trans. med. phys. Soc. Bombay*, 1857/58, 4: 275.

The author himself does not indicate whether this immunity was acquired through heredity or by environmental conditioning. It is also worth noting that it was not just Indians who were deemed more resistant to venereal diseases: medical writers in New Zealand were trying to build a similar case for the Maoris.²⁵

Recent work by Seema Alavi has suggested yet another explanation for the seemingly low rates of venereal infections among the sepoy: her examination of the records of the insane asylum established for these troops hints that syphilitic sepoys may have been committed to such institutions.²⁶ That a policy of this kind could exist in early-nineteenth-century India is by no means surprising. Not only could syphilis lead to mental debility, thus justifying the dispatch of the patient to an asylum, but arguably the British would not have wanted to have physically or mentally disabled men returning to their villages, for sepoys were among the most important symbols of colonial rule. Whereas injuries sustained in battle could reinforce the status of the sepoy, a disease contracted through sexual liaisons delivered a much less complimentary message. However, Alavi's research has so far indicated that no more than twenty-five sepoys infected with venereal disease were committed to asylums in any given year. This is an insignificant proportion of the total number of sepoys and, while suggestive of how the army and the medical service framed venereal disease, it does not in itself support the conclusion that venereal disease was a major problem within the sepoy units of the India army.

Once again we need to consider the available evidence carefully, especially the numbers of venereal cases amongst the sepoys which were listed in the medical reports. Sepoys were often reluctant to seek out western medical treatment for their ailments, preferring to be treated by local medical practitioners (though often the treatments were very similar—a good number of Indian doctors prescribed mercury for venereal complaints). There were even cases when Indian servants and assistants to European surgeons chose local remedies over what the surgeon advised. In one instance, a surgeon awoke to find his bungalow in flames. His orderly, rather than come to him for medical treatment for his venereal infection, had instead prepared a sacrificial fire that had blazed out of control.²⁷ In another, and even more revealing case, an Indian doctor attached to a sepoy regiment, who had graduated from the native medical college where he had been trained in western medicine, repeatedly went to a *hakim* (Muslim medical practitioner) in Dinapore for treatment rather than see the European surgeon.²⁸ Interestingly, the *hakim* put him on a course of mercurial treatments (calomel), which is probably what his own supervisor would have recommended.

There is even less information available about the incidence of venereal diseases amongst the European officers. I have found only a few fleeting references. One was to several regiments of the Bombay army which were acting together as a field force in 1817.

²⁵ Malcolm Nicolson, 'Medicine and racial politics: changing images of the New Zealand Maori in the nineteenth century', in David Arnold (ed.), *Imperial medicine and indigenous societies*, Manchester University Press, 1988, pp. 79–80.

²⁶ Seema Alavi, *The sepoys and the Company: tradition and transition in northern India, 1770–1830*, Delhi, Oxford University Press, 1995, pp. 146, 150.

²⁷ NLS, Diary of Assistant Surgeon Henry Oswald, 1 Feb. 1851, MS 9005.

²⁸ A Campbell, 'On native medical education', *Indian J. med. Sci.*, 1834, 1: 320–1. The relative status of western medical practices and Indian medical practices is discussed in C A Bayly, 'British orientalism and the Indian "rational tradition", c.1780–1820', *South Asia Res.*, 1994, 14: 1–10.

They experienced 7 cases of venereal infection as compared with 105 amongst the non-commissioned officers and enlisted men.²⁹ Another reference was to the Madras army: of 207 officers between 1829 and 1838, 12 were admitted to hospital for syphilis and 18 for gonorrhoea.³⁰ Yet these numbers probably tell only part of the story. European officers had the option of seeking out private medical treatment which might have been of higher quality, and was certainly more discreet. It is likely that many officers who had contracted a venereal complaint turned to private practitioners to avoid the stigma associated with sexually transmitted diseases.

Medical Interventions and the Imperial Milieu

The most common treatment for syphilis at this time was mercury. Syphilis was often attributed to an especially virulent poison which had entered the patient. The poison needed to be driven out of the body, and, because it was so elusive (as proven by its ability to lodge itself in all places of the body), strong medicine was required. Mercury fitted this requirement perfectly: its powerful effects were attested by the salivation and perspiration which were taken as signs that the poison was being forced out of the body. Moreover, given the moral stigma attached to venereal disease, the patient was often expected to endure some suffering or penance during the cure. The brutal effects of mercury certainly satisfied this expectation. Mercury was administered to the patient in three basic ways, orally in the shape of what were colloquially known as “blue pills” (a mixture of mercury, confection of roses and powdered licorice), as an ointment (referred to as applied by “friction” in contemporary texts), and finally, and less commonly, as mercury vapours.³¹ While we find that mercury was also used to treat gonorrhoea, this practice was not nearly so widespread. Instead, leeches, silver nitrate washes and other caustic solutions were applied to the immediately affected area.

Opposition to the use of mercury in treating syphilis was, however, growing in the early nineteenth century, particularly within the ranks of the army’s medical service. George Ballingall, who became professor of military surgery at the University of Edinburgh, surveyed surgeons in a number of stations and, based on their reports, he questioned the efficacy of mercury. He expounded on these views in several textbooks, which became standard reading for many surgeons in the army.³² Opposition was even more pronounced in India, where the use of mercury in treating fevers was also falling into disfavour by the 1830s.³³ One surgeon set out the anti-mercurialists’ position in evocative terms: “During

²⁹ OIOC, Prevalence of venereal disease in the detachment under Colonel East, April 1817, F/4/63.

³⁰ Wellcome Institute for the History of Medicine (hereafter WIHM), Report on the medical topography and statistics of the presidency division of the Madras army, Madras, 1842, RAMC 2046.

³¹ Wyke, *op. cit.*, note 19 above, pp. 81–2.

³² George Ballingall, *Outlines of the course of lectures on military surgery, delivered in the University of Edinburgh*, Edinburgh, Adam Black, 1833. See also his papers in the library of the Wellcome Institute for the History of Medicine, London.

³³ Between 1816 and 1818, a circular issued by the army revealed that 1,940 cases were treated without mercury, and 2,827 were treated with mercury. WIHM, Army Medical Department, circular on syphilis, 2 April 1819, WMS 6905/7. For the popularity of mercury in India, see Arnold, *Colonizing the body*, *op. cit.*, note 3 above, ch. 1. There were however surgeons like William Twining who were switching from mercury to quinine in treating fevers. I am grateful to an anonymous referee for drawing my attention to the latter point.

the period of mercurial mania, how common an event was destruction of the nasal and palatine bones; and men who were then said to have suffered in the wars of Venus, probably suffered more from the wars of Mercury.”³⁴ Mercury’s opponents rested their case in part on the idea, also common in France at this time, that syphilis was primarily a disease of inflammation, and therefore it required an antiphlogistic regime of diet, enemas, laxatives, and occasionally bleeding to counteract the irritation of the inflamed membranes. But there was also a uniquely Indian side to this anti-mercurial position, and one that related to what its proponents saw as the peculiarly hostile effects of the Indian environment on the European constitution. As Mark Harrison has noted, colonial medical practices did not simply mimic metropolitan medicine.³⁵ Medical thought on the colonial periphery was heavily weighted in favour of environmental influences, and diseases were often presented as having characteristics which differed according to the part of the world in which they were experienced. As one surgeon explained, “in tropical regions, disease is of the most acute kind and rapid in its progress”.³⁶ The author then concluded that, despite its initial ferocity, secondary or constitutional syphilis was less of a concern because hot climate diseases do not produce the same chronic conditions found in other climates. Such views can be dated to at least the seventeenth century, for the French surgeon and traveller, François Bernier, had made the same claim.³⁷ It was for these stages of the disease that mercury was most commonly prescribed. Paradoxically, those who favoured mercury could also build a case on environmentalist arguments. In particular, some of them believed that penile chancres were especially tenacious in India, and so there was more of a need for mercury to attack these symptoms at their first manifestation.³⁸

