JHSR Journal of Historical Studies and ResearchISSN:2583-0198
Volume 5, Number 3 (September - December,2025),PP.212-220.
Open Access, Peer-reviewed, Refereed Journal
Website:www.jhsr.in
Email:jhsr.editor@gmail

Historical Roots of Inequality in Plantation Health care in Darjeeling: An Enquiry

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Abstract:*This paper traces the evolution of public healthcare systems in Bengal across the colonial and postcolonial periods, highlighting the stark contrast between Calcutta and the Darjeeling hills. In colonial Calcutta, public health operated as an instrument of governance, with British perceptions of disease and urban order shaping policy interventions. This resulted in the establishment of segregated hospitals and regulations that institutionalized racial hierarchies in medical access. In plantation regions, health initiatives were severely uneven, with resources concentrated on European troops and residents. Sanatoria such as Eden and Lowis Jubilee served as spaces of medicalized leisure for colonizers, while Indian populations received minimal and inadequate provisions. Rural communities continued to rely on culturally embedded traditional healing systems, including herbalists (Vaidyas, Amchis) and spiritual healers (dhami-jhankri, phedangbas), which remained central to their health practices. After independence, the state attempted to integrate these indigenous systems through the AYUSH initiative to strengthen public health. However, in under-resourced areas such as the tea plantations, AYUSH often functions as an insufficient substitute for absent primary healthcare infrastructure rather than as a complementary system. This historical perspective reveals the enduring inequalities in healthcare, shaped by the complex interplay of colonial legacies, traditional knowledge, and postcolonial policy shortcomings.*

Keywords*:Bengal, British, Colonial, Deconstruction, Municipal, Public Health etc.*

Date of Submission: 29.09.2025 **Date of Acceptance: 05.10.2025**

Introduction

British perceptions of Calcutta underwent a significant shift from the early 19th century, when from being described as an oasis of Western calm set amidst tropical beauty, Calcutta

began to be associated with unpredictable weather and epidemic disease. The cholera outbreak in lower Bengal in 1817 deepened the shadow over the city, and a contrasting depiction of the disappointment of visitors to Bengal in the 1840s was offered by the missionary James Kennedy, who wrote of visitors having to approach Calcutta through malarial swamps and impenetrable jungle along the river Hooghly, where many succumbed to marsh fever, or to the arrival of cholera when many more fell to this new tropical disease .[1]

The expansion of the mercantilist government from its Calcutta base invested it with the concerns of becoming a colonial state. The growing discourses on public health were prominently addressed by S.W. Goode's 1916 account of Municipal Calcutta detailing the history of the city's waterworks & sewers, road-building, slum clearance and electrification, etc. Focusing more on the 19th century, Choudhuri (1973) examined the evolution of municipal governance against the rise of nationalism in Bengal, exposing the race and class biases deep-seated within municipal development. Both works presupposed the existence of a 'public' sphere whose 'health' concerns needed to be addressed.[2]

Harrison (1994) explored how the politics of public health in India evolved in conjunction with the spread of Western medical practice. The reformist character of colonialism in India, brought about the focus on 'public health' that built upon the themes of reforms, improvement and public good. Deconstruction of the reasons advanced for the limited outreach of public health revealed inner imperatives of colonial authority, ideology and rule by consensus. Precepts like public health and public good thus proved attractive to the Indian elites that had implicitly absorbed these precepts, helping to create general acceptance for the concept of colonial modernity.[3]

While the bourgeois public sphere has been defined philosophically in Habermas (1989) as the realm created by the opinions professed by the 'reasoning public', historians instead describe the public sphere as being created when the authority of the colonial state gradually extends over the urban sections of the population towards whom state action is directed, and whose informed consent is sought and negotiated[4]. Thomas Metcalf described the realm of the public sphere as codified by colonial law in India, as drawing upon an authoritarian version of utilitarianism used to justify the implementation of colonial education, public works and public health policies by the colonial state.[5] While the development of a highly restrictive and regulated 'protopolitical' public sphere in colonial India had been alluded to in Kaviraj (1997), the governmentality of state action in introducing

public sanitation was explored in India and Sri Lanka by Prakash (1999) and Wickramasinghe (2015), where 'backward' sections of the native population were deemed incapable of self-regulation.

