Palgrave Series in Indian Ocean World Studies

General Editor
Gwyn Campbell, Indian Ocean World Centre, McGill University

Advisory Board
Philippe Beaujard, EHESS, CNRS, CEMAF, France
William Gervase Clarence-Smith, The School of Oriental and African Studies, University of London
Masashi Haneda, IASA, University of Tokyo
Michael Pearson, University of New South Wales
Anthony Reid, Australian National University
Abdul Sheriff, Zanzibar Indian Ocean Research Institute
James Francis Warren, Murdoch University

The Palgrave Series in Indian Ocean World Studies is the first series dedicated to the study of the Indian Ocean World from early times to the present day. It incorporates, and contributes to, key debates in a wide array of disciplines, including history, environmental studies, anthropology, archaeology, sociology, political science, geography, economics, law, and labor and gender studies. Moving beyond the restrictions imposed by Eurocentric time frames and national and regional studies analyses, this fundamentally interdisciplinary series is committed to exploring new paradigms with which to interpret past events, particularly those that are influenced by human-environment interaction. In this way, it provides readers with compelling new insights into areas from labor relations and migration to diplomacy and trade.

Starvation and the State: Famine, Slavery, and Power in Sudan, 1883–1956
Steven Serels

Sailors, Slaves, and Immigrants: Bondage in the Indian Ocean World, 1750–1914
Alessandro Stanziani

The Making of an Indian Ocean World-Economy, 1250–1650: Princes, Paddy Fields, and Bazaars
Ravi Palat

The Portuguese in the Creole Indian Ocean: Essays in Historical Cosmopolitanism
Fernando Rosa

Trade, Circulation, and Flow in the Indian Ocean World
Edited By Michael Pearson
Histories of Medicine and Healing in the Indian Ocean World: The Medieval and Early Modern Period, Volume One
   Edited By Anna Winterbottom and Facil Tesfaye
Histories of Medicine and Healing in the Indian Ocean World: The Modern Period, Volume Two
   Edited By Anna Winterbottom and Facil Tesfaye
These volumes are dedicated to medical workers around the world who risk their lives to help others in situations of conflict.
Contents

List of Illustrations ix
Acknowledgments xi

1 Making Medical Ideologies: Indentured Labor in Mauritius
   Yoshina Hurgobin 1

2 Treating Black Deaths in Egypt: Clot-Bey,
   African Slaves, and the Plague Epidemic of 1834–1835
   George Michael La Rue 27

3 Rockefeller Public Health in Colonial India
   Shirish N. Kavadi 61

4 Colonial Madness: Community and Lunacy in
   Nineteenth-Century India
   Anouska Bhattacharyya 89

5 Russian Medical Diplomacy in Ethiopia, 1896–1913
   Rashed Chowdhury 115

6 Tropical Disease and the Making of France in Réunion
   Karine Aasgaard Jansen 147

7 Medicine on the Edge: Luso-Asian Encounters in the
   Island of Chiloane, Sofala
   Cristiano Bastos and Ana Cristina Roque 171

8 Zigu Medicine, between Mountains and Ocean:
   People, Performances, and Objects in Healing Motion
   Jonathan R. Walz 197

9 Indian Ocean Worlds: Tracing South African
   “Indigenous Medicine”
   Julie Laplante 219
Illustrations

Figures

7.1 Indian Ocean map showing Chiloane, Goa, and Macau 172
7.2 Medical School of Goa 175
7.3 The Harbor and Islands of Chiloane (IICT—CDI-0483–1952) 178
7.4 Excerpt from the registry book of the plant samples collected by Ezequiel da Silva (1883), IICT, AHU, Códice_SEMU_2186 184
7.5 Gynandropsis gynandra 186
9.1 Rastafarian sakmanne photographed during our visit of the medicinal plant garden, part of the Indigenous Knowledge Lead (Health) Program of South Africa’s Medical Research Council at the Delft laboratory facility in November 2007 234

Tables

2.1 Plague mortality in Alexandria, Egypt, in the epidemic of 1834–1835 34
2.2 Mortality rates in Alexandria, Egypt, in the plague epidemic of 1834–1835 35
2.3 Plague deaths in Cairo in 1835, by ethnicity/nationality 39
7.1 Registry table for the collected samples 185
Acknowledgments

We would like to thank the Indian Ocean World Centre, directed by Professor Gwyn Campbell, for hosting the conference “Histories of Medicine in the Indian Ocean World” from which the process of writing this book began. We are also very grateful to Professor Nicholas Dew and the SSHRC Situating Science project, and to Professor David Wright and the Institute for Health and Social Policy for financial and logistical support. We are grateful to Professor Howard Philips for joining us as the keynote speaker. We would like to thank Erin Bell, Lori Callaghan, Omri Bassewitch Frenkel, Peter Hyde, Lorna Mungur, Caroline Seagle, and Dr. Hideaki Suzuki for their help in organizing the conference and Professors Rachel Berger, Laurence Monnais, Andrew Ivaska, and Jon Soske for chairing sessions and commenting on papers. Many thanks are also due to Christopher Lyons for providing a tour of the Osler library. We are grateful to Melissa Kawaguchi for preparing the index.
Making Medical Ideologies: Indentured Labor in Mauritius*

