

## LEGAL INSTRUMENTS OF HYGIENE: PUBLIC HEALTH REGULATION AND STATE POWER IN THE UNITED PROVINCES (1890–1935)

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### **Abstract**

This study explores the structure of law in public health in the United Provinces (UP), in British India, during the time period of 1890 to 1935; a time when colonial sanitary government expanded with an extensive array of legislation, local ordinances, and measures to control epidemics. I used historical analytical methods based upon colonial records of law, reports from the Sanitary Commission, minutes from local government meetings, and gazetteers to trace how the colonial state used various legal tools including the Epidemic Diseases Act of 1897, local sanitation ordinances and vaccination requirements as ways to expand their administrative authority over the Indian body, dwelling place and urban space. The results show that both the law and its administration were dual-purpose: addressing real public health issues including plague, cholera, and malaria; and supporting the establishment of racial hierarchies, expanding the authority of the bureaucracy and exercising disciplinary power over Indian populations using the cover of modern hygiene. Additionally, this paper examined how Indian political actors, members of the municipal boards, and nationalist leaders in the United Provinces challenged, utilized, and reframed these sanitary laws to articulate demands for self-government and social reform. Ultimately, the research shows that the public health law in colonial UP was not simply a technical response to a disease issue but was a constitutive part of the state's power to define the limits of sovereignty, citizenship, and resistance in late colonial India.

**Keywords:** colonial public health, United Provinces, sanitary laws, the Epidemic Diseases Act, state authority, Indian national identity

### **1. Introduction**

Colonial India is a prime example of how the linkages of the three concepts of law, hygiene, and state power are indicative of the dynamics of imperialism. Between 1890 and 1935 the United Provinces (the area of the Indo-Gangetic plains), where the population density was high due to the location of ancient pilgrimage routes as well as numerous epidemic diseases occurring on a recurring basis, experienced this relationship at its most intense form. It was in these years that the colonial state established a highly developed framework of regulations related to public health; the colonial state intervened in the daily life of Indians: their houses were subject to inspections and demolition; they were prohibited from moving around during an epidemic; the bodies of Indian subjects could be compelled to receive vaccinations; and the trade and commerce of Indians were regulated by sanitary laws to which Indians did not have the ability to contribute to the formulation of such laws.

This study argues that, during the British colonial period, public health legislation in the United Provinces was not simply a series of responses to specific diseases; it was also an instrumental component of colonial state-building -- one that provided a mechanism for responding to actual epidemiological threats while extending the administrative reach of the colonial state into areas previously governed by customary law, caste systems, and community practices. The legal mechanisms for maintaining public hygiene (from the broad emergency powers granted by the Epidemic Diseases Act of 1897, to the narrow regulatory functions governing municipal waste collection and sewage management) are characterized as the "colonization of the body," a term used by David Arnold to describe the process through which western medicine and its attendant legal frameworks became increasingly important arenas for conflict between colonizer and colonized.

The time frame selected for this study, 1890-1935, is intended to be deliberate. It begins at a time when there is increasing concern regarding the spread of infectious diseases in India, and when sanitation reform efforts were gaining momentum, due in part to the recommendations of the Royal Commission on the Sanitary State of the Army in India. It ends at a time when the Government of India Act of 1935 had transferred the responsibility for public health administration to elected provincial ministries in India, effectively changing the political economy of sanitary governance in the United Provinces. Between these two points, the United Provinces were affected by the devastating plague pandemic that occurred in 1896; the passage of the Epidemic Diseases Act in 1897; the institutional growth of municipalities, and district health services; the adoption of the Montagu-Chelmsford Reforms of 1919, which placed public health under Indian-led dyarchy; and the nationalistic movement, which transformed issues related to hygiene into questions of swaraj (self-governance), rather than imperial beneficence.

