

**From Plantation Medicine to Public Health: The State  
and Medicine in British Guiana 1838 - 1914**

David Aickin

Thesis submitted for the degree of PhD  
University College London  
August 2001

ProQuest Number: U642065

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.



ProQuest U642065

Published by ProQuest LLC(2015). Copyright of the Dissertation is held by the Author.

All rights reserved.

This work is protected against unauthorized copying under Title 17, United States Code.  
Microform Edition © ProQuest LLC.

ProQuest LLC  
789 East Eisenhower Parkway  
P.O. Box 1346  
Ann Arbor, MI 48106-1346

## Abstract

This thesis is about health, medicine, and the state between 1838 and 1914 in the sugar producing colony of British Guiana. Its main theme is the transformation of colonial attitudes towards 'native' health. I argue that at emancipation the government demonstrated little interest in the health of plantation workers or in the health of those who lived in the towns and villages. At this time health provision was primarily a 'private matter' organised by the estate owner or individual.

Over the course of the century, this situation changed, beginning with a concern about the health of migrant labour. Later, both government and medical practitioners became deeply interested in the health of the 'people', and in questions of fertility, population, and the problem of infant mortality. I explore what this means by examining the rise of a 'supervisory bureaucracy' and by looking at the political and social conditions of the colony and plantation world. Crucially, I also show that the widening focus for medical provision was not simply the outcome of geographically local or politically internal concerns – but was shaped by wider considerations including ideas of race, civilisation, gender, and not least, by the influence of metropolitan (British) and other imperial political interests.

One of the most notable interventions by government was to take away from plantations medical responsibility for estate workers in 1873. Arguably, this marked a profound shift in colonial thinking about the role of the state in organising medical provision. This shift in attitude is further explored by analysing the way in which public health measures in Georgetown, the colony's capital, were developed to deal with infant mortality. There were two specific responses: better midwifery, and cleaner milk. In the chapter on midwifery, I look at how the authorities attempted to alter 'native' midwifery practices. This theme of enculturation is continued in the final chapter on milk. In both cases, I show that Western medicine did not just expand and spread in the colony but was part of a complex process of knowledge dissemination that involved contestation and negotiation.

## Contents

List of tables	5
List of figures	6
Abbreviations	7
Acknowledgements	8
<b>Introduction</b>	<b>9</b>
<b>1 Corridors of power: Labour, migration, and health provision 1838-1847</b>	
1.1 Introduction - race and labour, politics and bureaucracy	26
1.2 Emancipation immigration and race	28
1.3 Immigration and imperial governance: Britain and India	36
1.4 Medical provision, the plantations, Georgetown and hospital legislation	40
1.5 Culture, power and medical practice in the colonial hospital, Georgetown	48
1.6 The re-negotiation of immigration to British Guiana	58
1.7 Conclusion	69
<b>2 Medical provision, plantations and the state 1847-1873</b>	
2.1 Introduction	72
2.2 Doctors and the Hospital Ordinance of 1847	74
2.3 Immigration, government, and the Hospital Ordinance of 1859	80
2.4 Politics, doctors and the Immigration Ordinance of 1873	87
2.5 Consequences and developments	92
2.6 Conclusion	95
<b>3 Plantation hospitals – disease, mortality and race</b>	
3.1 Introduction	97
3.2 Plantation hospitals 1848-1870	98
3.3 Nursing Care	110
3.4 The State and Hospital Registers	112
3.5 Disease, mortality and statistics	117
3.6 Race, acclimatisation, and labour	125
3.7 Conclusion	137
<b>4 Politics and population 1880-1914</b>	
4.1 Introduction	140
4.2 Population, environment and commerce	143
4.3 Social context and critiques of immigration	147
4.4 Studies in Life and Death	152
4.5 Conclusion	161
<b>5 Disease, infant mortality and colonial perceptions of ‘native’ motherhood</b>	
5.1 Introduction	163
5.2 Disease theory and public health in the colony	163
5.3 Disease and infant mortality	166

5.4	Women, the medical profession and infant mortality	169
5.5	The problem of illegitimacy	173
5.6	The problem of breastfeeding and infant nutrition	176
5.7	Conclusion	182
<b>6</b>	<b>Training the servant class: colonial midwifery in British Guiana 1890-1914</b>	
6.1	Introduction	185
6.2	'Native' midwifery and the medical profession	187
6.3	Georgetown Public Hospital	190
6.4	Midwifery nursing and training	196
6.5	Midwives, doctors and duties	202
6.6	Georgetown, midwifery, and health visitors	205
6.7	Conclusion	212
<b>7</b>	<b>Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1910</b>	
7.1	Introduction	215
7.2	Georgetown and urban reform	219
7.3	Food adulteration, testing and the Government Laboratory	225
7.4	Production and consumption: milk, the countryside and Georgetown	227
7.5	The politics of disease management: Georgetown and plantations	232
7.6	Rhetoric, persuasion, and the bacteriological laboratory	236
7.7	Milk legislation and the politics of discontent	238
7.8	Albouystown revisited	247
7.9	Conclusion	250
	<b>Conclusion</b>	<b>255</b>
	Appendices	265
	Archives and bibliography	275

## List of tables

3.1	Hospital provision on the West Coast Region of Demerara 1848-1895	107
3.2	Number of patients in the Estates' Hospitals and categories of disease: 1863	119
3.3	Return of diseases of in-patients treated in hospitals, districts and counties from the 1 <sup>st</sup> April 1900 to 31 <sup>st</sup> March 1901	121
3.4	Morbidity and mortality rates of immigrants 1848	134
4.1	England and British Guiana compared: age of marriage, rate of illegitimacy, still birth and birth rates 1891	155
4.2	Mortality rates between England and British Guiana compared 1898	156
4.3	Average infant mortality rates by race 1880-1890	158
4.4	Average rate of mortality by age and race compared (1887-1896)	159
4.5	Infant mortality between town and country compared 1880-1890	160
6.1	Ratio of health visitors to total births	210
6.2	Percentage of births assisted by government midwives	210
7.1	Number of milk samples and percentage of adulteration 1890-1914	246

## List of figures

1.1	Admissions to Georgetown Hospital by country of origin: July 1847-June 1848	52
1.2	Occupation of patients admitted to Georgetown Hospital: July 1847-June 1848	52
1.3	Admissions by age to Georgetown Hospital: July 1847-June 1848	52
4.1	Birth rates per 1000 according to racial category 1897-1914	157
5.1	Principle causes of death of children under 1 year 1900-01	167
5.2	Infant mortality rate between the races 1899-1905	180
6.1	Hospital births compared to total births Georgetown 1892-1914	191
7.1	Malarial infection in estates' hospitals 1902-1914	235
7.2	Fish in Milk. Comment on the milk trade in the <i>Daily Argosy</i> 15 January 1910	242

## Abbreviations

AR	Administration Report
BGMA	British Guiana Medical Annual
BGMAHR	The British Guiana Medical Annual and Hospital Reports
GRCLEC	General Report of the Colonial Land and Emigration Commissioners
MCP	Minutes of the Court of Policy
REH	Report of Estates' Hospitals
RIAG	Report of the Immigration Agent General
RIS	Report of the Inspector of Schools
RMC	Report of the Mortality Commission
RSG	Report of the Surgeon General
RSPC	Report of the Society for the Protection of Children
WIMC	Report of the Proceedings of the West Indian Medical Conference 1921

## **Acknowledgements**

Most especially, I would like to thank my supervisors Andrew Wear and Lara Marks. Many other people have read and commented on chapters or given advice and support. In particular, I would like to thank Caroline Essex, Gwyn Griffiths, Fiona MacDonald, Sharon Messenger, Janet Rasmussen, Neil Rogal, Laurie Simonds and John Waller. Finally, I am extremely grateful for the support given to me by the Wellcome Trust and for the generous and helpful assistance of the staff at the Wellcome Library.

This thesis is dedicated to my father, Sam.

## Introduction

In many ways the British Empire was about geography, power and authority. When in 1870, the Secretary of State for War, Edward T. Cardwell, surveyed with a reforming eye, the extent of British military might, garrisons of imperial defence and British naval stations stretched from one end of the world to the other.<sup>1</sup> These sites of concentrated technical and political power, and the European commercial world which clustered around them, sheltered under an assorted range of political systems: colonies, protectorates, dependencies and 'spheres of influence'.<sup>2</sup> British Guiana, located on the north eastern side of South America came under the rubric of 'colony' (see appendix I for map.) To its north, it was framed by the Orinoco river and Venezuela, to the west Brazil, and to the south, Dutch Guiana. Basking in steady high temperatures and high rainfall, most of its 83,000 square miles of mountain, highlands and savannah, were covered during the nineteenth century, as they still are today, by thick and impenetrable tropical forest. From the mountains in the west, and fanning out towards the hillier hinter regions of the country, and then onto the flattened coastal strip, innumerable rivers and streams carried from the interior, clays, silts, sediments and sand. It was these deposits, built up over many thousands of years, which made up the rich, fertile but low lying coastal plain. This narrow belt of coastal land which was no more than ten miles deep has dominated the country's history.

Guiana was first successfully settled by Europeans in the early seventeenth century when the Dutch established a small number of slave plantations producing sugar. Later, as Alan Adamson in *Sugar Without Slaves* explains, the Dutch were joined by phalanxes of English planters from nearby islands who were attracted to Guiana by its reputation for 'legendary' profits from easily grown sugar and other staples.<sup>3</sup> The British, who brought their slaves with them, set about massively expanding production. At the turn of the new century some 100,000 Africans toiled to produce cotton, coffee, and sugar for the rapidly growing population of Britain. Although vastly outnumbered by those they ruled over, the British, nevertheless, soon accounted for the majority of

---

1. C.C. Eldridge, England's Mission The Imperial Idea in the Age of Gladstone and Disraeli 1868-1880 (Macmillan 1973), p. 71. A. N. Porter (ed.), Atlas of British Overseas Expansion (Routledge 1991), p. 118-121.

2. Bernard Porter, The Lion's Share. A Short History of British Imperialism 1850-1983 (Longman 1984), p. 114.

## Introduction

Europeans in each of the country's three coastal districts: Demerara, Essequibo and Berbice. In 1803, as a result of the French revolutionary wars, the British assumed administrative control of the entire colony from the Dutch. From this point onwards the British occupation of Guiana was uninterrupted until independence in 1966.<sup>4</sup>

One of the effects of empire in the nineteenth century, especially after the ending of slavery, was to accelerate the way that countries were integrated into new global relationships of trade and exchange. Communities relatively isolated by culture and geography, and by local forms of production and narrow patterns of consumption were opened up to the pressures of the world economy.<sup>5</sup> In the process old industries were transformed. Raw materials were drawn from the remotest parts of the world and consumption often took place far from the sites of production. A comment by Marx from the Communist Manifesto, on the restless nature of this system, still seems relevant in this context:

The need of a constantly expanding market for its products chases the bourgeoisie over the whole surface of the globe. It must nestle everywhere, settle everywhere, establish connections everywhere.<sup>6</sup>

The imprints of these developments were seen in the movements of people both within and between countries. As finance and commercial enterprise sought advantage and settled in foreign excursions, so South African mines, Fijian plantations, West Indian sugar factories (to give just a few examples) reached out, competed for, and gathered together, former agricultural labourers and impoverished artisans. Much of the travelling generated out of these processes was regional, but as already suggested, there was a growing global dimension. The nineteenth century saw an unparalleled movement of East Indians, Africans, Pacific Islanders, and Chinese travelling to destinations far from home.<sup>7</sup> Unbeknownst, as these individuals began their journeys from land to town,

---

3. Alan H. Adamson, Sugar Without Slaves. The Political Economy of British Guiana 1838-1904 (Yale University Press 1972), pp. 15-18.

4. *Ibid.* p. 22.

5. E. J. Hobsbawm, The Age of Capital 1848-1875 (Abacus 1977), pp. 64-102.

6. Karl Marx, The Communist Manifesto (Beijing 1988), p. 37.

7. Martin Legassick and Francine de Clercq, 'Capitalism and Migrant Labour in Southern Africa: The Origins and Nature of the System', in Shula Marks and Peter Richardson (eds.), International Labour Migration Historical Perspectives (Institute of Commonwealth Studies 1984). Adrian Graves, 'The Nature and Origins of Pacific Islands Labour Migration to Queensland, 1863-1906', Marks and Richardson, *ibid.* Hugh Tinker, 'Into Servitude: Indian Labour in the Sugar Industry, 1833-1970', in Marks and Richardson, *ibid.* Hugh Tinker, A New System of Slavery. The Export of Indian labour Overseas 1830-1920 (Hansib 1993). David Northrup, Indentured Labour in the Age of Imperialism 1834-1922 (Cambridge University

## Introduction

and from town to distant lands, they traced the uprooted and destabilising experiences of their fellow subjects in the metropolitan centre, many of whom were seeking new opportunities by embarking on voyages to the colonies of settlement, or as technocrats, administrators, army officers and colonial officials were setting out to take up their posts managing the commercial and political reins of empire. That it was still considered imaginable, practical, and finally realisable in the post-slavery period, to adjust deficits of labour in one part of the empire by transporting humans across the globe to work in other more distant parts of the empire, is a demonstration of how far the linkages of imperial power were capable of being harnessed to further the interests of the City of London, merchants and 'Gentlemanly capitalism.'<sup>8</sup> Between 1838 and 1924, as part of a wider dispersal of Indian migrants to Mauritius, the Pacific islands, Burma, Ceylon, Natal and the Malay Straits, some 438,000 East Indians were transported to the West Indies and set to work in the sugar plantations and cotton fields. Of these the majority, about 239,000, were sent to the former slave colony of Guiana.<sup>9</sup>

The motor behind this vast movement of people was economic, the need to match labour with capital. One of the important points about this development, however, and one which particularly applies to British Guiana, was that neither land and natural resources, nor capital and labour were pre-given entities. In a sense, each was created out of the other. Labour created capital by furnishing the means to clear land and expand production, as much as capital helped conjure into existence labour through its search for profitable enterprises. The dynamic interplay between these two forces, and the political structures which grew up to supervise them, was responsible for the colonial 'development' of Guiana. It follows that these investments in finance and physical effort were not spread evenly over the whole colony.

It may be helpful to think of Guiana as comprising of four distinct but interrelated regions: the plantations, the towns, the rural villages and the hinterland. These areas did not so much represent geographical spaces but marked out the varying political, social and economic interests of Europeans. They were also imaginative

---

Press 1995). Marina Carter, Voices from Indenture. Experiences of Indian Migrants in the British Empire (Leicester University Press 1996). Philip D. Curtin, 'Africa and Global Patterns of Migration', in Wang Gungwu, (ed.), Global History and Migrations (Westview Press 1997).

8. P. J. Cain & A. G. Hopkins, British Imperialism Innovation and Expansion 1688-1914 (Longman 1993), pp. 25-29.

9. Northrup, Indentured, p. 53.

## Introduction

spaces. In particular, the plantation was a place of enormous symbolism for the British, a medium which concentrated historical and cultural understandings. Plantations were institutions which spanned many human generations, and their attributes also varied over time and through the perspective of social place. To some they represented bastions of good social order and rationalised modern industry, to others they were nests of cruelty and places of despair, markers of despotic slavery and human waste.

Migration transformed Guiana. By the end of the nineteenth century the streets and markets of Georgetown, the colony's capital, thronged with Creole Blacks, with migrants from Madeira, the West Indian islands, China, West Africa and Europe, and with native Aborigines and various 'coloured' or mixed races. Explorations of what happened to these diverse groups of people as they stepped ashore or were drawn into Georgetown have been undertaken by a number of historians.<sup>10</sup> The central framework for analysis, such as that carried out by Adamson has been the plantation.<sup>11</sup> Without doubt, plantations were by far the most important commercial enterprise in the colony during the nineteenth century. It is this feature of absolute economic dominance which suggests that plantation societies represented a special type of social formation. How far plantations individually actually corresponded to a qualitatively different mode of production is open to debate.<sup>12</sup> But as a total system of production plantations do seem distinctive, especially in the way that virtually whole colony populations depended upon them for their livelihoods. The view taken here follows that of the historian Brian Moore who has argued that Guiana was *par excellence* a plantation society. The chief characteristics of this were: sufficient supplies of capital and land; access to technology; monocultural production for export; a political regime which secured planter dominance; cheap plentiful labour, and impersonal standardised commercial control over the labour force.<sup>13</sup> In Guiana, these qualities applied just as much before the abolition of slavery as they did afterwards.

---

10. Peter Ruhomon, History of the East Indians in British Guiana (Daily Chronicle 1947). Leo A. Despres, Cultural Pluralism and Nationalist Politics in British Guiana (Rand McNally 1967). Dwarka Nath, A History of Indians in Guyana (London 1970). Dr. Basdeo Mangru, Benevolent Neutrality. Indian Government Policy and Labour Migration to British Guiana 1854-1884 (Hansib 1987). Brian L. Moore, Cultural Power Resistance and Pluralism. Colonial Guyana 1838-1900 (McGill-Queens University Press 1995).

11. Adamson, Sugar.

12. Clive Y. Thomas, Plantations, Peasants, and the State (Centre for Afro-American Studies, UCLA 1984), Chapter 1.

13. For a discussion of plantation societies see Brian L. Moore, Race, Power and Social Segmentation in Colonial Society. Guyana After Slavery 1838-1891 (Gordon & Breach 1987), pp. 9-10.

## Introduction

The point of entry for this thesis is the moment after abolition. The planters, as it is suggested above, remained economically dominant and empowered politically after the abolition of slavery and the collapse of the 'apprenticeship' scheme. Nevertheless, the coming of 'free labour' posed a profound challenge to their whole way of life.<sup>14</sup> The lifting of physical compulsion on the estates was marked by a steady and seemingly irreversible decline in the numbers of individuals prepared to stay and work on them. Unlike many other West Indian islands Guiana possessed swathes of fertile but uncultivated land from which the former slaves were able to gain a livelihood. Amongst those who remained, 'combinations' and 'task gangs' were formed to seek out the highest wages.<sup>15</sup> The origins of immigration to the colony and that of indentured labour flow directly out of this post-abolitionist shift in planter fortune.

The arrival of immigrants to Guiana produced change but also made possible continuities. The system for organising labour after slavery was indentureship, this system bound individuals under contract to estates for varying periods of time, and thus made possible the continuation of a plantation based system of production. Indentureship was not slavery, but neither was it free labour.<sup>16</sup> Although indentured labour contained a consensual element, it was nevertheless held in place by a battery of laws, penalties and various forms of coercion.<sup>17</sup> Psychologically, too, the labourer, far from home, confronted by unfamiliar work, domestic arrangements and surroundings, was at a disadvantage to the well established European and 'native' hierarchies on the plantation. Essentially, labour was performed under the threat of penal sanctions, all of which ensured that planters retained their position of dominance on the estates. While indentureship at the level of the plantation undoubtedly contained many threads of continuity with slavery, it also ushered in deep and lasting changes to the wider society. Crucially, planters were not allowed to supply labour to their plantations through *laissez faire* economics or private initiatives. To achieve their aims, planters required the active

---

14. Nigel Bolland, 'Systems of Domination after Slavery: The Control of Land and Labour in the British West Indies after 1838', in Hilary Beckles and Vera Shepherd (eds.), Caribbean Freedom. Economy and Society from Emancipation to the Present (James Curry 1993), pp. 107-123.

15. James G. Rose, 'The Strikes of 1842 and 1848', in Winston F. McGowan, James G. Rose, David A. Granger, (eds.), Themes in Africa-Guyanese History (Free Press 1998), pp. 158-160.

16. K. O. Laurence, 'The Evolution of Long-Term Labour Contracts in Trinidad and British Guiana 1834-1863', in Beckles and Shepherd, Caribbean, pp. 141-151.

17. Yash Ghai, 'Migrant Workers, Markets, and the Law', in Wang Gungwu, (ed.), Global History and Migrations (Westview Press 1997), pp. 157-163.

## Introduction

and involved support of the state. In the event, bringing labour to the West Indies and Guiana involved complex inter-governmental agreements, systems of global bureaucratic co-operation, finance and regulation. In short, the politicisation of space through the establishment of immigrant depots, governmental management of shipping and transport, and the supervision of estates.

How were the Dutch and then the British in Guiana able to maintain their rule? Over the past decade, historians have emphasised the importance of technology for making excursions and settlements abroad possible. It has been argued that both the 'Tools of Empire', the steamer, quinine and the quick-firing gun, and the confident ideologies of progress and political rationality, assisted and sustained the European abroad.<sup>18</sup> This was no doubt true, but the relationship between these two elements, the technical (which may include medicine) and the cultural or ideological, is complex and somewhat disputed, perhaps unsurprisingly given the wide range of interests which were packed into the different sites of empire.<sup>19</sup> On this question of technology and ideology, medicine seems to straddle both sides. Besides the practical benefits it provided for Europeans (the comforting familiarity of blood lettings, purgatives, and array of therapeutics, as well as guidance on dress, habitation and food) medicine undoubtedly represented a wider social and political force. To most of its mid-century practitioners, Western medicine was self evidently superior to native practices. Medical theory (in this model of belief) simply reflected the facts of nature.<sup>20</sup> Medicine, therefore, was able to add another thread to the thickening rhetorical weave of superiority and progress which surrounded the empire. It not only had the power to explain, define and catalogue, but could thereby help broker relationships with non-Europeans, bolster political institutions, give force to administrative decisions, and not least, provide a measure of self justification for the British presence in foreign lands. In this thesis, it is this

---

18. D. R. Headrick, The Tentacles of Progress: Technology Transfer in the Age of Imperialism, 1850-1940 (Oxford University Press 1988), pp. I-X. Thomas R. Metcalf, Ideologies of the Raj (Cambridge University Press 1995), pp. 29-43.

19. David Arnold, 'Medicine and Empire', in David Arnold (ed.), Imperial Medicine and Indigenous Societies, (Manchester 1988), pp. 3-10. Roy MacLeod, 'Introduction', in Roy MacLeod and Milton Lewis (eds.), Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion (Routledge 1988), p. 1. Megan Vaughan, 'Healing and Curing: Issues in the Social History and Anthropology of Medicine in Africa', Social History of Medicine Vol. 7. (1994), pp. 283-295. Shula Marks, 'What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health?', Social History of Medicine Vol. 10, no. 2 (1997), pp. 205-219.

## Introduction

dynamic of medicine, its ability to both construct understandings about the world, and in turn be structured by that world, which forms a central theme.

Another way of looking at medicine in the empire is to ask *who* was it for? For the most part it has been seen as a resource mainly available to the representatives of European trading interests, colonial administrators, and the military. In the Dutch Indies it has been claimed that Western medicine was, 'virtually synonymous with military medicine'.<sup>21</sup> In French Equatorial Africa a similar picture emerges.<sup>22</sup> David Arnold has claimed, with reference specifically to India, but his argument seems to have a wider relevance, that medicine's greatest impact was on European 'enclaves' and not the health of the population as a whole.<sup>23</sup> However, dates are important here, and as Arnold goes on to point out:

Western medicine...was never content to be confined to the white ghetto: it was too restlessly ambitious merely to minister to sick civil servants and ailing generals, even had it been deemed practical to draw a neat dividing line between European and "native" health.<sup>24</sup>

At least from the 1850s in India, dispensaries were a notable feature of the medical landscape and could be seen as part of the 'improving' presence of the British in India.<sup>25</sup> Illustrating perhaps that the clinical and wider cultural dimensions of medicine were inseparable. Elsewhere in the world, around the same time, the Colonial Office was nudging colonial officials into taking account of the health needs of indigenous peoples. But this was not a uniform response, and local factors were important in shaping colonial policies. For example, the differences in government policy between New Zealand and Australia, two countries in the same geographical region, were stark. In New Zealand hospitals were opened in the hope of fixing, 'in the minds of the natives an impression that we are their sincere friends, disposed, really and

---

20. Byron J. Good, Medicine Rationality and Experience. An Anthropological Perspective (Cambridge University Press 1994), p. 8.

21. Rosalia Sciortino, 'The multifariousness of nursing in the Netherlands Indies', in Peter Boomgaard, Rosalia Sciortino and Ines Smyth (eds.), Health Care in Java Past and Present (KITLV Press 1996), p. 28.

22. This holds true for other European powers as well. See for example Rita Headrick, Colonialism, Health and Illness in French Equatorial Africa 1885-1935 (African Studies Association Press 1994), p. 47.

23. David Arnold, Colonizing the Body. State Medicine and Epidemic Disease in Nineteenth Century India (University of California Press 1993), p. 61. Radhika Ramasubban, 'Imperial Health in British India, 1857-1900', in MacLeod and Lewis (eds.), Disease Medicine and Empire p. 39. Dorothy Porter, (ed.), The History of Public Health and the Modern State (Rodopi 1994), p. 11.

24. Arnold, Colonizing p. 291.

25. *Ibid.*, p. 248.

## Introduction

practically to secure them and ameliorate their condition.<sup>26</sup> Hospital building and vaccination programmes were evidence, according to Derek Dow in *Maori Health and Government Policy*, of a, 'continuing concern for the health of the indigenous population.'<sup>27</sup> The true motives for this humanitarian interest may have been self interest. The Maoris were a significant military force, and in terms of population far outnumbered the British who needed to find a means to negotiate their presence there.<sup>28</sup> Nevertheless, an utterly different story emerges from Australia. In this country, no attempts were made to broker treaties, and settlement proceeded ruthlessly, without any concessions to the Aboriginal communities.<sup>29</sup> It follows from this that the health of Aboriginal people was not important for the government. In fact, little or no concern was shown for Aboriginal health until the 1960s.<sup>30</sup>

The point of these three examples, India, New Zealand and Australia, is to show that health care for non-Europeans during the nineteenth century cannot be easily packaged, it changed over time, it varied according to place, and local political and economic dynamics were crucial in shaping government attitudes and motivations towards providing it. This uneven picture also holds true for plantation societies. For example, in Sri Lanka the health needs of the labouring masses received little attention from government or plantation owners during the nineteenth century.<sup>31</sup> This was also the case in Dutch Guiana (now Suriname). As Rosemarijn Hoefte argues in her book *In Place of Slavery*, substantial improvements to the medical system were not brought about until the 1920s.<sup>32</sup>

In British Guiana, on the other hand, as this thesis shows, the situation was quite different. During the 1840s the health of estate workers became the subject of intense interest to the government of the colony, and indeed to Parliament also. A concern for

---

26. *The New Zealander* (newspaper), in Derek A. Dow, Maori Health & Government Policy 1840-1940 (Victoria University Press 1999), p. 27.

27. Dow, Maori p. 56.

28. Raewyn Dalziel 'Southern Islands: New Zealand and Polynesia', in Andrew Porter (ed.), The Oxford History of the British Empire. The Nineteenth Century (Oxford University Press 1999), p. 581.

29. Donald Denoon with Marivic Wyndham, 'Australia and the Western Pacific', in Porter (ed.), Oxford History p.563.

30. MacLeod, 'Introduction', Disease, p. 9. Lindsey Harrison, 'Government Policy and the Health Status of Aboriginal Australians in the Northern Territory, 1945-72', in Lara Marks and Michael Worboys (eds.), Migrants, Minorities and Health (Routledge 1997), pp. 125-146.