Not all surgeons in India subscribed to the anti-mercurialists’ position, and consequently venereal treatments tended to vary between hospitals as regimental surgeons were left free to employ whatever therapy they thought best suited to the case at hand. Nor can surgeons be conveniently lumped into those who used mercury and those who did not. Many army surgeons in India opposed the blanket adoption of mercury in all cases, and called instead for its selective deployment. They insisted that a distinction should be drawn between simple syphilis and complicated syphilis (or primary and secondary syphilis): only the latter required mercury. Simple syphilis, which they argued was more common in the army, was better treated without mercury for in such cases the cure, that is heavy metal poisoning, was believed to be ultimately more harmful than the disease.³⁹ Proponents of mercury, even the half-hearted ones, could also build their case on pragmatic grounds. They emphasized that non-mercurial treatments required a much longer stay in hospital. Soldiers would therefore be taken out of active service for longer stretches of time without there being any solid evidence to suggest that such a regime offered a better chance for recuperation.⁴⁰

³⁴ Clark, *op. cit.*, note 8 above, p. 409.

³⁵ This argument is developed in Mark Harrison, ‘Tropical medicine in nineteenth-century India’, *Br. J. Hist. Sci.*, 1992, 25: 299–318. See also *idem*, ‘“The tender frame of man”: disease, climate, and racial difference in India and the West Indies, 1760–1860’, *Bull. Hist. Med.*, 1996, 70: 68–93.

³⁶ Clark, *op. cit.*, note 8 above, p. 405.

³⁷ François Bernier, *Travels in the Mogul empire*

(first published in 1670), Delhi, Chand and Co., 1972 ed., p. 253. I thank one of my reviewers for pointing this out to me.

³⁸ WIHM, John Hall, Deputy General’s Report for 1851–52, RAMC 397/ERM 1/1.

³⁹ Clark, *op. cit.*, note 8 above, p. 390.

⁴⁰ WIHM, Army Medical Office, Dublin, report on venereal disease, 26 Oct. 1831, WMS 6905/22.

While these debates on the use of mercury were framed in terms of existing medical and scientific theories, they were simultaneously sited within a broader discussion of what powers the colonial state could declare over its subjects, European as well as non-European. No one could ignore the simple fact that no medical therapy in the nineteenth century could guarantee a cure. Attention therefore switched to preventative measures. Yet owing to the sexual nature of disease transmission, and the fact that venereal diseases in India were so deeply entangled with questions of race and gender (the “victims” were commonly presented as white and male, the “perpetrator”, that is the prostitutes, as Indian and female), discussions about how to try and interdict transmission of the disease ranged well beyond narrow epidemiological and clinical boundaries. The production of an official position on sexuality, and its subsequent regulation, was crucial to imperial efforts to police the various hierarchies which sustained the imperial project, namely hierarchies of race, gender, and class.⁴¹ The health of the European troops became a critical venue for rehearsing these positions.

By the late nineteenth century, the soldiers who contracted a venereal disease were often portrayed as victims—innocents seduced by crafty and amoral Indian prostitutes.⁴² Such representations are fully in keeping with the iconography of venereal diseases. Sander Gilman’s work on nineteenth-century depictions of such diseases has pointed to the common practice of playing up the maleness of the sufferer, for “he is the incidental victim of the female’s infection”.⁴³ The emphasis that this iconography placed on gender meant that it was particularly well attuned to the hyper-masculine culture which prevailed in the army. European troops were not only commonly viewed as the ultimate foundation of colonial rule, but their sexual activity comprised the biggest and most obvious zone of sexual contact between European males and indigenous females. Hence, debates on how best to deal with venereal diseases in the Indian and British armies offered an ideal opportunity for demarcating between colonizer and colonized, male and female, and the various possible permutations and combinations which stemmed from these categories. Differences were identified and articulated using sexual criteria. We have already seen how the ideological agendas and cultural baggage of surgeons in India impinged on their clinical perspectives. Similarly, colonial ideologies and cultural frames of reference impacted upon how the sexual nature of these diseases were discussed. Masculinity was one handy yardstick which came into play. Indian males could be compared to Europeans and their alleged differences accentuated. Similarly, Indian women and their sexuality were also conceptualized as being different in critical ways from European women and their physical needs. Once such distinctions had been drawn, it became easier to demand a programme of medical intervention and regulation which would have been unthinkable in metropolitan Britain.

⁴¹ An important new study of this relationship between sexuality and racism is Ann Laura Stoler, *Race and the education of desire: Foucault's History of sexuality and the colonial order of things*, Durham, N.C., Duke University Press, 1995. Ashis Nandy also explores the question of how sexuality informed ideas and modes of power, but he works from the premise that sexuality did not become complicit in colonial discourses until after 1830. This position seems to rest on a traditional periodization

of Indian history which assumes that a decisive rupture occurred in the 1830s. As is evident from the arguments here, I maintain that such traditional watersheds need to be rethought. Ashis Nandy, *The intimate enemy: loss and recovery of self under colonialism*, New Delhi, Oxford University Press, 1983, pp. 5–6.

⁴² Whitehead, op. cit., note 7 above, p. 48.

⁴³ Sander L. Gilman, *Sexuality: an illustrated history*, New York, Wiley, 1989, p. 238.

In Britain, many social reformers, evangelicals and members of the middle classes were outraged at the sins around them. Apprehensions about the moral and physical consequences of venereal diseases persuaded a number of doctors, philanthropists and local officials that something had to be done.⁴⁴ Venereal diseases could no longer be tolerated. Armed with an increasing array of statistics and in an era of mounting interest in sanitation and in social engineering, sanitary and moral reformers tried to combat venereal diseases. Therefore, it is no accident that the campaign to control venereal diseases through the introduction of lock hospitals in India coincided with the opening of a number of lock hospitals in Britain: Glasgow (1805), Newcastle (1813), Manchester (1819), Liverpool (1834), and Leeds (1842).⁴⁵ However, it must be noted that in Britain these hospitals lacked the blatantly coercive character of their counterparts in India. Moreover, lock hospitals in Britain directed their efforts not only at curing the disease, but also at dealing with the moral failings which it was felt had led the patient to contract the disease in the first place.⁴⁶ In India, while similar moral positions were occasionally articulated, demands for sanitation and regulation were not normally set in the rhetoric of reform. Instead, as we shall see, the rhetoric of reform was taken up by opponents of lock hospitals.