### **1.1 Literature Review**

The study of colonial public health in India has had an important evolution in the last 40 years; from institutional accounts of medical success to a more contemporary study of medicine as a tool of colonial power. In his book *Colonising the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (1993), David Arnold produced the key research that demonstrates that the colonial state's public health efforts particularly those conducted during smallpox, cholera and plague epidemics are forms of bodily colonization. Arnold's research indicates that the public health efforts in India by western doctors were "neither simply a matter of transferring the medical practices of the West to the East nor merely of applying them to local Indian conditions, but were instead made in response to both local needs and Indian conditions" thereby creating a space of negotiation between western medical practice and the local context.

Mark Harrison's *Public Health in British India: Anglo-Indian Preventative Medicine, 1859–1914* (1994) added to Arnold's work by examining the institutional and professional aspects of colonial public health. Harrison examines how sanitary officers in the colonies attempted to balance their desire to create a "sanitary utopia" with the reality of financial and political limitations placed upon the colonial government. Harrison argues that public health policy was

often influenced by bureaucratic politics and fiscal concerns just as much as scientific knowledge, and that the colonial government often under funded sanitary measures while still requiring the appearance of successful outcomes.

Since Harrison's study, researchers have begun to explore other aspects of the relationship between colonialism and public health. Prashad (2001), for example, analyzed the technologies of sanitation in colonial Delhi and found that sewerage systems were constructed primarily to service European residential areas while leaving Indian neighborhoods without adequate access to sanitation services. This demonstrates the racial assumptions and biases that existed in the design of sanitary systems. Kidambi (2007) found that the plague epidemic in Bombay resulted in the creation of Improvement Trusts which were responsible for conducting large-scale slum clearing projects. Although these projects were ostensibly justified based on public health concerns, they ultimately facilitated the colonial authorities' ability to exercise greater control over the urban environment and acquire land. More recently, Singh and Singh (2025) explored the medico-legal frameworks through which the colonial authorities governed the prevention of disease. They documented how various laws including the 1897 Epidemic Diseases Act and the 1881 Indian Vaccination Act functioned simultaneously as mechanisms of health governance and as tools of political control. The 1897 Epidemic Diseases Act has been subject to increased academic scrutiny in recent years, as scholars including Yadav and colleagues (2024) have analyzed the domestic and international pressures including the international sanitary conventions and the threat of European quarantine that prompted the passage of the legislation.

Studies of colonial Punjab have provided additional insights into how epidemic policies functioned as mechanisms of biopower. For example, Waris (2022) argued that public health responses to epidemics in colonial Punjab were a deliberate attempt by the colonial powers to protect and advance the empire's "core political, economic and military interests," leading to a shift in the focus of epidemic policies from enclavic (or limited) approaches focused on the protection of European populations to broader policies aimed at controlling the spread of disease within the Indian population. Building on Waris' analysis, Burki (2022) argued that quarantine, sanitation initiatives, segregation orders and mass vaccination programs were all examples of "decisive instrument[s] of biopower" that enabled the colonial authorities to establish "governance over the native body and population." Legg (2013) examined the transition from contamination-based to contagion-based models of social hygiene in the inter-war period, and found that the introduction of the system of dyarchy created by the Government of India Act of 1919 reorganized the scalar politics of health governance.

Although there is now a wealth of literature on the history of colonial public health, studies of the United Provinces as a separate unit of analysis are relatively rare compared to other regions of India. Most studies have concentrated on the three presidencies (Bombay, Bengal and Madras) or Punjab, where the military requirements for public health measures were most intense. The United Provinces, however, represent a unique area for studying the intersection of sanitary law and the uses of state power and Indian political agency due to the presence of

significant numbers of Hindu pilgrims, Muslim urban populations and a powerful nationalist movement that frequently employed the rhetoric of social reform and self-improvement.

## 1.2 Research Objectives

The aim of this study is to follow four objectives:

1. Identify and map the legal framework for the regulation of public health in the provinces of British India from 1890 until 1935; identify the major legislative instruments used to regulate public health; detail the mechanism by which public health was administered; and detail the structures within which the institutions enforcing public health legislation operated.
2. Explain the ways in which these instruments of the law served as a technology of the power of the colonial state to extend its bureaucratic control over populations of Indians using the language of hygiene and preventing diseases.
3. Examine and detail the forms of Indian resistance, opposition, and use of sanitary law that existed at both an elite level of municipal politics and at a popular protest level, as they evolved in the provinces of British India from 1890-1935.
4. Assess the effect of the constitutional changes implemented in 1919 and 1935 upon the political economy of the governance of public health, with particular emphasis on the transfer of the responsibility for administering sanitation to Indian led provincial governments.