31. Soma Hewa, Colonialism, Tropical Disease and Imperial Medicine. Rockefeller Philanthropy in Sri Lanka (University Press of America 1995), p. 44

## Introduction

the health of estate workers ultimately pushed the government into taking over the organisation of plantation health provision. Aside from a short article by the historian K. O. Laurence, this remarkable transfer of responsibilities has not yet been examined by historians.<sup>33</sup> More generally still, surprisingly little has been written about the genesis of post-emancipation health legislation in the Caribbean area. Where the health of plantation workers has been addressed – it has been the period of slavery which has drawn the attention of historians – not the later period.<sup>34</sup> More often these societies have been analysed from the perspective of the plantation and the operation of power, the exigencies of economics, and through patterns of consumption.<sup>35</sup>

This thesis, *From Plantation Medicine to Public Health: The State and Medicine in British Guiana 1838-1914*, is an attempt to redress this imbalance by charting the place of medicine in a plantation society after emancipation. Although Guiana was not the most economically important part of the British Caribbean, it was the country which took the largest numbers of immigrants during the nineteenth century and where, therefore, the elaborate system of indentureship was most fully developed. This alone makes Guiana of special interest. However, like most British colonies in the West Indies its population was small, even by the start of the First World War it had only just reached 309,000.<sup>36</sup> The proportion of Whites in Guiana was also small; in the 1891 census they accounted for just 1.6 per cent of the total population, roughly 4,500 individuals.<sup>37</sup>

Until the Immigration Ordinance of 1873 most doctors worked privately for plantations or worked in the capital city. Afterwards, virtually all of those who tended estate labourers became government employees. For the historian, one effect of such a

---

32. Rosemarijn Hoefte, *In Place of slavery. A Social History of British Indian and Javanese Labourers in Suriname* (University Press Florida 1998), pp. 150-154.

33. K. O. Laurence, 'The Development of Medical services in British Guiana and Trinidad 1841-1873', in Beckles and Shepherd, *Caribbean* pp. 269-273.

34. Kenneth F. Kiple, *The Caribbean Slave: a Biological History* (Cambridge 1984). Richard B. Sheridan, *Doctors and Slaves: a Medical and Demographic History of Slavery in the British West Indies, 1680-1834* (Cambridge University Press 1985). A. Meredith John, 'Plantation slave mortality in Trinidad', *Population Studies* Vol. 42. 1988. B. W. Higman, *Slave Populations of the British Caribbean 1807-1834* (University of the West Indies 1995).

35. Sidney Mintz, *Sweetness and Power: The Place of Sugar in Modern History* (Viking 1985). Philip D. Curtin, *The Rise and Fall of the Plantation Complex: Essays in Atlantic History* (Cambridge University Press 1998).

36. W. J. Duncan, M. B., C. M., 'The Public Health Statistics of the Colony', *The British Guiana Medical Annual for 1915*, (hereafter the BGMA), (Argosy 1916), p. 173.

37. Moore, *Race*, p. 274.

## Introduction

small medical presence is the absence of personal observations about how doctors experienced life in the colony. Also, there were no large or prestigious medical institutions, experimental stations, or laboratories. Correspondingly, the opening in England of the Schools of Hygiene and Tropical Medicine, while exerting an influence on medical practice in Guiana, are not central features of this story.<sup>38</sup>

However, the history of medicine in Guiana is present in the official record. The reports of Immigration Officers and Surgeon Generals, the journals of the colony's medical profession, and the correspondence between Whitehall and the Governor provide invaluable insights into the workings of the official mind and the place of medicine in the colony. These reports, studies and missives, if read 'against the grain' can also on occasions unexpectedly reveal non-European perspectives on Western health provision, although the voices of non-Europeans were often inaudible to officials and rarely entered the official record. Generally speaking, for most of the nineteenth century, doctors in the colony saw no reason to understand, address or comment on 'local perspectives, concerns, and values.'<sup>39</sup> The colony's newspapers also offer a valuable source of comment on the activities of government, Town Council and officials. Both government and Town Council business was often reported verbatim. The *Royal Gazette*, *Daily Chronicle* and *Argosy*, all of which have been extensively used in this thesis, were without exception unwaveringly opposed to any democratic forces which challenged the hegemony of planters. The *Argosy* in particular was considered a planters' paper often giving prominence to discussions on sugar technology, duties and prices. Their bias, for the historian, is sometimes their strength, as tensions generated out of different expectations about the role of colonial government frequently spilt over into the press.

It is also worth mentioning here that this study is not a comparative work, the focus for the thesis remains firmly on the events and developments in Guiana rather than

---

38. Helen Power, 'The Calcutta School of Tropical Medicine: institutionalizing medical research in the periphery', *Medical history* Vol. 40. 1996. Michael Worboys, 'Manson, Ross and Colonial Medical Policy: Tropical Medicine in London and Liverpool, 1899-1914', in MacLeod & Lewis (eds.), *Disease Medicine and Empire* pp. 21-37. Lise Wilkinson and Helen Power, 'The London and Liverpool Schools of Tropical Medicine 1898-1988', *British Medical Bulletin* Vol. 54, no. 2 1998. E. D. Rowland, 'Some Remarks on the Treatment of dysentery', *The British Guiana Medical Annual and Hospital Reports* (Georgetown 1895), pp. 31-49. Helen Power, *Tropical Medicine in the 20th Century: a history of the Liverpool school* (Paul Kegan London 1998).

39. Robert A. Hahn, *Anthropology in Public Health. Bridging Differences in Culture and Society* (Oxford University Press 1999), p. XVII.

## Introduction

elsewhere. Nevertheless, throughout the thesis I have attempted to show how the introduction, supervision and extension of health systems across the colony were not unconnected to the way bureaucracy, medicine, politics, and commerce unfolded beyond Guiana's borders. A brief framework of these changes is set out below.

Although the endemic presence of disease provided an enduring justification for the activity of doctors in the colony, the character of their labours, who was treated and where they were treated, was shaped rather less by epidemiology than by the wider politics of health, and indeed by the broader societal changes taking place in Britain. The chronological outline of this thesis travels the latter half of the nineteenth century to the first decade of the twentieth. This was a period, in Victorian Britain, of rapid social, cultural, scientific, economic and political change. In a large measure, a society dominated by monarchy, the land-owning class and the established church, gave way to political reform, non-conformism, the middle class and new professional elites.<sup>40</sup> With regard to economics, free trade measures gained ascendancy and set in motion profound changes. Abroad it ultimately destroyed mercantilism and the old colonial system, while at home it undermined and hastened the decline of the landed aristocracy.<sup>41</sup> Significantly, the repeal of the corn laws and the Sugar Act of 1846 were passed in the same session of Parliament.<sup>42</sup> Before long British manufacturing had gained a reputation as the 'workshop' of the world.<sup>43</sup>

Medicine also underwent transformations. Regulation, professionalisation and theoretical advances garnered it with new status, and produced among a number of its practitioners notions of sanitary utopianism.<sup>44</sup> In public policy, medicine became a force to contend with amongst government officials and of course amongst the growing number of health officials – the latter being a recent creation sprung from the consequences of epidemic diseases and overcrowding in Britain's bulging crisis ridden

---

40. Harold Perkin, The Rise of Professional Society. England Since 1880 (Routledge 1989), p. 29.

41. Cain and Hopkins, British Imperialism p. 104.

42. The Sugar Act started the process towards equalising duties on British and 'foreign' sugar. Philip Curtin, 'The British Sugar Duties and West Indian Prosperity', in Beckles and Shepherd, Caribbean Freedom, pp. 314-318.

43. F. Crouzet, The Victorian Economy (Methuen 1982).

44. Anne Digby, Making a Medical Living. Doctors and Patients in the English Market for Medicine, 1720-1911 (Cambridge University Press 1994), p. 315. Roy Porter, 'Medical futures', Interdisciplinary Science Reviews, 2001, Vol. 26, no. 1. p.37.

## Introduction

cities.<sup>45</sup> In science, new intellectual disciplines, dramatic discoveries and novel theories, not least Darwin's evolutionary claims, questioned long held understandings of humanity's place in nature. Perhaps more importantly with regard to health and medicine, and as Dorothy Porter has suggested in *Health Civilization and the State*, the growing power and prestige of science lent a new dispassionate language to bureaucratic reformers, that of statistics and scientific rationality.<sup>46</sup> Ian Hacking describes how the 'avalanche of printed numbers' transformed the nature of political, social and economic debate.<sup>47</sup> Life, labour and health entered the quantitative realms of the normal and the pathological. The collection and analysis of social statistics by high profile figures such as Edwin Chadwick (1800-90), William Farr (1807-1883), and John Simon (1816-1904), appeared in surveys, enquiries, reports and Royal Commissions, holding out the promise of informed, rationally grounded, centralised and codified state administration.<sup>48</sup>

It would be surprising if these intellectual developments did not find some expression in the colonies. In, *Natures Government: Science, Imperial Britain, and the 'Improvement' of the World*, Richard Drayton draws our attention to the importance of the rising 'bureaucratic tide' which gradually but inexorably spread from the metropole to the periphery during the Victorian era.<sup>49</sup> As Drayton points out, one legacy of enthusiasm for efficiency in government was an increasing intolerance in the colonies for, 'anarchy, indolence, ignorance, or merely resistance to 'civilised' lifeways'.<sup>50</sup> In British Guiana, these sentiments manifested themselves amongst government officials in two broad ways. Firstly, there was the promotion of 'proper values' in the form of Christianity and the supposed rewards of work and education. Secondly, there was an emphasis on the importance of government, law and regulation. Labour law, property

---

45. Elizabeth Fee & Dorothy Porter, 'Public health, preventative medicine and professionalism: England and America in the nineteenth century', in Andrew Wear (ed.), *Medicine in Society*. (Cambridge University Press 1992).

46. Dorothy Porter, *Health Civilization and the State. A history of public health from ancient to modern times* (Routledge 1999), p.73.

47. Ian Hacking, 'Biopower and the Avalanche of Printed Numbers', *Humanities in Society* Vol. 5. Summer 1982, p. 279.

48. Roy Porter, *The Greatest Benefit to Mankind* (Norton & Co. New York 1998), pp. 407-415. John M. Eyler, *Victorian Social Medicine. The Ideas and Methods of William Farr* (John Hopkins University Press 1979), pp. 13-36.

49. Richard Drayton, *Nature's Government Science, Imperial Britain, and the 'Improvement of the World* (Yale University Press 2000), p. 223.

50. *Ibid.*, p. 223.

## Introduction

law, and congenial rules of trade and exchange provided the legal superstructure around which Europeans held Guianan society together. Good governance, which was increasingly informed by the gathering of statistical data, had the merit of weaving together and merging economic priorities with an ideology of progress.

Medicine too may be seen as part of this discourse of government. As suggested earlier, it was possible for the colonial bureaucrat to discover invigorating sources of legitimisation for their rule in the achievements of science, technology and medicine.<sup>51</sup> Certainly, a regard for scientific progress, ideas of civilisation, and what it meant to be a European in the colonies, were closely intertwined.<sup>52</sup> However, such intellectual beliefs need to be set within specific contexts. In this thesis I have attempted to show how the rhetorical justifications of empire were always grounded in larger more practical activities and aims. Namely, the transportation and organisation of labour for commercial purposes, and the search for legitimacy of government.

Chapter one examines how immigration to Guiana was organised, and looks at the genesis of post-emancipation health provision in the colony. I discuss how the colonial government's attitude towards the health of labourers was shaped by the importance of politics, anti-slavery sentiment and race. In chapter two this political theme is continued as I examine how the authorities were gradually drawn further and further into the organisation of health care for plantation workers. Ultimately, this led to the government taking responsibility for the health care of labourers through a system of Government Medical Officers.

The connections between race, racial thinking and colonialism that thread through these chapters allude to the nature of colonial power. Throughout European expansions abroad, the relationship between these elements was varied and complex, specific to particular places, times and circumstances.<sup>53</sup> However, the broad outlines are clear. Colonial discourses about the 'other', from Linnaeus' early eighteenth century classificatory initiatives onwards, invariably rested upon certain observed physical features of the human body which were assumed to stand for various mental attributes

---

51. Deepak Kumar, Science and the Raj 1857-1905 (Oxford University Press. Delhi 1997), p. 15.

52. Michael Adas, Machines as the Measure of Man. Science, Technology, and Ideologies of Western Dominance (Cornell University Press 1989), p. 3.

53. Ania Loomba, Colonialism/Postcolonialism (Routledge 1998), pp. 104-133.

## Introduction

or cultural dispositions.<sup>54</sup> By the second decade of the nineteenth century there was a rich seam of this material. What individuals and societies were, or could be, was filtered, constructed or selected, in diverse ways: out of legacies of older historically fashioned accounts; from individual experience; through scientific investigation; and via the precepts of rule. Nevertheless, despite Victorian racial thought bearing the imprints of so many influences, its conclusions were remarkably uniform. Hierarchies were assembled, and individuals, groups, communities and nations were identified as intrinsically suited for particular tasks in the colonial order. As Megan Vaughan has suggested, it follows that the body may be seen as the site of power relations in society, for example in the way ideas of race are encrypted onto bodies.<sup>55</sup> Other social scientists have gone further than this and contend that bodies also constitute and reproduce power relations in society.<sup>56</sup> This I think may be put in a different manner, as Bryan Turner in *The Body and Society* explicitly states: 'The body lies at the centre of political struggles.'<sup>57</sup> What do these theoretical insights tell us about the role of medicine in the colony?

This is examined in chapter three by looking closely at the workings and organisation of the plantation. The sugar estate was the most important societal unit in Guiana. This was the place where labour, discipline, organisation and technology were brought together and defended, renewed and modified, most systematically and for the longest periods.<sup>58</sup> Here also was the site where medicine assessed, measured, and enumerated immigrants. As doctors and colonial officials moved through these productive spaces, they were vested with the authority of medicine and the privileges of political rule to materially affect the lives of the labourers they encountered. In other words, plantations were about the exercise of power, and medicine in its own way directly helped to maintain the institutional stability of plantations and thereby to reproduce and strengthen the fabric of colonial structures in Guiana.<sup>59</sup> In this chapter the

---

54. See for instance Edward Long's *History of Jamaica* published in 1774. Michael Banton, *Racial Theories* (Cambridge University Press 1987), p. 11.

55. Megan Vaughan, *Curing their Ills. Colonial Power and African Illness* (Polity Press 1981), pp. 12-13.

56. Alec McHoul & Wendy Grace, *A Foucault Primer. Discourse, Power and the Subject* (UCL Press 1995), pp. 63-64.

57. Bryan S. Turner, *The Body and Society* (Sage Publications 1996), p. 67.

58. Ann Laura Stoler, *Capitalism and Confrontation in Sumatra's Plantation Belt, 1870-1979* (University of Michigan Press 1995), p. 9.

59. Mark Neocleous, *The Fabrication of Social Order. A Critical Theory of Police Power* (Pluto Press 2000), pp. XI-XII.

## Introduction

different perspectives on plantation health, that is between colony government and plantation owners, are shown. I examine the scale of medical provision, and also discuss disease and mortality. In addition, I also demonstrate how ideas about race, the bureaucratic supervision of plantations, and medicine, were brought together and marshalled for the purposes of furthering commercial enterprise.

The way ideas of race were woven through Guianan society leads on to the issue of medicine as a tool for 'social control'. There are two sides to this question. Social control in the sense that it is imposed from the outside, as with quarantine and segregation, or from a rather different perspective, social control as exercised through individuals, who voluntarily manage their lives in accordance with Western medical theories about the body and hygiene. Both meanings of social control were present in Guiana. Caveats aside, on the plantation medicine was imposed upon workers. As noted above, we can see this in the array of organisational and legislative mechanisms which were designed to place the African or East Indian labourer under the eye of western medicine. Within the boundaries of the plantation, it is possible to identify the incipient thickening and spreading grasp of colonial bureaucracy, knowledge and power, wrapping themselves into the experience of the immigrant.

However, outside of the plantation institution, and especially by the early twentieth-century, it is clear that doctors were keen that 'native' mothers, milksellers, and urban inhabitants took up, practised, and acted in conformity with medical ideas about infant care, feeding and cleanliness. The reasons and the effects of this important change in thinking is taken up and developed in chapters four, five, six and seven. The broadening focus of medicine, from the plantation to wider numbers of colony inhabitants, forms a vital part of this thesis. Briefly, I argue that the British saw a direct connection between labouring capacity and wealth creation, and between colony population and 'progress'. Towards the end of the century these ideas helped prompt doctors into examining questions of low fertility and high infant mortality amongst the 'native' population. A widely held view amongst officials was that the population was stagnating. In chapter four I look at how doctors constructed or discovered this 'problem' of population. In much the same way that they had previously attempted to 'know' the labourer by mapping the presence of disease, morbidity and mortality on the plantation, they now began producing new statistical pictures of colony inhabitants. At

## Introduction

the same time I show that new social forces helped to shift the attention of officials towards the population living outside of the plantation – to those in the villages and towns.

This analysis is followed in chapter five by a discussion on how doctors attempted to understand and explain the colony's low population growth and high infant mortality. These problems sanctioned a more detailed scrutiny of non-Europeans. Infant disease was linked by doctors to the way mothers fed their infants, and more generally to race and the mothers' lifestyle. In this chapter we see the way that 'native' mothercraft became an issue of enduring concern for European doctors. Other intellectual developments were also taking place at the same time, most importantly the germ theory of disease was becoming quickly taken up by doctors in the colony, and 'public health' sentiment was making an impact on official thinking. In a sense, the medical focus on mothercraft was both a reflection of these new ways of understanding the world and itself helped to push them along.

The aim of the final two chapters in the thesis is to develop this point about public health, and its meaning for colonial officials in Guiana, more fully. I look in detail at two of the administrative responses which were developed *specifically* to tackle infant mortality. Chapter six examines the role of midwifery, and chapter seven looks at 'sanitary spaces', in particular at town council and medical attempts to improve the quality of milk on sale in Georgetown. As will be seen, town officials and doctors were guided in their initiatives by metropolitan practices. In a similar manner to their English counterparts, officials in the colony showed an enthusiasm for bureaucratic solutions: registration, certification and legislation. They then attempted to map these administrative formulae onto the social landscape of the colony. How successful were they?

In these last chapters, which conclude the thesis, themes introduced earlier, those of colonial progress, the presence of ideas about civilisation and race, issues over political legitimacy and governmental expediency continue to surface. One important shift that comes across in this material is the changing nature of the relationship between colonial authorities and non-Europeans. I argue that outside of the restrictive and disciplining reach of the plantation, the spread and usage of western medicine, relied less on dictate and far more on negotiated arrangements. Effective measures to reduce

## Introduction

infant mortality required, in the view of doctors, an element of shared understanding about the role of germs and dirt in disease. The adoption of new strategies designed to spread western biomedical ideas of health among non-Europeans signalled the arrival of a medical service which was no longer simply an adjunct of the plantation system. At the same time, as doctors fashioned and to an extent borrowed a language of 'public health' suitable for their situation in the tropics, it is still possible to see the workings of power and authority in the cause of colonial prosperity. Managing dirt and disease and promoting civilised values continued to provide sustenance for European rule.

---

## Chapter 1

### 1.1 Introduction - race and labour, politics and bureaucracy

This chapter is about European medicine in the British colony of Guiana. It is about how medicine, the quest for labour and the exercise of political power were brought together for the purposes of furthering the commercial interests of West Indian planters.

The politicisation of health in the Caribbean had its antecedents in the arguments for and against slavery. In British Guiana, and in other islands, measures to ameliorate conditions of slave labour (such as restriction on the use of stocks, floggings and the hours of field labour) had been introduced in the 1820s and early 1830s. In 1825 legislation in Guiana stipulated that every proprietor must provide a 'sick house, furnished with proper conveniences and attendance for the sick'.<sup>1</sup> Across the Caribbean similar reforms took place with the grudging support of each colony's governing body – in Guiana this was the planter-dominated Court of Policy. Crucially, however, throughout the Caribbean much of the health care side to these reforms seems to have been abandoned with the collapse of the slave system.<sup>2</sup> One of the tasks of this chapter is to examine the circumstances whereby medical provision for plantation workers once again surfaced as an issue requiring action by the British government. In Guiana, a new seriousness about plantation health care was evident in the 1847 Hospital Ordinance. This legislation, which aspired to deliver to plantation workers the supposed benefits of western medical practices, represented a qualitative shift in the colony's thinking about medical provision.

Perhaps surprisingly, the causes of this change in official sentiment are not to be found exclusively in the internal political and economic dynamics of the colony, or even in local epidemiological factors. While these necessarily shaped the character of the legislation, as well as the manner of its introduction and implementation, they did not determine its arrival. In fact, as this chapter explains, the plantocracy used their political

---

1. By 1829 it was recommended that punishment in the stocks should not exceed six nights. C. O. 114/10. Demerara and Essequibo Vade Mecum. Containing the Principles, Laws and Regulations of the United Colony (Georgetown 1825), p. 15. Cecil Clementi, A Constitutional History of Guiana (Macmillan 1937), p. 101. See also William Edward Carroll, The End of Slavery: Imperial Policy and Colonial Reaction in British Guiana (Ph.D. thesis. University microfilms international 1980), p. 74, 81, 89. Claude Levy, Emancipation, Sugar, and Federalism. Barbados and the West Indies, 1833-1876 (University Press of Florida 1980), p. 21.

2. Sheridan, Doctors pp. 45, 323-5, 337-339.

power to impede reform. To understand these local developments in Guiana, it is necessary to widen the historical focus, to include a broader framework of global British political interests and commitments which surfaced with the ending of slavery. Secondly, we have to understand how all of these elements meshed with the colony's desperate need for labour in the post-emancipation period.

In the West Indies the production of sugar and other commodities had already been in recession for a number of years by the time of emancipation in 1834. Freedom, which involved the transfer from slave labour to wage labour, simply compounded the difficulties faced by planters by adding further substantial costs to production.<sup>3</sup> Thus, the new social order was not just politically destabilising but also economically damaging to vested interests. In addition, many ex-slaves were reluctant to work in the fields. Gradually, the imperatives of production pushed planters in British Guiana into seeking new workers on the world market. India especially, came to represent for the West Indian sugar producer, a vast source of dormant but easily manageable labour power.

Two further features stand out. The first, as already suggested, concerns the internal political dynamic of the colony. It will be seen that on the question of health provision, planters took a distinctive approach compared to that of the colony's governor and his appointees. Planters resisted government interference and opposed the imposition of hospital legislation as an unwarranted threat to their independence. Secondly, I bring out the crucial role of the old colonial hospital in Georgetown. As immigrants arrived in the colony, the character of this institution (and its smaller counterpart in the town of New Amsterdam) was transformed. During the period of slavery the colonial hospital (later more usually known as the Public Hospital) was primarily a place for the treatment of Europeans. This narrow racial aspect of the hospital was permanently altered as successive waves of immigrants stepped ashore. I introduce a brief examination of this transformation by taking the end of the nineteenth century as a point of comparison to illustrate the hospitals' important place in the workings of colonial society. I also bring out the way that the culture of empire, in the form of 'civilising values' informed the practice of medicine in this institution.

In summary, it will be argued here that the post-emancipation reform of medical provision in British Guiana was mainly the result of global and not local factors. Most importantly, the British state, which was committed by the 1830s to the abolitionist

path, remained sensitive to accusations that large scale labour migration reintroduced slavery by the back door. The key to understanding state enthusiasm for labour selection procedures, health inspections, transport regulations, and plantation hospital provision, lay in the perceived need to reduce mortality and thereby defuse political opposition.

## 1.2 Emancipation, immigration and race

In 1823, the East Coast of Demerara, in the colony of British Guiana, witnessed the second of three major rebellions staged by slaves in the British West Indies. Each of these struggles finally ended with the triumph of the planter class, who ruthlessly suppressed these strivings for a new order.<sup>4</sup> However, the unintended outcome of this show of force and reestablishment of planter order in the West Indies, was a strengthening of the political forces aligned against them at home. In 1833 the British Government passed an act abolishing slavery in British Guiana and the rest of the British Caribbean with effect from the 1 August 1834. The former slaves were now 'free', although in practice they were still tied to the sugar estates through a system called 'Apprenticeship'. This modified form of slavery was finally abandoned exactly five years later, on the 1 August 1838.

One of the major questions which loomed large after emancipation was that of labour. Even before 1838 it was apparent that without the coercive measures of slavery, many plantation workers were going to abandon the estates.<sup>5</sup> This was considered especially likely because of the ample amount of fertile but uncultivated land which existed in Guiana. A free 'independent' peasantry was a real possibility.<sup>6</sup> As was the case in other parts of the British Caribbean, a decline in the Guianan workforce began before emancipation, and was then accelerated. In the mid 1840s, there were probably only 38,000 ex-slaves working on the plantations, about forty-three per cent of the workforce at the time of emancipation.<sup>7</sup> These numbers continued their dramatic decline in subsequent years. In 1848 only 16,000 'free' labourers worked on the plantations.<sup>8</sup>

---

3. Richard A. Lobdell, 'Patterns of Investment and Sources of Credit in the British West Indian Sugar Industry, 1838-1897', in Beckles and Shepherd (eds.), *Caribbean Freedom* pp. 319-320.

4. Barbados 1816 and Jamaica 1831. Winston F. McGowan, 'The Demerara Revolt, 1823', in McGowan, Rose and Granger, *Themes in African-Guyanese History* pp. 107-140.

5. William A. Green, *British Slave Emancipation* (Clarendon Press 1991), p. 192. Kathleen E. A. Monteith, 'Emancipation and Labour on Jamaica Coffee Plantations, 1838-48', *Slavery and Abolition* Vol. 21. December 2000. pp. 125-135.