Class-based prejudices also came into play. Officers viewed European soldiers as beyond moral redemption. Most officers and surgeons would have agreed with Wellington's famous dictum that the British soldier was the "scum of the earth". Not only was the soldier thought to be ruled by his baser instincts, but any attempt to meddle with these could have unfortunate consequences for the British army. Sexual activity not only vented the soldier's frustrations, it served to prove his masculinity, a demonstration of great symbolic weight given that masculinity assisted the British in distinguishing between themselves as manly conquerors and many Indian males typecast as effete and effeminate. For many officers this ruled out the possibility that venereal diseases could be checked by appealing to the soldier's morality. There was also a lurking fear that should these soldiers not be given the opportunity to vent their baser instincts, even worse consequences might arise: more violence in the barracks, more desertion, and increased alcoholism; and most unsettling of all was the unspoken fear of homosexuality.⁴⁷

Not all surgeons however shared this bleak prognosis of the soldier's character. There were some who called their medical colleagues to task for failing to consider that pernicious moral influences might be as threatening to the soldier's health as the local environment was widely believed to be: "I am strongly of opinion that too low a view has been taken of the

⁴⁴ The emergence of this mentality is explored in more depth in Roy Porter and Lesley Hall, *The facts of life: the creation of sexual knowledge in Britain, 1650–1950*, New Haven, Yale University Press, 1995.

⁴⁵ T J Wyke, 'The Manchester and Salford Lock Hospital, 1818–1917', *Med. Hist.*, 1975, 19: 73–86, p. 73.

⁴⁶ *Ibid.* Paul Werth sees this coupling of plans to reform and remake the "fallen woman" with advocacy of the Contagious Diseases Acts as indicative of the appropriateness of a Foucauldian paradigm in understanding the micro-level operation of discipline. However, the fact that in the 1830s and

1840s it was the opponents and not the proponents of lock hospitals who pitched their campaigns in the language of reform illustrates just how important is the colonial context. Werth, *op. cit.*, note 7 above.

⁴⁷ It is significant that prosecutions for homosexuality were the only ones that were held in a closed court, and their rulings were rarely circulated to the army. The army was determined that homosexuality should never be publicly acknowledged, not even to condemn it. See my 'Sepoys, soldiers and the lash: race, caste and army discipline in India, 1820–1850', *J. imp. Commonw. Hist.*, 1995, 23: 211–47.

influences which affect the health of the soldier in India—that too much has been attributed to climate and soil, and too little to the moral influences which surround the soldier in that country.”⁴⁸ However, such opinions were in the minority, and even those officers who did concede that the humanity and dignity of the soldiers could be appealed to, at the same time often feared the consequences. A soldier in search of self-improvement was not what the army wanted, even if a number of surgeons and officers had made the connection between disease and intemperance; it needed soldiers who lived for the moment, not those who saved for and thought about the future. Drink and sex were thought to be part of the soldier’s natural environment. Any attempt to alter this state, by encouraging celibacy or temperance, was frowned upon by most officers. One wrote that “temperance societies are opposed to military discipline, and are of little efficacy.”⁴⁹ Moreover, as Ann Stoler has convincingly argued, the army’s enthusiasm in sanctioning the sexual drives of the soldiers also helped to reaffirm the class distinctions between officers and other ranks for it was the officer’s ability to sublimate his drives which confirmed his superiority.⁵⁰

From Medical Intervention to Surveillance and Interdiction

While surgeons continued to debate the efficacy of various medical treatments for venereal complaints, military officers, desperate to arrest the spread of these diseases within their own corps, had begun to experiment with preventative measures. In the absence of effective physical barriers—mass-produced condoms had to await the development of vulcanized rubber and the first really affordable ones (½d each) were not available until 1900⁵¹—efforts were directed at the carrier of the disease. This in practice meant the prostitutes, who were, according to contemporaries, easy to locate and, given the powers available to the colonial state, easy to police. And there certainly appeared to be many of them. For example, the census of 1848 for Kanpur estimated the number of prostitutes at 420, of which 110 were working out of the bazaars in the cantonment.⁵²

Soldiers, who were thought incapable of resisting temptation at the best of times, were considered to be at even greater risk in India, where prostitution was commonly understood by the British to be a time-honoured profession with little or no shame attached to it. As early as 1810 one commentator was insisting that “in every part of India the profession of a prostitute is devoid of that stigma annexed to it in Europe; persons following it are protected by law in certain privileges”.⁵³ This archetype of the Indian

⁴⁸ Dr F J Mouat, ‘The British soldier in India’, *J. R. United Serv. Inst.*, 1866, 10: 347–86, p. 363.

⁴⁹ *Idem*, *The British soldier in India*, London, Lepage, 1859, p. 63.

⁵⁰ Stoler, op. cit., note 41 above, p. 182.

⁵¹ Michael Mason, *The making of Victorian sexuality*, Oxford University Press, 1994, p. 58.

⁵² R M Martin, *Statistical report on the district of Cawnpore*. Calcutta, Bengal Military Orphan Press, 1849, appendices. The targeting of the prostitute as the site for official intervention was not unique to India as Quétel’s work on France has amply demonstrated. Claude Quétel, *History of syphilis*, Cambridge, Polity Press, 1990.

⁵³ Captain Thomas Williamson, *East India Vade-*

Mecum, London, Black, Parry and Kingsbury, 1810, vol. 2, p. 423. Whitehead, op. cit., note 7 above, looks more closely into how prostitutes fit into colonial constructions of Indian femininity. Much more work however needs to be done on identifying these prostitutes. Recent works on prostitution in Madras and Bengal argue that many prostitutes were widows forced into selling sex to support themselves, but this is neither backed up with much evidence, nor developed further. See B Joarder, *Prostitution in nineteenth and early twentieth century Calcutta*, New Delhi, Inter-India Publications, 1985, p. 19, and M Sundara Raj, *Prostitution in Madras: a study in historical perspective*, New Delhi, Konark, 1993, p.15.

prostitute can be partly accounted for by contemporary readings of caste and occupation which gave priority to hereditary explanations, and partly by the increasing use of sexuality and gender as important means of establishing a moral and cultural hierarchy in which Europeans ranked above Indians. As Levine has pointed out, the mere existence of a prostitute “caste” (into which were folded commercial prostitutes as well as courtesans and temple dancers) was useful proof to the British of just how debased Indian society had become.⁵⁴ Closely coupled to this construction of the Indian prostitute was the more general idea that Indian women were inherently less able to control their sexuality, proof of just how far their environment and society had frustrated any chances of moral regeneration from within. Once again medical proof was forthcoming to bolster these assertions. “The women’s diseases, we know and hear little of; but, as strictly sexual, we may infer, from their early marriages, that they will be more the diseases of debility and relaxation (diseased mammae and ovaria), than those of an opposite nature to which the female is prone in European countries.”⁵⁵ The argument that Indian prostitutes would accept genital examination with nonchalance was advanced as further proof of the degraded nature of Indian women.⁵⁶ Such representations of Indian women, which undercut their claims to a common humanity, prepared the groundwork for others who would defend the use of “a little wholesome coercion” to combat venereal diseases in India.⁵⁷

Other commentators tied the rise and fall of venereal disease to agrarian conditions and thus embedded prostitution in the social and economic structures of the sub-continent. They argued that in times of famine, the number of women around stations increased, and with it venereal disease became more common. One surgeon serving in the Madras Presidency calculated the rates of infection over a seventeen year period, and showed that the rate was highest in years of dearth. The average for the 13th Dragoons was forty cases per year, but in 1824–25 and 1833–34 (both periods of famine) the number topped one hundred. In those years, “the poor and half starved villagers have been known to cohabit with the men of our regiment for a handful of grain.”⁵⁸ The suggestion that prostitution in India might be a rational act by women faced with a dismal choice between starvation or sexual labour, strengthened criticisms of Indian society for its allegedly poor treatment of women, as well as the argument that intervention from outside was needed for there was little hope of change from within.

