JETIR.ORG ISSN: 2349-5162 | ESTD Year : 2014 | Monthly Issue
JOURNAL OF EMERGING TECHNOLOGIES AND INNOVATIVE RESEARCH (JETIR)
An International Scholarly Open Access, Peer-reviewed, Refereed Journal

Epistemic Segregation and the Erosion of Colonial Public Health: A Socio-Historical Analysis in Madras Presidency

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Abstract : This paper examines the history of public health administration in the Madras Presidency during the 19th and 20th centuries, arguing that the introduction of Western medical and sanitary practices was fundamentally undermined by the region's rigid social structure. The colonial administration's attempts to implement modern health standards, such as sanitation and disease control, were systematically blocked by the practice of untouchability and pervasive caste-based segregation. The Brahmin minority leveraged its educational monopoly to dominate public health and medical bureaucratic positions, ensuring that resources were administered through a caste-defined lens. This administrative control, coupled with philosophical resistance to scientific inquiry and medicine—which was deemed antithetical to religious custom—created a system of unequal modernization. The resulting health crises became the empirical evidence used by social reformers to expose the failures of the socio-religious order, validating the indigenous demand for a new society based on rationalism and equal access.

I. INTRODUCTION

The Madras Presidency, spanning vast territories of South India in the 19th and early 20th centuries, represented a complex nexus of colonial administration, ancient social stratification, and acute public health crises. Endemic diseases, such as cholera and smallpox, frequently swept the region, laying bare the stark inequalities inherent in the social order. The subsequent sections will analyze the Brahmin administrative monopoly over the new medical infrastructure, the impact of caste pollution on sanitation and access to resources, the philosophical conflicts that blocked the adoption of scientific health standards, and the eventual social and political struggle for equal medical access. The study of this era reveals that health and science were not neutral colonial imports, but were fundamentally shaped and distorted by the pre-existing system of social degradation.

II. THE ADMINISTRATIVE AND CASTE STRUGGLE FOR MEDICAL ACCESS

The imposition of modern public health administration under the British Crown inadvertently created a new arena for the perpetuation of existing social inequalities, rather than serving as a leveler. Colonial authorities often sought the most readily educated and available Indian personnel for bureaucratic positions, a criteria that had been historically and systematically monopolized by the Brahmin community. Consequently, the entire administrative structure responsible for managing epidemics, sanitation, and hospitals was overwhelmingly controlled by a minuscule elite.

The Brahmin Monopoly on Colonial Services - Colonial records and official reports of the time unequivocally confirm the entrenched dominance of the Brahmin caste in public administration, including those roles crucial for dispensing modern health and education. The Brahmin population, which constituted only about 3.2 per cent of the total population of the Madras Presidency in 1901, had secured an outsized and disproportionate share of high-ranking positions.

Colonial Recognition of Disparity - The British Administration itself, driven by concerns over political instability rather than social justice, documented this overwhelming monopoly. Officials repeatedly warned that this administrative imbalance was detrimental to governance. As early as 1854, the Revenue Board of Madras issued an order that directed district collectors to be careful to see that subordinate appointments were distributed "among the principal castes". In the 1871 Madras Presidency Census Report, Superintendent Mr. W.R. Cornish brought to the government's attention that the Brahmin caste monopolized services. Cornish urged the government to put an end to this situation, stating that the "True Policy of the State would be to limit their number in official positions and to encourage a large proportion of the Non-Brahmin Hindus and Muslims to offer official services". Sir Alexander Cardew, a member of the Governor's Executive Council, explicitly stated that "It is impossible to apply a system of open competition to the recruitment of the civil services in India unless a monopoly is to be accorded to the Brahmins".

He also noted that "the power of the Brahmins would not diminish unless all other communities were educated". The Brahmins' response to any challenge was defensive and immediate: in one instance, when a resolution was passed in the Congress party by Periyar and S. Ramanathan stating that caste distinction should not be practiced, "all the Brahmin Congress leaders" immediately resigned. This demonstrates the extent to which maintaining administrative and social control was prioritized over even national political unity. This control over the administrative machinery—from the collector's office to the legislative assembly—meant that the implementation of modern public health policies, the location of hospitals, the distribution of sanitation funds, and the admission to medical training institutions were all regulated through a narrow, caste-defined lens, setting the stage for the systematic segregation detailed in the next section.

III. THE INFRASTRUCTURE OF SEGREGATION: HEALTH AND THE CASTE SYSTEM

The most profound challenge to colonial public health initiatives was the ubiquitous and immutable caste system, particularly the practice of untouchability, which fundamentally dictated access to resources essential for sanitation and disease control. Public health demands a shared space and common infrastructure for waste management, water supply, and disease containment, but South Indian society operated under a code of ritual purity and pollution that made such cooperation impossible. The very architecture of South Indian towns was segregated, physically separating communities into distinct, unequal zones. This created an environment where Non-Brahmins, and particularly the Scheduled Caste populace, were relegated to conditions inherently detrimental to health, living in social and infrastructural "darkness for peace, progress and prosperity".

