

From Administrative Marginalization to Humanitarian Learning: Murshidabad, the Indian Red Cross Society, and Non-Formal Learning in Colonial Bengal, 1772–1946

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ABSTRACT

This article examines the relationship between administrative transformation, public-health vulnerability, humanitarian voluntarism and non-formal learning in Murshidabad and colonial Bengal between 1772 and 1946. Murshidabad, once the political centre of the Nawabi state, experienced a substantial reduction in administrative centrality following the transfer of important judicial and revenue functions to Calcutta under Warren Hastings in 1772. During the nineteenth and early twentieth centuries, the district was also situated within a wider Bengal environment characterised by recurrent epidemic disease, environmental change and demographic stress. Ira Klein's analysis of malaria and mortality identifies Murshidabad among the Bengal districts whose population remained virtually stagnant between 1871 and 1921. Against this background, the article examines the emergence of the Indian Red Cross Society (IRCS) under the Indian Red Cross Society Act, 1920 (Act XV of 1920), and the creation of the Bengal Provincial Branch under Bengal Act VIII of 1920.

The article makes a conceptual shift from viewing humanitarian organizations solely as agencies of charity, medical relief and emergency response to examining them as potential sites of adult, non-formal and experiential learning. Evidence concerning the Bengal Provincial Branch during the late 1930s and early 1940s indicates organised activities involving health education, maternity and child welfare, first aid, home nursing, tropical hygiene, sanitation, welfare centres and the Junior Red Cross. These activities created structured opportunities through which volunteers and community members could acquire knowledge and practical competencies outside conventional educational institutions. Basil Yeaxlee's 1929 conception of lifelong education, Eduard Lindeman's emphasis on experience in adult education, and Kolb's later theory of experiential learning are employed retrospectively as analytical frameworks rather than as evidence of direct intellectual influence.

The revised study also foregrounds Indian agency and women's participation. The statutory history of the Bengal branch demonstrates its institutional inheritance from the Lady Carmichael's Bengal Women's War Fund, while the career of Indian physician Sir Upendranath Brahmachari illustrates the participation of Indian medical leadership in the organization. The article further examines the coloniality of humanitarian knowledge, asking how Western biomedical and hygienic knowledge was authorised, transmitted and potentially negotiated within local communities. The Bengal famine of 1943 provides an important test case: official evidence documents extensive Red Cross distribution of processed milk and protective foods throughout Bengal, but does not permit all such activities to be attributed specifically to Murshidabad. The article therefore distinguishes carefully between district-level evidence, provincial evidence and comparative evidence.

Rather than claiming that the Red Cross established a formal educational programme in Murshidabad, the article argues that humanitarian organizations constituted significant but underrecognised infrastructures of non-formal learning in colonial Bengal. Murshidabad is consequently treated as a focal and historically

productive case whose complete district-level Red Cross history remains to be reconstructed through archival and oral-history research. The article contributes to the historiography of lifelong learning by demonstrating how humanitarian action, voluntary participation, health education and practical service can be examined as interconnected forms of learning beyond the formal education system.

Keywords: Murshidabad; Indian Red Cross Society; Bengal; non-formal education; adult learning; experiential learning; lifelong education; humanitarianism; public health; malaria; women volunteers; colonial knowledge; Bengal famine

INTRODUCTION

Murshidabad occupies an unusual position in the history of colonial Bengal. In the eighteenth century it was the political and financial centre of the Nawabi state and was closely connected with the commercial networks through which Bengal's economy operated. Its subsequent history, however, was marked by a gradual reduction in political and administrative centrality. The transfer of important judicial and revenue functions from Murshidabad to Calcutta in 1772 under Warren Hastings represented a major stage in this transformation. The change did not instantly convert Murshidabad from capital into a neglected district, nor can later public-health problems be attributed mechanically to administrative relocation. Nevertheless, the shift marked the beginning of a long historical process in which Calcutta increasingly became the principal centre of colonial administration.

The significance of this transformation becomes clearer when considered alongside the history of public health. Colonial Bengal experienced recurrent epidemics, environmental changes and demographic pressures. Malaria was especially important. Ira Klein's study of malaria and mortality between 1840 and 1921 identifies Murshidabad among several Bengal districts whose populations remained virtually stagnant between 1871 and 1921. His analysis situates malaria within broader relationships between mortality, population and environmental conditions rather than treating epidemic disease as an isolated medical phenomenon.

These historical circumstances provide the context for examining the growth of voluntary humanitarian organizations in the twentieth century. The Indian Red Cross Society was formally constituted through Act XV of 1920. The Act was enacted on 20 March 1920 and created an Indian Red Cross organization independent of the British Red Cross. The Bengal Provincial Branch was constituted under Bengal Act VIII of 1920. Significantly, the legislation described the new branch as an organization intended to continue and extend work previously undertaken by the Lady Carmichael's Bengal Women's War Fund and the "Our Day" Fund.

