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Gendered Social Sorting in Ireland and India: Colonised and Contagious Women under the Contagious Diseases Acts.

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I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of M.Litt is entirely my own work and has not been taken from the work of others save and to the extend that such work has been cited and acknowledged within the text of my own work.

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Abstract

The use of gendered surveillance has, thus far, been overlooked in conversations surrounding the operationalisation of the Contagious Diseases Acts. The language used throughout the legislation by Britain constructed all women as potential pollutants of men; as threats to the governance of the Empire's White ruling class that had to be contained, controlled, and corralled into 'docile' bodies that adhered to the behaviours expected during the Victorian era.

This research is a contextualised, comparative analysis of the Contagious Diseases Acts 1866-1869 in Ireland and the Indian Contagious Diseases Act 1868 in India. Based on a close reading of each country's enacted legislation, this research thesis brings together surveillance studies, with queer, feminist, and critical race theory, to interrogate how poor-and working-class women, in both jurisdictions, were constructed by the colonial British State. In examining the legislation introduced across both Ireland and India, this research takes David Lyon's definition of surveillance, along with his notion of social sorting, together with the work of Sherene Razack, Chandra Mohanty, and Scott Lauria Morgensen's definition of heteropatriarchy, to interrogate the coalescing of intersectional systems of oppression, and to provide a nuanced understanding of the impact of the Contagious Diseases Acts on the women who worked under them.

This research argues that the Contagious Diseases Acts represent a colonial governmentality; one that sought to exert the dominance of the British State through gendered surveillance and penal sanction. This research provides future researchers with the knowledge, and tools, necessary to interrogate the Contagious Diseases Acts through a multidisciplinary lens; one that incorporates legal, surveillant, feminist, and critical race spheres of thought, to deepen our understanding of how the law shaped Britain's colonial project.

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Introduction

British colonialism has a long history of racial, class, and gender exploitation. The spread of venereal disease, syphilis and gonorrhoea, among the soldiery presented a significant threat to the maintenance of racial and class boundaries. To maintain those boundaries between the coloniser, and the colonised, and to quell the spread of venereal disease throughout the Empire, it became imperative to heavily regulate the sexual relations of all citizens, both within and beyond the metropole.

The Contagious Diseases Acts were introduced across Britain and its colonies in a bid to curb the rates of venereal diseases among its troops. Rather than address the issue that male sexual license was the primary contributor to the spread of disease, the colonial State, instead, introduced legislative sanctions that targeted solely women. Despite being framed as a humanitarian drive to protect the soldier, and wider British society, from infection, the Contagious Diseases Acts were inherently punitive and specifically gendered in their operation.

Both Ireland and India were subjected to Contagious Diseases Acts[1], but until now there has been no comparative research on how the legislation constructed women from either jurisdiction. This research brings together the discipline of surveillance studies, with feminist and critical race theories, to analyse the gendered, colonial legislation that resulted in the discrimination of women, and to provide new insights into the enactment of State sanctioned violence against women.

To discern how the British State regulated the sexual relationships between its colonising citizens, and those they oppressed, this research will interrogate the ways in which Britain's colonial strategy constructed colonised women, and weaponised the social categories of race, class, and gender, to legitimise its imperial power. To do so, it will answer four primary research questions, each of which pertain to both Ireland and India:

1) What was the social context in which the Contagious Diseases Acts were implemented?
2) How did the Contagious Diseases Acts facilitate the social sorting of racialised, poor-and working-class women through surveillance?
3) How were colonised women constructed and categorised under the Contagious Diseases Acts?
4) Can surveillance studies, combined with feminist and critical race theory, help us understand how the Contagious Diseases Acts were operationalised?

Before delving into the research, however, this introductory chapter will provide the reader with a brief overview the Contagious Diseases Acts, their operation and purview. This is followed by examining Britain's history of colonial occupation in both Ireland and India. This introduction ends with a description of the methodology used throughout this research thesis, before concluding by laying out the structure of the project.

[1] See Contagious Diseases Acts 1866-1869 in Britain and Ireland. Also see The Indian Contagious Diseases Act 1868.

What were the Contagious Diseases Acts?

The Contagious Diseases Acts 1864, 1866, and 1869, were a regulatory measure taken by the British State and adopted across its colonies to counter the spread of venereal disease. The first Act, passed in 1864, permitted the compulsory inspection of prostitutes for venereal disease in certain military camps in both England and Ireland (Walkowitz 1980). The initial Act was amended in 1866 and further amended yet again in 1869. Under the Acts 1864, 1866, and 1869, any woman could be arrested on suspicion of being a prostitute, be taken before a magistrate, who held the power to certify her as a common prostitute, and thereby order her to submit to a compulsory, fortnightly internal examination (Walkowitz 1980; Hiersche 2014).

The Acts further provided police officers the unlimited authority to arrest any woman or girl suspected of being a prostitute, and granted them the power to conduct surveillance of any and all women, brothels, or 'bawdy houses', as well as apprehend those procuring abortions, and conduct arrests of those distributing pornography (Walkowitz 1980). In India, similar legislation was introduced in 1868, which sought to prevent the spread of certain contagious diseases, primarily venereal disease, being spread among both rank-and-file soldiers and army officers. The Indian Contagious Diseases Act of 1868 granted the Local Government in India the power to take action against both common prostitutes, and brothel-keepers, to reduce the spread of disease. A full interrogation of the Acts, in both Ireland and India, is conducted in chapter 2 of this thesis.

Colonial Occupation in Ireland and India

To give context to this research, this section will first discuss Britain's history of colonisation in Ireland, where Britain first practiced its strategy of colonial domination. It will then discuss Britain's colonisation of India, where the State's colonising practices were further refined. It bears mentioning that while Irish women were racialised under Britain's colonial regime, this racialisation was different from that experienced by Indian women due to the nature of Britain's colour-based, colonial hierarchy. Categories of 'race' are constructed and flexible, they are neither determined by genetics, skin colour, or biology (Peatling 2005; Malik 1995; Guillaumin 1995). Race, as a term, has no stable, biological foundation (Foucault 2003). Rather, it has historically been a means of categorising indivudals, and fluctuates depending on the governing authory (Foucault 1978; McWhorter 2010). British discourse regarding the Irish treated them as a distinctly inferior racial group (O'Malley 2023). The colonial racism espoused by Anglo-Irish relations constructed the Irish Catholic as a historically significant 'Other' (Hickman & Walter 1995).

Anti-Irish sentiment encapsulated two elements of racism: the colonial and the cultural, therefore constructing the Irish as being both inferior and alien to the majority in Britain (Hickman & Walter 1995). Anti-Catholicism under British colonialism thus constructed the Catholic identity as a set of inherited characteristics that marked Irish people as

fundamentally lesser than their Protestant coloniser on account of their religion and class. As a result, Irish women were not exempt from colonial racism but rather found that their discrimination was compounded by Britain's anti-Catholic sentiments. Britain's colonial hierarchy did not equate Celticness to Blackness, but it did position Celticness under British Whiteness, resulting in Irish citizens being aligned with non-white people (O'Malley 2023). Colonialism's shifting legal and social classifications meant that the Irish, in time, could 'become white', through either voluntary or forced assimilation, and upward social mobility (Fenelon 2023). Indian women, conversely, were not granted such opportunities because their racial markers, such as skin colour, fixed them permanently as 'non-white' according to Britain's hierarchical colonial structure (Fenelon 2023).

The history of British colonisation in Ireland is contested, with scholars mostly agreeing that it began as early as the twelfth century (Veach 2018; Lydon 1995). Not ending until the twentieth century, Ireland was central to Britain's first experience of colonial expansion (Rahman et al 2017). As the first colony of the British Empire, the colonial model was 'perfected' in Ireland and then exported further abroad (Rahman et al 2017). The domination of the English in Ireland was facilitated through the formation of a ruling class of Anglican landlords and officials (Moore 1972).

In stratifying the native population, Britain's policy of 'divide and conquer' played a vital role in its imperial conquest, constructing Gaelic identity and tradition as inferior to the dominant Protestant coloniser (Rahman et al 2017). This strategy weaponised religion, creating further distance between the colonised and the coloniser (Rahman et al 2017). British political control of Ireland was secured by the seventeenth century, following the end of the Nine Years War and the accession of James VI of Scotland to the English throne in 1603 (Gibney 2008). Penal legislation throughout the seventeenth century excluded Catholics from politics and restricted their acquisition and inheritance of land (Moore 1972).

This policy forced Irish middle-classes abroad, leaving only the Catholic clergy remaining as leaders of Irish natives (with detrimental outcomes, though these are far beyond the scope of this research project). By the nineteenth century, Ireland was ruled in both colonial and metropolitan terms, having been partially assimilated within a British cultural context (Kenny 2004). Despite Catholic emancipation in 1829, Protestant powers remained coercive, maintaining control of the economy, magistracy, and grand juries (Moore 1972). By making Ireland a part of the British Empire, Britain imparted its gender and class hierarchies onto the bodies of Irish natives in a bid to better absorb them into the colonial body.

The impact of colonialism and capitalism on Irish towns and cities meant that some women had to engage in labour that was deemed 'unrespectable' within Victorian society, namely prostitution, begging, or 'huxtering', the latter being to advertise or sell their labour and wares in an 'aggressive or dishonest way' (Luddy 1995: 12; Mirriam-Webster n.d). Prostitution was often the last resort for many women, in a country where changes to economic circumstances like loss of employment or desertion by a spouse or breadwinner could plunge a family into poverty (Luddy 2008). There are few reliable statistics as to the extent of prostitution in Ireland

aside from the Dublin Metropolitan Police, who recorded the highest number of arrests at 4,784 in 1856 (Luddy 2008).

The construction of prostitutes as 'emissar[ies] of death' who threatened the physical and moral health of the nation by spreading venereal disease led to the belief that the strength of the British army, both at home and abroad, was under attack by high rates of disease (Bryder 1998; Acton 1857; Luddy 1995). While brothels and were not formally established in Ireland, there were laxly policed designated 'vice zones', such as the Monto in Dublin, which ensured that military and naval men could purchase sex without prosecution. During the mid-Victorian period, encroaching fears regarding the spread of venereal disease, and the devastating impact it posed to the British Empire, caused the colonial government to react with a series of punitive sanctions.

The spread of venereal disease throughout this time period, specifically syphilis, led doctors and public health officials to believe it to pose a serious health hazard to the British public (Walkowitz 1980). Doctors felt confident that the disease could be halted through the sanitary supervision of prostitutes, as it was thought to be predominantly spread through 'sexual contact' with them rather than through the sexual activities of rank-and-file military and naval men from poor-and working-class backgrounds (Walkowitz 1980). The introduction of the Contagious Diseases Acts in Britain and Ireland aimed to preserve the heteropatriarchal structuring of Victorian society, positioning White, British men as victims of disease, and the racialised, poor-and-working-class prostitutes as perpetrators of moral degeneracy and impending sterility.

Having learned from their experience of colonising Ireland, the British State turned its colonial gaze further afield. British involvement in India began during the early seventeenth century, when the East India Company was first established (Ballhatchet 2012; Dinakaran et al 2025). Formed in 1600, the East India Company was a British trade corporation operating in the East Indies (Makepeace n.d). The Company functioned as a 'surrogate British State in India', wielding sovereign powers such as raising taxes and administering justice, all of which were funded by Indian revenues and staffed by both British and Indian personnel. British authorities were established in three Presidencies: Bengal, Bombay, and Madras, each governed by a Governor or Governor-General (Ballhatchet 2012; Marshall 1997).

The colonial strategy employed by Britain was one of segregation (Ballhatchet 2012). The purpose of segregating military men from Indian towns was twofold: to protect British officers and soldiers from any perceived 'Oriental vices', and to assure that imperial power remained both visible and unthreatened (Ballhatchet 2012). In Madras, military cantonments were spaces for the ordering of camp followers along racial lines (Cherian 2004). Camp followers were not a homogenous group, rather a range of different castes, or 'labouring classes', including prostitutes, who were recruited into the army for their services (Cherian 2004). This racialised divide, as initially practiced in Ireland through the ideological division of Catholics and Protestants, and further implemented across its colonies, ensured Britain's imperial prowess by keeping the boundaries between the rulers and the ruled clearly demarcated.

Not gaining independence until 1947, India's period of colonisation was shaped by the political, economic, cultural and social structures of Britain (Ballhatchet 2012; Dinakaran et al 2025).

Taking direct administration over two-thirds of the sub-continent, Britain achieved economic and political success in India following the Battle of Plassey in 1757 (Rahman et al 2018). Bolstered by the East India Company, colonial England extended its influence across India and gradually consolidated its power through both the acquisition of territory, and through the administration of a complex social, cultural, and political regime that stratified the colonised population into easily manageable categories.

Come the nineteenth century, this strategy of segregation was strictly policed, enforcing the differentiation between the White coloniser and the racialised colonised (Ballhatchet 2012; Legg 2009, 2012). The East India Company continued to exercise quasi-control until the early nineteenth century, against a backdrop of complex, agrarian-bureaucratic political order with centralised administration, permanent armed forces, and a 'relatively efficient tax collection' system (Lange et al 2006; Stokes 1973). In 1857, the Indian Rebellion compelled Britain to make India an official colony under the control of London (Lange et al 2006; Summers 2015). It further caused Britain to rely heavily on its troops, leading British soldiers to outnumber Indian sepoys[2] two to one (Ballhatchet 2012).

Given the number of British men stationed across India, most of which stemmed from poor- and working-class backgrounds, there persisted the belief that their rampant sexual licence would drive them toward 'immoral' behaviours (Ballhatchet 2012). The colonial State believed that any effeminacy among British troops would collapse Britain's imperial conquest, leading them to view homosexuality as an existential threat to the Empire (Ballhatchet 2012; Bryder 1998). The colonial system depended on the portrayal of British soldiers as White, masculine, oppressors, contrasting their non-White, feminised, colonised counterparts. Thus, to provide the soldiery with a (hetero)sexual outlet, the prostitution of native Indian women was deemed a 'necessary vice' (Ballhatchet 2012).

As in Ireland, the rates of venereal disease among British troops led to the belief that British superiority was being undermined by visible signs of contagion. In its 1863 report, the Royal Commission on the Sanitary State of the Army in India recommended several measures to quell the rate of communicable disease among troops, to which the Government of India took several measures and attended 'with great expense' (Renzy, 1883). To protect British soldiers from risks to their morality, measures were taken to establish an elaborate system for registering prostitutes, their inspection, and detention, in hospitals whilst maintaining their strict separation from the colonising White soldiers (Ballhatchet 2012; Arnold 2004). Thus, the British State introduced the Cantonment Act in 1864, which allowed for Lal bazars (government sanctioned red-light districts within military cantonments) to be regulated, inspected, and monitored by appointed State officials. This was followed by the Indian Contagious Diseases Act of 1868, that provided further grounds to regulate, maintain, and preserve prostitution in military stations across the subcontinent.

[2] A sepoy was an Indian soldier in the armies of various States and European trading companies in the Indian subcontinent, and, from the second half of the 19th Century, in the British Indian Army.

Methodology

This thesis is a contextualised, comparative analysis of the Contagious Diseases Acts 1866-1869 in Ireland, and the Indian Contagious Diseases Act of 1868. The approach has been to conduct a close reading of both the Irish and Indian Acts, using surveillance studies as a focal lens through which to view the legislation. In this comparative analysis, this research employs a Foucauldian, feminist lens, adopting his social control theses to demonstrate how surveillance, the act of watching one another, functions as a core mechanism of governmentality in both the Irish and Indian contexts.

While Foucault never demonstrated a direct interest in feminist struggles, his work on power, knowledge, and the construction and control of both sexuality and the body, make him a valuable asset to this research. Where his interrogation of power, and the interference of the State into the lives of its citizens, is limited in regard to the experience of marginalised and racialised women, this research also employs feminist, and critical race theories, to counter the limitations of his work. It is because of Foucault's insights into how States enact their power that his work proves invaluable.

Surveillance is, as defined by David Lyon (2003: 5), the "routine ways in which focused attention is paid to personal details by organisations that want to influence, manage, or control, certain population groups". It is a fundamental element of each of Foucault's modalities of power, and is weaved throughout disciplinary, biopolitical, and governmental modalities of government. Surveillance operates along a continuum of 'care' and 'control', of which neither reside in neatly demarcated zones. The caring, or controlling, nature of surveillance, as explored throughout chapter one of this thesis, is most visible in instances of identification and registration by a State. Identification can, in some instances, result in positive outcomes. But, despite how well intentioned an identification system may be, there is always the chance that it may be subverted for other means (Lyon 2014). Thus, the approach of this research has been to apply the theoretical concept of surveillance, and social sorting, to the legislative landscape of Ireland and India during the mid-Victorian period.

Given the scope of the project, this research is limited in that it does not include the voices, nor the lived experiences, of those women who navigated Victorian society under the Contagious Disease Acts in Ireland and India. This is a significant limitation of the research, albeit an unavoidable one given the nature of the project. Another limitation of this research is that it does not include a detailed exploration of how women in England navigated the operation of the Contagious Diseases Acts. As this project focuses on how the Acts in Ireland and India were operationalised, and the differences herein, there was little room left for an interrogation of what separated impoverished English women from the racialised poor-and-working class Irish women who faced heightened discrimination as a result of the Acts.[3]

[3] For more information regarding how the Acts operated in England, and the logic behind their more racialised aspects, please see the following: Sparks (2012), for insight into Victorian theories of race and class; For information regarding what influenced the Acts in England prior to their introduction, see Henderson (2025); Regarding the functioning of the Contagious Diseases Acts in both England and Ireland after the fact, see Jacob (1886); Knox (2022) examines the Acts in relation to prostitution in 19th Century England.

Thesis Structure

Chapter 1 centres on Foucault's theses of social control, delving into his notions of disciplinary, biopolitical, and governmental power. Opening with the recognition that surveillance is a core element in all of Foucault's modalities of power, this chapter brings together the works of Foucault, with surveillance studies scholar David Lyon, as well as with queer, feminist, and critical race theorists Sherene Razack, Chandra Mohanty, and Scott Lauria Morgensen, to demonstrate how surveillance is weaved throughout colonial systems of oppression and power. This chapter will answer the research question: can surveillance studies, combined with queer, feminist and critical race theory, help us understand how the Contagious Diseases Acts were operationalised? In doing so, this chapter seeks to show how colonialism produces a mode of governmentality that relies on the surveillance, segregation, and categorisation, of individuals, and groups, for ease of management.

Chapter 2 examines the social and historical context in which the Contagious Diseases Acts were enacted. This chapter will answer the research question: what was the social context in which the Contagious Diseases Acts were implemented? To analyse what connects Ireland and India, this chapter examines the social climate that preceded, and existed alongside, the enactment of the Contagious Diseases Acts. In discussing the use of lock hospitals in both Ireland and India, along with Lal bazars, the enactment of the Indian Cantonment Act 1864, and the Contagious Diseases Acts 1866-1869 in Ireland and the Indian Contagious Diseases Act of 1868 in India, this chapter explores the context prior to, and during, their enactment.

Chapter 3 is divided into two sections, and will provide an analysis of the Contagious Diseases Acts 1866-1869 in Ireland, as well as the Indian Contagious Diseases Act of 1868. The chapter provides an overview of both pieces of legislation, as they were enacted in Ireland and India respectively. The first section of the chapter examines the similarities, and differences, between the Irish and Indian Acts. This is to provide the reader with a clear view of the power wielded by the British State in Ireland, and the powers it granted to the Local Government in India, to dictate the rules to which women would navigate, both within lock hospitals and in wider Victorian society.

Section two of chapter three then provides an analysis of the Contagious Diseases Acts through a Foucauldian lens of governmentality, with the aim of demonstrating how surveillance, and social sorting, was weaved throughout Britain's colonial regime. Drawing from David Lyon's (2003, 2007) definition of surveillance, and notion of social sorting, as well as queer, feminist and critical race theorists Sherene Razack (1998), Maria Luddy (1995, 2005), Chandra Mohanty (1988, 2024), and Scott Lauria Morgensen (2012), this analysis will answer two research questions: how were colonised women constructed and categorised under the Contagious Diseases Acts?; and: how did the Contagious Diseases Acts facilitate the social sorting of racialised, poor- and working-class women through surveillance? In discerning Britain's strategy of colonial governmentality, one that used both disciplinary and biopolitical

modes of governance, part two demonstrates that the construction of colonised women as dangerous vectors of disease institutionalised heteropatriarchal norms that both maintained, and legitimised, the racial, class, and gendered domination of the British State.

Chapter 1: A Foucauldian, Critical Feminist Approach to Colonialism in Ireland and India.

Introduction

This theoretical framework draws upon Foucault's disciplinary, biopolitical, and governmentality theses, and brings them together with David Lyon's surveillance literature, along with queer, feminist and critical race theorists Sherene Razack, Chandra Mohanty and Scott Lauria Morgensen, to better understand the impacts of the Contagious Diseases Acts on Irish and Indian women. This chapter aims to answer the research question: can surveillance studies, combined with queer, feminist and critical race theory, help us understand how the Contagious Diseases Acts were operationalised?

Colonialism fits neatly within Foucault's thesis of governmentality; a modality of power that, both directly and indirectly, shapes the conduct of entire populations. Governmentality gathers and disperses information by punishing and rewarding individual behaviours that either stray from, or align with, the overarching goals of the governing body. Governmentality utilises strategies of surveillance, the act of watching one another, both on the individual through discipline, and on the wider population, through biopolitics (Scott 2005; Foucault 1991).