Interlinkage between hygiene and public health, theorised in Foucault (1977) as part of the Foucauldian discourse on 18th century Europe, was reinvoked again in 19th century approaches to public health in India, where the tropical climate further amplified the threat of epidemic disease. Public health in colonial Calcutta covered a wide range of municipally-regulated activities that were administered by European mercantile interests and citizen's committees set up at the instance of the colonial government in order to formulate public policy. A significant municipal initiative involved the setting up of hospitals, attesting to the gradual dominance of Western medical practice in colonial healthcare policy. In Calcutta, commencing from the late 18th century, colonial authorities established a General Hospital & Sanatorium, a Police Hospital established in 1789, a Lunatic Asylum and Leper Asylum, as well as a Native Hospital established in 1794 with partial support from Government funds. Colonial healthcare was however designed to provide segregated public healthcare. Thus, the General Hospital and Lunatic Asylum catered exclusively to Europeans, while the Police & Native Hospitals catered to different classes among the Indian public, including the labouring classes, as well as destitutes.

While Foucault had observed that public healthcare policy in Europe was not limited solely to regulation of the labouring classes, the economic motives behind public healthcare regulation became much more evident in colonial India. European doctors at the Police and Native hospitals in Calcutta emphasised the need for state regulation of labour, and the need for new 'Fever' hospitals catering to a better class of natives to combat the spread of epidemic disease.[6]

Historical Healthcare Challenge in Plantation Regions

Macfarlane (2003) and Rappaport (2017) described tea alternately as a symbol of 'civilization and free trade' and as 'central to British cultural identity'. The close colonial association of Darjeeling, after its 1835 acquisition from Sikkim, with subsequent British commercial interest in the growth of tea cultivation, commenced after the first British Superintendent of the territory Dr. Archibald Campbell had successfully planted out the original tea bushes

smuggled in from China. By 1856, several private tea companies had begun to invest in the region, and smaller private estates were already operating. Original Chinese tea-masters had also been brought to transfer their knowledge tea-making, and the first tea-processing factories had been established.

While colonial medicine tended to prioritise the health of troops, the rural populations tended to remain neglected. After initial establishment as a sanatorium town, limited accommodation for Indian patients was offered separately at Lowis Jubilee Sanatorium, and the clinic at Victoria Memorial Dispensary served European and local Indian patients. The much larger rural communities were served traditional practitioners who conducted magical ritual treatments. Even today, tea regions in Darjeeling still exhibit these pre-modern tendencies. With plantation employment remaining family-based, tea-workers today are mostly descendants of the original tea-workers.

The evolution of colonial public health services in India has been explored at length from the advent of Crown rule up till the commencement of the World War I in Harrison (1994). Incorporation of this thematic approach into conventional history reveals the extent of social and political nuances that had influenced the development of public healthcare. Besides negotiating the internal dynamics within the Indian Medical Service (IMS), colonial medical services also had to cope with relative differences in educational and social status, that influenced the professional landscapes, the intricacies in registration acts, as well as differences between the presidency and sanitary services

The choice of period also allowed facts to emerge about the nature of changes that occurred in European perceptions about Indian lifestyles in the aftermath of the 1857 rebellion, which resulted in severe fallouts for tropical public hygiene, disease theory and preventive medicine. Scrutiny of public health policy also reveals the colonial balancing act that played out between the public health needs of European and Indian populations, and the nuanced colonial interventions made during epidemic disease, which gradually empowered local bodies in shaping public health in colonial India.[7]

Evolution of Public Healthcare in Darjeeling

While early British writing had been enthusiastic about Darjeeling, the Terai regions along the base of the hills was feared as the ‘Home of Fevers’ because of very high rates of

morbidity and mortality from malaria. Meanwhile, as a 'sanatorium town', Darjeeling was known to trigger the speedy recovery of well-being by all Europeans, although surges of diarrhoea aka the 'hill complaint' were known to hit Europeans in the hills. Long-term hill residents were known to suffer from contamination in the water supply. But Darjeeling also periodically experienced serious health issues on account of outbreaks of major communicable diseases that came to be seen as healthcare challenges.

