A Tale of Tragedy and Triumph: Mapping the Impact of Cholera on Kashmir's Changing Landscape

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Abstract: *The inextricable link between humans and diseases is undeniable; no individual is entirely immune to illness. While diseases can range from mild to fatal, their spread within a population is influenced by numerous factors, including environmental conditions. Climate change, characterized by shifts in temperature, precipitation, and extreme weather events such as heat waves, floods, and droughts, exacerbates the proliferation of infectious diseases. One such devastating disease is cholera, which has historically led to significant mortality rates. In the context of Kashmir, cholera has been a formidable threat, with the potential to claim thousands of lives. This paper contends that the cholera epidemic has left a lasting impact on Kashmiri society, fundamentally altering its sociological and environmental landscape. By examining Kashmir's historical trajectory from the early medieval period to the Dogra rule this study argues that the region's once-pristine environment and peaceful existence were violently disrupted by recurrent cholera outbreaks. Understanding these historical ramifications is crucial in framing contemporary public health strategies and mitigating future outbreaks in Kashmir and beyond.*

Keywords: Kashmir, Diseases, Epidemic, Cholera.

INTRODUCTION

Cholera is an acute intestinal infection caused by the bacterium *vibrio cholera*. It has a short incubation period of 1-5 days with early symptoms of diarhoea and vomiting. In about ten percent of cases, there is severe hydration that, without treatment, can lead to death. Vibrio cholera is found mainly in aquatic environments. There may be multiple causes responsible for the outbreaks like poor hygiene, sanitation, contaminated water supply systems and inadequate antibacterial treatment (Arnold, 1993, p. 334).

The tale unfolds in this paper as we witness the tragedy inflicted upon the people of Kashmir. The early outbreak of cholera and its subsequent waves of devastation are brightly portrayed, illuminating the severe reality faced by individuals and communities. The disease's rapid spread, high mortality rates, and the profound suffering endured by the afflicted are explored in detail.The narrative showcases the efforts made by the people of Kashmir to combat the epidemic. It shines a light on the heroic acts of medical professionals, community leaders, and ordinary individuals who fought tirelessly to save lives, implement preventive measures, and restore hope to a struggling society.

Moreover, the narrative examines the long term consequences of the cholera outbreak on Kashmir's landscape. It explores how the epidemic influenced urban planning, sanitation systems, healthcare infrastructure, and public health policies.The changing physical and social landscape of Kashmir, in response to the cholera crisis, is brought to the forefront, emphasizing the transformative impact of the epidemic on the region.

Cholera was recorded in India as early as 1543 by Gaspar Correa, who described a deadly outbreak in Goa. The Portuguese called it "*Mordechien*" by 1563. Though some claim the first authenticated outbreak was in Jessore (1817–18), cholera had long existed in India. The 19th century saw major epidemics, with Kashmir's outbreaks initially seen as local but later linked to Bengal's Gangetic delta. John Snow argued that Asiatic cholera's history before 1769 was unclear due to limited European medical records (Snow,1854, p. 1).

F. N. Macnamara's *Climate and Medical Topography* analyzes cholera's spread in 19th-century northern India. He observed a seasonal pattern: outbreaks began in Bengal (February–March), moved north to Punjab and the North-West Provinces (August–September), and extended into Kashmir (November–January). His study highlighted geographical, environmental, and socio-economic factors influencing disease transmission, offering key insights into cholera's epidemiology (Macnamara, 1880, pp, 112-13).

Kalhana's *Rajatarangini* records cholera outbreaks in Kashmir during Raja Uccala's reign (1101–1111 AD). Another severe epidemic occurred in 1783 AD under Azad Khan, claiming thousands of lives while sparing rural areas, an anomaly noted by Pandit Koul (Koul, 1925, p. 111).