In seeking to transform the behaviours of the colonised through information gathering, knowledge production, and the subtle regulation of life processes, colonialism operates a strategy of governmentality by harnessing surveillance as a core technology of governance (Foucault 1991; Ong 2005). Surveillance, as this chapter will demonstrate, is weaved throughout disciplinary and biopolitical modalities of government, and is used as a tool through which to identify, categorise, and socially sort individuals for differential treatment by a State (Foucault 1977, 1978, 1991; Lyon 2003, 2007).

First, to show how surveillance is used throughout all of Foucault's concepts of social control, this chapter begins by exploring Foucault's disciplinary power thesis to interrogate the ways in which surveillance contributes to the internalisation of behavioural norms and beliefs as set out by governing bodies. Disciplinary power is key to discerning how control is exerted through the threat, or assurance, of punishment. Turning then to Foucault's concept of biopower, the chapter explores how surveillance is used to assume control not only over the individual, but over the whole population, by gathering knowledge of a population's biological processes, and turning them into knowable subjects. By bringing together both disciplinary and biopower/political modalities of government, the chapter then examines governmentality: a modality of power that Foucault framed as being imposed through a series of positive operations on the bodies, thoughts and conduct of citizens to compel all individuals to self-govern (Hewson 2022; Foucault 1991).

Second, the concept of surveillance is explored by drawing largely from the work of David Lyon (2003, 2007, 2024). By positioning surveillance firmly within Foucault's social control theses, this research agrees with Lyon (2003): that surveillance functions along a continuum of care and control. Whether surveillance is used as a tool to discipline (control), or reward (care), an individual, or group, this is dependent upon the overarching goals of the governing body. This research further builds on that notion by arguing that surveillance is grounded in colonial governmentality strategies of domination and control.

This section then explores Lyon's (2005: 13) concept of 'social sorting': a strategy that "highlights the classifying drive of…surveillance". Social sorting places the act of surveillance 'firmly in the social'. Historically, surveillance, and social sorting, have been used as technologies of power by colonial governments to manage, influence, and control, certain population groups. Regardless of the initial intention of such surveillance systems, the registration and identification of citizens by a State can have negative consequences for those subjected to it. Colonial legislation, such as the Contagious Diseases Acts, provides us with significant insights into how colonial authorities categorised, and segregated, populations according to the social categories of race, class, and gender for ease of population management.

Finally, this chapter brings together notions of surveillance and social sorting with queer, feminist literature and critical race theories, by combining the works of Lyon (2003, 2005, 2024) with the work of Razack (1996, 1998), and Mohanty (1988, 2003), along with Morgensen's (2012) definition of heteropatriarchy, to critically engage with hierarchies of power. Discerning intersecting dimensions of oppression is imperative to better engage with conversations surrounding how women were targeted, and categorised, under the Contagious Diseases Acts. As such, it is important to interrogate the similarities, and divergences, in how Irish and Indian women were socially sorted under the Acts, and how their racial, class, and gendered categorisation contributed to differences in treatment. Discerning these differences will provide valuable insights into how women were constructed by the colonial British State, and contribute to the overall argument of this research project.

Foucault and Social Control

The following sections detail Foucault's conceptualisations of social control. Beginning with disciplinary power, and then moving into biopolitical power and governmentality, this chapter aims to show how the act of surveillance was weaved throughout each of Foucault's modalities of power. Foucault's notion of disciplinary power precedes his later conceptions of biopower, and governmentality, and acts as a contributory element of both. Surveillance is defined as the "routine ways in which focused attention is paid to personal details by organisations that want to influence, manage, or control certain population groups" (Lyon 2003: 5).

Surveillance is both a disciplinary, and biopolitical, mechanism of governance, used to regulate individuals through the constant, though not always visible, threat of observation (Foucault 1977). Such surveillance then results in the creation of conforming, 'docile' bodies, who are

used to maximise both the efficiency, and productivity, of the governing State (Foucault 1977, 1978, 1991). This chapter conceives of colonial governmentality as a system of regulation that exerts both micro, and macro, controls over both colonised, and colonising citizens, through a Foucauldian lens of surveillance.

Discipline

Foucault conceived of disciplinary power by tracing the machinations of governing institutions. Foucault (1977) stressed that disciplinary power was both distinct from, and worked in tandem with, his later concept of biopower. Both disciplinary power and biopower contribute to the operation of governmentality; each guiding and punishing a population according to the whims of the governing body. From the asylum to the hospital, the school, and the prison, Foucault (1977) emphasised the use of surveillance to demonstrate how disciplinary power encompasses a series of mechanisms, dividing them into three primary categories of surveillance: hierarchical observation, normalising judgement, and the examination (Foucault 1977; Hewson 2022). His interrogation of Bentham's Panopticon, the cylindrical prison whereby inmates are under constant surveillance by the governing body, embodies the core principles of disciplinary power (Hewson 2022). It is such an ideally punitive space that the very cells in which the prisoners spent their lives operated like well-oiled machinery, making the human subjects themselves possess a function through the internalisation of norms (Foucault 1977; Hewson 2022).

The chief function of disciplinary power is to 'train' individuals, binding them together to multiply, and use them (Foucault 1977). It separates, analyses, differentiates, and carries its procedures of decomposition, training the "moving, confused, useless multitudes of bodies and forces into a multiplicity of individual element…" (Foucault 1977: 170). Foucault goes further, describing discipline as the "specific technique of power that regards individuals both as objects and as instruments of its exercise" (Foucault 1977: 170). This technique of power is surveillance, and the panoptic gaze through which all inmates of humanity's observatories were viewed. In monitoring individuals, surveillance categorises, and classifies them, according to the predetermined norms of the governing institution. Should they deviate from the expected norms, they are punished accordingly. Thus, to avoid detection, and consequently, punishment, and because the surveillance conducted of them by the governing authority is not always visible, it becomes necessary for individuals to internalise the norms expected of them, thereby acting in accordance with the behaviours authorised by the governing body (Foucault 1977).

For Foucault (1977: 171), humanity's observatories bore an 'almost ideal model', first taking the form of military camps and then extending to the "construction of working-class housing estates, hospitals, asylums, prisons, schools…", spatially defining a hierarchised mode of surveillance. This shift in the architectural design of buildings that were 'no longer built…to be seen' to ones that inverted the disciplinary gaze allowed for the "internal, articulated and detailed control – [rendering] visible those who are inside it…an architecture that would operate to transform individuals: to act on those it shelters, to provide a hold on their conduct,

to carry the effects of power right to them, to make it possible to know them, to alter them" (Foucault 1977: 172). The prison, according to Foucault (1977: 231), is an essential element in a State's punitive panoply, an "important moment in the history of those disciplinary mechanisms that the new class power was developing: that in which they colonised the legal institution". His reference to the power of the ruling classes to leverage the prison over their subjects indicates to the shift in modalities of governance.

As 'complete and austere institutions', prisons must be 'exhaustive disciplinary apparatuses', assuming responsibility for all aspects of its subjects, their "physical training, [their] aptitude to work, [their] everyday conduct, [their] moral attitude, [their] state of mind; the prison…is 'omni-disciplinary'" (Foucault 1977: 235-236). To do so, the prison utilises its primary mechanism of discipline, seeking to exert total control over its prisoners through punishment. It achieves this through the above-mentioned strategies of hierarchical observation, normalising judgement, and the examination (Foucault 1977). Hierarchical observation is based on the concealed, and yet always assured, surveillance of those inmates (Hewson 2022). Modern modes of hierarchical observation are facilitated through architecture, catering to the functional needs of both ordinary people, and the disciplined. A perfected disciplinary apparatus makes it possible for "a single gaze to see everything constantly" (Foucault 1977: 173). Normalising judgement employs both penalties and rewards. A carrot and stick approach that is informed by the knowledge gleaned through hierarchical observation, its 'gratification – punishment' mechanisms establish "economies of privileges and punishment to incentivise and normalise" those under the disciplinary watch of the State (Hewson 2022: 677; Foucault 1977).

For Foucault (1977), punishment by way of 'subtle procedures…from light physical punishment to minor deprivations and petty humiliations' is doled out for even the slightest deviations in behaviour. The disciplinary apparatus hierarchises 'good' and 'bad' subjects, and in doing so judges individuals, implementing its discipline into a cycle of knowledge gathered on those subjected to it. The ritual of examination then brings together elements of both hierarchical observation, and normalising judgement, in a "ceremony of [this] objectification" (Hewson 2022; Foucault 1977: 187). Such a ceremony assesses, ranks, differentiates, and motivates the individual, with the knowledge produced through the process of examination allowing for those subjected to it to be constructed as a 'case', a "describable analysable object" which can be measured against other cases and disciplined accordingly (Hewson 2022: 677; Foucault 1977: 190). In making everyone a case, one is constituted as an object; both a branch of knowledge, as well as a hold for a branch of power (Foucault 1977). In turning the real lives of individuals into writing, power functions as a procedure of objectification and of subjectification. The following subsection explores Foucault's (1978) concept of biopower, a modality of governance that, for Foucault, operates in conjunction with disciplinary power.

Biopower

Surveillance is a central component of Foucault's notion of biopower/politics. For Foucault (1978), biopower shifts State power from an overt, punitive paradigm, to the more subtle

regulation of life processes. Biopower works in conjunction with disciplinary power, and both operate as a part of governmentality (Foucault 1991). Rather than disciplining individual bodies in confined spaces, utilising a disciplinary gaze that views all at once, such as the asylum or the prison, biopower uses surveillance to monitor entire populations (Foucault 1978). Where discipline trained bodies to internalise the norms prescribed by the State, biopower takes the knowledge gathered through disciplinary surveillance, and repackages it, to promote and regulate the behaviours States believe will better the longevity of their population. For Foucault (1978), maintaining power over life is essential to rendering it both manageable and productive. Biopower, Foucault (1978) writes, is the techniques and mechanisms that modern institutions use to govern the management of a population's biological processes. This includes their birth rates, death, and reproduction (Lazzarato 2002). It is a political technology that "brought life and its mechanisms into the realm of explicit calculations and made knowledge/power an agent of transformation [in] human life" (Foucault 1978: 143; Stoler 1995).

Operating in conjunction with biopower is biopolitics, a framework of political rationality that deploys these techniques of management into the population (Foucault 1978). Foucault (1978) states that power over life consists both in the individualisation, and subjectivation, of the body through discipline and surveillance, and through the regulation and manipulation of the overall qualities of the population: "The disciplines of the body and the regulations of the population constitutes the two poles around which the organisation of power over life was deployed" (Foucault 1978: 139; Kristensen 2013). This type of power does not only oppress, rather biopolitical surveillance produces new forms of surveillance and subjectivity by defining what is constituted as 'healthy', 'productive', or 'normal' (Foucault 1978). Just as disciplinary power induces conformity through normalising judgement, so too does biopower function through the normalisation of certain behaviours.

For biopower to conduct its regulatory and corrective mechanisms, it needs to adhere to an operational system of norms (Kristensen 2013; Foucault 1978). It shapes citizens' self-understanding and social expectations, with surveillance under biopower being as much about creating compliant, governable subjects as it is about preventing 'deviant' behaviours (Foucault 1978). Foucault (1978: 144) writes that the law "operates more and more as a norm, and that the judicial institution is increasingly incorporated into a continuum of apparatuses…whose functions are for the most part regulatory". Thus, a normalising society "is the historical outcome of a technology of power centred on life", given that it is the result of "a whole continual and clamorous legislative activity: these were the forms that made an essentially normalising power acceptable" (Foucault 1978: 144). Here Foucault is clear: a State's possession, and exertion, of power is realised in its capacity to control all aspects of life and "man as a living being" (1978: 144).

Foucault (1977, 1978) conceives of power as taking place on two levels: on the micro level through disciplinary techniques, and at the macro level through biopower/biopolitics. Both modes of power are aimed at maximising and extracting forces from the human body, to "produce life in a given form by utilising techniques of disciplinary subjection and biopolitical techniques of reinforcing life" (Kristensen 2013: 26). For Foucault (1978: 145) sex and its political issues concern both the development of the population and the "entire political

technology of life". It is at once tied to the disciplines of the body and is applied to the regulation of populations "through all the far-reaching effects of its activity, giving rise to infinitesimal surveillances, permanent controls, extremely meticulous orderings of space, indeterminate medical or psychological examinations, to an entire micro-power concerned with the body" (Foucault 1978: 145-146). Through knowledge-gathering by disciplinary and biopolitical mechanics, sex further provided "comprehensive measures, statistical assessments, and interventions aimed at the entire social body or at groups taken as a whole" (Foucault 1978: 146).

Sex, for Foucault (1978: 146), represents a means through which access is granted both to the "life of the body and the life of the species". As a result, it was sought out, tracked down, "pursued in dreams" and "traced back to the earliest years of childhood", as well as becoming a central theme of politics, economics, and ideological campaigns surrounding morality and responsibility (Foucault 1978: 146). It became a core element of a range of tactics that "combined in varying proportions the objective of disciplining the body and that of regulating populations" (Foucault 1978: 146). Sex, and consequently, biopower, is central to Foucault's account of the proliferating sexualities and discourses (Stoler 1995). Its importance spanned from the sexualisation of children, to the hysterisation of women (Foucault 1978: 146). Broadly speaking, sex occupied a space at the juncture of the body, and the population, and possessed a power that was organised around the management of life, rather than the impending 'menace of death' (Foucault 1978; Stoler 1995). In this respect, the Contagious Diseases Acts in both Ireland and India are another example of Foucault's biopower, given the colonial mandate to preserve the virility of the British Empire.

Foucauldian Power in Colonial Contexts

Colonialism has conditioned both colonised individuals, and the settler societies that occupy their lands, in "all political, economic and cultural processes that those societies touch" (Morgensen 2011: 53). We must theorise settler colonialism within Foucault's conception of biopower, lest it becomes naturalised through our engagement with the world, and the theoretical apparatuses we use to explain it (Morgensen 2011). Biopower transforms Western law, encompassing the procedures to produce individual life, and the collective lives, of the population (Foucault 1978). Foucault argues that it displaces the power of the sovereign, replacing it with a governmentality that enacts powers that can give and take 'life' (Morgensen 2011; Foucault 1978, 1991). While Foucault does not theorise colonialism as being intrinsic to the processes of biopower, Stoler (1995) demonstrated that colonialism's racial, sexual, and national power arose at, or among, its colonies and metropoles. In light of such work, modern biopower is determined as a product, and a process, of a colonial world (Stoler 1995; Morgensen 2011).

Foucault (1997) argued that the modern State, in defining itself as sovereign, and as maintaining power over life, needs racism. Foucault (1997) stated in his series of lectures *Society Must Be Defended*: 'The fact that the [O]ther dies does not mean simply that I live in the sense that his death guarantees my safety; the death of the other, the death of the bad race, of the inferior race…is something that will make life in general healthier'. This quote aptly describes the stance of coloniality, whereby the dominated group are eradicated by way of

either assimilation, or death. Patrick Wolfe (1999) theorised that settler colonialism performs genocide, alongside a variety of practices, to eliminate the colonised population. Taking Foucault's biopower, Wolfe (1999) emphasises that this elimination does not always seek to destroy life, but to produce it, as a means of merging the culture, people, and the land of the colonised into the settler population.

Colonialism situates Western law within a white-supremacist political, and economic system, that is perpetually premised on the elimination of the colonised (Wolfe 1999; Morgensen 2011). Morgensen (2011: 62) builds upon this, utilising Foucault's (1991) modality of governmentality to discern how settler-colonial governments pursue elimination through 'identity regulation' (Lawrence 2004), whereby the State intends to 'preserve life' by separating communities based on their nationality, "radically reduc[ing] land bases", and either determining or erasing the existence of the colonised population. For example, the settler governmentality espoused in Canada simultaneously removed Indigenous identity from the colonised population and imposed a patriarchal authority "within the law to assimilate them into the settler nation" (Morgensen 2011: 63). Scott (2005: 35) expands on this, arguing that colonial rule is characterised "by the emergence of a distinctive political rationality – a colonial governmentality – in which power comes to be directed at the destruction, and reconstruction, of the colonial space…to produce not so much extractive-effects on colonial bodies as governing-effects on colonial conduct".

Governmentality, as a modality of power, develops from statistical knowledge garnered through the disciplinary and biopolitical techniques that take whole populations as objects of the State (Hewson 2022; Foucault 1977, 1978, 1991). This form of government recognises that it is not the responsibility of the State alone to cater to and manage the conduct of individual citizens. Rather, it is a variety of actors and institutions that work in tandem across different social realms. Which institutions act to influence and manage the State's citizenry are determined through the surveillance and social sorting of groups and individuals, into distinct social categories. In this, the State identifies and measures an individual's worth according to the accepted norms of the governing body, enforcing and reinforcing long-term social differences, distinguishing, analysing and ordering one person from another to 'put them in their proper place'. This social sorting, as explored further below, often marginalises already marginalised groups within society, hierarchically positioning them above each other.

Governmentality

Governmentality, put simply, is "about how to govern" (Gordon 1991: 7). It is understood as the techniques, and procedures, used to direct human behaviour, of which surveillance functions as a core technology (Foucault 1997, 1991; Rose, O'Malley and Valverde 2006). In this instance, power not only operates through direct coercion, but also shapes the conduct of populations by rewarding certain behaviours. Surveillance is less an occasional tool, and more of a continuous process of knowledge gathering, a tactic that allows authorities to anticipate, guide, and optimise the welfare of a governed population (Foucault 1991). Developing from statistical knowledge garnered through disciplinary techniques, governmentality uses a complex variety of tactics, calculations and institutions that "take populations, rather than individuals, as their object" (Hewson 2022: 677).

Foucault (1993, 1991) frames governmentality as being imposed through a series of positive

operations on the bodies, thoughts, and conduct of the population, compelling the "supposedly 'autonomous' individuals to govern themselves according to 'conceptions of what is good, healthy, normal, virtuous, efficient and profitable' for the wider population" (Hewson 2022: 677; Foucault 1993, 1991; Rose and Miller 1992). Within governmentality, surveillance operates at two levels simultaneously, the individual (discipline) and the population (biopower) (Foucault 1991; Hewson 2022). Discipline, Foucault (1977) states, is enacted on the individual, separating them from the collective and exerting controls for the purpose of altering their behaviour. Biopolitics, then, does not supersede discipline, but represents a new form of power to be both defined, and administered, over a population (Buchanan 2022; Foucault 1978).

Similarly, Foucault's governmentality does not surpass biopolitics. Instead, governmentality brings together the individualising nature of discipline, with the indissoluble multiplicity of the broader population, to create a new form of governance (Buchanan 2022; Foucault 1991). Governmentality, thus, produces knowledge, giving rise to selected norms, and invites citizens to self-govern in accordance with these norms (Foucault 1991). It is a form of government that is enacted on the bodies *and* minds of the subjected populace. The governed are now those subjects whose conduct is to be "limited by law, individuals to be disciplined, or, indeed, people to be freed" (Rose, O'Malley and Valverde 2006: 85). This stance recognises that it is not the responsibility of the State, as a single body, to manage the conduct of individual citizens.

Rather, it involves a variety of authorities and institutions, each of which govern citizens, in different sites, and in relation to the different, overarching objectives of the State, such as the law, the economy, and the family (Foucault 1991; Rose, O'Malley and Valverde 2006). Government, Foucault (1991) argues, is concerned with the population. It is concerned with "men…in their relations, their links, their imbrication with those other things which are wealth, resources, means of subsistence, the territory with its specific qualities, climate, irrigation, fertility, etc" (Foucault 1991: 93). Thus, to govern is to know what needs to be governed, and to govern with consideration of that knowledge (Rose, O'Malley and Valverde 2006; Foucault 1991). Where the State once ruled through discipline, and its legitimacy fragile, it is now a range of institutions that enforce and reinforce the power of the State through positive reinforcement and punitive corrections, using both the economy and the family to exert external controls (Foucault 1991). The following section explores surveillance, as a concept, and as a technique of governmentality, with the aim of demonstrating that it flows throughout each of Foucault's above modalities of power.

Surveillance

Foucault's social control theses focus on the art of governance, and the process of making individuals, and their conduct, malleable to the governing authority through the use of surveillance. Surveillance is, in the most obvious sense, a means of making people visible (Lyon 2024). It is the "routine ways in which focused attention is paid to personal details by organisations that want to influence, manage, or control certain population groups" (Lyon

2003: 5). This definition of surveillance aligns with Foucault's social control theses, as the act of surveillance, of watching, is a fundamental element for each of his modalities of power. Thus, it provides a more accurate understanding of what it means to be watched. Because surveillance is understood as the systematic attention to the personal details of certain groups for the purposes of managing, or influencing, those specific cohorts (Lyon 2003, 2005, 2007), it thereby creates a system where individuals are easily identified by their social markers, and are thus made more visible for differential treatment.

Race, gender, and class each represent categories that individuals can be assigned to, which 'Other' and assign to them heightened, or lessened, visibility in the process. This visibility is inherent to surveillance, and is significant in discerning how the unequal distribution of State controls, like the economy, the law, or the family, by a governing State can act as punitive, or rewarding, mechanisms that impact individuals and groups (Foucault 1991, 1978). The heightened visibility surveillance causes to certain social groups ensures that their 'identities, conduct [and] events' are increasingly scrutinised, marking them as at risk of intervention by governing bodies. This visibility is garnered not only through interpersonal methods of watching one another, but can also involve the checking of written or digitised records, for example (Lyon 2007). Surveillance, in all modes, embraces a wide degree of methods in its endeavour to make people, and their activities, 'visible', bringing attention of, and to, others. Regardless of the method of surveillance used, the act of watching over one another operates along a continuum of "care" and "control", of which a combination of both may be involved (Lyon 2007: 3).