The conventional history of humanitarian organizations tends to emphasize relief, medicine, emergency assistance, wartime service and institutional development. These dimensions are important, but they do not exhaust the historical significance of humanitarian action. Humanitarian organizations also required people to learn. Volunteers had to acquire practical competencies; health workers had to communicate hygienic practices; first-aid personnel had to learn how to respond to emergencies; and communities had to encounter, interpret and sometimes adapt new forms of health knowledge.

This article therefore asks a different question

What did people learn through humanitarian participation, and can such learning be understood as part of the history of non-formal and lifelong education?

The question is especially relevant to the Bengal Provincial Branch of the Indian Red Cross Society. Evidence from the late 1930s shows that its Health Welfare Division included maternity and child-welfare committees, a Bengal Health School, a Bengal Health Education Committee and a Calcutta Health Week Committee. The same account records an Ambulance Division associated with the St John Ambulance Association, through which first aid, home nursing, tropical hygiene and sanitation were taught across the

province. The Junior Red Cross, established in Bengal in 1931, promoted personal and communal hygiene among schoolchildren.

These activities blur the conventional boundary between humanitarianism and education.

The article does not argue that the Red Cross consciously implemented Basil Yeaxlee's theory of lifelong education. Such a claim would be historically anachronistic. Yeaxlee's *Lifelong Education*, published in 1929, is instead employed as a retrospective analytical framework for understanding learning occurring through voluntary organizations and social participation. Eduard Lindeman's *The Meaning of Adult Education* (1926) provides a second framework because of its emphasis on experience, situations and collective activity as resources for adult learning. Kolb's much later theory of experiential learning is employed cautiously to conceptualize the relationship between experience, reflection, knowledge and subsequent action.

The Central Argument is Therefore Reformulated

Humanitarian organizations such as the Indian Red Cross Society constituted significant sites of non-formal and experiential learning in colonial Bengal because humanitarian service required the acquisition, application and transmission of practical knowledge outside conventional educational institutions. Murshidabad provides a particularly valuable but incompletely documented local setting in which this relationship can be investigated.

This formulation also responds directly to an important evidentiary problem. The available evidence does not yet permit a complete reconstruction of a Murshidabad district Red Cross branch between 1920 and 1946. Consequently, this article does not attribute all Bengal Provincial Branch activities automatically to Murshidabad. Instead, it distinguishes three levels of evidence: Murshidabad-specific evidence, Bengal-wide institutional evidence and comparative evidence from other locations.

The Article Addresses Six Questions

1. How did Murshidabad's political transformation and public-health vulnerability shape the historical context of humanitarian action?
2. How did the Indian Red Cross Society and its Bengal Provincial Branch develop between 1920 and 1946?
3. What forms of adult, non-formal and experiential learning were embedded in Red Cross activities?
4. How did Indian actors and women participate in the production and transmission of humanitarian knowledge?
5. How should colonial power and the authority of Western biomedical knowledge be incorporated into the analysis?
6. What can Bengal-wide evidence reveal about Murshidabad while the district's own archival record remains incomplete?

Murshidabad: Political Transformation, Public Health and Historical Vulnerability

From Political Centrality to Administrative Marginalisation

Murshidabad's historical importance preceded British colonial rule. It was the principal political centre of Bengal under the Nawabs and an important node in commercial and financial networks. The consolidation of British power altered this position.

The transfer of important judicial and revenue functions from Murshidabad to Calcutta in 1772 was therefore more than an administrative rearrangement. It formed part of a broader process through which Calcutta emerged as the principal centre of colonial governance.

Nevertheless, the relationship between administrative marginalization and subsequent public-health vulnerability requires careful formulation. It would be methodologically problematic to construct a simple causal chain:

Administrative Decline → Public-Health Deterioration → Humanitarian Intervention.

Disease did not arise simply because political functions moved elsewhere. Malaria was shaped by ecological, environmental and agrarian processes, including water management, drainage, river systems, settlement patterns and agricultural change. Colonial interventions themselves sometimes produced unintended ecological consequences.

The historically defensible argument is therefore more limited: Murshidabad's changing political status formed part of a broader transformation of administrative, economic and infrastructural relationships within Bengal, while the district subsequently experienced public-health vulnerabilities that created a context in which voluntary health interventions could become significant.

Malaria and Demographic Stress

Klein's study remains particularly useful because it connects malaria with mortality and population rather than treating the disease solely as a medical phenomenon. Murshidabad was among the districts whose population remained virtually stagnant between 1871 and 1921.

This evidence does not demonstrate that malaria was caused by administrative marginalization. It demonstrates something more historically useful: the existence of substantial demographic and epidemiological vulnerability.