Systematic attempts to combat venereal disease by seeking out and treating the women accused of carrying it had become a popular option among many officers by the end of the eighteenth century. There was no official policy at that time, nor were such efforts officially sanctioned, but officers were nevertheless beginning to experiment with various regulatory schemes. Samuel Hickson, a soldier in the East India Company’s army, wrote in the 1780s that in Bombay a committee of surgeons would regularly inspect the women of the bazaar, and forcibly detain for treatment any that were found to be infected.⁵⁹ In the early nineteenth century, it was reported that in many cantonments, “it is customary to

⁵⁴ Levine, 1993–4, *op. cit.*, note 7 above, pp. 585–6.

⁵⁵ MacKinnon, *op. cit.*, note 10 above, p. 35.

⁵⁶ Levine, 1993–4, *op. cit.*, note 7 above, pp. 585–6.

⁵⁷ OIOC, Report on the lock hospital established at Bangalore, July 1855, Madras Military Consultations, 30 July–26 Aug. 1856, P/273/41,

no. 55. I am grateful to Philippa Levine for sharing this nugget with me.

⁵⁸ Clark, *op. cit.*, note 8 above, p. 386.

⁵⁹ OIOC, Samuel Hickson to his cousin, 24 Dec. 1781, MS Eur B296/1, p. 79.

appoint a committee every month . . . for the inspection of such dulcineas as may be resident within the bounds of the cantonments: such as appear to be diseased, are instantly confined to a small hospital". This method was reckoned by the author to be superior to what were then known as lock hospitals, which at that time "only offers, but does not coerce to, a proper course of medicine."⁶⁰ In other instances commanding officers pursued an even more aggressive strategy. George Ballingall recounted that, early in the nineteenth century, the commanding officer of H.M. 2nd Regiment sent a surprise patrol through the cantonment one evening. All unmarried women were rounded up and subjected to a medical examination the following morning. Those that were clean were issued a certificate allowing them free movement in the cantonment; those that were diseased "were drummed out of the fort, after having their heads shaved and whitewashed, a mark of disgrace which was for a time indelible, and was a sufficient beacon to cause them to be shunned."⁶¹ Ballingall, while noting that this drastic measure seemed to work, took care to inform his readers that the days of the medical vigilante were over.

A more systematic effort at combating venereal diseases was mounted in 1807 when the Bengal government sanctioned the establishment of lock hospitals at some of the principal stations of the Bengal army, including Mathura and Fatagarh.⁶² Somewhat ironically, this regulation was approved by the then Governor of Madras, who was none other than William Bentinck. Perhaps Bentinck's willingness at this point to be won over by proponents of lock hospitals arose from his own recent experience with a venereal infection.⁶³ The Madras Army proceeded to establish lock hospitals at most of their major stations; in 1808 some 3,502 women were under treatment in seventeen lock hospitals.⁶⁴ By 1810 the Court of Directors were convinced of their utility and directed that such facilities be established at all stations in India where Europeans were likely to be cantoned.⁶⁵ It is important to note that the compulsory registration of prostitutes was being undertaken in France at this time, and though there is no clear indication that officials in India were watching French developments, the fact that at least one surgeon advocated the establishment of "medical police" in India (a very continental notion) suggests that the more pervasive and systematic French strategies were gaining some converts.⁶⁶

It was the regimental officers of the British and Company armies who led the campaign for lock hospitals in India. Initially, many surgeons had deep reservations about the efficacy of these institutions and the objections they raised were much the same as those

⁶⁰ Williamson, op. cit., note 53 above, vol. 2, p. 425.

⁶¹ Ballingall, op. cit., note 32 above, p. 462.

⁶² OIOC, General Order of the Governor General, 21 Sept. 1807, Bengal Military Consultations, 21 Sept. 1807, P/22/35, no. 145.

⁶³ Whether Bentinck did contract a venereal infection cannot be established beyond a doubt. However, his biographer has found in Bentinck's papers some interesting references to chancres at a time in Bentinck's life when he was living a high life and consorting with dancers and actresses. "Un maudit chancre me tient prisonnier". See John Rosselli, *Lord William Bentinck: the making of a liberal imperialist, 1774–1839*, Berkeley, University of California Press, 1974, p. 57.

⁶⁴ OIOC, Statement on military lock hospitals in Madras, 1808, F/4/345.

⁶⁵ OIOC, Military letter to Bombay, 5 Jan. 1810, F/4/563, collection 13819.

⁶⁶ The term medical police appeared quite early in India. In 1806, Surgeon Ainslie of the Madras establishment proposed the use of "military police of health" or "medical police" to maintain a *cordon sanitaire* around European cantonments. OIOC, Military letter from Madras, 12 Feb. 1806, F/4/226, collection 4903. Variants on this idea appeared in the medical press of the 1830s. See for example John Murray, 'Reports of the deputy inspector of hospitals to the director general of the army medical department', *Madras q. med. J.*, 1839, 1: 435–44. For the French, see Quétel, op. cit., note 52 above, p. 217.

voiced by later opponents. Critics pointed to the “difficulty of imposing the necessary restraint on the females admitted”, and to the “impolicy of resorting to any mode of compulsion”, the “aversion of the natives to our mode of treatment”, and “above all to the difficulty and uncertainty of effecting cures with unwilling patients.”⁶⁷ Such objections were overruled on the grounds of military necessity, and by the mid-1820s, all the major stations of the British army in India were equipped with lock hospitals which were placed under the control of the garrison’s senior surgeon. By 1822 the lock hospitals at the major stations of the Bengal army collectively treated over 4,000 women a year for venereal diseases.⁶⁸ In 1828, the figure had climbed to 4,830 women treated at a total cost of Rs 34,383.⁶⁹ By then there were a total of sixteen lock hospitals in Bengal. Lock hospitals in Bombay were also busy; it was reported that the peons attached to the hospital in Pune daily brought in twenty women for inspection.⁷⁰ One surgeon described the methods used:

[I] inspected the public women without determining any fixed period, but whenever any suspicions had arisen of a diseased woman being in the bazar—as these inspections were always ordered on a sudden, it has had the best effect, as it prevented precautions being taken by these people to prevent their disorders being detected which they used to do when they knew the precise time they would be sent for.⁷¹

The day-to-day running of the lock hospital was entrusted to a matron, who was assisted by a small staff. There were several peons, usually no more than four, whose duties included the apprehension of diseased or allegedly diseased women and standing guard at the hospital to prevent escapes. Sweepers and other domestics were employed to tend to the inmates’ needs. Funding for these hospitals was normally calculated by a combination of a set amount for facilities and a per capita fee for every woman treated.

William Bentinck and the Case against the Lock Hospitals

The experiment with lock hospitals ended in 1830 when the government of Bengal ordered their abolition in that presidency. Bentinck then appealed to Madras and Bombay to follow his lead. Their reluctance to accede to the Governor General’s request led the Court of Directors to issue a positive injunction against lock hospitals. Bentinck’s decision to do away with these establishments appears to have been based on the need to effect savings in the military department.⁷² The Burma War had caused tremendous strains on the Company’s finances, and economies were being eagerly searched out, especially within the bloated military establishments of India.⁷³ Closing lock hospitals netted a quick saving of Rs 30,000 per year.⁷⁴ By itself this was an insignificant part of the overall military budget, yet when combined with other cost-cutting exercises, it did result in a

⁶⁷ OIOC, Bombay Medical Board Consultations, 2 Sept. 1808, F/4/563, collection 13819.