Yoshina Hurgobin

Introduction

This chapter investigates how and why sugar estate owners in one Indian Ocean context—Mauritius—contributed to the making of a medical ideology that regimented the “body” of labor. While existing historiography of the relationship between colonial India and the British Empire in the tropics emphasizes the role of India as a center of sub-imperialism, this chapter argues that plantation colonies with their regulative security state apparatus, in collaboration with the Indian colonial state, acted as the source of particular medical ideologies and practices concerning indentured workers. By drawing on the experiences of health administration of indentured immigrant workers in Mauritius, a sugar colony in the Indian Ocean, this chapter highlights how medical ideologies concerning workers’ health and the control of pandemics among workers were contingent on various factors (such as cost-cutting measures, perceptions, and physicality of climates) and were formed diversely either in Mauritius or in medical circles in Calcutta.

Labor Historiography of India

Labor history is often viewed through the lens of class formation. Subaltern Studies scholars sought to replace the issue of class formation with the notion of a given static idea of community in order to explain the continuity of a peasant consciousness among working classes. In
this context, it has been argued that community acted as a conceptual category, which could not be subsumed within the capital’s hegemony. According to Subaltern Studies historian Dipesh Chakrabarty, in predominantly precapitalist societies, workers’ mentalities could not be distilled out of the ties they were born into, namely, caste, region, religion, and language. Such ties thus entrapped workers in a hierarchical culture, which, in the case of Bengal, allowed *bhadralok* (literally meaning “gentlemen”) trade union leaders to pave the political way for workers. Thus the nebulous process of the emergence of class consciousness was stymied by the very existence of precapitalist peasant community consciousness. In contrast to this “subaltern” perspective, Rajnarayan Chandavarkar’s history of labor politics in Bombay argues that working classes did not constitute a homogeneous entity and that class was not a given category but a social formation that was constantly in the process of making and unmaking itself through interaction and conflict between different political forces. Such political conflicts informed social relations among diverse socioeconomic groups and, in turn, shaped the responses and perceptions of dominant institutions toward historically subordinated socioeconomic groups. Chandavarkar further refused the primacy of cultural norms and structure as unchanging notions. While these historical debates between votaries of class and community provide insights into labor history, they tend to marginalize, and, on several occasions, erase the pivotal role of capital and the colonial state in disciplining and shaping labor processes in relation to the worker’s body and health.

**Disease in South Asia**

Historians of colonial medicine, such as David Arnold, have indicated the wider possibilities of colonizing the body in colonial enclaves in South Asia and demonstrated how tropics came to be equated with high rates of diseases. Mark Harrison has further argued that preventive medicine was not as central to empire building as was earlier believed and that the practice of medicine and everyday local realities surrounding such practices often clashed with imperial motives. He counters Philip Curtin’s and Daniel Headrick’s arguments that medicine was a straightforward “tool” of empire. While Curtin’s work underlined how improvements in medical and sanitation systems reduced mortality rates of Europeans in colonies, Headrick’s work showed how medical technologies supported European medical projects. More recently, Ryan Johnson and Amna Khalid have focused
their attention on how intermediary and often-subordinated entities implemented public health measures on the ground. These historiographies of colonial public health and epidemics have tended to focus on medical practitioners, the higher rungs of colonial sanitary officials and municipal bhadralok, and other subordinate sanitary staff. Such historiographies also tended to frame medical questions only in relation to medical circles or to the interaction between medical circles and the colonial state.

### Social Histories of Medicine

Meanwhile, social historians of medicine had been paying attention to workers’ health in relation to industrial and occupational hazards. However, such studies focused on work-related diseases in Britain and the United States and reproduced professionals’ view of workers’ health. Even though debates around workers’ bodies emerged, Christopher Sellers argued that the “‘body’ focus of worker history artificially sever[ed] ‘the body’ from its physical surroundings, in as complete a manner as modern medicine—and its historians—have done.”

While not entirely focusing on the role of physical and geographical place in connection with workers’ health, Indian indentured labor historiography did highlight how poor living conditions in coolie depots, on board ships, and on sugarcane plantations contributed to the even poorer health of indentured workers.

