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The Jurisprudence of Aversion: The Lepers Act and the Regulation of the 'Aesthetic Nuisance' in Colonial India

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Abstract

This paper examines the legal and social regulation of leprosy in colonial India, focusing primarily on the Lepers Act of 1898 as a key instrument of state control. It argues that the colonial response was shaped less by clinical understandings of the disease and more by what may be described as a 'jurisprudence of aversion', a legal logic concerned with managing the visible presence of diseased bodies in public space. By tracing the shift from hereditary to contagion-based theories of leprosy, the paper shows how the figure of the 'pauper leper' emerged as a primary target of regulation. This process was closely tied to efforts at spatial ordering and sanitation, aimed at maintaining the visual order and normative appearance of the colonial urban environment. In this sense, the regulation of leprosy was not only a matter of public health but also of governing how the city was seen and experienced. The paper further introduces a previously underexamined 1944 legislative proposal from Sind concerning the compulsory sterilisation of persons with leprosy marking an important shift from strategies of spatial segregation toward a more bio-political form of governance, focused on regulating reproduction and the future composition of the population. Furthermore, this proposal targeted the geopolitical regulation of inter-state migration.

Keywords: Lepers Act of 1898, Colonial India, Pauper Leper, 1944 Sind Proposal, Leprosy Commission (1890-91)

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I. Introduction

The colonial legal regime in India was persistently anxious about mobile and unsettled populations that escaped effective surveillance particularly after the rebellion of 1857. The administrative concerns ranged from threat of future rebellion to the health of European troops without provoking a backlash from the general populace (Harrison, 1994). They preferred a *civis* i.e. someone whose home does not move. In the early modern period, colonies were established by sending people to settle and plant (Edmond, 2006, p.178). By the late nineteenth century, this apprehension came to focus on people suffering from leprosy, especially pauper lepers who became tainted as figures of moral and social unease. While scholars such as Jane Buckingham and Sanjiv Kakkar have highlighted the exclusionary nature of legislations pertaining to leprosy, this paper attempts to shift the focus to the role of sensory aversion as a catalyst for shaping these laws by arguing that the Lepers Act of 1898 and the 1944 Sind proposal mandating compulsory registration and sterilisation functioned not simply as a public health measure but as a mechanism of spatial ordering intended to regulate the visible presence of diseased bodies in public spaces like bazaars and pilgrimage sites. By prioritising what were effectively visual considerations over precise medical knowledge, the colonial state reinforced a class-based distinction between the ‘respectable’ non-pauper and the vagrant, whose presence was seen to disrupt the ordered appearance of the colonial city. In framing sensory aversion as a key catalyst, this paper does not suggest that public health policy operated in a fiscal vacuum. Rather, it argues that while sensory revulsion provided the primary ideological impetus for legal containment, administrative limits such as police reluctance to physically handle diseased bodies and state budget constraints dictated its selective, pragmatic, and outsourced implementation. This paper examines specific moments in which law, medicine, and visual regulation intersected to produce a distinct form of colonial governmentality.

Note on terminology. The term “leper” is used throughout this paper to reflect the terminology employed in colonial legislation and archival sources. Contemporary scholarship generally prefers the person-first expression “people with leprosy”; however, the historical term is retained where appropriate to preserve the language and categories of the period under study.

II. Cultural Symbolism of Disease

Since the Middle Ages, disease has been perceived as something mysterious and morally transgressive. Leprosy has particularly been at the receiving end of this burden as compared to other diseases such as insanity, syphilis and tuberculosis as it has remained static in the way it has been understood (Gussow, 1989). The sheer visibility of physical deformities makes a strong case for this perception

as it paves the way for social judgment and as I shall later demonstrate, brings it under the radar of the state.

As Michel Foucault observed, the historical structure of leprosy segregation persisted long after the disease receded, establishing a cultural and institutional blueprint for confining non-productive or marginal populations (Foucault, 1988).

III. Shifting State Perspectives and the Prelude to the 1898 Lepers Act

Leprosy is a bacterial infection caused by *Mycobacterium leprae*, an organism closely related to the tuberculosis bacterium. Unlike tuberculosis, leprosy is difficult to contract and is rarely fatal. The exact mechanisms for the transmission of leprosy are still unknown, though it is believed that while bacteria can be discharged through leprous ulcers, the principal mode of transmission is by coughing and sneezing. Contrary to the popular belief, leprosy is neither sexually nor hereditarily transmissible. It can be treated with modern day cures such as multi-drug therapy (Buckingham, 2002).