6. Adamson, *Sugar* p. 34.

7. Moore, *Race* p. 37.

8. Figure tabulated from the Bonyun Report. C. O. 111/250.

Moreover, it was not just plantation workers that Europeans were short of, but also servants in order to maintain their existing social privileges. As the immigrant returns for 1838 show, aside from field labourers, immigrants were also employed as washers, seamstresses, cooks, domestics, butlers and ladies maids.<sup>9</sup>

A further difficulty for planters was the attitude of those labourers who remained on the plantations. This was exemplified by planter accusations of 'irregularity' and 'unreliability'. In a telling indication of the weakened lines of authority, the scarcity of labour enabled, indeed prompted, workers to band together and travel from one estate to the next in search of the highest wages.<sup>10</sup> Governor Henry Light in 1838, in 'an address to the idle', complained of field labourers:

when you have earned sufficient to fill your bellies, like wild beasts, after satisfying your hunger, you lie down to sleep, or idle your time...Are you not aware where this leads? The abandonment of estates! And your own degradation!<sup>11</sup>

These moralistic appeals failed to reverse the shortages of labour which increasingly hindered sugar production, the colony's main source of revenue. Sugar production showed a dramatic decline during the post-emancipation period, decreasing by almost half between 1833 and 1841.<sup>12</sup>

The abolition of slavery thus forced the 'problem' of labour to the centre of the colony's political life. Racial assumptions added further complexity to the issue. Quite simply, slaves and their descendants from the West Coast of Africa, were assumed to be the most physically suited to hard tropical labour. This view was expressed by a writer to the staunchly pro-planter newspaper, the *Royal Gazette* in 1834: '*NO OTHER race of mankind can be found capable of doing a reasonable day's field labour in the burning sun of the Tropics.*'<sup>13</sup>

One far-reaching solution to the problem of labour was to reconfigure the state's capacity to use force. Some planters nurtured hopes that by destroying the ex-slave provision grounds, by arming the police of the interior, and then by promulgating vagrancy laws, 'with such force to back them as may make opposition hopeless', a starving population could be compelled to return to the estate.<sup>14</sup> This line of thinking seems to have informed the colony's legislature. In 1837 the authorities embarked on a

---

9. Enclosure of immigrant returns. Light to Glenelg, 19 November 1838. Parliamentary Papers, (P.P.) 1839, Vol. XXXIX.

10. *Demerara after 15 years of Freedom. By a Landowner*, (London 1853), p. 15. Moore, *Race* pp. 37-38.

11. Gov. Light, 'To the Freed Men and Women of the First of August', 8 October 1838. C. O. 111/158/23.

12. Adamson, *Sugar* p. 25. p. 167.

13. Original italics. Letter, *Royal Gazette* 18 June 1834.

jail-building exercise, and the following year passed a new police ordinance establishing, for the first time, police stations in the capital Georgetown and throughout the colony. This rendered the organisation of the state's forces more appropriate to the unstable social conditions and circumstances of the colony.<sup>15</sup> Provision was also made for the suppression of vagrancy. Police were given new discretionary powers. Most importantly, they were permitted to enter private dwellings or apprehend and stop, 'Night Walkers, Rogues, Vagabonds and other idle Disorderly, Lurking and suspicious persons'.<sup>16</sup> A police officer's word was sufficient for conviction, and thirty days hard labour awaited those found guilty.

These confrontational tactics risked a dangerous escalation of tension in the strained post-emancipation period. But, other less hazardous alternatives also existed for re-establishing the dominant place of planters. Namely, encouraging fresh labour, under the control of planters, into the colony. To this end, a plethora of schemes was proposed. As the *Royal Gazette* noted, as early as 1835, if only half of them were carried into effect there would be in British Guiana:

Chinamen, Malay, Hindoos, Southsea Islanders, Peones of the Spanish Main, natives of Madeira, the Canaries, the Cape Verd, and the Western Islands, Moors, Arabs, and Kroomen, mixed with emigrants from European nations...<sup>17</sup>

Clearly, when it came to the practical business of organising field labour not all planters viewed the African as crucial. In fact, the planter John Gladstone (father of the Liberal statesman, William Gladstone) speculated that bringing new immigrants into the colony would provide a financial 'set off' against existing labourers. As he expressed it, immigration would, 'make us as far as possible, independent of the negro population.'<sup>18</sup>

Amongst some of the planter community the most favoured immigrants were Europeans. More specifically still it was northern Europeans, the Germans, English, Scots and Irish, that planters hoped to see working in the colony. As news of these preferences spread they met opposition. After all, it was well known that due to the

---

14. Ibid.

15. Drawing on recent reports from the district of Berbice, the *Guiana Chronicle* concluded that: '...the same stubborn resistance to law and authority exists amongst the labouring population as we have described to prevail throughout the sections of Demerara and Essequibo.' From the *Guiana Chronicle*, 13 August 1834, printed in the *Times*, 6 October 1834. Three substantial jails outside Georgetown were constructed between 1837-1840. The majority of the inmates were of African origin. C. O. 111/242/191.

16. Police Ordinance Number 13 of 1838. Vagabond Ordinance Number 16 of 1838. C. O. 111/158.

17. Editorial. *Royal Gazette* 20 January 1835.

18. J. Gladstone to Gillanders, Arbuthnot and Co. Enclosure no. 1, 4 January 1836. P. P. 1837-1838. Vol. LII. See also Light. 'To the Freed Men and Women of the First of August', 8 October 1838. C. O. 111/158/23.

difficulties of acclimatisation Europeans were not expected to flourish in the tropics.<sup>19</sup> Views on this matter differed. The *Royal Gazette*, for its part, emphasised there were no 'constitutional' obstacles to mass European colonisation.<sup>20</sup> Others promoted the efficacy of recent therapeutic advances, such as Dr. Carl Warburg's Guiana Vegetable Fever Drops, which were sold by Georgetown druggists.<sup>21</sup> Yet, as one colony doctor later reminded his readers in 1850: 'The grand *predisposing* cause of an attack of the [fevers] was the state of the constitution, induced by a previous and recent residence in a cold climate.'<sup>22</sup> A letter to the *Times* of London described those who favoured European immigration into Guiana as 'simpletons'.<sup>23</sup>

A significant factor weighing in favour of British immigration may have lain in the perceived need to bolster the social weight of Europeans in the colony.<sup>24</sup> Although, as already suggested, not all Europeans were equally well regarded. One writer warned against importing the 'half savages from the Canaries'. He went on, 'I have said import Europeans, but I must limit the expression to English, Scotch, Irish and Germans; no other nation will do.'<sup>25</sup> The social benefits of this proposed immigration appeared to outweigh any lingering doubts about constitutions or moral degeneracy through drink.<sup>26</sup> The *Gazette* was impressed by the positive cultural advantages and racial solidarity proffered by the arrival of British labourers. Through their example of steady work they were expected to implant amongst the ex-slaves the seeds of order and civilisation, and infuse amongst Blacks 'a new spirit and feeling' of responsibility.<sup>27</sup> Replying to those who continued to cast doubt on the suitability of Europeans for estate work, the *Gazette* drew attention to the 'greater intelligence' of British workers and their ability to work

---

19. See for example, Letter, *Royal Gazette* 18 June 1834.

20. *Royal Gazette* 13 February 1834. Elsewhere, similar discussions were prompted by the need for colonisation. See David N. Livingstone, 'Tropical climate and moral hygiene: the anatomy of a Victorian debate', *British Journal for the History of Science* Vol. 32. March 1999. pp. 93-110. Annemarie De Knecht-Van Eckelen, 'The Debate about Acclimatisation in the Dutch East Indies (1840-1860), in Nicolaas A. Rupke, *Medical Geography in Historical Perspective* (The Wellcome Trust Centre for the History of Medicine at UCL, 2000), pp. 70-85.

21. Letter, *Royal Gazette* 26 June 1834.

22. Daniel Blair. M. D. *Some Account of the Last Yellow Fever Epidemic of British Guiana* (Longman 1850), p. 58.

23. Letter, *Times* 24 January 1835.

24. A leader article of the *Royal Gazette* warned against encouraging the emigration of, 'half savage dissolute and idle negro population of the exhausted West Indian colonies in our neighbourhood.' *Royal Gazette* 18 November 1834. See also John Innes, *Letter to Lord Glenelg, Secretary of State for the Colonies Containing a Report from the Personal Observation on the Working of the New System in the British West Indian Colonies* (London 1835), p. 34.

25. Letter, *Royal Gazette* 26 June 1834.

26. Editorial, *Royal Gazette* 18 June 1834.

27. Letter, *Royal Gazette* 17 June 1834.

more effectively than Negroes. 'We should not', claimed the paper confidently, 'have the slightest hesitation in matching a 100 whites against a 100 negroes for a year's experiment.'<sup>28</sup>

Guiana was never to be the colony of first choice for many European migrants.<sup>29</sup> However, small numbers of German, Irish, and English labourers (about 1000) did arrive in the colony during the following years to work under contract on Guiana's plantations.<sup>30</sup> In 1841 they were joined by far larger numbers of Madeirans. By 1845 over 5,000 Madeirans had arrived, more than any other group from Europe.<sup>31</sup> By all accounts the climate, terms of work and the conditions of labour in the colony proved very difficult for all of these groups to adjust to, although as we will see later, on some plantations little provision was made for their arrival. As early as 1836 disillusionment in official circles with European immigrants, was beginning to set in.<sup>32</sup>

The reports by the colony's magistrates on immigrants for 1838 bluntly stated the reasons for this. Mainly, it was due to a combination of drink, disease, and immigrant resistance to the strictures of plantation labour. Mortality seems to have been particularly high amongst immigrants from Madeira, although Irish and Scottish labourers suffered as well. The problem of high mortality was spread across the whole colony, even on those plantations owned and run by doctors. Dr. J. Bryden, a colony medical practitioner and plantation owner, reported that only a 'small proportion' of his twenty five Irish labourers continued to survive.<sup>33</sup> Unflattering or hostile descriptions of these immigrants soon began to surface. For example, the planter F. Chignard was typical in describing his sixty-nine white labourers employed for coffee and plantain production as, 'a weakly, filthy set of people.'<sup>34</sup>

As in England, disease was often understood in terms of social order, and as a complex interaction between individual, behaviour and place.<sup>35</sup> In Guiana, the predisposing causes of disease were cited as the moral degeneration of immigrants, (cheap drink leading to chronic levels of drunkenness) and a physical inability to work

---

28. Editorial, Royal Gazette 21 June 1834.

29. Marjory Harper, 'British Migration and the Peopling of the Empire', in Porter (ed.), Oxford History pp. 75-87.

30. Moore, Race p. 42.

31. *Ibid.* Appendix II.

32. C.O. 111/146 Gov. Carmichael Smyth to Lord Glenelg. No. 264 22 Dec 1836.

Also see Royal Gazette 7 Sept 1839.

33. Enclosure of immigrant returns. Light to Glenelg, 19 November 1838. P.P. 1839. Vol. XXXIX.

34. *Ibid.*

in the climate. 'Dissolute habits' was the label magistrates increasingly cited. This weakness of moral character, it was understood, led to problems of discipline, which in turn provided the unstable conditions necessary for the spread of epidemiological menaces, such as fever.

Some groups of immigrants appeared to have especially poor standards of behaviour. The effects of drink - insubordination and disorderly conduct - were repeatedly commented upon with regard to the Madeirans and Portuguese. One magistrate summarised the experience of Portuguese immigrants on plantation *Kitty*: 'rude in the extreme...they are addicted to drunkenness, and take every opportunity to skulk from their work.'<sup>36</sup> These perceptions of disorder, disease and mortality on Guiana's plantations spread abroad. The *Barbados Liberal* asked 'Where are the Portuguese? Where are the Germans? Where are the Irish who have been introduced?' It then supplied its readers with the answer:

The journals of the estates on which these people were located will tell the sad tale; they are most of them in their graves!<sup>37</sup>

Although not all reports about immigrants were unfavourable, it became commonplace amongst planters and in official circles that European immigration had not been a success. By 1839 the Colonial Surgeon and Physician to the Seaman's Hospital, E. M. L. Smith M. D., had written to the governor emphasising the vulnerability of Portuguese, English, and Germans to fevers and other associated maladies.<sup>38</sup> Later, in 1847 the appalling mortality suffered by Madeirans was revealed by Dr. Bonyun, the president of the *British Guianan Medical Society*. Of the 15,699 Madeirans who had arrived in the colony up to the 31 October 1847, Dr. Bonyun estimated that 6,668 had died as a result of the climate, or had fallen victim to a recent yellow fever epidemic.<sup>39</sup>

The uneven experience of European immigration pushed the colony's administration and planters into considering from what other parts of the world they

---

35. Christopher Hamlin, *Public Health and Social Justice in the Age of Chadwick. Britain 1800-1854* (Cambridge University Press 1998), p. 19.

36. Enclosure of immigrant returns. Light to Glenelg, 19 November 1838. P.P. 1839. Vol. XXXIX.

37. Letter from Guiana to *Barbados Liberal* 27 March 1839. See *British Emancipator* 26 June 1839. Other Caribbean islands which received European labour, for example Jamaica, also had disappointing results from European immigration. See enclosure no. 1. John Ewart, Agent-General for Immigrants, 30 September 1842, in Elgin to Stanley 1 May 1843. P.P. 1844. Vol. XXXV.

38. E. M. L. Smith. Acting Col. Surgeon. Enclosure no. 4 in Light to Normanby, 12 August 1839. P.P. 1840 Vol. XXXIV.

39. Eighth General Report of the Colonial Land and Emigration Commissioners. (CLEC). Dr. Bonyun's Report, Appendix no. 18. P.P. 1847-48 Vol. XXVI.

could find suitable labour. The *Royal Gazette* stubbornly maintained its positive stance towards European immigration but acknowledged that, 'The opinion that European labourers cannot endure this climate is held by many men of experience in this colony.'<sup>40</sup> One of these people was J. Gladstone who wrote about the Europeans, 'these experiments have not been successful from the influence of the climate...generally producing a reluctance to labour, [and] increasing the desire for spirituous liquors.'<sup>41</sup>

Scepticism over the resilience of the European constitution, and its apparent incompatibility with manual labour in the tropics reinforced the perception amongst elite Europeans that native people from warm climates possessed innate qualities which made them uniquely suited for heavy labour.<sup>42</sup> These sentiments are to be found in John Gladstone's dispatches to Messrs. Gillanders, Arbuthnot and Co., Calcutta merchants who were already involved in the immigration trade to Mauritius. In Indian labour, Gladstone hoped to find a people who were not subject to the deleterious effects of the West Indian environment. Other advantages soon also emerged. As Arbuthnot shrewdly and persuasively observed, Indian labourers were, 'perfectly ignorant of the place they agree to go to, or the length of the voyage they are undertaking.' Even more pertinently, given the post-emancipation weakening of planter control over the labour process, Indian labour was 'docile and easily managed'.<sup>43</sup> The Dhangur hill tribes, a region to the north and west of Calcutta, seemed especially suited to the needs of West Indian planters. It was amongst these people that merchants identified the most desirable qualities for estate labour: inexpensive, manageable, but hard working and with few cultural encumbrances. As stated by Arbuthnot, the Dhangurs 'have no religion, no education, and in their present state, no wants beyond eating, drinking, and sleeping; and to procure which they are willing to work.'<sup>44</sup> In short, the Indian subcontinent represented a potentially unlimited pool of young, able-bodied, pre-acclimatised workers.<sup>45</sup> In England, supporters of West Indian planters also turned to examine India. One such person was the Rev. Mr. Lugar, a former resident of the colony. Writing in the *Liverpool Standard* in 1839, Lugar explained his conclusions on race and health.

---

40. *Royal Gazette* 8 May 1838.

41. J. Gladstone to Sir John Hobhouse, President of the Board of Control. 23 February 1837. C. O. 111/161

42. See for example, the *Times* 21 January 1835.

43. Enclosure no. 2. Letter from Gillanders Arbuthnot and Co. to J. Gladstone, 6 June 1836. J. Gladstone to Glenelg 28 February 1838. P.P. 1837-1838. Vol. LII.

44. Tinker, *New System of Slavery* p. 63.

45. J. Gladstone to Gillanders etc. Enclosure no. 14 January 1836 in J. Gladstone to Glenelg, 28 February 1838. P. P. 1837-38. Vol. LII.

## Corridors of power: labour, migration, and health provision in British Guiana 1838-1847

I know of no population so happily constituted for our field work, as the Hill Coolies. While all others require some time to acclimatise before beginning their labours, the Hindus, born and bred in a climate even more trying than [British Guiana] seems ready formed and modelled for our particular want.<sup>46</sup>

The Indian solution to Guiana's labour problems was enthusiastically backed by the colony's Governor, James C. Smyth. Already, in 1837, he had drawn the attention of London to the numerous benefits of mass immigration and the profitable outcomes of such an enterprise.<sup>47</sup> Smyth offered a new optimistic vision of Britain's role in shaping the colonial world and of Guiana's place in the scheme – providing they had sufficient labour. Later, Governor Henry Light also gave substance and colour to the English imagination about colonial possessions:

...unwholesome swamps will disappear; thousands of acres will be reclaimed from their state of nature or abandonment; and where we now count our population by thousands, their hundred-fold increase will lay the foundation of an empire, with sources of wealth to the mother-country inferior only to her India possessions in the East.<sup>48</sup>

This theme of colonial development was pervasive within the Colonial Office, and was threaded through many of the despatches which travelled between the diverse sites of colonial power. In Guiana, however, it was immigration, more than anything else that seeded these speculative outbursts. As late as 1857 an editorial in the *Royal Gazette* spoke of how in Guiana the 'desert would blossom' should the colony be seeded with unlimited immigration.<sup>49</sup>

Planters were also encouraged to look to India due to the already existing mechanics of signing up labour. According to the historian Hugh Tinker, representatives of planters from the island of Mauritius were already actively recruiting Indian labourers in the early 1830s.<sup>50</sup> By 1835 there was a well established network of European agency houses and Indian contractors clustered around the ports of Pondicherry, Calcutta and Madras. As Tinker has discussed, scant regulation existed to manage this movement of people. In fact, the Indian authorities expressed little more than mild concern over the transport of labourers. Formal legal structures to manage this trade (permits, limits on labour contract, and minimum standards of shipping) were not established until 1837.<sup>51</sup>

---

46. Rev. Mr. Lugar. Rector of Georgetown. Liverpool Standard 27 December 1839.

47. Smyth to Glenelg, 14 October 1837. P.P. 1837-1838. Vol. LII.

48. Light's address to the Combined Court 19 February 1839. Extracts from papers relative to the West Indies (London 1840), p. 199.

49. Royal Gazette 17 February 1857.

50. Tinker, A New System of Slavery p. 61.

51. Enclosure no. 2 in Hobhouse (India Board) to J. Gladstone, 25 February 1837. P.P. 1837-1838. Vol. LII. Tinker, A New System of Slavery p. 64.

### Corridors of power: labour, migration, and health provision in British Guiana 1838-1847

Notions of race, theories of acclimatisation, cultural judgements, and the administrative power to organise large groups of people, as well as the tacit support of colonial authorities, were all factors which helped draw West Indian planting interests to the shores of India in search of labour. Suitably impressed by the opportunities for meeting his commercial needs, Gladstone authorised agents to select prospective emigrants between the ages of twenty and thirty, who were free from disease, and in possession of full physical and mental faculties. Once on board ship their welfare was in the hands of surgeons. Provision was made for paying bounties (5s. per head to the Captain, and 2s. 6d. per head to the chief mate and ship's doctor) for each labourer landed alive.<sup>52</sup> Gladstone's *Whitby* with 249 immigrants set sail from Calcutta on the 13 January 1838 arriving in Guiana 112 days later on the 5 May. On the 29 January a second ship, the *Hesperus* with 165 persons on board, also left Calcutta for Guiana.<sup>53</sup>

Gladstone's instructions over the importance of maintaining immigrant health may have been expected to undermine potential criticism of the scheme. In fact, the discovery of Gladstone's project elicited considerable opposition in Britain, and it is to this that we now turn.

### 1.3 Immigration and imperial governance: Britain and India

This section of the chapter sees the closure of immigration to Mauritius and the West Indies. The process begins soon after Gladstone's scheme becomes known. The British Parliament, of the 1830s was an institution which exhibited increasing professionalism, and had begun to grapple with a number of important social issues. Correspondingly, it showed an appetite for intervening in the social organisation of society. The first Factory Act and the 1834 Amendment to the Poor Law Act indicate that working populations were now appropriate subjects for parliamentary examination.<sup>54</sup> Under the influence of Whigs, such as Earl Grey, a measure of political reform and the abolition of slavery had also been achieved. Both of these factors had

---

52. Enclosure no. 6. J. Gladstone to Gillanders etc. 10 June 1837 in J. Gladstone to Glenelg, 28 February 1838. P.P. 1837-1838. Vol. LII.

53. The *Whitby* immigrants comprised of 233 males, five females and six children. The *Hesperus* immigrants comprised of 135 males, six females and eleven children. Dwarka Nath, A History of Indians in Guyana (London 1970), p. 11.

54. Eric J. Evans, The Forging of the Modern State. Early Industrial Britain 1783-1870 (Longman 1983), pp. 228-231.

allowed the government to accrue a considerable amount of political legitimacy which they were not going to squander in blatant support for West Indian interests.<sup>55</sup>

Although slavery had been abolished in the British West Indies by 1834, this had not ended the role of the abolitionist societies in Britain. When it became clear that West Indian planters intended to continue production under the umbrella of 'apprenticeship', demands arose for a complete and thorough emancipation. The *British Emancipator*, the official journal of the Anti-slavery Society, maintained that 'apprenticeship' merely substituted 'one state of slavery for another'. This was a widely held belief in the abolitionist movement, and is shown by the extraordinarily high number of anti-apprenticeship petitions collected and sent in to parliament<sup>56</sup> The historian Claire Midgley has estimated that between 1837 and 1838, there were 4,175 of these petitions, containing more than one million signatures, presented to the House of Commons.<sup>57</sup> Domestic issues around political reform and 'rights' gave these demands special pertinence. The year 1838 also saw the publication of the 'Peoples Charter' and the first stirrings of Chartism. Many of the individuals in these organisations were sceptical of parliamentary manoeuvring and gradualism.<sup>58</sup> As the abolitionist Joseph Sturge later acknowledged, limiting the movement only to those who were committed to 'pacific means' was a stance 'which some of our friends feel most difficulty in adopting.'<sup>59</sup>

News of Gladstone's scheme to transport labour from India to the West Indies was quickly gathered up in the groundswell of anti-apprenticeship activity. The first parliamentary indication of this was a speech by the Whig abolitionist and social reformer, Lord Brougham, to the Lords on the 6 March 1838. Recalling the lofty ideals of the British anti-slavery struggle, Brougham linked indentureship to slavery. The emotional potency of such claims was high. The 'traffic' in Indian labour at the behest of West Indian planters was, according to Brougham a 'cruel and unjustifiable trade'. It

---

55. Robin Blackburn, *The Overthrow of Colonial Slavery 1776-1848* (Verso 1988), pp. 465-466.

56. Petitions against the apprenticeship system were presented to parliament in March 1838. According to the *Times* the petitions, '...proceeded from all classes and sects of the community, and among them were a vast number from corporate bodies and from public meetings.' *Times* 30 March 1838.

57. Claire Midgley, *Women Against Slavery. The British Campaigns 1780-1870* (Routledge 1992), p. 67. J. Walvin, 'The Propaganda of Anti-Slavery', in J. Walvin (ed.), *Slavery and British Society 1776-1846* (Louisiana State University Press 1982), p. 64. Betty Fladeland, 'Our cause being one and the Same': Abolitionists and Chartism', in Walvin, *Slavery* p. 69-99. See also Douglas A. Lorimer, *Colour Class and the Victorians. English attitudes to the Negro in the Mid-nineteenth Century* (Leicester University Press 1978), p. 115.

58. The possibility of abolitionist women's demonstrations outside parliament, rather than the gentlemanly presentation of petitions inside parliament, was mooted by women's abolitionist committees. Midgley, *Women* p. 86.

59. *British Emancipator* 1 May 1839.

degraded all those who participated, and, like the slave trade, was open to 'monstrous abuse.'<sup>60</sup> Damningly, an editorial in the *Times* of London called it the 'New Slave Trade'.<sup>61</sup>

Slavery from Africa to the New World and the Caribbean had for a long time been associated with notorious levels of mortality in what had become known as the 'middle passage'. It followed that if the conditions accompanying Indian emigration were comparable to those of slavery, a similarly high mortality could be expected. A detailed knowledge of the condition of immigrants on the state of their arrival, and subsequent fate on the plantation, was therefore crucial for both abolitionists, and for those in government sympathetic to free labour. Here, as elsewhere in the political world decisions hinged on the gathering, analysis and presentation of information. Lord Glenelg,<sup>62</sup> a renowned humanitarian and Secretary of State for the Colonies, stressed to Governor Light in May 1838 the importance of the home government being closely acquainted with labouring conditions in Guiana.<sup>63</sup> Later, in November, Glenelg again emphasised to Light the 'great importance' of acquiring detailed information about the situation in Guiana, including the names, sexes, ages, and health of all recently introduced immigrants.<sup>64</sup> Light's reassuring reply, which reported upon the 'general good health of the emigrants from India', offered considerable hope that parliamentary pressure over the issue would ease.<sup>65</sup>

This was not to happen. Brougham, in the Lords, cited mortality figures for Indian emigrants travelling to Mauritius, in order to cast doubt on the ability of shippers to transport safely labourers across the much further distance of the Indian and Atlantic oceans.<sup>66</sup> Continual doubts were raised over whether planters who had only recently defended slavery were competent to supervise or administer a system of indentured labour.<sup>67</sup> The case for suspending the transport of labourers to the West Indies was further strengthened after a delegation from the Anti-Slavery Society visited Guiana and reported on the poor hospital facilities available in the colony. This factor is looked at in more detail later.

---

60. Brougham, *Times* 8 March 1838.

61. *Times* 8 March 1838.

62. For an understanding of the Colonial Office under Glenelg, see Ronald Hyam, *Britain's Imperial Century 1815-1914. A Study of Empire and Expansion* (Macmillan 1976), pp. 83-84.

63. Glenelg to Light, 26 May 1838. P. P. 1839. Vol. XXXIX.

64. Glenelg to Light, 6 November 1838. Ibid.

65. Light to Glenelg, 19 November 1838. Ibid.

66. Brougham. *Times* 8 March 1838.

The response of parliament to this campaigning was, nevertheless, guarded, and in the end it preferred regulation, not abolition. As Glenelg commented to Light, 'there seems no reasonable doubt that a well conducted plan of immigration would be advantageous to the colony.'<sup>68</sup> In May 1838 a Natives of India Protection Bill was put before the house. This bill limited the duration of written labour contracts to just one year and forbade West Indian planters from arranging the contracts before immigrants landed in the colony.<sup>69</sup>

In India, evangelical and reformist opinion was also gathering against the transportation of labourers to the West Indies. The *Calcutta Courier* reported abuses in the treatment of labourers aboard Gladstone's ship, *Hesperus*. As with the abolitionist movement in England, the *Courier* recalled the imagery and conditions of overcrowded slave boats, claiming that ruthless guards extorted payments in return for access to fresh air. Deaths on board were, 'certainly accelerated, if not wholly caused, by the continuous confinement, in the mephitic atmosphere.'<sup>70</sup> The *Friend of India*, an influential organ allied with the Baptists, associated the transportation of labour abroad with the 'horrors of the middle passage'.<sup>71</sup> The *Calcutta Christian Observer* reminded its readers of the 'evils' of the apprenticeship system, alleging it to be worse than slavery.<sup>72</sup> So too did the *Chundrika Bengale* and the *Bengal Hurkaru*, which drew particular attention to the harsh working conditions of plantation production in Mauritius, and its similarity with slavery.<sup>73</sup>

These views and opinions sat uneasily with the paternalistic image of Company rule promoted by ambitious administrators. At this time a demonstration of 'good governance' was sought through evidence of the moral improvement of Indian society via education, land reform, changes to the ancient judicial system, and not least, the collaboration of Indians themselves.<sup>74</sup> The campaigns against Thuggee, the repression of

---

67. *British Emancipator* 31 January 1838.

