

Plague, Surveillance and Colonial Public Health in Malabar: The Tellicherry Outbreak of 1906–1907

Chandni CV¹

¹ Ph.D Research Scholar, Department of History, University College, Thiruvananthapuram, Kerala
email: chandni.kinal@gmail.com

Abstract: Epidemic disease became an important site of colonial intervention in India. The outbreak of bubonic plague marked a critical turning point in the history of colonial public health regulation. The emergence of plague in Tellicherry, an important coastal port and commercial centre posed a significant challenge to the existing system of epidemic regulation. The article argues that the outbreak brought the existing colonial regulatory framework into more intensive local operation. It also exposes the uneven administrative capacity of the colonial state. The implementation of epidemic measures depended on personnel, financial resources, administrative knowledge and public cooperation. Tellicherry's commercial networks and patterns of mobility further complicated attempts to regulate the movement of people and goods. The article mainly focus on government reports, plague regulations, sanitary records and the *Malabar District Gazetteer* as primary evidences. The article understands colonial epidemic governance as an uneven process in which regulatory authority was continually shaped by local administrative capacity, commercial mobility and social realities.

Keywords: Bubonic Plague, Tellicherry, Colonial Public Health, Epidemic Governance, Surveillance, Administrative Capacity

Introduction

The outbreak of bubonic plague in Bombay in 1896 created a major public-health crisis for the colonial government in India. Plague control involved more than medical treatment. It brought together health officials, municipal authorities, police and transport networks. These institutions sought to treat those affected by the disease and identified and regulated the routes through which infection might spread. The history of plague in colonial India therefore provides an important context for examining the relationship between epidemic disease, state intervention and everyday life.

The spread of plague was uneven across the Madras Presidency. Malabar remained comparatively less affected despite its proximity to infected territories such as South Canara, Coimbatore, the Nilgiris, Coorg, and Mysore which had severe infection. Its position on the south-western coast also connected the district to important maritime and commercial networks. Contemporary officials paid particular attention to the possibility that

plague could enter Malabar through its ports and transport routes. The Malabar District Gazetteer described the district as having remained relatively free from indigenous plague, while noting the precautionary measures adopted at passport stations, observation circles, and seaports (Innes & Evans, 1915, p. 279). This relative freedom makes Malabar an important setting for examining what happened when plague became established locally.

Tellicherry presented a particular challenge in this context. As a major port and commercial centre, the town was connected to maritime routes along the Arabian Sea as well as inland networks linking it with neighbouring plague-affected regions. Indigenous plague became established in Tellicherry in March 1906. By September 1907, contemporary records reported 213 seizures and 173 deaths, of which approximately 180 cases were classified as indigenous (Innes & Evans, 1915, p. 28; Government of Madras, 1908, p. 151). The outbreak was relatively limited in scale when compared with major plague centres elsewhere in India, but its occurrence in a district regarded as comparatively protected made it significant. It required the colonial administration to bring existing systems of epidemic surveillance and sanitary regulation into more intensive local use.

Studies of the Madras Presidency have also drawn attention to regional differences in plague incidence and to the importance of administrative measures in limiting its spread. However, the local operation of these measures in Tellicherry remains less clearly examined. A study of Tellicherry can therefore connect the broader history of colonial epidemic policy with the experiences and administrative realities of a specific coastal town.

This article argues that the 1906–1907 Tellicherry outbreak brought the existing colonial system of epidemic regulation into intensive local operation. Passports, inspection stations, plague police, sanitary measures, and controls over maritime and overland movement were used to make the movement of people and goods more visible and manageable. At the same time, the outbreak revealed the limits of colonial public-health administration. The implementation of regulations depended on available personnel, financial resources, local officials, and cooperation from the population. The Tellicherry case therefore demonstrates that colonial epidemic governance was neither entirely uniform nor completely effective; it was an uneven process shaped by the interaction between administrative authority and local social and economic realities.