⁶⁸ OIOC, Military letter from Bengal, 31 Jan. 1824, F/4/835, no. 22,253.

⁶⁹ OIOC, Lock hospital returns for 1828, Bengal Military Consultations, 31 July 1829, P/33/31, no. 81.

⁷⁰ OIOC, Dr McLeod to Adjutant General of the Bombay army, 24 Oct. 1831, F/4/1338, collection 53031.

⁷¹ WIHM, Surgeon John Francis Smet, remarks and observations on the health of the troops, RAMC 204/Box 19/5.

⁷² OIOC, Military letter from Madras, 6 March 1835, F/4/1532.

⁷³ See Douglas M Peers, ‘War and public finance in early nineteenth-century British India: the first Burma war’, *Int. Hist. Rev.*, 1989, 11: 628–47.

⁷⁴ OIOC, Military letter from Bengal, 29 May 1832, F/4/1338, collection 53031.

considerable saving for the Company. Another reason given to justify the closure of the lock hospitals was that they had failed to meet their objective—there was no noticeable decline in the cases of venereal disease during the period in which these institutions were most used. Instead, the familiar pattern persisted of variations by time and place being offset by a general rate hovering around 30 per cent. The only perceptible falling off in the numbers of infected soldiers occurred between 1824 and 1826, and this was easily explained by many European regiments from the Madras and Bengal establishments having been dispatched to Burma where wartime conditions enforced celibacy. In addition, anticipating future arguments, the Governor General expressed scepticism as to whether the women who had been rounded up and then confined in lock hospitals were actually those with whom the soldiers consorted.

While the initial case against lock hospitals was presented in pragmatic terms, Bentinck was also very moved by moral and ethical reservations; and more importantly, while the pragmatists' case against these hospitals was far from water-tight (the empirical data at hand were at best ambiguous), the moral fervour which underscored Bentinck's efforts could not be so easily refuted or overcome. Bentinck's determination to bring about the extinction of lock hospitals, even when the mass of medical and military opinion was lined up against him, is not as surprising as might at first appear for he was an intriguing blend of the passionate radical reformer and the quintessential Prussian martinet. This style of leadership, aptly termed "administrative generalship" by a recent biographer, is evident in many of his actions, and nowhere more so than when he encountered what he suspected was resistance from the military establishment in India.⁷⁵ His decision to declare the practice of *sati* illegal was made despite the many reservations expressed by those military officers he had canvassed, and his general order that prohibited corporal punishment on Indian sepoys was again undertaken against widespread opposition from within the army.⁷⁶ Bentinck was, moreover, a strong believer in the application of scientific methods of enquiry to the practice of government, and he thus proved to be particularly susceptible to statistical data.

Bentinck recoiled at the compulsion used in lock hospitals, for it offended his deeply-rooted reformist sentiments. He was somewhat ahead of his time in looking towards improving the conditions, and hence the moral standing, of his colonial subjects, and his paternalistic gaze extended to include the European soldier as well as the Indian prostitute. Lock hospitals were at best a short-term solution: they did nothing for the prostitute, and only indirectly checked the spread of infection amongst the troops. An improvement in the moral condition of the European rank and file, he believed, through offering better and more uplifting diversions (such as libraries, coffee houses, gardens, sports grounds), would bring the rate of infection down. Furthermore, he argued that once the advantages

⁷⁵ The term "administrative generalship" was coined by John Rosselli in his *Lord William Bentinck*. Bentinck's intense suspicions of the military establishment, even when he himself held the rank of general, can be traced back to the Vellore mutiny in 1806. Bentinck was recalled from the office of Governor of Madras following this mutiny of Indian sepoys. It was provoked by the remarkably insensitive handling of religious traditions in the

Madras army, and Bentinck not only never recovered from the ignominy of recall, he also thereafter harboured suspicions that military officers were doing things behind his back. See Rosselli, *op. cit.*, note 63 above, pp. 139–45, and Douglas M. Peers, *Between Mars and Mammon: colonial armies and the garrison state in India, 1819–1835*, London, Tauris, 1995, ch. 8.

⁷⁶ Peers, *op. cit.*, note 47 above, pp. 211–47.

of western medicine became more widely known, local women would come willingly for treatment, and not only for venereal diseases, but other complaints as well. By separating medical treatment from the coercive apparatus of the state, Bentinck hoped that the modernization of India would be accelerated as Indians began to accept voluntarily the benefits of western science and knowledge.

Bentinck's opposition to lock hospitals was strengthened in 1832 when he had William Burke, Inspector General of H.M. Hospitals in Bengal, prepare a detailed memorandum on the costs and efficiency of lock hospitals. Burke's critique of them was a surprising volte-face, for only five years before he had argued with equal vehemence that they were essential to the health of the European rank and file.⁷⁷ Among the measures he then recommended were the compulsory registering of all prostitutes, and the requirement that they submit themselves for examination every other week. Those that failed to do so were to be either punished or forcibly confined.⁷⁸

Burke completely reversed his position in 1832. He dismissed lock hospitals, arguing that they not only failed to curb venereal diseases, but actually encouraged their spread.⁷⁹ He claimed that when lock hospitals were common in the 1820s, on average one in every three European soldiers was being treated for venereal disease at any time. After 1830 the rate dropped to one in four, a decline that Burke attributed to the closure of several lock hospitals. These establishments, he argued, forced the better class of prostitutes to flee. In contrast to the many officers and surgeons who declared that Indian prostitutes looked upon the hospitals with equanimity, if not apathy, Burke insisted that prostitutes loathed these "places of confinement and punishment", and that consequently not only did few women come to them voluntarily, but the periodic sweeps through the cantonments resulted only in the apprehension of the "poorer, the most wretched and probably the most harmless class of the diseased."⁸⁰ Bentinck pushed this point further and questioned whether the staff at lock hospitals were competent to identify cases of venereal disease without "disgusting research such as must be extremely offensive to the more decent prostitutes".⁸¹ Burke's inquiries led him to conclude that most of the women who had hitherto been confined to the lock hospitals of the Bengal army were "generally from the *burrah* ["great", here referring to the main or central bazaar] bazaars, and not from the regimental bazaars, that is they were not of the class or number of females with whom the European troops had intercourse."⁸² This left soldiers with a choice: either they could seek out the ones left behind, who, Burke implied, would be the most destitute and therefore the most likely to be diseased, or they could set off in search of those prostitutes who had shifted their operations beyond the army's watchful eye, thereby exposing the men to other dangers. Burke warned that such travels risked "exposing [the soldiers] to all weathers, day and night, and thereby giving rise to fevers, dysentery, cholera, etc."⁸³

⁷⁷ OIOC, Inspector General William Burke, memorandum on the health of Europeans, 7 June 1827, F/4/1079, collection 29310.

⁷⁸ *Ibid.*

⁷⁹ OIOC, Dr William Burke to Military Department, 21 April 1832, F/4/1338.

⁸⁰ *Ibid.* This point was reiterated in a report from the officer commanding the Mysore division in 1855. OIOC, Officer commanding Mysore division to

Quartermaster General's Office, 3 July 1855, Madras Military Consultations, 30 July–26 Aug. 1856, P/273/41, no. 55. I am grateful to Philippa Levine who forwarded a copy of this document to me.