Medical understandings of leprosy remained uncertain throughout the nineteenth and early twentieth centuries, as authorities struggled to define and manage the disease. While its existence was unquestioned, there was no consensus on its treatment, and leprosy functioned more as a cultural label than a clearly defined medical condition (Moran, 2007). By the late nineteenth century, India was believed to have a large leprosy population (Gussow & Tracy, 1970), though reliable data was unavailable before the first Indian census of 1872. The census introduced the category of 'infirmity', grouping leprosy alongside conditions such as blindness, deaf-mutism and insanity (Das, 2025). Yet these figures were often manipulated. In 1891, for instance, leprosy figures in Bengal were deliberately inflated to generate fears of social degeneration and justify segregation. Reflecting these inaccuracies, the Indian Leprosy Commission (1890–91) found that 9.5% of those classified as lepers actually suffered from other diseases with similar visible symptoms, with poor and lower-caste communities being most vulnerable to misclassification (Das, 2020).

The Leprosy Commission Report (1891) concluded that leprosy was neither hereditarily transmissible nor contagious, finding no correlation between population density and disease prevalence. Since it did not constitute an 'imperial danger', the Commission regarded compulsory segregation as an excessive measure and criticised the economic restrictions imposed on pauper lepers (Leprosy Commission in India, 1893). Yet this position was rapidly overturned. The 1897 Berlin International Leprosy Conference declared leprosy to be contagious and endorsed compulsory isolation as the appropriate global response. Although Dr. Phineas S. Abraham, representing the British National Leprosy

Fund, questioned the practicality of strict segregation arguing that it encouraged concealment and was unworkable across India's vast geography, the conference nevertheless established isolation as international orthodoxy. Meanwhile, the Royal College of Physicians (RCP) gradually retreated from its own 1867 Report. A significant turning point was the death of Father Damien of Molokai in 1889, which undermined assumptions about European immunity and shifted authority over the debate from the RCP to the Damien Memorial Committee (later the National Leprosy Fund). Following the Berlin Conference, the Colonial Office sought a definitive statement from the RCP, culminating in the 1898 Leprosy Committee Report, which formally repudiated the 1867 conclusions and declared the communicability of leprosy to be "an established fact," with no evidence that the disease spread by any other means (Edmond, 2006).

IV. Act III of 1898 (Lepers Act)

This section shall analyse in detail the 1898 Lepers Act enacted by the Governor-General of India in Council on February 4, 1898 (Lepers Act, 1898).

The preamble of the Act explicitly outlined a mandate to "provide for the segregation and medical treatment of pauper lepers" (Lepers Act 1898, Preamble). While pan-Indian in its territorial scope, Section 1(3) decentralised its execution investing local governments with discretionary powers to implement or halt the mandate. Hence, it targeted primarily the economically vulnerable victims (paupers) of leprosy while also bypassing critical clinical metrics, defining a "leper" through a visible pathology i.e. "any person suffering from any variety of leprosy in whom the process of ulceration has commenced" (Lepers Act, 1898, Section 2 [1]).

The clause— "publicly solicits alms, exhibits physical deformities to excite charity, or exists at large without any ostensible means of subsistence" (Lepers Act 1898, Section 2 [2]) became the focal point and a means through which the disease was seen through the lens of public indigence. To contain this demographic, Section 3 authorised the establishment of designated leper asylums (Lepers Act, 1898). Enforcement relied heavily on surveillance; Section 6 (1) empowered police officers to arrest individuals without a warrant based on the subjective assessment that a person "appears to him to be a pauper leper" (Lepers Act, 1898).

Following arrest, individuals were subjected to binary administrative sorting at the police station under Section 7: Form A functioned as a certificate of release for those deemed non-leprous, whereas Form B formalised a diagnosis of leprosy, triggering immediate transfer to a magistrate (Lepers Act, 1898). Under Section 8(1), the magistrate could issue a Form C warrant for indefinite detention until

a Board or District Magistrate ordered a discharge (Lepers Act 1898). If an individual contested the diagnosis, the magistrate could adjourn the inquiry for clinical observation. However, under the second proviso of Section 8(1), detention could be averted only if a friend or relative executed a written bond guaranteeing proper maintenance and promising to prevent the individual from publicly begging. Conversely, Section 8(2) mandated the immediate discharge of any individual who was either non-leprous or who, despite having the disease, was “not a pauper leper” (Lepers Act 1898).

The statute further restricted the bodily and economic autonomy of afflicted individuals through various prohibitions. Under Section 9(1), lepers were barred from preparing or selling food, drink, drugs, or clothing; using public wells or tanks; and riding in public carriages other than railways (Lepers Act, 1898). The state criminalised compliance on both sides: individuals violating these prohibitions faced a fine of up to twenty rupees under Section 9(3), while Section 11 penalised members of the general public who knowingly employed a leper in these prohibited callings with a fine extending to fifty rupees (Lepers Act 1898). Under Section 10, repeat offenders faced forced expulsion from the district or compulsory asylum commitment (Lepers Act 1898).

