# SOCIAL HISTORY OF EPIDEMICS IN LUSHAI HILLS

A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF PHILOSOPHY

BY

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## CERTIFICATE

This is to certify that the dissertation entitled **"Social History of Epidemics in Lushai Hills"** submitted by Andrew Lalruatkima in fulfilment of Master of Philosophy is an original work and has not been submitted elsewhere for other degree. It is recommended that this dissertation be placed before the examiners for the award of the degree of Master of Philosophy.

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Andrew Lalruatkima

## Declaration

I, Andrew Lalruatkima, hereby declare that the dissertation entitled **"SOCIAL HISTORY OF EPIDEMICS IN LUSHAI HILLS"** is the record of work done by me, that the contents of this dissertation did not form the basis for the award of any previous degree to me or to the best of my knowledge to anybody else, and that the dissertation has not been submitted by me for any research degree in other Universities or Institutes.

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## Statement on Anti-Plagiarism

It is hereby certified that the M.phil dissertation entitled "Social History of Epidemics in Lushai Hills" is the result of Master of Philosophy research programme and have not taken recourse to any form of Plagiarism in any of the chapters of the dissertation, except for quotations from published sources which are clearly indicated and acknowledge as such.

The source material from works such as books, articles, essays, interviews and internet sources are properly acknowledge and quotations and paraphrases are clearly indicated. This dissertation or any version of it has not been previously submitted to any university and the same has not yet been published.


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# Glossary

*Aijal* : Aizawl

*Bawi* : a person who has sought a chief's protection, and his/her descendants

*Bawlpu* : A priests who offered sacrifices to the malevolent spirits in times of sickness

*Demagiri* : Tlabung, a census town in Lunglei district of Mizoram.

*Hridai theu* : To put a village in quarantine so observed at times of epidemics

*Huai* : Malignant or evil spirit

*Howsata* : Hausata

*Jhum* : A system of cultivation in the hills, in which a tract of forests or jungle is cleared by fire, cultivated for a year or two, and then abandoned for a new tract.

*Kelmei* : A tuft of goat's hair (tail)

*Lungleh* : Lunglei

*Lungsin* : Lungsen. It is a large village located in Lungsen Block of Lunglei district, Mizoram.

*Lakher* : A particular clan of the Lushai Hills inhabiting the southernpart and having their own dialect, also known as Shendu, known as Mara today.

*Mizo* : Previously known as Lushai, it includes various numbers of tribes under the Kuki-Chin group of tribes.

*Phar* : Leprosy

*Pathian* : The creator of all living beings, the benevolent God who preserves and blesses life.

*Sadawt* : Clan priests

*Sakhua* : tribe spirit, or viewed as creator or maker.

*Thlarau* : Spiritual realm

*Tlang hrileng* : Air-borne diseases

*Tlawmngaihna*: The Lushais social & moral code of selfless service, sacrificing one's reputation, prestige, and priorities etc. for the goodwill of the society.

*Zawlbuk* : bachelor's dormitory

# Abbreviation

ASA: Assam State Archive.

LMP: Licentiate Medical Practitioner.

MSA: Mizoram State Archive.

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## COLONIAL RESPONSE TO EPIDEMICS IN LUSHAI HILLS

# Chapter I:

## 1.1 Introduction

Epidemic events during British India were numerous and were recorded and documented by the colonial government. However, the documentation can be argued to have taken place predominantly in the non tribal settlements or provinces in other words the mainland India. Evidences of epidemic occurrences pertaining to the Lushai (Mizo) society will be the sole focus of this research. The advent of British colonialism cannot be said to have an exception in the field of public health. Events of epidemic and plagues have been recorded many a time across different countries and cultures, disease have had undeniable presence in the history of mankind and the symptoms and manner of its attack have always remain malignant.

In the course of our writing constant mention or use of Lushai or Lusei tribe is used, they were first known vaguely and differently by the colonial rulers as Kukis or Chins, in their earlier period of contact, occasionally and variedly referred to as Kukis, Chins or Lushais.[1] The Lushais are not a single tribe; they are a large ethnic group consisting of Clans and Sub-Clans, it is one of the tribe amongst various number of tribe under kuki-Chin group of tribes. In the past, the Lushais were known variously according to the place they settle by the Colonial masters. In Manipur, Cachar Hills, Assam, Tripura and Bangladesh, they were called Kukis; in the Chin Hills of Burma, they were designated as Chins while those in the tracts between Tripura and the Chin Hills, towards the south of Manipur, the same people were known as the Lushais, and the Hills they occupied came to be known as the Lushai Hills.[2] The Lushais before the arrival of the colonial power occupied the southern part of the Lushai Hills for a brief period of time but they were pushed towards the north by the stronger and more warring tribes like the Pawis and Suktes. The Lushai in turn fought amongst themselves and the Duhlian and Sailo groups drove out their kindred tribes like the Thadous, Vaipheis, Paites, Hmars and others from the Lushai Hills, who first occupied the land previously.[3] The word 'Lushai' was used in the writings of many colonial writers throughout the course of their administration, but was used often in a vague and ambiguous manner by the colonial administrators. Robert Reid describes:

[1] C.A. Soppitt, *A short account of the Kuki-Lushai Tribes on the North-East Frontier 1893*, Aizawl, Firma KLM for Tribal Research Institute, reprint 1976, p. 2
[2] L. Keivom IFS (Retd.), *'Towards Zo Unification'* in Prism of the Zo people , Lamka, Publication Board, 60th Zomi Nam Ni Celebration committee, 2008
[3] BC, Allen et al., Gazetteer of Bengal and North-East India, New Delhi, Mittal Publication, reprint 2005, p.458

> "The people form a mingling of clans, speaking so far as I know, dialects of the same language, who are known to us by various names- Kookis, Lushais, Pois, Shendus, Chins, etc."[4]

From 1847 to 1871 the Mizos constantly raided the British occupied territories partly because their jhums[5] are exhausted, and the supply of ivory and rubber is dying out,[6] as a result the British then finally sent punitive expeditions against the Lushais. A.S. Reid Medical Officer in Charge 2nd Battalion 4th Gorkha Rifles noted

> 'Since the days of Warren Hastings the various tribes whom we now include under this term have, at long and uncertain intervals, reminded us of their presence in a manner not calculated to inspire mutual regard or confidence. The first record of the raids of these savages dates from 1777, when the chief of Chittagong, a district which had been ceded to the British under Robert Clive by Mir Kasim in 1760, applied for a detachment of sepoys to protect the inhabitants against the incursions of the kukis as they were then called.'[7]

The Lushais were generally spoken of as "Kukis"- a Bengali word meaning hill-men or highlanders.[8] Francis Buchanan, who travelled to Chittagong in the late eighteenth century, mentioned encountering the Lushais and related 'tribes'. This perhaps is one of the earliest ethnographic accounts of the region. When the British came to the hills they used the Bengali term to designate the hill tribes whom they encounter as 'Kukis' and the word was use to generalise all the ethnic tribes living in the Chin Hills and the Lushai Hills. Later, the people living in the Lushai Hills were particularly referred as 'Lushais' this being the earliest reference by the colonial power seen in the report of Lister's expedition in 1850.[9]

However, having mentioned how the Colonial authority or the dominant culture call the 'Lushais' or the 'Chins', it is similarly important to know how the people call and address themselves. The Lushais call themselves "Zao" and the Chin call themselves "Lai".[10] The ancestors of the Lushais or Mizo usually refer to themselves as *keini Mizo* which means "we

[4] Robert. Reid, *History of the Frontier Areas Bordering on Assam 1883-1941*, Guwahati, Spectrum Publications, 1997, p. 3
[5] Jhum cultivation or slash and burn cultivation where plots of land are cultivated temporarily, then abandoned and allowed to revert to their natural vegetation while the cultivator moves on to another plot.
[6] *The Lushais*, Aizawl, TRI, Dept. Of Art & Culture, 2008 (2nd Reprint), p.106
[7] A.S. Reid, *Chin-Lushai Land*, Aizawl, TRI, 2008 (2nd Reprint), p.7
[8] Reid, *Chin-Lushai Land*, p.5
[9] Alexander Mackenzie, *The North-East Frontier of India*, Delhi, Mittal Publications, reprint 1995, p. 292
[10] Reid, pp. 5-6

the Mizos."[11] It is recorded that the people living in the region between Burma and the then Assam and Bengal provinces called themselves 'zo' variantly 'yo' or 'sho'.[12]

In order to portray a clear picture of the British's dealings and contact with the Lushais[13] the word 'Lushai' is often used here in our writing as our time period of research basically lies between 1898 to 1954 when the hills and the people were administered under the nomenclature 'Lushai' . The then Deputy Commissioner of Cachar 1871-72 also used the term 'Lushai' to describe the tribes living beyond the British territorial tracts of Cachar.[14] It was then used to connote the tribes inhabiting the tract immediately to the south of Cachar in place of 'Kukis'.[15] However, the word 'Lushai' itself is believed to be a corrupt form of the word 'Lusei' or 'Lushei' which denotes 'long headed'. This false translation has long been repudiated by Colonel J. Shakespear who wrote extensively about the Lushai people under the Colonial rule, and we can agree that it is certainly an eponym.[16] The distinction between the historically accurate term, 'Lushai', and the politically correct usage, 'Mizo' is that the latter is a politically charged post-colonial form of self-address and description that is considered to be more inclusive while the former denotes the administrative region named after an influential Mizo Clan who spoke the lushai language.[17] As a result it is acceptable to claim that 'Zo' is a generic term to describe the people of the Kuki-Chin-Lushai roots. The word 'Mizo' conglomerate the different tribes mentioned earlier.

Therefore, the term 'Lushai' was changed to 'Mizo' in 1954 when the Lushai Hills came to be called Mizo Hills and was again changed to Mizoram when it attained the status of a Union Territtory.[18] Therefore, the term 'Lushais' which was used by the British Colonial government to describe the people living in Mizoram means the same as the term 'Mizos'. As a result, both terms will be used interchangeably in our writing.

[11]Vanchhunga, *Lusei leh a Vela hnam dangte Chanchin*, Aizawl, Department of Art & Culture, 1994, p.iii
[12] G.A. Grierson, *Linguistic Survey of India 1892-1928*, Vol iii, Part III, Delhi, Low Price Publications, reprint 1990, pp. 3, 10
[13] Vumson, *Zo History: with an introduction to Zo culture, economy, religion and their status as an ethnic minority in India, Burma, and Bangladesh,* Aizawl, Vumson, 1986, pp. 56-57
[14] Sangkima, *Mizo Society and Social Change*, Aizawl, Spectrum Publications, 1992, p.7
[15] Reid, p.5
[16] J. Shakespera, *The Lushei Kuki Clans,* Aizawl, Tribal Research Institute, reprint 2008, p.42
[17] P. Thirumal and Laldinpuii, *Modern Mizoram*, Oxon, Routledge, 2019, p.6
[18] Sangkima, *Mizo Society*, p. 11

## 1.2. Lushai Hills under the British Colonial Government Influence

The Lushais and the British did not come in direct contact with each other until the 1840's. But the Lushais have been heard of by the colonial administration from their constant relentless raids on the British territories in the Cachar plains and the Chittagong Hill Tracts. The first recorded raid of the Lushais on the British territory was in September 1826.[19] This was followed by subsequent relentless raids resulting to loot and plunder as well as lives loss. The Colonial powers were baffled on what approach to take in order to counter the Lushai raids, their initial efforts of peace made by the frontier officers was proven to be unsuccessful as it was rendered to be meaningless by the Lushai Chiefs as peace did not prolong. The inaction and ineffective military policy of the Colonial power was realised when in 23rd January 1871 the tea gardens of Alexandrapur Cachar district was raided by the Lushai chief Bengkhuaia and a British planter Mr. Winchester was killed, and his daughter Mary Winchester was taken as captive. The threshold of a new era of influence by the Colonial power over the Lushais was introduced thereafter by the punitive Lushai Expedition of 1871-1872. This expedition though opens the administrative set up of the Colonial powers in Lushai country but the foundation of administration through means of military control was established in 1889-90 by the Chin Lushai Expedition, it cemented the Colonial powers settlement in the Lushai country. The British success in the Third Anglo-Burmese War (1885-86) also altered the dynamic of policies to be taken in the Lushai country to a great extend, as the military successes were followed by extension of tea plantation and increased European interest thus policy of relations changed completely for the hill tribes of Assam and Burma border.[20] Further administrative steps to be undertaken on the newly acquired tracts were the new dilemma of the British colonial government. Under these circumstances, James Wallace Quinton, Chief Commissioner of Assam, on 15th May 1890 remarked:

> "Mere occupation by a Police force of certain points in the tract referred to would not in itself be sufficient to bring under our influence the chiefs with whom we have been so lately in collision, and that, if this object was to be adequately attained, it was essential that an officer possessing both experience and judgement

[19] J. Zorema, *Indirect Rule in Mizoram 1890-1954*, New Delhi, Mittal Publications, 2007, p. 20
[20] Zorema, *Indirect Rule*, p.33

should be at the same time appointed to feel his way among the people and gradually accustom them to control."[21]

Therefore, the role of the Lushai chiefs in administering the smooth functioning of the colonial law and order cannot be ruled out. The chief is supreme; but if his subjects dislike his system of administration they move elsewhere. He settles all disputes, decides where the village is to cultivate, and when and where it shall be moved.[22]

It was felt that in terms of actual colonial rule, in the Lushai Hills as elsewhere, they should rule through locally established centres of authority and through institutions and customs that already existed. In 1896, there was a meeting of the officers of the Chin-Lushai lines, which outlined the kind of governance that was to be applied to the region. The officers generally recommended that village responsibility, for instance, be placed in the hands of traditional authorities. In the case of the Lushai Hills, chieftaincy was recognised as the legitimate local authority. The British not only recognised those already in authorities, but in course of time also made several individuals the chiefs of new villages, in return for their help to the colonial authorities.[23]

### 1.3. Formation of Lushai Hills

The attainment of the Lushai Hills district was rather peaceful yet assertive. Compulsory disarmament of guns owned by locals and civilians was implemented and this paved the way for administering the civilians as per the colonial law and order. Under the policy of guns to be licensed and the unlicensed firearms were confiscated and the owners of such guns were fined heavily. It was under such circumstances that the Lushai Hills was formed. One of the fundamental reasons for the amalgamation of the two North and South Lushai Hill district was on both political and financial ground as it would mean an annual saving of two lakh rupees.[24]

Thus, Lushai Hills which was annexed in 1891 as two colonial districts as mentioned above. It comprises the North Lushai Hill which formally was under the Province of Assam and South Lushai Hill formally under the North-East Frontier of Bengal. The territories were

[21] Reid, *A History of the Frontier Areas Bordering on Assam*, p.14
[22] *Imperial Gazeteer of India*, Vol XVI, Oxford, Clarendon Press, 1908, p.217
[23] Joy L.k. Pachuau, *Being Mizo: Identity and Belonging in Northeast India*, New Delhi, Oxford University Press, 2014, p.95
[24] Zorema, p.49

declared as part of British-India by a proclamation in 1895, and the North and South Hills were united to Lushai Hills District on 1st April'1898 under the Assam Province.[25]

### 1.3.1. Concerning issue of Epidemic events

As far as our geographical area is concern we will see in the subsequent chapters the types of disease and the causes of epidemics whether its causal is similar to the other provinces of Assam and the rest of the country. The British annexation of Lushai Hills, erstwhile Mizoram came along with evangelism brought about by the Christian missionaries pioneered and commissioned by the Arthington Aborigines Mission 1894-97, made by J.H. Lorrain and F.W. Savidge, before them Revd William Williams was sent to explore the region on behalf of the Welsh Presbyterian Mission (or Calvinistic Methodists) due to political turmoil couldn't succeed and stayed only few weeks.[26] The practice of Christianity imbibed as 'vernacular' and as 'local', facilitated people's identification with it. Conversion came about as a result of a complex interaction between missionary efforts, colonial intervention, and local participation. While missionary efforts can be constituted as a discursive practice aimed at disseminating the faith, which included making the faith relevant, the form it took was preaching in the vernacular, as well as providing educational and medical facilities.[27]

The paramount significance of the role of British colonial rule and the Christian missionaries was handling the events of epidemics through their policies and health care measures within the Lushai Hills district, this had a great impact. This can be argued with the evidences of disease causation perceived by the Mizos and their approach to treatment changed tremendously after the arrival of the British in the Hills. Christianity also facilitated engagements with modernity brought in by colonialism. While some have seen Christianity and its missionaries as collaborators in the modernity enterprise that has subverted local cultures, Mizos themselves saw Christianity as a means through which they could engage with the changes that had befallen them. Consequently, the effect of the incorporation of Christianity into their social constitution represented an unspoken acquiescence in the fact that, in the context of the creation of a new identity, Christianity was their new Sakhua ('tribe spirit'), nowadays almost always understood as 'religion'.[28]

[25] http://sevensisters.quora.com/Mizoram-A-History-During-British#WURoX (accessed on 5th April 2018)
[26] http://sevensisters.quora.com/Mizoram-A-History-During-British#WURoX (accessed on 5th April 2018)
[27] Pachuau, *Being Mizo*, p.232
[28] Pachuau, p.232

Epidemic can be caused by many things for instance geographical location and climate of the region could be one cause as well as sanitary practices. The causes of these epidemic diseases were deemed to be the lifestyle and food habits of the Indians by the colonial British government in India.[29] However, through Mizo vernacular history we see that the maintenance of hygiene and cleanliness was never given importance nor considered to be the cause of illness. Human movement across borders and contact with outside civilization have also been a contributing factor in disseminating epidemic diseases.

### 1.4. Disease afflictions across boundaries

The above point can be supplemented by the fact that in 1860, smallpox was contracted by the Mizos who raided Kassalong Bazar (Chittagong, Bangladesh).[30]The Mizos as tribe head hunters who dwell in the hills have often raided the Chittagong Hill Tracts, the semi-independent state of Hill Tipperah (Tripura), Sylhet, Cachar and Manipur.[31]

This was because the Mizos of the Lushai Hills traded in the frontier marts of the Chittagong Hill Tracts.[32] Such instances of raids and human movement were seen to have brought epidemic diseases amongst the Mizo community prior to the advent of the British Colonial government. In 1871-1872 the Lushai Expedition one of the participating units, the Peshawar Mountain Battery while returning got infected and was reported to have introduced Cholera in Jhelum, Rawalpindi, and Lahore.[33] The 1871-72 Expedition had two columns, one from the north and the other from the southwest, were sent and achieved more lasting success. Most of the chiefs in the Lushai Hills were compelled to submit to British authority, which meant that the British were allowed free access into Lushai country. After this expedition, bazaars were established at Changsil, Sonai, and Tipaimukh to encourage trade with the aim of establishing a long-lasting influence over the indigenous population. The expedition also permitted a topographical survey to be made of 6,500 sq. Miles of new and difficult territory.[34]In the early part of 1875, large numbers of Luhais came down and cut rubber in the British territory and in Manipur between the Jhiri River and Tipaimukh. Lushais would camp

[29] Sasha Tandon, *Social History of Plague in Colonial Punjab*, Punjab University, Chandigarh, Writers Choice, 2015, p.224
[30] T.H. Lewin, *The Hill Tracts of Chittagong and the Dwellers There in*, Aizawl, TRI, Government of Mizoram, 2004, p.151
[31] Reid, p.9
[32] Thomas H. Lewin, *A fly on the wheel or How I helped to Govern India*, Aizawl, TRI, 2005 (2nd Reprint), p.143
[33] Tandon, *Social History of Plague*, p.220
[34] Pachuau, p.92

out in large numbers in detached parties. These rubbers were then sent exported to traders in Cachar. The Lushais would kill elephants and sell the ivory to the traders who then sell it in the Cachar bazaar; due to these reasons in 1884-85 a Frontier Police Force into the Inner Line Forests Reserve was sent towards the Lushai Hills.[35]

Epidemics events could also be seen in the North- West Frontier Province which was one of the worst epidemic effected regions between 1850's to 1920's during the British rule.[36] During the Lushai Expedition of 1889 on the occasion of Advances on Howsata's Village there were many sickness suffered by the British officers, native troops, transport coolies, and public followers, during the four months of expedition. The two officers whose deaths are recorded were Lieutenant Pollen, belonging to the Government Survey of India, and Lieutenant A.T. Ward, Royal Irish Regiment, doing duty with the Transport Coolie Corps. Both died of the remittent form of Malaria fever, the former at Chittagong on the 26th March while proceeding to Darjeeling on sick leave, and the latter at Demagiri on the 2nd April after only ten days illness.[37] Similarly, during the advance of the Southern Chin Column to the Tashon Capital and close of the operations the most formidable enemy which the Southern Column had to contend with was the excessive amount of sickness which dogged troops and followers from beginning to end. Out of sixty-nine officers in the column only seven managed to keep off the sick list entirely, while over thirty were invalided during the expedition, and the remainder, with few exceptions, had to be sent to England on medical certificate, soon afterwards. One officer died at Kan, and two (Major Stoney and Major Ind), shortly after the close of the operations, from disease contracted in the Chin Hills.[38]

From our source and evidences we could arguably state that the uninterrupted transmission of disease such as cholera was manifold due to human movement. In our case the Lushai Expedition was carried out with huge displacement of the Lushais as well as the British colonial forces accompanied with dozens of coolies and hundreds of infantry who were on constant move across geographical borders that possess different climatic conditions. The coolies were the worst sufferers, malaria fever and bowel complaints were common amongst the coolies, along with ulcers of the feet. Twenty-two cases, all fatal, were reported and five deaths amongst Captain Du Moulin's corps of coolies, during the Lushai Expedition of

[35] *The Lushais*, p.97
[36] Tandon, p.218
[37] Reid, p.59
[38] Reid, p.183

1871.[39] The disease fortunely did not spread to the troops with the exception of two or three cases in the 28th Bombay Pioneers and one in the 22nd Gurkhas, many coolies were paid up and disbanded due to their unhealthy habits. Among the troops the 3rd Regiment of Bengal Infantry was the unhealthiest".[40]

It is further stated that one major Barr of the 3rd Bengal Infantry, who died at Rangamatti on the 22nd May from dysentery contracted at Demagiri. The followers i.e. the coolies, as is usually the case, suffered more severely, and at one time cholera threatened to assume an epidemic form amongst them.

### 1.5. Limited epidemic events in vernacular history writing

The Mizos of Lushai Hills as a Community have not kept written records of their experiences and history as a whole before the advent of the British colonisers in the Hills. And the available records today are the works of the Mizo writers who have laboriously collected the fragmented records. To the Mizos oral historical tradition of communicating their culture and tradition through songs, folklore and dialogue from one generation to the next has been imparted consistently until the Mizos were taught to read and write by the missionaries who came along with the Colonisers. The Mizo customary laws were also imparted through oral tradition by the Mizo forefathers and this was hand down to generations thereafter, and then was put into written form.[41] This oral historical information of the Mizos is basically in the form of three historical narratives namely Myth, Legend, and Folktale. The transmission of Mizo cultural practices which was usually done through hands-on practices (local culture of arts, artefacts, objects etc.) and language (oral tradition of rituals, songs, legends, story, etc.) that takes place on both individual and community level was quite alien to the colonial and Christian missionaries. Kyle Jackson argues that the missionaries were suspicious of the Mizo view of their past including the medical system, as a result they unconsciously attempted to reconstruct from the perspective of western linear world view.[42] There is a possibility of deviating from the true cultural essence with ambiguity in such reconstruction. One needs to look at the logic of socio-cultural practices. The cultural practices in most of the

[39] Reid, p. 188
[40] Reid, p. 188
[41] Dr. Laltluangliana Khiangte, *Tawngkaa Thu Inhlan Chhawn Hi Zo-Zia* (The Role of Oral Tradition in Mizo Culture), Aizawl, Seminar and Important Papers, TRI, p.213
[42] Kyle Jackson, *Mizos, Missionaries and Medicine: Religious and Medical Contact in Lushai Hills*, M.A. Dissertation, School of Oriental and African Studies, University of London, 15 September 2009, p.120

'tribal society' are combinations of real life, myth, legends or metaphor.[43] If any part of the socio-cultural practices are separated and translated in little terms, it makes little sense. This is what makes the non-literate society difficult to understand. And the colonisers and missionary were frequently trapped in this dilemma.[44]

The early writers of the history of Mizoram were mostly the British civil and military officers, aided by local men. They wrote whatever they saw, experienced through contacts and enquiries to serve the administrative purposes and military convenience and hardly to serve the public. At the beginning, the writings on the accounts of the Mizo were official reports dispatched by Civil and Military officers on the directive of the Government. These reports and documents submitted by the British Officers to the queries of the Government of India formed another set of historical writing on the history and culture of the Mizo. These writing were rather records of social customs and practices, traditional beliefs, recording of what they saw and experienced at the time of their visit.[45] There is clearly a dearth of scholarly literature written by vernacular writers, and most of the literatures available after Christianity usually write Lushai culture in western perspectives.