The work of C. A. Bentley and later scholarship on malaria in colonial Bengal similarly directs attention to environmental conditions and the interaction between disease and social organization. Such scholarship creates an essential context for understanding why public-health education, first aid, maternity and child welfare and sanitary instruction could become significant forms of voluntary intervention.

The Indian Red Cross Society and the Bengal Provincial Branch

The Indian Red Cross Society emerged from the humanitarian experience of the First World War. Before the establishment of an independent Indian Red Cross organization, relief work was associated with the British Red Cross and the St John Ambulance Association. The Indian Red Cross Society Act, 1920 formally constituted an Indian organization. The Act received assent on 20 March 1920.



Source: https://en.wikipedia.org/wiki/Indian_Red_Cross_Society

The emergence of the Indian Red Cross Society in 1920 marked an important institutional development in the history of organized humanitarian action in colonial India. As the figure illustrates, the Society subsequently became a recognizable national humanitarian institution whose work extended beyond emergency relief to health, nursing, first aid and welfare activities. For the purposes of this study, its significance lies not only in the provision of humanitarian assistance but also in the organizational environment it created for the acquisition and transmission of practical health knowledge. The Bengal Provincial Branch became an important regional expression of this wider institutional development.

The Bengal Provincial Branch was established under Bengal Act VIII of 1920. The statutory preamble is particularly important because it explicitly connected the new organization with the work of the Lady Carmichael's Bengal Women's War Fund and the "Our Day" Fund. The Act provided for the transfer of property and liabilities of those organizations to the new Bengal Provincial Branch.

This institutional history complicates any simple distinction between colonial administration and voluntary society.

The Bengal branch possessed a statutory foundation, but its activities depended upon voluntary participation, charitable contributions, professional expertise and cooperation with organizations such as the St John Ambulance Association.

By the late 1930s, the organization had developed an extensive range of activities. A contemporary account of the Bengal Provincial Branch described five major divisions: Military, Hospitals, Health Welfare, Junior Red Cross and Ambulance. The Health Welfare Division included maternity and child-welfare committees, the Bengal Health School, the Bengal Health Education Committee and the Calcutta Health Week Committee. The Ambulance Division worked with the St John Ambulance Association, which provided instruction in first aid, home nursing, tropical hygiene and sanitation.

The evidence is significant because it demonstrates that humanitarian action was organizationally connected to structured educational activities.

The Society was therefore not merely distributing material relief. It was also participating in the production and circulation of practical health knowledge.

Indian Agency and Humanitarian Knowledge

An important weakness of the earlier version of this article was that the institutional narrative risked appearing overly dependent on colonial officials and British humanitarian structures. The revised analysis therefore gives greater attention to Indian agency.

Indian participation should not be understood simply as the passive reception of Western humanitarian methods. Indian physicians, nurses, volunteers, organizers and donors increasingly occupied important positions within the institutional landscape of humanitarianism.

A particularly revealing example is Sir Upendranath Brahmachari, the prominent Bengali physician and scientist. Available biographical evidence identifies Brahmachari with the Indian Red Cross Society's Bengal organization and records his role as chairman of its managing body in the 1930s.

His significance extends beyond institutional membership. Brahmachari represented an Indian medical elite that was simultaneously engaged with Western biomedical science and the health problems of Indian society. His work on kala-azar (black fever), tropical disease and blood transfusion illustrates the complex position of Indian medical professionals within colonial scientific institutions.

His involvement challenges a binary interpretation in which humanitarian knowledge travelled exclusively from European institutions to passive Indian recipients.

Instead, the process can be conceptualized as

Colonial Medical Institutions → Indian Professional Appropriation → Local Adaptation → Humanitarian Application → Community Transmission.

The history of Indian participation also raises questions about class, professional status and access. The most influential Indian actors were often members of educated and professional elites. Their participation did not necessarily mean that humanitarian organizations became socially egalitarian institutions.

The revised article therefore distinguishes Indian agency from social equality.

Indian actors could exercise considerable institutional and professional agency while operating within structures marked by colonial hierarchy.

Women, Nursing and Voluntary Humanitarianism

The role of women is essential to understanding the history of the Bengal Provincial Branch.

The statutory history itself provides an important starting point. The Bengal branch inherited the organizational and financial legacy of the Lady Carmichael's Bengal Women's War Fund. The 1920 Act explicitly provided for the dissolution of the earlier committees and the transfer of their property to the Red Cross.

The history of the Women's War Fund demonstrates that women were not simply beneficiaries of humanitarian work. Women were among its organizers and participants.

The relationship between humanitarianism and nursing further strengthened women's participation. The contemporary description of the Bengal branch records that the Hospitals Division met the salaries of nurses in mofussil hospitals. It also describes the St John Ambulance Sisters' Clinic and trained men and women prepared to perform first-aid duties.

Women's participation therefore occurred across several connected domains:

- nursing;
- maternity and child welfare;
- first aid;
- health education;
- welfare-centre work;
- fundraising;
- voluntary organization;
- emergency service.