Sanatoria for Europeans an Indians

Although establishment of a British sanatorium had been advanced as the principal reason for seeking the gift of Darjeeling as a Grant from the Sikkim Rajah in 1835, the physical establishment of the sanatorium occurred only after Darjeeling had evolved the initial infrastructure of British hill station, including railway communications. Built to an architectural plan of M. Martin at a cost of Rs.20 lakh to the Bengal Government, Eden Sanatorium for convalescent Europeans was inaugurated in 1882 by then Bengal Governor, Sir Ashley Eden (Dozey, 1935*:* 88). As a convalescent-care facility, it mirrored European social life in Darjeeling, drawing in patients from multiple quarters, establishing a unique space for medicalised healthcare and leisure for the European social enclave.

Lowis Jubilee Sanatorium was inaugurated for Indian convalescents at the initiative of Mr. E. E. Lowis, Divisional Commissioner of Rajshahi, on land gifted by the Maharaja of Coochbehar, and a donation of Rs.90,000 by the Maharaja of Rangpur, celebrating the Golden Jubilee of Queen Victoria in 1887. Accommodations were available for richer Indians without homes in Darjeeling to visit maintain their ritual prohibitions in visiting Darjeeling. Separate accommodation was provided at the Sanatorium to orthodox Hindus with diet restrictions, and General individuals with no caste biases. Reservations were available for female patients too, as well as for free beds.[8]

Clinics and Dispensaries

Victoria Memorial Dispensary started out as a charitable hospital & dispensary under Darjeeling Municipality. With 45 beds, a hospital-cottage, an infectious diseases hospital and an operating room. the health facility was treating over 10,000 patients and conducting 389 operations annually by 1905. More than a century later, the public healthcare infrastructure in

Darjeeling has not kept pace with the urban population served. Then, although Eden Hospital was upgraded to a District Hospital in 2002, there are fewer beds than there should be at a district public hospital. Though private nursing homes have been constructed, mainly in the plains around Siliguri, the Darjeeling hill region which now comprises the two districts of Darjeeling and Kalimpong is badly underserved by public. The health situation of the poor plantation population remains as vulnerable to morbidity as it did 170 years ago, when the plantations were planted. The principles of social justice remain unrealised. The rural people in the hills have to depend on their own traditional healthcare systems. [9]

Cultural & Spiritual Healing Practice in Darjeeling

By the definition adopted in 1976 by the World Health Organisation (WHO), traditional healers are identified as being skilled in offering healthcare services thar aligned with the social, cultural, and religious mores of their community. Using techniques grounded in the knowledge and beliefs held by the community, they wholistically address the causes of diseases and disabilities, lowering the costs paid in terms of losses of knowledge. As untrained healthcare providers, traditional healers provide services based on traditional knowledge and experience. 'Native physicians' were instrumental in dealing with regional diseases. The dominance, that British-trained doctors came much later.

The Nature Healers

These herbal healers include *Vaidyas* (informal Ayurveda herbalists), *Amchi* (informal practitioers of *Sowa-Rigpa* or Tibetan medicine), and Hakims (informal practitioners of Arabic or *Unani* medicine), who relied solely on treating various health issues using medicinal plants. [10]Without formal qualifications, and lacking formal certificates or degrees, they learnt and practised their trade through private means like their family or *guru* traditions. The practitioners, some even specialised in treating ailments like jaundice or bone-fractures, exclusively used medicinal plants, minerals and products of animal origin like *ghee*, sometimes even selling compounded herbal medicine for profit. They also included specialists consulted for specific treatments like bone-setting and overcoming snake bites.[11]

The Faith Healers

These were spiritual healers who employed non-material approaches to diagnosis, prevention and healing of disease, invoking unseen spiritual values and forces, some among them even

integrating composite forms of treatment including healing mantras and herbal remedies. Depending on which community they served, these practitioners were known locally by varied names like *dhami-jhankri* (shamans), *jannne-manchhe* (knowledgeable person, well-versed in herbal and faith healing), *jhar-phuke* (dispellers of malevolent evil spirits), *mata* (female healers possessed by a Goddess), *jyotish* (astrologers guiding ritual appeasements of planetary forces like *grah-shanti*), and priestly healers like *pundits*, *pujaris*, *lamas*, *gubhajus* or *guruwas* who combined their faith-healing with priestly duties). [12]