Mizo writings on their past have tended to focus on either pre-colonial narratives or their conversion to Christianity. The literature about the pre-colonial period has focused on origins and on the pre-Christian socio-cultural and religious complex. The story of their conversion is inclined to highlight, interestingly, not so much missionary lives, as local agency in the proclamation and nativization of belief. Rarely is the history of colonial rule written, and when it is, it privileges the works of the Superintendents, the most powerful authority of the time, who brought about the institutional changes in the district.[46]

The historical study on epidemics in India cannot be taken into account without looking into the steps and actions the British Government in India had taken. The Epidemic Disease Act was passed in 1897 where the Governor General of India conferred special powers upon local authorities to implement the necessary measures of control of epidemics.[47] With this very Act the colonial government in the Lushai Hills district implemented and carried out village to village vaccination programme under the directive of the Assam Province administration. To

[43] Jackson, *Mizos, Missionaries and Medicine*, p.120
[44] Jackson, p.120
[45] Zochungnunga, *The Mizo Historiography*, Seminar and Important Papers, TRI, 2008, p.245
[46] Pachuau, p.85
[47] http://www.ijcm.org.in/temp/IndianJCommuintyMed3416-1964736_052727.pdf (accessed on 12th April 2018)

determine its success would be impossible without considering the socio-cultural aspects of the Lushai community. In nineteenth century colonial India, the health of the mass population was still largely unknown and unexplored, they offered unique opportunities for medical investigation and experimentation.[48] Although by the end of the nineteenth century western medical science began to pave its way to the Indian public and later on became the most confident expressions of British cultural and political hegemony. Medicine cannot be considered in isolation from the political, cultural and economic forces of British India. Many agencies were involved in the work of medical evangelization, medicine involved ideas and practices which need to be understood as part of the exploratory and regulatory mechanisms of colonial rule.[49]

### 1.6. Western Medical facilities introduced in Lushai Hills

The process of 'medical colonization' was a calculative and deliberative step taken by the British colonial power. Nonetheless, the process of accepting the western medicine or medicinal practice within the Mizo society was the result of the works of the Missionaries where familiarity with Christianity and their presence and living amongst the Mizos played a huge factor in Mizos perception of the unknown religion and culture of the white man. Medical and healthcare facilities provided by the missionaries in Mizoram is exemplified by the works of Dr. Frazer who in his short period of time preached the Gospel and constructed a large dispensary during 1910-11, expenses of 233 pounds were made from his pocket on the construction not by the Missions.[50] And through Frazer's work we saw how the interests of the colonial government and the interest of the work of the missionaries discord in the Lushai Hills.[51]

Furthermore, the western medicine were easily accessible in the local dispensaries and much less expensive than the religion of animism or nature worship which the Mizos were practicing where sacrificial rituals of animals were demanded to appease the evil spirits and cure from sickness or for their own personal goodwill. Though, initially the Mizos were very adamant and concern in preserving their identities through their customary practices. In

[48] David Arnold, *Colonizing the Body: State, Medicine and Epidemic Disease in Nineteenth-century India*, Berkeley, Los Angeles, University of California Press, 1993, p.115
[49] Arnold, *Colonizing the Body*, p.14
[50] J. Meirion Lloyd, *History of the Church in Mizoram*, Aizawl, Synod Publication Board, 1991, p. 152
[51] Fraser was adamant in his opinion on the *Bawi* system where he saw it as a clear instance of slavery within the British Empire. This was in contrast to the government policies where they term it as inevitable and the traditional creation within the Mizo community. And Frazer's seniors in the mission field could not speak up because they felt it will end eventually and opposing it would only jeopardise their mission work.

relation to the arrival of the colonial enterprise in the form of Missions in the Lushai Hills, it must also be emphasised that disease is more than the physiological and psychological breakdown of an individual. Powerful social factors determine whether people fall sick or not, and how and with what results they are treated.[52]

The earliest medicine used to combat malaria by the colonial government was the use of quinine[53] medicine and this was distributed widely across India.[54]The same was being implemented in the Lushai Hills district in 1935.[55] After the British took over the administration of the Lushai Hills it was under the administrative control of the Assam Province with its Capital in Shillong. Therefore, from there on any administrative matter on rules and administrations were taken care of by the colonial administration by introducing a number of legislative measures like the Scheduled Districts Act. XIV in 1874, that became effective in the district from 1898.[56] This became the guiding principle in the administration of the Lushai Hills till 1919. Even before the above Act came into force in the Lushai Hills the colonial authority in Assam had already made certain notifications relating to public health and more specifically on epidemics. For instance, on 18th January 1894, the Principal Medical Officer and Sanitary Commissioner of Assam had circulated a letter to all the Deputy Commissioners, Sub-divisional officers, Civil Surgeons, and Medical officers within Assam Province, instructing a strict and prompt investigation and report on outbreaks of all epidemic Diseases.[57] This order was in regard to the cholera epidemic where the Commissioner had ordered the investigation on the history of cholera in the locality, district, province or other areas, including tea gardens and carrying coolies.[58] Rules for dealing with outbreaks of epidemic diseases in the Lushai Hills were also declared on June 10th 1936, where the chiefs were instructed to report the outbreak of any epidemic to the circle staff immediately without delay.[59]

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[52] Erwin Heinz Ackerknecht, *A Short History of Medicine*, Baltimore, Johns Hopkins University Press, 1982, p.21

[53] Quinine is a bitter compound that comes from the bark of the cinchona tree first isolated from the bark of cinchona tree in 1820. Bark extracts have been used to treat malaria since at least 1632. The tree is most commonly found in South America, Central America, the islands of the Caribbean, and parts of the western coast of Africa. Quinine was originally developed as a medicine to fight malaria.

[54] Tandon, p.223

[55] Letter from the Director Botanical Survey of India informed the Superintendent of Lushai Hills Aijal of the supply of 490 packets of Quinine reinforced Cinchona tablets (MSA CB 3, Health 30).

[56] http://shodhganga.inflibnet.ac.in/bitstream/10603/26505/7/07_chapter%203.pdf (accessed on 10th April 2018)

[57] This copy was also forwarded to the Political Officer of the North Lushai Hills for information (MSA CB 1, Health 1).

[58] MSA CB 1, Health 1, paragraph(d)

[59] A.G. McCall, *The Lushai Hills District Cover*, Aizawl, TRI, Dept. Of Art & Culture, 2008, p.262

### 1.7. Humans as Disease Vectors

Occurrences of epidemics have time and again been a demographic changer where thousands even millions of people die from certain diseases during a period of time in a particular geographical area. Reiterate must be made that epidemic is a worldwide phenomenon and that diseases do not disseminate from one region to another without the movement of humans. Humans are the disease vector that carries and transmits an infectious pathogen into another living organism. Punjab during the colonial period was faced intermittently and recurrently with epidemics of malaria, cholera, smallpox, and the plaque. Twelve major cholera epidemics broke out in the Punjab between 1866 and 1921, affecting all its areas and killing 2, 49,050 people. On an average, 4,357 people died of cholera annually. The districts most affected by cholera were Gujranwala, Hazara, Rawalpindi, Ambala, Gurgaon, Lahore, Jalandhar, Peshawar, Amritsar and Shahpur. The recurrence of cholera in these areas was attributed to a large number of local and regional fairs which were marked by overcrowding, insanitary conditions, besides inadequate and contaminated water supply.[60] In case of Lushai Hills there were not any such deaths in terms of millions due to the low population, and from the numerous sources and evidence we can imply that the initial illness or disease infected persons were always the colonial army contingent who tirelessly tour and campaign in huge numbers with coolies and animals and such consistent movement took a toll in their health in the long run and become a vulnerable disease vectors.

The colonial government took stringent measures to curb epidemic outbreaks. Across the country, the movement of people from one place to another in both urban and rural areas was restricted during the course of the epidemic. Orders were issued prohibiting the granting of leave to government servants, sepoys and students to visit any infected area. People were not allowed to visit the neighbouring villages to fulfil social obligations. The district magistrates were given powers to prohibit the holding of caste gatherings and other social assemblies. Special measures were taken to prevent the periodic and local fairs, which were regular features of people's life in both urban and rural areas.[61] In the Kassalong region before T.H. Lewin made headway for the Lushai Expedition of 1871-72 he encountered people suffering severe dysentery and repeated attacks of fever.[62] This evidence reinstated that the Chittagong Hill tracts were indeed a disease hotbed for the Lushai raiders and traders as well. The Lushai

[60] Sasha Tandon, *Epidemics in Colonial Punjab*, Punjab University, Chandigarh, Writers Choice, 2015, p.218
[61] Tandon, *Epidemics in Colonial Punjab*, p.226
[62] Lewin, *The Hill Tracts of Chittagong*, p.254

expedition of 1871-72 was not the only political conflict faced by the Lushais; there were internal tribe conflict as well. The kukis[63] who had immigrated into the Lushai country in the 1830's would occasionally raid Lushai hills and take advantage of the weakness and disorganization of the Lushais, from famine[64], sickness, and internecine feuds, the kukis then would fled into Manipur.[65] The famine years were unkind and cruel to the livelihood of the Lushais.

It may also be noted that due to incessant hostilities among the chiefs and a famine which occurred in the hills in 1881-1882, many Mizos settled temporarily in the Cachar areas (Assam). Upon returning to the hills, cholera broke out and 'carried off one of the chiefs, Chungliana' and his village thus became susceptible to outside attack.[66]

After a decade of the expedition made by the British Colonial government, by the year 1884-85 the Lushais have devoted themselves to agriculture and did not think of war. The violent strains which their country underwent during the famine had almost entirely destroyed their exchangeable products, and they found that there was no ivory, no gong, no precious amber necklet which they could hope to sell in times of extreme necessity. The forest also appeared to have ceased from yielding a desirable quantity of rubber. Their only options were either to raid against their neighbours and live upon plunder, or to seek redress in agriculture.

The latter course of action was preferred amongst them.[67] We could also argue that these raids that were persistently carried out by the Lushais amongst themselves during the last decade of the nineteenth century and first decade of the twenty first century even after being subjugated by the colonial government, gave the government a cause to use military administrative tactics.

One peculiar reason why the administration of the Lushai Hills district by the British colonial government was so successful with lucrative gains was their investment of their time and energy in touring the rugged hills and steep valleys of the Lushai country. Possibly similar

[63] The kukis mention here is used to designate the other hill tribes (namely the Paite, Thadou, Vaiphei, Simte, Sukte, Hmar etc.) who were not classified as Lushais, although earlier even the Lushais were generalised as kukis as we have mentioned in our introduction. These tribes mostly settled in Manipur and have long been subjects to the ruler of Manipur.
[64] In 1881-82 a famine broke out due to the seeding of bamboo, the supply of food thus provided caused an immense multiplication in the number of rats, who then had exhausted the bamboo-seed, fell upon the rice crops and devoured them.
[65] *The Lushais*, p.48
[66] Mackenzie, *The North East Frontier of India*, p.327
[67] *The Lushais*, p.107

formulae were applied across the country, the constraints in geographical and physical terrain the Lushai Hills offered to administer efficiently was a great challenge to the colonial government thus constant supervision by touring was practiced and followed. There were two varieties of touring: official and missionary. The first was grand and strictly male; the second more modest and often included females who required special arrangements. But to the Mizos these differences were unimportant: Sap *vakvai*, 'crazy, wandering sap', referred to the constant touring of the sap, a strategy used by colonialists and missionaries alike.[68] The touring white men whether government servant or missionaries usually tour along with huge number of people who were mostly coolies carrying their belongings. Forced or impressed labour was imposed upon the Mizos in the initial years of occupation, where porters from the khasi hills and Santhals were imported to carry the loads. Later on almost all porters were Mizos: labourers who received a low daily wage (in the 1930's : Rs. 0.50 for a day march of up to 15 miles, carrying a load of up to 50 pounds). Even on the eve of the Second World War the authorities justified force labour and meagre investment in infrastructure by pointing to the difficult terrain saying labour by impressments is a part of the people's reasonable contributions to the government in return for services provided and on account of the almost insurmountable difficulty that would attend any attempt to create communications through the Hills capable of sustaining mechanical Transport.[69]

The missionaries were the touring champions of Mizoram because they saw it as their core business to visit people in as many villages as possible to spread the Gospel, provide elementary medical assistance and check up primary schools. Touring remained a significant missionary strategy in Mizoram into the mid-twentieth century, and it has its share of dangers as well. People would fall from the steep hillsides, boats would overturn in the dangerous rapids and malaria was lurking at the bottom of the gorges that had to be crossed. The natural world held other threats as well.[70] The medical professionals were as active as the missionaries in touring the remote villages, along with the vaccinators they would make sure that people were vaccinated on time. We will see the no. of people vaccinated in different districts in the subsequent chapters, such touring by the medical professions further strengthen the administrative mechanism of the British colonial government.

[68] Joy L.K. Pachuau and Willem van Schendel, *The Camera as Witness*, Daryaganj, Delhi, Cambridge University Press, 2015, p.154
[69] Pachuau and Schendel, *Camera as Witness*, p.155
[70] Pachuau and Schendel, p.158

In this chapter, we saw the interaction of knowledge, information and perception of diseases between the Lushais and the British colonial government. However, the Lushais knowledge of sickness and contraction of diseases from their raids on the Chittagong Hill Tracts and the Cachar plains was well established and the Lushais were aware of it. This could be said to be intensified by the British colonial Lushai Expeditions, as human movements possibly carried such diseases from one place to the other. Due to unavailability of written records about the epidemic diseases or written Mizo history per se, much of the records are of the observation of the British colonial agents and traditional oral sources as well. Similarly as political activity the medical activity also had a tremendous impact through the colonisation of the Lushai Hills after successful military expeditions. The missionaries were the ground breaking apparatus in the introduction and implementation of the western medicines in the form of dispensaries and training the Lushai men and women on hygiene and cleanliness awareness. Further, for affective governance the traditional system of administration i.e. the Chieftainship was employed and charged with maintenance of cleanliness and hygiene in their respective villages.

## 1.8. Review of Literature:

Literatures that delve with epidemic diseases and their outbreaks alone can be found enormously, but when we focus on the area of study it is very rare to find texts that precisely deal with epidemic prevalence and the government and people response thereafter in the Lushai Hills. Indigenous writers have not particularly explored and focussed on this context to a great extend, as opposed to the political context which is immensely available. Some of the texts which were congruent with the proposed research title are reviewed here apart from many other reference sources, and indeed became useful in developing multiple perspectives and thereby laid the knowledge foundation for my research.

*Social History of Plague in Colonial Punjab* (2015) Sasha Tandon writes and confined her subject specifically in the North-West Frontier Province as the title suggests which is known today as the state of Punjab in India. The book addresses about the impact and causal effect of the epidemic in Punjab. British policies, even the development policies of bridge and canal constructions were attributed to be the root cause of spreading and intensifying the epidemics like cholera and malaria. The huge difference of awareness amongst the people of rural areas against the urban areas is talked about thoroughly. The government measures were responded by the people ranging from mild opposition to even violent forms like riots. Varying attitudes

were seen from both sides. However, the Government did not easily succumb but rather carried on its campaign of health and sanitation actions to safeguard its economic interests.

*Colonizing the Body: State, Medicine and Epidemic Disease in Nineteenth-Century India* (1993) by David Arnold is an in depth study of how the colonial government came to establish its authority and have an imprint in the field of medical and public health. The book takes us through the journey of this establishment whereby initially the indigenous medicine like *Ayurveda* and *Unani* were viewed with great reverence but after acquiring enough knowledge about the indigenous medicine it was viewed as inadequate and its form of practice as ancient to the prevalent diseases. For instance, the indigenous medical practice preferred variolation/inoculation in treating smallpox victims which involves inoculation with live smallpox matter, whereas the western medical practice preferred vaccination which involves the use of cowpox vaccine to treat smallpox victims. As a result the colonial medical practitioners acquired all the methods they deemed as useful from indigenous practice and emerged this with western medicine and a strong State medicine with that of political and economic interests were propagated.

*Plagues and Poxes: The Impact of Human History on Epidemic Diseases* (2004) by Alfred Jay Bollet is a book about retracing and reinvestigating the causes and diseases of the epidemics in history. The author argues and reassures us that most of the causes of the epidemics are due to human intervention and food habits-for example today there might not be any cases of smallpox or say measles and cholera at least in the developed world. But this was due to change in civic sense and sanitary awareness. On the other hand we see cases of coronary heart diseases and many forms of cancer and AIDS epidemic today, which can be termed equally as the epidemic diseases of our age, and of course is largely caused by human habits and lifestyle. Therefore the author wants to revisit the past epidemics and traces the causes of the well known epidemics of the past which will thus help us tackle our future and current epidemic crisis. The book is a very insightful read and resourceful for our research.

*The Burdens of Disease: Epidemics and Human Response in Western History* (2009) by J.N. Hays. The book deals with individual reality of sickness and death. The construction of the meaning of disease by western societies is discussed here. The author termed disease as pathological reality and social construction. He argues that there is a strong connects between disease, social, and political changes. This in turn changes the medical practice. Finally, he

argues that the spread of diseases is in our hands which could be controlled by awareness since humans too have shortcomings.

*The social History of Health and Medicine in Colonial India* (2009) edited by Biswamoy Pati and Mark Harrison is a collection of articles by contributors that touches upon different aspects of health in colonial India and the means of capitalising and benefitting in the name of health education and awareness by the colonial government is emphasized upon. The health institution as a means of benevolent state institution is being argued against in some of the chapters in this book.

*The Calcutta Chromosome: a novel of fevers Delirium and Discovery* (1995) by Amitav Ghosh. This novel, although is a fictional work but is partly based on eventful facts as the author himself, born in Calcutta, is familiar with the medical pasts of the city where epidemic was not a stranger to the city. He dealt with superstitious beliefs of the majority of the people and how the protagonist traced the root cause of Malaria. Overall it gave us a sense of medical awareness and conscience in approaching our research topic.

*A fly on the wheel or how I helped to govern India* (1912) by Thomas H. Lewin who was a Lt. Colonel in the British government in India writes mostly from his personal experiences. The book is a compilation from a personal journal of the author that covers extensively from the Sepoy Mutiny of 1857 to the Lushai Expedition of 1871-72. It is a first account experience of the mutiny by the author where he narrates dark incidents committed by both the parties the Indians and the British. The book talked about his new experiences in Chittagong and how different were their languages and customs as well as their religions as opposed to the Hindu Bengalis. And the author also expresses his long desire to explore into the mountains of the Lushais which then was not penetrated by the British influence. The book is a valuable source for chronological events but to take into account all the narration as factual would be absurd. Since the narration is not backed by detailed evidences and references.

*Lushai Chrysalis* (1949) by A.G. McCall, an Indian Civil Servant is a detailed account about the Lushais or Mizos, which explains the geographical set up of the Lushai Hills and the historical past of their race and identity. As the book title suggests it covers the transitional period of the Lushais from nature worshipping tribe to Christian converts. And the role of the Christian missions and church institution in the field of education and how modern framework of administration was implemented and followed within forty years of contact.

The book is an invaluable source of information for the indigenous writers and researchers and students who are interested in the history of the Lushais or Mizos.

*Hmanlai Mizo kalphung* (1992) by James Dokhuma. It is one of the rare and detailed works done on the history of the Mizo people, their way of life, cultural and traditional practices, customs and laws that govern the Mizos as a community before coming under the influence of the British and before their conversion to Christianity. Their sacrificial practices of animal slaughter to ward of their sickness and ailments are mentioned. The status of Mizo women within the community is also emphasized along with the cultivation pattern and the harvest celebration thereafter. But one of the biggest drawbacks of the book is that no references are made to where the sources of interpretation were received from. This is a peculiar case in the earlier scholarships of Mizo history before Christianity. As knowledge were passed on through oral sources or oral tradition of record keeping.

*Mizo Chanchin (kum 1900 Hma Lam)* (2000) by Dr. Lalthanliana is more or less the encyclopaedia of Mizo origin and their customs, and language. The author emphasised on the different offspring's of tribe and their identity and how they came under the same roof of ethnic tribal classification or identification. Their geographical settlement across the state and in the bordering regions is also discussed. Intra tribe wars amongst the Mizos are also documented, while at the same time the characteristics of an honoured and dignified warrior is described. Well known historical figures before Christianity and the arrival of any outsiders are given a tremendous praise by the author.

*Mission and Tribal Identity: A Historical Analysis of the Mizo Synod Mission Board from a Tribal Perspective 1953-1981* (2010) by Vanlalchhuanawma covers the Tribal identity and colonization and how Christianity began to be accepted by the Mizo community. Unlike the previous book mentioned above by James Dokhuma, this book in contrast gave immense references which made it all the more a reliable source. The author emphasised that the Christian missions operation in the Lushai Hills gifted the Mizos with medical awareness.

*Mizoram Past and Present* (2005) by H.G. Joshi. The author in chapter 4 of this book dealt with religion and transformation. In this chapter he talks about the pre and post conversion and how it transformed the Mizo as a community. This chapter was a necessary read to know more about the perspectives of the Mizo before western medicine was established as a universal means of treatment for diseases.

*Modernization of the Mizo Society: Imperatives and perspectives* (2003) by R.N. Prasad and A.K. Agarwal. This is a book of multiple articles written by academicians of different field, and Chapter 3 'Modernization of Health care services in Mizoram' by B. Thangdailova discussed about the stages of development of healthcare delivery services under the Assam Government where in 1894 a tent was erected at Aizawl to provide medical aid facility to labourers which then was converted in 1896 to dispensary with emergency beds. When Mizoram was given the status of Union Territory there were drastic changes in the development of health infrastructure. It would not be incorrect to say that such development could be possible partly because of the Epidemic Diseases Act 1897.

*The Lushai Hills District Cover* (1980) by A.G. McCall provides standing orders, rules and regulations that administered the Lushai Hills District. Information from District formation to policies of different departments of administration is mentioned in the book. Most importantly, rules relating to outbreak of epidemic and the medical practices highlighted were of tremendous help and knowledgeable for my research.

*Chin - Lushai Land* (2008) by Surg.-Lieut.-Col. A.S. Reid gave a vivid account of the Lushai Expedition of 1871-72, the Lushai Expedition of 1889, and the Chin-Lushai Expedition of 1889-90. Constant mention is made of the health of the troops during the expeditions where it was relatively good however few British officers died of remittent form of malarial fever. Such accounts were a great assistance and important contributor in my research of epidemic diseases that befell the Lushai Hills. We saw many different kinds of sickness and disease that prevailed among the troops as a firsthand account which is invaluable source for my research.

*Indirect Rule in Mizoram 1890-1954* (2007) by J. Zorema though focussed hugely on the political upheavals and transitional period of the Mizo society from a traditional tribal administration to a modern administrative system devised by the British colonial government. As the name of the book suggests it argues and put forth the argument that the Lushai Hills or Mizoram was governed or ruled indirectly by the British this was done through consultation and empowering the chieftainship through nepotism whereby new chiefs were appointed under the government's policy and the Chieftainship succession was regulated. The chapter McCall's administration gave us the contributions and role played by the Christian missionaries where their effort and encouragement on cleanliness to be practiced by the

Mizos is emphasised. This could be seen as the prerequisite of preventing oneself from diseases. It was a great success in the Mizo society.

*5 Years in Unknown Jungles* (2012) by Reginald A. Lorrain is a book written by the pioneer missionary of the Lakher land where he writes in a very detailed manner about his calling and his personal endeavour to spread the gospel. The author writes in a diary or rather in a very personal perspective. The Lakher people's lives constantly permeated by avoiding offences towards evil spirit is emphasised hugely. Their perception on health and sickness and how they do not comfort the dying man was an unprecedented experience on the author's behalf. Such accounts helped in acknowledging the kind of diseases and sickness prevailing in the southern most part of Mizoram.

*The Lushais 1878-1889* (2008) is an administrative report of the British colonial government in the Lushai Hills. Information on outposts, the government relations with the Lushai chiefs, the relations of the Lushais with each other and between individual chiefs is mentioned here. However, the interpretation can be termed as one sided under an objective observation. Nevertheless, it was a helpful account as we saw mentions of famine (Lushai famine of 1881-1882) and raids attack on the bazaar in 1882. And mention of minor spread of cholera by a Cachar Kuki in 1874. Such information is a stepping stone in the construction of a narrative for the research.

*History of the Church in Mizoram* (Harvest in the Hills) (1991) by J. Meirion Lloyd is a book about the works of the Missionaries in Mizoram. In the midst of this report we saw reports on famine and diseases, the medical work and tremendous contributions made by Fraser on this field. Though viewed and read with a secular perspective, this book was a contributory factor while dealing with the people's response of government measures on epidemic diseases.

*The Lushei Kuki Clans* (2008) by Lt. Colonel J. Shakespear is one of the rare books on the Lushais with such a magnitude of information ranging from religion, laws and customs, domestic life, language, folklore, etc. cholera is mentioned as a feared disease and the abandonment of the people who contracted the disease, and the evacuation of the village deserting the sick practiced by the Lushais is emphasised. The religion section mentions the sacrificial rituals practiced by the Lushais, it would not be incorrect to say that the book is a threshold to information regarding Lushais history.

*The Lakhers* (2009) by N E Parry as the name of the book connotes is about the Lakher people's history from Domestic life to religious practices. We saw mentions of medicines as well as vaccinations being received willingly by the Lakhers, however they did not stop performing sacrifices when struck by sickness, the western medicine was seen as a supplementary to the sacrifices. And we also saw mentions of traditional remedies to counter conjunctivitis, snakebites etc. The information available here in terms of medicines is profoundly important and helpful as the book is one of the earliest account written on the history of the Lakhers.

The above selected texts are reviewed for being pertinent to the area of study from the numerous texts that have been acquired. 'Colonizing the body' deals with the epidemic and its medical remedies in the form of western medicine as more of a colonial construct and the book focuses too much on the colonial institutions but not on the perspectives of the colonised. 'Epidemic in Colonial Punjab' paints a vivid picture of the ground reality of the epidemic prevalence in Colonial Punjab. However, it would be possible to say that the Punjab context is prioritised to the extent that Indian context as a whole is shown as oblivious to epidemic prevalence. The writings of T.H. Lewin and A.G. McCall have tremendous importance for my research topic. Their narrations are so distinct with factual information that sometimes they sound more like a story telling books since references are seldom mentioned. However, the disadvantage of their work is that they both are civil servants of the British colonial government that makes them likely to interpret in the interest of the colonisers. 'Plagues and Poxes' and 'Burden of Disease' are very two different texts on epidemic causes and its impact on human history. But a common theme could be found in both whereby human activities are seen to be the cause of some of the epidemics thus being the reason for its proliferation. But Alfred Jay Bollet's take on today's diseases as the new epidemic of the twenty first century is something which could only be looked at in retrospection and researched upon in the future.

Despite being comprehensive, the reviews of these texts informs one that while medical history gain the status of a respectable historical pursuit at the global and South Asian contexts the subject focus has been limited in the case of Mizoram (Lushai Hills) and more precisely on epidemics in the published form. The research study seeks to address this issue and to understand the colonial medical interventions and perceptions of the colonized as far as epidemics are concern in the Lushai Hills.

### 1.9. STATEMENT OF THE PROBLEM:

My dissertation titled 'Social History of Epidemics in Lushai Hills' is an unusual topic that demands an arduous effort. A concise and holistic research have been attempted, considering the meagre number of records kept on epidemic occurrences across villages, and the lack of documentation thereof, especially by the indigenous people. The available evidences are confined to the government records crafted to their interests and are mostly in the form of facts and figures. Theses government record has its own drawback, since the government seldom writes about the experiences of the disease afflicted victims and the suffering of the indigenous people. Thus, to base our source entirely on these documents recorded by the government agents could possibly overwhelm our research approach and could create a bias narrative. As a result, multiple perspectives relying on available evidences were required. There are very few texts and literature from the colonised or indigenous perspective also, which makes the research altogether an ordeal task. In order to achieve this, a bias free analysis of the data collected is attempted into a narrative.

### 1.10. OBJECTIVES:

The objectives of the proposed study are:

1. To examine the perception and knowledge about epidemics in Mizo society.
2. To analyse governmental responses to epidemic outbreaks in the Lushai Hills.
3. To investigate people's response to government measures to control epidemics in the Lushai Hills.

## 1.11. Methodology:

Qualitative and descriptive analysis method is used for the study by collecting data through Primary and secondary sources as well as vernacular newspapers to address the issues related to the objectives mentioned above. Thus, reconstruction of the past by simultaneously addressing its concreteness and complexity is attempted. Primary sources in the form of unpublished thesis in the Libraries as well as documented files from different Archives ranging from non-profit Archive to academic as well as government Archives are consulted namely the Mizoram state Archive and the Assam state Archive. And secondary sources are collected from reputed libraries within the state like the state library, district library Aizawl,

Mizoram university library as well as the library of the Academy of Integrated Christian Studies, with regard to periodicals, and even personal journals, newspapers and reliable internet sources, although we must remember that all sources in the Archive are not archival sources.

The reliability of the information's gathered through archives are reconsidered with the published textual sources available to my access. Archival sources shed light on the information regarding vaccinations performed by the government agents; this was counter-checked with the published and unpublished textual sources available although constrained by limited information on the particular issue. The documents of the missionaries and the pioneer Mizo church leaders were tremendously helpful in enlarging and enriching our scope of research.

## 1.12. Area of Study

The area of study as the title suggests is confined to the Lushai Hills, the erstwhile name for the present state of Mizoram, which is the geographical area bounded on the north by Manipur and Cachar, on the east and the south by Myanmar, on the west by Bangladesh and Tripura. Our study addresses the Lushai hills from the 1870's when it came under British colonial influence up to the immediate post Independence decade when the Lushai Hills became an autonomous district in 1954 with a new nomenclature- Mizo Hills. The study attempts to analyse issues concerning epidemic outbreaks within the Lushai Hills and the measures adopted to curb the epidemic diseases by the government and the Mizos participation.