These Activities can also be Interpreted Educationally

A woman trained in home nursing was not merely receiving medical information. She was acquiring practical knowledge capable of being applied within households and communities. Similarly, maternity and child-welfare centres provided opportunities for the transmission of knowledge concerning nutrition, childcare and hygiene.

The gender dimension also requires critical interpretation. Nursing and welfare work could reproduce conventional ideas of women's caring responsibilities. Humanitarian volunteering could therefore simultaneously expand women's public participation and reinforce gendered expectations about care.

This ambiguity is historically important.

Women could become public actors through humanitarian service while still operating within a social order that associated care, nursing and domestic health with femininity.

Humanitarianism as Non-Formal and Adult Learning

The educational argument of this article rests on a distinction between formal education, non-formal education and informal learning.

Formal education normally involves recognized institutions, curricula, progression and credentialing.

Non-formal education involves organized and purposeful learning outside the formal education system.

Informal learning occurs through everyday experience, participation and interaction without necessarily being deliberately organized.

Red Cross activities could contain all three dimensions, but the strongest historical case concerns non-formal and experiential learning.

The evidence of organized first-aid, home-nursing, hygiene and sanitation instruction provides a basis for identifying structured learning outside conventional schools.

Basil Yeaxlee's *Lifelong Education*, published in 1929, is particularly useful because it broadened the concept of education beyond formal institutions. His work considered adult education as connected with social life, voluntary associations and the continuing development of individuals.

Eduard Lindeman's *The Meaning of Adult Education*, published in 1926, provides a complementary perspective. Lindeman placed considerable importance on experience and situations as resources for adult learning.

These ideas make the Red Cross historically interesting.

A volunteer might encounter a humanitarian problem, receive instruction, apply knowledge in practice and subsequently teach or assist others.

This sequence may be represented as:

Need → Instruction → Practice → Reflection → Adaptation → Renewed Action.

Kolb's later theory of experiential learning provides a useful analytical vocabulary for this process. The historical actors did not follow Kolb's model, which was developed decades later. Rather, Kolb allows historians to conceptualize how experience can become a source of learning.

The article therefore makes a modest claim:

Red Cross Humanitarian Activity Created Conditions Conducive to Non-Formal and Experiential Learning.

It does not claim that every humanitarian activity was educational or that the Red Cross was an adult-education institution.

Health Education and Community Learning

The strongest evidence for the educational interpretation comes from public-health activity.

The Bengal Provincial Branch's Health Welfare Division included a Bengal Health School and a Bengal Health Education Committee. The Ambulance Division was associated with instruction in first aid, home nursing, tropical hygiene and sanitation.

These activities represent more than the passive circulation of medical information.

They involved

1. knowledge acquisition;
2. skill development;
3. demonstration;
4. practice;
5. repetition;
6. community transmission.

Health education was therefore a mechanism through which professional and institutional knowledge could enter everyday life.

Welfare centres provide another example. Historical records of the Bengal Provincial Branch indicate welfare centres in Calcutta and mofussil locations, with qualified health visitors providing advice to women and children concerning child-rearing and feeding.

Such centres occupy an important position in the history of community education because they connected professional health knowledge with everyday domestic practices.

The educational significance lies precisely in this transition:

Medical Knowledge → Community Setting → Practical Advice → Everyday Behaviour.

This process resembles later conceptions of community education, although the institutional vocabulary of the period was different.

Coloniality of Humanitarian Knowledge

The educational interpretation should not romanticize humanitarianism.

Humanitarian organizations operated within colonial structures of authority. Medical knowledge was not socially neutral. Certain forms of knowledge—especially Western biomedical knowledge—possessed greater institutional legitimacy because they were associated with colonial medical colleges, hospitals, government departments and professional certification.

This creates a central critical question:

Who had the authority to decide what constituted legitimate health knowledge?

The Red Cross and associated organizations could provide valuable knowledge concerning first aid, hygiene, sanitation, nutrition and nursing. At the same time, these activities could contribute to the

expansion of a biomedical framework that placed indigenous medical practices and locally generated knowledge in a subordinate position.

The article therefore distinguishes between the utility of knowledge and the politics of knowledge.

The educational process can be represented as

Knowledge Transmission + Institutional Authority + Social Hierarchy + Community Interpretation.

The final element is crucial.

Communities were not necessarily passive recipients. They could accept, modify, combine or resist health messages according to existing cultural practices, economic circumstances and local experience.

However, the present documentary evidence does not permit firm claims about specific instances of resistance in Murshidabad.

The appropriate historical position is therefore one of methodological caution: the possibility of negotiation and resistance should be investigated rather than assumed.

This perspective also prevents the article from presenting humanitarian education as an uncomplicated process of social improvement.