68. *Royal Gazette* letter dated 19 December 1838. No. 86.

69. Order in Council 30 July 1838. P. P. 1837-1838. Vol. LII.

70. *Calcutta Courier*. See *British Emancipator* 2 May 1838.

71. *Friend of India*. See *British Emancipator* 23 May 1838.

72. *Calcutta Christian Observer*. See *British Emancipator* 2 May 1838.

73. *Chundrika Bengale*. See *British Emancipator* 23 May 1838. Basedo Mangru, *Benevolent Neutrality. Indian Government Policy and Labour Migration to British Guiana 1854-1884* (Hansib 1987), pp. 5-6.

74. Eric Stokes, *English Utilitarians and India* (Oxford 1959), p. 45, 46, 54, 65. Thomas R. Metcalf, *Ideologies of the Raj* (Cambridge University Press 1995), p. 33. Ranajit Guha, 'Dominance Without Hegemony And Its Historiography', *Subaltern Studies VI* (Oxford University Press 1989), pp. 240-249. Howard Temperley, 'The Delegalisation of Slavery in British India,' *Slavery and Abolition* Vol. 21. August 2000. pp. 168-187.

sati and internal slavery, offered opportunities for the British to maintain the moral high ground and take pride in their commitment of reforming 'despotic' Indian society.<sup>75</sup>

The outcry in the summer of 1838 over the condition of Indian indentured labourers landed on an administration whose professed political stance favoured movements against institutional oppression. William Wilberforce Bird, an evangelical, and acting Governor of Bengal promptly responded to accounts of mistreatment of Indian labourers in Demerara. On the 11 July 1838 the Governments of Bombay, Madras, and Bengal were instructed to prevent 'coolie' emigration to the West Indies. By November 1838 the prohibition on labour was extended to Mauritius and all other colonies. Finally, a Commission of Enquiry in respect of the large numbers of Indian labourers exported to Mauritius was convened on Bird's initiative.<sup>76</sup>

In summary, both the Indian and British governments had therefore acted to curtail the transport of Indian labour by the autumn of 1838. As suggested earlier, an important dimension of this abolitionist discourse also depended upon perceptions about conditions on estates. In the next section the narrative shifts back to the colony of Guiana, to the period immediately before the cessation of immigration to examine the state of hospitals and medical provision in the post-emancipation period.

#### **1.4 Medical provision, the plantations, Georgetown and hospital legislation**

Under slavery the health care of labourers was undertaken by the plantation. Health was a cost of production. Decisions about health, such as the allocation of resources to hospitals, were extremely vulnerable to the vicissitudes of plantation economics. As Barry Higman has pointed out, it was only on the largest of estates in the West Indies that a 'substantial' hospital was likely to have been provided.<sup>77</sup> Beyond this point generalisations about the quality of care provided to slaves are problematic as within each island the conditions of life varied. Another problem in analysing slave health is the highly politicised nature of the documentation. In Guiana the British government in 1825 instructed the colony's legislature to include medical provision in legislation designed to ameliorate the conditions of slaves.<sup>78</sup> Thus:

---

75. Metcalf, *Ideologies* p. 41.

76. Tinker, *A New System of Slavery* pp. 64-65.

77. Higman, *Slave Populations* p. 268.

78. In 1825 an Ordinance was enacted to provide monetary rewards for slave women who successfully gave birth to a healthy child, and to provide on each estate, a: '...sick house, furnished with proper conveniences and attendance for the sick.' *Demerara and Essequibo Vade Mecum* pp. 14-15.

## Corridors of power: labour, migration, and health provision in British Guiana 1838-1847

On every estate there shall be a commodious *hospital*, and a legally qualified medical practitioner employed to attend the sick; medicine, proper food, and all necessities to be provided; and a register of all cases to be kept.<sup>79</sup>

This statement, however, cannot be taken as a definitive description of medical provision in the colony. Laws to improve the condition of slaves were themselves embroiled in claim and counter claim by the supporters and opponents of slavery, and personalised reports of hospitals and medical provision were charged with polemical rhetoric.<sup>80</sup> According to calculations made by Higman, Guiana had a particularly poor record with regard to slave mortality, although it is difficult to say how far this reflects conditions or medical practices in slave hospitals. Either way, compared to its neighbour Trinidad, Guianan birth rates were lower, and its death rates were higher for most years between 1817 – 1833.<sup>81</sup> On the other hand, there is also evidence that some plantations in Guiana did take tangible initiatives in response to poor slave health. Slave inventories often included sick nurses and occasionally fairly substantial financial commitments for medicines.<sup>82</sup> Given the poor archival sources available, it is difficult to assess how far these traditions of care were carried over into the post-abolition period. However, there was a new Medical Ordinance which was passed in 1834. This specified that on every estate, where more than forty labourers worked, a medical practitioner was required to visit the estate weekly. The doctor was instructed to maintain a journal containing the names of the sick, and record the medicines or victuals necessary for the restoration of the patient.<sup>83</sup>

What remains important for the discussion here is governmental and public perception of medical provision in the colony and the treatment of labourers on the plantations. As already discussed, pejorative descriptions of plantation conditions were capable of mobilising support for the abolitionist cause. This was also true in the post-emancipation period. The historian Richard Sheridan has shown how during slavery plantation hospitals were criticised as places of violence, restraint and punishment.<sup>84</sup> According to the *British Emancipator*, (which wanted to halt the trade in labour) this

---

79. J. Ridgway, An Abstract of the British West Indian Statutes for the Protection and Government of Slaves (London. MDCCCXXX), p. 39.

80. See for example: Alexander M'Donnell, Considerations on Negro Slavery with Authentic Reports Illustrative of the Actual Condition of the Negroes in Demerara (London 1824), p. 206.

81. Higman, Slave Populations p. 310.

82. For example, the plantations *Goede Verwachting*, *Mon Repos*, *Young Rachel* and *L'Incertitude* had all built new hospitals by 1817. In 1825 *Vreed en Hoop* had a hospital with an estimated 1600 square feet. John Gladstone Papers. 2774, 2796, 2798. See also Bristol University. West Indies handlist part 3. DM 78/192, DM 78/193.

83. Medical Ordinance 1834. no. 43.

disciplinary character of the institution was carried over into the post-emancipation period. Writers for the journal also identified other continuities with past practices including flogging, prison, solitary confinement, hard labour on the treadmill, or in the penal gang, and use of the stocks. Amongst those punished, claimed the *Emancipator*, were the 'young, the aged, and infirm, nursing mothers, and pregnant females'.<sup>85</sup> In addition, the journal noted, whereas previously under slavery plantation managers had ensured there was sufficient food and other provisions for labourers, under the system of apprenticeship this practice had been abandoned.<sup>86</sup> Although the emancipated slave was now technically 'free', so too was the plantation manager 'free' from many of their former legal duties. Labourers from plantation *Affiance* addressed the local magistrate thus:

We are told we must pay for our provision ground, doctors fees, finding ourselves with all the necessarys, etc. What will be remaining for us in case of sickness?<sup>87</sup>

Women on the estates appeared to be doubly bound by the need to work and to tend to infants. The *Emancipator* published this quotation from the plantation manager Mr. Huie:

I make no difference respecting the hours of labour for apprenticed labourers whether under the age of fourteen or above the age of sixty. I send women to cut canes who have young children at the breast. No allowance is made in their favour in regard to work. I make no difference in regard to the hours of work. I make no difference with regard to the hours of labour for pregnant women. I have heard it rumoured that pregnant women were only to work six hours, but I did not believe it. My reason for not believing it was that the act of manumission did away with all former acts with regard to pregnant women.<sup>88</sup>

The journal also supplied anecdotal evidence of an increase in child mortality. In the abolitionist movement this factor was understood to be an exceptionally effective index of wider plantation conditions.<sup>89</sup> Medical treatment on the estates was heavily criticised, particularly the practice of doctors attaching themselves to several plantations and taking a flat fee for treating labourers.<sup>90</sup> In particular, descriptions of poor medical provision and high mortality rates on John Gladstone's estates provided valuable ammunition against any reintroduction of the Indian immigration scheme, and a platform upon which broader attacks on metropolitan privilege could be mounted. The

---

84. Sheridan, *Doctors* p. 270

85. *Ibid.* 3 October 1838. p. 57.

86. *British Emancipator* 16 May 1838. p. 90.

87. Quoted by Douglas Hall, 'The flight from the estates reconsidered: The British West Indies, 1838-1842', in Beckles and Shepherd (eds.), *Caribbean Freedom* p. 57.

88. *British Emancipator* 16 May 1838. p. 90.

89. *Ibid.*

journal pointed out to its readers that through the 'plundered wages' and 'wasted frames' of plantation workers, absentee proprietors in London or Liverpool gained social standing and political influence in society.<sup>91</sup> The contrast of privileges accrued by proprietors such as Gladstone and the treatment they meted out to their labourers could not have been greater. John Scobel, the secretary to the Anti-Slavery Society, gave this first hand (and therefore especially 'authentic') description of what awaited Gladstone's 'Hill Coolies' on the *Belle-Vue* estate should they become ill.

The house itself was wretchedly filthy, the persons and the clothes of the patients were filthy also; the poor sufferers had no mats nor mattresses to lie on; a dirty blanket was laid under them *and their clothes wrapped together formed a kind of pillow*. In one room where there were raised boards for the accommodation of seven persons only, eleven were confined-four of them lying on the floor. The squalid wretchedness of their appearance, their emaciated forms, and their intense sufferings from disease and sores, were enough to make the heart bleed! In the second room were found a worse class of patients. The scene in this room beggars description; out of the five confined there, two were dead, and one of the remaining three cannot long survive; should the others recover, it will be by a miracle - their bones appeared ready to protrude through their skin.<sup>92</sup>

The *Emancipator* maintained that instances of abuse in Guiana were so numerous, varied in circumstance, and uniform in character, that poor treatment of immigrants represented a '*general rule*', a stance which logically pointed to a total cessation of immigration.<sup>93</sup> This view was echoed amongst influential opinion formers in Britain. According to the *Times*, West Indian planters had reproduced the 'abomination' of slavery merely adding 'modern refinements'.<sup>94</sup>

As these accusations surfaced in Britain the colony's Governor, Henry Light set about challenging and undermining the abolitionist critique of Guiana. This was done, in the first instance, through a Commission of Enquiry, and by removing the sick and dying immigrants on the *Belle-Vue* estate to the colonial hospital for, 'humane care and skilful treatment'.<sup>95</sup> The colony's magistrates were commanded to compile reports on the conditions for labourers on the estates, and as a result further cases of poor treatment, unwarranted confinements, beatings and inadequate hospital care surfaced.<sup>96</sup> This suggests that the glimpse of plantation life supplied by the *Emancipator* was not

---

90. Ibid. 30 May 1838. p. 106.

91. Ibid. 31 January 1838.

92. John Scoble, HILL COOLIES. A Brief Exposure of the Deplorable Condition of the Hill Coolies in British Guiana and Mauritius and of the Nefarious Means by which they were Induced to Resort to these Colonies (London 1840), p. 13.

93. *British Emancipator* 16 May 1838. p. 90.

94. *Times* 29 July 1839.

95. Ibid. p. 14.

restricted to the Gladstone estates, but represented a wider social order. In the most extreme cases of mistreatment, Light ordered the prosecution of individuals.<sup>97</sup>

Crucially however, Light claimed that incidences of maltreatment were isolated, and that the accompanying accusations of high mortality aboard immigrant ships were unwarranted. The worst ship mortality had occurred on the *Hesperus* where just under eight percent of the passengers (thirteen) had died. From the perspective of the colonial administration in Guiana, who were perhaps aware of the still significant rates of mortality on the sea route from Liverpool to America, this level of death was quite acceptable.<sup>98</sup> For the most part Light cast the accusations of 'coolie' mistreatment as politically fuelled exaggerations.<sup>99</sup> On the question of disease the governor and proprietors were united. Gladstone claimed that the 'seeds' of disease which struck down his labourers had been brought to the colony from Bengal.<sup>100</sup> Light also carefully pointed out to the Colonial Office the 'indifference' of Indian immigrants to western medical treatment and to their 'filthy habits'.<sup>101</sup> This racialising of health by ascribing the causes of disease to cultural practices, soon became a common thread of thinking amongst the colony's doctors. Finally, Light located the problems of immigrant mortality in the Indian selection procedures, methods of immigrant regulation, and processes of supervision. On this last point, the governor received support for his opinion from the surgeons on board the *Hesperus* and *Whitby*.<sup>102</sup> Both surgeons testified to the weak regulatory regime at Calcutta.<sup>103</sup> Mr. Wiseman, a former assistant at Haslar Hospital, and ship's surgeon on the *Whitby* stated he had 'strongly remonstrated' against sailing with the 'old and infirm' and the 'diseased', who he discovered amongst his passengers.<sup>104</sup>

The question of immigrant health had, therefore, by 1839, become a central issue for the colony's government and had assumed a global dimension. This is evident in the raft of letters, descriptions, claims and counter claims which circulated between the

---

96. P. P. Vol. XXXIX. W. B. Wolseley. Enclosure no. 8 in Light to Normanby, 13 April 1839. H. E. F. British Emancipator, 16 May 1838. p. 91.

97. Nath, History pp. 15-17.

98. Robin Haines and Ralph Shlomowitz, 'Explaining the Modern Mortality Decline: What can we Learn from Sea Voyages?', Social History of Medicine 1998 Vol. 11, no.1. p. 23, 33.

99. Light to Normanby, 8 May 1839. P.P. 1839. Vol. XXXIX.

100. Gladstone to Normanby, 3 August 1839. P.P. 1839. Vol. XXXIX.

101. Light to Normanby, 13 April 1839. P.P. 1839. Vol. XXXIX. Light to Normanby, 21 May. 1839. P.P. 1839. Vol. XXXIX.

102. Richmond M.D. Enclosure no. 2 (Report on the General Health of the Coolies...in the Ship *Hesperus*) in Gladstone to Normanby, 3 August 1839. P.P. 1839. Vol. XXXIX.

103. *Ibid.*

### Corridors of power: labour, migration, and health provision in British Guiana 1838-1847

colonial governor's office, various magistrates, representatives of estates and parliament. Naturally, the official view from the colony was very much in favour of reopening immigration from India. Governor Light repeatedly emphasised that 'under proper regulations' emigrants from every port in the world could be safely transferred to Guiana.<sup>105</sup> In fact, by the time Light wrote these words the colony had already set about establishing a bureaucracy for supervising immigrants.

The principal gesture to metropolitan abolitionist and parliamentary opinion was the establishment of an 'Agent for Emigrants'. In October of 1838 W. B. Wolseley, the Assistant Government Secretary was appointed to this post.<sup>106</sup> Despite this reform the statutory powers and duties under which Wolseley worked remained undefined. Generally, he was expected to ensure that accommodation, food, and medical treatment for indentured immigrants were available, sufficient, and accessible, although he was given few resources to put these aspirations into effect. It is clear, as the following comment shows, that Light remained sceptical that the colony had gone far enough to placate opinion at home. In a speech to the Court of Policy in 1843, he stressed the importance that:

...our laws shall not only look well on the statute book, but moreover be provided with suitable administrators, so as to secure their practical operation in favour of the emigrant.<sup>107</sup>

Governor Light also wanted non-indentured labourers and other immigrants who worked on the estates covered by medical legislation. Plantations were under no legal obligation to provide health care to immigrants, such as Madeirans, who arrived under their own recognisance. In 1841, a Bill to provide for Rural Hospitals (open to all categories of worker) was put before the Court of Policy. This reform was rejected, highlighting the profound differences of opinion which continued to exist in the colony over the place of medicine in society, and of the plantations' role in organising their own independent procedures of care.<sup>108</sup>

One effect of the collapse of the rural hospital scheme, and the inability of plantations to provide suitable care for all of their workers, was that an increasing number of immigrants sought medical treatment at the colonial hospital in

---

104. Wiseman. Enclosure no. 1 in A. Colville to Labouchere, 31 July 1839. P.P. 1839. Vol. XXXIX.

105. Light to Normanby, 27 June 1839. P.P. 1839. Vol. XXXIX.

106. Enclosure no. 1 (Report of the Commissioners appointed to inquire into the State of the German, Portuguese, Coolie, and Maltese Immigrants) in Light to Normanby, 27 June 1839. P.P. 1839. Vol. XXXIX.

107. 27 September 1843. C.O. 116/16/295.

108. Royal Gazette 4 May 1843.

Georgetown.<sup>109</sup> This coincided with the beginnings of a steady migration to Georgetown from the countryside as individuals attempted to find alternative forms of employment. James Rodway, the nineteenth century historian of Guiana, noted that after emancipation the city swelled with 'idlers' the sick, and paupers from the estates.<sup>110</sup> This included lepers who were noted for theft. The question of immigrant health therefore touched on European anxieties about order and behaviour, crime and disease.<sup>111</sup> In the eyes of officials, healthy and industrious labourers, outside the tempering influence of the plantation, could quickly transform into unhealthy vagrants, those who 'wander the roads, sicken and die'.<sup>112</sup> These groups were especially troublesome to the authorities who were attempting to construct a new post-slave social order. Itinerants, who inhabited the urban fringes, or roamed about the countryside begging, were beyond the ordinary operations of authority and discipline, which had traditionally rested with the plantation. Laws existed to discourage vagrancy, but they were of little effect when it came to preventing sick immigrants drifting towards the urban environment.

The *Royal Gazette* was struck by the geographical origin of the patients in the colonial hospital – the vast majority of individuals treated were recent immigrants from Madeira.<sup>113</sup> Thus, with each passing year the hospital was treating more individuals, most of whom came from abroad, raising concerns that the 'general population' was being crowded out.<sup>114</sup> This forced expansion of the hospital's work also required extra funding. In 1846 expenses for the Georgetown Hospital were \$41,764; the following year provision had leapt to \$60,000.<sup>115</sup> In the same year a snap inspection of the hospital by the Hospital Board of Directors and Governor Light confirmed the *Gazette's* earlier observations, leading to pressure for a fundamental reorganisation of the colony's health provision, namely the:

re-establishment of the plantation Hospitals in the rural districts so as to obviate...the present practice of Coolies and other immigrants who may be sick, or having sores, resorting so generally to the metropolitan Public Hospital.<sup>116</sup>

---

109. Gov. Walker. Despatch. 4 December 1848. C.O. 111/260.

110. James Rodway, *The Story of Georgetown* (reprint, Georgetown 1997), p. 54.

111. Wodehouse was specifically referring to the problem of lepers. Governor Wodehouse. Despatch. 11 February 1856. C.O. 111/309.

112. *Ibid.*

113. *Royal Gazette* 2 March 1843.

114. Dr. Daniel Blair wrote to the Hospital Board explaining that the hospital population had quadrupled since 1843. Letter to Board of Hospitals 15 October 1846. C.O. 114/16/408.

115. C.O. 114/17. Minutes of the Court of Policy. 22 May 1847.

116. Minutes of the Special Meeting of the Board of Directors of Hospitals, 7 October 1846. C.O. 114/16/408.

This demand was echoed by the *Guiana Medical Society* which claimed that the main cause of mortality was not the climate, but the, 'general and total want of proper hospital accommodation on estates.'<sup>117</sup> The *Society* also criticised the 'insalubrity' of immigrant accommodation, the low remuneration given to the medics, and referred to the difficulties procuring the cost of proper medicines from the estates. Altogether, these views helped provide a climate for agreement in the colony's legislature over the need for new health legislation. In March 1847 the *Ordinance to Provide Medical Treatment and Medicines for Immigrant Labourers* finally passed onto the colony's statute book. This legislation eventually included: the mandatory provision of hospitals on estates; the registration of medical practitioners; the requirement for inspections; the importance of systems to record patients names, and treatment. Rules, regulations and books of records were going to characterise the delivery of plantation medicine.<sup>118</sup>

However, not all workers were to benefit from these measures. Mandatory health care was only extended to indentured, rather than non-indentured or 'free' labourers.<sup>119</sup> This fell far short of Governor Light's original Rural Hospital scheme which had included free medical treatment for all estate workers. Thus, non-indentured employees were, 'bound to work for such employer until he shall have paid him all costs, charges, and expenses of such sickness, medicines and nourishment.'<sup>120</sup> Discretion was left to the plantation in deciding these costs. Yet, despite this limiting of free care, Light regarded the proposed legislation as a significant step forwards. It set out in the fullest possible manner the obligations and duties of plantations to their indentured labourers.<sup>121</sup> Moreover, the cost of this scheme, the hiring of doctors, the provision of medicines and utensils, fell upon the plantation and not on the revenue of the colony.

Plantations also had their former powers to compel workers into hospital restored. This reflected their ability to temper legislation for their own interests. Plantation owners pointed to the way the 1834 Act of Abolition had removed their legal right to confine sick labourers to hospital, and how immigrants routinely 'refused medicine'. For example, plantation owner A. Colville, claimed there was a 'great

---

117. Guiana Medical Society, 15 July 1847. C.O. 114/17/21.

118. Report of Committee on Hospitals in the Rural Districts. C.O. 114/17/17.

119. The point at which medical treatment became available was later reduced to six months. An Ordinance to Provide Medical Treatment and Medicines for Immigrant Labourers. C.O. 114/17.

120. Ordinance to Provide Medical Attendance and Medicine for Immigrant Labourers. No. 4. 1847. C.O. 114/17.

121. Light to Grey, 29 March 1847. No. 58. C.O. 111/242/278.

difficulty in inducing the sick to follow out any regular course of treatment, either in point of medicine, food, or regimen.<sup>122</sup>

The 1847 Medical Ordinance, therefore, not only made provision for the better treatment of indentured labourers but re-established in law the authority of the doctor and plantation manager over labourers in matters of health. The potential for abuse raised concern in London, to which the Guianan Attorney General replied, deploying the language of paternalistic rule:

It may seem strange that an employer should be authorised to compel a sick immigrant to enter the hospital - such an authority is however necessary for the obstinacy with which all immigrants resist medical treatment in the first stages of sickness, and in fact until it is too late...Immigrants - especially those from Madeira and Asia resemble overgrown children rather than adult men and women, and hence it is necessary for such an application of mild coercion, as will secure to them the advantages of this ordinance.<sup>123</sup>

This power to compel labourers to enter the hospital indicated more than a legal modification of health provision in British Guiana. It completed a system of regulatory control which stretched from Africa and India to Guiana. From selection, to ship (discussed below), to plantation, to hospital, power was located in spaces where European authority held sway. This last authority, directing immigrants into plantation hospitals, was conferred very widely to the various managers and European staff on estates. It included: all employers, mistresses, foremen, attorneys, agents, overseers, clerks, and any other person engaged in hiring or superintending the immigrant labourer. Formally at least, once in the hospital, the immigrant was now subject to regulations established by the medical practitioner, but recognised in law as binding upon the immigrant.

### 1.5 Culture, power and medical practice in the colonial hospital, Georgetown

As already touched upon, the character of the colonial hospital in Georgetown, and also that of the hospital in New Amsterdam, was transformed by the introduction of immigrants into the colony. Both hospitals were pressed into use by the colonial authorities in order to meet the health needs of immigrants. The changes that these hospitals underwent were fundamental and permanent. They are discussed in this section, particularly with regard to the Georgetown Hospital.

---

122. A. Colville to Labouchere, 29 July 1839. P.P. 1839. Vol. XXXIX. See also enclosure no. 4 in Light to Normanby, 27 June 1839. P.P. 1839. Vol. XXXIX, and enclosure no. 2 in Light to Russell, 20 June 1841. P.P. 1840. Vol. XVI

123. William Arrindall, 30 March 1847. C.O. 111/242/286.

By the end of the 'Apprenticeship' scheme in 1838 the colonial hospital in Georgetown was staffed, organised and run very much as it had been during slavery. The hospital was primarily intended for use by visiting sailors and by the European poor who were unable to afford the cost of a doctor when sick.<sup>124</sup> The 1841 census gave the numbers of individuals from Great Britain residing in the colony as just 2,172.<sup>125</sup> Given the hospital's focus on Europeans, it was a justifiably small institution, although the population of Georgetown as a whole had risen to just under 20,000 by 1840.<sup>126</sup> During the five years previous to 1839, the daily average of patients rarely exceeded thirty. The gender divide was also unmistakable, almost all of the hospital's patients were male; neither women nor children seem to have been treated there.<sup>127</sup> Inside the hospital, a regime of rules and regulations, which stressed (in a similar manner to many English hospitals) the charitable nature of the institution, marked out the duties of staff and patient alike. Patients were required to:

Conduct themselves in a quiet and orderly manner; to submit themselves to the treatment ordered by the Medical Officers; to assist each other as far as may be compatible with their state, remembering that they themselves are receiving charitable aid...on pain of instant dismissal.<sup>128</sup>

Attached to the side of the hospital was a dispensary where medicines and advice were available to out-patients. However, this service does not seem to have been widely used. In 1840, the Colonial Surgeon reported that just 216 individuals had been seen by the out-patient dispensary.<sup>129</sup> For the vast majority of Georgetown inhabitants, who were mainly Creole Blacks, the colonial hospital was not, therefore, an important institution. Neither did the hospital have any particular special role to perform with regard to plantation workers.

As already discussed, this limited framework of care came under pressure with the arrival of immigrants into the colony, forcing the Hospital Board to rethink the role of the institution. The minutes from one of the Board meetings explained that not only did the category 'pauper' have a legitimate claim on the Public Hospital, but so too did that of the 'stranger'.<sup>130</sup> However, the implications of this were wide, going far beyond the current hospital practice of providing 'mere' charity. With regard to the treatment of

---

124. Royal Gazette 11 July 1839.

125. 1841 census report. C.O. 115/7.

126. According to the 1841 census report, Georgetown's population was 18,586. C.O. 115/7.

127. Report of the Colonial Hospital. Royal Gazette 12 March 1840.

128. Regulations of the Demerary Colonial Hospital 1839. C.O. 111/256.

129. Report of the Colonial Hospital. Royal Gazette 12 March 1840.

immigrant plantation workers, health and wealth were woven into the issue. As Dr. Smith the Colonial Surgeon calculated:

If the wages earned by a healthy labourer be the measure of the value of that labourer's health and life to the state, it is evident that (the state) is benefited in the same measure whenever a labourer, through the instrumentality of its hospitals, is saved from death or chronic disease.<sup>131</sup>

Underpinning professional and curative aspirations, there prevailed a close identification of the colony's economic wellbeing with bodily vigour. Treating immigrant labourers was not an end in itself, nor a gesture of medical generosity, nor charity, but was emerging as part of an elaborate social system whereby the sick were returned to work. The commercial health of the colony and the health of the labourer were therefore bound up in the institutional practices of the colonial or Public Hospital.