During the administration of Dewan Moti Ram,

Kashmir experienced yet another epidemic resulting in a significant death toll and records that thousands perished, though specific details of the outbreak and its management remain limited (Koul, 1925, p. 111). In 1827 AD, under the governance of Dewan Kripa Ram, Kashmir faced a catastrophic combination of epidemic and famine. This deadly duo lasted for a month, killing thousands. Historical records from Hassan, Bates, and Wingate provide insights into the harsh conditions and the overwhelming mortality rate, reflecting the severe humanitarian crisis of that period. During Sheikh Ghulam Mohiuddin's period in 1845 AD., Kashmir was again ravaged by an epidemic that lasted for three months. The death toll was so high that traditional burial practices were abandoned, and bodies were laid in graves without shrouds. Historical accounts by Hassan and Wingate report that twenty thousand people died in Srinagar alone, indicating the epidemic's severe impact on the population.

Sudden outbreaks of cholera in Kashmir during the 19th century have been described by many writers and physicians. The first recorded cholera epidemic broke out in Kashmir in December 1857, during the reign of Ranbir Singh, Kashmir endured another deadly epidemic. The outbreak began, paused for three months, and then resumed, continuing the cycle of death for two months. This period is marked by the relentless nature of the epidemic, which disrupted life and caused continuous fear and suffering among the population. Historical accounts illustrate the recurrent and devastating impact of epidemics on Kashmir over the centuries, shaping the region's social, cultural, and historical landscape (Khan, 2014, p. 318).

In 1867 AD, Kashmir was struck by another severe epidemic, lasting three to four months and causing thousands of deaths (Khan, 2014, pp. 318-19). According to Elmsile, the disease was introduced by Maharaja's soldiers who had visited Haridwar to bathe in the Ganges. The epidemic broke out almost immediately upon their return. Despite extensive efforts to prevent its spread, the disease eventually overwhelmed the city. For the safety of European visitors, a 'cordon sanitaire' was established around the European quarters, and the missionary dispensary was temporarily closed, (Elmslie and Thomson, 1875, pp. 195-96) noted that the city's poor were sadly neglected, even by those expected to care for them.

Another epidemic struck Kashmir in June 1872 and continued until December, as recorded. The Maharaja instructed hakims to cease the common practice of bleeding patients,(Gazetteer,1974) which was believed to worsen the situation. Local records from June 25 to October 12 provide the following statistics (Govt. Of India, 1875).

As per Walter Lawrence, the first time, cholera was reported to have occurred in Kashmir in 1598. Before that time the disease was unknown or was known by a name different to that now used '*Waba'* (Lawerence, 1895, p. 218). Most probably,Kashmiri name of cholera or any other epidemic, "*Wabah*" is the same what AbulFazl means by his words, "*a strong wind of destruction"*. The dreadfulness of the *wabah* was so common among the Kashmiris that its memory survives even today in the shape of *wabah-marguzar* (graveyard of those who died of cholera) found in Srinagar and its outskirts.

The first recorded cholera epidemic in Kashmir occurred in 1857, coinciding with the death of Gulab Singh, the founder of the Dogra dynasty. Throughout the nineteenth century, the Valley faced at least ten major cholera outbreaks, each causing widespread death and suffering. During Ranbir Singh's reign, cholera surged in late 1857, subsided briefly, and resurfaced in early 1858, lasting for months. The epidemic intensified in the latter half of the century due to improved communication networks, particularly the Jhelum Valley Road, which facilitated both human movement and the spread of disease. Kashmir's unique status as a year-round pilgrimage site, unlike other religious centres with seasonal pilgrim influxes, further contributed to recurrent outbreaks. The dense crowds and multiple pilgrimage routes acted as conduits for the rapid transmission of cholera, making the Valley not just a culturally rich space but also an epidemiologically vulnerable one (Kapur, 1992, pp. 95-96).