The study draws on both primary and secondary sources. Government reports, sanitary records, plague regulations, administrative documents, and the *Malabar District Gazetteer* provide evidence of the official response and the scale of the outbreak. These are read alongside the works of historians who have examined plague administration and public health in colonial India and the Madras Presidency. Particular attention is given to the distinction between regulations that authorised particular interventions and evidence showing that those measures were actually implemented in Tellicherry. This approach helps avoid treating the existence of colonial regulations as evidence of uniform practice.

The chronological focus of the article is primarily 1906–1907, the period during which indigenous plague became established in Tellicherry and was subsequently brought under control. Earlier developments are considered where necessary to explain the emergence of the colonial regulatory framework and Malabar's relative freedom from plague. The article first examines Malabar's position within the wider geography of plague in the Madras Presidency. It then considers the Tellicherry outbreak and the significance of the town's commercial and maritime connections, before analysing surveillance, plague policing, sanitation, and the regulation of mobility. The final sections examine administrative limitations and local responses, including negotiation, evasion, and resistance. Through this local case study, the article seeks to show how epidemic disease became a site where colonial public health, administrative power, economic mobility and everyday social life intersected.

2. Malabar and the Colonial Geography of Plague

Malabar was a vast district within the Madras Presidency, extending from the Arabian Sea from the northern borders of Cochin towards South Canara. It included densely settled rural areas, commercial ports such as Calicut and Tellicherry, and inland hill tracts associated with the Western Ghats. Its location at the west end of the presidency's administrative and epidemiological geography made it different from the main inland routes through which plague circulated throughout the Deccan and Carnatic (Mahammadh, 2020, p. 68).

Mark Harrison's analysis demonstrates that explanations of epidemic disease in colonial India grew as part of changing medical knowledge and sanitary practice. The environmental and entomological interpretations substituted the earlier explanations grounded in racial or moral assumptions about Indian susceptibility. The colonial authorities continued to emphasise the importance of sanitary intervention and preventive administration (Harrison, 1994, pp. 139-166). The history of Malabar's relative freedom needs to read with this wider evolution of colonial medical knowledge rather than just one explanation.

The plague epidemic also brought the bodies and everyday movements of Indian subjects into closer contact with colonial medical authority, particularly through inspection, segregation, and other forms of epidemic regulation (Arnold 1987). The geographical significance of Malabar was therefore its position between exposure and relative protection. The district bordered or remained connected to territories including South Canara, Coimbatore, the Nilgiris, Coorg and Mysore where plague had already appeared, while its coastal geography and existing administrative precautions contributed to its comparatively low incidence.

3. Tellicherry Port and Regulation of Maritime Movement

The status of Tellicherry as a significant seaport influenced significantly the colony's strategies for checking the spread of epidemics by sea. The seaport was regarded as an economic entity and a potential point of entry for infectious diseases. The plague did not become indigenous in Malabar until it had established a foothold

at Tellicherry in March 1906. Authorities took special measures in seaport towns to prevent the introduction of plague from sea (Innes & Evans, 1915, p. 279).

Regulation of maritime movement was not new to the colonial administration in Thalassery. The Malabar District Gazetteer recalled an incident that occurred in August 1800 when strict quarantine regulations were imposed on vessels arriving from the Gulf, Red Sea and Arabian Coasts because plague was believed to be raging in Baghdad. Vessels were ordered to anchor at a distance from the shore and were inspected before communication with the land (Innes & Evans, 1915, p. 279). Although the circumstances of 1800 were different from those of plague outbreak of 1906–07, this episode serves to highlight an earlier concern with controlling maritime movement during times of epidemic threat. By the early twentieth century such concerns had become entrenched in a system of sanitary surveillance.