The outcome of these sentiments was the reorganisation and expansion of the Georgetown Hospital. One of the first indications of this shift was a change in attitude towards funding the hospital. In 1840, Smith thanked the Board of Management and Governor for endorsing a new financial 'liberality' and for increasing the numbers of staff.<sup>132</sup> Recent appointments included a Resident Dispenser, steward, matron, interpreter, a number of new male and female nurses, and 'drudges'.<sup>133</sup>

The rapidly altering character of the hospital was evident in a dramatic fourfold increase in the daily average of patients treated there in 1840. The categories of person treated also changed as women and children (these were almost certainly immigrants) began to be admitted. The majority of the hospital's patients were still European – but now they were European immigrants (Irish, Scottish, German, Danish, French, Dutch, Italian, Spanish and Polish) rather than long-term colony residents. Alongside them, jostling for space in the hospital, and indicating the wide sweep of people who had travelled to the colony in search of work, were immigrants from Brazil, Barbados, Trinidad, Bermuda, Malta and Madeira.<sup>134</sup> In later years, with the arrival of new groups of immigrants the profile of the hospital changed once again. By 1847 there were large numbers of East Indians also being treated in the hospital. Correspondingly, the number

---

130. Minutes of the Board of Management of the Colonial Hospital 18 August 1840. Royal Gazette 1 September 1840.

131. *Ibid.*

132. Report of the Colonial Hospital. Royal Gazette 12 March 1840.

133. Minutes of the Meeting of the Board of Management of the Colonial Hospital. 23 July 1842. C.O. 114/16/166.

134. Minutes of the Board of Management of the Colonial Hospital. 18 August 1840. Royal Gazette 1 September 1840.

of Europeans treated fell. In other words, the hospital tracked the ebb and flow of immigrant workers in the colony.

The increase in patients and geographic profile of the hospital in 1847 is well illustrated by the charts on the following page. The first significant fact to notice in Fig. 1.1 is the huge increase from 1839 in the numbers of patients going through the hospital. The total number of patients in each 'country of origin' category are given in brackets. Between the beginning of July 1847 and the end of June 1848, a total of over 8,600 in-patients were admitted. This compares for example against the 1,547 patients treated in the fifteen months up to August 1840.<sup>135</sup> Unfortunately, the hospital statistics do not reveal the number of beds or wards at this time, although these figures do suggest a very significant increase in bed numbers. Secondly, Fig. 1.1 shows the country of origin of patients. Just two groups, the Madeirans and the East Indians account for the overwhelming majority of patients. That these two groups were immigrant workers from the estates is underlined by the breakdown in occupations. This may be seen in Fig. 1.2. Almost eighty per cent of all admissions were classified as plantation workers. The extremely low numbers of 'professionals' which would include plantation managers, schoolmasters, clergy and colonial officials indicates that these people almost always sought their medical care elsewhere. However, admissions from 'skilled labourers' which included bakers, barbers, blacksmiths, boat builders, carpenters (the most numerous category of skilled worker in the colony), shopkeepers, shoemakers, tailors and watchmakers indicate that the hospital was also becoming a resource for wider numbers of people from Georgetown.

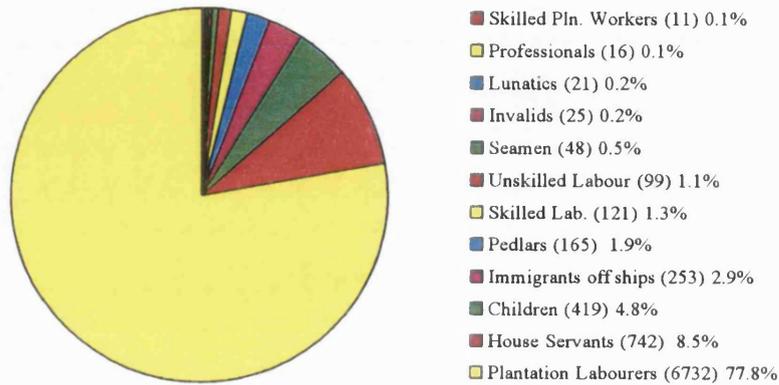
The age profile of admissions, shown in Fig. 1.3, also emphasises one of the characteristics of immigration, its youthfulness. As can be seen the bulk of admissions was of people aged thirty and under. Finally, it should also be noted that admissions were not divided equally between the sexes. The majority, seventy-six percent, were male.<sup>136</sup> This too tracks the demography of immigration, as far more males than females were recruited abroad for work in the colony.

The 1840s, therefore, saw the transformation of the colonial hospital, from a small institution primarily used by the indigent European poor to a much expanded institution, one whose resources were shifted towards the treatment of immigrants, seamen, and also it seems, small numbers of skilled labourers. For the remainder of the

---

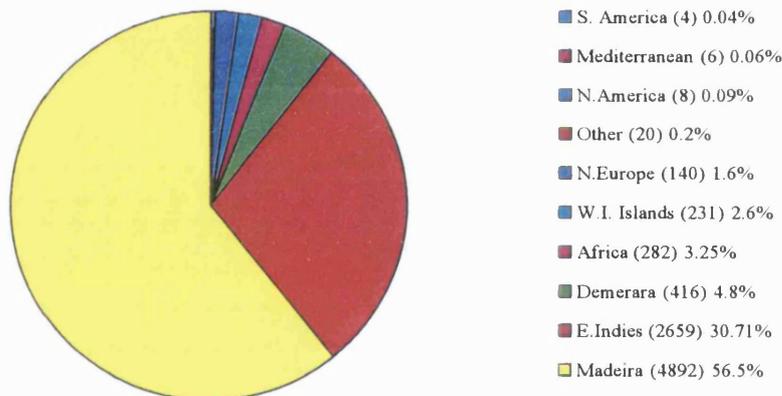
135. Ibid.

**Fig. 1.2 Occupation of patients admitted to Georgetown Hospital: July 1847-June 1848**



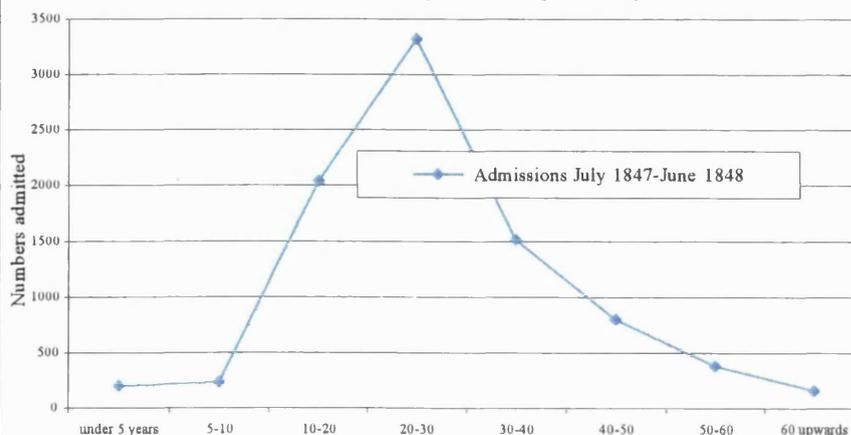
Source: Hospital Statistics 1847-48 C.O. 111/251 *Royal Gazette* 14 October 1848

**Fig. 1.1 Admissions to Georgetown Hospital by country of origin: July 1847-June 1848**



Source: Hospital Statistics 1847-48 C.O. 111/251 *Royal Gazette* 14 October 1848

**Fig. 1.3 Admissions by age to Georgetown Hospital: July 1847-June 1848**



Source: Hospital Statistics 1847-48 C.O. 111/251 *Royal Gazette* 14 October 1848

century the place of the colonial hospital in the organisation of the colony's health system was set, and it never reverted back to an institution primarily for the care of Europeans. Moreover, as the size of the colony grew, the hospital continually adjusted to meet new needs, gradually taking in more non-plantation workers. Well before the end of the century the hospital also began treating on a regular basis the police, government officials, and paying patients. Aside from buying a measure of privacy, this last category of patient benefited from certain privileges, such as the addition of custard, rice puddings and 'egg flip' to their diet.<sup>137</sup> Nevertheless, by the end of the century, plantation workers still made up just thirty per cent of admissions, these were taken in on a fee-per-person basis. One reason for the hospital's enduring role in the treatment of immigrant labourers was due to the surgical skills available at the hospital. Some of the more frequently performed operations show how far the institution continued to respond to the health needs of plantation workers. These included the incision of abscesses, amputations (often the result of chronic ulceration), reducing 'elephantoid' tissue and managing ulcers.<sup>138</sup> Another significant change which took place over the course of the century was in the usage of the hospital dispensary. Just over 33,000 out-patients' prescriptions were recorded for 1901, an impressive figure given that the population of Georgetown hovered just under the 50,000 mark.<sup>139</sup>

The style of treatment, and indeed the architectural topology of the colonial hospital, was also self-consciously in tune with forward-thinking metropolitan attitudes. In the following quotation from the resident surgeon of the recently reconstructed 150 bed New Amsterdam Public Hospital (1893), there is displayed before the reader all the modern technologies of space, volume, light, ventilation and order which were by now routinely desired in the struggle against disease in England, and deemed equally suitable for the colonies.

The principal sick wards are four in number, three for the male and one for female patients. They each have 24 beds with a window between each bed. They are 96 feet long and 24 feet wide; the wards on the lower floor are 14 feet high. The superficial floor space for each ward is 2,304 square feet or exactly 96 square feet per bed. The cubic capacity is 32,256 cubic feet for the wards in the lower floor and 25,346 cubic feet for those on the upper.<sup>140</sup>

---

137. Rowland. M. B. (Edin.), 'A Description of the Public Hospital New Amsterdam', The British Guiana Medical Annual and Hospital Reports (BGMAHR) (Georgetown 1894), p. 77.

138. Report from New Amsterdam Hospital for the year ending 31 March 1901. Table E. Report of the Surgeon General. Administration Report (AR) 1900-01. pp. 32-33.

139. Table G. Report of the Surgeon General. AR 1900-01. p. 33.

140. Rowland, BGMAHR 1894, p. 70.

A comment by the author of this piece, E. D. Rowland, provides a notion of the care which went into the precise siting of this Pavilion-style building. For a plan of this building, see appendix II and III. Rowland calculated that the prevailing trade winds blew through the hospitals wards at eleven miles per hour.<sup>141</sup> The hospital was, he stated, 'beautifully ventilated'.<sup>142</sup>

The physical size of the Georgetown Hospital and its staffing also reflected its expanded role in colonial society. It compared well to the provision in many English towns. For example, Norwich and Derby, with populations of 80,000 and 61,000 respectively, both had hospitals with less than 200 beds.<sup>143</sup> In contrast, from the 1870s onwards, the Georgetown Hospital supported 700 beds (but it should be remembered that it served more than the population of Georgetown) and later included a maternity ward. By 1901, there were 133 nurses and servants employed, and, in an effort to maintain nursing standards the hospital introduced a system of training complete with exams and certificates. The hospital was also linked to a number of other institutions in the colony. The mid-Victorian concern for destitution and madness was echoed in Guiana in the construction of an Alms House, Leper Asylum, Orphanage and Lunatic Asylum. The Georgetown Hospital had a pivotal role in assessing patients and transferring them to these other sites.

If one now turns to the bodies of patients in the colonial hospital we can see how doctors drew on the seemingly 'dispassionate' authority of medical science, to assemble and shape in particular ways views about immigrants, especially those from Africa and India. Megan Vaughan has explored how medicine in Africa constructed indigenous people as objects of knowledge (perhaps not unlike how doctors came to understand European populations) through systems of classification and other practices of power.<sup>144</sup> David Arnold has persuasively argued that colonialism used the 'body as a site for the construction of its own authority, legitimacy, and control.'<sup>145</sup> As we will see here and in following chapters, these impulses of objectification and subjectification were woven through the practice of doctors in Guiana. It is worth noting that the disparities of cultural and political power between European and immigrant were extremely wide.

---

141. *Ibid.* pp. 72-73.

142. *Ibid.* p. 72.

143. Jeremy Taylor, *The Rebirth of the Norfolk and Norwich Hospital 1874-1883*. (Wellcome Unit for the History of Medicine. University of East Anglia 2000), p. 5.

144. Vaughan, *Curing* p. 8.

145. Arnold, *Colonizing* p. 8. See also I. J. Catanach, 'Plague and Tensions of Empire', in D. Arnold (ed.), *Imperial Medicine and Indigenous Societies* (Manchester University Press 1988), p. 154.

Unlike in India for example, there was no need to temper Western medical values, or for medicine to seek social respectability from non-Europeans.<sup>146</sup>

An all too rare glimpse of colonial medical thinking about the meaning of race and the cultural role of western medicine, is provided by the Surgeon General's account of how he treated sick immigrants from the *Belle-Vue* estate. In all, twenty seven *Belle-Vue* immigrants were sent by the governor to the colonial hospital in Georgetown for treatment. Due to the intense interest shown in Britain for the fate of these people it is unsurprising that their care was overseen by the colony's Surgeon General, E. M. Smith. His report to parliament on the fate of these immigrants demonstrated that an ordered and well-run hospital existed in the colony. It was as much a political tract written, with the audience at home in mind, as it was a routine medical summary. All of the immigrants suffered from chronic ulceration. In most cases the damaged flesh was concentrated around the lower extremities of the body, the ankles, toes, and feet. Each of the (sometimes large) ulcers produced discharges, bleeding, and extensive, painful, ragged, inflamed areas. The symptoms of twenty-two year old 'Coolie' Jeeburn were fairly typical:

Left leg much swollen and shining, ankle enlarged; ulcer five inches in diameter, superficial in some parts, deep with ragged edges in the other; bleeding and foetid, without any disposition to heal; little toe lost, and in its place an ulcer of above nature.<sup>147</sup>

Despite the apparent seriousness of these afflictions, under Smith's supervision the *Belle-Vue* labourers were nursed back to health. Some three weeks after entering hospital all of the patients (bar five) showed signs of recovery. Jeeburn, for example, had responded quickly to treatment and now had 'one foot much diminished in size, and healthy, one little toe healed, leg reduced to a healthy state.'<sup>148</sup> This was western medicine at its healing best, and in effect it provided a practical riposte to the anti-slavery critique of health care in the colony.

Smith's intensive clinical encounters with Indian immigrants and his success in guiding them back to productive health also prompted confident hypotheses on the constitutional attributes of Indian labour. The question of long-term suitability to the colony and of labouring ability was paramount and doctors were sensitive to the commercial interests of the colony. Smith viewed the constitution of East Indians as

---

146. Arnold, *Colonizing* p. 252-251.

147. Enclosure no. 1 (Extract from the casebook of the Colonial Hospital 8 June 1839) in Light to Normanby, 27 June 1839. P.P. 1839. Vol. XXXIX.

superior to that of many other immigrants. This seemed especially so if the incidences of intermittent fever between the different 'races' were examined. Smith noted that:

Of the 30 coolies...placed under my charge, none have been attacked since the 7th June with the intermittent fever, the endemic of British Guiana, nor do any seem to have suffered prior to that period from that cause. This community when compared with the Maltese and Portuguese immigrants, is worthy of note.<sup>149</sup>

During this time, Smith also had under treatment seventy-six Maltese (men, women, children and infants) who suffered from intermittent fever. These immigrants had arrived at the hospital with constitutions 'already more or less impaired' from the rigours of their recent voyage. Smith also contrasted his experience treating German, English, and Black immigrants from neighbouring colonies, against the Indian labourers. Even taking the disadvantages of travel into account, none of these groups, in his view, possessed the 'Coolie' immunity to intermittent fever. Smith found it more difficult to decide whether or not Indian labour suffered a greater propensity towards ulcers, as only those affected by ulceration had been placed under his care. However, here too, by shifting responsibility for the disorder towards those who suffered from it, Smith was able to offer an optimistic diagnosis. Indians, he claimed:

were not constitutionally predisposed to [ulceration], but that they suffered in consequence...of their own ignorance of the proper mode of ridding themselves of these very troublesome insects. This opinion is strengthened by the fact that in 25 of the 27 cases, ulceration was confined to the toes originally, and extended to the foot.

The uncommon rapidity with which most of those severe cases progressed to a favourable termination is a negative proof of the non-predisposition of the coolies to the disease generally termed in this colony "constitutional ulcer", while it affords strong evidence of the great restorative powers of their constitution, surpassing that of every other class of labourers whom I have had occasion to treat for the same disease in this country.<sup>150</sup>

These results certainly impressed officials in London. According to the Colonial Office, it was evidence that proper care and treatment 'effectually counteracted' the spread of disease in 'coolies'.<sup>151</sup> Yet there was more to Smith's system of care than therapeutic interventions and observations about bodily attributes. The techniques of hospital treatment also embraced a broader programme to promote Christian values. As Smith saw it, the forced incarceration of the labourers in the colonial hospital, provided an ideal opportunity to undermine their 'prejudices', particularly with regard to diet,

---

148. Enclosure no. 2. Ibid.

149. Smith. Enclosure no. 4 in Light to Normanby, 12 August 1839. P.P. 1840. Vol. XXXIV.

150. Ibid.

151. Normanby to Light, 29 August 1839. P.P. 1840. Vol. XXXIX.

rituals of cooking and eating habits. That such a project was embarked upon, and written about with satisfaction and approval, indicates the closeness of colonial medicine in Guiana to contemporary ideologies of empire which stressed the improving and civilising side of European rule.

The *Belle-Vue* immigrants brought into hospital their own cooking vessels and apportioned amongst themselves the labour of cooking.<sup>152</sup> The significance of these acts should not be underestimated. These immigrants were poor and unable to carry many belongings from India. Cooking vessels were therefore powerful symbolic affirmations of home, providing identity and meaning. Smith however, was determined to confer upon these immigrants the full benefits of western medicine. From Smith's humanitarian perspective the strictures of medical practice demanded that his patients should receive the best food suited to their state of health. The stimulating and recuperative properties of food were widely accepted amongst doctors. In the colonies a sensitivity to diet for the management of health was considered important. Dietetics also had a long legacy in the western medical corpus dating as far back as the Greeks.<sup>153</sup> Thus, removing the dietary 'prejudices' of the Indian immigrants assumed great importance for Smith. In this conflict of culture, belief and commitment, the most powerful resources, particularly that of the hospital with its staff and organisation, lay with Smith. Nevertheless, he had to stoop to subterfuge in order to undermine the resistance of the Indians. His strategy was to deceive his patients into eating food, such as pork, that they would ordinarily reject. This experiment was conducted over a number of days. Smith noted how one of the cooks reacted:

...a young man, named Jan Hair Sing, who was induced to eat some ham, under the impression that it was food sanctioned by his religion, but prepared in a peculiar way. He was delighted with it; but on being shortly afterwards undeceived and told that he had eaten pork, his horror was so great that his stomach immediately rejected its contents.<sup>154</sup>

These experiments in cultural engineering seem to have eventually borne fruit. Smith recorded that the *Belle-Vue* labourers finally 'yielded their prejudices', and the usual food of the hospital was eventually prepared for his immigrant patients.<sup>155</sup> The abandonment of traditional culinary practices was apparently matched by a shift in religious perceptions. Smith's hospital was also a site for Christian proselytising.

---

152. Smith. Enclosure no. 2 in Light to Russell, 29 December 1839. P.P. 1840. Vol. XXXIV.

153. Harold J. Cook, 'Physical Methods', in Bynum and Porter (eds.), Companion Encyclopedia of the History of Medicine Vol. 2. (Routledge 1993), p. 940.

154. Smith. Enclosure no. 2 in Light to Russell, 29 December 1839. P.P. 1840. Vol. XXXIV.

Readings by the clergy in the wards complemented the curative side of treatment. For Smith, even in the rituals of death there were important battles to be waged in the proper manner of body disposal. In accordance with custom, Suttale Sing, in anticipation of death, requested to be thrown into the river. After a long period of remonstrance, he finally changed his mind, and after prayers agreed to be buried in 'duty' (earth). According to Smith's report, readings from the bible by the clergy induced others to demand instruction in Christian doctrines. Jan Hair Sing, one of the former cooks, now found that bible stories made 'the water run out of his eyes.'<sup>156</sup>

We do not know whether Smith invented his victories, or how far he really changed the minds of those under his care. The 'mask of obedience' may well have disguised the true feelings of the *Belle-Vue* labourers, as subordinates in the colonial order had good reason for not contradicting appearances.<sup>157</sup> Neither domination nor subordination are ever complete.<sup>158</sup> In a sense it does not matter, Smith's appeal was to Christian sentiment. By claiming for his European audience that he had wrought small but significant changes in the attitude and practices of Indian immigrants, he fulfilled one of the putative purposes of empire. In Smith's manipulative scheming, Christianity, medicine and progress provided essential threads for a flourishing colonial enterprise if harnessed to Indian labour. British rule, argued Smith, would be of, 'incalculable benefit to thousands of heathen brethren, should it seem good to the British Government to permit a further introduction of Coolies into this colony.'<sup>159</sup>

## 1.6 The re-negotiation of immigration to British Guiana

We have earlier examined how the authorities and planters in the West Indies shifted their attention towards India for the recruitment of labour, and the manner in which metropolitan political, and Indian governmental forces aligned themselves against this trade. Secondly, we have seen how as a response to immigration, and to wider political pressure, the colony set up a bureaucratic initiative, namely an 'Agent for Emigrants', and introduced legal changes with regard to plantation hospitals in the form of the 1847 Hospital Ordinance. Additionally, we have looked at how the resources of

---

155. Ibid.

156. Ibid.

157. Bertram Wyatt-Brown, 'The Mask of Obedience Male slave psychology in the Old South', in J. Williams Harris (ed.), *Society and Culture in the Slave South* (Routledge 1992), pp. 128-161.

158. Gautam Bhadra, 'The Mentality of Subalternity: Kantanama or Rajdharma', in Ranajit Guha (ed.), *Subaltern Studies VI* (Oxford University Press 1989), p. 54.

the colonial hospital were shifted towards the treatment of immigrants. All of these reforms may be seen as part of a broader regulatory structure which was gradually set up in different parts of the empire to organise and oversee the flow of immigrant labour. It is to this that we now turn. The discussion begins with India before moving to Guiana.

In India, after the suspension of emigration to Mauritius and the West Indies, a six person Commission of Enquiry was established (1 August 1838) to consider the whole question of indentured labour.<sup>160</sup> This investigation was matched by a similar one in Mauritius, and, as we have already discussed, by Governor Light's enquiry in Guiana. Commissions in British political life were relatively new bodies, designed to take evidence from all classes and thereby facilitate rational decision making. Yet, as we shall see with the Indian Commission, they made recommendations, not policy.

Powerful and influential knots of commercial interest and political ideology were bound up in the immigrant trade. It was not just the commercial pull of the West Indies which drew labour from India. In the ports of Calcutta and Madras, an extensive network of agents, 'crimps', 'duffadars' and shippers accumulated high revenues from their ability to procure and deliver labour to Mauritius planters. The organisation of this trade, the contracting of shipping, the hiring of labour, and supply of provisions and financial credit, further extended the numbers of individuals who benefited from this trade. It was this whole system of activity and profit that the Commission potentially threatened.

One simple but compelling reason for continuing with this trade lay in the pervasive ideology of 'free trade' and 'free labour'. It is worth briefly discussing what this meant in terms of the empire, since its influence amongst politicians was wide. For many members of the British and Indian governments, free trade was, as Lord Palmerston later argued, 'one of the great standing laws of nature.'<sup>161</sup> As Brian Harrison has shown, many Victorians believed that commerce would 'banish superstition, ignorance, war and brutality'.<sup>162</sup> In fact, the abolitionist movement itself was deeply

---

159. Smith. Enclosure no. 2 in Light to Russell, 29 December 1839. P.P. 1840. Vol. XXXIV.

160. 'Committee appointed to enquire respecting the exportation of Hill Coolies', 1 August 1838. P.P. 1841. Vol. XVI. p. 9.

161. P. J. Marshall, 'An Expanding Trade', in P. J. Marshall (ed.), Cambridge Illustrated History of the British Empire (Cambridge University Press 1996), p. 32

162. Brian Harrison, 'Philanthropy and the Victorians', in Brian Harrison Peaceable Kingdom: Stability and Change in Modern Britain (Oxford 1982), p. 230.

imbued with these views, and frequently drew attention to the superiority of 'free labour' over slavery.<sup>163</sup>

In India however, the ideas of free trade seemed to have less resonance. There, the circumstances of rule encouraged a strong strand of utilitarian thinking. This found expression in a concern for establishing the proper institutional frameworks, e.g. codes of law and taxation, deemed necessary for economic expansion and commerce.<sup>164</sup> Utilitarianism appears to have been particularly suited to the commercial opportunities and political circumstances of early nineteenth century India. In the progressive and reforming language of utility, it was possible to adorn Company Rule in the ideological garb of a civilising force, while reaping the commercial benefits which accrued through having a commanding political influence. One element of this discourse expressed itself by a European desire to foster the 'natural' industriousness of Indians. The most far-sighted policy for India, in the opinion of the East India Company official James Mill, was to:

...teach people to look for their elevation to their own resources, their industry and economy. Let the means of accumulation be afforded to our Indian subjects; let them grow rich as cultivators, merchants, manufacturers...<sup>165</sup>

Opinions such as this were easily adaptable to the commercial interests of certain Calcutta traders. One such person was W. Dawson, a merchant who was directly involved in the 'coolie' trade, and also a member of the afore mentioned Commission of Enquiry.<sup>166</sup> Mill had suggested that free individuals, voluntarily acting in their own interests, were at the centre of British political philosophy in India. Dawson developed the practical implications of this view by arguing that any opposition to emigration was an attack on individual liberty. Moreover, he elaborated, in the circumstances of India, restricting emigration simply condemned individuals to starvation and disease. Dawson linked prosperity and the development of colonies with the free movement of labour, and by implication, the economic destruction of colonies should the labour supply cease. This formulation effectively harmonised humanitarian anti-slavery ideology with pro-emigration free labour liberalism. Dawson went on to observe, 'the system is capable of

---

163. For example, see the Barbados Liberal 'Free Labour verses Slave Labour!' British Emancipator June 1839. G. R. Searl, Morality and the Market in Victorian Britain (Clarendon Press 1998), p 60.

164. Stokes, English Utilitarians pp. 87-93, 219.

165. James Mill, 'History of British India', in William J. Barber, British Economic Thought and India 1600-1858 (Clarendon Press 1975), p. 165.