## 1.13. Structure of the Study

**Chapter I: Introduction**

This Chapter introduces the background on which epidemic events takes place and how it is transmitted across geographical boundaries.

**Chapter II: The Historical Background of Epidemic Outbreak in the Lushai Hills**

The historical perception and knowledge of the diseases in the Lushai Hills is focused upon. Traditional treatment with such diseases and epidemics is dealt with.

**Chapter III: Colonial Response to Epidemics in the Lushai Hills**

The British colonial governmental pivotal role in handling epidemic outbreaks in remote villages within the Lushai District is discussed with factual figures and records.

**Chapter IV: People's Response to Government Measures**

Responses of the Mizos, the complex reaction of resistance followed by compliance to medicines and health care introduced by the government and missionaries among the public is discussed.

**Chapter V: Conclusion**

This chapter analyse and summarize the research findings.

# Chapter II:

## The Historical background of Epidemic outbreak in Lushai Hills

We must remind ourselves the colonisation of the Lushai Hill was by the British colonial government at the beginning, it was then followed by the Christian Medical Missions. In the coloniser's mindset, 'frontier' or 'backward tract' is often associated with non-civilized space of backwardness, barbarism, wildness, wastelands and savagerism[71], which have been subjects of many strange diseases.[72] As mentioned in the previous chapter during the rigorous Lushai Expedition of 1871-72 the British military troops suffered from diseases and due to this reason the colonisers felt the need to deal with new demands that would allow them to live in tropic region.

### 2.1. Mizos perception on Disease and Health during the Pre-Colonial Period.

Contrary to the British perception of Lushai Hills as being a disease infested region, the Lushai tribes considered many known diseases that troubled them in the colonial period were foreign diseases brought to their inhabited hills by the colonizers for instance cholera was unknown but smallpox and many other diseases were familiarize to the Mizos.

The valleys of Lushai Hills were seen to be malarious and unhealthy; because during the rains the climate, even on the lower hills, is moist and enervating, and malarial fever were common everywhere. On the higher ridges it usually was fairly cool and pleasant even in the hottest seasons of the year. In March and April violent storms from the North West sweeps over the hills.[73]

Diseases and illness were a common factor to the Mizos like any other culture and community; the Mizos also have their own way of perceiving sickness and how to deal with it. Mizos have their notion of health, the Mizo word *dam* literally means "to be in good health" and dam *lo* is sick.[74] According to J.H. Lorrain translation, *hrisel* is translated as "healthy, in good health, sound, in sound health, hearty, hale, free from disease or sickness.[75]

[71] The term 'Savages' is used repeatedly in T.H. Lewin in Wild Races of South-Eastern India to describe tribes beyond the Arakan Hills.
[72] Derogatory terms are used frequently to describe the hill tribe people dwelling in the north east frontier of Bengal. Please see Mackenzie, *Northeast Frontier of India*, pp. 576-578
[73] *Imperial Gazeteer of India*, p.214
[74] J. Herbert Lorrain & Fred. W. Savidge, *A Grammar and Dictionary of the Lushai Language (Dulien Dialect)*, Shillong, Assam Secretariat Printing Office, 1898, p.102
[75] Lorrain & Savidge, *A Grammar and Dictionary*, p.185

Again, *'hrisel lo'* means *"to be unhealthy"*. Another term *"Bawrhsawm"* has been used to denote someone who is not in a state of normal. Thus, health simply means the absence of sickness and the ability to perform daily work. However, the actual notion of the Mizo views on health is much larger.[76] To the Mizos health is often expressed as a balance between various energies such as a body, mind, and spirit or soul. During the pre-colonial period the Mizos recognised the interaction of both natural and spiritual. They saw these components as a continuous existence wherein each is merely a transformation of the other. Thus, the world view of the Mizo seems not to exclude the divine but rather to make nature itself divine.[77]

Prior to colonial period illness like fever, stomach-ache, indigestion, convulsions, epilepsy, diseases of the glands, vertiligo, boils, inflammation of the bowels, various diseases of children and general weakness of the body were very common and well known to the Mizos.[78]However, epidemic diseases such as typhoid, measles, diphtheria, smallpox, yellow fever, and cholera were unknown to the primitives before the arrival of the white man.[79] This was in the universal context. The Lushais personal hygiene has been described as extremely dirty as far as one could imagine as reiterated by J.H. Lorrain in his personal account and letters. He even claims that "English pigs were cleaner than the Lushais" and Lorrain further emphasised that "if such a disgusting people could be raised to be clean, industrious and God fearing" than anything was possible with God.[80]

Certain universally known diseases like dysentery, goitre, eye diseases, worms, skin sores, fever, stomach pains, rheumatism, diarrhoea, cholera, and respiratory diseases, were all recognised by the Lushais.[81] A Welsh Missionary Dr. Frazer have also recorded diseases such as pneumonia, heart diseases, phthisis, liver abscess, wound of abdomen, injuries of internal organ.[82] As soon as the British introduced tea plantation in 1855 in Cachar, the large scale expansion of tea cultivation and the granting of wasteland with easy leases by the authority for the tea cultivation, in many cases, led to the encroachment of the land belonging to the wild tribes (Lushais) by the tea planters which seriously affected the economy and the

[76] Jackson, p.117
[77] http://shodhganga.inflibnet.ac.in/bitstream/10603/103755/11/11_chapter%203.pdf (accessed on 18th December 2018)
[78] Vernacular writers such as James Dokhuma in *Hmanlai Mizo Kalphung* and Rev. Zairema in *Pi Pute Biak Hi* mentioned such traditional knowledge of sickness and illness amongst the Mizo Community.
[79] Ackerknecht, *A short History of Medicine*, p.16
[80] J.H. Lorrain, LB, 26th June 1895
[81] A.G. McCall, *Lushai Chrysalis*, Aizawl, TRI, Dept. Of Art & Culture, 2015 (4th edition), p.178
[82] Dr. Frazer, *Lushai Medical Mission*, The Report of the Lushai Hills 1911-12', cited in H. Vanlalhruaia, Colonialism, *Tribe and Disease in the North East Frontier India*: Some aspects on Lushai Hills, p.4

livelihood of the tribal people. This disturbed the bordering between settled British territory and the territories of independent tribes, leading to conflict. The Lushais, on their part, reacted to this with nothing but raided on the tea plantation in Cachar by burning villages and killing people. Such behaviour on the part of the tribes invited British retaliations. The tea planters considered they have a legal right over their gardens, while the chief of the nearest tribe claimed themselves to be free and sovereign people, who exercised authority in the plain of the foothills.[83] Even prior to the colonisers coming to North East Frontier India, the Lushais frequently conducted raids against their adjacent low-lying region of Tripura, Bengal (Bangladesh) and Manipur. However, tribal raids become more frequent with the coming of colonialism. Apparently, it was through such infiltrations that some of the communicable diseases repeatedly spread to the Lushai community. As a custom, infected warriors refused to return to their hills, even committing suicide to prevent the spread of diseases to their fellow villagers in the hills.[84] However, such diseases could not account as a reason to the Lushais and their chief to stop their raids against colonial encroachment to their so called hunting grounds. In fact, Lushais persisted in their plunder and raid activities in the low-lying plain areas as we have mentioned earlier it was partly because of economic reasons. The military expedition to the Lushai Hills reports showed that several new diseases were brought to Lushai Hills from the plain regions.[85] Nonetheless, this does not mean that disease was entirely absent amongst the Lushai. In fact, diseases and illness were very much part of the Lushai cultural life.

Amongst the Mizos, only when a person could not work in his agricultural land he was considered to be really sick and afflicted with serious and disabling diseases which prevented him from work. Good health therefore implies the ability to work. Mild sickness were regarded a normal occurrence and they tried to cure themselves with home remedies as much as possible this instinct to resort to the nearest available cure which could possibly be readily acquired is not very different from the instinct of a modern man. We saw similar practices generalised by the studies of Erwin H. Ackerknecht in 'A short History of Medicine' about

[83] Dhriti Kanta Rajkumar,' Raids made out by the Lushai Tribes in the Tea Gardens of Cachar during the colonial period: A study on the Historical Perspective', *IOSR Journal of Historical and Social Sciences (IOSR-JHSS)*, Vol 9, Issue 4 (Mar. -Apr. 2013), pp. 43-54

[84] The appearance of cholera, or any similar disease, is the signal of evacuation of the village. The sick are abandoned and the people scatter, some families taking up their abode in the jhum huts, others building huts in the jungle. As Lushai customs, when any contagious diseases is suffered they either abandon the sick or the sick isolates themselves. Please see J. Shakespear, *The Lushei Kuki Clans*, p.76. Also see Standing order No. 9 of 1909, Dated Aijal, 25 June 1909 (MSA)

[85]Based on the texts record written by colonial political agents like J. Shakespear and T.H. Lewin who took active part in the military Lushai Expedition.

the primitive communities across the world in regard to their conception of sickness and how they perceive it. As he mentions,

> "The best way to become familiar with primitive medicine is to observe a typical medical treatment as it is actually carried through in a given contemporary primitive society. An Apache feels ill he and his family behaves much as the modern man. At first there is not much speculation as to the character and origin of his "indisposition."[86]

In the traditional practice of the primitive Apache a sick person is asked to lay and rest while the traditional remedies are prepared and applied, if there is not any improvement in the health of the sick person only then the possibility of 'disease' as the causal factor is considered. As a result, the sick Apache assumes that his disease is caused by a super natural agency such as an animal spirit, a ghost or a sorcerer similarly the Lushais also believed that the *Huai* causes their sickness and disease affliction. Consequently, in such cases he summons, not a scientific doctor, but a magician, the medicine man who is known to have particular super natural powers against the particular agency which the patient suspects to be at the bottom of his trouble[87] similar association could be seen in the traditional believe system of the pre colonial Lushais which we will discuss later. The ceremony performed by the medicine man usually lasts for three to four days where prayers and magic formulas are applied, ranging from drumming and of touching the patient with such secret objects as pollen, feathers and turquoise. Minor and simple sickness and treatment are also performed by the medicine man occasionally. Traditional remedial steps are prescribed followed by giving the patient a magic amulet (similar to *Kelmei* being worn by the Lushais to ward off evil spirit) and perhaps he is forbidden to have a shadow fall upon him and to eat a certain food (this food habit prescription is also prominently followed in Lushai tradition as well) that is, a taboo is imposed.[88]

The Mizos also believed in the contagion of diseases as a result of which '*hridai theu*' or putting a village in quarantine was so observed at times of epidemics. This meant that if a village was afflicted with such an epidemic, no outsider was allowed to enter or visit their village for any reason and if a neighbouring village was too afflicted by the same, the chief

[86] Ackerknecht, p.11
[87] Ackerknecht, p.11
[88] Ackerknecht, p.11

would strictly forbade his subjects to visit such a village.[89] Similar practice by the Toungtha sub clan of the Khyoungtha tribe[90] who dwells to the south of Karnaphuli River in the Chittagong Hill Tract is seen, as mentioned by T.H. Lewin,

> "In case of epidemics, the custom of quarantine, or, as it is called, "khang", is universal among them. The quarantine is inaugurated and declared with a certain degree of ceremony. A sacrifice is offered, and the village is encircled with a fresh-spun white thread. The blood of the anima sacrificed is then sprinkled about the village, and a general sweeping and cleansing takes place, the house and gates being decorated with green boughs. They attach great importance to the quarantine being unbroken. It generally lasts three days, and during that time no one is allowed to enter or leave the village. I have known several murders committed, owing to persons persisting in breaking the "khang."[91]

Certain precautionary measures so as to avoid epidemics and other diseases were practiced by the Mizos. Stringent measures were followed from being infected that no one was permitted to play upon any musical instrument or even to hear the humming sound of the *vuk-vuk*, (a child's toy) since it was believed that such sounds would call forth the diseases.[92]

Based on oral tradition, Rev. Zairema, a native theological scholar in recent period has recorded a number of illnesses and diseases in his study of the Lushai religion in pre-colonial period. He identified, *Phungzawl* (epilepsy), *Khawsik pui* (malaria), *Pumna* (stomach pain) *kawng na* (waist pain), *Kaih* (chronic disease), *dawithiam dawi* (witchcraft), *Luhai* (pneumonia, typhoid), *Pum puar* ( related to stomach complication), *kaw chhe vei* (stomach related), *hrilawn/nau hri* (diptheria), *ruhseh* (rheumatism), *dam thei lo* (chronic diseases), *nau pai thei lo* (barren), *nau har* (delivery complicated), *khawhring* (spirit possession) and *hring* (curse of oath) which were common among pre-colonial Lushais.[93]

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[89] Mizo Lalte khua leh Tui Awp Dan Tlangpui, The Mizo Chief's Council, 1982, preface.
[90] The two are classified as "Kyoungtha" or "children of the river" and "Toungtha" or "children of the Hills". The former speak the old Arakanese dialect and profess Buddhism; the latter are a mixed group of people speaking different dialects and having no particular religion. The river – siders are more advanced than the hill – dwellers that live like savages.
(http://shodhganga.inflibnet.ac.in/bitstream/10603/205400/10/10_chapter%206.pdf (accessed on 30th October 2018)
[91] T.H. Lewin, *Wild Races of South-Eastern India*, London, W.H. Allen & Co., 1870. pp. 196-197
[92] C. Lianthanga, *Hmanlai Mizo Nun*, Serkawn, Lunglei, Mizoram Publication Board, 1998, p.118-119
[93] Rev. Zairema, *Pi Pute Biak Hi*, Aizawl, Zorun Community, 2009, p.77-114

The Mizos preserved their health based upon the traditional and the community standard. Traditional customs and practices were upheld violating these customs was believed to bring about illness, sickness and even death. Observance of community health by the chief was practiced and followed by his subjects. As mentioned earlier in case of epidemic the chief would declare '*hridai theu*' or quarantining the village. Another step taken by the chief was concerned with the proper maintenance of village springs which was the main source of water within the village. It may be noted that from time immemorial, the Mizos were quite particular and careful in the maintenance of t*uikhur* or village water source. Strict orders were given by the chief for preserving its cleanliness and punishment meted out to those who disobeyed his orders. In case it was located nearby to the village, no one was permitted to pass stool or urine at the source from which the spring begins; none were allowed to wash *sa pumpui* or the stomach portion of animals that were washed for consumption.[94]

### 2.2. Mizos perception on Disease after the arrival of the Colonial Government

The Colonial annexation of Lushai Hills saw the encroachment of the colonial power into the everyday lives of the Lushai people, their laws and customs, traditional perception of right conduct and freedom of movement and property were regulated into modern form of administration where almost anything was taxed and recorded in paper. As a result, the Mizo perception on sickness and disease changed tremendously, and many Mizo men and women were also recruited and trained in the field of medical profession like nursing.

By the second decade of the twentieth century the Mizo medically trained under the guidance of the missionaries and state aided programmes took health related measures and campaigns through survey and print media as a result pneumonia was found to be the most prevalent. According to Chalhnuna, from 1930-1935, the highest percentage of death cases in Aizawl occurred due to Pneumonia. He further asserted that later, with the introduction of a new medicine called Antiflogistine many people could be cured. In fact, by the time the Second World War (1939-45) drew to a close, the administering of M&B (Sulfapyridine) tablets along with Penicillin injections saved many people from untimely deaths.[95]

Tuberculosis was also quite prevalent throughout the length and breadth of Mizoram. The Mizos believed that the said disease was incurable and so was dreaded by all. It is to be noted

[94] Mizo Lalte khua leh Tui Awp Dan Tlangpui, p.6

[95]Chalhnuna, '*Inthawina duh lovin Damdawi kan duh e'* in Platinum Jubilee Souvenir, 1928-2003, Presbyterian Hospital Durtlang, 2003, p.23, cited in Zothanpuii, *History of Health Care in Mizoram*, PhD Thesis, Mizoram University, (unpublished), p.111

that at this time, death cases due to tuberculosis in Mizoram was quite high. According to Rosiama, then Sub Assistant Surgeon, Tura (Garo Hills), he remarked

> "Throughout the entire Assam District, Tuberculosis is most prevalent in Mizoram and in Halflong. In Mizoram, the common types apart from Pulmonary Tuberculosis were Tuberculosis of the spine, joints, and intestines.[96]

Apart from Tuberculosis, other category of respiratory diseases such as Bronchitis, Broncho-Pneumonia and whooping cough were also quite common. The Assam Vital Statistics that was prepared monthly even reported that most death cases in the Lushia Hills district was due to respiratory diseases and that nearly 300 persons died of this disease almost every year during the decade ending in 1960.[97] Dr. Lalthanliana opined that the high percentage of death cases due to respiratory diseases may be attributed to the fact that smoking of tobacco and tuibur (nicotine water carried about in a little gourd, small quantity of it being retained in the mouth until it loses its original taste and then spitted out) was from time immemorial a very common practice amongst the Mizos as compared to other hill people and which subsequently led to all sorts of respiratory diseases.[98]

Another common disease which was rampant throughout the length and breadth of Mizoram at this time was Malaria. Chronic malaria usually manifested in the form of swelling of the spleen. This was rampant in almost every village that the number of malaria patients was taken from the spleen index, i.e., from the total population of the entire village, it was then counted how many were suffering from swelling of the spleen.[99] Dr Pika, Sub Assistant Surgeon, noted that between January-March 1926 (Aijal Circle 3) the total number of persons who suffered from malaria fever were 258 and that the number of persons to whom he dispensed medicines for treatment of malaria was the highest as compared to those who received medicines for other types of diseases.[100] Within the next few years, malaria fever continued to be rampant as seen in the Report of the Civil Surgeon on the public health of the Lushai Hill District (LHD) which stated;

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[96] Rosiama, 'Ngawr Natna', in *Mizo leh Vai Chanchin Lehkhabu*, February, 1939, The Assistant Superintendent, N.Lushai Hills, p.25
[97] *Mizoram District Gazeteer*, Aizawl, Director of Art and Culture, Government of Mizoram, 1989, p.322
[98] Dr. Lalthanliana, *ka thil Tawn leh Hmuhte*, Aizawl, Gilzom Offset, 2008, pp.45-46
[99] Lalthanliana, *Ka thil Tawn leh Hmuhte*, p.173
[100] Pika, 'Sikserh Natna Laka Inven Dan', in *Mizo leh Vai Chanchin Lehkhabu*, July 1926, The Assistant Superintendent, N. Lushai Hills, pp.148-156

> ‘During the year 1929-1930, the health of the public during the year under report was not good as there had been many cases of malaria throughout the year, the prevalence of the same being much more than the previous year.’[101]

The Lushais as an ethnic group were active and confrontational in their approach of interaction and their perceive manner of survival. Before the arrival of the colonial government they were constantly on the move in their border areas for trade as well as raids which were imperative for survival. This movement as we have seen earlier brought sickness or diseases along with it, but these were taken care of by deserting the sick and suicidal steps by the sick themselves as mentioned earlier. But as long as they remained isolated, the pre-colonial Lushais were relatively healthy and the diseases were not so contagious in comparison to when the British colonial government arrived. The British colonial government brought significant population influx to the Lushai Hills. Mention has been made in this context by Kenneth F. Kiple as:

> “The low numbers and low densities of the populations reduced the incidence of viral and bacterial infections so that people were not troubled by contagious diseases such as smallpox or measles, whose pathogens require large and dense populations for survival”.[102]

**2.3. Reactions and steps taken by the Mizos at times of Epidemics.**

Lt. Colonel J. Shakespear noted that the appearance of cholera, or any similar disease, is the signal for the evacuation of the village. The sick are abandoned and the people scatter, some families taking up their abode in the jhum huts, others building huts in the jungle. The neighbouring villages close their gates to all coming from the infected neighbourhood, and to terrify the *Huai*, who is supposed to be responsible for the epidemic, a gateway is built across the road leading to the stricken villages, on the sides and arch of which rude figures of armed men made of straw with wooden spears and dahs are placed. A dog is sacrificed and the sherh are hung on the gateway.[103] Colonial ethnographer T.H. Lewin has narrated;

> “In 1861, when the some Lushai Chief invaded Bengali village in Chittagong Hill tract, they took back cholera with them. This disease terrorizes so much so that

[101] A short note on the Public Health of the Lushai Hills District during the year 1929-30 by the Civil Surgeon, Lushai Hills, dated, Aizawl the 23rd April 1930. (MSA)
[102] Kenneth F. Kiple, ‘The history of Disease’ in Roy Porter (ed), The Cambridge illustrated history of medicine, The Press Syndicate of the University of Cambridge, 1996, p.6-15, cited in H. Vanlalhruaia, p.12
[103] Shakespear, *The Lushei kuki Clans*, p.76

numbers of the Lushais put an end to their existence by suicide, blowing out their brain with their own guns on the first symptoms declaring themselves".[104]

Cholera was a complete alien disease to the Lushais; it was brought in to the Mizo hills by the British colonial agents and through exchange of goods and raids in the Chittagong Hill Tracts. After 1817, deltaic Bengal was regarded as the nucleus, the endemic centre; which had grown far beyond expectations. In 1817 cholera epidemic ravaged Bengal and by 1831 'the cholera began to spread to an extent not before known and in course of seven years it reached eastward, to China and the Philippines islands; southwards, to the Mauritius and Bourbon; and to the north-west as far as Persia and Turkey.[105] The movement of the disease was steered by the development aspect of the colonial India with new roads being built along with railway tracks, canals and busy ports. Further, the increasing annexation with huge movements of troops and caravans in the case of the Lushai Hills intensified the spread of cholera to the Mizos.

The trait of abandoning the disease afflicted persons behind, whether it's in the village or the jungle implies the apprehensions they have against diseases particularly cholera which was entirely unknown to them.

This drastic measure of abandoning the sick somehow denotes an uncivilised and tribal attitude as per the records of the British colonial account and narrations by the Europeans; this could be applicable to the Mizos as well.[106] However, we saw similar practices of abandoning the sick by the Malabaris in their treatment of smallpox, because they believed that Patragali send this disease, and they leave the patient at the hands of the devotees of Patragali pagod since they believe that Patragali causes the smallpox. They even perform ceremonies and sacrifice to please the idol of Patragali, by cutting the heads of one or two hens, whose blood falling on the earth, was licked up by dogs.[107]

It is certain that the Lushais did not have a remedial cure or sacrificial ritual to ward of the symptoms of cholera. Even in the first decade of the twentieth century after few of the Lushais have practiced or accepted Christianity this trait was still practiced as the Police

[104] Lewin, *Wild Races of South-Eastern India*, p. 142
[105] Deepak kumar (ed.), *Disease and Medicine in India A Historical Overview*, New Delhi, Indian History Congress, 2001, p. 146
[106] A former Dutch reformed missionary to Ceylon Philippus Baldeus wrote about the Tamil people of Malabar on how they perceive smallpox disease and their veneration and believe on being a work of Patragali the Hindu Deity. Being Hindus they practiced rituals of animal sacrifice and abandoning the smallpox victims. Baldeus constantly refers to them as uncivilised and pagans.
[107] Kumar, *Disease and Medicine*, p.89

Officer Douglas Gordon who was posted in the Lushai Hills in 1910 stated in his memoir, "Soon after I joined at Aijal, cholera broke out in the neighbouring villages to the west on the way to Sairang. I was detailed to accompany the Doctor to set up a cholera camp. We found a suitable clearing and detachment of police I took with me soon erected mat huts as a hospital and we set about our task. The Lushais were terrified of this disease and as soon as a case occurred in a house all the other inmates decamped into the jungle, leaving the patient to die in agony. We therefore had not only to search every house for possible victims, bring the still living to the camp and burn the dead. But, also, scour the countryside for those who had fled as many of them had contracted the disease and again were left where they lay when the attack over took them."[108]

Another case was reported among the kumis (cognate tribes of Lushais of Chittagong hill tract) in 1870. The report stated;

> "When small pox first made its appearance among the Kuki, they considered it to be a devil that had come from Arrakan...Kumis found that this was a very strong devil indeed, for exorcism were of no effect. They therefore abandoned their homes leaving the sick to take care of themselves; and men, women, and children fled to the jungles".[109]

It must be mentioned that the Mizos before the arrival of Christianity practiced the religion of animism and it had everything to do with their perception of health, sickness and settlement patterns. Therefore in order to maintain good health or to avert diseases people would normally wear charm like *kelmei* which was a tuft of goat's hair and dog's teeth around the neck as well as the nails of bears as a protective amulet against wild beasts.[110] The Mizos feared being contracted by the disease since it was viewed as the doing or curse of the spirits, as a result any minor injuries or mild illness were concealed to themselves. The Lushais, like most hill-dwellers, are a hardy and healthy race, and suffer mainly from disorders brought on by hard drinking. Cholera (which they call "the foreign sickness") and small-pox were unknown among them until the year 1861, when the former was introduced among them by some Bengali captives taken in a raid. The contagion spread rapidly infecting village after

[108] Sir Douglas Gordon, *Memoirs of Life as a Police Officer in India: 1907 to 1946*, Lulu Publishing Services, 2013, p. 64
[109] Lewin, p.226
[110] Zairema, *Pi Pute Biak Hi*, p.91

village and causing dire consternation.[111] However, due to the inhuman practice of deserting the sick and dying, the disease died out after slaying its thousands, and has not since reappeared.[112]

However, we must note that Mizos were not generally clean with the idea of upholding modern concept of cleanliness which included personal hygiene, cleanliness within the households-cooking utensils, clothing etc. Therefore by today's standard, the Mizos were generally dirty.[113] Domestic animals such as pigs were normally kept under the house who in turn ate up whatever was swept under the floor be it human excreta or any other household wastes. The fact that major infectious disease seems to have originated with animal hosts did not seem to have occupied prime importance among the Mizos. However, they did have certain knowledge of animal diseases that infected humans such as *ui thak* (disease of dogs) etc.[114]

N. E. Parry when he visited the Southern part of the Lushai Hills the so called Lakher land noted that villages are very filthy, being littered with the dung of mithun, pigs, and other domestic animals. No attempt is made to clean them, and it is only thanks to the voluntary scavenging done by the pigs and dogs that they are kept even moderately decent, and that the people are not a constant prey to serious epidemics.[115] Cleanliness awareness and its maintenance in early Mizo society may have been quite difficult and may not have occupied prime importance in their lives. For instance, one reason for this was probably that people were always very busy in tending to their jhum lands, staying away from home the best part of the day as a result of which they were unable to or could not give due importance to cleanliness and sanitation.[116] Another possible reason could be the inaccessibility of the natural spring water at the Lushai wishes. They have to fetch water for cooking and drinking, consequently cleaning themselves could not occupy a huge priority as this would mean greater demand for water.