### Indian Ocean Studies

While the above historiographies approached the worker’s body in a segmented manner, Indian Ocean studies have tended to center on trade and commerce. However, more recently, as Kären Wigen’s *Oceans of History* has highlighted, a sudden interest in seas has permeated historical fields as diverse as labor history, the history of ideas, environmental history, and business history. Wigen’s piece underlines how the Mediterranean was “the original maritime region in the Euro-American imagination” and remained a sea basin characterized by “round-trip exchange.” The Braudelian influence is undeniable here, with a focus on human-environment interaction. Fernand Braudel, a French historian of the post-1945 era suggested that empires, nation-states, and other bounded entities were insufficient in themselves in providing and producing historical processes. Rather, human-environment interaction could indicate larger connections.
New waves appeared in Indian Ocean historiography as the Indian Ocean was touted as “the coming strategic arena of the twenty-first century.” Thomas R. Metcalf’s and Sugata Bose’s recent works have sought to insert this understanding into Indian Ocean history by examining governmentality and cultural interaction of political ideologies within this sea basin. By borrowing Tony Ballantyne’s conceptual frame of “a complex web . . . of horizontal filaments that . . . connect various colonies in addition to ‘vertical’ connections between the metropole and individual colonies,” Metcalf demonstrated how British India could be considered a “sub-empire” in its own right. Flows of ideas, institutions, policies, and practices poured out of India to areas as diverse as Zanzibar, Singapore, Durban, Basra, and Penang. Sugata Bose has attempted to cover similar flows circulating through the Indian Ocean while characterizing the sea basin as an “interregional arena” rather than a “system” and emphasizing the political and cultural relationships that existed within the region. Similar to Metcalf, Bose examines the diffusion of colonial practices from the Indian subcontinent to the other British colonies of the Indian Ocean. Moreover, Bose elaborates on how the Indian Ocean allowed for an “extraterritorial identity and universalist aspiration.” As explained above, both phases of Asian-centric scholarship on the Indian Ocean emphasized trade, commerce, and governmentality. Less attention has been paid to labor connections and institutional frameworks controlling labor across the Indian Ocean. While Thomas Metcalf and Sugata Bose have approached Indian Ocean history from the nodal point of India, Gwyn Campbell has demonstrated how Madagascar was “an integral part of southern and eastern Africa” and how it was a crucial link in the Indian Ocean World economy namely because of its role as an importer and exporter of slaves to other Indian Ocean and Mascarene countries (La Réunion and Mauritius).

Building on the above existing historiographies, this chapter engages in an analysis of how the colonial state and its ally, colonial capital, intervened in relation to the worker’s body. Often pandemics and moments of crises triggered the legislation of oppressive laws toward workers. The colonial state viewed the worker’s body as a crucial link to the regime of production processes since workers’ health directly determined his or her productivity. While colonial capital sought to control the “fitness” of the worker’s body, it also developed a medical framework on sugar plantations and estates to control the type and frequency of medical care workers received.
While recent work provides an overview of hospitals and their institutionalization in “non-Western contexts,” there is a marked lacuna regarding hospitals and dispensaries addressing workers’ health in different locales of the Indian Ocean. Moreover, while the body was central to Arnold’s thesis, he divorced it from the rule of capital. In this regard, this chapter traces the medical ideology, which regimented workers’ bodies from coolie depots in Calcutta, Bombay, and Madras, on board ships crossing the Indian Ocean, to land in the sugar estates of Mauritius.

By using the Indian Ocean as a framework of analysis, this chapter brings the nexus between two historiographies: labor migration and social history of medicine and diseases to bear on a hitherto unexplored topic: workers’ bodies and health. While the worker’s health was crucial to the functioning of the production process, it needs to be placed within the larger framework of particular environments and climates that produced diseases. The interactions of host, pathogens, and environment create diseases. For a disease to take on epidemic proportions, weather patterns were important. David Arnold has demonstrated how by the nineteenth century the Indian Ocean had become a site of epidemiological transfer. Arnold argues that the ocean was part of “a common Eurasian disease pool,” which facilitated the outbreak of diseases. Steamships contributed to an increased and quicker mobility through the Indian Ocean and this could have possibly led to a higher transference of diseases.

Finally, through a study of indentured labor migration, this chapter seeks to establish how the colonial state in its various roles as the surrogate mother of the laboring population pinned the population within an institutional framework. Thus medical ideologies overlapped with the physical and geographical form of the island, and used hospitals as an instrument for controlling pandemics involving working classes and to further prevent their mobility within the island. The selection of Mauritius is not accidental. Mauritius was considered the test case for implementing indentured labor in the rest of the British Empire. Not only did it receive the largest number of Indian indentured immigrants, but also it became a major producer of commodities such as sugar.