166. Tinker, A New System of Slavery p. 66.

being regulated in its detail, so as to ensure to the labourers the fullest justice, security, and comfort.<sup>167</sup>

It is important to note that although Dawson's views have been given prominence above, they did not sway other members of the Commission. Amongst the massive amount of accumulated evidence on emigration practices there were too many incidences of coercion, brutality and abuse to ignore.<sup>168</sup> Two further difficulties stood out. Firstly, a practical problem, that of managing health on a lengthy sea voyage. The long sea route to the West Indies, the unavoidable journey around the Cape, and the inevitable hardships on board ship suggested a high mortality rate. This difficulty alone appeared to preclude any regular system of emigration.<sup>169</sup> Secondly, there were important political dimensions. Quarrels with foreign governments who still traded slaves remained likely, and thus, any renewal of the trade in Indian labour threatened to:

weaken the moral influence of the British Government throughout the world, and deaden or utterly destroy the effect of all future remonstrances and negotiations respecting the slave trade.<sup>170</sup>

Hence, the problem of labour emigration was capable of being approached from distinctly different political perspectives. Representations to the Commission by Calcutta merchants stressed the plausibility of a highly regulated system of emigration involving voluntary contracts, minimum standards of food, return passages, and 'kind personal treatment'. According to this view, an emigration system shorn of abuse would be 'not only defensible but worthy of commendation.'<sup>171</sup>

These tensions proved unbridgeable. When, in October of 1840, the Commission's Report came out, it contained strong criticism of indentureship. However, only three of the Commission's members signed the report and two others (one of whom was Dawson) submitted lengthy alternative views. Finally, therefore, when the report came up for consideration in London, it did not represent a unanimous condemnation of indentureship. Consequently, parliamentary opinion, in accordance with free trade thinking, and itself under pressure from West Indian commercial interests, gradually moved in favour of regulating the trade in Indian labour rather than total prohibition. The first step was to legislate for the island of Mauritius, and on the 15 January 1842, an Order of Council repealed the ban on emigration there. Subsequently,

---

167. Minute of Mr. Dawson. P.P 1841. Vol. XVI. p.16.

168. Tinker, *A New System of Slavery* pp. 66-67.

169. Committee on 'Hill Coolies', P.P. 1841. Vol. XVI. pp. 4-9.

170. Ibid. p. 9.

in parliamentary debates on this matter in March and July of that year, the abolitionist position, that of retaining a ban on emigration, was lost.<sup>172</sup>

Accompanying the Order of Council was a schedule of regulations. This is significant, because it was through the elaboration, development and reworkings of regulatory controls that emigration from India to the West Indies once again became possible. The sociologist Weber, has pointed to three principal characteristics of a bureaucracy: rules to delineate powers, hierarchies of subordination, and documentation.<sup>173</sup> As we will see, in the structures designed to oversee Indian emigration these criteria were wholly fulfilled.

The undoubted appeal of bureaucratic systems lay in their supposed rationality, the way they encouraged accountability and ordered relationships through the use of state officials, and by applying legal authority, precedent and routine. The language of emigration regulatory control, which was developed in India, very much stressed the numerous safeguards against abuse. The systems of certification posed a series of bureaucratic filters which were 'materially restrictive' to the unhindered flow of emigrant labour.<sup>174</sup> It is not in the remit of this thesis to discuss whether the regulations actually 'worked' to prevent abuse, what is clear is that they 'worked' in a political sense, in that they re-opened the emigration trade. Probably, it would be a mistake to take the rhetoric of control wholly at face value, especially since emigration, and the importance of its legislative regulation, was bound up in the polemic of parliamentary disputes over this issue. Furthermore, it should be remembered, these controls were not designed to *prevent* migration, but to *facilitate* migration, a task they successfully assisted in until the abolition of indentureship in 1917.

At the heart of the new regulatory scheme was a new post, the Protector of Indian Emigrants (fashioned after the Protector of Slaves) and the establishment of bureaucratic procedures to ensure the proper treatment of emigrants. Routines to assemble, isolate, observe, and assess the labourer structured the operation. From Calcutta to Mauritius, where a reciprocal set of regulations were arranged by the

---

171. Representations from the Merchants of Calcutta. Ibid. pp. 147-8.

172. Tinker, A New System of Slavery p. 74.

173. Max Weber, Economy and Society in Guenther Roth and Claus Wittich (eds.), (University of California Press 1978), pp. 956-958. See also Ken Morrison, Marx, Durkheim, Weber. Formations of Modern Social Thought (Sage 1995), pp. 293-304

174. Committee on 'Hill Coolies', P.P. 1841. Vol. XVI. p. 10.

colonial authorities, the process was marked at each juncture by a complex system of certificates and registration monitored by salaried state officials and ships' surgeons.

In fact, this style of supervision had already been deployed on convict ships, and from 1831 onwards, on government assisted emigrant ships bound for Australia. In both of these cases mortality rates had begun to decline. Robin Haines and Ralph Shlomowitz have demonstrated how colonial immigration officials and ships' surgeons developed a system of pre-departure medical examinations for British emigrants. In addition, ships' surgeons reduced on-board crowding, and improved shipboard sanitation. Cleaner water, better ventilation and a superior diet complemented these reforms.<sup>175</sup> In a modified form, these technologies of health, supervision, space and diet, were also applied to the ports of Calcutta and Madras for the departing indentured labourers. As a result of these official interventions into the running of emigrant ships, the onboard mortality levels for Indian immigrants to the West Indies did gradually decline, although the figures were uneven from year to year. A severe outbreak of disease on one ship could skew the figures for a whole year. Still, by the 1870s shipboard mortality had fallen by more than half, to 7.1 per 1000, although it was still greater than that of European emigrants to Australia during the same period.<sup>176</sup>

The laws permitting Indian emigration to Mauritius did not yet extend to the West Indies. Amongst most parliamentarians confidence in the West Indian planter remained low. Yet activity on this issue in Guiana, despite the prohibition of labour from India, had not subsided over the previous years. In fact, with the collapse of the Gladstone scheme, planters had redoubled their efforts to establish emigration schemes to bring labour into the colony. None of these private initiatives found favour with the colony's Governor who enlisted the support of the Colonial Office in order to press for the establishment of better regulatory structures within the colony. Light wrote to the Colonial Office in October 1839 pointing out the decisive role of the home government's attitude to events in Guiana:

The anxiety to meet the views of Her Majesty's Government, expressed by the community at large on the subject of immigration, will enable your Lordship to assume any position in protection of immigrants you may think necessary.<sup>177</sup>

Light was particularly sceptical that 'individual enterprise', or 'private speculators', could safely transport immigrants into the colony.<sup>178</sup> It was far more

---

175. Haines and Shlomowitz, 'Explaining' p. 16.

176. *Ibid.* p. 23.

177. Light to Normanby, 14 October 1839. P.P. 1840. Vol. XXXIV.

preferable, in Light's view, to bring about a whole-scale government scheme, whereby bounties were paid out of public revenue and the control and supervision of emigrants rested in proper government appointed agents.

Planters were also keen to open up the route to Africa. To this, the home government remained 'decidedly hostile'.<sup>179</sup> Moving labour from Africa to the West Indies remained far too politically sensitive to receive sanction, threatening, as the Marquis of Normanby for the Colonial Office put it, to bring 'discredit on the sincerity of efforts made by this nation for the suppression of that system of guilt and misery.'<sup>180</sup> Nevertheless, over the course of the next year, petitions from planters and memorials from Liverpool-based West Indian merchants were steadily conveyed to the Colonial Office. Each one was an appeal on behalf of the 'hard pressed' West Indian planter for permission to import labour.<sup>181</sup> The West Indian Committee hinted at the racial benefits of using labour from warm climates, and drew attention to the rationale of seeking labour from those colonial possessions where labour was 'surplus'. In its opinion, the very survival of Guiana depended upon labour arriving from 'densely populated countries whose inhabitants, from climate and other circumstances, are best adapted for tropical labour.'<sup>182</sup>

These views were complemented by positive assessments of labouring conditions in Guiana, which were also made known to the Colonial Office. From the early 1840s, Magistrates increasingly adopted an optimistic and favourable stance towards plantations. On the formerly notorious *Belle-Vue* estate, the sheriff of Berbice wrote about the workers 'nothing could be more favourable than the condition in which I found them.'<sup>183</sup> A complimentary assessment of Guiana, by the delegates of the Free Coloured People of Baltimore, added to the view that conditions for labour in Guiana had undergone a transformation.<sup>184</sup> In some magistrates' remarks about the physical and 'moral' improvement of immigrants, we can see how far the cause of emigration was embedded within European culture. The magistrate C. H. Strutt, clearly had the broader visions of empire in mind, as well as the concerns of the colony, when he argued:

---

178. Light to Russell, 4 June 1840. P.P. 1841. Vol. XVI.

179. Normanby to Light, 15 August 1839. P.P. 1840. Vol. XXXIV.

180. Ibid.

181. Letters signed by representatives of Liverpool West India Association and another from the directors of the Colonial Bank, various merchants and the M. P. James Blair. Enclosures no. 1 and no. 2 in Russell to Light 15 February 1840. P. P. 1840. Vol. XXXIV.

182. Encl. No.1. Ibid.

183. C. R. Winfield. Sheriff of Berbice. Enclosure in Light to Russell, 4 April 1840. P.P. 1841. Vol. XVI.

## Corridors of power: labour, migration, and health provision in British Guiana 1838-1847

The Coolie in India is badly paid, badly fed, and wholly uninstructed in the principles of Christianity. The African in Africa leads the life of the savage, and preys, or is preyed upon, by his neighbour, murder and bloodshed being as familiar to his eyes as the trees of the forest in which he dwells. In this country, on the contrary, the labourer is protected by humane and wholesome laws, liberally paid for the work he performs, comfortably housed and carefully attended in sickness, whilst his opportunities of acquiring religious and moral instruction are rarely equalled.<sup>185</sup>

Governor Light also stressed to the Colonial Office the benefits of the colony's moral framework (church, chapel, school) for immigrants.<sup>186</sup> These were views highly congenial to London, and the committed colonialist, Lord John Russell, when head of the Colonial Office, was prompted to write to Light in full agreement with these civilising notions.<sup>187</sup> At the same time, the legacy of the earlier emigration from India, which had drawn the opprobrium of the Anti-Slavery Society, weighed heavily against planting interests in Guiana. While the Government of India continued with its Commission of Enquiry, Russell, like his predecessor Normanby, refused to sanction further emigration to the West Indies. The free trader Russell extolled the virtues of 'Freedom of Labour', but only under suitable political conditions.

In the mean time, under the auspices of the colony's Emigration Society, the ship *Venezuela*, landed a small number of emigrants from Barbados and America. Russell surveyed this scheme and encouragingly declared the endeavour not 'unobjectionable in itself.'<sup>188</sup> However, for the scale of immigration required, substantial amounts of finance were needed, namely loans raised in London, to be paid for out of the colony's *future* revenue. The scale of these financial arrangements made the backing of the home government essential, but this support was not forthcoming. These circumstances produced bursts of acrimonious and bitter conflict within the ruling circles of the colony, most especially between the Governor and planter representatives on the Court of Policy.<sup>189</sup> Planter frustrations were channelled into hindering the business of government, and it was not until February 1841, after the home government had finally relented, and assented to Guiana passing an Immigration Ordinance and thus allowing them to raise capital for immigration purposes, that a semblance of ruling class solidarity returned to Guiana.

---

184. Enclosure in Light to Russell, 15 June 1840. P.P. 1841. Vol. XVI.

185. C. H. Strutt, Magistrate. Enclosures C in Light to Russell, 29 January 1841. P.P. 1841. Vol. XVI.

186. Light to Russell, 17 July 1840. P.P. 1841. Vol. XVI. Copy of a despatch from Governor Light to Normanby, 21 May 1839. P.P. 1839. Vol. XXXIX.

187. Russell to Light, 20 March 1841. P.P. 1841. Vol. XVI.

188. (No.108.) No.70. Russell to Light. 29 July 1840. P.P. 1841. Vol. XVI.

189. Clementi, Constitutional pp. 109-115. See also: Light to Stanley, 29 April 1844. P.P. 1846. Vol. XXX.

The Immigration Ordinance came with limitations. India remained closed. Interestingly, it was African labour that West Indian planters were allowed to hire. The precise reasons for this, given that British politicians had previously appeared particularly sensitive about Africa, are unclear. It may have been due to the relative shortness of the route and the good prospects for low ship-board mortality. Perhaps this was thought necessary in order to 'prove' the safety of the journey. Certainly, the health of immigrants remained paramount for the proposed scheme of immigration. Governor Light spoke to the legislature and warned the planters:

...in every case, that discomfort and want of cleanliness and disease may ensue from the Africans being crowded together on any estate in buildings not intended and not fitted to be other than temporary dwellings; should such evils occur and be traced to these causes, there would soon be, by order of Government, a stop put to Emigration from Madeira and Africa. It is my anxious desire to encourage Emigration to this colony by showing to Her Majesty's Government that the happy condition of the Emigrant now in this colony, and of those we daily expect, is a strong reason for permitting us to seek in India to remedy any inadequate supply from those countries which are now open to our Emigration Agents.<sup>190</sup>

The same criteria that Gladstone's agents had deployed in selecting immigrants from India (youth, health and muscularity), drove assessments of Africans.<sup>191</sup> To supervise these matters, a bureaucracy of emigration to oversee the handling of Africans and ship-board provisions, was assembled in the port of Freetown, Sierra Leone.<sup>192</sup> The hand of the home government and the co-operation of local colonial officials was clearly visible in these activities. For example, Emigration Agents were given the rank of Lieutenant in Her Majesty's Navy, and provided with uniforms.

A battery of procedures, rules, inspections, and tasks such as daily musters, accompanied the immigrant once on board ship.<sup>193</sup> Regulation and good order, it was generally held, contributed to safe and harmonious voyages, in just the same way that ill discipline and irregularities were the supposed attendants of ship-board disease.<sup>194</sup> Within the confines of the ship the surgeon was encouraged in the care of his charges by a bounty system. Bonuses of two shillings per head landed alive awaited surgeons at

---

190. Memorandum presented to the Court of Policy, 17 May 1842. C.O. 114/16. See also enclosure no. 1 in Light to Russell, 23 February 1841. P.P. 1841. Vol. XVI.

191. Schedule A. Light to Russell, 23 February 1841. P.P. 1841. Vol. XVI.

192. Ibid. See also: Enclosure in No.5. Stanley to Light. 10 June 1843. Daily allowances for emigrants (male and female) from Sierra Leone to the West Indies were: 1 quart or 2 lbs. of rice, or 1 lb. of biscuit; 1/2 lb. of salt beef, or salt pork, or salt fish; 1/2 oz. of coffee or cocoa; 1 1/2 oz. sugar, 1 oz. lime juice; 3/4 oz. Sugar for mixing with lime juice; 1/4 gill of salt; 1 gill of palm oil; 1 gallon water; 1/2 pint of vinegar weekly. P.P. 1844. Vol. XXXV.

193. 3<sup>rd</sup> Report. CLEC. P.P. 1843. Vol. XXIX. p. 48.

194. Christopher Lawrence, 'Disciplining disease: scurvy, the navy, and imperial expansion. 1750-1825', in D. Miller and P. Reill (eds.), *Visions of Empire* (Cambridge University Press 1994).

their destination.<sup>195</sup> On some occasions this incentive may have contributed to forceful medical interventions, and not uncommonly immigrants resisted the strictures of shipboard life. For example, the surgeon Rawlins, claimed that he was 'frequently compelled', 'to give them medicine in the same manner that an old nurse gives it to an obstinate child - by force.'<sup>196</sup> The vaccination of immigrants was also sought, but was difficult to achieve. After vaccination, doctors were often disappointed that no effects to the skin were observable. The 'peculiarities' of the African constitution was raised as one possible explanation.<sup>197</sup> Surgeon Leich from the *Arabian* had insufficient lymph for his purposes, and doubted its efficacy in the tropical climate.<sup>198</sup> However, immigrants were also reluctant to subject themselves to this procedure which led to surgeons administering it after they had set sail.<sup>199</sup>

In their task of managing the on-board health of immigrants, the Colonial Office considered these surgeons as generally successful. For assessment, the mortality rate across the Atlantic was crucial. In 1843, the Colonial Land and Emigration Commissioners (the department responsible for overseeing convict voyages and emigration) announced that for the preceding year, there was not a single casualty on any of the three ships which sailed to the West Indies.<sup>200</sup> By 1845 they were able to declare that:

As regards the health of the people on the passage, we are happy to be able to state that these vessels have continued singularly exempt from any mortality among the passengers.<sup>201</sup>

Thus, sometime before the Indian authorities in 1842 resumed emigration to Mauritius, Emigration Agents were appearing on the shores of the British colony of Sierra Leone in West Africa with the approval of the British government in order to once again begin the flow of labour to the West Indies. Official reports were favourable to the management of this trade. As already discussed, administrative changes had also taken place in Guiana, and a bureaucratic system for regulating immigrants somewhat symmetrical to that constructed in Sierra Leone was already in place in Guiana. These

---

195. Letter from Colonial Land and Emigration Commissioners to Stephen, 12 March 1847. Recommendation that medical officers should be rewarded by the colonies for each emigrant landed alive: 2 shillings per head for the surgeon, and 1 shilling to the assistant. C.O. 114/17/53.

196. 3<sup>rd</sup> Report. CLEC. P.P. 1843. Vol. XXIX. p. 52.

197. 5<sup>th</sup> Report. CLEC. P.P. 1845. Vol. XXVII. p. 18.

198. 3<sup>rd</sup> Report. CLEC. P.P. 1843. Vol. XXIX. p. 50.

199. Ibid.

200. For the year ended 31 December 1842 1,079 Africans emigrated to the West Indies. 189 were sent to British Guiana. CLEC. P.P. 1843. Vol. XXIX. p. 20, p. 32.

201. 5<sup>th</sup> Report. CLEC. P.P. 1845. Vol. XXVII. p. 17.

administrative developments, on both sides of the Atlantic, marked the beginning of mass government approved immigration to the colony. The linkages of a government organised, run, and supervised system of immigration was in place. From this point onwards, immigration to Guiana continued more or less uninterrupted into the second decade of the twentieth century. The official perception of success (politically, practically, and health wise) in transporting labour from India to Mauritius, and from Africa to the West Indies, further increased pressure on parliament to lift the ban on immigration from India to the West Indies.<sup>202</sup> In 1843, the current Secretary to the Colonies, Lord Stanley, wrote that 'the precautions adopted by Her Majesty's Government, and by that of India, have been highly successful in guarding the renewed emigration against abuses formerly practised.'<sup>203</sup> The way was finally open for a renewed trade in labour from India to the West Indies.

Over the next decade the regulations overseeing emigration underwent alterations, extensions, and various legislative amendments. Portside procedures were refined, emigration depots were enlarged, and shipboard practices of immigrant management were altered in the light of experience.<sup>204</sup> In particular, the role of ships' surgeons was enhanced, their presence quickly became mandatory on all voyages, and uniform schedules of medicines were adopted.<sup>205</sup> The flow of information between different ports and London permitted a generalisation of experiences. It is uncertain how many ship's surgeons may have read R. D. Ward's M. R. C. S. L., *Hints for the Improvement of Coolies on Board Ship* but the presence of this document in the official papers of British Guiana suggest it may have had a wide currency.<sup>206</sup> For the rest of the nineteenth century public officers continued to oversee the system. In London, the Colonial Land and Emigration Commission in close association with the Colonial Office maintained overall responsibility for all colonial traffic, including that of immigrant ships.<sup>207</sup> In the colonies, the establishment of Protectors of Emigrants and Emigration Agents remained central to the workings of this organisation. These

---

202. Ibid. p. 15.

203. Stanley to the Commissioners for the Affairs of India. 29 November 1843. P.P. 1844. Vol. XXXV.

204. See letter to T. Caird, Emigration Agent at Calcutta from B. Hawes on behalf of Grey. 5 July 1847. C.O. 114/17/47

205. 6<sup>th</sup> Report. CLEC. P.P. 1846 Vol. XXIV. pp. 57, 58. The regulations were based upon the Passengers Act 1835, but were significantly different. The proposed amendment to the 1835 Act mandated for a qualified medical practitioner for 100 or more passengers. Report of the Land and Emigration Commissioners on the necessity of amending the Passengers Act. P.P. 1842. Vol. XXV.

206. Ward, 15 May 1847. C.O. 114/17.

207. Haines and Shlomowitz, 'Explaining', footnote 6. p. 17.

authorities promoted good ventilation, order, cleanliness and moral behaviour, communicating these ideals through interpreters and trusted native assistants.<sup>208</sup>

The year 1844 thus saw two different colonial governments, India and Guiana, each rooted in profoundly dissimilar economic and social circumstances, move and adjust themselves to meet the political and practical requirements of a trans-global trade in labour. Through the channels of the Colonial Office, an extensive array of bureaucratic initiatives was assembled. These connected the commercial needs of one part of the empire and harnessed them to the resources of another. In so doing the character of British Guiana underwent a profound and irreversible series of transformations which reached deep into the social and political fabric of the colony.

## 1.7 Conclusion

The development of health provision in British Guiana until 1847 offers an example of how administrative attitudes in the British Empire varied towards indigenous health. Comparison between the authorities in Ceylon (Sri Lanka) and British Guiana is instructive. Both were plantation societies and part of the empire, but there were substantial differences of approach towards the health of plantation workers. In Ceylon in the 1840s, despite evidence of appalling health conditions, the government adopted a policy of non-intervention towards plantations over conditions on the estates.<sup>209</sup> In the example of British Guiana, the chronic shortages of labour, and the way that this became politically interconnected with anti-slavery forces in Britain, was crucial in pressing the planter-dominated colony's government into taking an interventionist stance towards plantations. In Guiana, the relatively weak economic and political position of planters ensured that they responded to metropolitan concerns over immigrant health and the conditions of estate work, even though the preoccupations of the abolitionists had gradually shifted over the 1840s towards America.<sup>210</sup>

Some of the complex and dynamic relationships - economic, social, and political - between the metropolitan centre and the periphery of empire, and between the different parts of empire, are also brought to the surface by examining the emergence of governmental concerns for plantation and immigrant health. In the organisation of immigrant transport, it is apparent that amongst colonial officials and government

---

208. Appendix 16. 5<sup>th</sup> CLEC. P.P. P.P. 1845. Vol. XXVII.

209. Hewa, *Colonialism* p. 39-46.

210. David Turley, *The Culture of English Anti-slavery, 1780-1860* (Routledge 1991).

officers, although separated by continent and ocean, they were nonetheless connected by strands of shared cultural values. A deference to the priorities of trade, the putative benefits of western medicine, notions of paternalism and cultural superiority, and appeals to civilising influences infused their reports and comments. It is clear that European ideas of race, as expressed by planters in Guiana, had some influence on officials at home and within India. These ideas were enduring and often helped to justify the character of British rule. In 1857 an editorial in the *Royal Gazette* remarked with satisfaction that, 'many [Africans] who come here as rude, untutored savages have learned to appreciate the blessings of civilisation and Christianity'.<sup>211</sup>

As we have seen, news of the scheme to transport Indian labour to the West Indies (sometimes termed by its opponents as the new slave trade) broke out just as the British Government was attempting to distance itself from associations of aristocratic patronage and respond to fresh demands for parliamentary reform. A government tainted by slavery risked squandering its political capital. At the same time most parliamentarians remained committed to free trade, free labour, and to a degree, sympathetic to the economic plight of the West Indian planters. The pervasiveness of these ideas can be seen in comments by the humanitarian Lord Glenelg of the Colonial Office. Overriding almost all other considerations was the need to bring labour to the British plantation economies, thus 'the first motive in question, and its ultimate object, is to supply labourers to a colony which is in want of them.'<sup>212</sup> The best method of securing this aim, in the light of sensitive political circumstances, in Glenelg's view, was government supervision of departure, shipping and arrival procedures. Thus, members of the Colonial Office worked hard to construct the regulatory mechanisms believed necessary to ensure minimum sickness on board transport ships. Conditions in the colonies were also of concern. The Colonial Office felt unable to tolerate widely publicised accounts of ill treatment of labourers in Guiana. Reform of hospital provision and suitable methods of monitoring were gradually adopted as items of legitimate colonial governance. The private world of plantations was slowly being opened up to the official gaze. The regulation of 'Coolie' transport and steps to improve hospital provision on plantations in Guiana, provided the bureaucratic instruments to harmonise free trade principles and the mass transport of labour.

---

211. *Royal Gazette* 31 March 1857.

212. Glenelg to Light, 19 December 1838. *Extracts* pp. 638-9.

## **Corridors of power: labour, migration, and health provision in British Guiana 1838-1847**

Coursing through these activities were countless assumptions concerning the character and nature of immigrants, and by implication the character and nature of Europeans. To describe, in the colonial hospital, the clinical features of the immigrant 'constitution', their tolerances or weaknesses to disease, their cultural resistance to Western medical practices, was also to supply, by implication, a glimpse of how Europeans saw themselves. As we have seen the colonial hospital over this period assumed an important role in the management of immigrant health in the colony. This orientation did not alter for the remainder of the century. Chapter two examines how far the colonial authorities were successful in implementing the 1847 plantation hospital reform, and the circumstances which prompted further legislative initiatives in 1859 and 1873.

-----

## Chapter 2

### 2.1 Introduction

In the preceding chapter we saw how inter-colonial political considerations shaped discussions about plantation health in British Guiana. I argued that the existence of hospital legislation provided an important sign of the colony's genuine, though not necessarily altruistic, concern over imported labourers. In short, to keep the wheels of commerce in motion, planters were required to submit to a measure of control in how labour was brought to the colony and in the conditions of its use. This regulation of labour and health provision was a necessary precondition for safeguarding the economic and political stability of the colony.

This analysis also holds true for the period under discussion in this chapter, 1847 to 1873. During this time there were two further pieces of colony legislation which touched specifically on the health of labourers, the 1859 Hospital Ordinance and the 1873 Immigration Ordinance. As previously, both of these legislative initiatives were prompted by external pressure in the form of the Indian and British governments, as well as by anti-slavery reform movements. In other words, discussions about the health of plantation workers continued to be shaped by global factors.

In practice, plantation health measures in themselves did not provide a panacea for solving the colony's labour shortages. Despite the introduction of shipping, hospital, and labour codes, and the public intervention of the British and Indian governments in the welfare of migrants, suspicions remained over the advisability of transporting fresh labour to the West Indies. Anti-slavery groups continued to raise concerns over the levels of morbidity and mortality on the estates, and about the moral treatment of women migrants. The trade in labour never managed to entirely scotch accusations of kidnapping, slavery and prostitution.<sup>1</sup>

Aside from health issues, the task of organising arrangements whereby large numbers of indentured labourers could be brought into the colony, required that the government of British Guiana broker complex financial agreements and set-up long range transport systems. The historian Hugh Tinker has shown how the problems of

### Medical provision, plantations and the state 1847-1873

gaining political support from London and India for an indentured labour system, and the complications of setting up the organisation and logistics of immigration, i.e. the appropriate methods of labour recruitment, management, transportation and distribution, resulted in protracted discussions and numerous inter-colonial disagreements.<sup>2</sup> In Guiana the problems of indentureship were further dominated by uncertainties over the financing of the scheme. Systemic economic imbalances, prompted by unstable sugar prices and difficulties accessing money markets, constricted the ability of planters to fund immigration. For most colony officials and plantation representatives, the difficulties surrounding the economics of importing labour often loomed far larger than any questions over their health. Although plantation hospitals became an important strand by which the colony represented itself, it should be remembered that they were discussed only sporadically by government officials, and that the health care of plantation workers often assumed a low profile in the colony's ruling body.