This continuum, Lyon (2003, 2014) writes, becomes most apparent in instances of registration and identification by a State. This continuum is made up of an amalgamation of different aspects of surveillance, and does not reside in neatly demarcated zones where acts of 'caring' or 'controlling' can be clearly discerned (Lyon 2007). Some elements of either care, or control, are always present, and largely dependent on both the goals of the ruling institution, and where a citizen is placed along it (Lyon 2003). Identification by a State has the capacity to both promote or deny ones access to human rights, despite how well intentioned the system was initially thought to be. There always remains the propensity for identification schemes, despite being introduced for the betterment of the population, to be subverted for other means (Lyon 2014).

This continuum is also present in historical instances of surveillance by a governing State, just as it is in Lyon's (2007) contemporary examples. Where surveillance, with categorisation as an intrinsic element of its operation, is crucial to contemporary governance, it was also a necessary element of colonial domination (Browne 2012, 2015). The delineation of social boundaries according to racial, gender, and class hierarchies allowed for ease of management by the governing body. In conducting surveillance over the personal details of individuals and groups, for purposes of managing, or influencing, those specific cohorts, the written database produced identifies people according to their social markers, and assigns them differential treatment by the State. Just as Lyon's (2024, 2003, 2007) research is grounded in the contemporary, this research is firmly planted within historical contexts. The enactment of the Contagious Diseases Acts across Britain's colonies provides a clear example of surveillance

being used as a means of control by the governing body.

The following subsection explores the notion of social sorting, an element of surveillance that enables the categorisation of certain individuals and groups for ease of management and control.

Social Sorting

Surveillance, first and foremost, is a means of identifying and measuring an individuals' worth according to the preassigned characteristics of the governing institution. It is also a vital means of sorting populations into distinct groups. Lyon (2005) proposed that surveillance represents an insidious, and powerful, means of 'creating and reinforcing' long-term social differences. The surveillance of everyday citizens has been, and continues to be, implicated in modes of social reproduction (Foucault 1991). Everyone is exposed to surveillance, and consequently, is subjected to the deeply encoded inequalities it harbours (Monahan 2008). Social sorting individuates us, distinguishing, and identifying us from one another. The information gathered is then analysed, transacted, and communicated about us, while we have little to no input as to how the information is being assessed (Lyon 2003; Bowker and Star 1999).

The human experience, despite our yearning for spontaneity, thrives on the mundane (Bowker and Star 1999). We seek to place everything, and everyone, into categories (Bowker and Star 1999; Lyon 2003). As Bowker and Star (1999) aptly put it, to classify is 'decidedly human'. The things and people we classify are, while essential in our lives, typically invisible (Lyon 2001; Marx 2002; Bowker and Star 1999). Despite these categories being so integral to our lives, we often are unaware of the social and moral order that they create (Bowker and Star 1999). Their impact, however, is indisputable, regardless of their invisibility. Classifications and standards are central to the ordering of society, granting benefits or consequences depending on where one falls (Lyon 2003; Bowker and Star 1999). Both these positive and negative outcomes of surveillance are, as indicated above, most visible in cases of registration and identification by a State (Lyon 2003, 2014).

Bowker and Star (1999:53 *emphasis added*) write that things that are "perceived as real *are* real in their consequences". Those things and individuals that we categorise, whether formally or informally, mould their behaviours to better fit those conceptions (Bowker and Star 1999). It is when the formal characteristics of categorisation are built into bureaucracies that their power is strengthened. They become naturalised, spilling into social institutions. The example Bowker and Star (1999) provide is in apartheid South Africa. Social sorting in apartheid South Africa was not accidental, but a continuation of older, colonial surveillant practices used to control bodies (Bowker and Star 1999). The method of identification and registration used by the apartheid State is a clear use of surveillance for the purposes of socially sorting the population. The racial classifications that were operationalised under apartheid enforced, and strengthened, previously existing socio-economic and gender hierarchies. This exertion of social control over the South African populace reinforced racial hierarchies among the population, sorting individuals for discriminatory treatment.

Another example of racialised social sorting is the United States throughout the seventeenth,

eighteenth and nineteenth centuries. Browne (2015) writes that practices of surveillance and social categorisation are deeply rooted in the colonisation of North America by British and European nations. Racializing surveillance is not static, rather, it relies on techniques to reify boundaries according to racial lines (Browne 2012). By sorting bodies according to racial hierarchies, colonial powers were better able to exert social control over the colonised population (Browne 2015). Lyon (2024) writes, to classify individuals is to 'put them in their proper place'. The 'slave pass[es]' used by slave owners relied on the idea that an individual "could be known through a written identification document" (Browne 2015:52). This pass, which they would carry on their person, fixed them permanently in the subordinate position of 'owned'. Racial segregation in the United States did not end with the abolition of slavery. It continued well-into the twentieth century, with the Supreme Court's 'separate but legal' doctrine remaining in effect until the Civil and Voting Rights Acts of 1864 and 1865 respectively (Ware 2012).

In Ontario, yet another settler colony, alcohol permit books, provided by the Liquor Control Board to its indigenous citizens, bear an uneasy resemblance to the slave passes of colonial America (Genosko and Thompson 2006). Research on the Liquor Control Act in 1920s Ontario describes in detail the development of a 'vast bureaucracy of surveillance', known otherwise as the 'Indian list', whereby First Nations People who consumed alcohol were sorted for extra controls by the colonial State (Genosko and Thompson 2006). Permit books, permit cards, and purchase forms were, under the Act, issued to those individuals who had been identified as alcohol consumers. To purchase alcohol, one needed to acquire, through application, a permit book, placing them in a state of permanent visibility. This would be kept on their person, and reviewed for 'over consumption' and 'misspending of income' by the governing authority (Genosko and Thompson 2006). Those registered were subject to disciplinary action should they be found to be "abus[ing their] permit privilege" (Genosko and Thompson 2006: 5). Such a disciplinary system highlights the punitive nature of social sorting, and the propensity for it maintain a system of discriminatory practices which keep category membership static.

Historically, one's so-called 'proper place' was more fixed (Lyon 2024), their geographical location and social status confining them to the colonial government's select categories. This functioned on a large scale due to the emergence of the modern nation-State (Lyon 2024). Each case of State control above demonstrates the targeting and sorting of certain individuals based on their social classification. Similarly, each case was influenced by the impact of colonialism (Genosko and Thompson 2006; Browne 2012,2015; Bowker and Star 1999). Here is where this thesis wishes to connect these incidences to this research. Colonisation, for the most part, strove to, and was dependent on, the classification and assignation of worth to different individuals and groups. This segregation and categorisation of individuals was done to exert further control by the ruling body. For those already experiencing marginalisation, most often the poor, racialised and gendered bodies that ruling classes sought to dominate, the sorting process was, and remains to be, felt much more severely.

The following section will bring queer, feminist and critical race theories, together with the notion of social sorting to discuss how colonial States used categories of race, class and gender,

to divide the population into manageable cohorts for ease of governance.

Categorisation under Colonialism: Prostitution, Subordination and the Racialised 'Other'

Social categorisation under colonialism follows a distinct pattern: the masculine coloniser contrasted against the feminised, colonised populations. Beneath these dichotomous categories, colonial States further delineate individuals into manageable cohorts based on bodily differences. Racial differences, for centuries, have been present within scientific discourses in the West to justify White political power and colonisation (Mason 2013). The advent of a two-sex gender model of women to men is a social construction that is created and performed according to certain beliefs and norms (Butler 1990, 1993; West and Zimmerman 1987; Risman 2004; Mason 2013). Discourse regarding one's capacity to exert self-control also highlights a common mechanism for transforming differences into inequality, with Foucault's argument that body management and self-control are used to legitimise and exert influence over a governed population (Foucault 1991, 1978, 1977; Mason 2013). This section looks to these social categories, and how they have been used by colonial bodies to govern a colonised population.

Razack (1998) and Mohanty (2003) both argue that racialised 'Otherness' was fashioned in opposition to the White, 'respectable' and masculine coloniser. Foucault's (1978) work has proved insightful in discerning the ways in which the bourgeois male sought to develop his identity as separate, or opposed to, the colonised 'Other'. He argues that the repression of sexuality during the nineteenth Century was part of a larger project of domination by the governing State (Foucault 1978). To mark itself as different to both the working classes and the aristocracy, the bourgeoise engaged in the disciplining of individual bodies, making their homes, and their person, a site of self-control and order (Foucault 1978; Razack 1998). The Victorian city was not one with rigid social borders, thus the fear of 'degeneracy' permeating the respectable boundaries of the White middle-classes, despite their best efforts to contain it to the slum, starkly resembled colonial fears of 'natives [rising] up to…murder people in their beds' (Razack 1998).

Colonialism's impact on the segregation of social groups affected the urban and social geography of Victorian cities, leading to unequal power relations between the governing State and its subjects (Kozma 2017). Colonisation "almost invariably implies a relation of structural domination, and a discursive or political suppression of the heterogeneity of the subject(s) in question" (Mohanty 1988: 61). Hierarchical relations among women can be traced across *all* categories of subordination (Razack 1996; bell hooks 2000). As such, it is important to understand the connections between coalescing systems of oppression, and that gender oppression cannot be separated from race and class (bell hooks 2000). Acknowledgement of an interlocked matrix of oppression (Hill Collins 1990) must serve as a reminder of how easily we can slip into positions of domination should we fail to recognise how our social positioning structures racial privileges (Razack 1996; bell hooks 2000). Racialised, poor-and-working

class women are those most impacted by systems of colonial domination.

This is not to characterise all women as singular 'feminine victims of the gender binary' (Mohanty 2003,1988). Rather, to highlight that women, as a sociological group, possess different "*already constituted* categories of experience, cognition, and interests…" (Mohanty 1988: 78). Race, gender, and class are not each 'distinct realms of experience', but rather they exist 'in and through relation to each other', even if in contradicting and conflicting ways (McClintock 1995). Reinvented through imperial capitalism and colonial bureaucracy, the notion of the family was projected outwards to bolster the nineteenth century's cult of domesticity (McClintock 1993,1995). The significance of this change saw a new imaginary unfold; one of the heteronormative family within which the subordination of women to men, and children to adults, was deemed a 'natural' fact (McClintock 1993). This 'natural' hierarchy legitimised the exclusion of groups who did not embody familial social formations, and naturalised a patriarchal and paternalistic conception of colonialism as the 'White' male figurehead, ruling over his racialised, 'immature' colonised children (McClintock 1993).

Patriarchy, according to Smith (2015) is reliant on a gender binary, whereby only two genders exist, with one being dominated by the other. Hunnicutt (2009: 557) expands on this definition, describing patriarchy as a set of "social arrangements that privilege males", in which men dominate women "both structurally and ideologically". Going further, Hunnicutt (2009: 558) elaborates by stating that although gender hierarchies are the central organising feature of patriarchal systems, "age, race, class, sexuality, religion, historical location, and nationality [all] mediate gender statuses, assigning males and females varying amounts of social value, privilege and power". This definition of patriarchy aligns neatly with colonialism's modus operandi, with the coloniser utilising gendered and sexual power to assert dominance over the feminised native population (Morgensen 2012). Within this nexus of layered oppression, encompassing sexual, colonial, and racialised domination, heteropatriarchy becomes the naturalised form of governance. Heteropatriarchy – a social system in which White, cisgender, heterosexual men hold power and privilege over other social groups – relies on the heterosexual family unit (Morgensen 2012).

To ensure heteropatriarchal governance, the sexual behaviours of the colonised population must be heavily scrutinised. As a result, non-conforming women become the targets of pervasive surveillance practices and increased external controls. As noted above, the categorisation of people under colonialism is no neutral nor benign practice, but a deliberate exertion of power that seeks to both define and confine colonised subjects (Browne 2015). This is done through the surveillance and documentation of those 'Othered' under colonial regimes for the purposes of control, influence, and management (Lyon 2003; Browne 2015; Razack 1998; Mohanty 2003). Such categorisation is, as explored above, a core strategy of surveillance. When a person becomes a biographical account of their existence, they are reduced to quantifiable data that allows the State to know them by their written documentation, rather than their individual characteristics (Fanon 1967). Such a process turns bodies into objects, easily sortable and highly visible, ensuring that every aspect of their life fits neatly into predetermined, racialised and gendered frameworks (Browne 2015; Lyon 2003). This process will be further explored, in relation to the Contagious Diseases Acts in Ireland and India, in

chapters 2 and 3 of this research.

Conclusion

Foucault's (1991) concept of governmentality is imperative to this research. It provides us with useful insights into the operation of Britain's colonial Empire in both Ireland and India. The calculated and rational nature of colonialism aligns neatly within governmentality's remit. The coalescing of disciplinary and biopolitical technologies of government that gathered information and assigned norms based on the collected data by the governing body fits the rationale of colonial State authorities, who strove to manage both the colonising, and colonised, populations. Colonial Britain shaped the behaviour of its dominated subjects by employing a range of disciplinary measures and biopolitical methods of social control to assure its dominance. Societies that are based on domination must naturalise racial and patriarchal hierarchies onto the bodies of those they colonise, because that allows the law of the colonisers to be legitimised when their rule becomes inevitable.

Governmentality brings together both disciplinary and biopower to produce knowledge and invite citizens to self-govern in accordance with the norms it creates. Governmentality maintains surveillance as a core technology under its purview, ensuring that the power of the colonial State not only operates through the direct coercion of its citizens (discipline), but also shapes their conduct by compelling them to adhere to the whims of the State through positive operations on the bodies and minds of the population (biopower). Disciplinary power shifted the gaze inward, and biopower redoubled it, using surveillance as a technique of power to regulate, influence, and prevent deviant behaviours. Governmentality shifts the responsibility from the State, as a single governing body tasked with the management of citizens, and firmly situates it in the hands of various authorities and institutions across different sites, and in relation to different objectives of the overall State. Overtly concerned with the population, governmentality concerns both men and things – humans and their surroundings – which give way to the longevity of the population.

Surveillance is a tool through which to make people visible. Colonial States sought to know their colonies intimately, focusing their attention on the collection of intimate and personal details regarding individuals, and groups, for better control, management, or influence, over their behaviours. Colonialism utilised stratifying methods of surveillance to bring colonised people in line with the overarching goals of the Empire. Foucault's conceptions of power – disciplinary, biopower/political, and governmentality – each delineate the ways in which surveillance was operationalised by the ruling class. Discipline trained individuals, separating, analysing, and differentiating them according to the whims of the authoritative body. Biopower/politics situated the State as the observer of life and death, and governmentality operated as an all-encompassing force for the direction and management of individual and collective behaviours.

A key feature of colonial regimes, and indeed of surveillance, is the categorisation of different social groups for ease of management. It is a long-standing technique of State governance.

Classifications and standards have become central to the ordering of society, the benefits and consequences bearing long-lasting impacts on individuals, and the groups in which they reside. The 'slave pass' in eighteenth century United States, apartheid South Africa, and the Ontarian 'Indian list' in Canada, are each examples of colonial logistics aimed at managing and controlling a population through surveillant and governmental means. Many of the negative outcomes of social categorisation stem from racialised processes of colonial sorting. As this research argues, and will demonstrate in later chapters, the Contagious Diseases Acts represent yet another incidence of historical colonial domination.

In using surveillance as a lens through which to interrogate the enactment of the Contagious Diseases Acts, this research brings together feminist and critical race theory to investigate the ways in which colonialism categorised and constructed racialised, poor-and-working class women. In societies based on domination, hierarchy and violence *only* work when they become perceived as inevitable outcomes of colonial life (Smith 2015). To be considered as a prostitute under the Contagious Diseases Acts was to be 'diseased' and in need of extra moral and social controls (Walkowitz 1980; Thomas and Vagishwari 2025). The notion that women were the pollutants of 'respectable' bourgeoise men permeated economic, political, and social categories. It made all women suspect under the Britain's colonial regime, and reinforced the State's intersectional matrix of oppression (Walkowitz 1980; Luddy 1995,1997; bell hooks 2000; Hill Collins 1990).

The following chapter will detail how the Contagious Diseases Acts were operationalised, following which chapter 3 will bring together this theoretical framework with the legislation in both Ireland and India to provide a contextualised, comparative analysis of the Contagious Diseases Acts 1866-1869, with the Indian Contagious Diseases Act 1868, respectively.

Chapter 2: Contextualising the Contagious Diseases Acts in Ireland and India

Introduction

There is a rich vein of research that explores the social and political history of prostitution in nineteenth century India and Ireland (Legg 2009; Walkowitz 1980). This chapter aims to consider the Contagious Diseases Acts as they operated in both jurisdictions during the Victorian period. Embedded into the social landscape of Ireland and India, they were positioned as being for the benefit, and to assure the health of, British troops across the colonies. They were, as will be demonstrated throughout this research, the beginning of the tradition of medical, political and social intervention into the lives of women and girls, under the guise of national safety and sexual security. They represent a strategy of colonial domination that sought to regulate prostitution by segregating women according to their gender, race and class (Legg 2009, 2012; Wald 2009; Ballhatchet 2012).

In India, this categorisation and regulation of women was exacerbated by a misinterpretation of the caste system, and in Ireland, this was fuelled by Victorian social hierarchies (Legg 2009; Luddy 1995, 2005). Colonialism, in both countries, introduced gender binaries that framed women as either 'respectable' and 'clean', or 'immoral' and 'diseased', each of which curbed women's movement and sexual agency (Wald 2009; Innes 1994; Luddy 1995, 2005). The ways in which Irish and Indian women were viewed was largely dependent on their perceived position along the hetero-patriarchal hierarchy—a structure which portrayed them as them as being both a commodity of the imperial army, and as a dangerous temptation to the moral standing of the British empire. The shift from traditional to imperial altered the social position of all women, making them vulnerable to strategies of cultural and economic domination, restructuring the cultural hierarchies that were already in place in favour of the domineering colonial, heteropatriarchal State (Morgensen 2012; Rifkin 2012; Kozma 2017; Smith 2015).

This chapter aims to answer the research question: what was the social context in which the Contagious Diseases Acts were implemented? While this chapter focuses on the historical context in which the Contagious Diseases Acts were implemented in both Ireland and India, for a full understanding of this it is imperative to bear in mind the theoretical foundations of this research. Foucault's theses of social control, with governmentality as a focal lens, is a core element of this research. The disciplinary function of the lock hospital system, coupled with biopolitical sorting techniques, functioned together to create a colonial governmentality; one that exerted and ensured Britain's strategy of control-at-a-distance, designed to both influence and manage women through the regulation of their sexuality and sexual licence. The dichotomous depiction of Irish and Indian women as being both a product of, and a threat to, the colonial State, positioned them within a nexus of layered oppressions - encompassing sex, race and class distinctions - and marked them as targets for external controls by the State.

To analyse what connects Ireland and India, this chapter will examine the social climate that preceded and existed alongside the Contagious Diseases Acts. To do this, the chapter opens with an interrogation of the lock hospital system that was in operation in both Ireland and India, on account of their foundational role in the functioning and operation of the Contagious Diseases Acts. Second, the chapter examines the Contagious Diseases Prevention (Cantonment) Act 1864, demonstrating that this piece of legislation preceded efforts to limit the spread of venereal disease among British troops in India, and represents a pivotal moment in the regulation of prostitution in colonial India.

Third, an examination of Lal bazars in India, designated red-light districts that housed prostitute Indian women within military cantonments. Lal bazars played a role in the regulation of prostitution in colonial India on account of their being a key feature of military cantonments both prior to, and following, the enactment of the Contagious Diseases Act of 1864. Fourth, the chapter examines the enactment of the Contagious Diseases Acts 1864, 1866 and 1869 in Ireland, contextualising the climate in the run up to, and during, the enactment of the legislation. Finally, the chapter examines the Indian Contagious Diseases Act 1868, demonstrating that the reasoning for the Act mirrored the Acts in Britain and Ireland – to quell the rise of venereal disease among its military men.

Lock Hospitals

Lock hospitals emerged in the eighteenth century as a means of containing the spread of venereal disease. The Contagious Diseases Acts 1866-1869, and the Indian Contagious Diseases Act 1868, both relied heavily on their operation. A punitive solution to a medical problem, they spanned across Ireland and India, their directive distorted by social attitudes to morality (Jebb 1984). In segregating diseased prostitutes from their male clients, the colonial State was able to exert control through increased intervention, rather than address the social and economic causes of prostitution. The perceived ability of some women to devastate the White settler population through sterility and visible disease meant that the bodies of *all* women became sites of contamination. Thus, it was imperative that the threat they posed to the White colonial settler was quelled.

This perception by the colonial State contrasted the reality: that venereal disease was more likely to be spread by rampant male sexual licence, than by women. It was easier to accept, however, that it was women who needed sexual regulation. Thus, this perspective evoked a heightened hostility towards female sexual licence, and the status of women in Victorian society. This was both regarding securing treatment for venereal disease, and in navigating wider Victorian class constructs of respectability (Walkowitz 1980; Luddy 1995). Hence, women, beneath the guise of a humanitarian approach to alleviating the problems of military life, became a contagion to be treated.

Ireland's Lock Hospitals

Lock hospitals were in operation across both Ireland and England throughout the nineteenth century. Housed alongside asylums, lock hospitals were to treat women for venereal disease

where other hospitals could, and would, not (Romero-Ruiz 2010). Tasked with containing and punishing women who leveraged their sexual licence, for fear their propensity for disease would contaminate the delicate balance of male, heteropatriarchal governance and Victorian social order, lock hospitals were fundamental to the disciplinary apparatus of British colonial governmentality. These certified, voluntary hospitals in Ireland operated according to an inpatient system, of which the inpatient care was provided by specialised Medical Officers, Visiting Surgeons and Assistants, each of which wielded special powers of detection and detention under the Irish Contagious Diseases Act 1866-1869.