3.1 The March 1906 Outbreak

It was in early 1906 that an indigenous foothold of plague first developed in Tellicherry (Thalassery), a coastal urban centre. The Tellicherry outbreak represented a local transmission cycle that had taken hold in an area otherwise relatively free of plague. Plague had become established in the municipality during the first quarter of 1906. The season for plague activity ran its usual course elsewhere in the Presidency (Government of Madras, 1907; Mahammadh, 2020, p. 76). The vulnerability of Tellicherry to the introduction of infection was considerable since its geographical location and commercial function, linked to maritime trade routes along the Arabian Sea. Also, it had inland networks running via the Ghats, with goods, merchants and labourers connecting it to South Canara in the north, Coimbatore and the Nilgiris to the east, and the princely state of Mysore.

Contemporary municipal and district figures collated in the reports to the administration of the Presidency record a total of approximately 213 reported seizures (cases) and 173 deaths with roughly 180 of cases considered indigenous (Government of Madras, 1908, p. 151; Mahammadh, 2020, p. 76). Compared with the much larger epidemics recorded elsewhere in Bombay or in the Punjab, these were relatively modest figures. Cases became concentrated during the cooler months (late 1906 and early 1907) with substantial mortality continuing into the next reporting period. During the 1907–08 administrative year, Tellicherry recorded 78 deaths, a noticeable share attributed to the ten municipalities that reported plague in the Presidency (Government of Madras, Report on the Administration of the Madras Presidency During the Year 1907–08, p. 151). Tellicherry thus formed a localised focus of activity within a district in which the incidence was otherwise comparatively limited.

The municipal and sanitary authorities undertook health measures including house-to-house inspection, segregation of the sick and suspected contacts, disinfection and destruction of rats. These formed part of the

general regulatory and sanitary regime developed by the administration of the Madras Presidency and revised in response to the ongoing plague crisis (Madras Medical Department, 1906; King, 1907). The intervention reflected the more generally interventionist approach adopted by the authorities in response to an epidemic that posed serious threats to population health.

High mortality was recorded during this period, showing that plague caused many deaths even in areas with relatively few cases. The immediate outbreak ended by the middle of 1907. However, the outbreak led to extensive administrative and sanitary records. It showed that the relative protection of some parts of coastal Malabar could be threatened when infection appeared in an important urban centre.

3.2 Tellicherry as an Epidemic Space

Tellicherry was an important port town and commercial centre. Its location influenced how the local authorities understood the spread of the epidemic. The port was connected to the wider Indian Ocean trade network, linking the Malabar coast with Bombay, the Persian Gulf, and East Africa. As a result, many labourers, merchants, travellers, and pilgrims moved in and out of the town. Trade also brought grain and other goods from inland areas affected by plague. The authorities were therefore concerned about Tellicherry's proximity to infected regions. South Canara was one such closely connected region. It recorded 153 plague deaths in 1906 and had strong commercial links with Tellicherry, Coimbatore, and Mysore (Mahammadh, 2020, p. 68; Government of Madras, 1907).

Colonial authorities saw these trade and travel networks as important for the economy, but they also considered them a possible source of disease. They introduced passport and inspection systems to monitor people travelling by road and rail. These measures were also connected to the surveillance of the port.

The physical structure of Tellicherry increased the risk of plague spreading. The town had narrow streets, closely connected residential and commercial areas and grain storage facilities. These conditions could support the growth of rat populations after plague entered the town. Thus, movement of people, trade, crowded urban areas, and rats all influenced how the colonial authorities understood Tellicherry as an epidemic centre.

Later studies suggest that climate and the presence of rats may have limited the spread of plague beyond Tellicherry. However, in 1906–1907, the main concern of the authorities was to contain the disease within the town and prevent it from spreading to the wider Malabar countryside (Harrison, 1994, p. 157; Ramesh, 2023, pp. 85–86). Their measures therefore focused not only on infected individuals but also on households, commercial areas, the movement of people, and the transport of goods.