## 2. Methodology

**Historical Analysis:** This research uses a historical-analytic approach that utilizes both primary archival data and secondary historiographic material to examine how public health was implemented in the late-colonial period in India. Primary sources used to complete this analysis included the Annual Report on Sanitary Measures in India; the Proceedings and Reports of the United Provinces Legislative Council; the United Provinces District Gazetteer; Proceedings of Municipal Boards in major cities (Lucknow, Allahabad, Benares, Agra, Cawnpore); and selected legislation (the Epidemic Diseases Act of 1897; the United Provinces Municipalities Act of 1916; the United Provinces Town Improvement Act of 1919; and a number of Provincial sanitary by-laws and vaccination orders). In addition, secondary sources were employed in order to critically evaluate the existing historiography of colonial medicine and public health in South Asia and to determine if they were applicable to the United Provinces.

**Theoretical Framework:** Foucault's theories of biopower and governmentality provided the basis for the analytical framework. Biopower refers to the modern state's use of regulation as a mechanism of governance over the population to manage the health, reproduction, and daily lives of subjects. Additionally, the theoretical framework also recognizes the presence of colonial dynamics such as racial hierarchy, financial constraints, and nationalist opposition that

differentiated the Indian case from other European countries where these theoretical frameworks were initially applied.

### **3. The Legal Architecture of Colonial Hygiene in the United Provinces**

#### **3.1 Foundational Legislation: Sanitary Commissions and Early Municipal Law**

In addition to creating a large-scale bureaucracy, the Sanitary Commission would eventually have the power to collect data and make decisions regarding the environment, sanitation, and disease in the provinces. The first officer to assume this duty in the U.P. was the Deputy Sanitary Commissioner, who advised the provincial government on all matters related to public health, inspected all of the sanitary arrangements of municipalities in his area, and reported on all epidemic outbreaks.

The North-Western Provinces Municipal Act of 1873, and subsequent acts, gave municipal boards formal responsibility for a wide range of issues including: sanitation; drainage; water supply; regulating offensive trades; and managing markets and slaughter houses. Boards were also empowered to create ordinances concerning: the construction of buildings; the disposal of waste; the maintenance of toilets; and the elimination of nuisances. However, the colonial government maintained a significant amount of oversight authority and could override the boards' decisions at will. Furthermore, the boards themselves were composed largely of appointed representatives and not elected ones until reform occurred in the early 20th Century. As a result, the Indian taxpayers of the municipalities were required to fund sanitary improvements through taxation, yet they had little or no input into the policy decisions that impacted the quality of life in their urban environment.

#### **3.2 The Epidemic Diseases Act of 1897: Emergency Power and Its Use**

Although many pieces of legislation were passed during the late 19th Century in regards to public health in India, one of the most significant pieces of legislation passed was the Epidemic Diseases Act (EDA) of 1897. The Act was passed so quickly that it took only a matter of weeks for the bill to pass from introduction to enactment, after the arrival of the bubonic plague in Bombay in September 1896. This Act provided provincial and municipal governments with a vast array of emergency powers, allowing them to take "such measures and by public notice to prescribe such temporary regulations to be followed by the public" as they saw fit to prevent the spread of dangerous epidemic disease.

The EDA was characterized by its extreme brevity consisting of only 4 sections, and its vague nature, which allowed almost limitless discretion to the authorities on the ground. According to the EDA, the colonial government in the United Provinces authorized: compulsory house inspections; the forced removal and segregation of plague patients; the evacuation and disinfection of homes; restrictions on travel; and the establishment of cordons around infected zones. In addition, according to the Act, authorities were also empowered to inspect and detain travelers on railways, an issue of particular importance in the United Provinces because of the location of major trunk railways and the massive religious gatherings that occur at locations

such as Allahabad (the Kumbh Mela); Benares; and Mathura, where cholera and plague find ideal conditions for transmission.