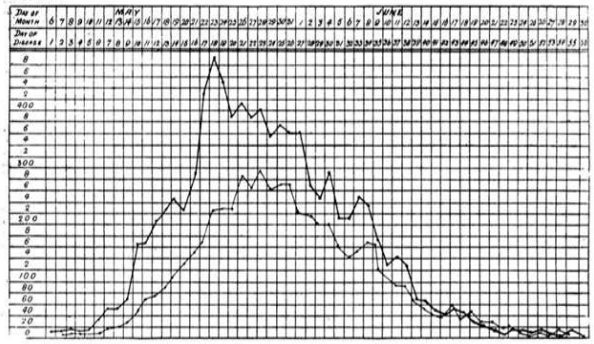
Dr. Mitra reached a conclusion that the state lies outside the natural endemic zone of cholera. Kashmir region became affected by cholera if germs anyhow got entry from outside and got favourable condition for multiplication and growth and their spread until they die a natural death by destructive force of nature.Not every epidemic in Kashmir was local, the geographical study of disease has made it clear that many of the epidemics would travel from other parts of India into Kashmir, (Akhtar, 2008, pp. 211-230). During 1855, cholera broke out in Agra and spread in the adjoining areas in Punjab. All the epidemic of cholera in the state were imported from Punjab (Gulzar, 2013, p. 8). During the time of Maharaja Pratap Singh, ten thousand lives were lost in 1888.Dr. Mitra observed that the epidemic's impact extended throughout the valley, making the summer of 1888 unforgettable for the survivors (Mitra,1892, p. 11). This epidemic coincided with a planned visit by Viceroy Lord Dufferin, who had to leave Kashmir prematurely due to the health crisis.

The intensity of cholera outbreaks in Kashmir increased significantly around 1890 after the road connecting Punjab and Baramulla was opened. This development prompted Lawrence to express serious concerns about the situation. He emphasized that the new road linking Srinagar to India created a pressing need for sanitation reforms in Kashmir. There were two main reasons for this urgency: firstly, if cholera became endemic in Kashmir, it would pose a constant threat to the neighboring regions such as Punjab and the important military cantonment at Rawalpindi. Secondly, due to the interconnectedness facilitated by trade routes, any cholera epidemic in India would likely spread to Kashmir via these newly established roads.Before the Baramulla-Punjab road was constructed, the pattern of cholera outbreaks was quite different. Between 1867 and 1890, Punjab experienced twelve epidemics of cholera, whereas Kashmir had only five outbreaks during the same period. This disparity was largely due to the isolation of Kashmir from the major trade routes and population centers of India at that time.However, with the opening of the road, the dynamics changed dramatically (Lawrence, 1895, p. 220).

Lawrence predicted that once cholera reached Punjab, it would easily travel along the congested road and through the narrow valley leading to Srinagar. This geographical vulnerability meant that Kashmir, previously relatively insulated from cholera outbreaks in India, was now at much greater risk due to its direct connection via the road network.In summary, the opening of the road between Punjab and Baramulla in Kashmir in 1890 significantly increased the risk of cholera outbreaks in Kashmir by

facilitating the spread of the disease from India. Lawrence's observations underscored the urgent need for sanitary reforms in Kashmir to mitigate the potential impact of cholera epidemics stemming from its newfound connectivity to the broader Indian subcontinent(Lawrence, 1895, p. 299).

Out of the ten cholera epidemics observed in the state in the nineteenth century the last epidemic of 1892 was devastating the entire state. The 1892 epidemic resulted in 5,781 deaths in Srinagar alone (Shepherd, 1926, p. 55). During the day Hindus burnt and Muslims buried the dead, but during the night they simply threw them into the river. Eyewitness accounts of the epidemics make horrific reading. As Arthur Neve on the epidemic of 1888 and 1892, Srinagar was a *'City of Dreadful Death*.' Walter Lawrence also commented on that epidemic of 1892 (Lawrence, 1895, p. 220).



Above the graph shows death rate in the month of May and June, 1892, (Harvey, 1892, pp, 345-47).

Tyndale Biscoe highlights the epidemic of 1902, (Biscoe, 1922, p. 306)"*The epidemic of 1902 was my first experience of this terrible visitation. The people were terribly scared; offices and schools were closed, and the people sat in their houses, as they said, waiting to die . . . Ten thousand deaths were reported in the city, there must have been hundreds more unreported."*

The State saw several cholera outbreaks during the 20thcentury, but these were less fatal than those of the previous century because by then, a number of preventive and precautionary measures had been put in place. Nonetheless, cholera epidemics were noted three times in the first ten years of the twentieth century: in 1900, 1907, and 1910.A cholera epidemic struck the province of Kashmir in 1910, with 18,000 instances of the illness recorded, (Kapur,1992, pp. 97-100).