4. Surveillance, Sanitation and the Colonial Response

The colonial response to the Tellicherry outbreak of 1906–1907 followed an existing system of epidemic surveillance, sanitary control, and regulation of movement. This system was supported by the Epidemic Diseases Act of 1897 and the plague regulations introduced and revised by the provincial government. The Madras plague regulations for areas outside the Presidency town had been revised up to October 1906. These rules covered more than the treatment of infected people. They also allowed officials to inspect passengers and vessels, regulate movement, and control areas affected by plague. Public health was therefore not limited to medical treatment. It also became a way for the colonial administration to identify and control possible routes through which the disease could spread (Government of India, 1897; Madras Medical Department, 1906; Harrison, 1994, pp. 139–166).

Passport arrangements were an important part of the colonial system of plague control. The regulations allowed officials to inspect people travelling from infected areas and require them to follow sanitary precautions (Madras Medical Department, 1906; King, 1907). Passports also helped officials record and regulate movement through areas considered vulnerable to infection.

In Malabar, these measures were supported by inspection stations and observation arrangements. The Malabar District Gazetteer credited passport stations and observation circles with helping to protect the district from plague and noted the special precautions taken in port towns (Innes & Evans, 1915, p. 279). However, this does not necessarily mean that these measures operated in the same way in Tellicherry. Where evidence comes from provincial regulations rather than local records, it is more appropriate to view it as part of the wider administrative framework.

This distinction is important because regulations indicate what officials were authorised to do, while municipal and sanitary reports show how such measures were actually implemented. The Tellicherry outbreak therefore represents a more intensive application of an existing system of plague control rather than the creation of a new one.

4.1 Plague Police and the Enforcement of Mobility Controls

The enforcement of plague regulations involved medical, municipal, and police authorities. In Malabar, plague police were stationed at municipalities, road-frontier inspection stations, and major ports. In municipalities, two constables assisted medical officers in tracing people who did not comply with passport requirements. At road-frontier stations, they helped inspect passengers and traffic. At ports, they assisted with the inspection of vessels and prevented unauthorised persons from boarding ships. Two constables were specifically appointed as plague police at the ports of Cannanore and Tellicherry (Navaneetha, 2022, pp. 37–39).

Their role connected medical inspection with administrative enforcement. Rather than dealing only with ordinary law-and-order matters, the plague police helped enforce sanitary regulations and restrict movement when necessary. Their presence at roads, municipalities, and ports shows that plague control focused particularly on important points through which people and goods moved.

4.2 Sanitation, Segregation and Local Disease Control

The colonial administration used measures to separate infected people and improve sanitary conditions. The plague regulations gave sanitary authorities powers over infected persons, their contacts, houses, and affected areas. These included quarantine, segregation, and disinfection (Madras Medical Department, 1906, pp. 25–32). Other measures included cleaning streets, removing waste, improving drainage, disinfecting places, and destroying rats. These practices were based on the contemporary belief that poor sanitation and rodents played an important role in the spread of plague (Harrison, 1994, p. 157).

However, the regulations should not be treated as evidence that all these measures were actually carried out in Tellicherry. The existence of legal powers does not by itself prove that infected houses were evacuated, specific areas were closed, or people were forcibly detained. Such claims require evidence from municipal, sanitary, or district records relating specifically to Tellicherry. This distinction is important because the regulations gave officials wide powers, but their actual use could vary according to local conditions.

Even with this limitation, the available evidence shows that colonial plague control extended beyond medical treatment. It involved the management of people, houses, movement, and the urban environment. Mahammadh's study of plague administration in South India also highlights the importance of sanitation and mobility control in the colonial response (Mahammadh, 2020, p. 96).

4.3 From Regulatory Authority to Administrative Capacity

The existence of detailed plague regulations did not guarantee their consistent enforcement. The regulations provided officials with considerable authority to intervene during an epidemic.