The use of the EDA in the United Provinces generated considerable opposition. To the Indian population, the provisions of the Act were seen as an invasion of the private domain of home life; as violations of traditional purdah and caste norms; and as racist in intent and application. In cities such as Cawnpore, Lucknow, and Benares, anti-plague measures resulted in protests, petitions, and occasional violent outbursts against house searches; the removal of the sick to isolation hospitals; and the destruction of property deemed insanitary. The colonial government responded to these protests with a combination of coercion and concessions. On the whole, officials in the United Provinces were slightly less heavy-handed in their methods than those employed in the infamous plague administration in Bombay under W.C. Rand, whose authoritarian methods ultimately culminated in Rand's own assassination in June 1897.

### **3.3 Municipal Sanitary Governance: Bylaws, Inspections, and the Regulation of Urban Life**

In addition to the dramatic use of emergency powers by the EDA, there existed a far more ubiquitous and mundane legal structure: the complex of municipal sanitary by-laws that controlled the construction of buildings; regulated drainage; managed waste; managed the licensing of food markets; and licensed those trades considered offensive or dangerous to the health of the general populace. The United Provinces Municipalities Act of 1916 codified and extended these powers establishing a comprehensive regime for municipal public health governance that remained intact, with amendments, through independence.

Under this legislation, municipal boards in the United Provinces were obligated to establish systems of conservancy (waste removal); establish and maintain public latrines; see to it that surface waters were drained; control the construction of new buildings to ensure proper ventilation and access to light; inspect food establishments; and enforce vaccination mandates. The boards employed sanitary inspectors, vaccinators, health officers, and conservancy staff a bureaucratic apparatus that represented one of the most visible means by which the colonial state interacted with the Indian population in cities across the country.

However, the implementation of these laws was highly uneven. European civil lines and cantonments were invested with disproportionate amounts of sanitation-related resources (e.g., piped water, underground drainage, paved streets, and regular conservancy) compared to Indian quarters, which relied upon open drains, public wells of questionable purity, and spotty waste collection. The spatial disparities in service delivery were not arbitrary; they were reflective of the racial priorities of the colonial government as well as the financial constraints of local governments in a system in which Indian rate-payers had little input over budgetary decisions.

### **3.4. Vaccination Law and the Control of the Human Body**

Vaccination against smallpox was one of the earliest and most contested areas of public health law in India. The Compulsory Vaccination Act of 1892 provided for the selective application of its provisions throughout the United Provinces, authorizing municipalities to require the vaccination of infants and re-vaccination of adults, with corresponding sanctions for refusal to comply. Vaccination practices within the United Provinces utilized an army of Indian vaccinators who traveled from town to town, providing both arm-to-arm and lymph-based vaccinations, registering immunized populations, and submitting reports to the district sanitary authorities.

Resistance to vaccination law occurred at multiple levels: distrust of the safety of the vaccine; religious objection to the introduction of animal product into the body; caste-based objections to contact with low-caste vaccinators; and more broadly based political opposition to compulsory bodily interventions by a foreign government. Compliance rates among the districts of the United Provinces varied widely, with compliance rates being significantly higher in urban areas than in rural and tribal areas. Colonial officials attributed the continued resistance in rural and tribal areas to "lack of knowledge" and "superstition." However, the resistance was indicative of rational assessments regarding risk and trust in government.

## **4. Public Health Law as an Instrument of State Power**

### **4.1 The Biopower of Hygiene**

Colonial sanitary laws in the United Provinces (a colony) created an example of "biopower," which is the regulation of populations through various methods targeting biological processes such as birth, death, disease and health. The colonial sanitary system produced a massive network of documentation and monitoring: vital statistics registers, reporting of epidemics, records of inspections of every house, registration of vaccinations, and annual sanitary reports detailing mortality rates, incidence of diseases and sanitary conditions across the entire province. This information-based structure provided two functions: it allowed for epidemiological interventions, while it also allowed the colonial state to render the Indian population legible to itself in a new way.