Beginnings of Indenture in Mauritius

The confluence of overlapping and interrelated factors led to the presence of indentured labor in Mauritius. Sugar production, preferential tariffs from the British government, and the abolition of slavery
all created ripe conditions for the arrival of indentured labor on the island. During French colonization (1715–1810), Governor Mahé de Labourdonnais actively used slave labor for the cultivation of sugarcane. When the British fought and defeated the French in 1810, they sought to fructify this new addition to their empire. Sugar production saw an exponential increase. Sugarcane acreage increased from 58,500 in 1841 to 123,000 acres in 1861. Global political and economic phenomena—including the Haitian revolution of 1804 and a dip in West Indies sugar production—also played a role in the sugar boom of Mauritius. Furthermore, the British government had removed preferential tariffs on West Indian sugar entering the British market in 1825. This propelled sugar cultivation on the island; as a result, revenue from sugar exports made up an increasing percentage of the island’s economy: 29 percent in 1823 and 85 percent in 1829. As the British enforced the 1807 parliamentary ban on slavery in Mauritius, Mauritian planters resorted to illegal means to bring more slave labor into the island between 1811 and 1827. However, in doing so, planters had not accounted for the increasing death rates among the slave population and their declining health, which affected available labor for the cane fields. To be fair, even before the formal abolition of slavery in Mauritius in 1835, planters had anticipated the abolition of slavery and had been seeking fresh supplies of labor. As the illegal slave trade in the Mascarenes (Réunion and Mauritius) encountered its “demise” in 1827, planters turned their attention to India for “‘free’ agricultural labourers.”

Thus the booming sugar production and illegal slave trade in the Mascarenes as well as the abolition of slavery laid the foundation for the arrival of indentured labor in Mauritius. Often ignored among the above reasons is the decreasing health of slaves. The latter did not reproduce quickly enough to generate a new pool of labor, and several diseases had struck the Mascarenes in the early to late nineteenth century. Between 1834 and 1839, in collaboration with the British metropolitan and the Indian colonial governments, Mauritian planters organized themselves to introduce 24,300 Indians under a largely unregulated indentured system. Planters’ investments in the growing sugar industry drove the demand for labor, and by extension dictated the conditions of the first indentured workers. Such conditions in the early phase of indentured labor paid scant attention to immigrants’ health. Furthermore, Mauritian planters were the ones shouldering the cost of the passage to Mauritius and the return passage to India; thus, at this point in time, they were not concerned by workers’ health. The
cost factor was so prohibitive that it remained absent in discussions of workers’ health.

**Temporary End of the Indentured Labor System in 1838**

A number of factors would coalesce to lead to the temporary end of the indentured labor system. Poor conditions and high mortality rates on board ships, as well as poor conditions on sugar estates, increased. T. Parry Woodcock, from the Bengal Civil Service who traveled to Mauritius between March and May 1836, noted how “the lower decks [of the ship] were stowed with rice” and that coolies were “unprotected from change of weather and climate” and would have suffered much if not for the clement weather. Once in Mauritius, the misunderstandings between workers and employers arose because a mismatch existed between the Indian indentured worker’s expectations and those of the Mauritian planter. The latter, for instance, looked unfavorably upon “men unfit for work, from age and infirmity,” while the former felt they had been deceived with a larger workload and a smaller wage than had been promised. Woodcock further added that a number of misconceptions would arise because of the vague contract conditions. He underlined how it seemed emigrants had been fraudulently recruited, and were unaware of their contract terms. Meanwhile, on December 27, 1836, Sir William Nicolay, the then governor of the island, had encouraged estate owners to select workers more carefully, and that—inter alia—the chosen ones be “real agriculturalists” in India.

However, despite Nicolay’s injunction and his attempt to prohibit the entrance of new immigrants, immigration did continue, thus indicating planters’ outright disregard for the governor’s order. Outrage of British abolitionists and humanitarians recalled the bitter debates around the abolition of slavery. Not wanting to equate indentured labor to slavery, the British Parliament moved to stop migration on July 20, 1838. A commission of enquiry was quickly established in Calcutta on August 1, 1838 to investigate emigration and its numerous consequences in Demerara and Mauritius. It mainly concluded that “coolies and other natives exported to Mauritius and elsewhere were…induced to come to Calcutta by misrepresentation and deceit.” As coolies’ conditions (traveling, living, and working) spurred British abolitionists’ discontent, the same could be said of Indian industrialists.
The Calcutta Commission of Enquiry—1838

Interestingly enough, Russomoy Dutt, member of the committee appointed to investigate the circumstances behind the exportation of Indian Coolies to British colonies, was part of a Calcutta elite that had, for years, tried to protect the “landed property in Bengal” through the Landholders’ Society and to “improve the position of the zamindars” (large landholders). Dutt was highly self-interested in his decision to ban indentured immigration. His strident criticism of hill coolies’ recruitment for Mauritius was well known among members of the commission since, according to him, fraudulent practices were rife and because “hill coolies,” according to him, were “incapable of understanding the nature of the contracts they were said to have entered into.” Dutt portrayed labor emigration still more negatively by arguing that emigration created dire conditions for immigrant workers’ families in the “districts of Bancoorah and Maunbhoom” where most “vagrant” and “paupers” came from. To better understand Dutt’s vilification of immigration, it is important to examine Dwarkanath Tagore’s testimony in front of the commission. Also a member of the Landholders’ Society, Tagore’s rationale for banning immigration was that coolies “would be easily induced...to leave their homes” and that “if they [the indentured workers] perfectly understood that they would be required to go [on] a voyage of a month or six weeks, it would be difficult to get their consent.” However, the more economic reason—and probably more accurate reason—given by Tagore was that labor emigration to Mauritius would drain catchment areas of labor for Indian industrialists’ purposes. Since the late 1820s, Tagore had emphasized the importance of “indigo cultivation and a greater European presence” in that part of India.