After four years, there was another cholera epidemic in 1914 marked the beginning of the outbreak, which lasted until December. The top of the valley was where this sickness first appeared. In 1915, there was another outbreak that originated in Muzzafarabad about 3000 cases occurred in about eight months.There have been reports of cholera epidemics in 1918, 1919, 1924, 1929, 1930, and 1935. In 1919, cholera returned, starting in the Kulgam was apparently '*the severest ever experience in Kashmir* (Chohan,1994, p. 31). The government began administering mass vaccinations to combat the sickness. Vaccination is proven to be an adequate means of protection. But for those who were already afflicted, vaccination was not helpful, and they were unable to prevent contracting the illness.However, the shorter immunity period for inoculation, approximately six months, was chiefly responsible for the disease's recurrence in the state. In Srinagar city epidemic of cholera was again observed in 1941 (State Archive, 1941). Various steps were taken by the administration to check further spread of disease like disinfection of houses and city, inoculating people and appointment of temporary sanitary inspecting staff (State Archive, 1941).

Both indigenous and western medical practitioners took different approaches and practices to cholera therapy. Native Hakim depended on eliminative thinking, whilst western medicine professionals focused on halting the dejections. It was widely held among native healers that limiting waste elimination from the body would lock up the cholera toxin in the body. As a result, they administered irritating purgatives to the patients, causing them to die (Neve,1914, p. 55).The practice of venesection was also common among the indigenous healers. By severing a vein, the sufferer was given permission to bleed. The humoral hypothesis of disease states that every illness is the result of a fluid imbalance in the body, which can be corrected by removing blood from the body. This approach was deemed ambiguous in light of contemporary therapeutic modalities, and it consistently proved lethal. Maharaja Ranbir Singh outlawed venesection in Kashmir in 1872 with a government decree (Bates, 2005, p. 17).For cholera treatment Hakims suggested a pendiluvium of willow (*Salix alba*) leaves, as well as the herb kot (*Ancklandiacostus*). Despite the fact that western doctors used a variety of medications depending on the stage of the disease, such as Chlorodyne, Murray's pills, Cotter's pills, Salol, Morphine injections, and Atrophia, no effective cure for cholera was discovered (Lawrence, 1895, p. 219).

Cholera and Pilgrimages

Cholera outbreaks at places of pilgrimage can be attributed to factors such as overcrowding, inadequate sanitation facilities, and contaminated water sources. Pilgrimage sites with large gatherings may struggle to maintain proper hygiene standards, facilitating the rapid transmission of cholera, which is primarily waterborne. Implementing robust sanitation measures and ensuring access to clean water are crucial in preventing cholera outbreaks during pilgrimages. In Kashmir Cholera became more common in the state in the latter half of the nineteenth century. This was due to the establishment of means of communication throughout the state, which facilitated travel.Cholera epidemics increased in frequency as a result of the Jhelum valley road making it easier for people to travel throughout the state.The spread of the cholera pandemic was attributed in large part to religious pilgrimages. On a few times, it was reported that infection had spread from the well-known pilgrimage sites, Amarnath cave (Neve, 1914, p. 80), Harmukh cave, and Haridwar *Kumbh Mela*.The epidemic of cholera in 1900 was said to have occurred because ofAmaranth pilgrimage. At various occasions, the famed Mohammedan fair of Kashmir served as a dispersal site for cholera epidemics. In 1889, during a week of this exhibition, cholera broke out in Kashmir. People in Kashmir believed that if the tank of *Makhdum Sahib*(Neve, 1914, p. 82),stayed full with water, the disease of cholera could be avoided. People would flock to fill the water tank whenever a disease outbreak occurred in any part of the region. Every visitor used the water as a preventive measure against cholera (Neve,1914, p. 82) and pilgrims from tainted areas occasionally brought it. Along with the spread of germs and diseases from these *Melas* and pilgrimages, pilgrims from far and wide traveled to these religious assemblies to pay their respects. Consequently, myths and beliefs exacerbate.

These religious gatherings, which attracted

pilgrims from distant areas, inadvertently facilitated the spread of germs and infections. Pilgrims would come to pay homage, bringing with them and dispersing pathogens, thereby exacerbating the epidemic. Thus, the intertwining of religious beliefs and superstitions played a significant role in the propagation of cholera and other infectious diseases during such events.