The enforcement of plague regulations required the coordination of medical officers, sanitary officials, police personnel and other subordinate staff. Evidence from the plague administration indicates that some officers at inspection stations were not fully familiar with the regulations and required additional guidance. Plague-police detachments could also be reduced because of financial constraints (Navaneetha 2022, 37–39). These difficulties are significant because surveillance depended not simply on the existence of regulations, but on officials who could understand, communicate and enforce them. The expansion of the regulatory framework therefore did not automatically produce an equally extensive administrative capacity. The distinction between regulation and implementation is particularly important in relation to mobility control.

Passport arrangements and inspection stations provided formal mechanisms through which the government could record and regulate the movement of people from infected areas (Madras Medical Department 1906; King 1907). Yet their effectiveness depended upon the availability of personnel at particular points of movement and their ability to identify travellers, verify documents and respond to suspected cases. The presence of plague police at Tellicherry and Cannanore indicates that the administration recognised the importance of policing key points of movement. But the available evidence does not establish that all movement into and out of Tellicherry could be monitored continuously (Navaneetha 2022, 37–39). The significance of these arrangements therefore lies less in demonstrating complete surveillance than in showing the attempt to make important forms of movement administratively visible.

The problem was particularly relevant to Tellicherry because of its commercial and geographical position. Colonial epidemic policy therefore operated within a tension between the need to maintain commercial and social mobility and the desire to restrict the circulation of people and goods associated with possible infection. Harrison's study of colonial public health similarly demonstrates that sanitary and preventive measures were closely connected with the regulation of movement and the wider administrative management of epidemic risk (Harrison 1994, 139–166).

Administrative limitations were not confined to staffing alone. Effective epidemic control also depended upon communication between different branches of government, knowledge of regulations, financial resources and the ability to obtain reliable information about the movement and condition of the population. Contemporary administrative records point to difficulties in tracing passport holders and to problems of incomplete reporting of deaths (Government of Madras 1908, 151; Bedford 1905, 28–35). Such difficulties are important because surveillance depended upon the production of accurate and timely information. If individuals could not be traced or deaths were not consistently reported, the administration's knowledge of the epidemic remained incomplete.

This gap between administrative ambition and institutional capacity is also visible in the wider history of plague control in colonial India. Catanach has shown that the development of plague policy generated tensions between the objectives of the colonial administration and the practical and social conditions within which those policies had to operate (Catanach 1988). Harrison similarly demonstrates that colonial public-health intervention involved an expanding administrative apparatus whose effectiveness depended upon the practical organisation of sanitary measures and their interaction with local society (Harrison 1994). In South India, Mahammadh's study further highlights the importance of administrative measures, sanitation and mobility control in the management of plague (Mahammadh 2020, 94–96).

Local Responses and Resistance: Aftermath of the Tellicherry Outbreak

The colonial response to the Tellicherry plague outbreak did not take place in isolation. Local people responded to the new restrictions in different ways. Some cooperated with the authorities, while others tried to avoid or resist them. Across British India the families often tried to hide cases of plague. Some avoided reporting illness because they feared isolation or separation from their families. Others left their homes or moved to another locality to escape official attention (Harrison, 1994, pp. 149–152; Mahammadh, 2020, p. 94).

Similar difficulties arose in Tellicherry. The town depended heavily on trade and the movement of people. The introduction of plague passports therefore affected everyday travel and commercial activity. Some people tried to avoid the official checkpoints. They used smaller routes along the coast or travelled by boat instead of using the main roads or the harbour checkpoint. Others used passports under different names or avoided medical inspection altogether (King, 1907, pp. 24–31; Madras Medical Department, 1906, pp. 12–18).

Resistance was also visible at the household level. Some residents refused to leave their homes when evacuation was ordered. Others objected to visits by plague police and sanitary workers. For many families, the inspection of their homes was not simply a public health measure. It meant allowing officials into private spaces. There were also concerns about the privacy of women and the handling of household belongings. Grain stores and other possessions could be disturbed during inspection and fumigation (Ramesh, 2023, pp. 62–64).