Climates and Perceptions of Climates

The medical ideology shaping indentured workers’ lives was a nebulous process. While Mauritian planters’ lack of concern about indentured workers’ health resided in their cost-cutting beliefs, Indian industrialists, on the other side of the Indian Ocean, were concerned about “their” supplies of labor. On one hand, the Mauritian planter with the collaboration of the local island British administration drove the demand for indentured labor, established emigration agencies to recruit it, and was responsible for its transportation to Mauritius. On the other hand, the Indian industrialist scrambled to stop emigration
since it would drain catchment areas of labor for his own purposes (for indigo production). Acting as allies to the colonial state, both entities played a role in the formulation of the medical ideologies deployed to control indentured workers.

Besides concerns over the supply of labor, the Calcutta Committee of Enquiry had preconceived ideas about possible positive effects of the island’s climate on indentured workers’ health. While debating about testimonies that attested to the island’s beneficial weather on indentured workers’ “general healthy appearance and their apparent contentment, and…improved condition,” the commission was intent on negating any such claimed benefits. For instance, the commission stated that “any benefit derived from the superiority of climate at Mauritius or elsewhere may,…very reasonably be put out of question, as a mere European notion.” While Tagore had affirmed the need for greater European presence, this statement suggests the contrary sentiment. Thus the components of the medical ideologies went beyond medical practices and encompassed attempts to interpret the effects of climates. The commission, however, was inaccurate since the climate in Mauritius was far from superior. From the early nineteenth century, inhabitants of Mauritius had to contend with fevers (including a major epidemic in 1867, which was thought to have been malaria), and cholera from 1819 to 1821. Such colonial assumptions about climate were thwarted by the high death rates of coolies on board ships and in Mauritius between 1834 and 1837. Thus the making of a medical ideology concerning workers’ health not only depended on medical conditions of workers but also was mediated through how apparently unhealthy certain regions of the Indian Ocean were perceived by Indian industrialists and, to a larger extent, by Mauritian planters.

### Climates, Medical Circles, and Coolie Depots—At Ports of Embarkation

While Mauritian planters emphasized their need for healthy workers and those free from disease, certain discussions within the medical circles of Calcutta between the 1820s and 1830s facilitated the actions of coolie depot doctors. The dialectics of contestation over labor supply between Indian industrialists and Mauritian planters was but one element that informed the medical ideology regimenting coolies’ lives. Preexisting medical concern with the growing presence of disease in deltaic and marshy Bengal formed another layer, which rendered the requests for labor of Mauritian planters even more potent.
The climates’ importance amid medical circles had increased over time, and a possible link can be drawn between the increasing discussions about climates and constitutions on one hand, and medical treatment meted out to coolies traveling to Mauritius on the other. Since the 1820s, medical circles in Calcutta had been busy propounding the importance of climates in influencing the constitutions of the colonizers and the colonized. Mark Harrison has argued that debates over acclimatization of Europeans to Indian climates took a pessimistic turn in the nineteenth century.\footnote{56} Before 1770, medical texts reflected the belief that the Indian environment rendered people particularly prone to disease and that knowledge about tropical disease was needed to advance European medical knowledge.\footnote{57} According to Harrison, such discussions gave rise to further deliberations on “the need for a fundamental reappraisal of European medical knowledge.”\footnote{58} Thus, the tropical environment came to be viewed exclusively as a trove of diseases.

While perceptions about climate were approached discursively, when the spread of cholera from Bengal in 1817–1818 happened, beliefs about the subcontinent’s disease-provoking environment were solidified. Further, Harrison has argued how the “hostile climate” was considered to have ravaged soldiers with scurvy and dysentery during the First Burma War (1824–1826) and that, as a result, the rise of medical topography led to a vigorous search for healthy and unhealthy locales within India.\footnote{59} Topographers emphasized clear connections between the influence of climate and national or ethnic character. This pessimistic turn as to the adaptability of bodies to tropical climates determined colonial health policies.\footnote{60} On the other hand, certain diseases came to be seen as “man-made and, therefore as preventable.”\footnote{61} As urban issues became more prominent in 1820s India, more sanitary measures to remove filth were implemented.\footnote{62} Such a sanitary mentality also diffused itself to coolie depots in Calcutta; thus sanitary measures, such as showers for coolies before their voyage, were made compulsory. A prominent measure that characterized this emphasis on sanitation and the removal of filth was the funding of the Calcutta Fever Hospital in 1835.