Precautionary measures and actions that could possibly prevent and abate epidemic diseases were taken. These were for the welfare of the community, for instance their nomadic lifestyle. J. Shakespear has stated that the Lushais have been nomadic ever since their

[111] Lewin, *A Fly on the Wheel*, p.246
[112] Lewin, p.246
[113] F. Rongenga, *Zofate Lo khawsak Chhoh Dan*, Aizawl, F. Rongenga, 2000, p.40
[114] Kate Kelly mentions how man over century's man took time to realise that animals were hosts of many diseases that disseminate across borders in her book The Scientific Revolution and Medicine: 1450-1700.
[115] N. E. Parry, T*he Lakhers*, Tribal Research Institute, 2009, p.62
[116] Rongenga, *Zofate Lo Khawsak*, p.40

ancestors started on their western trek some 200 years ago.[117] Shifting their settlements after every four or five years due to *Jhum* cultivation apart from this it was to an extent a reflection of their attempt in caring for their health and to avert the possibility of illness and diseases that may fall upon them similarly these migrations could also be caused by famines as well.[118] Epidemics caused by unhygienic treatment of the water supply, animal and human refuse (washing the intestine of an animal killed for consumption), or treatment of the dead, one or all, might give rise to a loss of public confidence in the site.[119] Thus they are compelled to move and search for a new settlement. J. Shakespear further noted their custom of burying their dead within the village tends to make a site unhealthy, especially as the water supply is usually so situated as to receive the drainage of the village, and when the rate of mortality rises unduly high, a move is at once made.[120] It was only in 1930 under colonial rule that proper burial grounds or *thlanmual* existed in Mizoram.[121] The practice of burying in a veng thlanmual, a locality graveyard, thereby collectivizing death, was the direct consequence of colonial intervention.[122]

The Lushais were always very particular about their place of residence, and considerable thought was spent on the subject of the village site. The highest the hill top started as favourite and the site subsequently chosen would be that which constituted the most impregnable stronghold, combined with the hope of a good water supply, which would not dry up in the hot weather.[123] These constant moves have had a great share in moulding the Lushai character, for when you have to carry all your worldly goods from your old to your new house every four or five years, it is not strange if you are disinclined to amass more than is absolute necessary, and gradually become content with very little, and prefer ease and idleness to toiling in the hopes of being able to add to your worldly possessions.[124] F. Rongenga has enumerated the basic reasons for the relatively healthiness of the Mizos; that their entire time was spent in trying to wrest adequate means of subsistence from their agricultural lands, be it rain or sunshine, and their subsistence on crops reaped through their own efforts had made them hardy, energetic and healthy; that they were not overly burdened

[117] Shakespear, p.22
[118] James Dokhuma, *Hmanlai Mizo Kalphung*, Aizawl, Gilzom Offset, 1992, p.61
[119] McCall, *Lushai Chrysalis*, p.166
[120] Shakespear, p.22
[121] C.G.G Helm, Superintendent, Parwana (order) No.273, 21st May, 1930 in Zatluanga, *Mizo chanchin*, Aizawl, Published by the author, 1966, p.15
[122] Pachuau, p.233
[123] McCall, p.165
[124] Shakespear, p.23

or were not particularly anxious by worldly worries such as the need for more material gains in terms of housing, clothing etc apart from their basic needs required for their daily existence.[125] One particular reason for selecting the hilltop for settlement by the Lushais is their conception of health and their health awareness constituted them to make such decisions. The Lushai villages were well planned and systematic that the early colonial ethnographers and Christian missionaries were surprised. A Christian missionary in the first half of the 20th century writes, "up to present century all Lushai villages were built on safe mountain ridges and enclosed within strong stockades and their number was small."[126] Edgar also noted, 'the villages of the inhabitants of the tracts are, as a rule situated on the higher hills'.[127] The top hills were usually selected to seek refuge not only for defence purposes from external forces but also because of their conceptualization of diseases. The plain area or river valley were avoided, rather they were in favour of the higher hills for logical reasons. Air was considered clean and malaria was less at the hill tops whereas the plain or rivers valleys were considered unclean with too much humidity and prone to malaria. H.S. Luaia suggests,

> "Despite being a savage, diseases and illness were not so common in those days".[128]

## 2.4. Healing practices

### 2.4.1. Sacrifices

In order to deal with the Mizos perception and knowledge of the outbreak of the epidemics, mention must be made of the sacrificial practices and their perception of what cause such sickness or illness. Such sacrifices are to appease the demons or spirits known as *Huai* to the Mizos who are believed to inhabit the hills, streams, and trees. These spirits are uniformly bad and all the troubles and ills of life are attributed to them.[129] Further, common sickness such as fever, abdominal pain and chest pain were due to loss of soul of the patient which was believed to be captured by evil spirits. For instance, when a hunter upon reaching home becomes ill, it was believed that on his way home, his soul had been captured by evil spirits.

[125] Rongenga, p.46
[126] Llyod, *History of Church in Mizoram*, p.3
[127] Mr. J Ware Edgar was the Deputy Commissioner Cachar District, during his three month tour of the Lushai Hills bordering on Cachar district in 1869. He observed the Lushais so as to conciliate with them and met the chief Suakpuilala and greeted him with immense gifts.
[128] Rev. Dr. H.S. Luaia, *Kan Mizo Nunhlui kalsan tawhte*, Serkawn, Mizoram, Published by the author, 2011, p.13
[129] Shakespear, p.65

As such *thlakoh* or calling back the lost soul had to be done.[130] Certain types of abdominal pain where no cure could be affected were believed to be the result of consuming *dawi* or witchcraft that had been secretly sprinkled on to the food by the *dawithiam* or magician. Mizo knew common cold and common cough etc were air-borne and did their best to avoid it. These were believed to have been caused by *tlang hrileng* or air-borne diseases.

Since, the Mizos believed in malignant spirits responsible for their illness likewise there were expert healers or medicine man; they could ward off such sickness caused by *dawi* or witchcraft. In traditional Mizo society there were two kinds of healers - the *Bawlpu* who was the priestly class and those healers who based their skills through experience. It may be noted that the *puithiam* or priests were of two kinds – *Sadawt* and *Bawlpu* who presided over all religious ceremonies and sacrifices.[131] In every Mizo village were the *Bawlpu*, their number depending on the size of the village. It was the duty of the *Bawlpu* to diagnose illness and prescribe the required sacrifices. Unlike the *Sadawt* wherein each clan had their own specific *Sadawt*, the abilities of the *Bawlpu* could however be utilized by all the clans if and when required. His remuneration was in kind i.e., paddy equivalent to a full *fawngte* (a small shallow plaited bamboo basket) and also what he partook from the sacrificial meat.[132]

The *Sadawt* did not involve in ritual sacrifices for health but he also diagnosed and identified the causation of illness and diseases. He was the Clan priest and was endowed with the customary rules and ritual observance of his own particular clan.

### 2.4.2 Traditional Medication and remedial measures

Apart from the fact that Mizos performed sacrificial offering to cure themselves from illness and epidemic diseases they have their own medicinal practices as well, in terms of food consumption and herbal properties. It is also probable that the Mizo knowledge of many medicinal plants were derived through their observation of other animals in nature, as well as their deep observation and understanding of the environment.[133] The existence of traditional remedies is emphasised by T.H. Lewin who lived amongst the Mizos as he remarked,

> "They have their own pharmacopoeia of simples, herbs and roots."[134]

[130] Lianthanga, *Hman lai Mizo Nun*, p.62
[131] B. Lalthangliana, *Pi Pu Zunleng*, Bethlehem, Aizawl, B.Lalthlengliana, 2007, pp.198-207
[132] Vanchhunga, *Lusei Leh A Vela Hnam Dangte Chanchin*, p.230
[133] McCall, p.179
[134] Lewin, p.287

Opposition of traditional medicine (both empirical and ritual healing) was very strong among the missionaries. For instance, instruction has been given to the natives that they would first give up their *Kelmei awrh* (A tuft of goat's hair considered as prevention from diseases generally caused by negative spirit) to become a Christian. Hence, the missionaries in their attempts to improve the health of Lushais through the introductions of western medicine and Christian healing were over-sensitive to the complex system of traditional medicine. There was a tendency to believe that Lushais medical practices were all part of tribal religion or 'religion in itself'. An American Baptist Missionary wrote "Sacrificing to evil spirits was their only religion and system of medicine".[135] While Lushais medical system was closely related to religion and the borderline is difficult to define, the two are not identical and they may be two sides of the same coin, but not always. In a larger context, the existence of man, divine or spiritual and nature was widely recognised by traditional Mizo. Theoretically, traditional worldview shows that maintaining a balance in the relationship between man or *mihring*, space (village or jungle or *khua*) and the spiritual or *thlarau* realm was required for the maintenance of their community. However, these forces may not always relate each other especially when it comes to the practical or empirical level. For instance, diseases caused by imbalances of physiology or spiritual interference were observed separately.[136] Missionaries on the other hand observed that the process of healing conducted by *bawlpu* involves animal sacrifice which was a sign of savagery. Therefore, *bawlpu* is portrayed as someone who had dubious knowledge to cure illness or diseases. This empirical knowledge of the traditional healer has been generally left out in both the textual records of the missionary and colonial agents.

Meat was usually considered unsuitable in fever cases; hot ginger, soda, and water were used for colds and stomach relief. The Lushais seems to have recognised the existence of tuberculosis, although it may have been mistaking it for chronic bronchitis. The Mizos probably had no antidote to the chronic bronchitis which the associated with some evil spirit or a wizard with evil designs on the victim. Although, they knew that this disease was not contagious, they took some precaution when the patient died by cutting a hole in the roof, and exit was provided to the spirit of the deceased, which it was believed could set upon the members of the afflicted family. In order to appease the spirit the neighbours often nursed the

[135] Lian H. Sakhong, *In Search of Chin Identity: A study in Religion, Politics and Ethnicity Identity in Burma*, Copenhagen, NIAS Press, 2003, p.232
[136] H. Vanlalhruaia, p.7

patient lying in the bed.[137] The fat of the hornbill was used for external application in the case of respiratory diseases which was reasonable, in view of the large oil and fat content. The bile of a wild boar mixed with water served as one medicine, while drinking a cup of cow's urine was another. Massage with the application of the fats of the python, tiger, or bear, was popular for rheumatism, as well as wearing of the bones of a hoolock gibbon over the aching joints. Drinking of the bile of python was used for diarrhoea or cholera cases. Many jungle creepers, lilies, or leaves, dried or powdered, were used as supplementary cures, either internally or externally, especially in the case of black water fever when the vitex pedunculous was, and still is, a very effective cure. There is, in fact, much interesting group for a close examination of local growths as regards their efficacy as sources for modern medicines.[138] N E Parry in his book "The Lakhers" mentioned quite a number of traditional remedies which were followed and practiced by the Lakher or Mara people of southern Lushai Hills.

The Lakher people applies fresh urine whilst it is still warm to the eyes of the person suffering from sore eyes due to conjunctivitis, this was believed to be effective when it is applied three times a day. In case of a snake bite they believed that if a burned hot iron is plunged into bitten area this cauterise the affected part however the patient is made to drink alcoholic drink first so as to numb him from the pain. As a remedy for scabies the branch of a *thlava* tree is cut and the bark and outer wood are removed. One end is placed in a fire, which causes a black juice to exude from the other end. This black juice is collected in a bamboo cup and then the patient is bathed in hot water and the scabs are anointed with the juice obtained, it is believe to be very effective.[139]

According to N E Parry, one of the diseases most dreaded by the Lakhers is syphilis, and it was present in certain villages. Initially the disease was unknown in the Lakhers villages, it was first introduced by a man who migrated from Veuko village in Haka to Iana, and then it spread rapidly to other villages. As the disease was introduced from Veuko, the lakhers call it veukohri, or the Veuko sickness. Syphilitics are taken very seriously by the Lakhers a separate part of the house is kept for the disease victims, and they were made to sleep on the floor; they are given separate plates and spoons and are not allowed to feed with the other members of the family. We can conclude that precautions were taken seriously which

[137] *Mizoram District Gazetteer,* 1989, p.318
[138] McCall, pp.178-179
[139] Parry, *The Lakhers*, p. 169

indicates that the Lakhers have certain elementary ideas of the contagiousness of diseases.[140] The following is a prescription for a remedy for syphilis.

> "Take ten or twenty crabs, place them in a hollow bamboo, fill the bamboo up with hot water, close it and keep it on the shelf above the hearth for three or four days until the crabs are well rotted. Cook the rotten crabs with rice and administer to the patient." It is believed that the juice of the rotten crabs enters the blood and kills the syphilis germ. If the patient is lucky, this medicine is said to be efficacious.[141]

The Mizos have their own traditional medicinal remedies with regard to sickness and minor injuries these practices were in accordance to their tribe oriented lifestyle and could be said to be based solely on empirical evidences. Based on the account of C.Chawngkunga for the sickness of *Ngawr* (Tuberculosis) roasted caterpillar and the liver of hoolock Gibbon must be consumed. And the outer cover of cinnamon should be boiled and the soup must be consumed. And for blood sugar the leaves of the *Zunthlum Kung* (this is a made up name, since the plant does not have nomenclature in Mizo language) however its botanical name being Orthosiphon Stamineus, the Mizos use the dry leaves of this plant, it is boiled and consumed as tea.[142] Modern scientific research have concluded that this same plant have medicinal usage for the treatment of kidney stones, diabetes, inflammatory disorders (fever, cold, rheumatism), also gonorrhoea and syphilis.[143] This strongly indicates that the traditional medicines or remedial practices of the pre colonial Lushais were reliable to a great extent. In addition to these there are many traditional medicinal practice and beliefs on remedial purposes and one of the most important one being the consumption of charcoal. It is suggested to be consumed in empty stomach this way its reaction could be most effective, it is even believed to cure poison consumption. To get rid of the poisonous chemicals one must consume ten times charcoal to the amount of poison consumed.[144]

The missionary thus view native medical system as nothing but a tool of "devil worshipping". This view has profound impact on the reconstruction of Lushai medical history as Kyle Jackson argues, "Lushai System of healing have been chronologically misrepresented. The worst offenders of all were the missionaries who, writing reports for public consumption in

[140] Parry, p. 170
[141] Parry, pp. 169-171
[142] C. Chawngkunga, *Tual Chhuak Damdawi*, Aizawl, Directorate of Health & F.W., 1996, pp.157-287
[143] https://examine.com/supplements/orthosiphon-stamineus/ (accessed on 28th Dec 2018)
[144] Chawngkunga, *Tual Chhuak Damdawi*, pp.157-287

Britain, cleverly distilled Lushai healing practices down to catchy, two-word sound bite: 'demon worship'.[145] The Lushai traditional perspectives of illness and diseases which had been practiced for many years was ignored and viewed with stereotypical disdain. It was viewed as mere savagery and superstition.

The traditional medicinal practice of the Lushais did not die out abruptly instead the process of western medicine taking over the domestic establishment was gradual.

During the colonial period, Mizo medicines were consistently utilised especially in the rural areas since they were easily procured within the immediate vicinity. This was mainly on account of poor access to the health services and medicines provided by the government. K.N. Pannikar has observed in the Indian context;

> "Since most of the medical centres were located in urban areas, colonial medicines were almost unavailable to the rural population, that the facilities afforded by colonial medicines were at no point of time sufficient to supplant the indigenous system."[146]

The establishment of health services in the form of dispensaries and hospitals indeed created tremendous awareness in terms of health and hygiene within the Lushai community. Nonetheless, we must keep in mind that the Lushai Hills district was the far corner district of the British colonial Government and extensive measures as effective as the other plain districts could not be imposed due to the difficult terrain and lack of accessible roads for train and motor vehicles to ply. As a result, the dispensaries established in the rural areas did not cater the farfetched corners of the district; this in turn made the continual practice of the traditional remedial medicines inevitable to some extent. Travelling dispensary was a very effective implementation by the government but was not just sufficient.

Even after the Independence of India, there was proposal to establish a dispensary at Vahai in the Lakher Area of the Lushai Hills district in 1951.[147] It was successfully granted but this proposal was objected by the fanai community near Kolodyne River to rather build a hospital instead in South Vanlaiphai where eight villages namely Darzo, Lungleng, Muallianpui,

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[145] Jackson, p.13

[146] K.N. Pannikar, *Culture, Ideology, Hegemony-Intellectuals and Social Consciousness in Colonial India*, London, Anthem Press, reprint 2002, pp.151-152

[147] Letter from the Superintendent to the Civil Surgeon of Lushai Hills, dated 5th January 1951, (MSA CB 3 Health 29)

Lungpuitlang, Pangkhua, Sangau, Cheural, Lunglian and Vartek surround it and it would cater to all the villages unfortunately this proposal was rejected.[148]

This clearly showed the shortage of medical services in the form of dispensaries and hospitals in the Lushai Hills district.

### 2.5 Contradicting perception on Lushai Hills as disease-ridden region

The theory, that of low lying areas to be prone area for sickness and epidemic occurrences is consolidated by Sasha Tandon who focuses her research on epidemics in the Punjab region stated, 'It should be possible by now to discern a pattern in the outbreak of epidemics and also understand the factors that probably contributed towards this situation. The outbreak of malaria coincided with the periods of heavy rainfall, which caused flooding of vast areas, water-logging of the sub-soil and providing a breeding place for mosquitoes. After the monsoons, various low lying areas got flooded, the subsoil level was high and the conditions were conducive for the growth of mosquitoes. Sixteen epidemics of the plaque reached their height in the months of March and April. About, seventy-seven per cent of the total deaths from the plaque were reported in these months when the humidity level and temperature were most conducive for the proliferation of rat fleas'.[149]

The concept of the Hills having purer air and perceived to be immune from epidemic diseases were more or less followed and practiced by the colonial British government in northern India as well. In the city of Delhi European Enclaves like the cantonments, civil lines and hill stations special efforts were made to protect the area from epidemics as they were meant for the British civil and military personnel. There already was physical distance from the areas inhabited by the natives. During the outbreak of epidemics the cantonment were cordoned off so as to prevent any communication with the infected areas.[150] The imposition of quarantine in the immediate vicinity of cantonments came to be generally regarded as 'a means of protection', which 'certainly can do no harm'. The Europeans acquired immunity from smallpox after vaccinating themselves and procuring quinine, this gave them some protection against malaria. Due to concentration of the sanitary measures in and around the civil station and cantonments, the European enclaves became relatively free of cholera as well. In the early years of the plaque, however, the Europeans did not have any protection against this

[148] Letter from Chief Lalkhama South Vanlaiphai to the Superintendent of Lushai Hills, dated 19th February 1951, (MSA CB 3 Health 29)
[149] Tandon, p.219
[150] *Proceedings, Home: Medical and Sanitary*, May 1875, Serial Number 7, p.381. cited in Tandon, p.227

disease. The administration, therefore, sought to protect them by cordoning off their residential areas. The Hill station was another safe area for the Europeans. Its layout and administration ensured that epidemics were kept away. The preventive measure taken in Shimla reveal the extent to which the colonial authorities worked to keep it safe from epidemics. Because Shimla was the summer capital of the British Indian Empire from 1864 and the summer headquarters of the Punjab Administration, special measures were adopted there to keep it free from epidemics.

On the contrary to this theory, the colonizers in Assam blamed the Mizo hills as feverish and unhealthy. During the second half of 19th century, Chief Secretary of Bengal Mr. Edgar has rejected the British occupation of Lushais inhabited hills on ground of "un-healthiness of the climate".[151] Lushais inhabited hills fall under the tropical region which were generally considered disease infested areas. Such speculation was basically drawn from their early experiences in the hills. However, there was no proper study on whether the Lushais inhabited hills were truly disease infested areas. In many cases, it was purely a matter of adaptation from one region to another geographical area. Apparently, a European coming from an entirely different eco-system was not immune to the hill environment. When the Lushai Expedition was launched in 1871 it has recorded that, out of 840 coolies (mostly Nepalese), 251 died of cholera.[152] Depot Hospitals were set up in different regions of the Lushai Hills during the early years of annexation by the colonial government in order to monitor and maintain the health of the troops. Robert Harvey Medical Incharge of Depot Hospital Tipaimukh wrote in the Indian Medical Gazette on how the Lushai Hill was perceived by the colonial power, he emphasised that the reputation of Lushai land for unhealthiness is as bad as, if not worse than that of Bhutan, and it is popularly supposed that no European could live through the rainy season, even on its highest peak. This is no doubt an exaggeration, but there can be little question that the region must be a very unhealthy region during the rainy season. The rainfall being great, swamps were numerous, the days were usually warm but the nights were raw and chill, when the dew fall it is enormous and thick mists covers which wet everything that is exposed to it in a few minutes. And leave the

[151] Zorema, p.23
[152] Field Marshall Robert, Forty-one years in India: from subaltern to commander-in-chief, (first published, London, 1897), New Delhi, reprint 2005, Cited in H. Vanlalhruaia, p.10

trees dripping with moisture, after sunrise. The Lushai country is well known for such weather that promises immediate fever according to the colonial perception.[153]

After a thorough investigation was conducted, it was found that the main causes of such enormous sickness and mortality in the Lushai campaigns were sanitation and hygiene, insufficient clothing, lack of shelter, excessive work, and improper diet, lack of medical supply, overcrowding in river transportation, and lack of transport.[154]

Numerous sickness were encountered in Fort Tregear (a post at *Darzo Tlang*/mountain midway between Lunglei and Hakka) in 1890, and an interesting account of how influenza travelled possibly by a letter could be seen in the account of Moir on Malaria Fever and Influenza in his letter we saw that, there was an outbreak of influenza amongst the 1st Battalion, 2nd P.W.O Goorkha at Dehradun. The first cases appeared there between 25th March 1890 and 1st April 1890. The symptoms that were seen are fever, vertigo, frontal headache, great prostration, and bronchitis, pain in the limbs and back, and congested sore throat which coincidently were the exact symptoms that were seen at Fort Tregear.[155] Now the 2nd Battalion that has its station in Dehradun was away from Dehradun on active service with the Lushai left column in the Chin-Lushai Expedition of 1889-90. While on its return it was split into three portions, (1) the detachment that went with the Northern Column via Cachar and reached Dehradun about the 10th April, 1890 (2) the main body of the regiment that left Chittagong on 5th April and reached Dehradun on the 20th April (3) The detachment left behind at Fort Tregear.[156] It was received that two-third of the total number in the 1st Battalion had been affected more or less by the time the first portion of the split 2nd Battalion reached Dehradun on 10th April 1890. They were followed by the main body of the 2nd Battalion who reached Dehradun on the 20th of April 1890. Hence, they both probably got influenza from the 1st Battalion. This would give the remaining 2nd Battalion (third split portion) at Fort Tregear a terrible chance of infection by letter-post form Dehradun, either from the 1st Battalion or from one or the other portion of the 2nd Battalion, but more probably from the later arrivals, because they were more likely to write to their comrades at Fort

[153] Robert Harvey M.B., Notes with the Lushai Field Force-Left column, *Indian Medical Gazettee*, April 1st 1872, pp. 94-95
[154] Surgeon-Colonel R. Harvey, 'Reviews and Notices of Books', on the improvement of military medical arrangements in India since 1871, as illustrated by the Lushai campaign of 1871 and the two Miranzai expeditions, *Indian Medical Gazette*, Feb. 1893, pp.60-61
[155] Surgeon D.M. Moir, M.A., M.B., I.M.S, Malaria Fever and Influenza at Fort Tregear, Lushai Hills Tracts, *Indian Medical Gazette*, December 1890, p. 358
[156] Moir, Malaria Fever and Influenza, p.358

Tregear as they had recently parted and with whom they have been intimately associated during the expedition, in this case they would probably be attacked by the epidemic by the last week of April.[157] Now a letter from Dehradun takes exactly three weeks to reach Fort Tregear which would bring to us to about the 21st May 1890, the date of the outbreak at Fort Tregear.[158] Moir further stated that if his explanation is correct then it would mean a remarkable case of an epidemic transmitted by letter over 1,500 miles.

From this letter we can arguably ascertain that Lushai Hills was not an epidemic infested region as opposed to the rest of the country particularly the low lying regions of Cachar and Chittagong Hill Tracts. Moir rather suspected it came and travelled from Siberia in October of 1889, and spread over to whole of Russia during November. Then to Poland, Austria, Germany, and Denmark in the first 10 days of December and by January 1890 it travelled to Canada and the United States. Then to Egypt and Persia, and then within February it appeared in India.[159]

Another colonial military officer Marshal Robert recorded his experience in Lushai expedition 1871-1873 as follows:

> "Cholera pursued us up to and beyond Cachar; the wretched coolies suffered most, and it is a disease to which Gurkhas are peculiarly susceptible, while a feast on a village pig from time to time probably helped to make matters worse for them".[160]

The contention of whether the Lushais dwellings were disease infested or it was brought about to the Lushai Hills by the white man and its colonising troops is a paradoxical one. The biased or stereotypical perception the Colonisers had on Lushai Hills could also play a huge role in influencing the ethnographer's perspectives. J.H. Lorrain had mentioned about meeting a man name Moir before he came to the Lushai Hills and enquired about the Lushai Hills, whether it is the same Moir mentioned above is uncertain, Moir's verdict on the Lushai were he remarked,

[157] Moir, p. 358
[158] Moir, p. 358
[159] Moir, p.358
[160] Field Marshall Robert, p.319, cited in H. Vanlalhruaia, p.10

> "The country is rotten, the people are rotten and the language is rotten, the people are not men but animals and are quite happy without the Gospel."[161]

Through colonial sources and texts we have learned that many known diseases during the initial years of colonizing the Lushai Hills, were completely unfamiliar to the Lushais. Campbell has recorded his experience among the Lushais in 1874,

> "The women especially were very clean and good-looking, their hair tastefully arranged in coronets over their heads; they seemed very happy and cheerful"[162].

Another colonial officer who led the expedition in 1871-72 R.G. Woodthrope remarked, 'they (Lushais) seem to have few diseases, and only one man did we see marked with small-pox."[163] A civil Medical Officer, Chittagong hill tract, Brojo Nath Shaha also reported on how the Lushai people referred to Ringworm (*Vai hren hri*) as a disease of the plain people.[164] *Vai hren hri* literally means plain people's dhoti sickness; it was believed to arise from wearing of a *dhoti*.