The law embedded class-based disparities into its mechanisms of legal recourse. Section 15 restricted the statutory right to appeal medical certificates exclusively to an individual “other than a pauper leper” (Lepers Act, 1898). Furthermore, institutional release was structurally tethered to public convenience rather than clinical recovery; the Form E order of discharge signed by the Asylum Board required explicit confirmation that the inmate could be safely released “without hazard or inconvenience to the community” (Lepers Act 1898, Section 14).

Poverty and leprosy were deeply intertwined in colonial discourse. The vagrant pauper leper, being the most visible to the colonial state, became the principal target of confinement, experimentation, and institutional care. Similar associations existed in pre-colonial Hindu customary law, where impoverished lepers experienced severe social and religious exclusion. Colonial officials typically imagined the leprosy sufferer as Indian or Eurasian, male, poor, and itinerant. Although poverty was not considered the direct cause of leprosy, medical officers associated it with the disease through notions of ‘filthy habits’ and ‘debauchery’. On the other hand, wealth enabled concealment, allowing affluent sufferers to avoid both enumeration and institutionalisation. Officials too acknowledged that compulsory segregation of the wealthy would be socially unacceptable because of the stigma attached to the disease (Buckingham, 2002).

The colonial census functioned as a means of “knowing” India (Cohn, 1996). As noted earlier regarding the deliberate inflation of 1891 figures in Bengal, census data suggested a higher prevalence

of leprosy among lower castes, though this was distorted by differential concealment (Das, 2020). However, regional variation appears to have been more significant than caste. Occupational statistics identified agricultural labourers, village menials, and hill tribes as the most affected, while beggars and vagrants despite being the most visible were often undercounted. At the same time, moral assumptions linking leprosy with sexual immorality persisted despite medical evidence to the contrary. Pauper lepers were represented as ‘wretched beggars’ and ‘eyesores,’ justifying proposals empowering the police to remove them from public spaces.

Their arrest reflected the broader colonial assumption that poverty itself bordered on criminality. Although some provisions even restricted access to public water, enforcement remained inconsistent. Many patients entered institutions voluntarily and departed once symptoms improved. Consequently, the legislation failed both to control leprosy and regulate vagrancy (Buckingham, 2002). Rather, criminalisation and institutionalisation hardened social stigma and further alienated sufferers from society (Krishna, 2012).

This interpretation requires further scrutiny in light of the realities faced by poor people with leprosy. If a pauper leper was defined by the absence of visible means of subsistence, it remains unclear whether having a family would exempt someone from institutionalisation, especially when impoverished families could not realistically prevent members from begging. The Act also overlooks the impracticality of a family in poverty supporting one member in private shelter while the rest lived on the streets. Moreover, its provision allowing individuals to deny allegations of leprosy raises questions about diagnosis. If someone suffered from another contagious disease, the Act’s lack of medical precision suggests they could still be excluded by the legal system. Leper asylums were often feared because begging remained an essential means of subsistence, particularly during festivals and pilgrimages (Kakkar, 1996).

The Act’s reliance on visible ulceration as a defining criterion ignored lesions concealed within the nasal passages, throat, or mouth, demonstrating that perceptibility, rather than pathology, determined state intervention. Police were empowered to arrest anyone appearing to be a pauper leper, even though affluent sufferers frequently escaped census enumeration through concealment (Neelakantan, 2024). As Wellesley Cosby Bailey observed, many sufferers were abandoned by their families and forced to survive through begging (Gussow, 1989). The inability to heal visible sores or regulate the movement of lepers prompted the colonial state to pursue legal segregation (Das, 2025).

The economic burden imposed by the Act fell overwhelmingly upon the poor. Fines of twenty and fifty rupees under Sections 9 and 11 represented enormous sums for the colonial working classes.

Contemporary price data indicate that common rice sold for approximately three and a half rupees per maund during the late nineteenth century (Department of Statistics, 1919, p.14), making these penalties equivalent to the purchasing power of several hundred kilograms of grain. In an economy marked by recurrent subsistence crises, such fines effectively criminalised survival itself by penalising both the labour of persons with leprosy and those who employed them.

The colonial administration also recognised that universal compulsory segregation was financially impossible. Isolating even fifteen per cent of India's leprosy population was estimated to cost between thirty and forty lakh rupees annually. Consequently, responsibility for constructing and administering leper asylums was increasingly transferred to Christian missionary organisations, allowing the colonial state to reduce the fiscal burden of institutional segregation while retaining its broader policy objectives (Das, 2025). This transfer of asylum management to Christian missionaries demonstrates the manner in which fiscal pragmatism shaped the execution of sensory governance. Unable to finance universal spatial removal, the state offloaded the economic burden onto religious organisations, ensuring that the visual threat of the pauper leper was managed without draining imperial coffers.