Lock hospitals operated alongside penitentiaries, and a number of them were founded by philanthropists, to 'rescue' and reform so-called 'fallen' prostitutes (Romero Ruiz 2010). Lock hospitals in Ireland, particularly following 1850, followed similar teachings to neighbouring Magdalene Homes (see Smith 2007) in that they taught women traits of domesticity and submissiveness, in line with the Victorian era's core patriarchal values (Romero Ruiz 2010; Riordan 2012). Often there was an asylum installed on the premises of lock hospitals that was tasked with providing the women incarcerated with a "moral cure", while the hospital was for the treatment of venereal disease (Romero Ruiz 2010: 143). Ireland's lock hospitals functioned as disciplinary institutions, legislatively ordained to provide for the moral reformation of the women who entered.[4] White Irish women were, as per their socially sorted position, expected to perform their categorisation according to Victorian concepts of race and class. This performance was one of Victorian domesticity and piety, in which Irish Lock hospitals provided a space to train both (Romero Ruiz 2010). The reeducation of Irish women by the colonial authority through hard labour and servitude informed the notion that White Irish women were worthy of redemption, which would be enshrined into legislation with the enactment of the Contagious Diseases Acts 1866-1869.

Women were immersed in an intense religious atmosphere that, by the 1850s, focused on the moral reformation of their patients (Walkowitz 1980; Luddy 1995). The rules governing the hospital did not allow patients to "lie in bed", rather they had to remain on the wards, except for during mealtimes, and at no point were they to "expose themselves by looking out of the windows" (Riordan 2012: 76). Patients of the lock hospital were also tasked with cleaning the wards and were expected to be engaged in needlework on behalf of the institution. Irish lock hospitals could be better described as a prison than a hospital, with patients being required to wear 'drab clothing' or uniforms to appease the governors of the institution (Hopkins 2002; Walkowtiz 1980). The carceral and punitive conditions of Irish lock hospital system are emblematic of the classist, and misogynistic attitudes of Victorian society. Because all women were regaled to the domestic realm, they were doubly punished upon entering the lock hospital: first, for being apprehended outside of the home, for any proximity to the thoroughfare placed women in a position of disreputation; and, secondly, for working as a prostitute, a position considered so morally lax that it was reserved for only the lowliest classes of women.

Women confined to lock hospitals were subjected to a probationary period of three months, after which they were to be trained as 'laundrywomen, servants, and needlewomen' to assist their re-entry into 'respectable society' (Walkowitz 1980). Occupying an "imprecise position…between a reformatory and a hospital" (Riordan 2012: 76), the Dublin Westmoreland Lock promoted the redemption of patients through hard labour (Romero Ruiz

[4] See Section 12, Contagious Diseases Act 1866.

2010; Riordan 2012). The presence of a laundry, staffed by patients, was not commercial like later Magdalene asylums. Rather, work in the hospital's laundry was considered a privilege for women chosen to work there, given that the work was paid and not compelled (Riordan 2012). Many locks installed an asylum on their premises, for women who had been cured of disease but who wanted to remain to "devote two years of their lives to being morally reformed" (Romero Ruiz 2010: 146). Despite the incentive of paid work within the lock's laundry over the years, prospective patients were deterred by the belief that "all bad cases…are *destroyed* by being smothered between mattresses" (Riordan 2012: 77 *emphasis added*).

Ireland had a number of prominent lock hospitals operating throughout the eighteenth and nineteenth centuries, one located on Dublin's Townsend Street, and another in County Kildare that was associated with the Curragh Military Camp which housed British soldiers (Crawford 2013; West 2025). They promoted the redemption of penitents through hard labour, and the symbolic "purging of sin" through the cleansing of dirty laundry (Riordan 2012: 76). Drawing on Lyon's continuum, lock hospitals in Ireland often traversed the line between 'care' and 'control', functioning as a means of providing both sexual healthcare to prostitutes, whilst also controlling all those within their walls, and wider society as a whole, with the threat, and promise, of detainment, should they be considered by a doctor, magistrate, or policeman to be a 'common', diseased prostitute (Walkowitz 1980; Lyon 2007, 2014; Hiersche 2014; Wallis 2014; Romero-Ruiz 2011).

Supporters for the regulation of sex work in England and Ireland advocated for the designation of segregated 'vice zones' (Howell 2000). The Monto, a well-known red-light district, and the largest in Europe between 1860 and 1925, in Dublin's inner city, serves as one such example of a laxly policed 'de facto' tolerated zone (Howell 2003). Proponents argued that the profession should be allowed to flourish within its specified areas, so that it might remain a service provided to men in private (Howell 2000: 380). The attempt to regulate prostitution by removing it from the public eye ensured that prostitutes in England and Ireland remained an object of male desire, a target for "sex…blame, disease, exploitation, and degradation" (Wallis 2014: 43; Hiersche 2014; Baker 2012). Dublin's Westmoreland Lock Hospital was established in 1792, and after 1820, only treated women (Riordan 2012; Walker 2010).

While there were other lock hospitals in Ireland, such as the Limerick Lock and Fever Hospital (now known as St. John's Hospital), and the Kildare Lock Hospital near the Curragh Camp, this research is limited in its capacity to provide a full account of their operations.[5] Inside Dublin's lock hospital, married women were expected to produce their marriage certificate to distinguish themselves from the single women suspected of, or known to be engaged in, prostitution, who also received treatment there (Luddy 1995; Walkowitz 1980). Patients were also segregated by religion, and whether they had been previously admitted to the hospital. Functioning as a disciplinary institution, patients of the Westmoreland Lock were confined to it until they were declared 'free' from infection (Riordan 2012; Walkowitz 1980). The Dublin Lock remained in operation, though with limited funding and a notorious reputation, until the end of the nineteenth century (Wheelock 2011; Walker 2010).

[5] For more information regarding these lock hospitals, see Sources for Irish Women's History, and Dwane (2013) for information on Limerick's Lock and Fever Hospital. See also Crawford (no date), and Excavations.ie for more information on Kildare's Lock Hospital.

India's Lock Hospitals

Lock hospitals in India were first established during the late eighteenth century across the three British Presidencies of Madras, Bengal and Bombay, finally closing in 1888 following the formal repeal of the Contagious Diseases Act (Gopalakrishnan 2022; Legg 2009). Lock, or 'small hospitals', were often placed within military cantonments, where the women residing there, predominantly from racialised and impoverished castes, could be "rounded up and subjected to a medical examination" at random (Peers 1998: 150; Ballhatchet 2012; Legg 2009). Cantonments were areas designated to housing British troops. There is evidence that there were regulatory practices in place for prostitution as early as the 1780s, with surgeons in Bombay authorised to regularly inspect 'public' women in markets bazars, and to detain them for treatment if needed (Kumar 2017). Market bazars were civilian marketplaces that emerged just outside of or within the gates of British military cantonments.

Lock hospitals were established in 1805 due of rising statistics of venereal disease across India (Ballhatchet 2012). Following 1805, women diagnosed with venereal diseases were (often) forcibly detained in these institutions until they were certified by an army medical officer as having been 'cured' of venereal disease (Tripathi 2024; Ballhatchet 2012; Peers 1998)[6]. Lock hospitals were established at most cantonments between 1805 and 1833, with support for their use most apparent among army officers (Peers 1998). Many institutions were closed following 1833, but "statistics continued to rise", reopening local lock hospitals first, and across India from 1864 (Ballhatchet 2012: 160). There was no formal, legislative focus on the moral reclamation of the women who entered, contrasting the explicitly punitive nature of their Irish counterpart (Walkowitz 1980; Luddy 1995, 2005). The aim of the Indian colonial authorities was to control the spread of venereal disease among British and European troops stationed across the country. Rather than address the issue of male sexual licence contributing to the spread of V.D., the colonial government sought to exert control over the sexuality and sexual licence of native women (Gopalakrishnan 2022; Legg 2009; Ballhatchet 2012).

Similar to Ireland, hospital patients were further delineated according to religion (Curtis 2010). Conversion was not a motivating factor amongst lock hospital staff, instead there was a belief that the women treated there were "born to this role" and that their experience of venereal disease was an expected aspect of their position within the British colonial empire (Curtis 2010: 89; Ballhatchet 2012; Tripthi 2024). While not legislatively explicit, the Indian lock hospital system did bring on a number of Indian subordinate staff to oversee the stable and successful operation of the institutions. Matrons, for instance, were women hired as supervisors to oversee the inmates, assist with medical exams and enforce discipline within them (Gopalakrishnan 2022; Ballhatchet 2012). They were expected to conduct surveillance of hospital patients, be present during examinations, and to function as nurses assisting the Visiting Surgeons during the treatment of the women incarcerated (Gopalakrishnan 2022).

Matrons also held a disciplinary function, and were expected to both apprehend, and prevent, women from escaping lock hospitals' (Gopalakrishnan 2022). While there was no expectation to turn 'unruly' women 'virtuous', matrons were expected to be a "persuasive influence" inside lock hospitals: to display superior moral and chaste behaviours to influence lock

[6] This precedes the introduction of the Indian Contagious Diseases Act of 1868.

inmates (Gopalakrishnan 2022: 36). Debates surrounding the appointment and training of European matrons ultimately culminated in debates regarding the financial burden their salaries placed on imperial funding (Gopalakrishnan 2022). The need for matrons was remedied in the appointment of both Indian and European brothel-keepers to act as matrons within the Indian lock hospital system (Gopalakrishnan 2022).

The Indian lock hospital system relied heavily on various lay staff to function effectively (Gopalakrishnan 2022). These included peons, lay medical staff employed as police, chowdranies, dhais, matrons, and gomastahs (see Gopalakrishnan 2022; Ballhatchet 2012). Chowdranies maintained a list of the prostitutes working in the cantonment area and reported infections (Gopalakrishnan 2022). Dhais acted as midwives, inspected lock hospitals, while Gomastahs acted as detectives, tasked with monitoring women and uncovering those operating as 'clandestine prostitutes' (Gopalakrishnan 2022). The decision to extend the lock hospital system to the brothels themselves, and while brothel-keepers, since the 1840s, had been legislatively ordained to provide information regarding clandestine prostitution, the decision to bring them on as lay-staff to surgeons officially instated them as informers for the State (Gopalakrishnan 2022).[7] Official attitudes towards prostitutes were mostly ambivalent, with no condemnation of them on moral grounds, unlike the proposed 'vice zones' in Ireland and Britain. At various stages and across India, lock hospitals were closed and reopened depending on the levels of venereal disease in the area (Ballhatchet 2012).

The following section will examine legislation introduced prior to the Indian Contagious Diseases Act of 1868, to provide insights into the social environment that preceded legislative attempts to treat venereal disease of military men stationed across the subcontinent.

An Act to Make Provision for the Administration of Military Cantonments 1864

In 1863, The Royal Commission on the Sanitary State of the Army in India made several recommendations pertaining to disease surveillance and reporting. This publication (Royal Commission 1863) directly influenced the Act to Mark Provision for the Administration of Military Cantonments 1864 (otherwise known, and hereafter referred to, as the Cantonment Act 1864[8]), with its findings highlighting the widespread issue of disease and poor sanitation within military cantonments in India (Ballhatchet 2012; The Royal Commission 1863; Venereal Disease Among the British Troops in India, no. 85, 1899; Legg 2012). The Cantonment Act 1864 both regulated and structured prostitution within British military bases, making compulsory the registration and regular health checks for women who serviced British soldiers (Chatterjee 2021; Legg 2012). Lal bazars, as explored below, are one example of the outcome of the Cantonment Act 1864.

The scope of the Act was confined to a four-mile radius of military cantonments (Chatterjee 2012). Following the Cantonment Act 1864, deliberations soon emerged regarding the legal mechanisms that would be necessary to regulate prostitution in cities without large cantonments (Legg 2012; Chatterjee 2021). The scope of this Act also included the

[7] See Section 9, Indian Contagious Diseases Act 1868.

[8] Named as such because the legislation pertained to only the military cantonments across India.

standardisation of monthly reports on admissions, discharges, diseases and deaths, along with annual health reports across the British Presidencies, and to introduce the periodic inspections by district Sanitary inspectors (The Royal Commission 1863). The Cantonment Act 1864 was introduced to extend the regulation of the lock hospital system across India's three Presidencies (Legg 2009). The Cantonment Act 1864 represents a pivotal moment in the regulation of prostitution in colonial India, and provided for the registration and inspection of prostitutes who served British soldiers (Legg 2009; Levine 2003). The Cantonment Act 1864 legislated that women acting as prostitutes were registered as such within military cantonments, were examined fortnightly, and would be detained in a lock hospital if found to be infected (Ballhatchet 2012; Legg 2009). These regulations both preceded, and succeeded the Contagious Diseases Acts, and regulated various types of prostitution (Legg 2009).

The Act divided prostitutes into two categories: 'private prostitutes' who serviced Europeans and high-ranking officers, while the second were classified as 'public prostitutes not so frequented' who serviced foot soldiers (Ballhatchet 2012; Curtis 2010; Legg 2009; Kumar 2017). Prostitutes of different castes could be identified by how they described themselves, with higher caste women using the term 'patita' or 'fallen woman', while those from the lower orders of British India referred to themselves as sex workers or 'thakanhi', or 'beshya' (Kumar 2017). The Cantonment Act 1864 sought to bring the latter under regulation. The women who catered to Europeans were registered within cantonments and underwent examination every month (Ballhatchet 2012). Within cantonments there could be no public soliciting, and any woman suspected of being a non-registered prostitute would be reported to the authorities (Legg 2009).

The Cantonment Act 1864 gave further authority to the Cantonment Committees (administrative bodies established by the British to manage the British Indian Army military cantonments and later replaced by the Cantonment Board in 1924) to extend their powers beyond the enclosure if other prostitutes were 'readily available' to British troops (Legg 2009; Jha 2023). The partitioning of registered homes as *chaklas*[9] within the cantonment meant that the premises could be inspected at will by the appointed lay-medical staff, Indian brothel keepers and midwives respectively, to maintain a degree of cleanliness as dictated by the Cantonment Committee (Gopalakrishnan 2022; Legg 2009). The goal was not to decrease the number of prostitutes, as was so often the argument in Britain and Ireland, but to maintain them as a necessary and 'inevitable evil, which may be controlled, but which cannot be got[ten] rid of' (Legg 2009; Kumar 2017).

The following section will examine the use of Lal bazars in Indian cantonments, designated red-light districts that were bolstered by the introduction of the Cantonment Act 1864. These designated areas within military zones are integral to understanding the climate in India prior to the enactment of the Contagious Diseases Act of 1868, on account of both their perceived necessity by military personnel, and in that such arrangements were not accepted in Britain for reasons of morality.

[9] Chaklas housed Indian prostitutes either inside or just outside the walls of military cantonments.

Lal Bazars

Lal bazars were designated and segregated areas within cantonments that housed working prostitutes (Ballhatchet 2012). Established across many regiments, oftentimes without any formal, proposed submission to the colonial Government, they were a central component of the British colonial strategy to regulate the sexual activity of British soldiers (Ballhatchet 2012; Legg 2009). In essence, Lal bazars were a regulationists' ideal: designated sex districts where prostitution flourished, unimpeded by moral politics, where brothels would be accepted and inspected, and "from which prostitutes were rarely moved on" (Howell 2000: 380). Despite conjuring notions of disease and sexual laxity, these red-light districts were rationalised as providing 'safe' sexual recreation for British troops that would work to quell other 'dangerous alternatives' (Chang 2007; Arondekar 2009; Ballhatchet 2012).

The health of British soldiers was paramount in the formation of policy, given the Cantonment Act's preoccupation with the spread of venereal disease, and the structuring of prostitution across India. Lal bazars were thought to provide a solution to the expense of lock hospitals. Prostitutes dwelling within Lal bazars were housed in *chaklas*, official brothels within these commercialised zones, catering to a select few military men, rather than those 'disorderly' prostitutes frequented by rank-and-file soldiers (Ballhatchet 2012; Peers 1998; Sameen 2022; Chakraborty 2016). *Chaklas* were further divided into three categories according to skin colour; two of which, Gora Chakla and Lal Kurti Chakla, were reserved for White army officers and soldiers respectively, while the third, Kala Chakla, was reserved for Indian soldiers (Chakraborty 2016). Lal bazars embodied the colonial view that working-class British soldiers lacked the capacity to abstain from sex, thus it was imperative that their needs were catered to, and that the women provided were heavily regulated to avoid the spread of infection (Ballhatchet 2012).

Prostitutes in Lal bazars were obliged to carry the burden of regulation, with authorities only keen on preventing the spread of venereal disease amongst these women alone (Mishra 1999). Chatterjee (1992) has written that through the act of registration, Indian prostitutes were 'enrolled' as colonial subjects. They were enrolled through the ritualised nature of their medical examination in lock hospitals, where women were asked to provide a description of their social and physical status, and after which those details would be translated into regional languages and published in small booklets such as the 'Beshya Guidet' (*Guide to Prostitutes*) (Chatterjee 1992). The task of maintaining a "steady supply of 'attractive women' to keep the British soldiers contained within the cantonment" proved problematic, with authorities using 'any excuse' to "drag in young, healthy and good-looking Indian women registered as prostitutes in the cantonment bazars who could…be physically examined" (Chatterjee 1992: 51).

The following section will examine the Contagious Diseases Acts 1864, 1866, and 1869 in Ireland, as well as the social climate in the run up to their formal introduction.

Contagious Diseases Acts in Ireland, 1864, 1866 and 1869

In Britain and Ireland, the increased medicalised response to venereal disease brought together the existing class and sex prejudices of the mid-Victorian period and resulted in the introduction

of the first of three Contagious Diseases Acts in 1864 (Walkowitz 1980; Luddy 1995, 2005). The 1864 Act provided for the sanitary inspection of prostitutes in specific military depots across Southern England and Ireland, covering eleven garrison and dock towns (Walkowitz 1980; Contagious Diseases Prevention Act 1864). It provided that "a woman identified as a diseased prostitute by a plain-clothes member of the metropolitan police undergo examination" (Walkowitz 1980: 76; Malcolm 1999). Should she be identified as having a venereal disease, she could be detained in a Lock Hospital for up to three months, to which she could elect to go voluntarily, or she would be admitted under magistrate's orders (Walkowitz 1980: 76; Malcolm 1999). What identified a woman as a potential prostitute was unclear, but the powers of arrest granted by the Act enabled the police to apprehend and detain *any* woman that possibly resembled a prostitute (Walkowitz 1980; Hiersche 2014).

In 1866, British parliament sought to rectify the initial flaws of the 1864 Act, as well as build upon its successes (Hiersche 2014). According to the Report of the Royal Commission upon the Administration and Operation of the Contagious Diseases Acts Volume 1, the 1864 Act had been repealed, but its "principal provisions were re-enacted" (1871: A2). The 1866 Act added two more districts, Chatham and Windsor, to the list of areas subject to the first Act and extended it to include a mandatory fortnightly inspection of all known prostitutes in these areas (Walkowitz 1980: 78). What the 1866 Act did not do was clarify who or what would constitute as a 'common prostitute' (Walkowtiz 1980; Luddy 1995). Women remained 'Othered' before the law, and as a result *all* women could potentially assume the position of 'common prostitute' within Victorian society. The women so targeted by the Acts were largely from garrison and port cities, were impoverished, racialised, and were continuously subjected to an invasive and non-consensual medical examination (Bettes 2017; Walkowitz 1980; Hiersche 2014).

For middle-class British women, the forced and invasive inspections by medical officers were immoral and unconstitutional, akin to 'instrumental rape'[10] (Levengood 1992; Walkowitz 1980). Issues surrounding sex prejudices and class arose from the controversy surrounding the internal examination of female venereal disease patients, and in particular the use of a speculum to identify gonorrhoea and syphilis (Walkowitz 1980). The device was thought to 'constitute as a shocking immorality' when imposed upon 'virtuous women' (Walkowitz 1980). For those racialised and impoverished women who engaged in prostitution however, the speculum was thought to be adequate as they were "unsexed" and already "dead to shame" (Walkowitz 1980: 56-7; Levengood 1992). Such arguments surrounding the impact of a speculum on a woman's chastity indicate to the extent to which providing a woman with gynaecological and reproductive healthcare was presumed to be an indecent act. They are also indicative of her precarious position within Victorian society; so unstable was her social status, that should she present herself within any proximity to the prostitute, she would be subject to a loss of social status and perceived respectability. This made it so that she was in a position of constant scrutiny, with her value to society easily rescinded should she deviate from the prescribed Victorian norm of domesticity and sexual morality.

Again, in 1867, there came a campaign by the Harveian Medical Society in London to extend the Acts further North (Hiersche 2014) This relied heavily on evidence submitted by

[10] This argument was promoted by repeal campaigners, with Josephine Butler spearheading the repeal movement in Britain and Ireland and often encouraging activists to take the movement beyond the metropole. This thesis is limited in its capacity to fully examine the repeal movement in Ireland and India. For more information see the following: Tollan (2018); Ichikawa (2015); Ramsey (2014); Levine (2003); Stansfeld (1876).

proponents of legislative extension as to the success of the initial Acts in reducing the number of brothels, prostitution and juvenile prostitution in the subjected districts. According to Deakin (1871), the Harveian Society made recommendations that explicitly focused on the safeguarding of European officer's reputations, urging the segregation of 'unclean' women, and their compulsory quarantine and treatment under military supervision (Deakin 1871). These recommendations were incorporated into the final 1869 Contagious Diseases Act and further included their extension to another five districts across Britain, the imposition of a nine-month detention on women with venereal disease to a lock hospital, along with the provision of "…moral and religious instruction of the women so confined" (Walkowitz 1980: 86). Other recommendations made by the Harveian Report in 1841 called for the detention of women who were "unfit" to undergo an examination, made the Contagious Diseases Acts 1864 and 1866 effective for an indefinite period, and extended the jurisdiction of the Acts up to a ten-mile radius of the subjected districts (Walkowitz 1980: 86; Hiersche 2014).