\section*{Calcutta Fever Hospital in 1835 and Coolie Depots}

Dr. James Ranald Martin was a major proponent of the Calcutta Fever Hospital, appealing to Governor General Lord Bentinck for funds to build the hospital. The “purpose of producing and maintaining greater salubrity” was of utmost consideration for those who gathered on
June 18, 1835 to discuss the funding of the fever hospital. Martin’s words suggest that if the fever hospital was not constructed, the British in Bengal would suffer from further deterioration in their health. Discussions about the creation of the Fever Hospital started with Martin’s letter of April 9, 1835 explaining how “the central part of the Native Town of Calcutta” was affected by “the constant universal and frightful prevalence of fever among the Native inhabitants.” He further condemned those “Native Doctors” who, he claimed, worsened the conditions of the “poorer classes of Natives.” Already by 1834, Martin had drawn the topography of Calcutta, whereby he highlighted the importance of “removing defects of locality to remedy those of climate.”

Geographical and physical backgrounds and/or place thus played a central role in influencing how certain policies were implemented either in Mauritius or in Calcutta. Medical circles in Calcutta were impregnated with the fear of importing epidemics into the city and their ramifications for the city. It was no different in Mauritius where doctors and immigration officers sought to cordon off the island, and send sick immigrants to small islets around Mauritius. It seems that a similar atmosphere of distrust about the Indian Ocean’s epidemic climate reigned over two nodes of the ocean during the nineteenth century. Martin’s focus on the hospital could also be tied to the sanitary conditions, which became common parlance amongst coolie depots in Calcutta. Recruited indentured workers were kept for at least five days at the Emigration Depot in Calcutta before their embarkation for Mauritius. They had to be examined by the surgeon and recommendations were made for them not to mingle with the local bazaar (market) populace. The influx of coolie labor to Mauritius followed the peaks and troughs of the sugar fortunes of the island and in years in which more labor was recruited, medical considerations were discarded at the emigration depots. For instance, in July and August 1865, medical examinations were eschewed so that the embarkation could start as quickly as possible. While the above addressed Calcutta as a port of embarkation, indentured workers’ conditions of fitness changed in other ports of embarkation (Bombay and Madras).

On Board Ships—1838

The Calcutta Commission of Enquiry’s investigations revealed much about conditions on board ships and how medical ideologies did not follow rigid patterns of beliefs and were bound by various conditions.
These discussions often highlighted the living conditions on board ships and on the sugar estates. Between 1838 and 1839, on board coolie ships, a host of actors—including ships’ captains, master pilots, shippers, “native doctors,” “European” doctors, and sirdars—regimented coolies’ health in a rather haphazard manner. Far from being a well-oiled apparatus, medical practices were applied in an ad hoc manner and there was no general consensus about how the journey affected coolies’ health. For example, Captain James Rapson felt most coolies died of “old age and sickness,” while Captain A. G. Mackenzie underlined coolies’ “generally good” health. Most ships at that time had a “native doctor” rather than a “European surgeon” to treat coolies. However, the captains felt entitled to “[act] as . . . doctors.” Captain Rayne further reaffirmed this stance by suggesting that he knew “something of medical treatment” and that he “took . . . upon [himself] the direction of the native doctors.” Ship captains tended to view the “native doctor” as incompetent or even “wholly ignorant,” citing examples such as the “enormous doses of calomel” that some would administrate to the coolies and, in one case, the inability to bleed a coolie properly. Moreover, native doctors could not do much in saving newborn babies or their mothers. The overcrowding on board the ships noted by various parties was thought to contribute to the problem of coolies’ health and the available medicines were often ineffective. Coolies in pain could, at times, not tolerate it and jumped overboard but were then considered “deranged.” Abdoolah Khan, a “native doctor” traveling to Mauritius for a second time in early 1838, underlined how Captain Charles Edward forced him to administer specific doses to coolies. Khan blamed Edward for the death of five coolies at sea, even though the former had already noted their frail conditions while the ship was still at Kedgeree on the bank of the Hooghly River. Such power struggles between the captain and the “native doctor” often impinged on coolies’ health. Besides such tugs of power, lack of drinking water and space on the ship made the passage through the Indian Ocean excruciating. James Smart, master pilot on Edward’s ship, noted that the space between “the fore to the main hatchway” was not enough for coolies. Most other captains felt seasickness did not affect coolies as they spent most of their time in the “’tween decks” area. In other cases, the “’tween decks were divided between the crew and space allotted for coolies’ hospital on board the ship.

The Calcutta Commission also interrogated three returnee immigrants—those who had traveled to Mauritius and returned to India.
either after their five-year contract or before the end of their contract. The testimonies of these three immigrants highlight how conditions during the early phase of indenture (1825–1838) were detrimental to immigrant workers. Bibee Zuhoorun worked for a Mr. Boileau who sought to make her his mistress, which she “refused, and three times made complaints to the police.” Zuhoorun’s testimony elaborates on the dire conditions in the early years of migration. Whenever coolies would complain of sickness, the estate doctor would accuse them of laziness. Zuhoorun recounts how, unable to cope with the “hardships of the life they led,” some male indentured workers either “hung themselves” or, at times, died in the sugar estate hospital. Estate doctors tended to be related to sugar estate owners or, at times, tended to be estate owners. As the questioning of Bibee Zuhoorun was done in Calcutta, Special-Justice Anderson visited 12 of the 31 establishments that had been visited by a special commission. He concluded that coolies’ lodgings “[were] either too confined or disgustingly filthy” and that “none of the establishments had sufficient hospital accommodation, and the expense of the public hospital was always urged as an excuse for not sending [coolies] there.”