V. Visual Order and Urban Space: Policing Infirm Bodies in Colonial Cities

The analysis of the Act in the preceding sections demonstrates that repulsion was the dominant response to leprosy. I argue, however, that this individual sentiment evolved into a broader administrative concern as the presence of the leper disrupted the colonial vision of a modern, orderly city. Accordingly, this section shall examine the correspondence of colonial officials alongside legislative enactments and administrative orders to show how sensory aversion in public spaces became the primary catalyst for state intervention.

H.P. Wright, a nineteenth-century British commentator whose writings on disease and segregation actively framed central debates on colonial health policy in India (Staples, 2024), articulated the moral and visual imperatives behind spatial control. Writing on the regulation of leprosy, Wright argued that it was imperative "to remove from sight of, and contact with, healthy men, women, and children, the diseased and repulsive leper" (Wright, 1889). He posited that the "passive tolerance of frightful disease" was evidence of "blunted sympathies" or "reprehensible indifference" within indigenous communities, framing the visible presence of leprosy in urban spaces not merely as a medical threat, but as an "offensive and hurtful" moral and physical evil that required state intervention to establish standards of imperial hygiene (Wright, 1885, 1889). While Wright spoke as an independent commentator rather than a direct statutory authority, his arguments captured a broader colonial consensus that elevated sensory repulsion into a rationale for state-enforced spatial isolation.

Legislative developments further codified these sensory anxieties; a 1936 amendment to the statute explicitly noted that while certain vagrant lepers were “non-infectious,” they remained “no doubt unsightly & repulsive to the eye and are [a] feature of all larger urban centres.” By prioritising the visual economy of the city over clinical contagion, the amendment reinforced state containment, declaring that “the responsibility for the arrest of [the] pauper leper, who is considered to be a menace or danger to society devolves upon the local government” (Director General Indian Medical Service [DGIMS], 1936, pp. 4–5).

The Bombay government proposed an amendment modelled on Section 89 B Indian Lunacy Act, 1912 which sought to hold the local governments financially liable for the maintenance of affected individuals who had resided for five years in an adjacent province, a measure ultimately rejected due to financial strains (DGIMS, 1936). The everyday mechanics of enforcement were undermined by the police’s instinctive aversion to the arrest and physical handling of pauper lepers, resulting in a total absence of annual admissions to the Albert Victor Hospital. Bureaucratic rhetoric rationalised this enforcement failure by asserting that the poor naturally preferred a life of vagrancy, actively gravitating toward urban centres with greater municipal amenities to maximise alms collection (DGIMS, 1936). This enforcement gap reveals an inherent contradiction: the very physical revulsion that motivated the law also hindered its on-the-ground mechanics. Police officers’ visceral reluctance to physically touch and arrest leprous individuals reveals how embodied disgust disrupted statutory execution, leaving a gap between legislative ambition and practical administrative compliance.

Where containment was enforced, it took an overtly penal character, for instance; Matunga Leper Prison was heavily militarised with barbed wires and police guards. The state’s communication addressed to the Government of Burma regarding the broader “leper question” also explicitly stated that the “fear ordinarily entertained regarding them arises from aesthetic causes rather than from any accurate knowledge of the dangers of infection” (DGIMS, 1936, p. 18). The purpose of the Act was also stated to be preventive and, as such, “it is worthwhile to isolate only those pauper lepers who are infectious. The others need to be kept out of markets, fairs and crowded bazars only for the sake of protecting the public from repulsive and distressing sight. Public fear was a product of concerns about the visual order rather than accurate medical knowledge” (DGIMS, 1936, p. 93).

The British Empire Leprosy Relief Association’s New Delhi report dated 1946 stated that obvious defect in the 1898 Act is “that they do not make any distinction between the infectious and non-infectious types of leprosy. This is a very serious defect, since there is no need or justification for these restrictions to be applied to non-infectious cases, and since nearly threequarters of the cases of lep-

rosy in India are of the non - infectious type. Moreover, the provisions of the Lepers Act appear to be based on the assumption that leprosy is spread by indirect contact, through clothes, water, food, etc.; whereas we know that the most common mode of spread is direct contact between the infectious cases and healthy individuals, especially children. Again, the Lepers Act deals mostly with the problem of leper beggar, while the leper beggar does not constitute a real problem from the public health point of view; it is the leper in the general population that constitutes the real problem from this point of view” (Director General Indian Medical Service [DGIMS], 1946, p. 8). Otherness was asserted by labelling non-pauper lepers as “respectable” class who continued their employment as dhobis, cooks, teachers, lawyers etc (DGIMS, 1925, p. 9). Pauper lepers were excluded from the ‘respectable’ occupations, indicating that they could not move into the category of respectable non-paupers to begin with.

The belief that leprosy spread through indirect contact was a scientific misconception which persisted for so long as a result of institutional rivalry between the Indian Medical Service (IMS) and the Sanitary Department. The latter ultimately secured administrative control over policy making and prioritised sanitary science focusing on drainage, water supply, trade regulation etc, as opposed to germ theories or contagionist perspectives advocated by independent researchers such as H.V. Carter which were more closely related to scientific reasoning. This institutional bias ensured that leprosy was managed as a problem of environmental hygiene rather than one of clinical transmission (Buckingham, 2002).