Sanitary legislation gave colonial authorities permission to enter into Indian houses; inspect Indian bodies; limit the movements of Indians; and destroy Indian property all in the name of public health. These powers were applied unequally; European populations were almost completely exempt from the more invasive provisions, while Indian populations were forced to bear the entire burden of sanitary regulation. As a result, the application of hygienic law acted as a form of race-based governance and reinforced the colonial hierarchy under the guise of scientific medicine and cultural advancement.

## **4.2 Fiscal Politics and the Transfer of Burden**

An important aspect of the public health governance of colonial India, specifically within the United Provinces, was the regular transfer of financial responsibility for public health to Indian municipalities. The provincial and central governments continued to retain regulatory power. Colonial government consistently declined to allocate funding for significant sanitary infrastructure (water supply, sewerage, hospitals), from central funds. Instead, the colonial government directed the municipalities to provide the necessary financing from local taxes and debt. This fiscal strategy ensured that the populations most adversely affected by the absence of adequate sanitation would be responsible for providing the majority of the funding required to improve sanitation, while the colonial government maintained regulatory and standard-setting control.

Municipal boards in the United Provinces operated at a low level of funding, and faced numerous competing claims on their resources, therefore they were consistently underfunded for their sanitary duties. Annual reports from the Sanitary Commissioner for the United Provinces documented a consistent disparity between the amount of sanitary regulations the municipalities were legally obligated to implement, and the amount of money available to them to do so. Therefore, sanitary improvements occurred unevenly throughout the provinces favoring the larger and wealthier municipalities, while fewer sanitary improvements were made in smaller municipalities and rural areas.

## **5. Indian Contestation and the Nationalist Reframing of Hygiene**

### **5.1 Municipal Politics and Elite Resistance**

Indian municipal board members in the United Provinces became an important group of individuals who would challenge colonial sanitation governance terms. Since the 1890s Indian municipal board members have contested how sanitary expenditures were allocated; they have called for increased investments in Indian residential areas; they have questioned the authority of European sanitary inspectors; and they have opposed measures seen as culturally insensitive or racially discriminatory. In Benares, the tension between Indian members of the municipal board and the colonial sanitary government was most intense due to Benares' sacred status, and the consistent complaints made by the colonizers that Hindu religious practices bathing in the Ganges River, the burial of the deceased, and the gathering of pilgrims presented sanitary risks.

### **5.2 Nationalist Reinterpretation: Gandhi to the Congress Municipalities**

The Indian nationalist movement and particularly Gandhi's program of constructive work, fundamentally changed the way sanitation politics was understood in the United Provinces. Gandhi's argument that India needed to show the world that it is capable of self-government through demonstrating sanitary discipline through his programs for cleaning villages, constructing toilets, and eliminating untouchability in labor related to sanitation, converted the field of hygiene from being a colonial regulated area into a nationalist area of contention. After 1920, Congress controlled municipalities in the United Provinces attempted to create sanitary

programs based on Indian needs and values, in direct opposition to the colonial notion that sanitary conditions can only be maintained with the direction of Europeans.

The Montagu-Chelmsford Reforms of 1919, which established public health as one of the "transferred" subjects managed by Indian ministers under the system of dyarchy, provided new institutional opportunities for this nationalist reinterpretation. In the United Provinces, the transfer of public health to Indian led ministries initiated discussions concerning the allocation of sanitary expenditures; the integration of indigenous medical systems (Ayurveda and Unani) into the governance of public health; and the transformation of sanitary policies from a colonial focus on urban European welfare to a broader concern with rural health; maternal and child health; and the social determinants of disease.

### **5.3 Subordinate Resistance and Subaltern Agency**

In addition to the elite municipal politics and organized nationalism, the legal instruments used to govern the health of the colony generated forms of resistance from the people at large that are harder to uncover from the historical record, but are no less significant. The resistance to plague measures in the cities of the United Provinces the avoidance of inspections of homes; the hiding of family members who are ill; and the fleeing of those affected by the plague to avoid quarantine, represented a widespread rejection of the colonial state's claims to authority over the private, personal spaces of home life. While these acts of non-compliance did not articulate a position of resistance in a political sense, they demonstrated a deep disagreement with the legitimacy of the colonial health authorities governing health.