Through the indigenous writers we have come across many diseases generally leading to death during this period such as influenza, cholera, typhoid, pneumonia, tetanus, and tuberculosis, diseases of the respiratory system and gastric and intestinal disorders (dysentery) and infant mortality. The harmful effect of Influenza has been vividly described by Liangkhaia;

> "In 1918, influenza epidemic took place throughout the length and breadth of Mizoram which grew worse in the following year, the said epidemic first affecting those from the military which then spread to the rest of the population. Never had such an epidemic which occurred in Mizoram taken its toll on the lives of the people such as this, and that in villages of about hundred families, 100-120 people died from the disease, the highest death case occurring in chief Letzakaia's village, Hrangtuiek where 380 people succumbed to the epidemic."[165]

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[161] Lorrain LB, dated 26.1.1892
[162] A.Campbell, On the Looshais, *The Journal of the Anthropological Institute of Great Britain and Ireland*, Vol. 3, 1874, pp.57-65
[163] R.G. Woodthorpe, *The Lushai Expedition*, 1871-1872, London, Hurst and Blackett Publisher, 1873, p.91
[164] Surgeon Brojo Nath Shaha, *A Grammar of the Lushai Language*, Calcutta, Bengal Secretariat Press, 1884, p.58
[165] Rev. Liangkhaia, *Mizo Chanchin*, Aizawl, Mizoram State Library DG4300 L.T.L. Publications,(5th Edition) 2002, p.169

Evidently, many of the diseases had been brought to the hills by colonialists through their successive military expedition in the second half of the 19th century. A colonial Military officer R.G. Woodthorpe wrote in this context:

> "Hill-men dread the invasion of foreigners, more on this account perhaps than any other I mean the introduction of strange diseases. Small-pox and other diseases have from time to time been spread among them by traders, though the Northern Lushais with whom we had to do, had, hitherto, enjoyed apparent immunity from the consequences of intercourse with strangers, as, out of the many who visited our camps, we only saw one man at all marked with small-pox."[166]

This statement clearly shows that smallpox was indeed known to the Lushais and had been familiarised with its symptoms before the arrival of the British as colonisers. To further supplement our claim smallpox was known by the Lushais as *Zawng hri*. In the pre-colonial period, the disease may not have been very common due to the great fear attached to the said disease by the people in the colonial period. As early as in 1908, when a Mizo vaccinator named Thanga reported on the death of one Gurkhali (Nepali) in Aizawl due to the said disease, it gave rise to a widespread fear of the disease whereby Government vaccinated 600 soldiers in a day.[167]

There are several cases of contagious diseases which spread amongst the Mizos. Once a case was reported in the colonial document of 1871-1872 as follows:

> "The 42nd also suffered very severely. But among the sad consequences of the return march, was the introduction of this fell disease into tea-gardens and villages near the river or road, by the troops and coolies passing through. The seeds of the disease were left as a legacy among the Lushais, and, if we may believe reports, cholera has been busy among them since we left".[168]

No one knows the certain magnitude of this disaster. As a result of this, the Lushais in the foregoing years did not welcome the English man. In 1881-1882, a colonial official Mr. Place (sub-divisional officer of Hailakandi) was sent to visit the Lushai chiefs in the hills to

[166] Woodthorpe, *The Lushai Expedition 1871-1872*, p.327
[167] A Short note on the Public Health of the Lushai Hills District during the year 1929-30 by the Civil Surgeon, Lushai Hills, dated, Aizawl the 23rd April 1930. (MSA CB 3 Health 29)
[168] Woodthorpe, p.326

ascertain the famine relief measures taken by the Colonial government. Much to the astonishment of Mr. Place he was greeted with friendliness, despite the well known fact that Lushais believe on the ground that "Englishman visit is (was) believed to be generally followed by cholera".[169]

Based on oral tradition, a native scholar Liangkhaia claimed that plaque was unknown in pre-colonial period.[170] J.H. Lorrain in the first half of the 20th century has recorded two cases of small pox disease in South Lushai Hills. He wrote 'probably these are the first cases recorded in South Lushai Hills'.[171]

It would seem that the Mizos did not have any specific names for diseases, diseases so being named in accordance to the signs and symptoms with which it occurred such as headache, stomach ache, and abdominal pain etc. Therefore, the category '*pumpui na'* or abdominal pain may have included the various problems of the stomach such as gastritis, stomach ulcers, dysentery, intestinal problems, appendicitis etc.[172]

We can assert that the accounts of the British colonisers were contradictory and conflicting in its content about the Lushai Hills as a disease ridden place. However, certain factual accounts could be accounted as a reliable source. The conflicting reports about the Lushai Hills has also been expressed by Lorrain as he remarked,

> "We get glowing accounts one day from a man who has been there, and an opposite account the next day from another who has also 'been there'. Better go provided for famine and find plenty than go expecting plenty and find famine as we did at Kassalong."[173]

In this chapter, we saw that the Mizos much like the other primitive tribes across the world regarded health according to the community and cultural standard. They have their own priests who would perform certain rituals and ceremonies to cast or ward of the evil spirit whom they believed to be the reason for the cause of their illness. Such was the perception of the Mizos before the arrival of the British colonial government in the Lushai Hills. Common illness and their symptoms like epilepsy, pneumonia, typhoid etc. were familiar to the

[169] Makenzie, p.327
[170] Liangkhaia, *Mizo Chanchin*, p.112
[171] South Lushai Mission (B.M.S) Report for 1906, in The Annual Report of BMS on Mizoram 1901-1938, Gospel Centenary Committee, Baptist church of Mizoram, p.56
[172]Dr. Lalthanliana, *Mizo Chanchin (kum 1900 Hma Lam)*, Aizawl, Vanlalhmuaka and Vanlalhruaii, Vanbuangi Gas Agency, 2000, p.263
[173] Lorrain, LB, dated Silchar 30.3.1893

Lushais. And they were very well aware on the contagion of many diseases for which as we saw '*hridai theu*' was imposed. Many traditional remedial practices that were quite effective were practiced, but this native medical system was never promoted and embraced by the British colonial government and the missionaries as well. Certain food habits were followed by the Mizos as well, but the remedy for cholera was unknown as they termed it as a foreign sickness because they were not familiar with the disease. On the other hand as we saw earlier the Lushais were particularly careful in their source of water supply and if they happen to doubt its cleanliness they would resettle themselves somewhere else, could this be an indication of their familiarity with water borne diseases like Cholera. As the British administration began to be setup in the Lushai Hills, the Lushai who were educated by the missionaries started to analyse their community health and the most common disease apart from tuberculosis of joints and spines were the respiratory diseases. This was found to be prevalent because of vast smoking of tobacco by the Mizos both by men and female. Malarial fever was another rampant disease; however we saw that number of deaths were comparatively low due to the scarce population of the Lushai hills as opposed to the other district of Assam and the Bengal province. The health services catered by the British colonial government was successful due to the implementation of dispensaries including travelling dispensaries, however this was inadequate in the longs run as the Lushai population gradually grew simultaneously with their health consciousness.

# Chapter III:

## Colonial Response to Epidemics in the Lushai Hills

### 3.1. Lushai Hills after 1891

Colonial annexation meant that the hill people were now ruled from the plains – an entirely new experience for them. The first few decades after 1891 brought serious self-reflexion and reorientation. They had to adapt to new overlords, new political institutions and new procedures. But most of all, they had to come to a new understanding of their place in the world. This required vigorous cultural adaptation.[174]As soon as British rule was assured, missionaries began to arrive. The various hill groups responded quickly to the attempts made to spread Christianity and the missionaries soon became well-respected members of society. Offering health and educational services in addition to evangelization, they established multiple links with many local people.[175] The relations between the missionaries and the Lushais effectively dictate people's counteraction to government measures and policies. Government's contribution to changing Lushai has been quite properly the provision of law, order, and a modicum of utility services, all backed by a policy of upholding the social customs of the people, and the impact of the missions, backed by as many as twenty Europeans, has been dynamic and sustained.[176] Government personnel changes constantly, while missionaries, often actuated by religious fervour, remain years on end at their posts. The changes they have wrought have been often spectacular, necessarily involving attack after attack on tradition.[177]

### 3.1.2 Colonial Government and Christian Missionaries resolve towards epidemic

When such a non-official body like the Christian missionaries is entrusted by Government with the spiritual, educational as well as teaching of a people it is quite impossible to deny that the most effective daily influence on all the people of the hills must be that exercised by the employees of the Mission educational and Church departments.[178] In such circumstances, the only hope for any administration towards exercising some influence to ensure that "the

[174] Pachuau and Schendel, p.36
[175] Pachuau and Schendel, p.12
[176] McCall, p.199
[177] McCall., p.199
[178] McCall, p.200

suitable idea gets in first" lies in its ability to secure the co-operation of the missions in applying any influence the administration would wish to apply.[179]

Consequently, during times of epidemics the government makes an effort to counter the illness and sometimes makes vaccination compulsory, which evidently does not succeed all the time. Actions and measures on to tackle the dissemination of diseases was one of the utmost priorities of government administration. Similar measures were taken in the mainland India too, where the movement of rail passengers were monitored and they were subjected to medical examination at various inspection posts. The clothes, bedding and other belongings of the passengers were also checked, and 'filthy' articles, belonging mostly to third class passengers, were burnt. Those third class passengers who seemed likely to be carrying the plaque were detained. Here, the authorities went by their 'dirty' appearances and their social background. It was believed that lower classes were more likely to spread the disease as they travelled in gangs whose whereabouts could not be traced on arrival at their destination; nor could they be depended upon to give correct information. The detained men and women passengers were taken to a separate disinfecting tank and quarters where they were disrobed, and their own clothes were disinfected with the steam apparatus after which the passengers were allowed to proceed with their journey. By contrast, the Europeans and Eurasians, even if they were sick, were allowed to continue with their journey in the rail carriage in which they were travelling. Their relatives and friends could also accompany them. Rather, special efforts were made to protect the European enclaves-cantonments, civil lines and the hill stations- from epidemics.[180]

Thus, epidemic control measures would in turn save the government a huge economic expense, since prevention of diseases against the Indians in our case the Lushais who were probable tax payers and service providers that keeps the exchequer in check.

Lushai Hills saw the simultaneous arrival of modern medical knowledge with the British Colonial subjugation. This was carried out with the particular trait of exclusive introduction of western medicine and health services to their colonial agents and their Indian counterpart. The masses or the subjects governed were the least priority. However, under certain circumstantial events for instance in the case of epidemic events the British colonial government only then provided medical and health services for the subjects governed. This

[179] McCall, p.200
[180] Tandon, p.226 & 227

step was also taken at their best interest in order to generate consistent revenue and ensure a proper functioning of administration. As Lord Bentick Governor of Madras remarks in 1805, "In a country where the state derived so large a share of its income from the cultivation of the land, "every life saved," he reasoned, "is additional state revenue and an increase to the population and to the prosperity of the company's territories in an incalculable ratio." This was commented over the case of approving official expenditure on vaccination. When the colonizer and the missionary arrived in the Lushai Hills they assumed that Mizo medicine was being all related to magico-religious practices.

One of the noting administrative developments in the Lushai Hills is the amalgamation of the North and South Lushai Hills into one district under the Chief Commissioner of Assam. It was at length accomplished on the 1st April 1898. The staffs of the new district consists of one Superintendent and two Assistants; previous to the amalgamation, the staff of the two districts consisted of one Political Officer for the Northern hills and one Superintendent and two Assistants, with a third in the cold weather, for the Southern hills.[181]

### 3.2. Public Health

During the first half of the 20th century, known diseases and newly familiarise diseases and their names were recorded in the Lushai Hills. The first census in 1901 reveals that, out of the total population of 82,434. 29 persons were recorded as insane, 16 were deaf mutes, and 19 persons were blind and 1 person with lepers.[182] The London Baptist Mission Society in South Lushai Hills recorded the existence of chicken pox, German measles and bowel in 1906.[183] The second census in 1921 has claimed that insanity is widespread among the Lushais. The census noted "the affliction is worst in the Lushai Hills". Apparently, the colonial government was particularly concerned about the number of madness due to classification into 'productive' and 'non-productive' for exploitation purposes. Usually, a mad person was not liable to be a forced coolie. Beyond this concern, no investigation has been made as to why madness was common among the Lushais.[184]

The year 1894-95 was not marked by any epidemic. However, sporadic cases of cholera or small-pox were normal occurrence. A single case of the latter disease was seen in Aijal

[181] ASA, *Admin. Report of the Lushai Hills 1898-99*, p.1
[182] B.C. Allen; *Assam District Gazetteers*, Volume X, (The Khasi and Jaintia Hills, the Garo Hills and the Lushai Hills), Allahabad, The Pioneer Press, 1906, p.23
[183] South Lushai Mission (B.M.S) Report for 1906, p.56
[184] H. Vanlalhruaia, p.5

station in December the sufferer was a khasi (native of Meghalaya) coolie, he was promptly isolated, and as a result there were no further cases. During the same year of 1894-95 a severe epidemic of malaria fever was reported to have carried off nearly 100 souls in the village, 323 houses were afflicted at Chim Lalbura village during the month of May. The Colonial government dispatched one compounder to treat the cases and report on the nature of the outbreak, unfortunately he arrived too late to be of much service. The number of death reported by the Lushais was doubted by the government and believed to be much exaggerated. The general health of the North Lushai Hill district during that year was good. [185]

### 3.2.1. Sporadic Epidemic instances

There was no epidemic of cholera or small-pox at Lungleh (Lunglei a prominent town in the southern Mizoram today) and Lungsin (Lungsen, a large village located in Lunglei district), not even a sporadic case occurred in these two stations throughout the year of 1897-98 this was a good and positive sign considering the health care facilities provided by the Colonial government during this time, which we will discuss in this chapter. But at Demagiri (today known as Tlabung, a census town in Lunglei district of Mizoram) there was a mild epidemic of cholera that occurred amongst a new batch of coolies, the total number of cases were 13 with 7 deaths during this year. There was not a single case of small-pox throughout the district which was a huge relieve. Compared with the previous year i.e. 1896-97 the absence of cholera at Lunglei and Lungsen was satisfactory, as there were 4 cases at Lunglei the previous year with 2 deaths, one case was reported at Lungsen who died. But at Demagiri we saw two cases of cholera during the year 1896-97, both of the victims recovered, whereas in 1897-98 thirteen cases with seven deaths occurred in Demagiri these were mostly caused by cholera.[186]

One fundamental observation we can put forward and argue regarding the epidemic victims is that, majority of the sick were normally coming from the coolies. This has been emphasised in the preceding chapters where during the Lushai Expeditions also we saw that the coolies were the worst affected. Since they normally carry huge number of heavy loads from one destination to another, and they were not at the position to intake good healthy food as well as immediate health care services.

[185] ASA, *Admin. Report of the North Lushai Hills 1894-95*, p. 6
[186] ASA, *Admin. Report*, p. 6

In spite of importance and care given to maintain the stations cleaner, the outbreak of malarial fever increased considerably in 1897-98, there were 379 cases in the Lunglei Hospital alone against 239 the previous year. This is probably due to the scanty supply of water at Lunglei and Lungsen during the summer months when the poor had to drink muddy and impure water owing to the springs drying up. When springs dry up, water scarcity a problem in Lushai Hills, the missionary Lorrain had even remarked 'that it would take all of a man's time to collect the little water we use.'[187]

The food-supply of the district was plenty and quite wholesome. Due to the increased number of sickness despite huge effort made by the government, focus was given to make considerable improvement regarding the cleanliness of the stations. [188]

In 1897-98 there was a considerable increase of Malaria fever with enlargement of spleen amongst the sepoys resulting in 5 deaths. Of these 3 deaths occurred from malaria fever, one from pneumonia and one from peritonitis. Dysentery was not a stranger to Lushai Hills, the disease was mostly seen amongst the sepoys, but it was never too serious to cause huge mortality rate.[189]

The Colonial government health care initiative were slowly penetrating the social and cultural prejudice of the Lushais, by the year 1897-98 in the North Lushai Hills, the Lushais were slowly beginning to appreciate the advantages of taking medicines, and outposts dispensaries in places like Sairang, Kolasib, Champhai, Kairuma, Sellukot, Serchhip, and Thenzawl were visited by the Lushais . [190]

As mentioned in the earlier chapter the North and South Lushai hills were amalgamated together in 1898 as a result thereafter it together came to be known as Lushai Hills. 1913-14 was the year of epidemics in the Lushai Hills. Outbreaks of dysentery were seen in the area of Aizawl sub division during the months of March and April and were in most instances traced to an infected water-supply. Prompt measures were taken to counter the outbreak and it was carried out successfully.[191] Despite the measures initiated by the colonial government to counter the epidemic occurrences across Lushai Hills we saw that conditions were not normal in the villages around Aijal and Lungleh where the crops of the previous year were destroyed

[187] Lorrain, LB, 26th March 1895
[188] ASA, *Admin. Report of the South Lushai Hills 1897-98*, p. 6
[189] ASA, *Admin. Report* , p.7
[190] ASA, *Admin. Report* , p.8
[191] ASA, *Admin. Report of Lushai Hills 1913-14*, p.5

by rats until August when the maize, millets, and other crops were harvested. Other prevailing diseases in the same year were malaria fevers, diseases of the respiratory system and diseases of the digestive system. There was also an outbreak of foot-and-mouth disease in September and October of the same year. The disease came up from the direction of the Silchar road, but was prevented from spreading beyond Aijal by stopping traffic on the Champhai, Vanlaiphai and Lungleh roads. This incident further reinstate the argument mentioned in the earlier chapters that Lushai Hills was not a disease ridden place as has been accounted by few early Colonial writers on Lushai Hills. During this very fateful year we saw an incident of epidemic occurrence on animals as well, 70 cattle were reported to have died across the Lushai Hills and veterinary assistant was sent by the Superintendent, Civil Veterinary Department, under the veterinary many cattle were treated.[192]

In the year 1926 the general health of the Lushai Hills district was not very good due to an outbreak of influenza in certain villages, north of the Aijal and Lungleh subdivisions. A campaign in connection with the treatment of Syphilis by intravenous injections of Neo-Kharsivan was initiated in the month of July 1926. In order for this government measure to be a successful one, each village Chief was ordered by the Superintendent to send in persons suffering from the disease to the nearest hospital for treatment.[193] We are reminded of the importance of the Lushai Chiefs where their role has been emphasised earlier, without them the British Government and Mission movement could not have successfully amalgamated the Mizo cultural practice with the Christian belief.

The public health awareness and consistent vaccination programmes by the government in the Lushai Hills did have significant impact in capturing the health consciousness of the Mizos which of course was not achieved overnight. The death rates of the Mizos reduced in 1926 to a considerable amount although the reduction number was not very significant. We could imply that the overall health was not improving at a very fast pace. The following table shows the recorded birth and death-rates in the hill districts during 1925 to 1926:

[192] ASA, *Admin. Report* , p.6
[193] ASA, *Annual Public Health Report of The province of Assam for the Year 1926*, p.6

| Districts | 1925 | | 1926 | |
|---|---|---|---|---|
| | Birth-rate | Death-rate | Birth-rate | Death-rate |
| Khasi and Jaintia Hills | 28.15 | 12.75 | 23.65 | 14.06 |
| Naga Hills | 24.51 | 21.47 | 16.10 | 19.65 |
| Lushai Hills | 49.37 | 28.73 | 48.12 | 26.55 |
| Garo Hills | 28.69 | 21.98 | 29.17 | 22.98 |

Source: Annual Public Health Report of the Province of Assam for the Year 1926 (ASA).

### 3.3. Pioneering Healthcare services

One of the most important aspects of health care extended by the colonial authority was the hospital work in the early decade of the twentieth century. It is to be noted that under the British rule, hospitals in each Province were placed under the Inspector General of Civil Hospital. Province was further divided into Districts and each District was placed under Civil Surgeons and under him were the Assistant Surgeons who were Indians finishing their courses from Medical Colleges.[194]

#### 3.3.1. Indispensable Civil Dispensaries

There was no regular civil dispensary as yet at Fort Aijal in the 1894-95, all the sick patients from different communities be it Lushais and natives of India, including Political and Public Works Department coolies, were all treated by the Civil Surgeon.[195] There were 397 Lushai outdoor patients during 1st May 1894 to 31st March 1895 out of the total 1792 patients. Occasional outside cases were also treated at the dispensaries who were mostly coolies as a result 383 admissions were recorded for coolies coming from outside of Lushai Hills, and a total of 14 deaths was recorded, chiefly from dysentery and ague. The epidemic measures on behalf of the government have not been initiated at a huge scale during this period as a result we can arguably state that these lives lost could have been saved and prevented because as we have seen in the year 1913-14 there was an outbreak of dysentery but there were no deaths, which reasonably was because of better and prompt response measures by the colonial government.

[194] Lalthanliana, *Mizo Chanchin*, p.163
[195] ASA, *Admin. Report of the North Lushai Hills for the Year 1894-95*, p.6

Even by the year 1897-98 there was no regular civil dispensary in the district of South Lushai Hills, nonetheless Lushais and other people were attended sincerely when they came for treatment, and a record of their attendance were regularly kept. A considerable increase in the attendance of the Lushais is seen this year than the previous year, which shows that the Lushais are gradually casting off their prejudices and appreciating the benefit of English system of treatment. [196] The hospital buildings throughout the South Lushai Hill district were in excellent condition, damages caused by the cyclone during that year were also thoroughly repaired. The proposal for construction of female ward in the Lungleh Hospital was underway, since there was a great demand for female ward. Arrangements were already made at Demagiri during the same year for admission of female in-patients, and 16 female patients were admitted and treated at Demagiri. Medical instruments were on high demand to meet the specialists and expertise work these instruments were also provided by the Colonial government.[197]

The North Lushai Hills in the same year i.e. 1897-98 had only one civil dispensary the one at Aijal, but at each military outpost a good deal of work among the Lushais has been done by the Hospital Assistant in Charge. This was possible because of the work done by the civil Surgeon-Captain E.C. Macleod.[198] Gradual improvement was recorded in the Aijal dispensary during this year, the numbers of out-patients of Lushais in 1895-96 were 324, and in 1896-97 the numbers of out-patients Lushais were 317 during this year the number declined but then the number of Lushais out-patients increased tremendously to 803 numbers of people the next year in 1897-98.[199] The increase in the number of Lushais were very satisfactory, and was chiefly due to the great interests taken in their treatment by the Civil Surgeon Captain E.C. Macleod, who learned the Mizo language rapidly, this had a great impact on the Lushais as they felt Macleod was a approachable man, he also performed many successful operations which have inspired the Lushais with great confidence in him.[200]

[196] ASA, *Admin. Report of the South Lushai Hills for the year 1897-98*, p. 6
[197] ASA, *Admin. Report*, p.6
[198] ASA, *Admin. Report of the North Lushai Hills 1897-98*, p.8
[199] ASA, *Admin. Report*, p.9
[200] ASA, *Admin. Report*, p.9

Below are given the numbers of out-patients treated at the various dispensaries and hospitals during the year under review, and also some previous years:

| Station. | Year. | Lushais. | Others. | Total. | Daily Average |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |
| Aijal Dispensary | 1895-96 | 324 | 1,246 | 1,570 | 7.93 |
| | 1896-97 | 317 | 1,947 | 2,264 | 16.01 |
| | 1897-98 | 803 | 2,026 | 2,829 | 25.80 |
| | 1898-99 | 1757 | 1,733 | 3,490 | 28.53 |
| Lungleh Station Hospital | 1895-96 | 60 | 1,935 | 1,995 | ..... |
| | 1896-97 | 60 | 1,510 | 1,570 | ..... |
| | 1897-98 | 401 | 1,260 | 1,661 | ..... |
| | 1898-99 | 499 | 611 | 1,110 | ..... |

Source: Adminstration Report of the Lushai Hills for the Year 1898-99. (ASA)

In our table chart we could say the out-patient number amongst the Lushais increased in the end of the nineteenth century however, the number of out-patients who were from outside of the Lushai Hills is staggeringly higher than the number of Lushais. So if we were to see only the total numbers of out-patients without classifying the natives and others, the numbers could be quite misleading, as the total numbers increased year after year. Nevertheless, after the firm establishment of political control was maintained, the coolies imported from outside also declined gradually, and lots of Mizo coolies as impressed coolies began to be employed.

A subsidised dispensary was opened at S.Vanlaiphai in the Lunglei sub-division on 1 April, 1940 and Dr. Chawnghranga L.M.P (Licentiate Medical Practitioner) started his duty as a government subsidised doctor on the said date.[201] By the twentieth century the colonial government made efforts to train and employ the Lushais as much as possible in many of the profession. A similar change was seen in the Mission field as many converts were taught and trained to be translators and preachers as well. By 1913-14 the number of out-patients increased tremendously by 20,000 this could be more or less termed as a huge success and the takeover of health consciousness of the Lushais by the western medicine over the

[201] Letter from Gupta, Civil Surgeon, Lushai Hills to the Inspector –General of Civil Hospital, Shillong, Assam, No. 1368, dated 18.4.1940, (MSA Health 29)

perception of traditional treatment of disease. This is partly due to the re-opening of the Sialsuk dispensary and the closing down of one Mission dispensary in Aijal.[202] The increase in the Mizos acceptance of the dispensary as a place to cure ones sickness is a foreseen incident and the growth of this acceptance is astounding considering the work done by the Missions as far as health consciousness campaigns and educational programmes, that were then incorporated by the Mizos.

In 1922, there were 8 dispensaries in the two sub-divisions of the District i.e. North and South apart from two travelling dispensaries to serve areas not served by regular dispensaries. Challiana one of the earliest and prominent western educated Mizo who was also a translator for the missionaries recorded that within the same year in 1922, medicine was dispensed to a total of 74,186 persons in the different dispensaries throughout the hills.[203] Further, according to the census report of 1921, the actual population counted in the hills was 98,406.[204] This is a definite evidence and indication of the acceptance of medical care provided by the colonial government by the majority of the Lushai population. However, this was not to conclude that the level and standard of medical care provided were entirely sufficient and satisfactory to the Lushais there were many hindrances as well since the people from rural villages were not able to access the western medical care.

In the 1940's, due to increase in population, dispensaries in Aizawl and Lunglei were upgraded to full-fledged Civil Hospitals. It may be noted that in the census report of 1941, the population of Mizoram rose to 152,786; the area of the District was 8,142 square miles and the number of villages in the District shot up to 508 villages with as many as 8,142 houses.[205] The lists of hospitals and dispensaries under the Medical Department as recorded by Dr. M Ahmad, then Civil Surgeon of the Lushai Hills for the years 1944-45, 1950-51, 1951-52 were as follows; Aizawl Civil Hospital, Aizawl A.R. Hospital, Lunglei Civil Hospital, Lunglei A.R Hospital, Kolasib dispensary, Sairang dispensary, Sialsuk dispensary, Champhai dispensary, N. Vanlaiphai dispensary, Tlabung dispensary, Tuipang dispensary, Aizawl travelling

[202] ASA, *Admin. Report of 1913-14 Lushai hills*, p.5
[203] Challiana, 'Damdawi la zat', *Mizo leh Vai Chanchinbu*, October, 1923, The Assistant Superintendent, N.Lushai Hills, Aizawl, pp.263-264
[204] *Census of India*, 1921, Assam Vol. 3 Chapter 1, Subsidiary Table IV, Government Press, Shillong, 1923, p.26
[205] *Census of India*, 1941, Vol.IX, Assam, Manager of Publication, Delhi, 1942, p.2

dispensary, Lunglei travelling dispensary.[206] In 1953, Vahai (south Mizoram, Saiha district) dispensary was added to the lists of hospitals and dispensaries.[207]

### 3.3.2. Military Hospitals

Pioneering construction of hospitals was taken up by the military. As a result military hospitals were the first to be constructed in the Lushai Hills. The Military Police Hospital commenced in 1893-94, was completed in August 1894, and was occupied the same month. It consists of two long blocks, and provides accommodations in three wards for forty patients, besides medical store-room, office, dispensary, lavatory, operating room, and quarters for compounders. [208] The establishment of hospitals by the Assam Rifles in Lushai Hills may also be mentioned. In order to ensure peace and security in the border areas of China and Burma the Indian Government has stationed at five places, Military Police Battalions. In the North Lushai Hills, at the end of 1893, a separate unit, the 'North Lushai Hills Military Police Battalion' was established under Captain G.H. Loch.[209](G.H. Loch was the Captain and the Commandant of the Assam Rifles and later became the fourth Superintendent of the Lushai Hills). We need not ponder much on the true purpose and priorities given to the construction of military hospital. It was to ensure the health of the troops so that effective administration through policing was carried out.

In an attempt to improve the station of Aizawl, Captain G.H. Loch trained some of his men in quarrying and shaping stones, instructed greater number of the sepoys in stone work, carpentering, and road-making, gradually developing his Battalion more on the lines of a pioneering constructions than of an ordinary Infantry Unit.[210] This naturally required the opening of a hospital to serve the needs of those serving in the military. The hospital was put under the charge of the Inspector General Civil Hospital, Assam who was also the overall in-charge of the Assam Health Services. Such Battalion hospitals were however not placed under the supervision of Army doctors but supervised instead by the Civil Medical Officer

[206] Letter from Dr. Ahmad, Civil Surgeon Lushai Hills to The Deputy Commissioner, Lushai Hills, Office of the Civil Surgeon, Lushai Hills, dated Aijal, 21.1.1953. Government of Mizoram, Aizawl (MSA CB 2, Health 17)
[207] Letter from the Civil Surgeon to the Deputy Commissioner, Lushai Hills, dated Aijal, the 28th October, 1953. Government of Mizoram, Aizawl (MSA CB 3 Health 29)
[208] ASA, Admin. Report of the North Lushai Hills for the year 1894-95, p.4
[209] L.W. Shakespear, *History of the Assam Rifles*, Kamla Nagar, Delhi, Cultural Publishing House, reprinted 1983, p.99
[210] Shakespear, *History of Assam Rifles*, p.99

Grade Eleven (11).[211] The Military Police Hospital at Sairang was also converted into a civil dispensary.