The following section examines the Indian Contagious Diseases Act of 1868 and provides the reader with an overview of the social climate in colonial India prior to their formal introduction. Where the prior Cantonment Act 1864 provided for the segregation, examination and registration of women engaged in prostitution, the Contagious Diseases Act 1868 made compulsory their detention and treatment in lock hospitals.

The Indian Contagious Diseases Act 1868

The Royal Commission on the Sanitary State of the Army in India (1863) made the recommendation that improvements be made to regiment facilities to better military 'occupation, instruction, and recreation' (Ballhatchet 2012; The Report of the Royal Commission 1863). The Royal Commission recommended that 'commissions of public health' be appointed by military and colonial authorities to formulate rules under the Cantonments Act 1864 (Ballhatchet 2012). This committee was "constituted as to represent the various elements, civil, military, engineering, sanitary, and medical; to give advice and assistance in all matters relating to public health…" (The Report of the Royal Commission 1863: lxxxiv). This commission operated under the administrative framework established in the Cantonment Act 1864, and further proposed that prostitutes should be divided into two separate classes: 'clean' or 'foul' (Ballhatchet 2012; Curtis 2010; The Report of the Royal Commission 1863; Mishra 1999).

Broadly, there were two dominant themes in the Report of the Royal Commission (1863), the first being to increase the number of married soldiers into the ranks of the British army, and the second to return to the system of lock hospitals in a 'more thorough-going and stringent manner' (Mishra 1999; The Report of the Royal Commission 1863). The question of marriage was proposed due to the Report's (1863: xxi) estimation that "married officers [were] healthier than the unmarried", due to their living quarters being "better placed" than that of the unmarried soldiers' quarters, and also because they are "not driven to drink or debauchery" out of boredom. The belief that unmarried men were incapable of self-restraint is a recurring element of the Report (1863) and is inherent to Victorian notions of class and respectability. That soldiers be 'occupied, and their minds…actively engaged in the discharge of their duties' was

crucial to the presumed proper functioning of the British military, and as a result it was imperative that a system be put in place to cater to the needs of the soldiery. The Report's (1863) advocacy for marriage was not to encourage Victorian family values, rather than to dissuade the men from causing the State further embarrassment on account of their forays in 'cohabitation' with native women, homosexual, or 'mercenary love' and 'masturbation' (Ballhatchet 2012).

Prior to publication of the Report (1863), the establishment of lock hospitals was regiment specific, meaning that only those regiments that had complained of rising incidents of venereal disease were granted a facility (Mishra 1999; Ballhatchet 2012). While a more systematic effort had been made by the Governor-General of India to check for V.D. since 1816, the Medical Board of the government had declared the system 'useless' and called for its abolition (Mishra 1999). Lock hospitals in Bengal had been abolished in 1830, and while governments in Bombay and Madras had been asked to follow suit, only Madras opted to discontinue the regime. Thus, when the Report (1863) recommended that lock hospitals be reinstated and improved across the three Presidencies, the government acquiesced (Mishra 1999; Ballhatchet 2012). Having rejected the recommendation to allow military men to marry, the purpose for the return and improvement to the lock hospital system was twofold: first to reduce rates of venereal disease among unmarried soldiers who were so lacking in self-restraint as to abstain from 'debauchery'; and secondly, to institute a mechanism of social control that would both dominate colonised women and the working-class rank-and-file soldiers.

The control of sexuality in India was imperative as it allowed for both social control, and for the construction of a self-identity based on Western centric notions of morality and modernity (Grossman 2018; Kumar 2017; Ballhatchet 2012; Razack 1998). Framing Britain as the White, masculine coloniser positioned the colonial Empire in opposition to the racialised, feminine colonial India. As such, the colonial government wanted to legitimise prostitution, to 'make it respectable', and appear less 'dangerous' (Ballhatchet 2012; Curtis 2010; Kumar 2017). In order to rule over India, British and European soldiers needed to be unrestrained, thus their irregular indulgences with native women were marked according to wider colonial ideas of male virility, 'the virile coloniser', that would subjugate the bodies of the oppressed (Mishra 1999). The shift from a medicalised response to venereal disease to a legislative one first appeared in the Cantonment Act 1864, following Britain's first Contagious Diseases Act (Ballhatchet 2012; Gopalakrishnan 2022). Authorities in India, who faced similar concerns regarding rates of venereal disease documented in the Report of the Royal Commission (1863) adopted a similar approach with the enactment of the Cantonment Act 1864. Any indication of syphilis was viewed as a sign White inferiority, hence the Cantonment Act 1864 moved to remove such imagery by subjugating the bodies of Empire's subjected women.

The year 1868 saw the enactment of the Indian Contagious Diseases Act, hereafter referred to as the Indian Contagious Diseases Act 1868. This Act allowed local governments to tailor the rules of the Cantonment Act to regional conditions and bring brothels and their keepers under inspection (Ballhatchet 2012). The 1868 Act contained no provision for segregation, but did require compulsory registration and health inspection in brothels (Chatterjee 2021). Those women engaged in practices with no European equivalent were classed as 'immoral', while those practising prostitution in and around cantonments were viewed as threats to both the men and the stability of the imperial project (Wald 2009). As is characteristic of surveillance systems, those made most visible to authorities were those already easily

marginalised and identifiable (Lyon 2003, 2005).

Conclusion

Lock hospitals, in both Ireland and India, functioned as sites of indeterminate detainment; a home for those women unfortunate enough to 'fall' from respectable society. In Ireland and England, they often occupied an imprecise space between a hospital and a reformatory and operated alongside penitentiaries and asylums. A key difference between the Irish and Indian lock hospital system was the stigma surrounding prostitution, and the women who entered their doors. More specifically, the British interpretation of the stigma surrounding Indian women engaged in prostitution differed from that directed towards White, Irish and English women. Hence, there was no focus on the moral reclamation of prostitutes so housed, rather a belief that they were 'born to the role', and that venereal disease was an expected aspect of their profession. This identity contradicted the idealised Victorian woman, who was both morally refined and sexually repressed (Curtis 2010; Baker 2012; Walkowitz 1980; Bettes 2017). In focusing on the salvation of White women's morality, the colonial State defined whose lives were worth preserving through the logic of epidermal racism. Indian women were, on account of the colonial hierarchy, constituted as both a resource and a risk to be managed by the colonising soldiery, rather than women worthy of moral salvation.

In both the Irish and the Indian case, the conflation of sexual deviancy and venereal disease with the 'lower classes' of society allowed the Contagious Diseases Acts to target those already marginalised and apply further social controls on account of their social class and racial background. The Contagious Diseases Acts perpetuated notions of female sexuality as being inherently diseased, positioning prostitutes as paradigm examples of fallen morality. She was made a scapegoat for all things wrong with the social mores of the Victorian era (Baker 2012). The forced categorisation and registration of prostitutes, both in Ireland and India, culminated in the increased surveillance of women, and trapped women into the social identity of 'common prostitute', whilst simultaneously providing the police the opportunity to increase their presence in working-class areas of Victorian cities and reinforced the stratification between classes (Baker 2012). The broad, gendered definition of 'prostitute', with no clear definition of what that constituted as, meant that discerning whether a woman was engaged in prostitution was largely left to the discretion of the police and magistrates (Baker 2012).

The Contagious Diseases Acts institutionalised a solely female quarantine system for venereal disease (Baker 2012). As a result, all women in the subjected districts were suspect, their bodies sites of medical-legal discipline that each upheld the patriarchal assumption that only women were 'contagious' (Baker 2012). The expense of lock hospitals warranted the installation of Lal bazars across many regiments in India by the colonial Government. Rationalised as a means of providing 'safe' sexual recreation for the soldiers and officers across cantonments, official brothels, in which women were housed, ensured that male sexual licence could flourish unimpeded by the constraints of morality. Where soldiers were expected to be unable to resist their sexual urges, native women were expected to bear the burden of legislation. The maintenance of racial hierarchies was crucial to the colonial empire, and so it was imperative that British soldiers were separated from the native population, to prevent against any 'Oriental

vices', or anything that would bring the British army into disrepute.

To segregate the colonists from the colonised, the British State imposed racial, social and gender hierarchies onto the bodies of native populations, both in Ireland and India. The registered *chaklas* being divided into separate categories according to the skin colour of the women working within them is emblematic of the racial categorisations to which prostituted Indian women were assigned. Irish women were viewed through a dichotomous lens, one that framed them simultaneously as poisonous threats to the stability of the colonial State, and as chaste, feminine victims to the patriarchal order, too delicate to navigate the dangers of Victorian society. Conversely, Indian women were deemed 'born to the role' of prostitution, and as being poisonous temptations to the military men stationed across India. Neither portrayal provided women with much agency, as either depiction confined them to a position of gendered inferiority. Whether confined to the home, the *chakla* or brothel, or the street, every woman became the target of legislation and punishment under the Contagious Diseases Acts. These themes of racial inferiority, women's contagion, and colonial social sorting are explored in more detail in the following chapter.

Chapter 3: Constructing 'Contagious' Women: Gendered Social Sorting in Ireland and India

Introduction

As explored in chapter 2, British involvement in Ireland and India allowed for Britain's gendered, racialised, and classist hierarchies onto the bodies of the colonised. Women, in both jurisdictions, were portrayed through a dual lens, as both possessing limited agency, and as active agents in the tempting and poisoning of White, British men. As a result, all women, regardless of class or race, were targeted under the Contagious Diseases Acts. In sorting women into these two categories, the colonial State enacted a colonial governmentality, one that encompassed the disciplinary powers needed to produce docile bodies, as well as the biopolitical powers necessary to shape the conduct of its citizens at-a-distance.

This chapter analyses the Irish Contagious Diseases Acts 1866-1869, and the Indian Contagious Diseases Act of 1868, through the lenses of surveillance studies, queer, feminist theory, and critical race theory. Drawing from David Lyon's (2007) definition of surveillance, along with his theory of social sorting, and using Foucault's thesis of governmentality, in conjunction with critical feminist and race theorists Sherene Razack (1998), Chandra Mohanty (1988, 2024), and Anne Stoler (1987), along with Scott Lauria Morgensen's (2012) definition of heteropatriarchy, this chapter examines the intersectional impact the legislation had on poor- and-working class women in Ireland and India.[11]

This chapter's analysis is divided into two primary sections. The first will examine the Contagious Diseases Acts 1866-1869 in Ireland, and provide an interrogation of the legislation by detailing the operationalisation and functioning of the Acts. This section begins with the Contagious Diseases Act 1866, before examining the amended legislation introduced in 1869 (1.1). Section 1.2 will then examine the Indian Contagious Diseases Act of 1868, both interrogating and comparing the Indian legislation against the Irish 1866-1869 Acts. This first part of the chapter seeks to provide a clear understanding of the differences in operation between both pieces of legislation, as well as investigate how both Irish and Indian women were perceived as, and constructed under, the Contagious Diseases Acts in both jurisdictions.

Section 2 of this chapter is then broken into five subsections, each of which will apply the Foucauldian, critical feminist theoretical framework, as explored in chapter 1, to the legislative landscape of both Ireland and India. This section will answer the research question: how did the Contagious Diseases Acts facilitate the surveillance and social sorting of racialised, poor- and working-class women? This part of the chapter first examines the differing pieces of legislation through the lens of surveillance studies, to demonstrate the inherent surveillance aspects of the legislature, in both Ireland and India, respectively, as well as the overt power

[11] This chapter does not consider The Prevention of Contagious Diseases Act 1864 on account of it being discontinued following the enactment of the 1866 Act in Britain and Ireland, and as it is not directly comparable to the Indian Contagious Diseases Act of 1868.

demonstrated by the colonial State through its surveillant regime.

The following subsections take Foucault's social control theses, and apply them, first, to the operation of the lock hospital system, highlighting the disciplinary nature of the Irish, and Indian, institutions, and the strategy of disciplinary power they facilitated through hierarchical observation, normalisation, and examination. Following disciplinary power, the chapter applies Foucault's biopower to the Contagious Diseases Acts, and examines it in relation to the use of social sorting and categorisation of women in Ireland and India. In doing so, it makes clear that the vague terminology inherent to both the Contagious Diseases Acts 1866-1869, and the Indian Contagious Diseases Act of 1868, made all women targets for extra controls by the colonial British State.

The chapter then utilises surveillance, as well as feminist and critical race theories, to understand how women were sorted under the Contagious Diseases Acts. This subsection takes the categories of race, gender, and class, and demonstrates how Irish and Indian women were categorised, and as a result, constructed, under the Contagious Diseases Acts. This chapter will answer the remaining research question: how were colonised women constructed under the Contagious Diseases Acts? The similarities in construction of Irish and Indian women are highlighted, as well as the differences in portrayal on account of their race and skin colour, social position, and gender. The chapter ends with an interrogation of how women were constructed under the colonial governmentality of the British Empire.

The Contagious Diseases Acts

Legislation in Colonial Ireland

In 1866, An Act for the Better Prevention of Contagious Diseases at Certain Naval and Military Stations (1866) was enacted by the British State, encompassing both Britain and Ireland (referred to in this chapter as The Contagious Diseases Act 1866).[12] It added terms such as "Police", and "Superintendent", "Chief Medical Officer", and "Justice"[13], which in Ireland meant that the police within the districts affected, and physicians and/or surgeons employed by lock hospitals, were granted the power to conduct surveillance, apprehend, arrest and detain women suspected of, or known to be engaged in, prostitution.

The vague definition of the term 'common prostitute', as noted throughout the legislation, contrasts the clearly demarcated roles of the police and medical officers, who each bore the responsibility of categorising women as prostitutes, regardless of whether they were actively engaged in prostitution or not.[14] Furthermore, the failure of the State to provide a clear definition as to the term 'common prostitute' is consistent with the conservative treatment of

[12] See Section 3, Contagious Diseases Act 1866. This Act commenced immediately after the initial Contagious Diseases Act 1864 ceased to operate.
[13] See Section 2, Contagious Diseases Act 1866.
[14] The provision of such definitions within the 1866 Contagious Diseases Act granted powers to the male Metropolitan Police of the subjected districts to conduct surveillance of women, and their places of residence, who were thought, or known to be, prostitutes. It further allowed for them to be apprehended and detained under the Act.

women, as an outlying group, within the legal system. They were 'Othered' before the law, and as a result, all women could potentially assume the position of a 'common prostitute' within Victorian society.

Of the 42 Sections in The Contagious Diseases Act 1866, four Sections match the original Act word-for-word[15], with another five Sections in the 1866 Act adding on to the original Contagious Diseases Prevention Act 1864.[16] It further extended the limits of the 1864 Act by up to five miles surrounding the subjected districts[17], and enshrined into legislation that lock hospitals provided for the strict 'Moral and Religious instruction of the women' incarcerated. The promotion of the penitents 'moral redemption' is emblematic of Foucault's Parisian prison, which cemented into legislation the disciplinary techniques characteristic of institutions during this period. Ireland's lock hospitals functioned as disciplinary apparatuses and are indicative of Victorian attitudes towards women.

The task of containing and punishing women who leveraged their sexual license, for fear their propensity for disease would contaminate the delicate balance of male, heteropatriarchal governance and Victorian social order, enabled lock hospitals to exert disciplinary power over Ireland's colonised women. The 1866 Act also made explicit reference to record keeping[18], noting that certificates regarding a woman's status, whether as a convicted prostitute or not, would be signed and made in 'triplicate[19]' for ease of management. These records would be then divided, with one sent to the woman, so that she could retain a record of her status, and two sent to the superintendent of police, to be kept on file and shared with the magistrate if necessary.

This bid to create multiple copies of data regarding a woman's status facilitated the colonial State's surveillant apparatus. This both indicates the need for the State to create a written database of records to regulate the movements of known prostitutes, and make visible the most marginalised in society. The State also recorded the residences of women suspected of prostitution, further contributing to the written database held by the governing body.[20] In creating this bureaucratic database, the Contagious Diseases Act 1866-1869 collected information regarding a woman's occupation, class, and sexual health, and recorded and retained it for future use by the colonial body. In creating this catalogue to identify and trace prostitutes throughout Britain's colonies, the State's colonial governmentality both gathered, and produced, knowledge to better exert its control over the colonised population.

Under the Contagious Diseases Act 1866, women could be served with a notice by a plain-clothed member of the police should she be suspected of, or known to be, engaged in prostitution. The powers granted under the Acts permitted the Superintendent of Police, should he believe his informant had good cause to suspect the woman of prostitution, provide such information to the Justice who would then summon her to court.[21] She could either elect to go voluntarily to the medical exam, or refuse to and be brought by force, to prove whether she

[15] See Sections 4, 5, 10, and 36, Contagious Diseases Act 1866.
[16] See Sections 6, 7, 16, 18, and 19, Contagious Diseases Act 1866.
[17] See Sections 15 and 32, Contagious Diseases Act 1866.
[18] See Sections 20 and 23, Contagious Diseases Act 1866. Also see Section 9, Contagious Diseases Act 1869.
[19] Definition: to make three copies of; multiply by three.
[20] See Section 41, Contagious Diseases Act 1866.
[21] See Section 15, Contagious Diseases Act 1866.

had a venereal disease.[22] The vulnerability of women subject to the Acts is apparent in the reliance of the Justice on the word of the Superintendent. Whether the woman was engaged in prostitution was left to the discretion of him and his informants, who, as men, maintained power over all colonised women.

In positioning men as those wielding power over the subordinated prostitute, the 1866 Acts framed all woman according to a hierarchical dichotomy of power*ful* and power*less*. In targeting solely women, the 1866 Act in Ireland assessed the colonised population according to a gender binary. This binary adheres to the heteropatriarchal ideal that maintains men as the governors of women's respectability and chastity, granting them the power to survey, apprehend, detain and punish those women who breached the boundaries of Victorian sexual morality. The direct reference to '[a]ny Woman' throughout the 1866 Act leaves little room for negotiation as to who may constitute as a 'common prostitute'. Given its lack of clarity as to what identifies '[a]ny Woman' as such, all women became targets of its disciplinary gaze. Such ambiguity is indicative of surveillance systems (Lyon 2003), and positions all within a broader category of 'dangerous' or 'risky'.

Come 1868, An Act to amend the Contagious Diseases Act 1866 was introduced (referred to in this chapter as the Contagious Diseases Act 1869). This amendment Act was considered as being one with the Contagious Diseases Act 1866.[23] Designed to 'fix' the 1866 Act, the Contagious Diseases Act 1869 was much shorter than its predecessor, containing thirteen Sections as opposed to the previous forty-two. This piece of legislation repealed certain aspects of the 1866 Act[24], while also extending the limits of the 1866 Act to a further ten miles surrounding the designated districts.

The extension of these limits categorised and sorted women according to their geographical location, and further extended the powers granted to the police to charge a woman named as a 'common prostitute' should she be seen outside of those limits 'for the purpose of prostitution in the company of men resident within those limits…'.[25] The legislation made no mention of the men she could be seen with, other than, should they live within the specified districts, it is assumed that she is with them for the purposes of prostitution. Such ambiguity made it so that the discretion of the superintendent would determine her 3 to the men in her company.

The 1869 Act further extended the period under which a woman would be called for medical examination, enforcing it for as long as a woman remained a resident within the ten-mile limit.[26] It also extended the period of which a woman could be detained under the 1866 Act, providing that she 'may be detained for a further period not exceeding three months, in addition to the six months allowed under Section 24 of the principal Act'.[27] In both instances of

[22] See Section 16, Contagious Diseases Act 1866.
[23] See Section 2, Contagious Diseases Act 1869. Both the 1866 Act and the 1869 Act were intended to be cited together as one piece of legislation.
[24] See Sections 4 and 12, Contagious Diseases Act 1869.
[25] See Section 4, Contagious Diseases Act 1869. This Section makes the assumption that should the woman have been seen within the prior fourteen days to be 'acting as a common prostitute', then she could be apprehended if she is seen either inside or outside the areas affected if she is in the company of men who are resident within the designated districts. This meant that the relationship between a woman and these men was inherently suspect, and entirely determined at the superintendent's discretion.
[26] See Section 4, Contagious Diseases Act 1869.
[27] See Section 7, Contagious Diseases Act 1869.

extension, the 1869 Act ensured that all women remained under the surveillant eye of the colonial State, further facilitating the disciplinary nature of the Acts by both gathering and producing knowledge of women in the subjected districts for ease of management.

The 1869 Act focused largely on the collection and maintenance of written data regarding the regulation of prostitution. Her discharge from a lock hospital was recorded and submitted to the superintendent of police[28], as well as the process under which a woman could remove herself from the periodical examinations list.[29] This change added yet another written record to the regulated prostitution database, now allowing for a record to be kept when a woman was removed from the register. This meant that even when she was no longer engaged in prostitution, she would remain visible to the State on account of her permanent record as having been a prostitute.