Besides Zuhoorun, another returnee migrant would come forward complaining about Mauritius. Karoo, from Khurkotta in India related how after he received two months’ pay he fell sick. While he did not specify his condition, Karoo explained how he ended up for four months in the hospital and that when he recovered “the police sent [him] to the house of correction for two months” to “break stones.” To add to Karoo’s misfortune, at the “house of correction,” he was struck by smallpox. Karoo was not sent back to the hospital and when he was finally cured, the magistrate asked him whether he wanted to “return home.” Because of his sickness and his inability to work on sugar plantations, Karoo’s “master” refused to pay him his wages of eight rupees. When asked whether he would advise his fellow countrymen to travel to Mauritius, Karoo was categorical: “I would not advise my countrymen to go to the Mauritius.”

Another example of a returnee immigrant who left Mauritius with a bitter taste was Suboo, resident of Hazareebaug. A Mr. Stewart hired him but while he was “a good man,” his “blacks,” possibly former slaves, would beat him. He relates how “from the effect of the beating [he] fell sick, and was in the hospital for four months.” The hospital did not do much for the recovery of Suboo. He continues by saying how “from the hospital he was sent to the chief police” who informed him that he “was disabled by the fall of a tree on [his] wrist” and he
“had better return to [his] country.” As a result, Suboo received two months’ pay of eight rupees, which were taken away from him by “the blacks.” Suboo was as categorical as Karoo: “I would not go to Mauritius again, nor would I advise any of my friends to go there, I wish to go and live in my own country.”

Thus the early arrivals of Indian indentured workers to Mauritius saw several cases of indentured workers’ sickness and of long stays in the sugar estate hospital. In his account to the commission, Ramdeen, a coolie *sirdar* (jobber), recounts how of the “80 men who went with [him],” five were attacked with fever, then headache, and were eventually sent to the estate hospital of Mr. Bordaille. They died within ten or fifteen days of their admission despite the presence of a “European doctor.” Thus the institutional setup of hospitals on sugar estates did not necessarily mean the resolution of medical conditions for coolies. They were, in most cases, built because the colonial administration required it. Ramdeen also reports that dead bodies were dissected and probably used to experiment with. In contrast to Bibee Zuhoorun, Karoo, and Suboo, Ramdeen wished to return to the island, but added that had he not “been promoted to the rank of sirdar” he would not have been “anxious to return to Mauritius.” This means that the status of sirdar allowed him a certain protection, one that was not available to other ordinary indentured workers.

More than the physical presence of hospitals, prolonged stays in the hospital entailed a lower wage. Before being sent to Mauritius in March 1835, coolies had signed a contract that specifically stated that “while in hospital from sickness or any other cause, the pay is stopped during such time.” As discussed earlier, such arbitrary rules contributed to allegations of abuse against Indian indentured workers. This led to the prohibition of indentured immigration from 1838 to 1842.

**Indentured Labor Resumes**

Mauritian planters’ “urgent and imperative demand” for “agricultural labor” made the English metropolitan colonial state reconsider its position on Indian indentured labor. Charles Anderson, judge of the court of peace and of police in Mauritius, thus drafted a report suggesting revisions in the contract length. Should indentured recruits reach the island in poor health, medical treatment would be free. Lest indentured labor be compared to slavery, the metropolitan colonial government would also pay more attention to indentured workers’ health and medical attendance during the voyage.
When indentured workers were reintroduced in 1842, utmost attention was paid to their health and fitness to work. However, the predominant concern for workers’ health now was not so much the actual worker’s health but how crucially the body fitted within the production process. The following only reaffirms the importance of a sturdy body. The “emigrant” had to be “in good health and not incapacitated by old age, bodily infirmity or disease.” Sugar estate owners and estate doctors now complained about the “unfitness” of the migrant sent, or of ploys by the recruiting agent and the medical officer in Calcutta to alter the route of migrants. While Indian industrialists sought to retain labor in India, at times, doctors in charge of examining coolies at coolie depots in Calcutta reacted randomly, sometimes sending workers to a different destination than the one agreed upon. For example, Dr. Nilmany Biswas, a depot doctor at the Calcutta coolie depot, and Taylaknauth Mitter sent migrants to Demerara instead of Mauritius, claiming that there were no available migrants for Mauritius. These ploys to alter the route of indentured workers could be explained by how networks within the empire were highly enmeshed. Oftentimes, emigration agents working for different sugar estate owners (based in Trinidad, Demerara, or Mauritius) would compete with each other to send indentured immigrants first. In the present case, it is possible that Drs. Biswas and Mitter may have received bribes to send immigrants to Demerara instead of Mauritius. Complaints from Mauritius about such fraudulent actions informed the stricter medical controls that were imposed at the depot in Calcutta.