## **6. The Government of India Act of 1935 and the Transformation of Public Health Governance**

The 1935 Government of India Act provided a major shift in the relationship between public health governance and the political economy of public health in the United Provinces. The Act provided for full Provincial Autonomy and abolished Dyarchy, thereby providing for Public Health Administration to be conducted solely by elected Indian Ministers who were responsible to the Provincial Legislature. The Congress Ministry that came to power in the United Provinces in 1937 took over a sanitary infrastructure developed by colonial legislation over the course of four decades and immediately had to consider how best to adapt the existing structure to serve the public health priorities of India.

The legal instruments of hygiene that were developed during the colonial period and included the Epidemic Diseases Act, the Municipal Sanitary Codes, and the Vaccination Laws continued to exist following the transfer of power, although the political value attached to them changed dramatically. Laws that were previously experienced as having been imposed upon Indians by foreign authority were now viewed as being part of the machinery of national development and were employed by Indian Governments to achieve public health goals that reflected the political priorities of Indians. This represents a larger phenomenon associated with the

transition from colonial to post-colonial governance -- the institutional framework of the colonial state has proven to be much more resilient than the regime that created it.

## **7. Conclusion**

The legal instruments of hygiene that were employed in the United Provinces from 1890-1935 demonstrate the intimate interrelation of public health and state power in colonial India. The legislative measures of the colonial government including the Epidemic Diseases Act of 1897, the Municipal Sanitary Codes, and the Vaccination Laws were used by the colonial state as a mechanism to extend its administrative authority into all aspects of Indian life including the home, the body, the marketplace and the pilgrim routes. While these legislative measures responded to real epidemiological crises, they also helped to reinforce social hierarchies based upon race, required colonized populations to bear the costs of sanitation efforts, and facilitated the development of new systems of bureaucratic surveillance and control.

The Indian response to the legal instruments of hygiene employed by the colonial government was not one of either passive acquiescence or simple rejection, but rather involved a series of contests, negotiations, and appropriations of various types. Upper class municipal politicians contested the racially-based distribution of expenditures for sanitary purposes, nationalist leaders re-framed hygiene as a field of self-governance, and ordinary Indians resisted through daily practices of non-compliance which ultimately limited the extent to which colonial sanitary authority could be implemented effectively. The constitutional changes enacted in 1919 and 1935 progressively transferred responsibility for the governance of hygiene from the colonial authorities to the Indians, while leaving the underlying legal framework intact, and thus serving as a testament to the enduring institutional legacy of colonial public health law.

This study demonstrates that public health legislation cannot be evaluated in a vacuum from the political context of its creation and implementation. The history of the law of hygiene in colonial United Provinces illustrates the significance of the body, the home, and the sanitary environment as a site of contestation in the broader struggle over sovereignty and self-determination in modern India.

## **8. Recommendations**

- Future researchers should conduct comprehensive analyses of the municipal board meetings of the United Provinces, which are currently unindexed in the Uttar Pradesh State Archives, in order to provide access to the voices of Indian representatives of municipalities that engaged in opposition to sanitary policies at the local level.
- Systematic comparisons should be made of the experiences of the United Provinces with those of other provinces, such as Punjab, Bengal, Bombay, and Madras, in order to establish the unique characteristics of sanitary governance in different regions of India with different political and epidemiologic conditions.
- Scholars should expand the scope of the sources consulted to include Urdu and Hindi-language newspapers, pamphlets, and petitions that expressed Indian perspectives

regarding the regulation of public health, in addition to expanding the range of languages utilized in the colonial archives to include non-English language sources to capture the complete spectrum of Indian responses to public health regulations.