Legislation in Colonial India

The Act for the Prevention of Certain Contagious Diseases (1868), otherwise known as 'The Indian Contagious Diseases' Act 1868, incorporated elements of the Cantonment Act 1864 by allowing for the Local Government to tailor the rules of the 1864 Act. It further allowed the Local Government in India to alter the places in which the Act applied as it deemed fit.[30] This differs from the 1866-1869 Acts, which had placed the Admiralty and War Office in charge of the expenses surrounding execution of the Act, the appointment of Visiting Surgeons and hospital Inspectors, as well as the certifying of selected hospitals for treatment of venereal disease patients.[31]

The Indian Act 1868 also brought brothels and their keepers under inspection.[32] It defined the term 'brothel-keeper' as the 'occupier of any house, room or place to or in which women resort or are for the purpose of prostitution and every person managing or assisting in the management of any such house, room or place'.[33] This differs from the 1866-1869 Acts in Britain and Ireland, which made no official mention of brothels other than the explicit mention of the penalties that would be applied for harbouring women suspected of prostitution.[34] There was no allowance for brothel-keepers under the 1866 Act in Ireland and Britain, as the regulation of prostitution was prohibited entirely under the Contagious Diseases Acts 1866-1869 (save for within laxly policed 'vice zones'[35]).

Another deviation from the 1866-1869 Act was the need for all prostitutes, whether infected with a venereal disease or not, to be registered as such under the Act.[36] Unlike in Ireland, where a woman would be issued with a notice of registration should she be apprehended whilst contagious, in India, women had to be registered as a prostitute regardless of her sexual health status. Her name, age, caste, and place of residence would be recorded and retained for future

[28] See Section 8, Contagious Diseases Act 1869.
[29] See Section 9, Contagious Diseases Act 1869.
[30] See Section 3, Indian Contagious Diseases Act 1868.
[31] See Sections 5, 6, 7, 8, 9, 11, 12, 14, and 18, Contagious Diseases Act 1866.
[32] See Chapter 2, this research thesis.
[33] See Section 2, Indian Contagious Diseases Act 1868.
[34] See Section 36, Contagious Diseases Act 1866.
[35] See Chapter 2, this research thesis.
[36] See Section 6, Indian Contagious Diseases Act 1868.

use.[37] Similarly, the name and residences of brothel-keepers was also recorded and retained by the Local Government for purposes of regulation and identification.[38]

Should a woman be found to be carrying on the business of a 'common prostitute', or any person be found conducting the business of a brothel-keeper, without evidence of their registration under the Act, he and/or she would be punished with imprisonment, a fine, or both.[39] Differences in punishment appear in the Indian Act 1868 in comparison with the 1866-1869 Acts in Ireland, wherein the latter, if a person was found harbouring an infected woman, or if she refused examination, or was found to be 'acting as a common prostitute' without evidence of having been cleared of infection, would be sentenced to a term of imprisonment 'with or without hard labour'.[40]

The penal sanctions which underpinned the treatment of Irish and Indian prostitutes served a wholly punitive function, rather than one of public health. This is true of both the Contagious Diseases Act 1866-1869 and the Indian Act 1868.[41] While there were legislative differences in punishment between Ireland and India, the strategy of control through discipline remained the same. Irish women were still racialised by the colonial State, but because they were still seen as (epidermally) White women, they were expected to adhere to the moral standards of Victorian society. Hence, their punishment for deviating from the rules of the Contagious Diseases Acts 1866-1869 were harsher because they were deemed both morally bankrupt and dangerous vectors of disease, actively spreading illness among the British soldieries. Irish women were deemed worthy of salvation on account of Britian's colonial hierarchy and racial prejudices (Martin 2014; O'Malley 2023). Thus, Irish women were sorted for increased disciplinary controls in a bid to produce docile White bodies that would both preserve and legitimise Britain's colonial hierarchy.

Indian women, conversely, were considered 'born to the role' of prostitution, thus, they were not regarded as worthy of treatment. Rather, infection was deemed an expected aspect of their occupation.[42] As a result, their punishment was to be 'cured', and returned, to their designated position of regulated and registered prostitute for consumption by British soldiers. This difference in treatment is highlighted again in the provisions made for Indian women to be provided with an allowance whilst she is undergoing treatment and thus unable to work in the brothels.[43] There were no such provisions made in the Contagious Diseases Act 1866-1869, other than, upon discharge from a lock hospital, she could be returned to her residence 'without expense to herself'.[44] The provision of an allowance to Indian prostitutes indicates to the British State's pursuit of colonial governmentality, whereby this cohort of colonised people were constituted as a risky resource to be managed and measured.

Another fundamental difference in the Indian Act 1868 was the taking on of brothel-keepers as informants of the State.[45] This piece of legislation extended the disciplinary gaze of the

[37] See Section 5, Indian Contagious Diseases Act 1868.
[38] See Section 5, Indian Contagious Diseases Act 1868.
[39] See Section 4, Indian Contagious Diseases Act 1868.
[40] See Sections 28, 31, and 36 of the Contagious Diseases Act 1866.
[41] See Sections 28, 29, 30, 31, and 36, Contagious Diseases Act 1866.
[42] See Chapter 2, this research thesis.
[43] See Section 19, Indian Contagious Diseases Act 1868.
[44] See Section 27, Contagious Diseases Act 1866.
[45] See Section 9, Indian Contagious Diseases Act 1868.

Local Government into the residences of prostitutes, and made all who inspected brothels de facto government employees. This deviated from the 1866-1869 Acts in Ireland on account of the prohibition on both brothels and brothel-keepers. It marks a clear distinction between who are 'Othered' and who are not. In Ireland, the task of detecting and reporting on suspected prostitutes lay firmly on the colonial body, whereas the Indian Act 1868 sanctioned the regulation of prostitutes by responsibilising brothel-keepers to act as extensions of its surveillance regime.

The Indian Act 1868 also mirrored the 1866 Act in that it granted powers to the Local Government to create new rules regarding when, where, and how periodical examinations of women were conducted.[46] Where the responsibility for periodical examinations fell to the Admiralty and War Office, along with funding and certification of lock hospitals, and the appointment of medical staff, the Local Government in India bore the responsibility for these elements of government, along with the power to 'alter and add to any rules or regulations made under [the] Act'.[47] Another difference in the Indian Act 1868 was that women were not permitted the same opportunity to voluntarily submit themselves for examination, unlike Irish and British women who could voluntarily undergo examination.[48]

A key difference between the Irish and Indian legislation is evidenced in the allowance under the 1868 Act for the 'Out-door Treatment of Prostitutes'.[49] There was no option for outpatient treatment of venereal disease for Irish and British women, the only option available to them was to be treated as inpatients at certified lock hospitals. Furthermore, the Local Government in India was granted the power to allow appointed surgeons to both provide outdoor treatment to prostitutes, as well as to dictate when and where a woman could attend for medical treatment. Failure to comply with these regulations would see her convicted before a Magistrate and punished with either imprisonment, a fine, or both.[50]

Other fundamental differences in both pieces of legislation is the segregation of prostitutes in India from regular Indian women, the removal of a prostitute's name from the registry created under the Indian Contagious Diseases Act 1868, and the need for prostitutes to notify the Local Government of changes to their address.[51] In the 1866-1869 Acts, there is no mention of the removal of women with a contagious disease from any specific area, nor is there any mention of the need for prostitutes to notify the Admiralty or War Office regarding changes in their address. There is some similarity in the Irish Acts 1866-1869, which allowed a woman to remove herself from the examinations register following a successful written application to the Visiting Surgeon.[52]

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[46] See Section 11, Indian Contagious Diseases Act 1868. Also see Section 18, Contagious Diseases Act 1866.
[47] See Sections 5, 10, 11, 12, 13, 17, 20, 21, 23, and 26, Indian Contagious Diseases Act 1868. Section 26 allows the Local Government to alter and add to any rules or regulations made under the Act, provided they did not directly conflict with the rules sanctioned under the Indian Contagious Diseases Act 1868.
[48] See Section 14, Indian Contagious Diseases Act 1868. Also see Section 17, Contagious Diseases Act 1866.
[49] See Section 17, Indian Contagious Diseases Act 1868.
[50] Ibid.
[51] See Section 20, 21, and 6 respectively, Indian Contagious Diseases Act 1868.
[52] See Sections 33, 34, and 35, Contagious Diseases Act 1866. Also see Section 9, Contagious Diseases Act 1869. This Section amended the 1866 Act (Sections 33 to 35) that stated a woman could remove herself from the periodical examinations list by making a written application to the Justice, who would then arrange a hearing, at which the woman would plead her case, and enter into a "Recognizance, with or without Sureties" with the woman "for her good Behaviour during Three Months thereafter" not engage, or be seen to be in "any public

Both the 1866-1869 Act in Ireland, and the Indian Act 1868, demonstrate differences in treatment depending on which racialised category a woman was assigned to. Indian women, on account of the logics of epidermal racism, were subordinated to the position of prostitute, segregated into differing chaklas according to their clientele, and were all subjected to registration and identification by the colonial State. Irish women, conversely, were considered a part of one category: potentially diseased prostitutes. Both pieces of legislation work to socially sort women into easily manageable categories, exerting disciplinary and biopolitical controls to ensure all adhered to the colonial governmentality of the British Empire.

Gendered Surveillance and Colonial Governmentality

The broad scope of Foucault's concept of governmentality fits neatly with the calculated and 'rational' nature of colonialism (Scott 2005). Governmentality largely encapsulates the actions of the colonial British State, who dictated the behaviours of its subjects, exerting control-at-a-distance to legitimise and enforce its power. The enactment of the Contagious Diseases Acts, in both Ireland and India, represents a means by which the colonial government sought to exert control over all within its colonised territory. By weaponising women's sexuality, and regulating prostitution (and all colonised women by extension), the State ensured that it could insert itself into the lives of both the colonisers and the colonised.

Britain's colonial strategies of governance encapsulated both punitive and biopolitical modes of operation, and punished those who were representative of that which was too far removed from the colonial, heteronormative, White ideal. Colonialism, this thesis argues, is a practice of power; one that works to either include or exclude the colonised population through categorisation. Surveillance, and social sorting by extension, each represent technologies of power. Both are present within Foucault's disciplinary and biopolitical modes of governance, both functioning together under the modality of governmentality. As a result, this research uses governmentality as a core lens through which to interrogate the Contagious Diseases Acts. Colonial governmentality is a deliberate exertion of power; one that both defines, and confines, its subjects (Browne 2015). Colonial governmentality, thus, is a system of regulation, whereby micro controls, such as the individualising sorting process of categorisation and the creation of norms to influence the broader, macro population, are wielded over colonised citizens to foster docility.

The Contagious Diseases Acts, as outlined above and evidenced in both Ireland and India, segregated the colonised population. The Contagious Diseases Acts 1866-1869, as well as the Indian Contagious Diseases Act 1868, ensured that the State could classify, detain and punish those who deviated from its sanctioned norms, and thereby becoming more visible under its gaze. Using surveillance theory, as outlined in chapter 1, this research conceptualises how colonial Britain utilised a surveillant apparatus that individualised as well as commoditised Irish and Indian women. This section will explicate how the Contagious Diseases Acts constructed a colonial regime of governmentality, one which socially sorted and

Thoroughfare, Street, or Place for the Purpose of Prostitution, or otherwise…conduct[s] herself as a common Prostitute".

disproportionately disciplined colonised women according to their race, gender, and class.

Legislating Surveillance: Ireland and India under the Contagious Diseases Acts

Surveillance is, as defined by Lyon (2007: 14), "the focused, systematic, and routine attention to personal details for the purposes of influence, management, protection or direction". It is not simply about direct control, but rather it evokes a disciplinary gaze that punishes those that transgress its borders of 'acceptability', extending beyond just the act of monitoring (Clegg 1998; Zureik 2003). In both Ireland and India, the Contagious Diseases Acts worked to facilitate a surveillant apparatus, as seen in Ireland in the stringent maintenance of 'Certificate[s], Order[s], Notice[s], or other Instrument[s]' by the colonial State to record a woman's status as a 'common prostitute', a building as a 'certified hospital', and the changes made to the 'regulations' of those certified institutions.[53] The surveillance continuum of care and control is made most visible in this incidence of registration and identification by the colonial State. In identifying and registering women suspected of prostitution, regardless of the supposed 'benefits' of such medicalised intervention, the controlling nature of the Acts proved inherently punitive. This surveillant apparatus was one that distinguished between the coloniser and the colonised, and subordinated and colonised women.

The 1866-1869 Acts empowered the police and appointed Medical Officers to enter, patrol, and inspect any part of the naval and military stations it named in its First Schedule. It broadly defined the term Police to include the metropolitan police, as well as any other member of the police or constabulary previously authorised to act in any part or place under the Act. It further confined the operationalisation of the Act to specific naval and military stations, each varying in size, thus defining their precise boundaries by extending, up to five miles, areas surrounding the principal garrison towns and dockyard stations. Under the 1869 Act, the limits were extended to further encompass up to a ten-mile radius around the affected districts. These combined measures, as evidenced in the legislation, provided authorities with the power to both monitor and regulate the covered areas, and consequently, the women confined therein.

The specific terminology used in the 1866-1869 Contagious Diseases Acts in Ireland targeted primarily women, making no mention of men other than in reference to the male Medical Officers' assisting male Visiting Surgeons in certified hospitals[54], the powers granted to the male Admiralty or War Office staff certifying hospitals[55], male Justices' ordering medical examinations[56], Chief Medical Officers'[57], certified hospital Inspectors[58], and the male brothel-keepers or 'harbourers' of infected prostitutes.[59] The sorting of all women into the risk category of 'common prostitute', and therefore 'vectors' of disease, meant that *all* women became suspect and worthy of increased surveillance. Meanwhile men, having been excluded from the legislation, retained a position of superiority over women in that they were only conceived of as brothel-keepers, Magistrates, Superintendents, and members of the Police.

[53] See Sections 7, 8, 9, 14, 20, and 23.
[54] See Sections 6, 19, and 20, Contagious Diseases Act 1866.
[55] See Section 9, Contagious Diseases Act 1866.
[56] See Section 16, Contagious Diseases Act 1866.
[57] See Sections 22 and 25, Contagious Diseases Act 1866.
[58] See Section 23, Contagious Diseases Act 1866.
[59] See Section 36, Contagious Diseases Act 1866.

The heightened visibility this awarded women ensured that they constantly remained under the disciplinary gaze of the colonial body.

While the British and Irish Contagious Diseases Acts 1866-1869 did not explicitly state that surveillance ought to be conducted of brothels or 'bawdy' houses, the legislation did grant the Police and authorised Medical Officers the broad authority to inspect, detect, detain, and medically examine women suspected of prostitution should they be operating within the naval and military depots listed.[60] Triplicating the information gathered on those women (as outlined on page 37) accused of prostitution, as well as the houses in which they were suspected or proved to be operating, gave the colonial State a surveillant apparatus that made visible the most marginalised in Victorian society, sorting them for extra controls in accordance with their social, sexual, and racial category.[61] Further, it functioned to create a database of information, one that recorded and retained information regarding '[a]ny Woman's' arrest, sexual health status and detention.[62]

Much like its Irish counterparts, the Indian Contagious Diseases Act 1868 facilitated a surveillance system that actively marginalised low caste Indian women. Already racialised under the colonial regime, those who engaged in prostitution continuously faced significant disadvantages on account of their social position (Ballhatchet 2012). Although not specifically named as surveillance, the 1868 Act granted similar powers to the Magistrate "or of a Subordinate Magistrate…and includes a Magistrate of Police in a Presidency Town"[63] to detect and detain any woman 'carry[ing] the business of a common prostitute'.[64] While the 1868 Act neglected, much like its predecessor, to define the term 'common prostitute', it broadly applied to all women within the designated districts as "the Local Government shall from time to time…specify by notification…".[65] Such ambiguity surrounding who constituted as a 'common prostitute' in the legislation left *all* Indian women vulnerable to the State's disciplinary mechanisms.

The surveillance of women engaged in prostitution was further emphasised in Section 9 of the 1868 Act, which stated that brothel-keepers were "legally bound to furnish information on any subject relating to his business to such officers and in such manner and at such times as the Local Government shall from time to time prescribe in this behalf. Every such officer shall, for the purposes of this section, be deemed to be a public servant". This added layer of formal surveillance by the Local Government ensured that women residing in military cantonments were consistently placed within a system of hierarchical observation (Foucault 1977) on account of the brothel-keepers acting as extensions of the Local Government's power, extending directly into the residences of the women under regulation.

The Indian Contagious Diseases Act 1868 further positioned women according to a gender

[60] See Section 2, Contagious Diseases Act 1866, and Section 9, Contagious Diseases Act 1869.
[61] See Sections 20 and 23, Contagious Diseases Act 1866, and Section 9, Contagious Diseases Act 1869.
[62] Ibid.
[63] Magistrate of Police refers to a police official who would have been responsible for administering justice in minor cases. The term is rooted in late 18th Century legal systems. The term 'Magistrate' in colonial India refers to the Crown's local judicial and executive officer, who combined criminal-judicial authority with administrative and policing powers. Magistrate refers to a colonial official who was legally authorised and oversaw surveillance-based policing practices, using magisterial powers to label, monitor, and punish those deemed 'dangerous' or 'risky' through preventative measures and courtroom decisions (See Singha 2015).
[64] See Section 2, Indian Contagious Diseases Act 1868.
[65] See Section 3, Indian Contagious Diseases Act 1868.

binary, much like the Contagious Diseases Acts 1866-1869. This binary adhered to the heteropatriarchal norms of Victorian Britain and encompassed a racial undercurrent that positioned native Indian woman beneath the White, male coloniser (Razack 1998). Given that, on account of their racialised position within British Indian society, women with darker skin were assumed to engage in prostitution as a consequence of her 'natural position'[66], the lack of legislative clarity on who was classed as a 'common prostitute' ensured that there was only one cohort of the population affected under the Act. Similarly, direct references to 'any', 'such' and all 'registered' women leaves little room for confusion as to who the legislation applies. Like the Irish Contagious Diseases Acts (1866-1869), there is no reference to men other than in their capacity to act as brothel-keepers, once again defining prostitutes according to gendered and colonial narratives of the masculinised Owner and the feminised Owned.

What the Indian Act does differ in is the lack of gendered terminology to refer to the Magistrate, Magistrate of Police, or Local Government, which strays from the original language of the 1866-1869 Acts in Ireland. Where it was clearly marked in the principal 1866 Act (and reinforced in the 1869 Act), the Indian Act fails to position the Local Government in India, as well as its officials, including Magistrates and Magistrates of Police, according to the colonial masculine ideal. In making this distinction in legislation, the colonial State continues to fashion itself in opposition to the feminised colonised population, developing an identity that is separate from the 'degenerate' and 'racialised' Other. It reinforced the relationship of structural domination between the coloniser and colonised, and weaponised the bodies of Indian women in the process. In targeting women, constructing them as diseased and in need of extra controls, the Indian Act preserved White superiority whilst maintaining a system of colonial domination over all the colonised population.

Another point of difference is that the Indian Contagious Diseases Act 1868 does not mention any focal point or radius in which the Act applies[67], unlike the prior Cantonment Act of 1864. As such, there was no one localised area to which the Act was instated, rather it was that all women, in all parts of India, were under surveillance, with those in military cantonments and, more specifically, operating in Lal bazars, under particular scrutiny (Ballhatchet 2012). Yet another deviation from the Contagious Diseases Act 1866 is the extent to which powers were granted to the Local Government to create regulations pertaining to the registration, and appointment, of officers to register prostitutes, and brothel-keepers, as well as create rules pertaining to the examination of prostitutes.[68] This is significant as it potentially granted the Local Government with the power to allow any person (read: man) to detect, arrest, and detain a woman suspected of prostitution, whereas the legislation in Ireland placed those powers squarely on Medical Officers, and the police, and their appointment would be formalised by written advertisement in the London or Dublin Gazette, depending on where they were appointed.[69]

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[66] As discussed further below, see section 2.4 (this chapter). Also discussed in chapter 2.

[67] I.e: there is no specific reference to the distance surrounding a garrison or dockland town, nor to the areas to which the Act is instated, other than in Section 3, which states "the places to which this Act applied shall [be] such places as the Local Government from time to time, with the previous sanction of the Governor General of India in Council, specify by notification in the official Gazette. The Limits of such places shall, for the purposes of this Act, be such as are defined in the said notification, and may from time to time, with such sanction as aforesaid, be altered by a like notification".

[68] See Sections 5 and 11, Indian Contagious Diseases Act 1868.

[69] See Sections 6, 7, and 13, Contagious Diseases Act 1866. Also see Section 20, Indian Contagious Diseases Act 1868, pertaining to the segregation of prostitutes, which notes that "In any place to which the Local Government

Further, the Local Government was granted the power to make rules "from time to time to declare by what officer anything directed to be done by this Act shall be done, and by what class of officers information regarding anything made an offence by this Act...".[70] In essence, the 1868 Act provided that the Local Government could enact any power it wished, provided they did not contradict the provisions made prior. This enactment of colonial power provided that the British State maintained its control and extended its disciplinary remit across its colonised and feminised territory. Lock hospitals[71], as explored in the previous chapter, represent one of two techniques of Foucauldian (1977) power, utilising disciplinary mechanisms of surveillance, examination and normalisation to create docile and productive subjects. Lock hospitals were the backbone of the Contagious Diseases Acts, both in Ireland and India, and served as reminders of the power of the colonial State.

The repeated legislative emphasis on the punitive nature of the institutions, and the penal ramifications should a woman fail to act in accordance with the rules of the institution, indicate the extensive use of surveillance as a disciplinary mechanism within them. This theme of disciplinary power is further analysed in the following subsection.