Another area of difficulty, for reform minded members of the colony's government, lay in implementing health care legislation. As will be shown in the next chapter, which further examines the social and economic context of hospital legislation, supervising the colony's plantation hospitals proved troublesome. Not least, this was because the government lacked sufficient political will to go against planter opinion. The system of government depended, according to one critic, upon an:

irresponsible and unchecked governor acting under the dictation of a clique of plantocrats (Slaveholders once, and having the Spirit of Slave Holders life within them still).<sup>3</sup>

This characterisation, as we saw in the last chapter, was not entirely true. Now and again, despite mutual commitments to see the continuance of sugar, and shared understandings about the importance of European rule, significant differences of opinion surfaced between London-appointed Governors, and the colony's planters. On the other hand, evidence does suggest that colony Governors were often slow to tackle any perceived problems of plantation health care. Arguably, the introduction of new hospital reforms in 1859 signalled a shift in this stance. With this legislation the colony government was drawn further and further into the organisation of medical provision on

---

1. In 1871 the Pioneer of India suggested that women were recruited in India and sold into prostitution in the West Indies. Minute paper March 1871. C.O. 111/383

2. Tinker, A New System of Slavery pp. 61-115.

### Medical provision, plantations and the state 1847-1873

the estates. Later, these threads of intervention became stronger, and eventually culminated in the complete transformation of colony medical services.

In many ways the 1859 reforms represented an important turning point for managing the health of indentured labourers. Until this time the government had expressed neither the inclination nor the will to gather systematically any annual data about the mortality and morbidity of estate workers. The hospital legislation passed in 1847 (discussed in the last chapter), formally set out the duties of the estates with regard to the treatment of indentured labourers, and there it seems, the matter rested. This chapter begins by examining the legacy of the 1847 legislation and then explores the way in which government interest in plantation hospitals was reawakened. Briefly, as the colony once more stepped up its demands for indentured labourers, so the question of medical provision and hospital care was again thrust onto the colonial agenda. The result was the 1859 Hospital Ordinance, that introduced novel forms of accountability, with which doctors had to comply, namely inspections and reports.

A further and more thoroughgoing reorganisation of the colony's medical services took place in 1873. This was partly the result of recommendations by a Commission of Enquiry set up to investigate the living and working conditions of indentured labourers in the colony. The consequences of this Commission were far reaching: all organisational responsibility for immigrant medical care was entirely removed from estates, and a new medical system based upon District Medical Officers was formed. The resulting system of health care marked a profound shift in colonial thinking about the responsibilities of governance and by 1873 the boundaries of legitimate government interest had been redrawn. The internal working of the sugar estate, for so long a closed and private world, remote from government interest, was no longer able to avoid the bureaucratic gaze of colonial officialdom.

#### 2.2 Doctors and the Hospital Ordinance of 1847

By examining the response of governments to the health problems of the poor it is often possible to discern the nature of wider relationships in society, such as those between poverty and wealth, obligation and responsibility. How far governments concern themselves with the extent of sickness and disease in a community is shaped by

---

3. Quoted from Emery's Journal Light to Grey, 15 March 1847. C.O. 111/242.

### Medical provision, plantations and the state 1847-1873

secular and religious factors, as well as by understandings of disease and by various traditions regarding appropriate forms of intervention. Also important are the expectations of the poor and elite members of society, including medical practitioners, as to what kind and levels of disease demand the involvement of officialdom. In Europe, until the middle of the nineteenth century, epidemic disease rather than endemic illnesses were the main prompts for government action.<sup>4</sup>

In light of this, perhaps it is not surprising that the health care of plantation labourers in British Guiana initially received little attention from the colonial authorities. After all in Britain, even after the influential Chadwick Report of 1842, it was not part of government policy to manage the health care of workers. In England, Christian civic duty to the poor provided the main framework of care and grounds for establishing and overseeing hospitals.<sup>5</sup> No such motives were alive in Guiana. Missionaries here were more concerned with moral health than with corporeal wellbeing. As this chapter shows, once the home government was satisfied that legislation was in place to provide for plantation hospitals, very little was done to monitor its effectiveness, and in the colony itself, few resources were made available for ensuring that plantations complied with the legislation.

Tracking the quality of medical provision in Guiana during the early 1840s, was primarily left to employees of the Immigration Department. These officials met the incoming immigrant ships, checked they conformed with passenger regulations, provided food and lodging, and, through the Health Officer, ensured that medical inspections were carried out on all new arrivals. It seems that few records of this activity were kept. In 1847, the incoming Immigration Agent General was simply handed a book containing the names of those persons who had arrived during the previous five years.<sup>6</sup> In 1851 the remit of the Department was extended to include visits to plantations. The colony's twelve (often less) Immigration Agents paid re-indenture bounties on behalf of the government, granted return tickets to those who wished to travel home, investigated complaints and drew up reports for the governor about the state of labour and the

---

4. Dorothy Porter, 'Public Health', in Bynum and Porter (eds.), Companion Vol. 2. pp. 1241-1242.

5. Lindsay Granshaw, 'The Rise of the modern hospital in Britain', in Andrew Wear (ed.), Medicine and Society (Cambridge University Press 1998), pp.199-201.

6. Nath, History p. 152.

### Medical provision, plantations and the state 1847-1873

conditions under which indentured labourers worked.<sup>7</sup> In 1852, premises were found in Georgetown to house recently arrived immigrants. This was a two-storey building which also provided accommodation for the Immigration Agent General.<sup>8</sup>

On paper, the activities of the Immigration Department looked impressive. But it appears that their inspections of plantations were not particularly thorough. This may have been partly due to the small resources given to the department. James Crosby, a graduate of Trinity College, Cambridge, and the colony's Immigration Agent General between 1858 and 1880, spoke bitterly of the 'crippled imbecility and forced weakness of the Immigration Department' as late as 1872.<sup>9</sup> But for much of the Immigration Department's early history it took a very narrow perspective on its duties. The main purpose of making reports on estates was to gather information about the quality of labour, and identify those estates where labour was short, rather than to provide information about where health provision was lacking or where conditions were poor.<sup>10</sup> Officials from the department were urged to, 'promote industry and good conduct' amongst immigrants.<sup>11</sup> Thus, the industriousness of the labourer and the difficulties of managing indentureship were of more concern to government officials than the quality of accommodation or medical care. T. C. H. Moore, an agent working in the county of Berbice, was unexceptional when he stated blandly that he had, 'inspected the habitations and hospitals provided for emigrants, and find that every necessary attention is paid to their comfort in health and disease.'<sup>12</sup>

Occasionally, out of the apparent uniformity of the colonial bureaucracy, an alternative and more critical view was presented. Dr. Bonyun, who was the President of the British Guiana Medical Association, and who in 1848 reported on plantation hospitals for the government, is significant in this respect – his report is discussed more fully in the next chapter. But there were also other voices which hinted at the poor quality of medical provision. For example, in 1852 the Magistrate John M'Swiney alluded to hospital buildings being commandeered for storage purposes, insufficient

---

7. Duties of Immigration Officers. C.O. 111/290/251.

8. Nath, *History* p. 152.

9. James Crosby. Immigration Agent General. Half yearly report. 23 April 1872. Enclosed in Scott to Kimberley, 8 May 1872. C.O. 111/390.

10. Ordinance 20. 1850.

11. Duties of Immigration officers. C.O. 111/290/251.

12. Report to the Government Secretary 1 October 1852. Minutes of the Court of Policy (MCP), 15 November 1852. C.O. 114/18.

### Medical provision, plantations and the state 1847-1873

medicines, a lack of trained nurses and poor record keeping. Being paid servants of the estate and subject to summary dismissal by the employer, it was impossible, M'Swiney argued, for hospital attendants to associate themselves with unfavourable reports of hospitals.<sup>13</sup> James Caird, the Indian Emigration Agent and government official who visited the colony in 1853, on behalf of the Colonial Land and Emigration Commissioners, also suggested that hospital care and medical treatment of indentured labourers left much to be desired. Caird revealed that visits of medical men to estates were often brief and that they frequently failed even to examine sick workers.<sup>14</sup>

It should be borne in mind that, after Guiana was opened up for immigration in 1841, there was a slow but steady increase in the number of indentured labourers and other immigrants arriving in the colony. In the ten years between 1841 and 1851, over 45,000 immigrants were settled onto plantations.<sup>15</sup> We can measure the effectiveness of the supervisory schema working in the colony by the fact that many of these individuals drifted almost immediately into the hinterland, or joined the village communities, out of sight of officialdom. A snapshot of the number of labourers on estates in 1848 revealed there were just under 30,000 individuals actually regularly employed.<sup>16</sup> Nevertheless, these numbers threw a considerable burden upon the estate medical system. Serving the medical needs of these workers, thousands of whom were drawn from outside of Guiana and who therefore spoke a variety of languages, including Hindustani, Bengali, Tamil, Telugu and a number of African and Chinese dialects, were thirty-nine or forty European medical practitioners.<sup>17</sup>

Under the 1847 Hospital Ordinance each of these doctors was attached to one or more plantations. Within sections of the government a critical view of this service began to take shape. The uneven distribution and entrepreneurial nature of medical practice was especially noted by Governor Philip Wodehouse (1854-1861). Unlike his predecessor, Sir Henry Barkly, Wodehouse did not own plantations in the colony,

---

13. John M'Swiney, Magistrate. Court of Policy, 15 November 1852. C.O. 114/18.

14. Report by J. Caird. For the Colonial Land and Emigration Commissioners. 18 March 1853. C.O. 318/202/167.

15. Governor Hinks 2 February 1865. C. O. 111/350.

16. Bonyun Report. CO. 111/250.

17. Adamson, *Sugar* p. 161. See also Mr. Smith, MCP. *Royal Gazette* 12 February 1859. The *lingua franca* of Indian immigrants seems to have been the Hindi dialect from eastern Bihar. See Moore, *Cultural Power* p. 162.

### Medical provision, plantations and the state 1847-1873

although as Alan Adamson has argued he was nonetheless, 'vigorously pro-planter.'<sup>18</sup> Still, not having such a direct material interest in the workings of the colony may have given Wodehouse a more critical edge. In his view, doctors often had unfeasibly large practices, although the situation would not have been very different from many rural areas in Britain.<sup>19</sup> Travelling up the Rivers Berbice or Demerara, it was not unusual to find one doctor in charge of four or five estates. That same doctor might also be in possession of a town practice in either New Amsterdam or Georgetown. To the east and west of Georgetown doctors were in charge of eight, ten or even fourteen estates. In other parts of the country, such as the east bank of the Demerara river, there were no medical men. On the lower part of the west coast fourteen estates were under the supervision of just one medical practitioner. For the entire island of Leguan, there was only one medical man and further north on the Arabian Coast, twenty estates were attended by just two partners.<sup>20</sup>

For individual doctors there were distinct pecuniary advantages for covering such large areas, since remuneration, as had been the case during slavery, was commensurate with the size of their practice.<sup>21</sup> The business of medicine was especially rewarding for a minority of practitioners. A successful doctor residing on an estate was unlikely to pay rental, was able to stable his horses for free and might, if he had a number of estates under his charge, have an income approaching £1,200 a year.<sup>22</sup> If accurate, this figure compared well with the earnings of provincial physicians in England. Without doubt, this placed a minority of doctors, some of who had their own small estates, amongst the wealthiest of inhabitants in the colony.<sup>23</sup> Governor Scott, writing in 1871, estimated that at least two estate doctors were in receipt of over £1000, although the majority earned

---

18. Adamson, *Sugar* p. 56.

19. For the Highlands see David Hamilton, *The Healers. A History of Medicine in Scotland* (Canongate Pub. Ltd. 1987), pp. 173-174.

20. Circular. February 10 1859. *Royal Gazette* 12 February 1859.

21. It was customary in the West Indies, and the practice in British Guiana during slavery, to pay doctors per head of slave. Therefore, the larger the number of slaves on the plantation the greater the emolument of the doctor. For the treatment of whites on the plantation the doctor received an extra flat fee. For example, in 1827 a Dr. P. F. Watt was paid six guilders per slave per year, and received a further sixty-six guilders for attending two whites on this plantation over a six month period. As well as their plantation responsibilities, it was also customary for doctors to seek out further fees by attending to Europeans in Georgetown. Here, a fixed fee was typically charged for visiting the patient and for performing surgical practices. See, inventory of land buildings, slaves and livestock, John Gladstone Papers. Box 2798. *Demerara and Essequibo Vade Mecum* (Georgetown 1825), pp. 260-261. See also Higman *Slave* p. 262

22. Mr. Smith. Court of Policy. *Royal Gazette* 8 February 1859. *Royal Gazette* 15 February 1859.

23. Anne Digby, *Making a Medical Living* p. 192.

### Medical provision, plantations and the state 1847-1873

less than £500 per annum.<sup>24</sup> Governor Wodehouse spoke of the 'absolute impossibility' of doctors visiting a large number of estates over long distances.<sup>25</sup> This was especially likely to be the case where the number of labourers working on estates was small. For some doctors, therefore, the geographical size of a practice was more a mark of their struggle to obtain a livelihood, rather than a statement of advantage. What seems certain, is that the salaries of doctors varied enormously.

Besides the geography of medical provision, care was also shaped by the overriding influence of the plantation manager. On some estates, and contrary to regulations, it appears that doctors were expected to supply medicines out of their own pocket. According to one proprietor, this was 'generally the case throughout the county of Berbice', and we can assume the practice was widespread in the colony.<sup>26</sup> Furthermore, the isolation of many estates, combined with the material dependency of doctors and their families upon the goodwill of estate managers for employment and social contact, undoubtedly undermined medical independence. The large resources at the command of the estate were used to soften the harsher features of life, or conversely, to make life intolerable. Simply withdrawing ordinary social courtesies effectively isolated the individual.

Similar social constraints applied to Magistrates. Although they were charged with ensuring estates complied with hospital regulations, few apparently did so. As with many doctors, they may have shared with planters a common outlook regarding their role in society. In addition, they too were dependent upon the estate for the exercise of their duties, courts were sited on the plantation, and, like doctors, magistrates often resided on or nearby the estate. The close alliances between the forces of the state and plantations is indicated by the way that, in some courts, plantation managers were assigned official roles, and about one third of the colony's justices of the peace were resident managers on estates.<sup>27</sup> In fact, doctors too served as justices of the peace. Nine doctors had this position in 1859.<sup>28</sup> From the planter's point of view, magistrates who

---

24. Despatch. Governor Scott, 25 July 1871. C.O. 111/386.

25. Circular. 10 February 1859. Royal Gazette 12 February 1859.

26. Wodehouse. Report of the Court of Policy. Royal Gazette 8 February 1859.

27. Des Voeux letter. Report of the Commissioners Appointed to Enquire into the Treatment of Immigrants in British Guiana. June 1871. (1871 Commission) P.P. 1871. XX. p. 491, 567.

28. Official Gazette C. O. 115/35. Pp727-729.

## Medical provision, plantations and the state 1847-1873

dared to raise criticisms were cast in the role of an 'officious set of people always giving trouble.'<sup>29</sup> The same attitude undoubtedly applied to 'officious' doctors.

All in all, the special circumstances of employment, not least the tropical climate, the relatively small numbers of Europeans resident, and perhaps the lack of prestige attached to the colony, conspired against any substantial increase in the number of doctors arriving in search of a medical living. In turn, this ensured that many of the largest estates and settlements, especially those in the remoter and more inaccessible districts, continued their dependence upon a single medical man. Worse still, sickness, inclement weather and poor or unpassable roads frequently made it impractical for doctors to travel. During outbreaks of epidemic disease whole districts were sometimes left without medical management.<sup>30</sup> Moreover, as doctors were unable to gain any monetary advantage from treating the poorest inhabitants of the colony – mainly those who lived in the villages, medical care stopped at the perimeter of the estate.<sup>31</sup> In the early 1850s the vast majority of the colony's 127,000 inhabitants were left to face disease according to their own devices.<sup>32</sup>

In short, on the available evidence, it seems that medical provision for plantation workers was structured primarily by geography, the economics of medical practice, and the social power wielded by plantation managers, rather than by the health needs of the labourers.

### 2.3 Immigration, government, and the Hospital Ordinance of 1859

The system of indentureship secured for planters a means to procure, manage, organise and discipline, a workforce. If emancipation saw the collapse of 'steady labour', indentureship saw its reconstruction. The sociologist Michael Mann has argued that the power of elites in society has often arisen out of their ability to 'organise and control people, materials and territories'.<sup>33</sup> This claim seems particularly apposite for the post-emancipation period of the Caribbean. The indentured labour system and the individual plantations which sustained it, were spaces entirely devoted to the production

---

29. *Royal Gazette* 8 February 1859.

30. During the outbreak of cholera in the Colony in 1857, plantations on the island of Essequibo had no doctor. *Royal Gazette* 15 January 1857.

31. *Royal Gazette* 17 February, 5 March 1857.

32. 1851 Census. C.O. 111/284/318.

### Medical provision, plantations and the state 1847-1873

of sugar, and the people who worked there were organised with this single purpose in mind. This vast system of plantations and labour, production and trade, which stretched across the Caribbean, was also the mechanism which ensured the dominance of Europeans in the West Indian colonies.

Yet indentureship, indeed plantation societies generally, also engendered endemic levels of resistance.<sup>34</sup> Usually these were small daily struggles by labourers against the pace of work or against perceived indignities. More sporadically, there was mass organised violence against the dictates of managers, which inevitably brought out detachments of police and their musketry. In addition, amongst ruling circles, splits and divisions could occur. As we saw with the Colonial Office in the last chapter, there were tensions in Guiana between the different European elements of colonial society, i.e., the planters and the wider colonial polity, over the organisation and management of indentureship. It is to this that we turn next.

Throughout the latter half of the nineteenth century planters attempted to strengthen further their institutional control over labour by lengthening the period of indentureship.<sup>35</sup> This they sought to achieve through various Immigration Ordinances. The Colonial Office had the final say in this matter, and despite its evident broad agreement on many issues affecting the colony, they often limited or otherwise adjusted the terms of ordinances. Planters were also keen to increase hugely the number of immigrants arriving in the colony, and appealed to the Colonial Office for permission to raise their allocation.<sup>36</sup> Apart from the political and organisational difficulties of securing sufficient immigrants, the colony was plagued by problems of finance. As Alan Adamson has pointed out, by the end of 1854 the colony had accumulated a substantial public debt.<sup>37</sup> This was almost entirely due to immigration loans. Nevertheless, planters responded to their plight by claiming they were:

---

33. Michael Mann, The Sources of Social Power. Vol. 1. A History of Power from the Beginning to A.D. 1760 (Cambridge University Press 1986), p. 2.

34. Ed Beechert, 'Labour Relations in the Hawaiian Sugar Industry 1850-1937', in Bill Albert and Adrian Graves (eds.), Crisis and Change in the International Sugar Economy 1860-1914 (ISC Press 1984), pp. 281-291. Bill Albert, 'The Labour Force on Peru's Sugar Plantations 1820-1930: A Survey', in Albert and Graves (eds.), Crisis pp. 211-215. Arturo Warman, 'The Cauldron of the Revolution: Agrarian Capitalism and Sugar Industry in Morelos. Mexico 1880-1910', in Albert and Graves (eds.), Crisis pp. 165-179.

35. Moore, Race p. 165.

36. For the years 1857-58, 1858-59 and 1859-60 planters ordered 3,000, 4,300 and 5,400 immigrants. See P.P. 1859 II. XIV; P.P. 1860 XXIX.

37. Adamson, Sugar p. 106.

## Medical provision, plantations and the state 1847-1873

...subjected to the unreasonable, unjust, and impolite restrictions in procuring suitable labourers, and in sufficient numbers, to enable us to sustain competition we are exposed to with other countries not hampered by such vexatious difficulties.<sup>38</sup>

These 'difficulties' were largely based on metropolitan perceptions of the West Indian planter. In the late 1850s, over two decades after the abolition of slavery, the organised transport of labour to the West Indies was still capable of mobilising political debate in Britain. In *Colour, Class and the Victorians*, Douglas Lorimer characterised the anti-slavery movement during this time as an 'ageing group' with a 'dying cause'.<sup>39</sup> Andrew Porter has likewise claimed that they had lost their 'drive, energy and political weight'.<sup>40</sup> Yet there remained topics which continued to nurture abolitionist sentiment. The issue of conditions of indentureship in the West Indies was one of these. Although the humanitarian influence in Parliament had declined with emancipation and the rise of free trade ideology, the Anti-Slavery and Aboriginal Protection Societies remained sufficiently active to throw into doubt the ability of plantation owners to care for their imported labourers properly.<sup>41</sup> Illustrative of how some individuals viewed the West Indies was a letter to the *Times* which speculated whether the 'crimes' committed against the Chinese in Cuba were reproduced in British Guiana.<sup>42</sup> Other newspapers continued to link the system of indentureship with slavery and retained a measure of public support for these views.<sup>43</sup> For example, the *Daily News* regularly questioned the transportation of labour to the West Indies from Africa and India.<sup>44</sup>

In much of this material, allegations and rebuttals over the mortality levels of labourers provided grist to the arguments around indentureship. Yet precise figures for indentured mortality were difficult to obtain, since only the colony government had the

---

38. Speech by member of the Combined Court. *Royal Gazette* 28 April 1857.

39. Lorimer, *Colour, Class and the Victorians*, p. 117. For a recent discussion see Charles Swaisland, 'The Aborigines Protection Society, 1837-1909', *Slavery and Abolition* Vol. 21 August 2000, pp. 265-280.

40. Andrew Porter, 'Trusteeship and Humanitarianism', in Porter (ed.), *Oxford History* p. 214.

41. The Anti-Slavery Society also campaigned against the government in British Guiana introducing a Registration Tax on labourers. *Royal Gazette* 16 June 1857.

42. As a result the Court of Policy ordered a report on the Chinese in British Guiana. *Royal Gazette* 30 April 1857.

43. Article in the *Morning Star* quoted in *Royal Gazette*. *Royal Gazette* 29 December 1857. See also letter to *Times* quoted in *Royal Gazette* 5 January 1858. Governor Wodehouse referred to the strength of public opinion regarding the importation of free Africans into the Colony at a dinner in London. 'The fact is, that the British Public is not quite sane where the African is involved (cheers and laughter) and nothing will induce them to believe that there is not in the heart of the West Indian planter some hankering after the old system of slavery.' *Royal Gazette* 27 February 1858.

### Medical provision, plantations and the state 1847-1873

ability to collect this information. Many dimensions of plantation life regularly appeared in the colony press, but rarely were there discussions over immigrant mortality. As the *Creole* newspaper in Guiana pointed out, hospital returns from estates were a 'jealously kept secret' precisely so that the colony's opponents should not gain ammunition against the importation of labour.<sup>45</sup> Nevertheless, such was the continuing vigour of the Anti-Slavery Movement in the 1850s that the Guianan planters formed a committee to refute, point by point, its criticisms of the colony.<sup>46</sup> In a passionately written missive to Earl Grey, the Secretary of State for the Colonies, planters argued that the Anti-slavery Society had no 'official status' and represented nothing more than a 'miserable fraction of the English people, who hold peculiar opinions on the subject of tropical labour.'<sup>47</sup> The epitaphs 'Deluded' and 'self conceited' summed up the *Berbice Gazette's* views of the Society.<sup>48</sup> There was, according to the staunchly pro-planter *Royal Gazette*, an 'unholy warfare against the much injured planter.'<sup>49</sup>

Despite the force of these views emanating from Guiana, the home government was unable to brush wholly aside the ideological challenges to indentureship raised by the Anti-Slavery Society.<sup>50</sup> Also, although scepticism about the benefits of empire were prevalent amongst some politicians, the British government still believed it necessary to intervene across the world in colonial matters.<sup>51</sup> British Guiana was no exception to this approach. Perhaps with a backward glance to those forces critical of the British role abroad, the Colonial Office found justifications for empire in the promotion of 'civilisation' and 'progress', two causes few mid-Victorian politicians could dissent from.<sup>52</sup> In the case of Guiana, this meant ensuring the colony turned its attention towards various social and moral issues, promoting the Christian religion, providing elements of education and supporting moral institutions such as marriage.<sup>53</sup> In this discourse of

---

44. Items from the *Times* and the *Daily News* along with letters, were published in the Colony by the *Royal Gazette*. See *Royal Gazette* 28 January 1858, and the 2, 9, 13 February 1858.

45. See *Royal Gazette* 16 February 1858 citing the *Creole*.

46. Committee appointed to report upon a Communication from the *Anti-Slavery Society* dated 22 March 1850. MCP. 19 June 1850. C.O. 114/17.

47. *Ibid.*

48. *Berbice Gazette* 2 July 1857.

49. See *Royal Gazette* 3, 22 March 1859, and 2, 30 July 1859.

50. Grey. M.C. P., 2 June 1851. C.O. 114/18.

51. Timothy H. Parsons, *The British Imperial Century 1815-1914* (Rowman & Littlefield 1999), pp. 18-19.

52. Ronald Hyam, *Britain's Imperial Century 1815-1914* (Macmillan 1993), pp.1-73.

53. Circular by B. Kay Shuttleworth on the importance of education in the Colonies. Presented to the Court of Policy. 6 January 1847. C.O. 114/17

### Medical provision, plantations and the state 1847-1873

civilisation, medicine had a dual role. The presence and availability of Western medicine for plantation workers indicated the regime's progressive nature – whilst medicine, despite its unregulated character, also served the interests of planter society more directly, by tending to the colony's labour force.

Some acknowledgement of the political force of medicine existed amongst planters. For instance, the *Royal Gazette* in 1859 noted the important role of medical legislation in favourably influencing Parliament.<sup>54</sup> Governor Wodehouse also stressed this point when he reminded the colony's legislative body that the home government viewed with concern any lapse regarding hospital treatment on the estates.<sup>55</sup> In short, maintaining political sympathy at home and economic stability in the colony, the latter premised upon continued immigration, required a visible and demonstrable policy towards the health care of labourers. As Wodehouse explained:

Looking to the probability of the speedy introduction of a large number of immigrants from India and China, and deeply impressed with the personal responsibility...for securing to the immigrant during his indentured service the real enjoyment of the benefits promised to him in his contract – for these and other weighty considerations – the Governor can no longer defer bringing to the notice of the Proprietors and Attorneys of Estates, and more particularly those in Demerara and Essequibo, the defect in the existing [hospital] arrangements.<sup>56</sup>

These sentiments may not have been shared by planters in the colony's Court of Policy, but there did emerge a broad agreement that some mild reforms were possible in order to ratchet up the rate of immigration. Mr. Smith, speaking on behalf of planters, chided the governor for using 'strong terms' in describing the old practice of doctors 'finding medicines' (this was the practise whereby doctors paid for the medicines to treat labourers). He went on, 'The regulations of the [estate] hospital might require amendment, but he thought they were on the whole tolerably good.'<sup>57</sup> Wodehouse himself favoured a radical change towards a system of district hospitals, as had one of his predecessors Governor Light, but was unable to gain any support for this amongst the planter body. Just as employers at home had fought against the factory acts, planters in the colony opposed 'meddling and interference' in how they organised and provided

---

54. *Royal Gazette* 22 February 1859. See also *Royal Gazette* 20 September 1859.