- The intersections of sanitary law with gender norms (specifically the norms of purdah) and caste hierarchies (specifically the hierarchy of caste within the ranks of sanitary workers) need to be analyzed in detail as a dimension of the politics of colonial hygiene in the United Provinces.
- Researchers should examine the influence of colonial public health legislation, specifically the Epidemic Diseases Act of 1897, which remained in effect until 2020, in shaping public health governance in post-colonial India, including analyzing the persistence and transformation of colonial legal frameworks in the post-colonial state.

## References

- Arnold, D. (1993). *Colonizing the body: State medicine and epidemic disease in nineteenth-century India*. University of California Press.
- Burki, S. (2022). Biopower and the contested landscape of colonial epidemic policy in Punjab (1866–1922). *The Historian*, 1–18. <https://doi.org/10.65463/17>
- Catanach, I. J. (2007). 'The gendered terrain of disaster'?: India and the plague, c. 1896–1918. *South Asia: Journal of South Asian Studies*, 30(2), 241–267. <https://doi.org/10.1080/00856400701499235>
- Harrison, M. (1990). Towards a sanitary utopia? Professional visions and public health in India, 1880–1914. *South Asia Research*, 10(1), 19–40. <https://doi.org/10.1177/026272809001000102>
- Harrison, M. (1994). *Public health in British India: Anglo-Indian preventive medicine, 1859–1914*. Cambridge University Press.
- Hopkins, D. (2006). *Fractured states: Smallpox, public health and vaccination policy in British India, 1800–1947*. Orient Longman.
- Hume, J. C. (1986). Colonialism and sanitary medicine: The development of preventive health policy in the Punjab, 1860 to 1900. *Modern Asian Studies*, 20(4), 703–724. <https://doi.org/10.1017/S0026749X0001369X>
- Johnson, R., & Khalid, A. (Eds.). (2011). *Public health in the British Empire: Intermediaries, subordinates and public health practice, 1850–1960*. Routledge.
- Kidambi, P. (2001). Housing the poor in a colonial city: The Bombay Improvement Trust, 1898–1918. *Studies in History*, 17(1), 57–79. <https://doi.org/10.1177/025764300101700103>
- Kidambi, P. (2007). *The making of an Indian metropolis: Colonial governance and public culture in Bombay, 1890–1920*. Ashgate.
- Legg, S. (2013). Planning social hygiene: From contamination to contagion in interwar India. In R. Peckham (Ed.), *Empires of panic: Epidemics and colonial anxieties* (pp. 149–172). Hong Kong University Press.

- Mahammadh, V. R. (2020). Plague mortality and control policies in colonial South India, 1900–47. *The Indian Economic and Social History Review*, 57(4), 499–537. <https://doi.org/10.1177/0262728020944293>
- Mushtaq, M. (2009). Public health in British India: A brief account of the history of medical services and disease prevention in colonial India. *Indian Journal of Community Medicine*, 34(1), 6–14. <https://doi.org/10.4103/0970-0218.45369>
- Prashad, V. (2001). The technology of sanitation in colonial Delhi. *Modern Asian Studies*, 35(1), 113–155. <https://doi.org/10.1017/S0026749X01003626>
- Singh, A., & Singh, N. (2025). Historical analysis of disease prevention in colonial India: A medico-legal perspective. *St Andrews Law Journal*, 5(1). <https://doi.org/10.15664/stalj.v5i1.3008>
- Topal, H. V., & Atasoy, Z. B. (2025). The role of the third plague pandemic in colonial India as the impetus for the improvement trusts and urban transformation in Bombay, Mysore, and Calcutta. *Planning Perspectives*. <https://doi.org/10.1080/02665433.2025.2460160>
- Waris, F. (2022). The calculus of contagion: Imperial anxiety, policy, and resistance in colonial Punjab's public health landscape (1850–1918). *The Historian*, 1–22. <https://doi.org/10.65463/19>
- Yadav, P., & R, M. V. (2024). The Epidemic Diseases Act (1897): A study of international and domestic pressures on British epidemic policy formation in India. *National Medical Journal of India*, 37. [https://doi.org/10.25259/nmji\\_420\\_2023](https://doi.org/10.25259/nmji_420_2023)