### 3.3.3. Civil Hospitals

The Aizawl Civil Hospital was constructed under the initiative of Major J.Shakespeare the then Superintendent of Lushai Hills around 1904 and 1905, the hospital thereafter have become the backbone of medical care in the history of medical and health care services in Mizoram. Initially functioning as a treatment camp for labourers who were mostly people from outside of Lushai Hills, it was then open to facilitate and provide treatment to the sick local people due to growing population and higher demand of health care facilities.

The hospital in the early period of its construction was however far from satisfactory and suffered from lack of facilities. It could house only about thirty patients and consisted of the main building, the outdoor dispensary, kitchen, go-down and an isolation ward. In the initial period, the hospital was placed under the charge of a senior Licentiate Medical Practitioner (LMP) Doctor. The outdoor dispensary was placed under the charge of another LMP doctor who was aided as and when needed in certain cases of major and other complicated surgeries by the Civil Surgeon. Subsequently, with the growth in population and increase in public demand, other head quarter dispensaries such as Champhai, Lunglei and Kolasib were also upgraded to the ranks of hospitals.[212]

The numbers of patients treated in the civil hospitals were quite deceptive, as the vast majority of patients treated were imported coolies employed, these forming a large majority of the civil population of Aijal. The dispensary buildings were all of a temporary nature, and fund for their maintenance were often minimal, and they were built and kept in repair entirely by the transport coolie corps.[213] However, infrastructural improvements were made gradually. A house and a cook-shed were built for the compounder. Twelve iron spring mattress beds were placed in the hospital and two large almirahs were supplied for storing drugs. A Lushai who was being trained as a dresser was also placed and was the interpreter simultaneously. Repair of buildings, supply of medicines, quality of rations, water supply and sanitary arrangements etc. of the dispensaries were kept at the responsibility of the Civil Medical Officer/Civil Surgeon.

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[211] Lalthanliana, p.182
[212] Zothanpuii, p.98
[213] ASA, *Admin. Report*, p.9

### 3.3.4 Missionary Hospitals

Missionaries' arrival in Lushai Hills paved the dawn for the cultural transformation and transition of traditional practices of the Lushais. The Lushai ethos underwent a tremendous acculturation with layers of their identity including their belief system and health and hygiene perception etc. taking the route of the dominant culture portrayed by the missionaries.

The Durtlang hospital was established in 1928 by the Calvinist Methodist Church (now the Presbyterian Church of Wales). Initially a small building was constructed and run by a Welsh missionary named Fred J. Sandy as a nursing institute. It was then made into a fully fledged hospital under the supervision and guidance of Dr. John Williams, L.M.P., and a Welsh missionary on 22 February 1928. Earlier even Dr. Frazer who built dispensaries from his own pocket for the good of the Lushais, served the sick from this hospital during his short stint in Lushai Hills it was a small clinic during this time. After Sandy's death the Durtlang clinic continued to function though with much difficulty. Initially, there was a large Mission bungalow in Durtlang. Not very far there was a Theological School which was empty most of the time, since during these initial years, Bible students were very few. This theological school was shifted to mission veng, Aijal in 1926. This Theological school was the only building that was available and was never intended to be a Hospital, but Dr. Johns had to serve his purpose of providing medical care from this building in the initial years.[214]

Christian Hospital Serkawn or "Serkawn Hospital" was started in 1919 and formally established in 1923. Initially the idea of a hospital emerged from a nursing school and dispensary run by a missionary Nurse from Baptist Missionary Society London name Miss E.O. Dicks (Pi Dawki). The Serkawn Hospital was well known for nursing school thereafter, the Baptist Missionary Society posted many medical missionaries in the Lushai Hills and trained the Lushai people especially women the skills of nursing as midwife and cleanliness. Prominent nurses like Miss E.M. Chapman (Pi Zirtiri) who came to the Lushai Hills along with Miss Dicks in 1919 made a huge contribution in educating the women at the Primary and Secondary school level. Many Doctors and Nurses like Dr. Hanley G. Stockley (Dr.Zomuana) and Miss. Jean Stickley were posted at the Serkawn Hospital even after the Independence of India, this clearly indicates that the medical missionaries endeavour to

[214] Lloyd, p. 274

educate and modernise the Lushai people was distinctly beyond the interests of the colonial government.[215]

### 3.4. Positive outcome of Healthcare services

In order to assess how successful is the healthcare and medical work initiated by the colonial government, mention must be made of how many hospitals and dispensaries were established. We must analyse whether the numbers of medical facilities are in congruent with the response and attendance of the local population.

At the time of the amalgamation of the South and North Lushai Hills in 1898-99 there were four civil dispensaries, one station hospital, and four Military Police outpost hospitals, where sick civilians were treated. In considering the returns showing the work done in these hospitals and medical centre, it must be remembered that a decrease in the number of patients, other than Lushais, was a good sign; since all these admitted patients were government servants from outside Lushai hills including majority of coolies, and therefore a decrease in the number of their admission to the hospital either shows an improved state of health within the Lushai hills district, or a reduction in the numbers of imported men employed, either of which is a good sign. Nonetheless, contrary to this decrease, the number of Lushai patients treated in the Aijal dispensary has increased which was a good sign. The increase was nearly fivefold during this year i.e. 1898-99, which reflects great credit on Captain Macleod who has worked hard to gain the confidence of the Lushais and hospital assistant Mohim Chandra Chatterjee, who held charge of the dispensary during this time, and his sympathetic treatment has endeared himself to the people.[216]

So we can clearly state that by 1898 there was a rise in the number of out-patients amongst the Mizos who were gradually accepting western medical practices in addressing their illness. And if the dispensary is at a commutable distance then the Mizos were not hesitant in approaching the dispensary. The traditional practice of animal sacrifice in order to ward off one's sickness was way more expensive than the medicines and services provided at the village or local dispensaries.[217] In 1937, a system of subsidising private practitioners was

[215] *Zoram Baptist Chanchin Pawimawh Lakhawm*, Part I, Serkawn, Literature Committee, 1990, pp. 268-280
[216] ASA, *Admin. Report on Lushai Hills 1898-99*, p.9
[217] Due to the vast popularity of the dispensaries, two new dispensaries were projected at Ratu about 55 miles north-east of Aijal on the Tipaimukh road, and the other at South Vanlaiphai in the Lunglei subdivision.

introduced by the government. According to this, qualified medical practitioners were to be given a monthly subsidy by the government as well as an initial and recurring grant for the purchase of medicines and medical appliances on condition that they settle in certain specified villages and give free treatment to indigent persons.[218] Such policy was followed by the government in order to cater to the wider public and to promote government initiated healthcare services. They were also given the liberty to build up private practices for themselves and to accept such fees for medical treatment and attendances as they can get. In accordance with above mentioned regulation, in 1939 necessary provisions were made in the in the budget of the Lushai Hills to appoint a government subsidised doctor.[219]

Despite the establishment of healthcare services even after the second decade of the twentieth century, health services apart from the establishment of hospitals and dispensaries at strategic places many of the Lushai population could not access it. Those living in the interior were still unable to avail medical aid due to lack of improved roads for transportation and medical professionals. Sometimes patients had to make a journey of ten days or even more to reach the nearest dispensary for medical aid. According to Dr. A.Z. Chaudhuri, Civil Surgeon of the then Lushai Hills;

> "Although remote areas were visited from time to time by two Sub-Assistant Surgeons, there still existed some localities in the district which were badly in need of constant medical aid on account of their unhealthiness, remoteness and difficult communication from the nearest dispensaries."[220]

Even though the government had established distinguished hospitals and dispensaries across the district, at important military posts and administrative centres, nevertheless these were insignificant in its functionality since the technical facilities were inadequate and could not perform major operation and cases. The disbursements of medicine by the government were very limited in its outreach. Qualified and trained health personnel like doctors, nurses, vaccinators, mid-wives, health educators etc were limited in number.

It is hard to imagine the rapidity with which Mizos reconstructed their post-1890's world. We have seen how readily they took advantage of new opportunities: many of them threw

[218] Proceedings of the Governor of Assam in the Local Self Government Department, No.4224, dated 18th December 1937, Resolution on the Regulations for Government Subsidised Medical Practitioners, Government of Mizoram, Aizawl (MSA CB 3 Health 29)
[219] Zothanpuii, p.97
[220] Letter from Dr.A.Z Chaudhuri, Civil Surgeon, Lushai Hills to the Inspector General of Civil Hospitals, Assam, Shillong, dated 26.2.1940, Government of Mizoram, Aizawl (MSA CB 2 Health 17).

themselves into completely new religious and educational experiences and these transformed their worldviews and interpersonal relations. One consequence was that, for the first time, the world beyond the hills became an object of intense interest. The first Mizos to visit Kolkata, in the 1870's, had been decidedly uninterested and 'the magnificence of the City of Palaces did not apparently impress them...on the whole, the balance of their minds inclined in favour of their own hill-tops'.[221]

### 3.5. Vaccination by the Government

#### 3.5.1. Background and Motive of Vaccination

Vaccination was secular in character and alien in origin. It represents a significant extension of state power over the individual and community. Vaccination was taken up by the colonial State and became emblematic of its self-declared humanity and benevolence toward the people of India.[222] However, we must keep in mind the diverse nature of people whom the British colonial government administered. Therefore, it was not always implemented at the requirement of the people; the people governed also needed to reciprocate a positive reception and compliance. Therefore, the reaction to the vaccination programme will vary hugely between the non tribal people of the mainland India and the tribes of the North East India.

One of the interesting remarks mentioned by Erwin Heinz about the primitive people (in our case the Lushai tribe) is the fact of their believe that supernatural forces or maleficent spirits bring about diseases by shooting foreign matter into the body of the patient or by introducing spirits into it. Thus, this explains the fear of injections exhibited by many primitives.[223]

Dr. Lalthanliana stated "It has been opined by many that in the beginning the hospital was not intended for the general public, rather, its services were exclusively for the numerous government porters (non-Mizos) as well as for the many non-Mizos residents of Aizawl. But this may not be entirely correct because with the occupation of the Hills, the need to recruit a number of Mizos too as porter construction of new buildings etc. came about by the new

[221] Pachuau & Schendel, p.189
[222] Arnold, p.119
[223] Ackerknecht, p.13

administration wherein providing medical services for the many workers was naturally one of the most important step to be taken if things were to function accordingly.[224]

After the arrival of the colonial British government it was portray by the government that development and modernization of the Mizos was possible only by endorsing the western medicines and health services along with modern education. These were the foundational instruments of assimilating Christianity and modern education by the Mizos.

### 3.5.2. Vaccination in Lushai Hills

In 1894, a treatment camp was established at Aizawl to provide medical facilities to labourers (*Kuli* dispensary). Subsequently in 1896, this was upgraded into a dispensary with twenty beds. [225] There were no vaccinating staffs in the North Lushai Hills, in 1894-95. But the Civil Surgeon and hospital assistants under him vaccinate as occasion offers, both in Aijal and in the district when on tour. The Civil Surgeon remarks that in the initial years Lushais regard vaccination with great disfavour, and, having lost fear of small-pox owing to its long absence from their midst in epidemic form, cannot be made to understand the necessity of the operation.[226] The past three years of vaccination work are as follows:[227]

| | 1892-93 | 1893-94 | 1894-95 |
|---|---|---|---|
| Operations | 238 | 202 | 408 |
| Successful | 210 | 164 | 229* |

Source: Administration Report of the North Lushai Hills for the Year 1894-95 (ASA).

We could acknowledge that western medicine was not accepted by the Mizos in the initial years of introduction it was faced with doubt, ignorance and reluctance. The traditional medicinal plants and consumption of animal organs as remedies were rigidly embedded in their practice. However, we see changes in their approach and attitude towards the western medicine in the succeeding years. This arguably could be said to have been possible due to the measures taken by the Missions in imparting knowledge on education and health consciousness.

[224] Lalthanliana, p.165
[225] Zothanpuii, p.95
[226] ASA, *Admin. Report of North Lushai Hills*, p.7
[227] ASA, *Admin Report* , p.7

Consequently, by 1897-98 the Civil Surgeon has attached great importance to vaccination. Since the main road from Sairang to Demagiri passes right through the hills, the danger of the introduction of small-pox was very great.[228] But as we can see from our sources, the efficiency of numbers of vaccinations performed was highly dependent on the availability of medical professionals like the compounder as a result during the succeeding two years there was a decrease in the number of vaccinations performed from 766 to 486 due to the same reason. In order to propagate the importance of vaccination at a wider horizon across the hills, the Surgeon-Captain usually takes a tour for months. This leaves the Aijal dispensary to hospital assistant, who sometimes were incompetent to provide efficient medical aid considering the size of the community at Aijal. Thus we saw a petition in the annual report of 1897-98 for the need of an Assistant Surgeon to be stationed at Aijal while the Surgeon Captain was away on tour.[229]

Astonishingly there were no vaccinations attempted in the South Lushai Hills during the year 1897-98. Captain Macleod, with a view to removing the prejudice which the Lushais have against vaccination, appointed 3 Lushai Vaccinators. He reports as follows of their work:

> "The Lushai Vaccinators have not nearly come up to my expectations, but I think I would give them another year's trial. I am afraid they have not been looked after much, as the Assistant Surgeon was unable to inspect their work when I was away, and since my return I have not been able, from want of time, to make a regular inspection tour".[230]

The number of vaccinations performed by the three Lushai Vaccinators during this year was 230. In addition, 340 vaccinations have been performed by hospital assistants. A new communication road was constructed plying directly between Chittagong and Silchar through the hills, the danger of the introduction of small-pox was now a very likely contingency and every effort were made to extend the number of vaccinations. Nonetheless, the Mizos were not easily convinced of the necessity of being vaccinated since not many of the Mizos themselves had contracted the Small-pox disease in an epidemic form. And Captain MacLeod the Civil Surgeon has iterated that until small-pox has claimed some victims, the natural apathy of the Lushais towards vaccination will not be overcome.[231] With this being said the

[228] ASA, *Admin. Report on North Lushai Hills 1897-98*, p.10
[229] ASA, *Annual Report*, p.10
[230] ASA, *Annual Report*, p.10
[231] ASA, *Annual Report 1898-99*, p.10

total number of Lushai out-patients treated in all places has risen from 2,440 in 1897-98 to 3,540 in 1898-99.[232]

However, this apathy towards vaccinations by the Mizos changed tremendously after the first decade of the twentieth century. In the year 1913-14 annual report of the Lushai Hills, we saw that the lushais had no prejudices against vaccination. In fact they seem rather to like it, as instances of their coming to the dispensaries and asking to be vaccinated were not uncommon'.[233] This change in perception on vaccination from the indigenous people was not only in the Lushai Hills it could also be seen in the plain regions of the Assam province. As the Civil Surgeon of Nowgong (Nagaon district in Assam) remarks on the vaccination works in 1916-17 "I personally verified nearly 2,000 cases in parts of the district as widely separated as Bagori, the border of Golaghat, 52 miles from Nowgong station, in one direction and Dhing (a town in Nagaon district) on the banks of the Brahmaputra, 17 miles from Nowgong in the other direction. A most gratifying feature is that vaccinations have been done in villages where in former years the operations had been invariably objected to". It is noteworthy that 450 'Mahapurusias' and nearly a thousand Kacharis and Lalungs submitted to vaccination after 1917, even though these sects were prejudiced against vaccination on religious grounds. [234]

The following table is showing particulars of Vaccination in the Surma Valley and Hills Division in the Province of Assam during the year 1916-17 and 1927-28 (a span of over 10 years).[235]

[232] ASA, *Annual Report*, p.10
[233] ASA, *Annual Report 1913-14*, p.6
[234] ASA, *Triennial Report on Vaccination in Assam 1914-15, 1915-16, 1916-17*, p.4
[235] ASA, *Annual Vaccination Report*, 1926-27, Shillong, p.8

| District | Population of District according to Census of 1911 & 1921 | Total number of Persons vaccinated | | | | | |
|---|---|---|---|---|---|---|---|
| | | 1916-17 | | | 1927-28 | | |
| Surma Valley and Hill Division | | Male | Female | Total | Male | Female | Total |
| Cachar | 497,463 & 529,301 | 15,752 | 12,529 | 28,281 | 28,055 | 19,506 | 47,561 |
| Sylhet | 2,472,671 & 2,541,341 | 71,389 | 62,077 | 133,466 | 177,911 | 151,106 | 329,017 |
| Khasi and Jaintia Hills | 235,069 & 243,263 | 5,245 | 5,848 | 11,093 | 34,554 | 41,713 | 76,267 |
| Naga Hills | 149,623 & 158,801 | 2,494 | 2,241 | 4,735 | 7,886 | 6,475 | 14,361 |
| Lushai Hills | 91,204 & 98,406 | 2,429 | 1,827 | 4,256 | 6,075 | 4,826 | 10,901 |
| Total | 3,446,030 & 3,571,112 | 97,309 | 84,522 | 181,831 | 254,481 | 2,23,626 | 4,78,107 |

Source: Annual Vaccination Report of the Province of Assam for 1916-17 and 1927-28 (ASA).

The above table is important since it was in 1926-27 that several districts in Assam faced epidemics of various diseases, it was severe to the extent that revaccination was requested to

be made compulsory and it was passed and granted by the colonial government. From the table the ten years total vaccination of the Hill division can be acknowledged. And Lushai Hills had the least increase during the span of ten years as compared to Jaintia and Khasi Hills as well as Naga Hills. The increase in the Khasi and Jaintia Hills in 1917 from 11,093 to 76,267 is tremendously huge in the total number of vaccination, also in the Naga Hills from 4,735 in 1917 to 14, 362 in total number of vaccination these figures are comparatively huge to Lushai Hills where 4,256 were vaccinated in 1917 and it increased to 10,901 which is a meagre amount and not significant. However, the increase in the other two hill districts could be because of the kala azar epidemics the Jaintia Hills was facing as well as the smallpox epidemic in the Naga Hills in 1926, where even revaccination was implemented under the special provision of Epidemic Act of 1898 as mentioned.

### 3.5.3. Possible discrepancies in Vaccination data

The total number of person vaccinated in the year 1913-14 in the Lushai Hills was 4,004 against 3,810 the previous year. There was only one Sub-inspector of Vaccination he was a Lushai. He inspected 88 villages against 80 in the previous year. He also inspected vital statistics and had even detected 4 omissions of birth by the village writers.[236]

Such figures and numbers of vaccinations could sometimes seem like a fallacy. The accuracy of the statistics across the British Empire particularly in our case the Lushai Hills district and the Assam province was that occasionally field staffs responsible for data collection and entry were alleged to have manipulated data.[237]

The percentage of success of the operations performed by all establishments i.e. government agents through travelling dispensaries, civil dispensaries and hospitals combined was 97.73% in primary vaccinations in 1916-17 against 96.63% in 1915-16 and 96.22% respectively in 1914-15. Real variations in the success rate of the lymph used for vaccination was somewhat difficult to detect, owing to the common practice among vaccinators of marking nearly all cases as successful at the time of operation, it was detected that some percentage were merely documented as failures, according to the experienced vaccinators they show this as approximating to the actual results. This is done with the object of saving themselves the trouble of returning to ascertain and record the result of the operation. Such inaccuracies when detected by inspecting officers were liable to be passed over by accepting the plea of ‘a

[236] ASA, *Triennial Report*, p.4
[237] ASA, *Triennial Report*, p.5

mistake has occurred' until it was realised how common the practise actually was. Efforts have been made throughout the department to put a stop to these and other kindred practices, but it was not an easy matter to obtain accuracy and honesty in returns from the class of men who were employed as vaccinators.[238] The class of men here is referred to the local vaccinators in different part of Assam district including the Lushai hills, it connotes that the local people employed as vaccinators were inefficient and irresponsible, and they were only employed due to lack of vaccinators and health personnel.

Across the Assam Province there was a growing abuse of falsification of vaccination reports in certain districts. There was a tendency on the part of inspecting staff to spend unduly long periods at headquarters, this have been considerably reduced and has been checked by the issue of definite orders that not more than 7 nights per month in the working season may be spent at the headquarters. To ensure that these orders are obeyed, all travelling allowances bills submitted by the vaccination inspecting staff, together with tour diaries were checked by the sanitary Commissioner Assam countersigned by him before the bills were drawn.[239]

### 3.5.4. Problems associated with Vaccination

Another factor effecting the efficiency of the vaccination programme of the Colonial Government as far as the Assam Province is concerned is the issue regarding the storage of the vaccine lymph.

During the triennial year in 1916-17 668,559 capillary tubes were loaded as compared with 497,692 in 1915-16 and 547,447 in 1914-15. This increase was due to demand owing to an epidemic of small-pox and the availability of cold storage room of vaccine lymph in the Pasteur Institute. Provisions were made where the vaccine lymph will be kept in the cold storage during the off season and up to the maximum period of storage without deteriorating its potency. While being kept in this storage the vaccine lymph are experimented upon until all organisms like puss from the lymph disappear and no lymph from this storage will be issued until its practical sterility has been determined. Such developmental steps were crucial to prevent the occurrence of axillary abscesses and other septic infections from an infective batch of lymph. Although such cases are rarely seen, therefore such improvement of cold storage and experimentation of the lymph will result to an ample supply of lymph at anytime

[238] ASA, *Triennial report*, p.3
[239] ASA, *Triennial Report*, p.3

of sudden epidemic occurrences.[240] To further rationalize our point for the importance of the cold storage, it was the failure of lymph supplied to the plains districts during the months of October in the previous years that has been a common cause of complaint and source of inefficiency in the past. Investigation and observation of the cause of these failures led to the conclusion that the cause had been the exposure of the lymph to the adverse influence of heat in October by too early an issue of the first supply, which was previously sent out from the vaccine depot before the commencement of the Puja holidays, during which period the lymph lay about in the districts until the vaccinators were ready to use it. In order to carry out this vaccination programme successfully, steps were taken to exalt the virus by passage through a rabbit at the commencement of the season and to ensure careful selection of cyst in the first two generations of the strain thus obtained.[241] Arrangements were then made to prevent any delay in the use of the lymph after issue by ascertaining from district Civil Surgeons about the latest date on which the lymph would be required for use after the Puja holidays which occurred in the early part of October. The superintendent of the vaccine depot was then asked to make arrangements for the despatch of the lymph from Shillong (which housed the cold storage for the Province of Assam) so as to arrive in the districts on the required date and not before it, and for this purpose it was necessary to carry on issue work in the vaccine depot during the Puja holidays. This administered vaccination programme has resulted in to the absence of any defect in potency of the October lymph supplies in the first year of its application.

### 3.6. Expenses of vaccine Depot in Lushai Hills

The Triennial Report (1914-15, 1915-16 & 1916-17) on vaccination in Assam is a detailed report on the government vaccine measures. It includes the procurement of vaccine lymph, the expenditure of vaccination in each district across Assam. It also indicates the existence of vaccine depot in the Lushai Hills and was quite affective in performing its duty of vaccination.

Surprisingly with the charges of the vaccine depot included the total amount of expenditure on vaccination in the Lushai Hills were in 1916-17 was Rs.52,636-11(paisa)-9(anna) which was lesser against Rs. 51,441-10(paisa)-9(anna) in 1915-16 and Rs. 62,169-9(paisa)-0 in

[240] ASA, *Triennial report*, p.7
[241] ASA, *Triennial Report*, p.7

1914-15.[242] This same triennial year (1914-15, 1915-16, and 1916-17) in the Lushai Hills 2,429 Male and 1,827 female with the total being 4,256 persons were vaccinated by paid vaccinators, however the total population of the Lushai district according to the Census of 1911 was 91,204.[243] This is just 4.6% of people vaccinated out of the total population. The average number of persons vaccinated by each vaccinator in the Lushai hills during the same period was 851.

During the same period of 1916-17 the cost of vaccination incurred in the entire Lushai Hills was Rs. 704 7(anna) 11(paise) with all the travelling allowance paid to the paid vaccinators the total amounted to 1,197 9(anna) 6(paise).[244]

### 3.7. Types of Disease causing Epidemics in Assam Province

The ratio per 1,000 of population of deaths from small-pox and the number of successful vaccination during 1907-1917.[245]

| District. | 1907-08 | | 1908-09 | | 1909-10 | | 1910-11 | |
|---|---|---|---|---|---|---|---|---|
| | Ratio of deaths from small-pox | Number of Successful vaccination. | Ratio of deaths from small-pox | Number of Successful vaccination. | Ratio of deaths fror small-pox | Number of Successful vaccination. | Ratio of deaths from sma pox | Number of Successful vaccination. |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Cachar | .004 | 15,563 | .01 | 13,533 | .02 | 15,177 | .03 | 15,635 |
| Sylhet | .09 | 82,033 | .08 | 83,817 | .07 | 79,768 | .07 | 83,189 |
| Khasi and Jaintia | | | | | | | | |

[242] ASA, *Triennial Report*, p.8
[243] ASA, *Triennial Report*, p.12
[244] ASA, *Triennial Report*, p.15
[245] ASA, *Triennial ReportLib/R016/S2/17*, p.20

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Hills | .08 | 13,179 | .43 | 21,272 | .59 | 8,815 | .04 | 5,026 |
| Naga Hills | .02 | 8,557 | ... | 4,777 | ... | 5,335 | ... | 4,518 |
| Lushai Hills | .01 | 3,517 | ... | 3,585 | ... | 2,738 | ... | 2,799 |
| Garo Hills | ... | 16,826 | ... | 14,851 | .09 | 17,120 | .15 | 13,219 |
| Manipur State | ... | 12,152 | ... | 11,370 | ... | 10,429 | ... | 12,082 |

| District. | 1913-14 | | 1914-15 | | 1915-16 | | 1916-17 | |
|---|---|---|---|---|---|---|---|---|
| | Ratio of deaths from small-pox | Number of Successful vaccination. | Ratio of deaths from small-pox | Number of Successful vaccination. | Ratio of deaths from small-pox | Number of Successful vaccination. | Ratio of deaths from small-pox | Number of Successful vaccination. |
| | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| Cachar | .006 | 19,596 | ... | 15,146 | .008 | 13,641 | .59 | 26,734 |
| Sylhet | .47 | 113,226 | .14 | 100,597 | .06 | 102,842 | .26 | 120,578 |
| Khasi and Jaintia Hills | .35 | 9,128 | .64 | 8,108 | .02 | 4,963 | ... | 9,385 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Naga Hills | ... | 6,363 | ... | 4,572 | ... | 3,843 | ... | 4,811 |
| Lushai Hills | .... | 3,027 | ... | 3,481 | .02 | 3,639 | ... | 3,610 |
| Garo Hills | .59 | 23,408 | .78 | 24,185 | 1.07 | 23,236 | .82 | 20,263 |
| Manipur State | 1.02 | 42,323 | .79 | 24,185 | 1.07 | 23,236 | .82 | 20,263 |

Source: Triennial Report on Vaccination in Assam for the Years 1914-15, 1915-16 & 1916-17 (ASA).