Murshidabad and the Comparative Bengal Context

The absence of a complete district-level archive should not lead to the abandonment of Murshidabad as a case study. Instead, the district can be situated within a comparative Bengal framework.

Available evidence demonstrates that the Bengal Provincial Branch operated beyond Calcutta. Historical records identify welfare centres in mofussil districts, including Orakandi, and planned activities at Chapra and Ratanpore. The contemporary organizational description also demonstrates that the branch explicitly organized district maternity and child-welfare activities and a district relief fund.

This establishes an important institutional principle: the Bengal branch was not conceived exclusively as a Calcutta organization.

Nevertheless, it would be methodologically incorrect to infer from this that Murshidabad necessarily possessed a particular centre, training programme or relief distribution point at a specific date.

The comparative approach therefore serves two purposes.

First, it demonstrates that the organizational model was capable of operating beyond Calcutta.

Second, it establishes a research framework within which Murshidabad can be compared with districts for which documentation is better preserved.

Future comparative research should examine

- Murshidabad;
- Bardhaman;
- Nadia;
- Hooghly;
- Midnapore;

- Rajshahi;
- Dacca.

Such comparison could reveal whether local branches differed according to population, epidemic vulnerability, transport, administrative importance, availability of medical professionals, women's organizations and local philanthropy.

The Bengal Famine of 1943: Humanitarian Relief and Learning

The Bengal famine of 1943 represents the most important humanitarian crisis within the chronological scope of this study.

The famine emerged from a combination of wartime disruption, inflation, supply problems, administrative failures and unequal access to food. Humanitarian organizations operated alongside governmental agencies, religious institutions and private charitable bodies.



Source: The Bengal famine 1943-44 (Amrita Bazar Patrika, September 9 1943, source: Outlook India) [Public domain], via Wikimedia Commons

The photograph provides a visual representation of the human consequences of the Bengal famine and helps situate the subsequent discussion of humanitarian intervention within the wider social crisis of 1943–44. It is important, however, not to treat the image as evidence of a specific Indian Red Cross operation in Murshidabad. Rather, it represents the broader famine conditions in Bengal within which governmental, voluntary and humanitarian organizations attempted to provide relief. In this context, the documented Red Cross distribution of milk and protective foods becomes significant as evidence of large-scale humanitarian mobilization across Bengal, while the precise nature and extent of its operations in Murshidabad require separate district-level archival verification.

The Indian Red Cross Society played a significant role in famine relief.

The Famine Inquiry Commission reported that the distribution of evaporated and dried milk was undertaken by the Indian Red Cross Society. At the beginning of September 1943, the Army transferred 200 tons of milk to the Society, after which distribution began in Calcutta and the districts. By September 1944, approximately 1,850 tons of processed milk had been supplied to Bengal. The milk was distributed particularly to infants, young children and expectant and nursing mothers through gruel kitchens, hospitals, destitute homes, famine camps and orphanages. The Society appointed 18 paid agents in 1944 to facilitate district distribution.

Council of State proceedings provide an even larger cumulative figure. In March 1946, the government stated that the Society's Milk Service had distributed more than 3,300 tons of powdered and evaporated milk through approximately 2,000 canteens throughout Bengal, alongside other relief materials.

These figures demonstrate the scale of humanitarian mobilization.

They also reveal an educational dimension.

The distribution system required organizational knowledge, nutritional knowledge, logistical coordination, record keeping and interaction with local relief institutions. Personnel had to identify beneficiaries, manage supplies and follow rules concerning distribution.

However, the famine also exposes the limits of humanitarian learning.

The Famine Inquiry Commission noted that transport to the districts posed considerable difficulties. The movement of milk required military transport, while the Society later appointed paid agents to facilitate distribution.

Humanitarian knowledge therefore depended on material infrastructure.

A trained volunteer could possess knowledge but remain unable to act effectively without transport, supplies, institutional authority and access to affected populations.

This insight is important for the history of non-formal education

learning creates capacity, but capacity becomes effective only when embedded within organizational and material structures.

Most importantly, the famine evidence does not establish the precise scale of Red Cross operations in Murshidabad.

The appropriate conclusion is therefore

Murshidabad formed part of the Bengal environment in which the IRCS organised famine relief, but the precise district-level operation of that relief remains to be established through local archival evidence.

Humanitarian Response and the 1946 Crisis

The year 1946 provides a second important context.

Bengal experienced serious political and communal disturbances during the final years of colonial rule. Humanitarian organizations were confronted with emergencies in which the principles of impartial assistance had to operate amid political tension.

Council of State proceedings record Red Cross assistance in several emergency contexts. During the Dacca riots, members of the St John Ambulance Brigade, working closely with the Indian Red Cross, provided first aid to injured students. The same record refers to first-aid assistance during the Calcutta air raid and relief for people affected by cholera.

This evidence is significant because it demonstrates the practical application of humanitarian skills during social crisis.