⁸¹ OIOC, Governor General's minute, 27 Dec. 1831, Bengal Military Consultations, 23 Jan. 1832, P/34/16, no. 23.

⁸² *Ibid.*, f. 73.

⁸³ *Ibid.*, f. 79.

Burke's attentions did not fall exclusively on the prostitute, for in what was a considerable departure from current thinking, he recommended that the army address infected soldiers, particularly when they refused to identify the prostitutes with whom they had intercourse. Burke advised stopping the soldier's ration of spirits in such situations. Soldiers should also be placed on more onerous duties following their discharge from hospital. While some officers did on their own initiative try to implement various punishments, they were generally unsuccessful, for such actions were usually in breach of military law. Burke's efforts to assign some of the responsibility for infection on the soldiers themselves (even if this was in a negative way) struck a responsive chord in Bentinck. Punitive actions against soldiers infected with venereal disease were, however, unacceptable to the British army, though such policies were well established in the French army.⁸⁴ With this route blocked, Bentinck's attempts to combat the disease by acting on the soldier were limited to improving and extending the recreational opportunities open to the European rank and file. This strategy did not prove to be successful, though in fairness to Bentinck financial constraints and the delaying tactics employed by many regimental officers meant that his proposed reforms were only haphazardly applied.

The case in support of lock hospitals was also weakened when suspicions were cast upon those charged with maintaining and supervising them. In terms similar to those used to question the trustworthiness of Indian police, the conduct of the Indian matrons and peons who were responsible for identifying and securing diseased women was scrutinized and suspicions raised.⁸⁵ It was widely rumoured that many women were confined in lock hospitals as a form of blackmail.⁸⁶ Burke also insisted that native doctors could not be trusted, a sentiment widely shared by those on both sides of the lock hospital debate. Even the European surgeons were not exempt from suspicion as they were provided with allowances based on the number of women being treated.⁸⁷ Burke concluded his report by insisting that "the lock hospitals in Bengal had completely failed in the object for which they were established."⁸⁸

Bentinck's campaign against the lock hospitals quickly secured the backing of the Court of Directors of the East India Company and the Board of Control of the British government. London accepted, seemingly without question, the pragmatic reasons deployed by Burke and Bentinck against continuing what was in effect state-regulated prostitution. They would remain true to this position, at least officially, until 1859 when, in the aftermath of the Indian Rebellion, a much more rigid racial hierarchy and an even more acute sense of alarm over the health of European troops overcame any lingering hostility to lock hospitals which they might have shared.

Lock Hospitals in All but Name

The abolition of lock hospitals did not end the discussion over how best to combat venereal disease. As one surgeon wrote, "The evil arising from the abolition of Lock

⁸⁴ Quétel, *op. cit.*, note 52 above, p. 103.

⁸⁵ I have looked briefly at British attitudes towards Indian police officials in 'Torture, the police, and the colonial state in the Madras Presidency, 1816–1855', *Crim. Justice Hist.*, 1991, 12: 29–56.

⁸⁶ OIOC, Adjutant General to Madras Government, 10 July 1849, F/4/2341, collection 122,775.

⁸⁷ OIOC, Dr William Burke to Bengal Military Department, 21 April 1832, F/4/1338, f. 80.

⁸⁸ *Ibid.*

Hospitals is a very serious and growing one.”⁸⁹ If anything, the matter became even more hotly debated as venereal disease continued to infect between 20 and 30 per cent of the European rank and file, and prostitutes were now plainly visible in most cantonments. It was calculated that of the European troops stationed in Madras between 1829 and 1838, one-third of the hospital admissions were for syphilis.⁹⁰ Statistics for one regiment, H.M. 21st Fusiliers, for the period between 1839 and 1847, indicate that between 151 and 473 soldiers per year were treated for venereal diseases, and given that the average strength of the regiment ranged between 453 and 1,046, this meant that in some years, nearly 50 per cent of the regiment’s rank and file were being treated for either syphilis or gonorrhoea.⁹¹ John Hall, the Inspector General of Hospitals in Bombay, computed that in a twelve month period (April 1851 to April 1852), there were 414 cases of syphilis (primary and secondary), 54 cases of penile ulcers, 202 cases of bubos and 301 gonorrhoeal cases.⁹² Only fevers and stomach and bowel complaints occasioned more admissions. A similar situation prevailed in the twelve months ending 31 March 1853 when of a total strength of 5,687 European soldiers on the Bombay establishment, 1,004 were admitted to hospital for venereal diseases.⁹³

Surgeons and army officers were caught in a dilemma. As they saw it, there was no reliable cure for most venereal complaints and the men could not (or as argued by most—should not) be punished or policed. Consequently, many officials felt that this left the prostitute as the only practical site for intervention. Yet Bentinck’s order removed the only means available to military authorities of controlling prostitutes within the cantonment. The obvious alternative of expelling the women was reckoned impossible given that demand for their services ensured that a steady supply would cross over the generally porous boundaries of the cantonment. While some argued that the solution lay in creating a watertight seal around the area, to do so would have entailed drastic revisions to the legal powers and responsibilities of the local commanding officer, as garrison commanders lacked sufficient legal authority to expel undesirables permanently from the cantonment.⁹⁴ Army officers had recourse to military law only, and hence most civilians—including prostitutes—lay beyond their jurisdiction. Judicial rulings were sought from the courts in the three presidencies and the army was disappointed to discover that the general consensus was that unless the individual was directly attached to the army, he or she was not subject to military law, and hence could not be evicted by the army’s writ.⁹⁵ The only exceptions were those traders and servants officially listed as part of the army’s establishment: prostitutes were not considered to be either traders or servants. The Adjutant General in Madras complained that “unless armed with authority by the state, the military authorities are powerless to effect local improvements and should they attempt it,

⁸⁹ Dr Brown, ‘Sick of H.M. 45th, 1 January 1832 to 14 November 1837’, *Madras q. med. J.*, 1839, 1: 101–50, p. 144.

⁹⁰ WIHM, Report on the medical topography and statistics of the presidency division of the Madras army, Madras, 1842, RAMC 2046.

⁹¹ MacKinnon, op. cit., note 10 above.

⁹² WIHM, John Hall, medical returns for 1851/52, RAMC 397/ERM1/2:45.

⁹³ WIHM, John Hall, medical returns for 1853, RAMC 397/ERM1/1.

⁹⁴ OIOC, Adjutant General to Madras Military Department, 1 March 1849, F/4/2341, collection 122,775.