It's crucial to acknowledge ourselves to the type of diseases that cause epidemics in the Assam province. Depending upon the geographical and climatic set up, diseases varies across the Indian Subcontinent. The chief causes of mortality in the Assam Province were reported. The following statement compares the ratios under the chief heads of mortality in 1926 with the mean ratios of the previous ten years:

| Diseases | 1916-25 | | | 1926 | | |
|---|---|---|---|---|---|---|
| | Urban | Rural | Combined | Urban | Rural | Combined |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Cholera | 1:17 | 1:95 | 1:92 | :71 | 1:51 | 1:49 |
| Small-pox | :17 | :38 | :41 | :12 | :71 | :70 |
| Plague | - | - | - | - | - | - |

| | | | | | | |
|---|---|---|---|---|---|---|
| Fever | 7:01 | 17:08 | 16:81 | 7:23 | 13:81 | 13:67 |
| Dysentery and Diarrhoea | 3:35 | 1:76 | 1:78 | 3:23 | 1:38 | 1:43 |
| Respiratory diseases | 3:65 | 2:2 | 2:23 | 2:73 | :72 | :77 |
| Injuries | :54 | :28 | :29 | :55 | :27 | :28 |
| All other cases | 7:45 | 5:02 | 5:06 | 8:01 | 4:58 | 4:66 |
| Total | 23:32 | 28:76 | 28:53 | 22:60 | 23:03 | 23:03 |

Source: Annual Public Health Report of the Province of Assam for the Year 1926 (ASA).

It is worth mentioning that around 1939 certain diseases such as Kala azar, Yaws, Leucoderma, Leprosy (*phar*) etc. which were quite common among the plain people were more or less absent among the Mizos. Dr. S.H. Paul, then Director of Public Health, Assam in his study of leprosy disease in the whole of the Assam district found out that there were only three cases of leprosy in Lushai Hills and those too living in the border areas of the plains.[246]

In 1926 vaccinations were increased in all districts except Darrang and Manipur State. Special importance was given in the hill districts like Naga Hills and Garo Hills, vaccination was increased to 11,151 and 21,205 in both districts. This was because small-pox was prevalent in epidemic form and vaccination was vigorously pushed on as a preventive measure. The epidemic was so severe that a proposal was made to avail the special regulations framed under the Epidemic Disease Act in order to make revaccination compulsory in villages which were notified as small-pox infected has been submitted to government for consideration.[247]

[246] Rosiama, '*Ngawr Natna*', p.115
[247] ASA, *Annual Vaccination Report of the Province of Assam for 1926-27*, p.2

### 3.8. Human movement monitored by vaccine

Human movement was supervised effectively and extensively during the time of epidemics in order to best prevent the dissemination of diseases consequently vaccination under the British Colonial Empire we are inclined towards propaganda measures that were taken by the government in order to convince the vast multi cultural and religious community that it administered upon. The Bengal Vaccination Act V of 1880 was an Act to make vaccination compulsory.[248] Under the Epidemic Disease Act, 1897 (III of 1897) to prevent outbreak or the spread of cholera in Assam much general information were prescribed by the Colonial government. Many districts were declared as compulsory vaccine districts since they were seen to be prone to epidemic outbreaks. Any person who fails to comply with the notice were liable to a penalty which may extend to Rs. 50; provided that the Deputy Commissioner or the Sub divisional officer may extend the period within which vaccination is to be performed if they were satisfied, on the account of illness or other cause of the unprotected child or person were not in a fit state for vaccination. All vaccination under these regulations were performed gratuitously, provided that it was done at such public vaccine-stations fully appointed by the Civil Surgeon with the concurrence of the Deputy Commissioner, or by house-to-house visitation in the case of females who for any recognised or sufficient reasons were unable to appear to the stations.[249]

The Civil Surgeon of Lushai Hills even though the district did not face the small-pox epidemic in 1926 but when the neighbouring districts were facing it, he suggested a brilliant solution to curb the epidemic so that the vaccination work could be completed during the vaccination season itself. He stated that the vaccinators at the beginning of the working season attend to the villages remote from headquarters and towards its close operate in the neighbourhood of headquarters. And this suggestion was given a trial.[250]

The Lushai Hills district was not notified as a compulsory region but stringent measures were taken by the government as we have seen vaccination was carried out wherever possible to keep any epidemic occurrences under immediate control. Such policy was even followed even after India's Independence as we saw in June 1948 a stock of anti-plague vaccine was

[248] http://bdlaws.minlaw.gov.bd/pdf_part.php?id=42 (accessed on 25th October 2018)
[249] MSA Health CB 1 SC 8
[250] ASA, *Annual Vaccination Report*, p.2

kept at Silchar to inoculate persons coming from or going to the effected epidemic zones.[251] This was a necessary prevention that anybody coming from effected zones gets inoculated at Silchar before entering the Lushai Hills district. This prevention measure was in response to the outbreak of plague in Calcutta since it was highly probable that the infection might spread to Assam through human intercourse via Air, water and road. It was even notified to the public in Lushai Hills by the Superintendent in the Mizo vernacular language,

Hriatirna:

> Tunlai hian Calcutta ah Hripui a leng a, damdawi inchiu zet lo chuan tumah zin suh u.[252]

This means, that no one should travel outside of Lushai Hills without being vaccinated as a plague has occurred in Calcutta. During the same year we saw measles epidemic at Lungleng which was then taken under control immediately by a Lushai travelling dispensary who inoculated over 40 people with vaccine.[253] We can certainly claim that these preventive inoculations would not have been possible without the compulsory vaccination Act.

### 3.9. Inadequate Manpower

In 1927 the widespread outbreak of small-pox in several districts had not subsided. As a result, vaccinators employed were increased from 448 in the year 1926-27 to 486 in the year 1927-28. The Lushai Hills district was raised permanently from 5 to 8 in order to improve the vaccination work of the district. Disinfectant carriers of epidemic units were employed on vaccination work when their services were not required for cholera duty. The average number of persons vaccinated by each vaccinator was 1,816 as compared with 1,290 in 1926-27 in the Lushai Hills. The number of persons successfully vaccinated per 1,000 of population

[251] Letter from District Medical Officer of Health Cachar, to the Civil Surgeon, Lushai Hills, dated 5.6.1948 (MSA CB 2 Health 16)
[252] No.2608-27G of 25.5.1948 (MSA CB 2 Health 16)
[253] Letter from Dr. Saptea., S.A.S. i/c Aijal Travelling Dispensary (Camp Lungleng) to the Civil Surgeon, Lushai Hills, dated 10th May 1948 (MSA CB 12 Health 16)

during the same year 1927-28 was 95:97 against 67:59 in the preceding year that is 1926-27.[254] Although the number of vaccinations performed during the year was larger than that of the preceding year, the disease was not held under control. This indicated the need for a better organisation Lushai Hills was not in the worse infected zone or district within the Assam Province but it is worth noting that in some district like Kamrup district the epidemic was so severe that 37 villages were infected with small-pox. The vaccination task was a humongous task that requires huge efficiency of skilled vaccinators who were limited in number; this problem was just the tip of the iceberg. The opposition to vaccination itself by the people especially in the rural areas obstructed the efficacy of vaccination programme of the government. Consequently, recalcitrant villages were notified as small-pox infected. Provision which were made during 1927-28 as mentioned earlier, for making revaccination compulsory with certain restrictions under the special regulations framed under the Epidemic Diseases Act; this measure has proved to be immense value in dealing with epidemics of small-pox in the Assam province.

The issue is aggravated by the inadequacy of permanent staff of 9 Inspectors and 20 Sub-Inspectors of vaccination who were in practice. Government, in view of this, sanctioned 10 additional temporary Sub-Inspectors in the year 1927-28. The sub-Inspector and Inspector of vaccination are in turn inspected by the Assistant Director of Public Health, Civil Surgeons and Assistant Surgeons. However, their work too has fall short of adequate result since they could inspect only 44,881 vaccinations out of a total of 902,072 in 1927-28 in the Assam Province. Vigilant and careful inspection by superior officers is very necessary especially in view of the fact that the work of vaccinators generally has been slipshod and careless and the mortality from the disease was steadily increasing year after year. Civil Surgeons cannot leave their important medical and jail duties and tour for prolonged periods in rural areas inspecting the work of vaccinators. In order to curb this avoidable discrepancy proposal was made and submitted to the Government, for the appointment of eight District Health Officers, one for each plain district. Without close inspection, which can only be exercised by such officers, it will be difficult to check the tendency on the part of vaccinators to return fictitious figures.[255]

In the Lushai Hills epidemic outbreak was taken very seriously and prompt action were seen to be taken, since the population of the district is meagre as compared to the neighbouring

[254] ASA, *Annual Vaccination Report of the province of Assam 1927-28*, p.1
[255] ASA, *Annual Vaccination Report*, p.2

district like the Cachar district as a result outbreak of epidemic was to be controlled and subsided at the earliest lest the whole population of the district could easily be at risk. There was a report of epidemic in the village of Tualbung in the month of June in 1948. Children were afflicted with diarrhoea including 5 adults, medicines were provided and with a strict investigation it was found out that it was not the case of cholera but it appeared to be cholera as a result 610 persons were inoculated with cholera vaccine as precautionary measures. And the vaccinator on his way back met people with measles in the village Seling and treated them immediately and 65 cases of malaria were treated as well.[256]

We can conclude that the colonial government and the Christian missionaries' activities were often reciprocal in terms of administrative decisions. Though the Missions have their own agenda of what they intend to do in the Luhshai Hills but in order to spread the gospel or visit certain remote areas they were required to take prior approval from the British colonial government this was done so in order to maintain the law and order as well as to keep a peaceful interaction between the missionaries and the Lushais because the Lushais could be apprehensive to their first encounter of the missionaries and their social perspective often influenced and dictated by their respective chiefs. Similarly, as the missionaries make headway into the community and cultural practices of the Lushais, the government would consult the missionaries for their advice and suggestions before implementing a new policy or legislation in our case compulsory vaccination, so as to avoid offending the Lushai people and to maintain a harmonious administration. Vaccination was a huge task performed by the government, in the initial years of its introduction we saw that the Lushais showed apprehensions towards it and was insensitive to its importance because they have not face a huge death toll or an epidemic form of smallpox. Gradually this perception was changed and by the first decade of the twentieth century we saw that the Lushais were not only receptive rather western medicine and healthcare almost completely replaced the sacrificial rituals and ceremonies to cast out a person illness. The colonial healthcare services in the form of dispensaries and disbursement of medicines was received positively and possibly embraced by the Lushais by the end of the nineteenth century. However, the considerable increase reported in the number of Lushai attendance to the hospitals and that they are casting off their prejudice and appreciating the benefits of English system of treatment is arguable. Because these are government reports and there is no vigilance by an autonomous organisation to

[256] Letter from Dr. Rohawka S.A.S Epidemic Unit, PHD Dept., Lushai Hills, to the Civil Surgeon, Lushai Hills, dated 15th June 1948 Aiijal, (MSA CB 2 Health 16)

countercheck these figures although these figures are to some extent true but are prone to excessive exaggeration. One reason being that the maximum numbers of patients admitted in the Aijal dispensary were imported coolies and imported government agents not Lushais. Thus, we saw tremendous change in perspective and attitude of the Lushais towards the western medicine which had much to do with the activities of the missionaries in inculcating modern medicinal and health care practices.

# Chapter IV:

# People's Response to Government Measures

### 4.1. Medical encounter between two cultures

In order to delve into the question of People's response to the government measures in addressing the health issues, we must in a larger spectrum see the health services of India in particular the Lushai Hills district, whether it was cooperated with growing health awareness by the native Lushais or whether it was resisted and lacked growth within the indigenous community. In a nutshell we could also perceive it more or less as the encounter between the indigenous medicinal practices of India and the western medicinal practice.

Western medicine according to anthropologist Mckim Marriot even till 1955 had hardly touched the villages of rural Uttar Pradesh in northern India. Clinics and dispensaries were at best, he wrote, 'momentarily stopping places on the sick man's pilgrimage from one indigenous practitioner to another.' "Western medicines sit outside the door of the village," he continued, "dependent upon government subsidy and foreign alms for its slim existence."[257]

Contrary to this many other writers have assigned to western medicine a more active and interventionist role dating back to some point during the nineteenth century. One of the critical moments in the expansionist career of Western medicine in India has been identified with the mid 1830s, when the triumph of the "Anglicists" over the "Orientalists" is seen to have ended colonial patronage of indigenous medicine and marked the confident assertion of the Western system as the only legitimate form of medical practice. But arguably, the moment of transition from enclavism to public health came only in the 1890s with the establishment of new "tropical medicine", based on the germ theory of disease, and a corresponding intensification in state medical intervention in India as in many other parts of the colonial world.[258]

The relationship between the western medicine and the indigenous medicine says more about the nature of economic and political power, under colonial rule, rather than two contrasting competing medical system of practices. In the late nineteenth century, as new methods of western medicines one in the form of vaccination as opposed to variolation or inoculation

[257] Arnold, p.12
[258] Arnold, p.12

practiced indigenously in the mainland India. It was met with apprehensions and the people were not as grateful as the British colonial government had anticipated. Similarly, the Mizos were also ignorant to pay heed to the western medicine in the initial period of introduction especially unless they were influenced by the Christian Missionaries on how effective their medicine was. This was because the inculcation of western education and Christian belief system by the mission movement and the British Colonial government has not made headway. Therefore, the indigenous Mizos could not grasp the notion of it, as traditional customs, and beliefs were still rigidly practiced.

### 4.2. Reaction to epidemic measures in the mainland India

The diverse measures which were adopted by the British to handle epidemics affected different sections of the population in different ways. Physical dislocation and economic hardships, especially of the poorer sections, were integral to this situation. Unsettling and hardships were built into the process of evacuation. In the mainland India, people complained of inadequate number of huts in the camps; following which they were asked to live under the shades of trees, in the open and in temples. During the Cholera epidemic in 1872, the villagers were 'huddled in quarantine camps'; they were exposed to 'harsh conditions and inclement weather'.[259] The vaccinators of the provincial establishment used the authority and influence of the local officials- *lambardars* and *zaildars*, for vaccinating the children who were often gathered forcibly and vaccinated without the consent of their parents. Women were dragged out of their homes and children snatched from their arms. The beards of the men were also pulled for not bringing the children out of their homes.[260]

The epidemics, followed by measures like cordoning, resulted in suspension of the means of livelihood of different sections of population. The worst effected were those whose subsistence depended on their daily earnings.[261] Measures like evacuation and cordoning prevented the pedlars and traders from selling their goods. Even the larger centres were affected. During the plaque epidemic, the wholesale market in Delhi was closed, resulting in paralysing local as well as external trade.[262] Agricultural production also declined in the process. During the cholera epidemic in 1872, quarantine prevented the farmers from

[259] J.M. Cunningham, Report on the Cholera Epidemic of 1872 in Northern India, Calcutta: Government Printing, 1873, p.28. cited in Tandon, p.228
[260] *Proceedings, Home: Medical and Sanitary*, February 1881, Serial Number 13, pp.82-83. Cited in Tandon, p.228
[261] The Tribune, 27 April 1901, p.2, cited in Tandon, p.228
[262] Narayani Gupta, Delhi: Between Two Empires 1803-1931, Society, Government and Urban Growth, New Delhi: Oxford University Press, 1997, p.137

cultivating their fields. The owners of those crops which required selling or processing immediately on ripening were the worst affected as they were unable to get through the cordon at every attempt in order to sell their produce. [263]

Similar hostile attitudes towards the government measures were seen in the Punjab region as well during times of epidemic occurrences. There was rumours circulating about what the actual motive behind the vaccination and cordoning intent made by the colonial government, this was the manifestation of the people's disapproval. Rumours revolved around the coercion associated with vaccination and the plague. Regarding vaccination, it was said by some that the government was marking the children because it was looking for people fit enough to be slaves. Some believed that the British were taking out blood to prepare a blood mummy. It was also rumoured that the government was trying to find a child who had milk in his veins as such a child would be the expected Imam Mahdi[264] whom the British were trying to kill. Vaccinations were seen also as a means of spreading Christianity.[265] Mission medicine "was not carried out for a purely medical purpose, but used as a beneficent means to spread Christianity."[266] The set of rumours associated with plague measures was equally interesting. To suppress the plague, the government was believed to be resorting to poisoning the afflicted persons. The medical subordinates were administering pills of suspicious character and a certain hospital assistant was believed to have died after consuming his own pill.[267] The native officers like the assistant surgeons and *naib tahsildars* were suspected of spreading the disease by distributing poisoned sweets or by poisoning the village wells.[268] The active resistance of the people was expressed in different ways. The general reaction to the government measures was to conceal the sick. The fear of separation from the family members added to the unpopularity of government measures. During the cholera epidemic of 1872, cholera cases were concealed because people were afraid of being quarantined.[269] Children were concealed in their homes till the tour of the vaccinator was over to prevent them from getting vaccinated. The fear of segregation was the main reason behind the concealment of plague cases. The rigour of the preventive measures resulted in giving of

[263] Tandon, p.228
[264] The term Mahdi literally means "guided one" is an eschatological redeemer of Islam who will appear and rule for several years before the Day of Judgement and will rid the world of evil.
[265] Tandon, p.229
[266] David Hardiman, Missionaries and their Medicine: A Christian Modernity for Tribal India, Manchester: Manchester University Press, 2008, p.12.
[267] *The Tribune*, 14 May 1901, p.3, Cited in Tandon, p.230
[268] *Proceedings, Home: Medical and Sanitary*, June 1901, Number 99-100, pp. 2-3. Cited in Tandon, p.230
[269] Cunningham, Cholera Epidemic of 1872, pp. 4-5, Cited in Tandon, p.230

bribes to the lower government functionaries. To avoid vaccinations of newborns in Ludhiana, the clerk registering births was bribed.[270] Traditional medicine practitioners were against the government measures very sternly as it was depriving them of their livelihoods.[271] Hindus and Jains were opposed to rat destruction on religious grounds. They either buried the baits laid for rats by the district administrators or released the rats caught in the traps.[272]

The resistance of people in fact ranged from mild opposition and attacks on subordinates staff to more violent forms like riots. During the early period, their anger was directed against the vaccinators. In 1883, the vaccinators were actually assaulted four times and were prevented from carrying out their duty. In another incident, the head vaccinator of Delhi, Ghalib Ali, was attacked in the bazaar. After outbreak of the plague, the anger of people was expressed through public demonstrations and threats to government functionaries and actual assaults on them.[273]

### 4.2.1. Reactions in Lushai Hills

We do not have sources telling the same fate for Mizos during the time of epidemic outbreaks due to the scarce population as compared to the northern part of India. And traditional measures like the *hridai theu* as mentioned earlier even under the colonial government was a safe practice for the Mizos. Vaccinations of course as we have seen in the previous chapter were taken up from village to village by the colonial government. However, vaccination was out of the questions if we do not acknowledge the work and effort of the missionaries in propagating the importance of the western medicine and its efficacy of healing sickness assisted with prayer. Children would literally run at the sight of government vaccinators.[274] The Lushai had labelled vaccination with the intimidating verb *ban-zai*, which literally meant 'to cut the arm.'[275]

The resistance of the Mizos in the initial years to western medicine can be gathered from an article issued in the *Mizo leh Vai Chanchin Lehkhabu* in 1913. According to Zanga of Thakthing, Aizawl,

[270] *Proceedings, Home: Medical and Sanitary,* June 1880, Serial Number 12, P.540. Cited in Tandon, 230
[271] Tandon, p.230
[272] *Proceedings, Home: Medical and Sanitary,* October 1907, Serial Number 70, p.75. Cited in Tandon, p.230
[273] Tandon, p.231
[274] Rowland's to Williams, 1 October 1909, LLGC/NLW CMA 27 300, p.3, cited in Jackson, p.3.
[275] Lorrain and Savidge, p.60

> "The Mizo abhorred or had an aversion to the use of western medicines due to the belief that the composition of such medicines included various organs of the human body such as the fats, brain, eyes etc."[276]

Such assumptions arose out of the belief that when the dead were post-mortem by the doctor, the various organs of the body were then extracted in the process in order to make medicine. An extract from Rev. J.H. Lorrain's letter, who was one of the pioneer missionary to the Hills also mentioned;

> "A post-mortem examination held on a sweeper found dead in his hut was rumoured all over Lushai land that the Doctor opened the man's body to make medicine out of his entrails....that a chief was dissuaded by his wife from taking quinine sent to the chief by the missionaries as it was made from the intestines of the above mentioned sweeper."[277]

Violent attitudes and responses from the indigenous people (Lushais) were not seen as oppose to the opposition and reaction displayed by the people of North India. But their attitudes towards western medicine and government health care measures during the initial years were antagonising and inimical, surmounted by incoherent suspicion. In the Lushai case also, the *bawlpu* or the native medicinal practitioner gradually began to lose his reputation and there were new and complicated disease which came along with the British colonisers. In order to meet such demand of healing, the *bawlpu* needed to expand his knowledge horizon, however such was not possible where the western medicine were readily and easily available and slowly started to gain reputation on its ability to heal or cure illness. The activities of the *bawlpu* is recorded in a very detailed letter by Edwin Rowlands on 18.9.1901, Rowland does not seem to revere the gesture and practice of the *bawlpu* as he mentions "mostly he (*bawlpu*) was not quite certain whether the jungle spirit or the water spirit was tormenting the sick girl".[278] The Christian missionaries had a pivotal role in the acceptance of western medicine and its practice in the Lushai social and cultural structure. Their inability to heal themselves from certain illness was taken advantage upon by the missionaries and thus the western medicine and evangelism was promoted simultaneously. But the process was rather slow and did not happen overnight. The Mission gifted the Mizos with medical awareness. In 1908 the

[276] Zanga, 'Damdawi Thu', *in Mizo leh Vai Chanchin Bu*, September 1903, W.B. Press, Sylhet, p.13.
[277] Letter, J.H. Lorrain to his parents, dated 28th October, 1896, Baptist Missionary Society, Lushai Hills Mission, 1894-1944, Academy of Integrated Christian Studies (AICS), Aizawl.
[278] Lloyd, p.50

mission started a medical work with Dr. Peter Frazer as in charge. Before he was asked to leave by the government in 1912, he treated more than fifty thousand patients.[279]

### 4.3. Medical propaganda

It was at the missionaries' medical dispensaries that the names of those Lushai wanting to become Christians were to be handed in, and where phials of medicine were handed out lined with paper Bible Verses.[280] At the same time, traditional Lushai religiosity was itself centred on the healing of the sick. The British military conquest creating "a vacuum and cultural void"[281] as we have mentioned in the earlier chapters, it was this void which the missionaries with the help of medical aid were able to penetrate into the religious realm of the Lushais. The Lushai religious world was as functional and proactive as it could possibly be to the Lushais. But the unprecedented administrative change that came along with the British colonial government had adverse effect on the cultural and religious establishment. In order to propagate their teachings the Christian missionaries put forth the necessity to help them clean themselves this being mandatory on how a Christian image or appearance should be portray. The earliest missionaries to Lushai Hills set out above all with soap to cleanse Lushai bodies and the Gospel to cleanse Lushai minds.[282] J.H. Lorrain's first impressions on the Lushais in an 1894 account revolved around the dirtiness of the Lushai and their "squalid hovels".[283] It was a criticism levelled as much at their spiritual state as their "hair matted with clay" and that 'children and pigs' wallows in the dirty village mud together during rainy season.[284]

The missionaries aimed to sell not only soap, but also their broader ideas of hygiene to what must have seemed a difficult Lushai market. They advertised through gifts and printed books, and styled themselves as models of hygiene along with their early converts. Their 'Great Gathering' of 1904 aimed to bring all the Lushai Christians of south Lushai Hills together for a conference. Its big finale featured free trials of soap, combs, and mirrors.[285] Missionaries

[279] Vanlalchhuanawma, *Mission and Tribal Identity: A Historical analysis of the Mizo Synod Mission Board from a Tribal Perspective 1953-1981*, Delhi, ISPCK, 2010, p.116
[280] Lal Dena, *Christian missions and colonialism: a study of missionary movement in northeast India with particular reference to Manipur and Lushai Hills, 1894-1947*, Shillong: Vendrame Institute, 1988, p. 107
[281] Kyle Jackson, *Missionaries' Pills and Lushai Hills*, presented at National Seminar on the Medical History of North East India, Diphu Campus, Assam University, on 27th and 28th September 2011, p.2
[282] Hardiman, *Missionaries and their Medicine*, p.11
[283] Lorrain, LB, 16th January 1894
[284] Lorrain, LB, 20th June 1894
[285] Lorrain, "Annual Gathering of Lushai Converts," The Missionary Herald of the Baptist Missionary Society, RPC, London: BMS, 1904, p.164, Cited in Jackson p.6

imported their concepts of hygiene with foreign concepts of time. Early phrasebooks for local colonial officials and missionaries taught sentences like, 'You have come too late, I cannot give you medicine'[286] a sentence that seems to have baffled the Lushai,[287] whose open at all hours village culture equally stunned the missionaries.[288] The missionaries work reflected and the response came quickest from the youth. This was another reason why visits to zawlbuk were so important. It was a wise strategy of approaching the zawlbuk on behalf of the missionaries where all the youth would gather most of the time. Pastor Phawka, the first pastor to be in charge of the West District, used to say that the first time he heard of the Gospel was from Edwin Rowlands in a remote village *Zawlbuk* in the west. The same applied to Rev. Challiana, a senior Baptist pastor and translator in the South, first heard the Gospel message from Edwin Rowlands in a *Zawlbuk*.[289]

Missionary ideas of hygiene came packaged in a European cultural framework, and apparently were hard to comprehend or adopt. Finally, structures of family authority came into play. In the early years, the missionaries attempt to approach the Lushai youth was met with hostile attitude, we hear of Lushai parents objecting to their children's contact with missionaries, their medicine, and message, similar to the apprehensions we saw in Northern India in the earlier chapter. Christian figures were not the problem; Christian exclusivity was. The Lushai tradition of *Sakhua*, or the sacrificing of animals to sustain ancestors, came into play here: parents argued that if their children turned absolutely to a new religion, it "would be certain death"[290] to the parents in the afterlife. Seniors, for whom this threat was most immediate, made up "the caucus of opposition."[291] Missionaries record how some grandmothers would beat or threaten those grandchildren who associated with the mission, and how other children would run from the missionaries, having been told that they would kidnap them.[292]

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[286] Lorrain (1898), p.44, Cited in Jackson P.9

[287] Savidge, "BMS Mission in the South Lushai Hills, Report for 1915," Calcutta: Baptist Mission Press, ULAM MS811/IV/64, 1915, p.12, cited in Jackson, p.9

[288] "Doors have no fastenings, and the idea of asking permission being quite foreign, privacy is quite unknown"; Chapman, "Day by Day in Darzo" clipping, RPC IN/65, p.139. See also Lorrain, "South Lushai," Annual Report of the BMS, 129th Annual Report, RPC, 1929, p. 17, cited in Jackson, p.9

[289] Llyod, p.52

[290] Report of Lushai Hills, 1901-2'', cited in Thanzauva, *Reports of the Foreign Mission of the Presbyterian Church of Wales on Mizoram 1894-1957*, The Synod Literature and Publication Boards, Aizawl, Mizoram, 1997, p.13.