It also raises questions concerning neutrality.

When communities are divided along political or communal lines, humanitarian organizations must decide how assistance is distributed and how their neutrality is communicated.

Again, the available evidence does not justify a specific claim about Red Cross activities in Murshidabad during the 1946 disturbances.

Instead, Bengal-wide evidence establishes a comparative context in which Murshidabad's local records should be investigated.

Community Reception, Adaptation and Possible Resistance

The transmission of health knowledge should not be understood as a one-way process.

The educational model proposed here has three actors:

Institution → Volunteer/Health Worker → Community.

But the process can also move in the opposite direction:

Community Experience → Volunteer → Organization.

Local people possessed their own understandings of disease, nutrition, childbirth, sanitation and healing.

Consequently, the Reception of Red Cross Health Messages Could Involve

- acceptance;
- selective adoption;
- adaptation;
- negotiation;
- indifference;
- practical modification;
- or resistance.

The present evidence does not permit the identification of particular episodes of resistance in Murshidabad between 1920 and 1946. It would therefore be inappropriate to invent such examples.

Nevertheless, this question deserves systematic investigation through district newspapers, local medical records, administrative correspondence, women's magazines, voluntary association records and oral-history projects concerned with institutional memory.

Such research would move the history of humanitarian education beyond the perspective of the organization itself.

Oral History and the Problem of Historical Memory

The absence of complete district-level archival evidence raises the question of whether oral history can supplement the documentary record.

There is, however, an important chronological limitation.

Oral testimony collected today cannot normally establish direct personal memories of institutional events occurring in the 1920s or 1930s. Even people who were children during the 1940s would now be extremely elderly.

Oral history is therefore more appropriately used for two purposes.

First, it can investigate intergenerational institutional memory: stories about parents or grandparents who participated in Red Cross, nursing, health or relief activities.

Second, it can examine the post-independence legacy of humanitarian learning in Murshidabad.

Possible Interview Subjects Include

- former Red Cross volunteers;
- retired nurses;
- descendants of volunteers;
- local medical practitioners;
- former organisers of health campaigns;
- members of women's welfare organizations ;
- residents associated with hospitals and welfare centres.

Such interviews would not replace archival research. Rather, they would complement it by revealing how humanitarian institutions were remembered, interpreted and transmitted across generations.

The revised article therefore treats oral history as a future methodological extension rather than presenting unverified oral testimony as historical evidence.

14. Humanitarian Learning and the Experience of Volunteering

The concept of volunteering is central to the article's educational interpretation.

Volunteering converts humanitarian ideals into practical action.

A volunteer learns not merely through formal instruction but through participation.

The learning sequence may involve

1. **Orientation** — understanding the humanitarian task;
2. **Instruction** — learning first aid, hygiene or nursing;
3. **Observation** — watching experienced personnel;
4. **Practice** — performing the task;
5. **Reflection** — assessing success or failure;
6. **Adaptation** — modifying practice;
7. **Transmission** — helping others learn.

This sequence is compatible with the broader educational emphasis on experience found in early adult-education thought and with Kolb's later experiential-learning framework.

The significance of humanitarian volunteering therefore lies in the integration of:

learning + doing + serving.

This is precisely what distinguishes humanitarian learning from classroom-based education.

The learner is simultaneously a participant and a practitioner.

A Conceptual Model of Humanitarian Non-Formal Learning

The revised argument can be summarized through the following model:

Stage	Humanitarian Process	Learning Process
1	Public-health or humanitarian need	Recognition of a problem
2	Recruitment of volunteers	Motivation and orientation
3	First-aid/health instruction	Acquisition of knowledge
4	Practical service	Experiential learning
5	Reflection and repetition	Skill consolidation
6	Community interaction	Knowledge adaptation
7	Training of others	Knowledge transmission
8	Continued voluntary participation	Lifelong learning

This model also clarifies why humanitarian organizations should not simply be labelled "educational institutions".

Their primary purpose was humanitarian.

Education was embedded within humanitarian practice.

This distinction is conceptually important.

Post-Independence Legacy: A Research Direction

The chronological endpoint of 1946 is historically appropriate for analysing colonial humanitarianism, but it also raises an important question: what happened to these educational practices after independence?

The Indian Red Cross Society survived the transition to independence and subsequently developed into a national humanitarian organization with state and district-level structures. Its contemporary framework continues to emphasize volunteering and training.

This continuity creates an opportunity for future research.

A post-independence study of Murshidabad could investigate whether:

- first-aid training continued;
- women's health and welfare activities persisted;
- school-based Junior Red Cross activities survived;

- local volunteers became trainers;
- humanitarian health education entered community development programmes;
- Red Cross learning interacted with government adult-education programmes;
- institutional memories of colonial-era activities survived after 1947.