Disciplinary Power: Lock Hospitals in Ireland and India under the Contagious Diseases Acts

Lock Hospitals in Ireland

In having the women incarcerated in lock hospitals always remain on the wards, they were visible, at all times, to the patrolling nurses and governing matron. This ensured that the disciplinary gaze of the institution was extended over every patient. The drab uniforms, coupled with the detail-oriented labour expected of them, heightened their visibility under the disciplinary regime by marking them as Other, and is reminiscent of Foucault's Parisian prison, whereby inmates were tasked with menial work (Foucault 1977: 6). Any letters sent to the inmates of lock hospitals were opened and read by the governing matron, and the women who worked in the laundry of the hospital could receive no visitors without the specified permission of the hospital's governor (Luddy 1995).

The oppressive environment of manual labour and moral teaching within the lock hospitals, coupled with the overt surveillance of its patients by the matron and her 'prison guard' nurses, facilitated the creation of docile bodies by extending the disciplinary gaze of the governing authority into the institutions (Foucault 1977). The Contagious Diseases Acts 1866-1869 made specific mention that "A Hospital shall not be certified under this Act unless at the Time of the granting of a Certificate adequate Provision is made for the Moral and Religious Instruction of the Women detained therein…", cementing into legislation the disciplinary techniques of the institutions (Foucault 1977).[72] The focus on the religious and moral reformation of Irish women reinforced the colonial, racialised hierarchy that positioned

shall, by notification in the official Gazette, have specially extended this section, it shall be lawful for such officer as the Local Government shall from time to time appoint in this behalf, to cause a notice to be served on any registered woman, requiring her, after an interval of not less than seven days to be mentioned in the notice, not to reside in any street or place therein specified".

[70] See Section 26, Indian Contagious Diseases Act 1868.

[71] Referred to throughout the legislation in Ireland and India as 'certified hospitals'.

[72] See Section 12, Contagious Diseases Act 1866.

White women above women of colour, framing Irish women as being worthy of salvation from the perceived degeneracy of prostitution on account of their Whiteness.

The emphasis placed on the religious and moral education of women confined to lock hospitals is a unique element of the 1866 Act and is not mentioned or amended in the subsequent 1869 Act. Much like Foucault's (1977) panopticon, the inmates of the Irish lock hospitals were surveyed to ensure that they acquiesced to the rules of the governing facility. These institutions represent total, austere institutions, with their doors being locked each evening to ensure that the patients could not leave until they were charged as being free from venereal disease. The Contagious Diseases Acts 1866-1869 also made sure to include the managing "or persons in control" of the hospitals held the right to create and modify the regulations of individual institutions "as far as regards Women authorised by this Act to be detained therein for Medical Treatment or being therein under the Medical Treatment for contagious Disease".[73]

This clear positioning of power into the hands of the institutions' governing authorities ensured that their disciplinary remit was firmly planted under the remit of the ruling class. As a result, the organisational structure of the lock hospitals ensured that patients were subject to Foucault's three primary mechanisms of disciplinary power: hierarchical observation, normalising judgement, and the examination (Foucault 1977). Rules of the Liverpool lock hospital, for example, constricted the patient's behaviour to better fit "middle-class notions of propriety and respectability" (Romero-Ruiz 2016: 127). Female patients were conditioned to model the behaviours of their middle-class superiors, who articulated and explained the gender norms of their class as part of the reformation process (Romero-Ruiz 2016).

Lock Hospitals in India

Where the Contagious Diseases Acts 1866-1869, in both Ireland and Britain, did make explicit mention of the need for certified hospitals to redeem 'fallen' women, the Indian legislation made no such assertion.[74] The application of the Contagious Diseases Acts in India bore a primarily punitive function, rather than a rehabilitative one. Unlike their White Irish counterparts, Indian women were categorised according to Britain's colonial hierarchy, and as a result they were deemed to be 'born to the role' of prostitute, and therefore unworthy of salvation. Serving as a juridico-medical regime that acted as a malicious means of social control, the lock hospital system deeply impacted already marginalised social groups (Hodges 2005). In India, lock hospitals served as the central node of the Contagious Diseases Act 1868, acting as the site where "the contrapuntal forces of colonial social hygiene and military discipline were brought to bear" (Hodges 2005).

Along with matrons, the State employed chowdranies, female subordinate staff who, under the Visiting Surgeon, were provided with regular payments and bonuses for the detection and reporting of diseased prostitutes (Gopalakrishnan 2022). Dhais were another essential component in the detection of clandestine prostitutes; only distinguishable on account of their

[73] See Section 14, Contagious Diseases Act 1866.

[74] Whether lock hospitals did indeed morally redeem their inmates is beyond the scope of this research, but it bears mentions that they functioned in a similar fashion to Magdalene Laundries (see Smith 2007), in that they adhered to a strict religious regime that promoted 'salvation through hard labour'. The Dublin Lock Hospital was arguably unsuccessful in its operations, with limited public or financial support and operating with low occupancy and a heavy reliance of government grants.

midwifery, they acted alongside chowdranies to identify women with venereal disease (Gopalakrishnan 2022). The hierarchical nature of the role of matrons, dhais, and chowdranies, ensured that women were under near constant surveillance by the governing authorities, and subsequently subject to tactics of hierarchical observation, normalising judgement, and examination (Foucault 1977).

Much like their Irish contemporaries, the staff of Indian lock hospitals were expected to influence the behaviours of the women incarcerated, and act as persuasive examples of superior moral and chaste behaviours befitting women of their station (Gopalakrishnan 2022). The underlying threat of punitive sanction should a woman deviate from the accepted norms and rules of the lock hospital, as determined by the governing staff, serves as reinforcement regarding the punitive nature of their detention there. In monitoring the incarcerated women, the watchers employed in lock hospitals categorised prostitutes into manageable cohorts, keeping them within the confines of disciplinary surveillance, and sorting them for differential treatment depending on their status (Foucault 1977; Lyon 2003). As is explored below, this categorisation of bodies was extended into the wider population, and became a biopolitical modality of colonial power, used to sort and categorise all women in Ireland and India.

Colonial Biopower: Social Sorting and Categorisatoin in Ireland and India under the Contagious Diseases Acts

The sorting of individuals and groups for differential treatment under surveillance has long represented a problem of State governance. When considering who ought to be the target of surveillance, the act of watching engages in the social sorting of individuals, within specific demographics (Lyon 2003). It now monitors *all* within the homogenous group in a bid to defend them from the domination of those the State would describe as 'Other' (Hall 2022). The categorisation of 'Others' contributes to how they are treated by the governing body (Jenkins 2012). Social sorting is central to the "formation and shaping of actors as particular kinds of people, with particular life chances, [who are] subject to particular constraints, and permitted access to particular opportunities, and to the historical emergence of institutional and demographic macro-patterns" (Jenkins 2012: 160).

Foucault (1978) viewed racism as a technology that connects to various contexts of social life, and which circulates throughout different threads of power. Foucault frames biopolitics as the eradication of the 'biologically incapable populations' in a bid to improve the productive capacity and vitality of the colonising population (Foucault 1978; Castro-Gomez et al 2023). In recognising that population management must operate through an intersectional matrix, or 'chain' of power, Foucault argues that a balance of powers was key to supranatural governance (Castro-Gomez et al 2023; Foucault 1978, 2008). Under the Contagious Diseases Acts 1866-1869, and the Indian Contagious Diseases Act 1868, Irish and Indian women were 'put in their place' by the governing authority, assigning them differential worth in accordance with their either 'respectable' or 'unrespectable' positions within Victorian society. In doing so, the colonial State defined who was worthy of salvation by neglecting to include specific reference to the 'moral and religious training' of Indian women in the Contagious Diseases Act 1868 in comparison with the initial 1866 Act in Ireland.

Biopower, as per Foucault (1978), utilises surveillance to direct, manage, and control a population's life processes. In extending the power of the governing body into the social realm,

and weaponising surveillance to monitor all aspects of social life, biopower makes knowledge an agent of transformation. In doing so, it defines certain activities as 'healthy', 'normal', and 'productive', framing them in opposition to the 'unhealthy' and 'abnormal' behaviours of the Other (Foucault 1978). Where disciplinary regimes induce conformity through the normalising judgement of the overseeing body, biopower also seeks to normalise specific behaviours, shaping individual self-understanding and social expectations to mould individuals into 'docile', governable bodies (Foucault 1978). In the Irish case, this was through the strict religious and moral training of the women incarcerated, whereas Indian women were not thought worthy of such reeducation or remoralisation. Through the categorisation of women into opposing categories of 'virtuous', 'clean', 'respectable' and the Othered 'diseased', 'disorderly' and 'contagious' prostitute, the colonial British government enacted a system through which to exert biopolitical controls over the most marginalised in its colonies.

Such sorting did not only encompass the bodies of the women subjected to the Acts, but also the spaces in which they traversed. By specifically targeting women in the legislation, the principal Act (1866) ensured that it was only women selected for differential treatment by the State. A central component of biopower is the role of sexuality in the management of populations (Thomas and Vagishwari 2025; Foucault 1978). In outlining how discourses on the classification, specification, and medicalisation of sexualities arose in the nineteenth century, Foucault (1978) demonstrates how the administration of spatial management and surveillance systems exert social controls over a population. By classifying certain members of the population as 'dangerous', or 'endangered', biopower can be understood as the result of a complex process, identifying a State's attempt to regulate the bodies of its subjects and justify its governance through legislation (Foucault 1978). The Irish Contagious Diseases Acts 1866-1869, as well as the Indian Contagious Diseases Act 1868, are representative of biopolitical power, and show how the conquering, colonising British State used the law to separate, and dictate, the norms and regulatory functions of both the individual, and the social, colonised body (Foucault 1978; Thomas and Vagishwari 2025).

By forcibly identifying and detaining women suspected of infection to lock hospitals and subjecting them to intrusive medical inspections against their will, the colonising State reinforced its hierarchies of power. In doing so it used medical control to assert dominance over an already vulnerable population (Thomas and Vagishwari 2025). Throughout the Irish 1866 Act, twenty-four of the forty-two Sections reference '[a]ny Woman', disproportionately highlighting her marginalisation before the State. The 1866 Act encompassed sixteen garrison and dock towns across Ireland and Britain, aimed at exerting controls over the sexual proclivities of the military men stationed there, and socially sorting the women residing there according to their geographical location, rather than any other defining characteristic.[75] The spatial appetite of the 1866 Act was extended by a further five miles under the 1869 Act, encompassing ten miles surrounding the designated districts, resulting once again in the women residing there to be socially sorted according to their geographical location.

With no clear distinction between who constituted a 'common prostitute' and who did not, should any woman traverse into the 'Thoroughfare' that was the city, she could be perceived

[75] See Sections 15 and 32, Contagious Diseases Acts 1866-1869.

as being in a 'Place for the Purpose of Prostitution'.[76] Given that the Acts 1866-1869 only referred to women who were seen "in the company of men resident within those limits…", interpretation of their behaviour was left largely to the discretion of the Justices, police, and Visiting Surgeons who, as men, held the right to determine her social position.[77] The sorting of women for 'moral and religious instruction' was not the only consequence of their social categorisation under the Acts. Women, who had received "any order" under the Contagious Diseases Acts 1866-1869 were subject to "periodical medical examination…as long as and whenever such woman is resident within ten miles of the limits of the place where the order was made…".[78] The prolonged surveillance and social categorisation of women residing in the affected districts, coupled with the lack of clear definition, made their visibility before the colonial State that much more pronounced.

Much like its Irish counterpart, the Indian Contagious Diseases Act 1868 sought to bring 'disordered' women under regulation. Indian women were sorted spatially, with the Act targeting those both inside and outside of military cantonments. Inside cantonments a system of registration was put in place to monitor the movements of the women exiting and entering the site. This pertained specifically to changes to their residence, making it so that should she wish to leave the military cantonment for any reason she had to "give notice thereof to such person and in such manner as the Local Government shall from time to time direct, and the necessary alterations shall be made in the said book and in the evidence of registration furnished to her as aforesaid".[79]

The keeping record of her change of address, much like the Irish case, created a database which could be accessed by Local Government officials, making it easier to sort her into the category of 'unruly' prostitute who would stray from her designated 'vice zone'. It further eased the ability of the Local Government to detain a woman with a contagious disease, as evidence of her place of residence would be recorded for further reference.[80] This paper database granted the Local Government the means through which to segregate surveyed prostitutes into 'clean' and 'dirty', 'unruly' and 'registered'. This sorting process placed select women into categories for differential treatment, particularly should they deviate from the norms expected of them as women under the colonial surveillant regime.

Such treatment is highlighted throughout The Indian Contagious Diseases Act 1868, from the periodical examinations of women so registered under the Act[81], and ranging to punishment with imprisonment to a fine (or both) should she be found without identification indicating to her status as a prostitute[82]; refusal to show evidence of registration[83]; disobey the rules as set out by the Local Government[84]; neglect or refuse to attend a 'certified' Hospital[85]; leave a hospital while under medical treatment[86]; undertake prostitution while under medical

[76] See Section 35, Contagious Diseases Acts 1866-1869.
[77] See Section 4, Contagious Diseases Acts 1866-1869.
[78] See Section 5, Indian Contagious Diseases Act 1868.
[79] See Section 6, Indian Contagious Diseases Act 1868.
[80] See Sections 5 and 6, Indian Contagious Diseases Act 1868.
[81] See Section 10, Indian Contagious Diseases Act 1868.
[82] See Section 4, Indian Contagious Diseases Act 1868.
[83] See Section 7, Indian Contagious Diseases Act 1868.
[84] See Section 11, Indian Contagious Diseases Act 1868.
[85] See Section 14, Indian Contagious Diseases Act 1868.
[86] See Section 16, Indian Contagious Diseases Act 1868.

treatment[87]; and reside in a street of [Lal bazar] after prohibition[88]. Women were targeted under the Indian Act 1868 on account of the social and racial categories they were assigned to.

The next subsection explores the categories of race, class, and gender, each of which was used to categorise and sort women under the Contagious Diseases Acts for differential treatment by the colonial State.

Sorting 'Contagious' Women: Race, Gender, and Class under Colonialism

To further demonstrate how the Contagious Diseases Acts 1866-1869, and the Indian Contagious Diseases Act of 1868, targeted *only* women in their bid to curtail incidences of venereal disease, this section identifies three categories within which women were sorted.

Race

Anti-Catholicism was a form of racialisation in the nineteenth century, constructing Catholic identity as a set of inherited characteristics marking Irish people as inferior (O'Malley 2023). What differs in the racialisation of Irish women from that of Indian women is the ways in which racial categories were legally manifested under British colonialism. Racial epistemology situated Irishness as the 'intersection of two contemporaneous racial formations', one that relied on the logic of epidermal racism, and the other, more fluid understanding of racial hierarchies that justified the British Empire (Martin 2014; O'Malley 2023).

The depiction of the Irish during this period did not exempt them from the rise of colour-based racism, rather it was compounded by anti-Catholic sentiments, as well as the increasingly feudalised Irish economy that was positioned, and understood, as a product of Irish culture and race (Martin 2014). Epidermal racial prejudices against Irish women arguably stemmed from their whiteness, because they were perceived as having lost their status on account of their religion, resulting in their being aligned with non-white people (O'Malley 2023). As a result, they were categorised as inferior according to Britain's racialised, colonial hierarchy, which did not equate 'Celticness' to Blackness, but did situate Celticness beneath British Whiteness.

The maintenance of racial superiority was crucial to the functioning of British and European colonial power (Curtis 2010; Ballhatchet 2012; Peers 1998; Stoler 1987; Mahmud 1999). Racial differences were key markers of colonial social sorting and categorisation, representing markers of differentiation between the masculine, White coloniser, and the feminised, indigenous colonised population (Curtis 2010; Razack 1998,1996; Mohanty 1988). The colonising British State made racialised assumptions about the native Indian population, profiling them according to the constructed British imaginary (Curtis 2010). The use of feminine analogy to describe India allowed British colonisers to assert dominance over the native population and is a common strategy of colonialism (Curtis 2010; Morgensen 2012).

India was personified as a land in need of salvation and modernisation, to which the British State sought to provide both (Curtis 2010). Blackness had long been associated with syphilis in European cultures (Curtis 2010; Gilman 1990), and this assumption was easily transferred to the native, dark-skinned Indian population. As in Britain, the middle-classes in India

[87] See Section 18, Indian Contagious Diseases Act 1868.
[88] See Section 20, Indian Contagious Diseases Act 1868.

associated poverty with dirt and disease (Curtis 2010). Added to this association was the racial differences inherent between the coloniser and the colonised (Curtis 2010; Mohanty 1988, Tripthi 2024; Razack 1998). Misinterpretations made by the British as to the caste system in India perpetuated the correlation between indigenous people and disease (Curtis 2010; Arnold 2004).[89] With this reasoning, all native women became suspects under the Contagious Diseases Act 1868.[90]

The legislative references to 'public', and 'common' women each explicitly related to the poorest of indigenous women from the lower castes of society (Curtis 2010; Act No. XIV 1868). The fundamental misinterpretation by Britain of the complexities of the caste system in India contributed to the conflation of disease with darker skin and social position (Curtis 2010; Ballhatchet 2012; Thomas and Vagishwari 2024; Kozma 2017; Kumar 2017). Further, the limited understanding as to the role played by Devadasi and Tawaif women, courtesans and concubines with considerable social standing (Thomas and Vagishwari 2024; Rai 2023; Kumar 2017; Chatterjee 1992), disrupted the colonial perception of 'deviant' woman.

Class

For many of the poorer classes of Irish women throughout the nineteenth century, their contribution to the family economy often meant the difference between destitution and survival (Luddy 1995; Bettes 2017). The precarity of their employment status meant that any loss of income could "plunge a single woman or family into destitution" (Luddy 1995: 10). Francis Finnegan's (2001) study has detailed that the majority of those who were targeted by local enforcement in garrison and dock towns across Britain and Ireland were often poor, Irish women, whose entry into prostitution was driven by economic necessity.

Be it due to widowhood, desertion, or lack of employability in other areas, prostitution was more often a means of achieving economic stability and familial security, rather than a drive toward 'sheer want' or vice (Walkowitz 1980; Bettes 2017; Finnegan 2001). As a result, Irish women were considered, socially, as the standard example of a 'fallen woman' and served as a reminder to working- and middle-class Englishwomen as to what could befall them should they stray too far beyond the realms of Victorian domesticity and sexual decency (Walkowitz 1980; Finnegan 2001; Bettes 2017). In this sense, Irish women were perceived as being economically desperate, morally bankrupt, and in need of increased medical regulation, rescue, and control (Bettes 2017; Finnegan 2001).

While syphilis was associated with race, it was also seen as a disease of the lower classes in Britain and Ireland (Curtis 2010). The perception of syphilis as being spread by army men reflected broader class distinctions *and* racial assumptions in Britain (Curtis 2010; Peers 1998; Ballhatchet 2012). Thus, for the women servicing soldiers in India, they came to be defined as common or 'public' prostitutes, given that they catered to the poorest classes of British men (Curtis 2010; Ballhatchet 2012). The Indian Contagious Diseases Act 1868, similar to the Irish case, does not define the term 'common prostitute', although the assumption is that it referred to prostitutes who worked on the streets rather than in brothels or Lal bazars (Curtis 2010).

[89] See chapter 2, this thesis.
[90] Also see Cantonment Act 1864.

The ‘common’ prostitute served an equally common soldier, while private prostitutes were reserved for officers and high-ranking officials (Curtis 2010). The elites of British India marked syphilis as a disease of the lower classes, thus the legislation was not characterised as applicable to them and acted more as a form of social control rather than one of public health (Curtis 2010; Peers 1998). According to Curtis (2010: 107), the officers and soldiers of the British army “were of two different countries and the prostitutes were different from both”. Chatterjee (1992), along with Ballhatchet (2012) have each drawn attention to the predominant Hindu population among cantonment prostitutes, who, as members of the upper castes, sought to escape the social restrictions that accompanied widowhood, and were driven to prostitution as a result.

Gender

Despite being framed as an issue of class, the Contagious Diseases Acts in Ireland and England worked to enforce a sexual double standard that benefitted men over women (Bettes 2017; Tollan 2018; Walkowitz 1980). Despite men, particularly those returning from the colonies, being the primary vectors for the spread of venereal disease, it was women who bore the burden of shame and socio-sexual controls to prevent its spread. Irish women, given their already impoverished and racialised position, and the class and nationality biases that accompanied that, were viewed as pathological carriers and dangerous transporters of venereal disease (Bettes 2017). Conversely, English women, and those from the upper classes, were depicted as victims of the patriarchy by activists and sympathetic politicians alike; the unfortunate fatalities of male desire, who needed a moral uplift rather than a punitive sanction (Bettes 2017).

The Indian Contagious Diseases Act 1868, as well as the Contagious Diseases Acts 1866-1869, were specifically targeted towards women, despite the narrative portrayed by the colonial government that they were to better the health of military men across its colonies (Ballhatchet 2012; Smith 1990; Walkowitz 1980). The gendered realm in which the 1868 Act resided identified Indian women, but more specifically poor and low caste prostitutes, as the primary carriers of venereal disease (Curtis 2010; Ballhatchet 2012). As a result, the Act curated a system of classification, whereby it was only women who were racially and economically visible to the colonial body that were apprehended, medically examined, and institutionalised in lock hospitals (Curtis 2010; Ballhatchet 2012; Peers 1998).