These reactions should not be understood simply as opposition to public health measures. People had practical concerns about their families, property, livelihoods, and privacy. For traders and workers, restrictions on movement could also affect their income. Fear of isolation could make families reluctant to report illness. Such concerns help explain why some residents tried to avoid official measures.

Local elites and community leaders occupied a different position. Municipal commissioners, merchants, and other influential residents often had to balance their relationship with the colonial administration and their responsibilities towards the local community. Some cooperated with officials because they understood that an uncontrolled outbreak could harm trade and lead to stricter restrictions. At the same time, they sometimes intervened on behalf of residents and sought to reduce the impact of official measures.

Indian officials working within the colonial system also played an important role. Sanitary inspectors, vaccinators, and police constables were responsible for implementing many of the regulations. Their position gave them some discretion in dealing with local residents. Religious and caste leaders could also influence how communities responded. Some worked with the authorities, while others helped residents negotiate or resist official measures. As a result, plague control did not operate through a simple top-down system. Local

relationships and negotiations shaped how the regulations worked in practice (Harrison, 1994, pp. 166–180; Mahammadh, 2020, pp. 94–96).

The geography of Tellicherry created further difficulties. As a coastal trading town, it had continuous movement through roads, markets, and the harbour. Completely controlling this movement was difficult. Smaller routes and maritime connections provided opportunities to avoid official checkpoints. The physical structure of the town also presented challenges. Crowded residential areas, markets, and grain storage facilities could support the presence of rats and fleas.

The surveillance system itself depended on people being visible to officials. Passports, inspection stations, observation circles, and plague police were designed to record and monitor movement. Yet these measures could not capture every movement or every case. Official records pointed to difficulties in tracing passport holders and to incomplete reporting of deaths (Government of Madras, 1908, p. 151; Bedford, 1905, pp. 28–35). This suggests that colonial authorities could gather information about the epidemic, but their knowledge remained incomplete.

By the middle and later months of 1907, the outbreak had come under control. Mortality declined and local transmission gradually subsided. The most intensive restrictions were then relaxed. However, the experience did not disappear from later public health policy.

The basic framework of plague control remained in place. The Epidemic Diseases Act of 1897 continued to provide the legal basis for government intervention. The Madras plague regulations were also revised over time, with the 1906 regulations remaining an important framework for areas outside the Presidency town (Madras Medical Department, 1906; King, 1907). After the immediate crisis had passed, large-scale evacuation and observation became less common. Greater attention was given to routine measures such as rat-catching, cleaning, drainage, and municipal sanitation.

For Malabar as a whole, the idea that the district had remained relatively protected from plague was again emphasised. Tellicherry did not experience another outbreak of similar intensity immediately after the 1906–1907 episode (Government of Madras, 1908, p. 151; Mahammadh, 2020, p. 76).

The Tellicherry outbreak therefore left an important administrative and social legacy. It showed that plague control depended not only on medical knowledge but also on the movement of people, the cooperation of local communities, and the work of local officials. The experience showed both what colonial public health measures could achieve and where they faced practical limitations. Later outbreaks in Calicut and Palghat during the 1920s again brought similar measures into use. However, the experience of Tellicherry had already demonstrated the importance of local cooperation, mobility, and the social realities of epidemic control (Mahammadh, 2020, pp. 68–96; Ramesh, 2023, pp. 85–86).

Conclusion

The Tellicherry plague outbreak of 1906–1907 was an important moment in the public-health history of Malabar. The outbreak occurred in a district that had remained comparatively free from indigenous plague. Its appearance in a busy coastal town therefore raised concerns about the possible spread of infection to other parts of the region. The response was based on an existing colonial system of epidemic control. Officials used passports, inspection stations, plague police, sanitary measures, and controls over movement to contain the outbreak. These measures brought different parts of the administration into close contact with one another.

The experience of Tellicherry shows that having regulations did not mean that they could always be enforced effectively. Shortages of staff, financial limitations, gaps in knowledge, and the difficulties of monitoring movement affected their implementation. The town's commercial connections also made complete control difficult. People continued to move through roads, markets, and maritime routes, while local residents responded to official measures in different ways.