However, the institution of new rules concerning workers’ health did not necessarily equate with improved conditions for indentured workers. Rather, when a gratuity was paid for the return passage of indentured workers, the Protector of Immigrants’ note seemed to suggest that the return of the immigrant to his native land was for his good. Such was the case of Kinaram, No. 75,332. The latter had reached Mauritius on April 14, 1849 but by February 22, 1856, he was considered “unfit for labour” and a Dr. Rogers had further provided a certificate verifying his medical condition and had recommended a gratuity of 10 shillings. The more telling case was that of Fareed, No. 88,741. After six years on the island, Fareed was sent to hospital twice for paralysis. After having been in the estate hospital from August 24 to November 12, 1855, he was considered “incurable.” Dr. Rogers, the treating physician, added that Fareed came to the hospital again between November 19 and 30 but “with no better result.”
He concluded by saying that if Fareed’s case was not paralysis, then he was probably “an accomplished impostor.” Dr. Rogers’s comment exemplifies the power that he exercised in the notes he issued about indentured workers’ fitness for labor. The resumption of indentured labor did not necessarily mean better conditions on board ships. On some occasions, doctors were even complicit in the mistreatment of coolies. For instance, a Dr. Basu “assaulted seven immigrants so severely that [as a result] one woman miscarried.”

Malaria Epidemic in 1866–1867

As indentured workers’ health faced threats aboard ships, the weather and climate conspired to make things still worse between 1866 and 1867. In the second half of the nineteenth century, doctors and scientific practitioners believed that the idea of miasma—“poisonous vapours from putrefying organic mater and stagnant water”—caused certain diseases. However, the miasmic theory also interacted with the combined relationship between geography and climate. In December 1866 when malaria broke out, the largest hospital on the island, the Civil Hospital, was “crowded [as] early as February 1867.” Malaria triggered the construction of 11 more hospitals. The major epidemic of 1867 was to mark the island for a long time to come. The massive number of deaths also affected how sugar estate owners would incorporate already existing medical practices. Indian immigrant workers were particularly prone to malarial fevers and started spending more time in sugar estate hospitals.

Since indentured labor had become crucial for the country’s economy by the late 1860s, more attention was paid to their treatment. In 1871, William Edward Frere and Victor Alexander Williamson, two London-based lawyers, were sent to Mauritius to investigate the living conditions and treatment of immigrants. They noted that not much had changed in terms of loss of wages because of hospitalization: “For each day in hospital [the migrant] forfeits the pay of that day, but for each day that he is absent from his work he forfeits two days’ pay.” As required by law, all estate owners had to provide hospital accommodation based on the number of workers on the estate and to pay a doctor “4s. per head per annum for his attendance.” However, as noted by Frere and Williamson, in 1871, out of the 217 sugar estates on the island, none of the owners were fined for violating this law.

Furthermore, admission to estate hospitals did not necessarily mean quick recovery. As Dr. O. Beaugeard noted, the “high mortality
rate amongst Indians can be attributed to several factors before their entrance within the hospitals: their physical conditions are considerably weakened by repeated bouts of malarial fever, malnutrition and lack of good nutrients.”

Thus according to Beaugeard, the average per thousand of fatal cases “among Europeans was 18.4, among Creoles 66.6 and among Indians 158.6.” At other times, when coolies were given medication, they were “not allowed to remain in hospitals and [were] sent to work with the bullocks,” as was the case on Mr. Poulin’s estate. However, hospitals were not meant mostly for sickness and recovery. While Frere and Williamson underlined several issues with Mauritian planters’ estates and their provision of health accommodations for indentured workers, they, nevertheless, suggested how Indian indentured workers “subsist[ed] at the expense of Government in hospital.” After the 1866–1867 epidemic, Mauritian planters and the island’s British colonial administration were wary of importing diseases to the island. Migrants were quarantined at the immigration depot in Mauritius before being sent to their respective masters’ sugar estates. Such stringent quarantines led to several deaths on board ships as indentured migrants waited to be discharged.

Conclusion

The historiography of Indian indentured labor in Mauritius has resolutely focused on working and living conditions of indentured workers, thus shedding light on the medical practices used in these workers’ daily lives. However, when combining the Indian Ocean as a framework of analysis with a reading of indentured labor and a social history of disease, new results appear. Sugar estate owners’ ideology of cost-cutting measures and profit motivated their lack of concern for adequate and efficient hospital services on sugar estates. However, a combination of geography and climate influenced their decisions (for example, an increase in the number of hospitals during the 1866 malaria epidemic). More specifically, the interdependence between climate and pathogenesis affected indentured workers’ metabolic rate (for example, their proneness to malarial fever) and, by extension, their health and productivity. Indian indentured labor’s productivity drove the island’s sugar industry.

While the allies of the colonial state (Mauritian sugar estate owners and Indian industrialists) had different aims, their ideologies hardly differed since they sought to preserve their economic self-