Similarly, Bhore Committee set up by the Government in 1943 to survey the ongoing developments with regards to general health conditions in India and make future recommendations concluded that the twin problems of leprosy and mendicancy are so interrelated that it is doubtful whether the question of leprosy can be isolated and dealt with satisfactorily (Government of India, 1946).

It is through this lens, that the urban elites of Bengal advocated restraining vagrant lepers who tarnished the Victorian cityscape. They repeatedly made requests to the government to protect the public from such a sight (Das, 2025). Correspondingly, in a 1946 suggestion submitted to the DGIMS, Ganesh Vasudev Mavlankar, a prominent lawyer and a freedom fighter, expressed his displeasure at the large number of lepers at the pilgrimage sites of Rishikesh and Laxman Jhoola. Describing their appearance along the banks of the Ganges as “shocking with mutilated organs or wounds exposed to view, they were a sight which anyone would shudder to look at,” Mavlankar urged the state to enact “an all-India legislation” making institutional confinement compulsory (DGIMS, 1946, pp. 9–10). While it remains unclear whether Mavlankar’s specific communication directly moved statutory policy or remained one voice among many, its significance lies in what it reveals about elite Indian atti-

tudes. Mavlankar's petition demonstrates that sensory aversion and concerns over visual order were not merely imported colonial constructs; rather, elite Indian nationalist opinion actively aligned with the colonial state's logic of spatial purging. By dismissing traditional almsgiving as "misplaced charity" and prioritising the visual discomfort of the observer over the lived suffering of the patient, Mavlankar presented the diseased body as a threat to the visual and spiritual sanctity of the landscape. In this framework, the asylum was envisioned not as a site of clinical care, but as a mechanism for total spatial erasure, hiding those deemed unsightly from the public eye, a exclusionary logic that extended even inside dispensaries, where disfigured patients were regularly kept out so as not to discourage early-stage sufferers from attending (DGIMS, 1924).

Before the enactment of the Lepers Act, the government was contemplating setting up voluntary asylums on the lines of Habitual Drunkards Act of 1879 (Home Department, 1896). By drawing a parallel between the habitual drunkard and the leper, the state consequentially blurred a crucial distinction between addiction and disease. Drinking, while often framed as a matter of individual choice, is more accurately understood as an addiction that can limit personal agency; leprosy, by contrast, is a disease entirely beyond individual control. The question of choice is therefore central to this comparison, or at least, the administrative correspondence consulted here does not explicitly address it. The eventual shift away from this voluntary 1879 model toward the compulsory segregation of the 1898 Act suggests that the state found voluntary reform insufficient for its larger goals of urban management. A drunkard might follow the path of self-reform and regain their place in the 'clean' city, but the leper's body remained a permanent visual transgression.

Historians have identified restrictions on public transport as one of the most discriminatory provisions affecting lepers. Section 71 of the Indian Railways Act prohibited them from travelling by rail on the grounds that they suffered from a "disorder," ostensibly to prevent disease transmission. Yet this prohibition was qualified. The Madras Public Health Amendment Act (1943) provided that "the owner or driver of any public conveyance may refuse to convey therein any person suffering from leprosy until he has been paid a sum sufficient to cover any loss and expense which will be incurred" (DGIMS, 1943, p. 9). The phrase "any loss and expense" remained undefined, granting transport operators broad discretion to determine both what constituted a loss and the amount payable. More significantly, the provision blurred the distinction between medical risk and social prejudice. If a person with leprosy could travel upon payment, the concern was evidently not contagion—since money could not reduce infection— but the discomfort, inconvenience, or stigma experienced by others.

The racist and exclusionary character of disease management in colonial India becomes even more

evident when responses to leprosy are situated within a broader imperial context. A memorandum by Leonard Rogers for the British Empire Leprosy Relief Association distinguished between Advanced White Dominions, such as Canada and Australia, where limited case numbers enabled routine management, and Tropical Colonies, where leprosy was portrayed as requiring extensive legislative intervention (Home Department, 1896). In settler colonies such as South Africa, segregation was explicitly racialised through the separation of White and Coloured populations (DGIMS, 1943). By contrast, in India and African colonies such as Nigeria and Kenya, the scale of the affected population made universal compulsory segregation financially impossible. Fiscal constraints therefore forced a compromise: rather than pursuing universal isolation, the colonial state concentrated on removing leprosy from crowded urban spaces through outpatient clinics and labour settlements while tolerating its presence in rural areas. Colonial medicine thus prioritised regulating the visibility and economic consequences of disease over reducing its actual mortality (Harrison, 1994).