⁹⁵ OIOC, Madras Military Consultations, 12 July 1842, F/4/2341, collection 122,775. Attempts in Bombay to work around these legal obstacles are noted in OIOC, Letter from the Adjutant General, Bombay military consultations, 8 Nov. 1848, P/363/56, no. 4182.

are at once liable to be involved in prosecutions before either the Supreme Court or the Civil Authorities in their immediate neighbourhoods.”⁹⁶ The Faujdari Adalat in Madras, the superior civil court, replied that under the existing regulations prostitutes did not fall under the legal competence of the military authorities in the cantonments.⁹⁷ Efforts to enlist the assistance of civilian magistrates to exclude prostitutes from the cantonments were often frustrated when the latter refused to co-operate.⁹⁸ Civil-military relations in North India were often ambiguous, and each side was wary of any attempt by the other to enlarge its authority. Control over civilians who attached themselves officially and unofficially to the garrison was a particularly ill-defined area, and neither side was willing to concede formally to the other. The consequence, in the words of John Murray, the Deputy Director of H.M. Hospitals in Madras, was that “at the present time neither the police nor commanding officers have any power to take up infected women and banish them from the neighbourhood of the cantonment, and the soldiers cannot be prevented from having intercourse with them while they roam about at large, nor can they be punished for contracting the disease.”⁹⁹

The difficulty of mobilizing support for the reopening of lock hospitals was considerably eased in the 1830s by the appearance in that decade of a growing number of professional publications through which army officers and medical surgeons could air their opinions.¹⁰⁰ The physical health, moral condition and efficiency of soldiers provided a site upon which these professional agendas could overlap, and venereal diseases were a frequent subject of articles and letters to the editors in both the military press and in the medical periodicals. Medical and military discourses were also more easily fused together in this period by the fact that sanitary approaches to disease, which many surgeons were drawn to in the absence of effective clinical treatments for such devastating illnesses as malaria, cholera and venereal diseases, were intellectually and culturally compatible with military culture. Discipline within the army was upheld by close surveillance backed up by the rapid application of authority: the same approach that lay at the heart of schemes of sanitary improvement. The popularity of such measures in the decades after 1830 is attested by the proliferation of medical topographical surveys. These emphasized that dangers to European health were everywhere, in climate, water, miasma, or the temptations of local liquor and women. They often concluded that the surest way to protect Europeans from contagion was to limit their exposure. It is not a coincidence that one of the prime movers behind these medical topographies, Sir James Ranald Martin, would later play a key role in framing the first of the Contagious Diseases Acts.¹⁰¹

⁹⁶ OIOC, Adjutant General to Madras government, 10 July 1849, F/4/2341, collection 122,775.

⁹⁷ OIOC, Registrar of the Faujdari Adalat to government, 7 Sept. 1839, Madras judicial proceedings, 7 Sept. 1839, P/325/65.

⁹⁸ OIOC, Adjutant General to Madras government, 10 July 1849, F/4/2341, collection 122,775.

⁹⁹ ‘Report and general quarterly return of the sick of the Queen’s troops’, *Madras q. med. J.*, 1839, 1: 444.

¹⁰⁰ Among these can be numbered: the *East India United Service Journal* (1833), the *Transactions of the Medical and Physical Society of Calcutta*

(1825–), *Transactions of the Bombay Medical and Physical Society* (1838–), *Indian Journal of Medical and Physical Science* (1834–). Essays on medical and military topics could also be found in the more general literature of the day including the *Calcutta Review* (1844–). For more information on the many medical societies which emerged in nineteenth-century India, see A Neelameghan, *Development of medical societies and medical periodicals in India, 1780–1920*, Calcutta, Indian Association of Special Libraries and Information Centres, 1963.

¹⁰¹ James Ranald Martin’s influence has been noted by many historians. See for example Radhika Ramasubban, ‘Imperial health in British India,

Caught between what they saw as unacceptable levels of venereal infection and London's express prohibition of lock hospitals, some military officers with the connivance of surgeons began to devise their own ad hoc responses. Voluntary lock hospitals and dispensaries were tried in Madras, where it was noted that free medical treatment, shelter and food did attract some of the more destitute women.¹⁰² Rates of venereal infection in the army, however, did not register any appreciable decline. In Bengal, the officer commanding at Dinapore in the early 1830s chose to hire the matron of the now defunct lock hospital. In return for a small salary paid out of the canteen fund, she was to watch over those prostitutes who regularly numbered soldiers among their clients, and ensure that they were not diseased. She had no legal power to back her up, but failure to keep disease under control was to be met by a reduction to her salary.¹⁰³ This system soon spread to other cantonments and was popularly known as the "old bawd" system. These "old bawds" mostly proved to be ineffective. Exasperation over their inability to control prostitutes persuaded some officers that the next best alternative was to monitor more closely their own troops. At Ghazipur in the 1830s, soldiers were subjected to weekly inspections, though there is no indication that those found to be infected were punished in any way.¹⁰⁴ Nor would we expect this to be the case given that such a course of action would be likely to land its instigator in legal trouble.

The most outspoken and sustained demands for the reopening of lock hospitals surfaced in Madras and Bombay. Military and medical officials in these presidencies did not feel that they had been adequately consulted when Bentinck ordered the abolition of the lock hospitals, and his arguments and those of Burke had failed to make much headway. The more aggressive commitment to lock hospitals in Madras and Bombay can also be explained by the historic tensions that existed between Bengal and the lesser presidencies. The administrations in Madras and Bombay rarely missed an opportunity to try and carve out a greater sphere of autonomy for themselves. They chafed at what they interpreted as the presumptuousness of Bengal to enact legislation for the whole of India and they further argued that such legislation did not take into account regional differences. Deepak Kumar has revealed that the mounting and organization of scientific surveys in India was undercut by similar rivalries.¹⁰⁵

Madras and Bombay made numerous appeals to London to have the abolition order rescinded.¹⁰⁶ The Deputy Inspector of Hospitals in Madras was so exasperated that he took the unprecedented step of publishing in a local medical journal the highly critical report he had made to the Director General of the Army Medical Department in London.

1857–1900', in Roy Macleod and Milton Lewis (eds), *Disease, medicine, and empire: perspectives on western medicine and the experience of European expansion*, London, Routledge, 1988, p. 39, and David Arnold, *Colonizing the body*, op. cit., note 3 above, pp. 23–7 and *passim*. See also Surgeon General Sir Joseph Fayrer, *Inspector-General Sir James Ranald Martin*, London, A Innes, 1897.

¹⁰² OIOC, Reports on the venereal wards at Bellary and Trichinopoly, 9 July 1844, Madras public consultations, P/248/13, ff. 1443–1454. I am grateful to Philippa Levine for forwarding copies of these reports to me.

¹⁰³ *Ibid.*

¹⁰⁴ OIOC, Dr William Burke to Military Department, 21 April 1832, F/4/1338, f. 79.

¹⁰⁵ Deepak Kumar, 'Problems in science administration: a study of the scientific surveys in British India, 1757–1900', in Patrick Petitjean and Catherine Jami (eds), *Science and empires: historical studies about scientific development and European expansion*, Dordrecht, Kluwer Academic, 1992, pp. 269–80.

¹⁰⁶ 'Report and general quarterly return of the sick of the Queen's troops', op. cit., note 99 above, p. 440.