Most writers on Kashmir agreed to the fact that cholera outbreak was the result of "*poor sanitary conditions*." The centre and nursery of cholera in Kashmir is the foul and squalid capital Srinagar, but if it is once established there it soon spreads to the dirty towns and villages. Besides crowding was another serious problem. Nearly 1,18,960 people live in 22,448 houses with a density of five persons per house, (Lawrence, 1895, p. 219) During the late 19th century, the initial phase of Western medicine in Kashmir emphasized eradicating epidemics, improving public health and sanitation, establishing municipalities, and vaccinating against diseases like plague, cholera, smallpox, and malaria, similar to British India. However, under Maharaja Ranbir Singh, other medical systems like Unani and Ayurveda were also promoted, which slowed the progress of Western medicine, (Dar, 2012, p. 91). It wasn't until the appointment of a Resident in 1889 that Western medicine received preferential support from the state, overshadowing indigenous systems and becoming the dominant medical practice in some areas.

During epidemics, temporary doctors were appointed to support the medical department. When doctors were unavailable, native *hakims* were enlisted and provided with instructions and medicines. In the 1892 cholera epidemic, Dr. Mitra personally trained *hakims* to handle cases. Larger cities were divided into smaller sections, each managed by medical officials, and native doctors and hakims visited patients at home. A medical assistant was always present at each police station.(Annual Administration Report, 1882-83, p. 63).

Sanitary Conditions

In 1910, a devastating cholera epidemic struck the Kashmir valley, starting in the first week of June and lasting until the third week of November, (Neve,1914, p. 273) The epidemic affected Anantnag as well, and the Chief Medical Officer of Kashmir implemented several measures to control the spread: People were advised not to enter any cholera affected house or associate with anyone from such houses.Families affected by cholera were instructed to boil their milk, and unaffected families were advised not to buy milk from affected families.It was recommended that only one person should attend to a cholera patient to minimize the risk of spreading the disease.People were encouraged to use spring water as much as possible to avoid contaminated water sources.The sale of unripe fruits, mulberries, and cucumbers within Srinagar's municipal limits was prohibited.Cholera affected houses were to be disinfected to curb the spread, (Dev, 1983, p. 123).

Dr. Mitra, Dr. Arthur Neve Dr. Ernest Neve, and others confirmed that drinking unclean water was a major cause of cholera's rapid spread and high fatalities. During cholera outbreaks, the state government enforced quarantine laws to prevent the disease from entering the state. Inspection posts were set up at entry points like, Baramulla, and Uri, where officials conducted strict check-ups on passengers. Walter Lawrence noted that authorities believed improving sanitary conditions in Kashmir was crucial to prevent cholera from becoming endemic in Srinagar. However, the link between sanitation and cholera was unclear, as the disease's occurrence did not always correlate with changes in sanitation.

Keeping in view the efforts made by the Government during the spread of different epidemics, it can be said that from the very beginning of the period under study, the state government was trying to establish hospitals etc. in order to improve medical facilities. Besides, Christian Missionaries were also active in this field during last forty years. Many hospitals were founded by the state Government established a number of hospitals and dispensaries at a number of places for the treatment of the patients.

Unfortunately we have very little evidence about damage caused in other parts of valley except Srinagar, but epidemics have caused massive damage in the form of causalities, these would also hinder the movement of people especially after 1890 A.D when they consistently broke out. The Sanitation issues and health care measures taken from 1890 onwards slowly helped in containing the widespread nature of disease and from 1925 A.D the disastrous nature of epidemics was contained to a large extent.

CONCLUSION

The history of epidemics like cholera in Kashmir highlights the significant impact of geographical and environmental factors on public health. The recurrent cholera outbreaks and other epidemics reveal the challenges faced by the region in maintaining hygiene and preventing disease spread. Despite considerable efforts to improve sanitation and public health, the persistent threat of epidemics underscores the importance of continuous vigilance and proactive measures. Efforts to combat these health crises have evolved over the centuries, reflecting a growing understanding of disease prevention and control. While historical accounts often emphasize the devastating effects of these epidemics, they also illustrate the resilience and adaptability of the Kashmiri people and authorities in the face of recurring public health challenges.

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