[291] Llyod , p.32

[292] Haudala, "A Lushai Pastor on Tour," The Herald, RPC, 1916, p.64; Savidge, "Progress among the Lushais," The Missionary Herald, RPC, 1907, p.223 Cited in Jackson, p.13

One such incidence on the attitude of the Mizos as to the use of modern medicines and consulting a doctor was concerned may also be cited here. According to Makthanga;

> "On 30 October, 1905, a woman was bitten by a snake on her foot. After an hour, she then lost her power of speech and trembled all over. In spite of such sufferings, her relatives and those near her did not take her to the doctor but tried to cure her instead by administering various indigenous medicines to her but to no avail. After a while, a young man seeing her condition enquired as to why a doctor was not called for her. The reply was that even the doctors would not be able to do anything for her. However, the young man quickly ran to call the doctor who on his arrival applied some medicine to the wound, tied her foot and operated upon it. Gradually, the woman got well again."[293]

The medicines they gave established mutual confidence and the Mizos were very sensitive to the kindness shown. The following was a common saying of those days-

> Zosap Venga ka va len leh
>
> Zosap in damdawi min pe
>
> I went to where the missionaries live,
>
> Good medicine is what they give.

In their early preaching they stressed that God was the maker of all things. "He is good and if you believe in him you will have supreme joy hereafter", they used to say, "And if you do not believe, and persist in your evil ways and adulteries, God will put you among the evil spirits in the everlasting fire and you will endure suffering forever and ever."[294] From this account we could see how the missionaries appeal and strategy of preaching the Gospel was making a positive impact gradually as the Mizos even compose a quote in regard to their benevolent distribution of medicine. Nonetheless, this kindness arguably was instilled with the preaching of fear, fear for the eternal hell, if they do not believe and mend their evil ways of sacrificing to the spirit. In the case of the Lakhers in the Southern Lushai Hills we saw that they have no objection to European medicines and are open to taking quinine and would submit readily to vaccination; however these western medicines were only regarded as supplementary to their

[293] Makthanga, 'Damdawi Tangkaina', in *Mizo leh Vai Chanchin Bu*, December 1905, A.G. Giles, Lushai Hills, pp.8-9
[294] Llyod, pp.31-32

sacrifices, which are still performed regularly as soon as a person becomes ill.[295] The belief in the Gospel of the missionaries and the healing properties of their medicine is a different concern all together; the simple trust entrusted on the missionaries by the Mizos could be a significant step towards transforming their cultural and tradition practices. It was the task of the missionaries to overcome the suspicion of the Lushais and this was achieved by winning over individuals one after the other. Perhaps most noticeably, the missionaries remained in the Hills through epidemics and *mautam* famines, petitioning the government on behalf of their Lushai friends while demonstrating their own explicit goal of "self-sacrificing love."[296] J.H. Lorrain would even travel to France during World War One with lanternslides of the Hills in tow to comfort homesick Lushai servicemen.[297] The deeds performed by the missionaries were a path breaker for the western medicines to be accepted by the Lushais.

Reginald A. Lorrain who went to the southernmost part of the Lushai Hills district into the Lakher or Maraland as a missionary gave us a vivid account of his experience as he mentioned on how he and his wife cared for one Lakher Chief,

> "On examination we found that he was in a very bad condition and exceedingly weak, but we asked him if he would take our medicine instead of sacrificing to the evil spirits, and allow us to pray with him, which he willingly did. After giving him his medicine, my wife and self knelt down beside the prostrate body and asked God, for Christ's sake, to bless the drug, and if it was His will, to spare his life, and to teach him the way of Salvation".[298]

The chief was supervised on a daily basis and was even given milk to drink, but it was given under the name of medicine and often at times small crystal of permanganate was added into it to change the colour of the milk, this was done because the Lakher-Maras do not consume milk due to its bovine production.[299] The colour of the milk was changed because the Mizos were curious to colour. The natural world is presented to them in chiefly browns and greens beneath a sky of unsaturated blue, the bright, saturated colours of the missionaries' gelatine-capsule pills were only possible in synthetically-produced artefacts that inherently over stimulate the visual cortex. The missionaries were hence not just introducing biomedicine,

[295] Parry, p.169
[296] Lorrain. "15th June, 1903," India & Ceylon Sub Committee, No. 5, RPC Acc. No. 195, Gen/CTTEE/1.508/Micro16/ShelfXXIV/2, 15th June 1903, p.221, cited in Jackson, p.20
[297] The 18,000 cigarettes and 53 cigars Lorrain also provided the Lushai servicemen could not have hurt his reputation either; Lorrain to Mrs. Lewin, 9 August 1917, ULAM MS811/IV/65/8, cited in Jackson, p.20
[298] Reginald A. Lorrain, *5 Years in unknown Jungles*, Aizawl, TRI, 2012 (2nd Reprint), p. 149
[299] Lorrain, *5 years in Unknown Jungles*, p.150

but also unnaturally rich hues of colour never before seen in the remote Lushai Hills.[300] The Lushais were picky they only wanted the most colourful pills[301] such medicines were only accepted by the Lushais. The medicines provided by the missionaries as well as the government were fused with the notion of the Lushai amulets or charms. The medicines were co-opted with their *kelmei* and use as an alternate to get well from sickness.[302] This fusion of medicine or amulets by the Lushais is a rather peculiar and interesting occurrence, very similar to the domestication of Christianity itself. In 1912, Thangkunga wrote an article entitled 'On Christian Customs,' which contained 13 exhortations to Mizos to adjust their behaviour in line with the faith. Rather than censuring all association with sacrifices, he proposed the following proper practice for Christian Mizos:

> Let us not head towards where the meat of the sacrifice is being served and if we know when offered that is the food of sacrifice, let us not eat it. If in a family there are those who believe and those who don't believe [in Pathian/God], let those who don't, sacrifice and those who do believe, since it is their meat too, they can eat it, but with prayers. This is up to them.[303]

### 4.3.1. Lushai perception of Western Medicine

Missionary medicine was deployed into this vibrant Lushai world of healing, a world with its own common sense, practices and expectations. Even the basic biomedical idea of a proper dose of medicine was turned on its head when it met new Lushai logics, since if a tiny dose held the key to gradual health, why not "drink the whole bottle for a quick cure?"[304] Savidge and Lorrain complaints that patients had too much faith in the properties of the pills, for they often put them under their pillows [or in their bags] instead of in their mouths and imagine the results will be the same."[305] Many Lushai had big expectations from missionary medicine. Some expected new eyes.[306] Others were convinced that a rub of the missionaries' liniments would cure their paralysis. Parents brought dying children to the missionaries, while one man

[300] Jackson, p. 19.
[301] Savidge, "The South Lushai Hills," Annual Reports of the BMS, 119th Annual Report, RPC, 1911, p.80, cited in Jackson, p. 18
[302] Lady B. Scott, Box 1, CSAS Lady B. Scott Papers, p.197, cited in Jackson, p.18
[303]Thankunga. 1912. '*Kristian Dan Thu*.' Kristian Tlangau (September): 134-35
[304] Rev. Zairema, *God's Miracles in Mizoram: a glimpse of Christian work among headhunters,* Synod Press and Book room, 1978, p.25
[305] Savidge, "Tribes on the Frontier," Report for 1911, BMS Reports, BCMCA Class No. 266.0231, Book No. L193, Accession No. 331, p.7, cited in Jackson, p.16
[306] Savidge, "A Preaching Tour in South Lushai," The Missionary Herald, RPC, London:BMS, 1912, p.234, cited in Jackson, p.21

clearly on his deathbed was convinced, he could still be healed with a little missionary medicine.[307] The first operation on a Lushai was on a woman whose leg was amputated while on chloroform, she revealed that she was dead and came back alive since it was the first time she had been drugged with chloroform, and she emphasised that she would have felt tremendous pain if a Lushai would have perform the operation with a "*chem*" or the traditional knife of the Lushais.[308] Another, incident of the Lushais believe in western medicine for its healing properties could be seen where a man who recovered from an illness by taking western medicine and he sacrificed a fowl as thanksgiving to *Pathian*, and he even sent another fowl (alive) to the missionaries as a thankful gesture.[309] This indicates that in the initial years of the introduction of the western medicine the Lushais accepted it as merely a supplement to their sacrificial rituals. The medicinal properties of healing were fascinating to the Lushais rather than the missionaries' gospel teachings.

This definite believe in the ability of the missionaries and the healing properties of their medicine by the Mizos came a very long way, since during the initial years of the introduction and preaching of the Gospel the Mizos who converted to Christianity were persecuted and viewed with strong aversion. Many of the youths of the village of Khandaih had converted to Christianity and the chief of the village was highly incensed at this. Anything which caused an estrangement between the chief and the young men in the *zawlbuk* could damage the structure of the village life. This would mean a loss of soldiers, police force and skilled labour for the chief. As the chief of the neighbouring villages who were brothers with the chief of khandaih, they unanimously took a decision in persecuting the villagers who listen and convert to Christianity the chiefs imposed a fined of one pig on (which was a valuable asset) who ever listen to the missionary D.E. Jones. And properties of Christians were ceased by the chiefs.[310]

The missionaries' health care services aided by the colonial British government paved a way for easy accessibility to medicine in the remote villages and the dedication of the missionaries who supervised the sick themselves this had a huge impact on the Lushais of wanting to experience and embrace Christianity. Dispensaries played a huge role in this evangelical movement where the disbursement of medicine was assisted with the preaching of the

[307] Savidge, "BMS Mission in the South Lushai Hills, Report for 1915, "ULAM MS811/IV/64, 1915, p.12, cited in Jackson p.21
[308] Lorrain, LB, 13th March 1895
[309] Lorrain, LB, 14th February, 1894
[310] Llyod, pp. 98-101

Gospel. Such dispensaries like the one started by Dr. Fraser made huge contributions. As Lal Dena remarked;

> "With the advancement of a technology to their own advantage, the missionaries worked with a highly naturalistic view of disease and medicine which accelerated the breakdown of traditional animistic world-view thereby acting, directly or indirectly, as an effective agent for conversion."[311]

The Christian practice and its means of healing was more inexpensive than the traditional means of sacrifice where one has to pay for the service rendered by the *bawlpu* and the animal to be sacrificed. And this even after sacrificing the animal cannot be consumed and was laid to waste or to be consumed by dogs and swine. Nonetheless, this is from an economic and historical evaluative perspective but if one truly considers the belief aspect of the Lushais into the new religion or God being introduced to them. And they chose to believe it after much consideration of the benefits and the risk of abandoning their traditional belief system. Nevertheless, it is indeed important to remember that the practice of the Lushai belief system was term merely as 'devil worship' as we have discussed. Despite this, the *bawlpu* were willing to share their knowledge to the colonial ethnographers and European missionaries. The *bawlpu's* ritual knowledge has been extensively recorded. However, his empirical knowledge on medicine has been left out in both missionary and colonial texts. There is a good reason to believe that both agents knew that many of empirical medical knowledge were effective which could have given less chance to the promotion of western medicine.[312]

If we are to analyse and see in retrospect of the people's response to the government measures to tackle and curb epidemic diseases that have been mentioned, it is imperative that we take note of the western medicines dominion over the indigenous medicinal practice at the pan India level. This includes the small Lushai Hills district, and their practice of traditional remedial measures of curing certain illness being curtailed. This was made only possible through political apparatus in the form of surveying and compulsory vaccination. Besides this, the actions and manner of providing health care services during epidemics was inhumane especially in the mainland India. It created aversions in the consciousness of the people, and this led to creation of rumours and suspicions amongst the people, against the

[311] Dena, *Christians Missions and Colonialism*, p.106
[312] Jackson, p.133

medicines and vaccines being used by the British colonial State. The rumours circulating were similar to the ones circulating just before the Revolt of 1857 about the chapatti being passed on during midnight, the rumours stemmed out of the fear and uninformed predicament of the people. Contrary to this, the British thought that they were performing a benevolent deed. It was because of these incidents, that the initial years of the State sponsored remedial health care and services during epidemics were not received positively by the people. In the Lushai Hills too, the Lushais were in the initial years apprehensive to the missionaries themselves not only their medicine, but their preaching of a new creator was not very appealing to them. However, their deeds and benevolent sacrifice paved a way for the gospel as well as the western medicine, but this would not have been possible without the helping hand of the Colonial State in the form of dispensaries and vaccination campaigns.

## Conclusion

We have seen the interaction of knowledge, information and perception of diseases between the Lushais and the British colonial government. However, the Lushais knowledge of sickness and contraction of diseases from their raids on the Chittagong Hill Tracts and the Cachar plains was well established and the Lushais were aware of it. This could be said to be intensified by the British colonial Lushai expeditions, as human movements possibly carried such diseases from one place to the other. Due to unavailability of written records about the epidemic diseases or written Mizo history per se, much of the records are of the observation of the British colonial agents and traditional oral sources as well. Similarly as political activity the medical activity also had a tremendous impact through the colonisation of the Lushai Hills after successful military expeditions. The missionaries were the ground breaking apparatus in the introduction and implementation of the western medicines in the form of dispensaries and training the Lushai men and women on hygiene and cleanliness awareness. Further, for affective governance the traditional system of administration i.e. the Chieftainship was employed and charged with maintenance of cleanliness and hygiene in their respective villages.

The Mizos much like the other primitive tribes across the world regarded their health according to the community and cultural standard. They have their own priests who would perform certain rituals and ceremonies to cast or ward of the evil spirit whom they believed to be the reason for the cause of their illness. Such was the perception of the Mizos before the arrival of the British colonial government in the Lushai Hills. Common illness and their symptoms like epilepsy, pneumonia, typhoid etc. were familiar to the Lushais. And they were very well aware on the contagion of many diseases for which as we saw '*hridai theu*' was imposed. Many traditional remedial practices that were quite effective were practiced, but this native medical system was never promoted and embraced by the British colonial government and the missionaries as well. Certain food habits were followed by the Mizos, but the remedy for cholera was unknown as they termed it as a foreign sickness because they were not familiar with the disease. However, this could be seen as unintelligible when viewed with a contradictory perspective. Because the earlier Lushais as far as our sources goes were not very particular in boiling their water prior to consumption. Having mentioned this, on the other hand as we saw earlier the Lushais were particularly careful in their source of water supply and if they happen to doubt its cleanliness they would resettle themselves somewhere

else. Traditional medicines were also applied in some form as opposed to sacrificial offerings which could be rather troublesome to a great extend as it involves attaining certain seasonal herbs etc. which would not be available at the time of need. Certain diseases were unknown to the Mizos and they were very dreadful of it. One the disease being cholera, which they considered it to be of an alien origin contracted from the low land and the plains or brought about by the white man, but diseases like smallpox were very familiar to Lushais. As the British administration began to be setup in the Lushai Hills, the Lushai who were educated by the missionaries started to analyse their community health and the most common diseases were studied, apart from tuberculosis of joints and spines the respiratory diseases were common. This was found to be prevalent because of vast smoking of tobacco by the Mizos both by men and female. Malarial fever was another rampant disease; however we saw that number of deaths were comparatively law due to the scarce population of the Lushai Hills as opposed to the other district of Assam and the Bengal province. The health services catered by the British colonial government was successful due to the implementation of dispensaries including travelling dispensaries, however this was inadequate in the long run as the Lushai population gradually grew simultaneously with health consciousness of the Lushai people.

Our research clearly showed us that the colonial government and the Christian missionaries' activities were often reciprocal in terms of administrative decisions. Though the Missions have their own agenda of what they intend to do in the Luhshai Hills but in order to spread the gospel or visit certain remote areas they were required to take prior approval from the British colonial government this was done so in order to maintain the law and order as well as to keep a peaceful interaction between the missionaries and the Lushais, because the Lushais could be apprehensive to their first encounter of the missionaries and their social perspective often influenced and dictated by their respective chiefs. Similarly, as the missionaries make headway into the community and cultural practices of the Lushais, the government would consult the missionaries for their advice and suggestions before implementing a new policy or legislation in our case compulsory vaccination, so as to avoid offending the Lushai people and to maintain a harmonious administration. Vaccination was a huge task performed by the government in the initial years of its introduction we saw that the Lushais showed apprehensions towards it and were insensitive to its importance because they have not face a huge death toll or an epidemic form of smallpox. Gradually this perception was changed and by the first decade of the twentieth century we saw that the Lushais were not only receptive rather western medicine and healthcare almost completely replaced the traditional healing

practices such as sacrificial rituals and ceremonies to cast out a person illness. The colonial healthcare services in the form of dispensaries and disbursement of medicines was received positively and possibly embraced by the Lushais by the second decade of the twentieth century. However, the considerable increase reported in the number of Lushai attendance to the hospitals and that the Mizos were casting off their prejudice and appreciating the benefits of English system of treatment is arguable. Because these are government reports and there is no vigilance by an autonomous organisation to counter check these figures although these figures are to some extent true but are prone to excessive exaggeration. One reason being that the maximum numbers of patients admitted in the Aijal dispensary were imported coolies and imported government agents not Lushais. Thus, we saw tremendous change in perspective and attitude of the Lushais towards the western medicine which had much to do with the activities of the missionaries in inculcating modern medicinal and health care practices.

If we are to analyse and see in retrospect of the people's response to the government measures to tackle and curb epidemic diseases that have been mentioned, it is imperative that we take note of the western medicines dominion over the indigenous medicinal practice at the pan India level. This includes the small Lushai Hills district, and their practice of traditional remedial measures of curing certain illness being curtailed. This was made only possible through political apparatus in the form of surveying and compulsory vaccination. Besides this, the actions and manner of providing health care services during epidemics was inhumane especially in the mainland India. It created aversions in the consciousness of the people, and this led to circulation of rumours and suspicions amongst the people, against the medicines and vaccines being used by the British Colonial State. The rumours circulating were similar to the ones circulating just before the Revolt of 1857 about the chapatti being passed on during midnight, the rumours stemmed out of the fear and uninformed predicament of the people. Contrary to this, the British thought that they were performing a benevolent deed. It was because of these incidents, that the initial years of the State sponsored remedial health care and services during epidemics were not received positively by the people. In the Lushai Hills too, the Lushais were apprehensive to the missionaries themselves not only their medicine, but their preaching of a new creator was not very appealing during the initial years. However, their deeds and benevolent sacrifice paved a way for the gospel as well as the western medicine, but this would not have been possible without the helping hand of the Colonial State in the form of dispensaries and vaccination campaigns.

**Findings:**

After much consideration of the available sources of both primary and secondary sources we witnessed the complex embodiment of epidemic diseases across social structure and community in the Lushai Hills. During the initial years of contact between the Lushais and the colonial government and missionaries we saw that the state of the Lushais was evidently traditional and their culture was rigidly practiced. The concept and practice of hygiene according to the western standard was the least and minimal amongst the Lushais. And the Lushais rarely bath and wash themselves, one of the possible reasons being that the village springs were usually a mile away and it was not possible to constantly wash themselves. Despite this the Lushais were comparatively healthy and were conscious of contagious diseases through water borne diseases and air borne diseases as well. We have seen that cholera could very well be colonial phenomena as we have argued in the preceding chapters, but the very name of cholera in Mizo is *"Tui Hri"* literally means water borne disease. The village springs were always maintained under strict regulation from the village Chief and no one was permitted to wash themselves and animal intestines at the site of the village spring, if it was suspected of being polluted or contaminated by some diseases then a move to find a new location was immediately made. Similarly during the pre colonial period *"hridai theu"* or 'quarantining the village' was implemented by the Chief in order to safeguard the village community from air borne diseases. But when the Lushais are confounded by an unknown disease possibly cholera they abandon the sick or disease afflicted victims and they move to the forests and built a new hut settlement to live. Such practices were also followed by the Lushai warriors, upon returning from the borderland raids to the plains if they contract an unknown disease they commit suicide rather than returning to their villages and transmitting the disease to his fellow Lushais.

The initial reaction of the Lushais in receiving the medical care from the colonial government and the missionaries was fear and apprehensions. Their curiosity was filled with fascination for the western medicine when consumed. Vaccination was feared to the extent that the Mizo term *"ban zai"* was synonymous with vaccination in the initial years. The medicine pills were consumed as a supplement to their sacrificial rituals.

Their perceived acknowledgement of sickness and their indigenous traditional belief system underwent a transformation from the dawning of the British colonial government and missionaries as well, who then assert their act of coercion with benevolent undertone. An

argument could be made where the reaction or response of the British in dealing with the epidemics can be said to be in two folds. The interests of the British colonial government was to subside and control the outbreaks of epidemics in different villages in the Lushai Hills district as well as the whole of the Assam Province, mention must be of this since most of the regulative measures regarding vaccinations and appointment of vaccinators came from Shillong the capital of the Assam Province. Many epidemic diseases like Kala azar or Beriberi which caused a huge number of deaths in the Assam Valley Districts like Sibsagar and Garo hills district were minimal in the case of Lushai Hills district. The colonial government opened a number of dispensaries in the Lushai Hills as early as 1895 at Aijal, Lunglei, in 1897 at Sairang and Kolasib. Vaccinations had already been given to the Mizos by this time. On the other hand, the missionaries focussed in the treatment of the sick with their own medicines in the form of pills which were disbursed with prayers and preaching of the Gospel in any form possible. The missionaries in turn paved the way for the government by spreading health awareness and setting an example through their benevolent gesture and gaining trust of the indigenous Mizos. The government gave priority to coercive vaccinations to make their compulsory vaccination campaign under Epidemic Disease Act of 1897 a success. Initially vaccination was viewed with suspicion and the vernacular nomenclature for vaccination- *ban zai* also failed to convey an assuring and confident opinion about it. We saw incidents of children literally running away at the sight of the government vaccinators. And the missionaries too faced persecution from the village chiefs and were ridiculed by the parents of the youth who gave themselves to Christianity. In the initial period it was a difficult task for the government as well as the missionaries. Gradually, the number of vaccinations increased and more dispensaries were opened, the dispensary at Aijal and Lunglei were then upgraded in to Station Hospitals.

Due to the late access or governance of the British government and scarce population we do not see the separation of the residential complexes between the indigenous people and the British officials in the case of Lushai Hills as it did in northern India. The missionaries roamed from village to village praying for the sick and providing them medicine, and preaching the gospel. They even entered remote villages where the administration of the government was least and sometimes entirely absent. From the interaction of the missionaries and the indigenous people we saw an emergence of change and transformation in the cultural and traditional practice of the Mizos, a peculiar blend of traditional belief system along with

the Christian beliefs, and the sacrificial and protective amulets substituted by the medicine pills of the missionaries since the medicines were co-opted as a protection from evil spirits.

The Mizo name for western medicine, *damdawi* which is literally a combination of two contradictory words *dam*, translated as 'good health' and *dawi* 'magic'; a combination of two contradictory words in terms of their usages due to the fact that *dawi* although it means 'magic' but it has a sinister undertone which could rather be 'to cast a spell' or to cause harm on someone through the use of witchcraft where as *dam* indicates either good health or safe from harm. Since, the Lushais before Christianity arrived they were practicing ritualistic ceremonies to ward of sickness and simultaneously throughout Mizo history the practice of *dawi* on someone was quite commonly practice in case of envy and rivalry. Therefore, to the Lushai or to the Mizo western medicine was perceived through their specific cultural lens, thus, the word *damdawi* gained popular acceptance or usage where it convey the blending of traditional ritualistic healing and it is not certain whether the term came to be used prior to the arrival of the western medicine or after. These activities were still functional alongside the intermittent government vaccination programmes. The blend of the believe system or rather the transition of their belief in the creator referred to as *Pathian* resonated in the God preached by the missionaries. God and healing associated strongly in the Christian Lushai mind. The tradition of sacrifice and feasting of the gayal was infused with Christianity of the Mizos but the sacrificial part is done away with. Along with this, traditional music instrument the drum was also incorporated with the newly acquired religion. The precise rational of this cultural transformation is difficult to measure, we can only analyse the cultural transition through historical sources. Along with the arrival of the British colonial government we saw diseases which were unknown to the Lushais due to this reason the immunity of the Lushais were compromised. Even disease like smallpox which was known to them, took the epidemic form only after the arrival of the British colonial government. Thus, to acknowledge themselves with the knowledge to cure for such epidemic outbreak was impossible and this very gap of not knowing how to deal with the diseases in the epidemic form was filled by the colonial government and missionary's medicines and vaccines.

It is important to note that the basis of the research topic or the time frame of the research from where the research began, the documents available is mainly the account of the British colonial agents. Who actively participated in the Lushai Expedition of 1871 and have documented their experience and observations about the Mizos. They were the indispensable administrative apparatus of the British colonial government, and their observations are bound

by their interest and loyalty to the British government. And reading the textual sources of the accounts of the government agents, also the missionaries and the vernacular texts we could say that there is not a definite concluding evidence to say that Lushai Hills is a disease infested region, and the proportion of cholera deaths was far higher among the white men than the Indians within the British army. The economic interests of the British colonial government knows no boundary, the extent to which the British colonial government was capable of exploiting the man power is emphasised in the preceeding chapters where the colonial government records the number of insane persons, this was done in order to classify their level of insanity and whether they would be eligible to work as 'productive' impressed coolies.

Looking from the Lushai perspective we could see how complex the interaction of medical and religious institutions could result into. One of the cultures that was dominant in all aspects across the world, the western culture that is very inclusive when encountered with other cultures contrary to their culture that of the Lushais being an exclusive one, where interaction with other culture was extremely rare and even with the neighbouring tribe their culture could vary extensively. This research reveals that the so called 'Imperial hegemony' is coupled with strings and branches of their dominance on its subjects and culture governed, medical hegemony being one of them and which could be said to have taken place in the Lushai Hills district replacing the medicine man or the *bawlpu* as much as it did the traditional medical practitioners like the smallpox inoculators in the wider Indian context. We saw the need to critically assess the assumption we had of the missionaries and their civilizing mission, although the sheer belief gesture and action of the indigenous people would be difficult to evaluate. To see it in a wider context, it is the replacement of the so called primitive and superstitious culture by the western progressive notion of science and belief system. Like all transitional phase the Lushais had to do away with their centuries old sacrifice and ritualistic ceremonies, in the course of this the profession of the *bawlpu* was completely obliterated.

The vast body of primary sources preserved in the archive have been utilised by scholars across the world. Though military may be used at the definite and ultimate means to control the colonised subjects but we should keep in mind how bureaucratic the British administrative system was structured.

As a result of this the colonial archive have been extensively researched and mined across the world by scholars of various discipline. Like their imperial contemporaries Christian missionaries were the product of European intellectual milieu and were ultimately answerable to an authority resident in a European centre. However, the missionaries enjoyed quite a considerable amount of autonomy from the centre just like the administrators as a result many decisions were taken up by them and they also in the process acquired quite a considerable amount of knowledge about the culture and the people.

Missionaries were the contemporary and products of colonialism and both are always closely associated by the intellectual discourse. But the missionaries were not always in agreement with the functions and administrative decisions of the Imperial authority, often they objected to Colonialism itself. And the colonial authority also does not always authorise the missionaries to venture in certain regions due to fear of disrupting the social harmony.

The overall perspective that could be put forward is that the Lushai Hills was caught in the midst of the British colonial expansion where modernism was introduced in order to better equip themselves for an efficient colonial administration of generating revenue and imposing their cultural values on the subjects governed. This in turn transformed the Lushai people and their cultural practices.

Therefore, it is in this light of sources and evidences that the research is conducted. An attempt to read and analyse the available sources and to arrive at an impartial reconstruction of the topic is made.

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