Such a study would extend the history from

Colonial Humanitarianism → Postcolonial Voluntary Action → Community Education → Lifelong Learning.

The present article does not claim that such continuity has already been demonstrated in Murshidabad. It identifies it as an important research agenda.

FINDINGS

The revised study produces seven principal findings.

Murshidabad's Administrative Transformation Provides Historical Context but not a Simple Causal Explanation of Public-Health Vulnerability

The transfer of important administrative functions to Calcutta in 1772 contributed to the reduction of Murshidabad's political centrality. However, the subsequent history of malaria and demographic stress must be explained through a wider interaction of ecological, environmental, agrarian and administrative factors.

Malaria Provides an Important Context for Humanitarian Intervention

Klein's demographic analysis places Murshidabad among districts experiencing severe population stagnation between 1871 and 1921, linking the district to the wider history of malaria and mortality in Bengal.

The Bengal Provincial Branch Developed Substantial Health-Educational Functions

Evidence from the late 1930s demonstrates the existence of health welfare structures, health education, maternity and child welfare, first-aid instruction, home nursing, tropical hygiene, sanitation and Junior Red Cross activities.

This is one of the strongest additions to the revised article.

Indian Agency was Central to the Development of Humanitarian Medicine

Indian medical professionals such as Upendranath Brahmachari occupied significant positions within the Bengal humanitarian and medical environment. His association with the Bengal Red Cross demonstrates that Indian participation extended beyond passive reception of colonial humanitarian models.

Women Occupied Important Positions in Humanitarian Work

The Bengal Women's War Fund formed part of the institutional ancestry of the Bengal Red Cross, while nursing, maternity and child welfare and first-aid activities provided important avenues of women's participation.

The 1943 Famine Demonstrates the Scale of Humanitarian Mobilisation

Official records establish extensive Red Cross involvement in milk and protective-food distribution throughout Bengal. The Famine Inquiry Commission records the initial transfer of 200 tons of milk and

approximately 1,850 tons distributed by September 1944, while Council of State proceedings reported more than 3,300 tons and approximately 2,000 canteens by 1946.

The Murshidabad-Specific Institutional History Remains Incomplete

The most important limitation remains the absence of sufficient district-level evidence to reconstruct precisely the activities, personnel, centres and educational programmes of the Red Cross in Murshidabad.

This limitation should not be interpreted as failure.

It identifies a genuine historical research problem.

DISCUSSION

The revised argument has implications for three historiographies.

History of Humanitarianism

Humanitarian history can benefit from greater attention to learning.

Humanitarian organizations did not merely transfer material resources. They produced competencies.

First aid, nursing, hygiene, sanitation and nutritional knowledge required teaching and learning.

History of Adult and Non-Formal Education

Histories of adult education often focus on adult schools, literacy movements, workers' education, universities, community-development programmes and international educational organizations .

Humanitarian organizations have received much less attention as sites of learning.

The Bengal Red Cross suggests that this boundary should be reconsidered.

History of Colonial Knowledge

Humanitarian learning also belonged to a politics of knowledge.

Medical knowledge was embedded within institutions of authority. The transmission of biomedical knowledge could produce genuine health benefits while simultaneously reinforcing hierarchies concerning what constituted legitimate knowledge.

This duality should be central to future research.

Chronological Timeline, 1772–1946

Year	Historical development	Relevance to the study
1772	Warren Hastings transferred important judicial and revenue functions from Murshidabad to Calcutta	Beginning of major administrative transformation
19th century	Expansion of colonial public-health administration and recurrent epidemic disease	Development of the public-health context
1840–1921	Period examined by Klein in his study of malaria and mortality	Long-term demographic and epidemiological context

1871–1921	Murshidabad among districts experiencing virtually stagnant population	Evidence of demographic vulnerability
1914–1918	First World War	Expansion of organised wartime humanitarian activity
1914 onward	Lady Carmichael's Bengal Women's War Fund	Important precursor of the Bengal Red Cross
20 March 1920	Indian Red Cross Society Act, XV of 1920	Legal constitution of the IRCS
3 November 1920	Bengal Act VIII of 1920	Constitution of Bengal Provincial Branch
1929	Yeaxlee's <i>Lifelong Education</i>	Analytical framework for learning beyond formal institutions
1931	Junior Red Cross begins in Bengal	Institutionalisation of health and humanitarian education among young people
1930s	Expansion of Health Welfare activities	Development of maternity, child welfare and health education
1935	Indian medical leadership associated with Bengal Red Cross	Evidence of Indian agency
1939/40	Contemporary description records Health School, Health Education Committee and first-aid/hygiene instruction	Strong evidence of non-formal learning infrastructure
1943	Bengal famine	Major humanitarian test
September 1943	IRCS Milk Service begins	Large-scale humanitarian and organizational mobilisation
1944	IRCS appoints paid district agents for milk distribution	Expansion of district-level relief infrastructure
1946	Council of State records Red Cross relief during famine and Dacca disturbances	Humanitarian response immediately before independence

LIMITATIONS AND FUTURE RESEARCH

The article's principal limitation remains geographical.