Indian women living and working under the Act were portrayed through two lenses. Unlike their Irish counterparts, they were considered to be ‘born to the role’ of prostitution, and dangerous seductresses capable of decimating the colonising male population (Curtis 2010; Walkowitz 1980; Luddy 1995, 2005; Peers 1998). This dual categorisation was then weaponised as a tool through which to justify the intrusive medical policies and practices of the era (Curtis 2010; Walkowitz 1980). The notion that women, specifically poor racialised women, needed extra controls for the betterment of British Indian society primarily contributed to their incarceration in lock hospitals (Curtis 2010; Ballhatchet 2012; Tripthi 2024).

The following subsection briefly examines the construction of women under the Contagious Diseases Acts, framing it as a strategy of governmentality; a modality of power that served to both discipline and reward certain behaviours to exert colonial control-at-a-distance.

Governmentality: Constructing ‘Contagious’ Women

The Contagious Diseases Acts in Britan and Ireland, and India, constructed women in one of two ways. The visibly diseased, unruly and unregistered prostitute that serviced rank-and-file soldiers, and the clean, private prostitute who worked with army officers (Peers 1998; Ballhatchet 2012; Kumar 2017; Kozma 2017; Thomas and Vagishwari 2024; Walkowitz 1980; Luddy 1995, 2005; Howell 2000: Hiersche 2014). The categorisation of women under British colonial rule served a dual function: to discipline the wayward, and to indirectly persuade the docile. This was to exert better controls over the colonised and manage their conduct. Marking women as ‘good’ prostitutes who adhered to the regulations put in place by the colonial authority, and ‘bad’ prostitutes who did not, provided colonial authorities the tools to shape their behaviours through a range of institutions and strengthened its legitimacy among the colonised population (Curtis 2010; Foucault 1991).

Conclusion

This chapter analysed the Contagious Diseases Acts in Ireland and India through the lens of surveillance studies. By first detailing the Irish Contagious Diseases Acts 1866-1869, this chapter examined the Acts and how they pertained solely to women. The gendered terminology of the principal 1866 Act in Britain and Ireland distinguished between men and women, positioning the latter as diseased prostitutes in need of extra controls. Men, contrastingly, were framed as being victims of their degeneracy, and responsible for maintaining control over them. Magistrates, police, medical officers, and brothel-keepers in India, could only be men. Such a distinction placed men firmly above women hierarchically, regardless of the specific public sphere he occupied, and resulted in the categorisation of women as the wards of those men responsible for the operation of the colonial State.

The 1866-1869 Contagious Diseases Acts were clear in their portrayal of women, marking them for external controls by granting the Police and authorised medical officers the broad authority to inspect, detect, detain and medically examine all women suspected of engaging in ‘common prostitut[ion]’. While the word ‘surveillance’ is not explicitly mentioned throughout the legislation, it is clear in its agenda of collecting and maintaining information of poor-and-working class women who, for all intents and purposes, could be apprehended by any man in a position of power over them. In its bid to triplicate the data collected on women suspected of prostitution, the colonial State facilitated a surveillant apparatus that made visible the most marginalised in Victorian society, earmarking them for extra controls on account of their social category. The bureaucratic database this created functioned to collect information regarding women’s occupation, class, and sexual health, and was recorded and retained for future use by both the woman, the Superintendent of Police, and the designated Magistrate. While the women under the Irish Contagious Diseases Act 1866-1869 were considered to be irresponsible and degenerate to their core, they were expected, as per the legislation, to be responsible for the retention of their ticket which marked them as infection-free. Should a woman be found without her certificate, she would be punished with imprisonment ‘with or without hard labour’.

This responsibility also lay with Indian women, who, under the Indian Contagious Diseases Act 1868, were subject to similar, although less harsh, punishments should they fail to retain evidence of their status. For the burden of proof to lie on both Irish and Indian women contrasts with the portrayal of all women under the heteropatriarchal State. Poor- and working-class Irish women were often portrayed as vindictive temptresses to middle-class men and their sons, while middle-class English women were, conversely, fallen women who had been failed by the State. Indian women were both viewed as being 'born' to prostitution, and as dangerous temptations to the dominant, male, White coloniser. Both constructions of Irish and Indian women framed them as being irresponsible, *and* destructive, and they would be treated as such until they could provide definitive proof that they were otherwise free from disease.

The surveillance of already racialised Indian women facilitated a system that actively marginalised those from lower castes, subordinating them to a position far below that of British rank-and-file soldiers. Under the 1868 Act, magistrates and the police were granted similar powers to detain women suspected of carrying on the business of a 'common prostitute', whilst simultaneously failing to provide any clear definition as to who might fall under the definition. All Indian women were suspect, and doubly so on account of their racialised position under colonialism, one which framed them as inherently dangerous to the colonial cause. Similarly, all Irish women were suspect, until they could provide evidence of their status, or their proximity to prostitution.

The 1868 Indian Act, conversely, made no specific mention of the areas to which the Act applied, rather it was targeted to all women both residing in and operating outside of military cantonments. Inside the cantonments, a system of registration was put in place, one which specifically targeted those women living and working in Lal bazars. Categorisation according to their place of residence was made increasingly clear by instilling in the legislation that they must notify the Local Government of changes to their address, meaning that should they ever move beyond the confines of the Lal bazar, they would remain targets under the Act for examination and detention should they be found to still be contagious, or otherwise fail to notify the State of their intention to disengage from prostitution. The problematisation of sexuality to colonial life ensured that they could not escape their social categorisation of 'common prostitute', 'contagious', and 'dangerous'. The biopolitical efforts of the British State to control the sexual endeavours of its military instituted the systematic regulation of prostitution, and in effect made all women victims of its heteropatriarchal remit.

Conclusion: Colonised and Contagious Women Under the Contagious Diseases Acts

The enactment of the Contagious Diseases Acts across Britain's colonies provides a clear example of surveillance being used as a means of exerting colonial governmentality to enact control-at-a-distance. Foucault (1991) viewed surveillance as a core technology of governmentality. Power, in this instance, operates not only through the direct coercion of individuals via punishment, but also shapes the conduct of populations through the gathering of knowledge, anticipating, guiding, and optimising the welfare of the governed population (Foucault 1991). Governmentality uses a complex network of tactics, calculations, and institutions that takes whole populations, rather than specific individuals as their object, imposing a series of positive operations on the bodies, thoughts, and conduct of the population to compel "supposedly 'autonomous' individuals to govern themselves" (Hewson 2022: 677; Foucault 1993, 1991; Rose and Miller 1992). Weaponising both disciplinary- and biopower, governmentality creates norms that aim to strengthen the State, and its powers, to intervene and manage the habits, and activities, of all its subjects (Rose, O'Malley and Valverde 2006).

Technologies of governmentality, according to Foucault (1991), encompass the practical means through which states enforce their legitimacy. Legislation, such as the Contagious Diseases Acts, can be used by governing authorities to shape, and guide, human behaviours, transforming the abstract political rationalities of government into tangible social practices. In gathering information regarding women engaged in prostitution, such as their name, age, place of residence, caste, and occupation, the colonial British State produced, and reproduced knowledge regarding the behaviours of the population, and constructed norms by which the colonised body was expected to adhere to. By inducing in the population docility through punitive sanctions, normalising judgement through the practice of segregating 'diseased' prostitutes, and examining the sexual behaviours of both the colonial, and colonised population, the British State shaped the conduct of its citizens to better fit the overarching goals of colonialism: the maintenance of racial superiority, heteropatriarchal rule, and class domination.

Under governmentality, the State decides the parameters of what constitutes 'healthy' and 'good', or 'abnormal' and 'dangerous', each working in conjunction to create malleable, 'docile', bodies that are both efficient and profitable (Hewson 2022; Foucault 1993; Rose and Miller 1992). In using discipline to punish individuals and groups who stray too far from acceptable behaviours, alongside biopower to administer positive controls over a population, governmentality brings together the individualising nature of punishment with the indissoluble multiplicity of the broader population to create a new form of governance. This new art of government is, as Foucault (1997, 1991) argues, a political rationality, one that positions the strengthening of society to be both in the interests of the State, and of the population.

In framing biopolitics as the eradication of the 'biologically incapable populations', Foucault (1978) recognises that to manage a population, a State must operate according to an intersectional matrix of power. The Contagious Diseases Acts 1866-1869, and the Indian Contagious Diseases Act of 1868, each defined who the colonial British State considered

worthy of salvation by enshrining into legislation the reformation of only White Irish women through religious and moral instruction. Both pieces of legislation sought to put colonised women in their proper place by removing them from the public realm, and assigning to them worth in accordance with their perceived biological function: to provide a sexual service to men in private. In weaponising surveillance to monitor the sexual relationships of all its citizens, the colonial British State utilised biopower to direct, manage, and control the life processes of the entire population, striving to 'save' White women through religious and moral training in a bid to preserve and legitimise the colonial hierarchy. A central component of biopower is the role of sexuality in the management of populations. Thus, by classifying, specifying, and medicalising the sexualities of all women under the Contagious Diseases Acts, the British colonial State administered both spatial management and surveillance to exert social controls over the entire population.

Racial differences are a consistent element of colonial domination, present within scientific discourses to justify the narrative of White racial superiority, Western political power, and colonisation. The gender binary, a construct that is, first, created, and secondly, performed by individuals, as well as rhetoric regarding one's capacity for self-restraint, highlight governmental strategies of control that seek to exert influence over a governed population. Racialised 'Otherness' was constructed in opposition to the dominant, 'respectable', masculine coloniser, just as the impulsive, 'unrespectable' and sex-obsessed, poor- and working-class wo/man was constructed to oppose the virtuous, morally restrained, and sexually repressed bourgeoise. The Victorian city was not one of rigid boundaries; its borders were permeable, on account of the ebb and flow of one's social class being linked to their economic status. The fear that White, middle-class legitimacy could be tainted by one's proximity to the 'degeneracy' of the slums is, evidently, closely related to colonial fears of Indigenous people rising to overthrow their oppressor.

Patriarchy, as a foundational element of colonialism, is reliant on a gender binary. This binary then provides for other systems of domination to mediate gender statuses, each assigning varying amounts of social value, privilege and power to those amid its hierarchy. Colonialism's modus operandi uses patriarchy, and the gendered and sexual powers it grants to men, to assert dominance over its feminised, colonised populations. It is within this nexus of layered oppressions, that encompass sex, colonial, and racial domination, that systems of heteropatriarchal control become naturalised. As witnessed with the Contagious Diseases Acts, the heteropatriarchal, colonial State heavily scrutinised the sexual relations and behaviours of the colonised population. As a result, all women who failed to conform to the standards expected of the British Empire became targets of pervasive surveillance practices and increased external controls. The deliberate exertion of power by the colonial government surveyed, documented, and 'Othered' colonised women, with the intention of controlling, influencing, and managing their conduct, so that it better aligned with Britain's predetermined, racialised, and gendered framework.

Surveillance under the Contagious Diseases Acts operated at two levels simultaneously: the individual, through discipline, and the population, through biopower. Its purpose: to alter the behaviours of not only the individual, but of the entire population, and ensure that all became docile bodies that adhered to the ordering of the ruling class. Discipline, under the Contagious Diseases Acts, manifested in the lock hospital system. The overt threat of punishment should a woman deviate from the norms of the lock institutions, in both Ireland and India, specify

their punitive function. In Ireland, the explicit mention of the need for these institutions to maintain a moral and religious function, to both re-educate, and re-moralise, the women incarcerated behind their walls, marked them as penal institutions, institutions that sought to preserve and legitimise the colonial hierarchy by marking solely White Irish women as worthy of redemption. Their oppressive environment of manual labour, coupled with the overt surveillance conducted by the governing matron, and her nurses, extended the disciplinary gaze of the State into the lock hospital wards, and ensured that all acquiesced to the rules determined by the colonial body.

While not as legislatively explicit as their counterpart, the Indian lock hospital system brought on a number of subordinate staff to facilitate the disciplinary nature of the institutions. Matrons, dhais, and chowdranies each bore their own responsibility of detecting, reporting on, detaining, and surveying prostitutes within Lal bazars and lock hospitals, both within, and outside of military cantonments. Serving a primarily punitive function, rather than a rehabilitative or reformatory one, Indian lock hospitals were a central node of the Indian Contagious Diseases Act 1868. Bringing together colonial social hygiene forces with military discipline, the Indian lock hospital system facilitated a surveillant apparatus that sought to punish, and corral, low caste Indian women into malleable subjects that would cater to the sexual appetites of White soldiers and officers. The colonising British State naturalised the position of Indian women, reducing them to a resource to be both exploited and managed by its soldiery. The appointment of brothel-keepers as informers for the State to detect, and report, incidences of venereal disease among prostitutes meant that Indian women were under constant surveillance by governing authorities, and subsequently, were subjected to tactics of hierarchical observation, examination, and normalisation while incarcerated.

Surveillance is a means of making individuals visible. It is the systematic and routine ways in which focused attention is paid to personal details for the purpose of influence, management, or control. This visibility is most evident in cases of registration and identification by a State. It embraces a wide range of methods in its bid to make people, their activities, and their behaviours, observable. In marking those select groups as visible, they become easily identifiable; marked and categorised according to the preassigned groupings of the governing State. Regardless of the method of surveillance used, or whether it pertains to disciplinary or biopower/political modes of governance, surveillance operates to create a database of records, either for the 'caring' or 'controlling' remit of the State. Race, class, and gender each represent a category into which individuals can be assigned, Othering them in the process of in/exclusion. The segregation between the dominant, White coloniser, and the racialised, colonised prostitute, was strictly policed through the enforcement of racial, class, and gender boundaries.

In neglecting to define the term 'common prostitute', the Contagious Diseases Acts, in both Ireland and India, ensured that the colonial British State could classify, detain, and punish any woman that deviated from its sanctioned norms. In Ireland, such norms sought to regale women to the domestic realm, as per Victorian standards, and in India, such norms positioned all women under the control of the British military, as concubines to their oppressor. The growing concern with the capacity for some women to devastate the White colonising population through sterility and visible disease meant that the bodies of all women became sites of contamination. Thus, the construction of prostitutes, in both Ireland and India, as 'emissar[ies] of death' that threatened the physical and moral health of the nation, resulted in the mass

regulation of *all* women suspected of prostitution. The stereotyping of colonised Indian women as being both 'born to the role' and as 'dangerous pollutants' to the dominant male coloniser was dependent upon defining, and delineating, the social characteristics of race, gender, and class, to ensure the dominance of the heteropatriarchal State. It further positioned them as a commodity to be consumed by the colonising soldiery, unlike Irish women who were worthy of salvation on account of their epidermal proximity to the coloniser.

Social sorting individuates us, dividing and identifying one person from another to allow the information gathered to be analysed, transacted, and communicated to varying degrees and between different governing institutions. The initial surveillance mechanisms, sanctioned by Britain, were only achievable through the social sorting of the colonised population. Similarly, the sorting of certain individuals, and groups, was only made possible because of the increased surveillance conducted of those select cohorts. The impact of such ordering is indisputable; classifications and standards are central to colonial governance, and assist us in answering the research question: how did the Contagious Diseases Acts facilitate the surveillance and sorting of racialised, poor- and working-class women? The sorting of bodies into distinct categories identifies and measures an individual's worth in accordance with the preassigned characteristics of the governing institution. By creating and reinforcing long-term social difference, the colonising State can identify the Other, distinguish them from the homogenous group, and exterminate them by way of assimilation, or death. The Contagious Diseases Acts serve as yet another example of colonial governmentality; a modality of power that sought to categorise, sort, and treat differing cohorts of society according to Britain's colonial regime of divide and conquer.

In separating the colonisers from the colonised, through the religious segregation of Catholics from Protestants in Ireland, and the spatial separation of White British soldiers from the native Indian population through cantonments, Britain divided its colonies into manageable cohorts, focusing its attention on the acquisition of territory, and the administration of a complex social, cultural, and political regime that divided British 'White', male colonisers, from the racialised, feminised, native populations of Ireland and India. The purpose of this stratification strategy was twofold: to protect British military men from perceived 'threats' to the legitimacy of the Empire; and to ensure that Britain's imperial power remained both visible and unthreatened. Parliamentary debates regarding the persistence of prostitution framed it in a dichotomous fashion. It was both a necessary vice for soldiers stationed in India, who, without a (hetero)sexual outlet, could collapse the Empire through homosexuality, and for those rank-and-file men stationed in Ireland, it was a dangerous blight on the landscape of respectable society, with prostitutes positioned as risks to middle-class men and their sons.

Classifications and standards grant both benefits and consequences to citizens depending on where along the surveillance continuum they reside. The continuum of 'care' and 'control' is most visible in instances of registration and identification by a State, of which the Contagious Diseases Acts are both. In creating a database of women suspected of, or known to be engaged in, prostitution, colonial Britain sought to provide improved sexual healthcare to military men across its colonies. What it achieved, however, was the systematic and regulated discrimination of its female citizens, regardless of whether they were, or were not, a part of its existing colonising body. Official rhetoric espoused the 'caring' nature of the Acts; their operationalisation, however, saw the political repression of all women on account of their gender. This repression was compounded by coalescing social categories of race and class, with

those from poor- and working-class backgrounds disproportionately impacted over other groups. In defining certain activities, and, by extension, certain women, as 'healthy', 'abnormal', or 'dangerous', the State shaped individual self-understanding and broader social expectations to mould women into easily governable subjects.

Under the Irish Contagious Diseases Acts, women were not only categorised according to their occupation, but they were also constructed as being one of two things. Visibly diseased, unruly prostitutes, incapable of self-governance and in need of extra controls, or as clean, private, virtuous prostitutes who catered to high-ranking and self-regulating men. The categorisation of women under colonial rule was two-fold, to both discipline the wayward, and to indirectly persuade the docile. Colonisation always infers structural domination, with hierarchical relations among men and men, men and women, and women and women, each returning to categorisations of race and class. By marking women as either 'good' or 'bad', 'clean' or 'dirty', 'respectable' or 'unrespectable' the colonial State could shape their behaviours through a range of institutions aimed at punishing those beyond its purview, and strengthen the legitimacy of its rule by rewarding behaviours that aligned with its mandate. Recognition of this dual construction of colonised women allows us to answer the research question: how were Irish and Indian women constructed under the Contagious Diseases Acts?

The creation, in both countries, of a register of prostitutes, had as much to do with the categorising of territories as it did with the categorisation of bodies. Women were not only constructed according to their race and gender, but also on account of their spatial location. The places that the Acts were enacted ranged across the initial eleven garrison and dockland towns, to five, and ten miles in the surrounding areas in Ireland. For the women residing in those areas, regardless of whether they were engaged in prostitution or not, they were categorised as risks to the governing State because of their geographical location, rather than any other defining characteristic. In India, the Cantonment Act 1864 ensured that women residing in Lal bazars, both within and beyond the walls of military cantonments, were subject to registration, identification, and periodical examination, and they remained under this regime following the enactment of the Contagious Diseases Act of 1868. The Acts, in both Ireland and India, were enacted primarily in military zones; places that already housed the poorest classes in both Irish and Indian society. Thus, the legislation was spatialised in its application, making the Acts as much a matter of class, as they were a matter of race and gender.

This thesis shows that further research in this area needs to undertake a multidisciplinary approach to understand the impact of colonialism. For too long the Contagious Diseases Acts have gone without the input of surveillance studies. Similarly, for too long has there been limited interrogation as to the different, and similar ways in which the legislation was operationalised across Britain's colonies. While the Contagious Diseases Acts were instated in both Ireland and India, both jurisdictions experienced the Acts to varying degrees. Both Irish and Indian women experienced the disciplinary gaze of the colonial British State, both bore the burden of race, gender, and class prejudices, and both navigated the surveillant practices enacted and operationalised by the British Empire. While Irish women, under the disciplinary gaze of the colonial State, did bear the burden of race, class, and gendered prejudices, Indian women's experiences were heightened on account of the epidermal-based, racial logics of the mid-Victorian period that positioned them as both a risk and a resource to be managed. The Contagious Diseases Act of 1868 marked them as a commodity of the British Empire, a cohort of the colonial population that was undeserving of redemption on

account of their racialised, heteorpatriarchal positioning along the colonial hierarchy.

In utilising a critical feminist and surveillance framework to discuss how Irish and Indian women were impacted according to their race, gender and class, this dissertation has shed light on the gap in knowledge surrounding the use of surveillance strategies of social control to govern colonial and colonised populations. Both surveillance studies, as a discipline, and social sorting, as a mechanism of surveillance, can inform how, historically, States have used their power to indirectly influence and control their citizens. By taking a Foucauldian approach to the enactment of the Contagious Diseases Acts, this thesis has demonstrated the ways in which the colonial British State enforced its legitimacy across its colonies, and in doing so, discriminated against those already experiencing marginalisation in mid-Victorian society. This thesis has deepened understanding of the Contagious Diseases Acts, as technologies of governmentality, how they were operationalised, and their function.

Future questions regarding the impact of the Contagious Diseases Acts might ask whether later Cantonment Acts in India continued to regulate prostitution within militarised areas, or where the records pertaining to the women registered under the Contagious Diseases Acts now reside. Another research avenue might explore the varying dimensions of success achieved by the repeal movement in both jurisdictions, and whether the delay in abolition of the Contagious Diseases Act in India was on account of the racist perception of the colonial State that Indian women, on account of their skin colour, were 'born to the role' of prostitution, or due to other issues to do with the colonial control of far-removed territories. This thesis was unable to ask, or provide answers to, these questions. Hopefully this project will inspire further research into the extensive database of race, gender and class based discrimination created through the extensive surveillance of poor-and working-class women in Ireland and India.

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