Shamans, known as *Phedangbas* to the Limbu people, conduct worship through their own specific observances and rituals. Although the details of these may vary depending on the occasion, they generally involve chants, invocations, and mesmeric action. The *Phedangbas* also use their traditional chants and invocations to connect with the divine to seek special blessings on the individuals or communities to whom they are providing the health service. Traditional ritual instruments like drums and bells may be used during certain worship rituals to create an atmosphere deemed conducive to this spiritual connection. Offerings are also made of food & drink, and symbolic presentation items gifted as a gesture of respect and gratitude to the divine entities. These offerings are then shared with the community that participated in the ritual.[13]

AYUSH in Darjeeling

Collectively defining six traditional systems of medicine found in wide use across many regions within India, AYUSH (denoting the traditional healthcare systems of Ayurveda, Yoga, Naturopathy, Unani, Siddha & Homeopathy} has been the acronym adopted since 1995 collectively replacing the older Department of Indian System of Medicine. The renaming also announced the intention of the Health Ministry to promote simultaneous development within multiple alternative medicine systems, to foster a better balance between modern allopathic medicine and traditional systems of healthcare. Launched a decade later, the National Rural Health Mission (NRHM) marked new health policy revisions that made a significant push towards AYUSH in public healthcare, integrating the AYUSH workforce, therapeutics and medicinal principles into all formulations of public policy. NRHM's 2006 implementation statement thus emphasized the mainstreaming of AYUSH and the revitalisation of local health traditions as being the twin cornerstones of the new Health Policy. [14]

The current approach today aims at expanding the choice of medical treatments available to patients, by enhancing the multiple functionalities of existing health facilities, strengthening the country-wide implementation of national health programs. Integration of AYUSH principles has since been taking place at multiple levels across Indian states, enabling them also to draw upon untapped personnel reserves and therapeutic approaches in extending healthcare to the community

Under the AYUSH group, two National AYUSH Institutes presently serve and administer the training needs of public healthcare within West Bengal. These are the National Institute of Homoeopathy and the National Research Institute of Ayurvedic Drug Development, both located at Salt Lake City, Kolkata.

In addition, there are also 11 Homeopathic Colleges (4 run by the state & 7 privately), 4 Ayurvedic Pharmacy Colleges (3 run by the state & 2 privately), as well as 1 private College & Hospital of Unani Tibb. Another private institution identified as Chagpori Tibetan Medical Institute, offers rigorous training in the practice of the *Sowa Rigpa* system of Tibetan *(Amchi)* Medicine, Darjeeling, with its pharmacy for Amchi medicines located close by at Salugara near Siliguri. *Sowa Rigpa* is the latest traditional system of medicine to be recognised recently as an approved traditional AYUSH system of medicine and treatment identified in the country.

The launch of NRHM in India since 1995 has strongly repositioned the perception of AYUSH within the country's health priorities. But it is one thing to imagine that AYUSH offers strong public health infrastructural support to a well-staffed and well-equipped primary healthcare system, and quite another to have AYUSH-equipped services filling in for what is essentially an under-funded and ill-equipped primary healthcare system. In the case of tea plantations across Bengal and Assam in Eastern & Northeastern India, the latter seems to be the case.

Conclusion

In colonial Calcutta, public health operated as an instrument of governance, with British perceptions of disease and urban order shaping policy interventions. This resulted in the establishment of segregated hospitals and regulations that institutionalized racial hierarchies in medical access. In plantation regions, health initiatives were severely uneven, with resources concentrated on European troops and residents. Sanatoria such as Eden and Lowis Jubilee served as spaces of medicalized leisure for colonizers, while Indian populations

received minimal and inadequate provisions. Rural communities continued to rely on culturally embedded traditional healing systems, including herbalists (Vaidyas, Amchis) and spiritual healers (dhami-jhankri, phedangbas), which remained central to their health practices. After independence, the state attempted to integrate these indigenous systems through the AYUSH initiative to strengthen public health.

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