The custom of untouchability manifested directly as a barrier to sanitation and hygiene. The notion of **touch pollution** decreed that food or water touched by a Sudra was unfit for Brahmin consumption, a practice explicitly documented in the Manu Dharma. This extreme aversion meant that shared public utilities—the cornerstone of modern public health—were non-existent or heavily restricted for the majority. Water was a key flashpoint; special provisions, such as separate water pots kept outside the school corridor for Scheduled Caste children, ensured that the basic necessity of hydration was served with humiliation and risk. Beyond touch, the system enforced **distance pollution**, dictating that "unapproachables" could not use the shared tanks and wells of the caste Hindus, confining them to inferior or contaminated water sources. This systematic denial of clean, shared resources guaranteed that disease outbreaks would be highly localized and disproportionately devastating to the oppressed communities.

The exclusion was not limited to water; it permeated all social and institutional spaces. Public businesses mirrored this segregation, with separate eating arrangements established for Brahmins and Non-Brahmins in hotels, creating literal caste-based partitions in commercial spaces. Even avenues for education or entertainment, which might have raised consciousness about health and hygiene, were actively denied: in 1899, an advertisement for a drama in Chennai explicitly included the caveat, "No admission to panchamas," illustrating the total exclusion from communal life. As documented in government reports, Scheduled Caste members themselves, even if holding minor official roles, were subjected to the humiliating ritual of sitting outside the Taluk Board office, where a peon would bring the minutes book out for their signature. Such pervasive social exclusion proved more potent than any colonial directive, ensuring that public health initiatives were doomed to fail the majority by being implemented in a society that refused to recognize shared human space or dignity.

IV. PHILOSOPHICAL CONFLICT AND THE MODERNIZING ETHOS

The entrenched social hierarchy was sustained not only by physical segregation but also by a pervasive, systematic ideology: the control of knowledge validation. Colonial public health measures were thus resisted not merely out of ignorance, but due to a philosophical and theological commitment to an existing worldview that fundamentally rejected scientific progress. For the non-Brahmin populace, the path to improved health and social status required nothing less than a complete epistemological revolution to dismantle the "blind beliefs" that opposed modernity.

Religious dogma and ancient scripture provided the rationale to resist any new idea that challenged the existing order, including modern medicine and education. Brahminical leaders and orthodox elements actively instigated people to revolt against British reforms, such as the opening of hospitals and girls' schools, claiming these initiatives were against "religion, were against culture and tradition". This philosophical barrier prioritized ritual over evidence:

- Epistemic Substitution**:** The belief system relied on astrology, omens, and the efficacy of charms. For example, people clung to "Lizard falling value, dream value, sneezing value are all lies" and believed Manthrams could perform miracles.
- Ritual over Reason: The pervasive focus on *bhakti* (devotion) meant that people believed that even after committing the "most sinful deed," a person could be purified by visiting a Holy Town, taking a bath in Holy water, or simply giving money to a Brahmin. This meant there was little incentive to be "ethical without doing any sin" or to adopt scientifically based preventative health.
- The "Barbaric Age" Critique: Reformers recognized that this mindset, which clung to worshipping a grinding stone or cow dung as God, belonged to a "barbarian age".

The response to this spiritual and scientific stagnation was the demand for a new, rational ethos for health and society. Social movements began to assert that knowledge must rule, making the intellectual process itself the supreme arbiter of truth.

- Knowledge as Liberation: The mandate shifted from spiritual salvation to empirical progress. It was argued that "Electricity, machines and scientific knowledge alone will give progress" and that humanity could only progress by accepting what appears right to one's "knowledge, experience, research and perception".

- The Economic Critique of Disease**:** The reformers connected the health crisis directly to the religious economy. They argued that "crores of rupees" were wasted on pilgrimages, festivals, and rituals, suggesting that if people would "confiscate the wealth of our country's gods, and start factories and schools, can the unemployment problem, illiteracy, foreigners swindling in the name of business exist even for half a minute?". This linked disease and poverty to the failure of religious institutions to manage wealth responsibly.

- Health as a Secular Priority: The emphasis moved from paying the Brahmin for a "ticket to Motcham" to the urgent need for mass education and health. The goal was to provide "money for the education of all" by closing the "hole of Motcham", demonstrating that collective welfare was now framed as a scientific and economic priority, explicitly superseding religious ritual.

This demand for a scientific temper transformed public health from a colonial administrative challenge into a revolutionary social project, one that aimed to rebuild the entire foundation of Dravidian society on principles of reason and equality.

V. Conclusion

The history of public health in Madras Presidency exemplifies unequal modernization, where colonial medical advancements were systematically undermined by the archaic caste system. Administrative control by the Brahmin minority created segregation and infrastructure failure (denial of shared resources), disproportionately impacting Sudras and Scheduled Castes. This crisis served as an empirical metric of social inequality, fueling arguments that only the dismantling of traditional knowledge structures could lead to a healthy society. Reformers exposed the economic and intellectual waste of rituals ("crores of rupees") compared to necessary public goods. The institutionalization of a scientific ethos and rationalism thus became the necessary pathway to health, equality, and authentic modernity for subaltern South India.

VI. References

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