This hierarchy also operated within patient populations themselves. In Robben Island, increasing numbers of white leprosy patients produced a racially differentiated regime of care. While Black and Coloured patients continued to be represented as dangerous and repellent, white patients were increasingly portrayed as unfortunate victims and received better rations, clothing, and opportunities for home isolation. Leprosy control therefore functioned not merely as a public health measure but as an instrument reinforcing colonial hierarchies of race and class (Edmond, 2006).

VI. Conceptualising Mobility and Marginality: The Politics of Containment

Governments have long perceived the urban poor as a volatile, “floating population” threatening the moral economy of respectable classes. Haunted by the memory of the 1857 uprising, British authorities initially exercised administrative caution, limiting intervention to keeping presidency towns like Bombay and Calcutta safe for military mobility and industrial continuity. While municipal responses varied across regions—such as the minimal intervention seen in Uttar Pradesh, the ultimate strategy across industrial nodes centred on spatial displacement. The colonial state banished the underclass to the urban outskirts to insulate commercial hubs and regulated bazars from perceived public disorder, deploying fiscal and municipal measures that condemned the economic activities of the poor as visual and sanitary blots on the urban landscape (Gooptu, 2001).

This socio-spatial policing intersected directly with the medical-legal management of the diseased body. Through the framework of colonial law, the state monitored and restricted the mobility of individuals affected by leprosy, presenting Western public health as a universal imperative to claim total dominance over the subcontinent’s medical-legal space (Das, 2025). This institutional shift fun-

damentally altered indigenous legal traditions. In traditional Sastric thought, leprosy was understood as a fluid spiritual and bodily mark of past karma that could disqualify an individual from inheritance but allowed for ritual restitution through penance (Buckingham, 1997). However, colonial administrators misread these adaptive customary codes as a rigid, universal legal system. By institutionalising Brahmanical texts within formal courts, the colonial state stripped legal categories of their ritual context, forcibly redefining the leprosy sufferer from a spiritual entity into a secular, medicalised subject (Buckingham, 1997).

During the late nineteenth century, this legal redefinition was further reinforced by the institutionalisation of ‘Tropical Medicine’. As geographic spaces like Bengal were increasingly pathologised as the natural home of parasites and insect vectors, laboratory medicine solidified the link between tropical environments and genetically distinct, partially immune “native” populations (Bhattacharya, 2012). This specialty created new avenues for imperial advancement while offering the domestic British public an optimistic narrative of containment. Crucially, this containment operated through a sensory register. Senses formed the baseline of imperial encounters, where elite anxieties were triggered by sound of bells, feel of cloth against the skin, faecal odours, and the tactile dread of corporeal boundary violation (Rotter, 2019). In this hierarchy of the sensorium, Western civilisation elevated sight as the ultimate marker of progress, relegating the poor, the unseemly, and the diseased to the lowest tier of physical and moral depravity (Rotter, 2019). Finally, this sensory revulsion was intellectualised through the European discourse of “degeneration.” By treating biologically tainted individuals as absolute degenerates rather than victims of socio-political processes, the state could successfully stigmatise the social elements it most thoroughly feared, thereby justifying aggressive spatial containment under the guise of scientific progress (Pick, 1989).

VII. Proposed Legislation; Sind Lepers (Registration & Sterilisation Act), 1944

In this section, I draw attention to a proposed piece of legislation concerning the sterilisation of persons with leprosy that has remained absent from the dominant historiography of the subject. Existing scholarship, including Buckingham (2006), has examined broader debates on sterilisation in colonial and postcolonial India but has not identified or analysed this specific legislative proposal.

During the 1940s and 1950s, discussions among leprosy workers and members of Parliament increasingly centred on the sterilisation of persons with leprosy. These debates reflected the influence of eugenic thought, particularly in proposals by members of the Rajya Sabha advocating compulsory sterilisation to prevent an increase in cases. Within this framework, the welfare of the larger popula-

tion was prioritised over the rights of individuals with leprosy.

The 1941 report on leprosy was produced at a time when India's population had become a central concern for colonial governance. The concept of 'population' became closely linked to poverty and underdevelopment. In his report on the 1931 Census, J. H. Hutton argued that India's social and economic conditions reflected a "population problem," understood not simply as numerical growth but as the expansion of supposedly "non-productive" groups, particularly impoverished agricultural labourers. By the 1940s, a large population was increasingly viewed as 'overpopulation'. Influenced by Malthusian thought, policymakers identified overpopulation as a major cause of poverty and disease, making population control central to economic development and encouraging eugenic and contraceptive approaches to governance.

Although these debates had not yet attained the international prominence they would acquire after the Second World War, leprosy control had long been embedded within transnational networks of disease management. Consequently, debates on sterilisation during the 1940s and 1950s reflected the convergence of colonial concerns about overpopulation, international discussions of the 'leprosy problem', and emerging strategies of population management. While some approaches prioritised patient welfare, others supported stricter regulation, evident in postcolonial arguments for compulsory sterilisation and in the portrayal of persons with leprosy as unfit for a modern nation.