The outbreak also shows that plague control affected more than public health. It entered homes, workplaces, markets, and spaces of everyday life. For some residents, inspection and evacuation raised concerns about privacy, property and livelihood. The Local officials, merchants, and community leaders therefore became important in mediating between government requirements and local needs. This makes the history of plague more than a history of government regulations. It was also shaped by the choices and responses of the people who experienced those regulations.

By 1907, the immediate outbreak had declined, and the most intensive measures were gradually reduced. Yet the experience left behind a stronger administrative understanding of how disease could be managed in a commercially active coastal town. Tellicherry demonstrated both the reach and the limits of colonial public health. The colonial state could introduce systems of surveillance and intervention. But their effectiveness depended on local conditions, administrative capacity, and public cooperation. The Tellicherry case therefore offers a useful local perspective on the wider history of plague in colonial India. It shows how a disease outbreak could bring together questions of health, mobility, commerce, policing, and everyday life. More importantly, it reminds us that colonial public health was not simply imposed from above. Its actual operation was shaped by the geography of the town, the institutions available to the authorities, and the responses of the people who lived and worked there.

References

- Arnold, D. (1987). Touching the body: Perspectives on the Indian plague, 1896–1900. In R. Guha (Ed.), *Subaltern studies V: Writings on South Asian history and society* (pp. 55–90). Oxford University Press.

- Arnold, D. (1993). *Colonizing the body: State medicine and epidemic disease in nineteenth-century India*. University of California Press.
- Bedford, J. P. (1905). *Report on the plague administration of the Madras Presidency*. Government Press.
- Catanach, I. J. (1988). Plague and the tensions of empire: India, 1896–1918. In D. Arnold (Ed.), *Imperial medicine and indigenous societies* (pp. 149–171). Manchester University Press.
- Government of India. (1897). *The Epidemic Diseases Act, 1897 (Act III of 1897)*.
- Government of Madras. (1907). *Report on the administration of the Madras Presidency during the year 1906–07*. Government Press.
- Government of Madras. (1908). *Report on the administration of the Madras Presidency during the year 1907–08*. Government Press.
- Harrison, M. (1992). Quarantine, pilgrimage, and colonial trade: India 1866–1900. *Indian Economic & Social History Review*, 29(2), 117–144. <https://doi.org/10.1177/001946469202900201>
- Harrison, M. (1994). *Public health in British India: Anglo-Indian preventive medicine, 1859–1914*. Cambridge University Press.
- Innes, C. A., & Evans, F. B. (Eds.). (1915). *Madras district gazetteers: Malabar and Anjengo* (Vol. 1). Government Press.
- King, W. G. (1907). *The plague inspector's manual*. Government Press.
- Klein, I. (1988). Plague, policy and popular unrest in British India. *Modern Asian Studies*, 22(4), 723–755. <https://doi.org/10.1017/S0026749X00015729>
- Mahammadh, V. R. (2020). Plague mortality and control policies in colonial South India, 1900–47. *South Asia Research*, 40(3), 323–343. <https://doi.org/10.1177/0262728020944293>
- Madras Medical Department. (1906). *The Madras plague regulations in force outside the Presidency town (revised up to 2 October 1906)*. Government Press.
- Navaneetha, P. (2022). *Plague quarantining in Kerala (1897–1920)* [M.Phil. dissertation, University of Hyderabad].
- Ramesh, A. (2023). The plague in Madras: The making of an “immune” city. *Journal of Urban History*. Advance online publication. <https://doi.org/10.1177/00961442231215829>
- Sanitary Commissioner, Madras. (1905). *Madras plague proceedings*. Government Press.

Publisher's Note: *The views and opinions expressed in this article are solely those of the author(s) and do not necessarily reflect those of the publisher, editors, or the editorial board.*