In it he claimed that “from documentary evidence [there has been] a great increase in this class of disease since the abolition of lock hospitals in 1835”.¹⁰⁷ He conceded that there were problems with the old system, in particular the “mode by which females used to be brought under examination was revolting to the habits and prejudices of the native community”.¹⁰⁸ However, such abuses called for reforms, not the outright rejection of a system that he believed was the only possible solution. Moreover, he poured scorn on Burke’s claim that lock hospitals led to an increase in rates of infection: “it is contrary to reason to suppose that a well conducted bazaar hospital could increase the spread of the disease.”¹⁰⁹ Interestingly, even Burke at the end of his memo had implied that an element of coercion might be necessary. In cases where a diseased prostitute refused to seek medical assistance, and where there was a risk that she could infect soldiers, he thought that an approach to the magistrate for a restraining order would be permissible.¹¹⁰ Military and medical personnel in Bombay were equally vigorous in protesting against Bentinck’s decision. Surgeons there complained that they had no means of treating diseased women, nor did they have any legal method of expelling such women from cantonments.¹¹¹

Lock hospitals in all but name began to reappear in Bombay and Madras in the 1840s and 1850s, first in the more isolated cantonments and then later in camps closer to the presidency capitals. At Secunderabad, the superintendent of cantonment police issued an order for a tax to be collected from all dancing girls and prostitutes, which would then be used to pay a matron to ensure their healthiness. The order also directed that any woman who deliberately concealed a sexually transmitted disease “shall be most severely punished”, though the punishment was not specified.¹¹² In this case, local officials had clearly overstepped the bounds. Such blatant deviation from official policy could not be ignored, and the offending officer was censured. Nevertheless, the Madras government was sufficiently convinced of the utility of lock hospitals to establish on a trial basis a lock hospital at Cannanore, though they were quick to reassure London that they had prohibited the use of “any measures of a compulsory nature.”¹¹³ Such prohibitions were in vain, for it was later discovered that once infected soldiers had identified the woman from whom they believed they had contracted the disease, a guard of peons was sent to take her into custody, and she was forcibly detained until cured.¹¹⁴ When the Madras government ordered the surgeon at Cannanore not to use force in the future, he replied that the lock hospital would then have to be closed as few women would willingly come forward. The archival trail unfortunately ends at this point, though the few scattered references to the continued existence of a hospital for diseased women at Cannanore suggests that perhaps the government tacitly agreed to avert their gaze, provided the military authorities in the town were less blatant in their use of coercion.

¹⁰⁷ Murray, *op. cit.*, note 66 above, p. 440.

¹⁰⁸ ‘Report and general quarterly return of the sick of the Queen’s troops’, *op. cit.*, note 99 above, pp. 443–4.

¹⁰⁹ *Ibid.*

¹¹⁰ OIOC, Dr William Burke to Military Department, 21 April 1832, F/4/1338, f. 83.

¹¹¹ OIOC, Bombay to Bengal, 11 Nov. 1831, F/4/1338, collection 53031.

¹¹² OIOC, Officer commanding at Secunderabad to Adjutant General of the Madras army, 17 June 1848, F/4/2341, collection 122,775. Secunderabad was reported to have 267 prostitutes living in or near the cantonments.

¹¹³ OIOC, Military letter from Madras, 10 Aug. 1849, F/4/2341, collection 122,775.

¹¹⁴ OIOC, Military letter to India, 27 Nov. 1850, E/4/807, no. 129.

Officers of the Bengal establishment were simultaneously pushing for a return to something akin to the lock hospital system, though, owing to Bentinck's legacy, they were apparently less inclined to threaten publicly to subvert official policy. The surgeon at Meerut in 1839 pleaded for a lock hospital, noting his dissatisfaction with the present system of weekly inspections of the women in the bazaar. If any were found to be infected, they were only encouraged to seek treatment as out-patients, while those that were uninfected were issued with a ticket to that effect.¹¹⁵ The commanding officer and senior surgeon at Ghazipur both recommended the re-establishment of a lock hospital in 1844 owing to the high rates of infection there. The government in Bengal disagreed, referring to Burke's memorandum as proof that lock hospitals did not address those prostitutes with whom most soldiers were likely to have intercourse.¹¹⁶ Yet mounting concerns for the health of the European soldiers meant that the official position against lock hospitals was beginning to waver even in Bengal.

London's response to pleas for the reintroduction of the lock hospitals, or for something along those lines, was ambiguous. While it continued to uphold the principle that compulsion should not be used, it did concede that "some deviation is occasionally admissible". The situation became even more fraught with contradictions when it coupled this to a warning that "the utmost discretion must be used in the application of anything partaking of the nature of constraint."¹¹⁷ Once London's firm commitment to a non-coercive regime weakened, authorities in India began to rebuild slowly the lock hospital system, though this time they would have the added advantages of an increasingly comprehensive legal arsenal at their disposal. Lock hospitals were reintroduced on a temporary basis in some stations of the Madras army in 1855.¹¹⁸ After a survey of prostitutes in the *sadr* bazaar in one cantonment in 1859 revealed that twenty of the seventy-five examined were infected, an experimental lock hospital was reintroduced in Bengal.¹¹⁹ Authorities in London approved this measure on a trial basis for one year. Hence, even before the Contagious Diseases Acts were passed, and perhaps in the knowledge that such legislation was in the offing, the government of India had quietly gone to work reinventing the lock hospital.

Conclusion

The rise, fall and rise again of lock hospitals in India during the first half of the nineteenth century offers an excellent vantage point from which we can observe how medical thought and military imperatives were configured by colonial understandings of race, class and gender. Venereal diseases were as much a social problem as they were a medical condition. Contemporaries made little effort at separating the disease from its mode of transmission, which in the early nineteenth century was read as passing from woman to man. In India, it took a further twist as it was being transferred not only between

¹¹⁵ Murray, *op. cit.*, note 22 above, pp. 10, 47.

¹¹⁶ OIOC, Military Department to Adjutant General, 19 July 1844, Bengal Military Consultations, 19 July 1844, P/39/8, no. 58.

¹¹⁷ OIOC, Public letter to Madras, 28 April 1847, F/4/2341, collection 122,775.

¹¹⁸ OIOC, Superintending Surgeon, Mysore

division to Deputy Assistant Adjutant General, 6 Sept. 1855, Madras Military Consultations, 2–9 Oct. 1855, P/273/26, no. 224.

¹¹⁹ OIOC, Brigadier Smith to Adjutant General, 19 May 1859, India Military Consultations, 6 Sept. 1859, P/191/29, no. 181.

the sexes, but also between races. Surgeons in India had early on become disenchanted with mercurial treatments, but they were also dissatisfied with alternative remedies. This failure to establish an effective strategy of medical intervention within the army prompted surgeons to agree with army officers that they would have to employ juridical methods to counter the putative carrier—the prostitute. Here we can see a parallel with the strategies being devised to deal with other “tropical” diseases like cholera. In these cases, as in that of venereal disease, the patient could not be easily or effectively treated, yet the carrier, once identified, could be isolated with the means available to the colonial regime, namely segregation and *cordon sanitaires*.

While this strategy of surveillance and control was not unique to India, it was certainly pushed with greater zeal because of the extent of the problem and the colonial context, which was employed to rationalize the draconian measures that such a strategy entailed. Military imperatives and medical policies in India were both part of a broader moral/cultural domain upon which were inscribed the prejudices and assumptions of a masculine colonial ideology. The fixation on the prostitute as the site for intervention was therefore underpinned by contemporary constructions of race and gender. The Indian prostitute, like India itself, was objectified and problematized in a way that would have been inconceivable had not colonial rule produced the types of cultural and scientific discourses that legitimated the belief in an inherent difference between India and Europe and between Indian prostitutes and European prostitutes.

From this perspective, the campaign to abolish the lock hospitals in the early 1830s can be viewed as an aberration, for it drew little support beyond that of the Governor-General and the Inspector General of Hospitals. Bentinck’s grounds for abolition certainly rested on his moral objections to the coercion of prostitutes. He also hoped that a more enlightened and tolerant policy would lead to improvements in the condition of the rank and file and a more general willingness on the part of those Europeans and Indians afflicted with syphilis and gonorrhoea to submit themselves to western medical care. However, this position won little support in India, though it did carry the day in London. Medical and military officers in India, and especially in Madras and Bombay, bided their time, and surreptitiously began to reconstruct a system of regulated prostitution which ultimately would be given London’s sanction in the form of the Contagious Diseases Acts.