Preventing childbirth among persons with leprosy proved difficult. Marriage between patients in leprosy institutions was often discouraged or prohibited, yet segregation between men and women was difficult to enforce, and relationships frequently continued. Sterilisation, particularly vasectomy, therefore came to be viewed as a permanent solution that would prevent reproduction while allowing greater freedom to marry. However, these proposals faced significant ethical and religious objections, and medical opinion remained divided. Leonard Rogers argued in 1941 that leprosy did not substantially reduce male fertility except in advanced cases, questioning the medical justification for compulsory sterilisation (Buckingham, 2006).

A clear expression of this thinking appears in a legislative proposal dated 20 July 1944, introduced by the Government of Sind but never enacted on the account of being highly controversial (Lepers Act 1898: Proposal Amendment by Sind Government, 1944). The proposal emerged within a broader administrative anxiety over the influx of migrant persons with leprosy into Sind and the prevention of

further migration from neighbouring territories.

The Government of Sind proposed three principal measures:

1. The compulsory sterilisation of persons with leprosy.
2. The compulsory registration and periodic medical examination of persons with leprosy.
3. Their removal from the province through periodic police round-ups and the prosecution of non-domiciled immigrant persons with leprosy who failed to remove themselves from the territorial limits of Sind (Lepers Act 1898: Proposal Amendment by Sind Government, 1944).

A close reading of these provisions reveals how public health logic was repurposed to construct an aggressive framework of street-level surveillance, administrative discretion, and penal coercion. Under Part III, registration was made mandatory for all sufferers. Crucially, police officers were empowered to require identifying information from anyone who merely ‘appeared’ to be a leper. By substituting clinical pathology with subjective perception, the draft codified visual prejudice into law, effectively legitimising police profiling based on bodily deformity or socioeconomic marginality.

This architecture of surveillance was further reinforced by Part III, Section 14(1), which authorised warrantless arrests for any unsterilised male sufferer and required individuals to produce an official sterilisation certificate on demand not only to provincial authorities but to ‘any such persons’ designated by the state. This demand for visible proof of bodily intervention stripped individuals of basic privacy, turning the sterilised body into a bureaucratically marked object subject to ongoing public interrogation.

Where compliance faltered, the draft deployed explicit penal violence. Under Part IV, state actors were sanctioned to use ‘reasonable force’, making non-adherence punishable by heavy fines, imprisonment exceeding three months, or both. By simultaneously designating all enforcing officers as ‘public servants’, the statute legally immunised state personnel from liability. This legal shield transformed public health intervention into aggressive policing, where violence against marginalised bodies was legally sanctioned. Most tellingly, the decision to repeatedly prosecute non-domiciled

sufferers including those who were explicitly non-infectious exposes the underlying logic of the draft: public health rhetoric was weaponised not to contain clinical contagion, but to enforce fiscal protectionism and purge “unproductive” bodies from provincial boundaries (Lepers Act 1898: Proposal Amendment by Sind Government, 1944).

The report itself acknowledged the proposal’s medical and legal vulnerabilities. While it defended the compulsory separation of infants from infectious parents on public health grounds, it admitted that compulsory sterilisation was difficult to justify given that medical science had failed to establish leprosy as a hereditary disease. It further noted that no comparable legislation existed elsewhere, although it claimed the proposal was “less drastic” than the mass execution reportedly practised in China (Lepers Act 1898: Proposal Amendment by Sind Government, 1944). Nevertheless, Dr. H. R. Wadhvani, Sind’s Minister of Public Health, considered sterilisation the most effective solution, arguing that its chief obstacle lay in public religious and social sentiment rather than medical evidence (Wadhvani, 1944).

Provincial governments were unwilling to finance the maintenance of people with leprosy who were not domiciled within their jurisdictions (Lepers Act 1898 Amendment, 1937). Consequently, the colonial administration sought to apply Section 89-B of the Indian Lunacy Act (1912), which assigned financial responsibility based on domicile. It was within this fiscal framework that official concern over migrant persons with leprosy intensified.

Leprosy was both racialised and sexualised, grouped alongside syphilis, insanity, and other conditions associated with the tropics and the transgression of racial boundaries (Edmond, 2006). The central issue was not simply contagion. Although syphilis was far more lethal, compulsory segregation was never imposed because it remained largely invisible to the public eye (Das, 2025). The visibility of the leprosy body, rather than its medical danger, therefore became central to colonial responses.