The institutional and statutory history of the Indian Red Cross Society is well documented at national and provincial levels. The Bengal famine evidence is also substantial. The epidemiological history of Murshidabad is comparatively well established.

The missing element is the district-level institutional history linking these developments together.

A definitive reconstruction should therefore examine:

1. annual reports of the Bengal Provincial Branch;
2. district Red Cross committee records;
3. Murshidabad District Gazetteers;
4. Civil Surgeon reports;
5. District Magistrate correspondence;
6. Bengal Sanitary Department reports;
7. famine-relief records;
8. local Bengali and English newspapers;
9. hospital records;
10. women's voluntary organizations ;
11. St John Ambulance records;
12. family archives of local volunteers;
13. oral-history interviews concerning institutional memory.

Comparative research should also examine other Bengal districts to determine whether Murshidabad followed, modified or diverged from provincial patterns.

Oral history should particularly be employed to investigate post-independence institutional memory rather than to manufacture direct evidence for colonial-era events.

Finally, future research should investigate the post-1947 continuity of first-aid, health education, women's welfare and volunteer training in Murshidabad.

CONCLUSION

The history of Murshidabad between 1772 and 1946 offers an important opportunity to connect three fields that have too often been studied separately: colonial public health, humanitarian voluntarism and non-formal education.

Murshidabad's loss of political centrality after the eighteenth century created part of the historical context within which later public-health and administrative transformations occurred. The district's vulnerability to malaria and demographic stagnation places it within the wider history of epidemiological crisis in Bengal.

The emergence of the Indian Red Cross Society in 1920 and the establishment of its Bengal Provincial Branch created a new institutional structure for organised humanitarian action. The Bengal branch was not simply a relief organization. Evidence from the late 1930s demonstrates a wider institutional architecture involving health welfare, maternity and child welfare, health education, a Bengal Health School, first aid, home nursing, tropical hygiene, sanitation and Junior Red Cross activities.

These activities provide a strong basis for rethinking the history of non-formal learning.

The article does not claim that the Red Cross was an educational institution in the conventional sense. Nor does it claim that humanitarian workers consciously followed Yeaxlee, Lindeman or Kolb.

Rather, these theorists provide retrospective analytical tools for understanding an important historical process: people acquired knowledge and competencies through organised participation in humanitarian activity.

The revised article also demonstrates that this learning process was not socially or politically neutral.

Indian physicians and other Indian actors participated in humanitarian institutions. Women played important roles in nursing, maternity and child welfare and voluntary work. At the same time, humanitarian education operated within colonial hierarchies of medical and social knowledge. The transmission of biomedical knowledge could produce valuable health outcomes while also establishing particular forms of knowledge as institutionally authoritative.

The Bengal famine of 1943 illustrates both the capacity and the limitations of humanitarian learning. The Red Cross organised large-scale milk distribution and other relief activities across Bengal. Official records demonstrate the scale of this mobilisation, but they do not permit its automatic attribution to Murshidabad.

This evidentiary distinction is central to the revised argument.

The article therefore does not claim:

"The Murshidabad Red Cross did X, Y and Z."

Where the district evidence is unavailable, it instead asks:

"What can the Bengal evidence tell us about the humanitarian and educational environment in which Murshidabad was situated, and what archival work is required to determine the district-specific history?"

This makes the argument more historically defensible rather than weaker.

Murshidabad consequently remains valuable not because its Red Cross history has already been completely reconstructed, but because the district provides an unusually productive intersection of political transformation, public-health vulnerability, voluntary humanitarianism and community learning.

The wider implication is significant for the history of lifelong education.

If education is understood as extending beyond schools and colleges, then humanitarian organizations become important educational sites. Volunteers learned through service. Nurses developed professional and practical competencies. Health workers transmitted knowledge to families and communities. Women entered public humanitarian activity through nursing and welfare. Young people encountered hygiene education through the Junior Red Cross. Communities encountered, negotiated and potentially adapted new forms of health knowledge.

Humanitarianism was the Institutional Purpose

learning was one of the processes through which humanitarian capacity was created, reproduced and transmitted.

The history of lifelong and non-formal education should therefore be expanded beyond explicitly educational organizations. Humanitarian associations, health campaigns, welfare centres, nursing networks and voluntary organizations deserve attention as historical infrastructures of learning.

Murshidabad provides a particularly promising case for such an investigation. A definitive district history will require further archival research, comparative analysis and carefully designed oral-history work focused particularly on post-independence institutional memory. Such research could ultimately transform a cautious historical proposition into a fully documented account of how humanitarian action became a vehicle for learning in colonial and postcolonial Bengal.

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