The 1944 Sind proposal reflects a clear transition in colonial control, moving from spatial exclusion to what Michel Foucault terms ‘biopolitics’ and ‘governmentality’ – the administrative regulation of population growth, reproduction, and biological efficiency (Foucault, 1978). While the 1898 Act operated through spatial discipline and sovereign removal of “paupers” from urban visibility, the Sind draft targeted the future demographic composition of the state through compulsory registration and sterilisation. Earlier measures, such as segregation and confinement, focused on removing visibly

diseased bodies from public space. The Sind proposal instead extended governmental intervention to reproduction, regulating not only the presence of persons with leprosy but also the possibility of their future existence. Sterilisation thus marked a shift from spatial to temporal control.

This shift indicates that leprosy was no longer understood primarily as a problem of contagion or visibility but as one of population management. The proposal was advanced despite the absence of medical consensus on the hereditary transmission of leprosy, suggesting that the central concern was not scientific certainty but the anticipation of a future burden on the population and the state. Persons with leprosy were consequently redefined from present social nuisances into future demographic liabilities. This future-oriented logic was inseparable from concerns over mobility and migration. Official anxiety surrounding migrant persons with leprosy suggests that the issue extended beyond reproduction to the circulation of bodies across provincial boundaries. Combined with compulsory registration and expulsion, sterilisation became a means of regulating both the biological reproduction and geographical mobility of persons with leprosy.

The proposal also reflects a broader pattern of colonial governance in which different populations were governed through different legal regimes. Colonial law was structured by the principle of colonial exceptionalism, allowing exceptional circumstances to justify exceptional measures. On the colonial frontier, legal procedures considered appropriate for “civilised” societies were deemed unsuitable for supposedly “barbarous” regions, legitimising more coercive forms of rule (Kolsky, 2015).

This logic rested on a temporal imagination of empire. British administrators such as Thomas Babington Macaulay viewed India as occupying an earlier stage of civilisation, justifying what he described as an “enlightened and paternal despotism,” in which the rule of law existed without political liberty. Colonial authorities likewise employed medical language to describe resistance, characterising events such as the Moplah uprisings as forms of ‘homicidal mania’. By recasting political disorder as disease, repression could be presented as treatment, with expressions such as the ‘Moplah disease’ and its remedy— framing coercive intervention as both necessary and curative. Taken together, these examples show how colonial authority operated through legal exception, temporal hierarchy, and medicalised discourse. Exceptional laws were justified by portraying colonised populations as historically backward, while disease metaphors transformed political and social questions into matters of administrative intervention (Kolsky, 2015). Hence, the “rule of colonial difference” explains how colonial governance legitimised unequal treatment by placing colonised populations within a distinct

temporal and civilisational category (Chatterjee, 1994).

VIII. Conclusion

The colonial governance of leprosy reveals a significant gap between medical rhetoric and administrative practice. Although the Lepers Act of 1898 claimed to promote segregation and treatment, its implementation centred on regulating impoverished persons with leprosy, exposing the close association between disease, poverty, and vagrancy in colonial governance. By privileging visible ulceration over infectiousness, the Act demonstrates that legal intervention was guided less by medical certainty than by the management of visibly marked bodies. Ultimately, the regulation of leprosy in colonial India was defined by the intersection of visual aversion and administrative pragmatism. Sensory disgust supplied the rationale for criminalising visibility, while fiscal limits and practical enforcement gaps dictated the boundaries of state action, resulting not in total clinical eradication, but in the selective spatial displacement of the unseemly.

In March 2023, the historical trajectories of spatial discipline and sensory policing reappeared on the banks of the Yamuna Pushta. For residents such as Jairam Trivedi, who had survived for years through Delhi's informal economy, municipal bulldozers, accompanied by nearly two hundred police personnel, demolished night shelters without warning as part of preparations for the G20 Summit (Aafaq, 2023). The operation displaced residents clustered around transit hubs such as Hanuman Mandir ISBT, relocating many to the city's periphery and severing them from the informal networks on which their livelihoods depended (Aafaq, 2023).

Viewed within the longer history traced in this paper, the events at Yamuna Pushta highlight the persistence of a familiar administrative logic. This comparison is not intended to suggest an unbroken continuity between colonial and postcolonial governance. Rather, it highlights an enduring genealogy in which structural poverty and marginality are repeatedly addressed through regulations aimed at beautification rather than socioeconomic reform. Just as colonial authorities sought to remove pauper persons with leprosy from bazaars, railway stations, and commercial centres, contemporary urban governance continues to displace populations whose visibility is perceived to undermine the image of a modern city. Whether articulated through the colonial language of sanitation and eugenics or the contemporary discourse of 'beautification' and 'world-class' city making, the underlying technology of rule remains strikingly similar: the regulation of visibility rather than the elimination of structural inequality and ensuring genuine well-being of the citizens. In this way, the colonial management of leprosy reveals more than the history of a disease. It shows how the state has historically regulated

marginalised populations, a pattern that continues to appear in the management of urban poverty and marginality, even when similar discriminatory practices are presented under different names and guises.

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