55. Wodehouse. Report of the Court of Policy. *Royal Gazette* 8 February 1859. See also Circular to plantations 10 February 1859, in *Royal Gazette* 12 February 1859, and Governor's speech to the Legislature, 17 September 1859 in *Royal Gazette* 24 September 1859.

56. Circular. 10 February 1859. *Royal Gazette* 12 February 1859.

57. Mr. Smith. Report of the Court of Policy. *Royal Gazette* 8 February 1859. See text at footnote 26.

### Medical provision, plantations and the state 1847-1873

for their labourers.<sup>58</sup> Accustomed to running their plantations almost entirely without government supervision, most of them looked upon changes in the way doctors worked on the plantations as a gross and unnecessary infringement of their freedom.<sup>59</sup> Another planter representative in the colony's Court of Policy, boasted, 'the labouring population on the estates [are] as well cared or better cared [for] than in any other country in the world.'<sup>60</sup> In particular, planters resisted moves to place on the estate doctor any formal responsibility for the treatment of non-indentured labourers.<sup>61</sup> This seems to have been an important sticking point for the planters and for the government. A huge swathe of the colony's labouring population was potentially without any form of medical supervision, although custom and practice on the estates ensured that doctors generally treated all plantation workers, indentured and non-indentured, alike.

The diverging views between representatives of private enterprise and colonial governance raised fundamental questions about the relationship between the state and plantation, namely, what was the role of government bodies in the organisation of medical provision, and how far were the representatives of the home government able to intervene in private economic matters. In the legislation which resulted, these questions were resolved substantially in the direction of planter opinion. When the new hospital bill was finally introduced before the legislature in the autumn of 1859, the powerful influence of planters in the Court of Policy became apparent. The governor conceded that the new hospital ordinance was:

...strictly limited in its requirements to what should be done on the estates for the benefit of the indentured labourer. Beyond the case of the indentured immigrants, the Government has no positive right in any manner to interpose its authority.<sup>62</sup>

The 1859 Ordinance to Provide for the Better management of Estates Hospitals was therefore a compromise between that section of the colonial government which wanted to improve medical attention for non-indentured and indentured labourers and those in the colonial government who represented planter interests. The limits of legitimate government interest were established in favour of the planters and went no

---

58. Wodehouse. Report of the Court of Policy, 17 September 1859. Royal Gazette 24 September 1859. See Ursula R. Q. Henriques, Before the Welfare State: Social Administration in Early Industrial Britain (Longman, 1979).

59. Mr. Smith. Report of the Court of Policy. Royal Gazette 8 February 1859.

60. Report of the Court of Policy. 28 February 1859. Royal Gazette 8 March 1859.

61. *Ibid.*

62. Wodehouse. Report of the Court of Policy. 17 September 1859. Royal Gazette 24 September 1859.

### Medical provision, plantations and the state 1847-1873

further than providing medical treatment for the indentured labourer. In other ways, too, the planter came off well, and the number of immigrants sent to the colony increased. Between 1851 and 1859, 18,678 indentured East Indians landed in the colony. Between 1860 and 1869 this number rose dramatically to 38,842.<sup>63</sup>

On the other hand, although planter resistance successfully scuppered the most far-reaching reforms (district hospitals and fixed salaries for doctors), Wodehouse's legislation opened the door to further change. Crucially, the manner by which estate hospitals were inspected was altered. Responsibility for this task was shifted onto the colony's Immigration Department, which itself was answerable to the Colonial Office in London. The significance of the new Ordinance, therefore, lay in the way it effectively put in place another layer of bureaucratic control over the emigrant worker. In theory, at least, it was becoming possible for officials far away in London, through their representatives on the spot, to 'see' into the plantation.<sup>64</sup>

In Guiana a new post, Medical Inspector of Estates' Hospitals (hereafter Medical Inspector), was duly created. Although under the auspices of the Immigration Department, he was directly responsible to the Governor. Significantly, his expenses and substantial salary (£1000 per annum) were not a charge on the planters, but upon the colonial revenues in general.<sup>65</sup> Dr. Shier, a committed supporter of the indenture system, an active member of the colony's Royal Agricultural and Commercial Society and, therefore, a congenial choice for planters, was appointed to the new position.<sup>66</sup> For the first time, an experienced medically trained person, who was familiar with the workings of the colony, but who possessed a degree of financial independence from the planters, was responsible for assessing the quality of health care on the estates.

The new Ordinance also went some way towards promoting standardisation of plantation hospitals. Uniform diet scales and lists of necessary medicines and their quantities were framed. The reforms were also characterised by new bureaucratic measures designed to enable the authorities to assess quickly the level of care. Hence,

---

63. Laurence, *A Question of Labour* p. 522.

64. Wodehouse and Smith. Report of the Court of Policy. *Royal Gazette*, 8, 12 February 1859. Report of the Court of Policy, 28 February 1859. *Royal Gazette* 8 March 1859.

65. Wodehouse. Report of the Court of Policy, 17 September 1859. *Royal Gazette* 24 September 1859. Merivale to Colonial Land and Emigration Board 3 November 1859. C.O. 318/226/75.

66. Shier was also keen to investigate various technical improvements that could be introduced into sugar production in Guiana. In 1851 he visited Europe and wrote a detailed appraisal about the benefits of the 'Centrifugal Machine' used in sugar beet production. MCP. 18 March 1851. C.O. 114/18.

## Medical provision, plantations and the state 1847-1873

Hospital Registers and case books to record the names, numbers, ages, sex, race, dates of admission, diseases, injuries, remedies and scales of diet became mandatory. Inspections of hospitals by 'Sub-Immigration Agents' and Magistrates continued, but were now supplemented by twice yearly visits from the Medical Inspector under the auspices of the Immigration Department. In the following chapter, in the section beginning with 'The State and Hospital Registers', I examine the difficulties in applying these measures.

### 2.4 Politics, doctors and the Immigration Ordinance of 1873

As with previous legislative initiatives, the 1873 Immigration Ordinance, which laid the foundations for a government run medical system, had its origins in the dynamic interplay of politics and economics between colony and home government.

In the decade following the 1859 Hospital Ordinance, the health care of indentured labourers continued to be assessed by doctors working on behalf of plantations. As we have seen, the standards of care on the plantation were now subject to greater monitoring, but the day-to-day management of hospitals remained with the local doctor and the plantation manager. In this relationship, the doctor was sometimes perceived as the weaker partner. Writing to the Secretary of State for the Colonies, Lord Granville, in December of 1869, the former Magistrate, des Voeux, drew attention to this:

At present their tenure of office is almost entirely dependent on the will, or rather the caprice, of the managers of estates. Several of the most upright of them have at different times deplored to me their position in this respect; and have shown me that any serious complaint on their part in respect of abuses, which they saw going on under their eyes, would only be followed by the loss of their livelihood, and the instalment in their practice of less scrupulous practitioners.<sup>67</sup>

Des Voeux, who had been prompted to write because of recent immigrant 'riots' on plantation Leonora, did not restrict his comments to the supposed inadequacies of medical organisation. He also questioned the effectiveness of colonial officials in protecting the interests of immigrants. The 'Voeux letter', as it became known in England, cast doubt on the colony's carefully built up reputation for paternalistic governance by citing cases of ill-treatment meted out to immigrants, and corruption by

---

67. Des Voeux letter. Report of the Commissioners Appointed to Enquire into the Treatment of Immigrants in British Guiana. June 1871. P.P. 1871. XX. p. 488.

### Medical provision, plantations and the state 1847-1873

plantation officials regularly who 'skimmed' wages. Once again accusations of labour mistreatment in Guiana focused government attention on to the colony. In des Voeux's view, the high fines and long sentences, which awaited those immigrants found in breach of their contractual duties, were themselves the cause of discontent, producing in their wake resistance and disorder. Moreover, claimed des Voeux, magistrates, who were supposedly there to uphold the interests of immigrants on behalf of the government, and not just those of planters, were 'in awe of the powerful planting interest which more or less pervades all classes, and reaches into the highest places.'<sup>68</sup>

This last observation received timely fulfilment in October 1872 when about 250 men and women from Devonshire Castle occupied the estate in a tense dispute over wages for weeding and shovel work. The magistrate Loughran, fresh from Ireland where he had gained experience 'quelling the Belfast riots of 1864', read the riot act before instructing his men to 'fix swords'. Loughran's intervention on the side of planters ended tragically for five immigrants who were killed.<sup>69</sup> In London anti-slavery forces, long dormant, stirred, and the *Times* called for an enquiry. It reminded planters that if 'the indignation of the Mother country be roused by any barbarous treatment of these Asiatics, the Coolie trade will be suppressed as relentlessly as the old African slave trade.'<sup>70</sup>

In fact, the controversial assertions of a former magistrate, combined with labour discontent on Leonora and other plantations, and the serious consideration of whether to send for troops from Barbados, had already prompted the home and Indian governments to demand a Commission of Enquiry to examine the conditions of labourers in the colony.<sup>71</sup> After all, it was only four years since Governor Eyre in Jamaica had been shaken by a local revolt, which had then spread rapidly out of control, threatening the very continuance of European rule. The appointment of William E. Frere, Judge of the Supreme Court of Bombay to the Guiana Commission shows the continuing strength of Indian involvement in the affairs of the colony.

The Commission, despite the dominating views of planters, led to a number of important changes in the colony. These principally involved the organisation of

---

68. *Ibid.* p. 489.

69. *Creole* 16 October 1872.

70. *Times* 5 November 1872, in *Creole* 29 November 1872. See also *Royal Gazette* 28 November 1872.

### Medical provision, plantations and the state 1847-1873

immigration procedures and the colony's medical structure. The pattern of colonial development elsewhere influenced the Commission's findings. In London, it was noted that in the islands of Jamaica and Trinidad a system of Medical Districts and Government Medical Officers had already been established, and appeared to be working well. A similar system for Guiana was favoured by the Commission, Governor Scott, the Colonial Office, and perhaps, just as importantly, by the Indian Government. For the administrators of the London-based Colonial Land and Immigration Board, organising Guianan doctors into a similar scheme promised to bring benefits of centralisation and the colony's harmonisation with other West Indian Islands.<sup>72</sup>

However, the supposed advantages of these proposed changes did not impress the colony's planters or indeed the *Creole* newspaper, which saw in the proposed reforms an added burden of taxation.<sup>73</sup> For planters, it was an issue about unwarranted government interference in the workings of the estate. Planters were determined to retain their freedom to hire doctors of their choice, and were sceptical that doctors hired by the government and set to work on the plantations would deliver a superior service. Precedent was important, as planters were 'not aware that any officer of the Government had ever been dismissed for incapacity.'<sup>74</sup> In England, the West India Committee lobbied the Colonial Office warning against far-reaching change.<sup>75</sup>

This level of agitation was unsurprising since the proposed introduction of government-salaried doctors (although they were effectively to be funded by plantations) marked a profound modification in the relationship between the state, doctors and private commercial enterprise. As Governor Scott recorded:

This reform in the medical supervision of immigrants implies not only an important change from the present practice, but an extensive interference on the part of the government both with the managers of the estates and a considerable number of medical practitioners: the former are not likely to regard it with much favour, and there can be little doubt that the latter will strenuously oppose it, in as much as it will in many instances cause a large reduction in the professional income which they now obtain under the present system.<sup>76</sup>

---

71. See Governor Scott's long despatch designed to reassure the Indian authorities. Scott to Kimberley, 22 May 1872. C.O. 384/128

72. Colonial Land and Emigration Board. Walcott to Herbert, 27 September 1871. C.O. 318/262.

73. Leader. *Creole* 19 July 1872.

74. Scott to Kimberley, 5 August 1872. C.O. 111/391.

75. West India Association to Carnarvon, 23 July 1874. C.O. 384/104/705.

76. Scott to Kimberley, 25 July 1871. C.O. 111/386.

### Medical provision, plantations and the state 1847-1873

Scott's goal of fashioning the colony's doctors into salaried officials under the authority of the Immigration Department, thus represented a fundamental and sweeping transformation of medical organisation in the colony. Scott's proposal for Medical Districts also included an ambitious programme to provide dispensaries for the scattered village populations in the colony. This suggests a significant broadening of the scope of Western medicine. Previous attempts to put medical care within the reach of rural dwellers had ended in failure.<sup>77</sup> At least one representative of the Court of Policy thought that making medicine available to villagers was essential from a 'political and humane point of view'.<sup>78</sup> However, it is worth noting here that the priorities of health care remained firmly with the plantations, and that few resources were put towards village health. In 1881, the acting Immigration Agent contended that in most villages medicine from dispensaries was 'unreliable', 'inert', 'useless' and 'expensive'.<sup>79</sup>

In response to planter concern over the reorganisation of the medical service, Scott and the current Secretary of State for the Colonies, Lord Kimberley, adopted a confrontational position. On a number of occasions during the latter half of 1872, Scott conveyed to the Court of Policy the non-negotiable nature of the changes. In June 1872 the *Creole* published one of Kimberley's despatches, in which he stressed:

I cannot too earnestly impress upon the Court of Policy the necessity of promptly passing such measures which will remove all ground for complaint on the part of the Indian authorities, and enable Her Majesties Government to maintain this system of emigration which has been of so great advantage to the colonies...and conferred benefits upon the Emigrants themselves.<sup>80</sup>

In short, unless the new ordinance was passed by the colony's legislature, further immigration from India would cease.<sup>81</sup> How were these proposals received by doctors?

In total, just under thirty doctors worked for plantations.<sup>82</sup> At least a proportion of these individuals were also opposed to altering the existing system. From their perspective, the change to Medical Districts and salaried employment were of dubious value. They feared a reduction in salary, of arbitrary allocation or removal from districts

---

77. Ibid.

78. MCP. 1 August 1872. C.O. 114/26.

79. C. B. King. Actg. Immigration General, 15 October 1881. C.O. 114/29.

80. Kimberley to Scott, 16 May 1872. *Creole* 26 June 1872.

81. Scott to Court of Policy. *Creole* 2 August 1872. Scott to Kimberley, 5 August 1872. C.O. 111/391. See also Despatch from Secretary of State for India read out to the Court of Policy, 11 June 1872. C.O. 114/26 and also Kimberley to Scott, 16 January 1873. Read out in the Court of Policy 21 February 1873. C.O. 114/26.

### Medical provision, plantations and the state 1847-1873

at the behest of an unaccountable bureaucracy, or perhaps through instructions from London. For some doctors, the individually negotiated financial agreements between themselves and the plantation were of mutual benefit and worth defending. Several prominent doctors, including Georgetown's Health Officer and the Surgeon General, penned a letter to the Court of Policy pointing out that the profession 'thrived' on competition.<sup>83</sup>

With regard to the medical profession Scott was more conciliatory. In order to diminish medical opposition to change, the sizes of Medical Districts were adjusted so that doctors received their existing levels of remuneration. This ensured that those doctors who had worked in the colony for twenty or thirty years and had the largest incomes did not suffer any financial discomfort. Medical Districts differed according to the size of estates and the number of dispensaries, police stations and villages within them. Therefore, opportunities of private practice were also assumed to make up the doctors total wage, and an elaborate scale of fees was eventually produced (see appendix IV). In addition, the larger Medical Districts carried the higher salary of £1000 compared to £500 for the smaller districts.<sup>84</sup> However, plans to restrict the private practices of some town doctors seem not to have provoked opposition. As had already happened in Trinidad, the Surgeon General and visiting physicians at the Public Hospitals lost their automatic right to attend plantation hospitals.<sup>85</sup>

These changes took place within a much strengthened Immigration Department. With a total staff of thirty (not including the new medical officers), it now possessed responsibility for managing the new Medical Districts, supervised (via sub-immigration agents) the work of doctors on the estates and possessed its own Medical Officer who mustered and classified the new arrivals, dividing them into the 'effective', the 'partially non-effective' and the 'non-effective'.<sup>86</sup> The management of plantation hospitals also fell under its authority. The Department did not interfere with the professional role of doctors within the walls of the hospital, but was responsible for ensuring that the

---

82. The government budgeted \$100,000 for twenty-seven doctors. Creole 2 August 1872.

83. Memorial to Scott. Creole 26 June 1872.

84. MCP. 1 August 1872. C.O. 114/26.

85. Scott to Kimberley, 5 August 1872. C.O. 111/391.

86. James Crosby. Half Yearly Returns, 24 July 1877. C.O. 114/27. For list of staff, see M.C.P. 26 May 1881. C.O. 114/29.

### Medical provision, plantations and the state 1847-1873

hospital regulations, medicines, dietary requirements, utensils and medical stores were in order.<sup>87</sup>

With these reforms the organisation of the medical profession was centralised under the colony's Immigration Department. The Immigration Ordinance, which was eventually passed in 1873, helped fashion plantation doctors into a cohesive and distinct sub-department of the wider bureaucratic immigration network. As such the medical profession became another link in a chain of supervisory departmental bodies, which stretched from India and other countries, to the West Indies and Guiana. The health care of immigrants, and to an extent, that of villagers, was now under the direct gaze of government officialdom: the Immigration Department and salaried medical practitioners. Both the Colonial Office and the colony legislature had, in the form of government employed doctors, a new layer of agents for pursuing administrative goals.

#### 2.5 Consequences and developments

In the following years the direct impact of this legislation can be seen in three areas: statistics; the allocation of immigrants; and 'food for work'. Each of these is now briefly examined in turn.

The 1873 Immigration Ordinance led to a burgeoning of statistical detail about immigrant health. In fact, even before the passing of the new Ordinance, it is clear that the Immigration Department had already embarked on a massive statistical project to compile the number of immigrants entering each plantation hospital, record the diseases treated, and set out the rates of mortality. To an extent this statistical enterprise filtered out for officials and other interested parties at home, the eye witness account or the 'lived reality' of working on a plantation, and the suffering involved as labourers came into contact with diseases. The composition of tables, the accumulation of facts, gave no clue to cause and effect, but tended to narrow the field of possible debate, marginalising speculations and counter views. In short, the language of figures challenged other forms of social description.<sup>88</sup> Yet, it was not the voice of the labourer that officialdom sought. What these statistics did, was to present officials of the Immigration Department and the Colonial Office with an easily understood comparative system for grading health

---

87. An Ordinance To Consolidate And Amend The Law Relating To Immigrants. No. 7. 1873.

### Medical provision, plantations and the state 1847-1873

conditions on plantations. The administrative and political difficulties encountered in assembling these statistics is examined in more detail in the next chapter. For now it is important to note that through this system, a vast amount of information about plantations was compiled and sent off to London.

One early consequence of this administrative interest was fresh endeavours to reduce mortality by the better allotment of immigrants. By 1870, the Immigration Department had taken to distributing immigrants in smaller numbers.<sup>89</sup> In India, the Bengal government had for a number of years restricted the supply of immigrants to special times during the year, depending upon the start and finish of wet seasons in Guiana. Experience showed that the period from October to March (avoiding the June rainy season) was the best time to introduce new labour.<sup>90</sup> These initiatives were possible because of the accumulated information gleaned from the estates' Hospital Registers. Topological features, patterns of disease and considerations of seasonal characteristics, coalesced into administrative understandings about those areas most likely to present problems for acclimatising immigrants. David Shier, the Medical Inspector, explained the principal underlying allotment of immigrants:

those Estates on which acclimatisation is attended with the greatest difficulties should have their Immigrants allotted at such times as will afford the greatest facilities.<sup>91</sup>

Thus, time of year, plantation hospital resources, and geography were all marshalled into consideration to help provide policy decisions. Later, tighter regulation of allotment was imposed by the Colonial Office. The year 1870 saw the government in Trinidad adopt a seven per cent rule. Under this system, estates with an annual mortality rate above this figure were prohibited from receiving new immigrants. The home government pressed for a similar system in Guiana.<sup>92</sup> As already mentioned, the compilation of medical statistics now made it possible for the colonial government, and the Colonial Office in London, to gauge conditions on even the remotest estates, and thus, link the allotment of immigrants directly to levels of mortality. The formula

---

88. This point is made by Joshua Cole, *The Power of Large Numbers, Population, Politics and Gender in Nineteenth-Century France* (Cornell University Press 2000), p. 9.

89. 11<sup>th</sup> Report of Estates Hospitals (REH). D. Shier. 29 April 1865. C.O. 114/22.

90. Emigration Board. 18 September 1873. C.O. 318/271.

91. 21<sup>st</sup> REH. 29 October 1870. C.O. 114/22.

92. K. O. Laurence, *A Question of Labour. Indentured Immigration into Trinidad and British Guiana 1875-1917* (James Curry 1994), p. 214.

### Medical provision, plantations and the state 1847-1873

adopted in Guiana was different from that of Trinidad, but the effect was the same. Where mortality exceeded double the average death rate amongst immigrants over the previous five years, allotments of immigrants were suspended.<sup>93</sup> Arguably, this was a generous calculation, but it nevertheless ensured that some plantations were refused new workers. Amongst the first estates to receive letters to this effect were plantations Spring Garden and Wales.<sup>94</sup> In the following years this policy was continued, nine estates were excluded in 1874 and 1875.<sup>95</sup>

The 'food for work' policy was also a consequence of greater bureaucratic control of immigrants. By the 1860s, a consensus amongst the colony's doctors was beginning to emerge about the variation in mortality rates amongst indentured labourers. Firstly, as indicated above, some districts appeared to be more dangerous than others to the newly arrived. Also, some classes of immigrant showed advantages over others, either from perceived superior stamina, from being already accustomed to field labours, or from the more favourable season of their arrival. Smaller allotments of better supervised immigrants who were liberally fed and lightly worked also seemed to increase the numbers who survived into their second year. Doctors often attributed diseases such as ulcers and debility to the 'incurable laziness of the patient', but also as the outcome of 'impoverished blood', and the consequences of dietary deficiency.<sup>96</sup> Many doctors preferred the stamina enhancing qualities of fresh beef and pork over the rice and fish diets of labourers. Dr. Stephen Scott, the acting Medical Inspector in 1864, lamented that 'great expense and strong prejudices of the Coolies [were] serious obstacles to its general consumption.'<sup>97</sup> Similar concerns about diet were raised by Dr. Shier, the Medical Inspector. He argued that new immigrants: '...should be carefully fed for a longer period than is customary on most estates and ... they should not be allowed to work by the task till they are physically able to undergo fatigue.'<sup>98</sup> A better diet and improved hygiene, access to fresh water and suitable accommodation, presented the possibility of superior health and more productive workers.

---

93. Despatch. Scott. 21 December 1871. C.O. 111/387.

94. Ibid. 22 November 1871. C.O. 111/387.

95. Laurence, *A Question of Labour* p. 215.

96. 9<sup>th</sup> REH. Stephen Scott, February 1864. C.O. 114/22. Report of the Commissioners Appointed to Enquire into the Treatment of Immigrants in British Guiana. June 1871. P.P.1871. XX. pp. 621.

97. 9<sup>th</sup> REH. Stephen Scott. February 1864. C.O. 114/22.

98. Suggestions as to the acclimatisation of immigrants. D. Shier. 20 October 1863. C.O. 111/342.

## Medical provision, plantations and the state 1847-1873

In view of the perceived benefits of properly acclimatised and fitter workers, the Immigration Agent General in 1867 suggested planters adopt a policy of dispensing food-stuffs and reducing the work load of new immigrants. Although plantations were subsequently permitted to pay a proportion of wages in the form of food, few actually did so.<sup>99</sup> This situation altered with the Commission's report and the Immigration Ordinance of 1873. As doctors became refashioned as government servants they were charged with administering a compulsory rationing system and organising inspections and monthly muster-rolls to operate the scheme. Employers became liable for dispensing daily rations including rice, dhal, ghee, 'curry stuff', sugar and salt, to new arrivals, the cost of which was met from the wages earned by the immigrant. In practice, the application of this system varied from estate to estate. Unsurprisingly, the 'food for work' policy was the cause of disputes between labourer and manager. Immigrants proved extremely reluctant to accept food in lieu of wages, they often refused to assemble in order to avoid being put on rations, and doctors generally felt unable to press the matter.<sup>100</sup> In this instance, immigrant expectations regarding their right to receive wages, rather than opposition from planters, effectively circumscribed medical authority.

### 2.6 Conclusion

In conclusion, taken together the 1859 Hospital Ordinance and the 1873 Immigration Ordinance marked a fundamental change in the relationship between the government and the plantations. Their introduction, in the face of planter opposition, shows that in a similar way to government in England, the concerns of the Guianan government were no longer confined to 'political administration', but extended to the management of populations.

Under the stewardship of the Colonial Office, British Guiana and other West Indian colonies were gradually swept into broad conformity with each other with regard to the organisation of medical provision. As doctors were changed into District Medical Officers (later, in 1886 Government Medical Officers), they were freed from much of their former financial dependency on plantations, and correspondingly a new more

---

99. Section 10. Ordinance Number 9 of 1868.

### Medical provision, plantations and the state 1847-1873

critical note about the health of immigrants and that of colony inhabitants began to emerge. A despatch from the governor's office in 1886 expressed the hope that the Medical Service would be 'independent' (presumably of planter influences), that it would keep in better touch with the profession at home, and 'form a powerful body to aid the Government'.<sup>101</sup> This is exactly what happened. Even by the late 1870s, the medical profession was pushing for the establishment of Cottage Hospitals throughout the colony in order to tackle infant mortality.<sup>102</sup> As the century progressed the medical profession in Guiana exhibited increasing cohesion, self-confidence and political influence. In 1887 they began their own journal, the Georgetown Hospital Reports. By the end of the century the Surgeon General had a seat in the legislature, and doctors, like their compatriots in the Indian Medical Service, received colonial pensions. Although subsequent legislation further readjusted the medical services of the colony, the rationale of government officers tending to the health needs of labourers was never again seriously challenged.

-----

---

100. See Second Half Yearly Report. Immigration Department. 16 January 1875. C.O. 348/106. P. Paton Watt. Report of the Medical Officer of the Immigration Department 14 June 1880. C.O. 114/29.

101. Encl. 20 August 1886. C. O. 111/436.

102. Report of the Immigration Agent General for 1879. C.O. 114/29. Small hospitals were finally opened at Suddie in 1880, Morawhanna in 1897 and the town of Bartica in 1903.

## Chapter 3

### 3.1 Introduction

The discussion in the last chapter focused on how, as a result of immigration, inter-colonial and British government influences shaped new hospital legislation in Guiana. For the purposes of this chapter these political factors recede, and the centres of government power, for the most part, are left behind, as we move more closely into the world of the plantation. It is worth noting here that the evidence available for reconstructing plantation hospital care in Guiana is uneven, as the compilation of health reports on indentured labourers was not always a government priority. However, a number of archival sources do stand out. Of great importance is the 1848 report into plantation hospitals by Dr. Bonyun, a respected member of the Guiana Medical Society. Just over ten years later, with the introduction of new hospital legislation the government did set in motion a more systematic gathering of statistical information. This material appeared, along with various comments about immigrants and their health, in annual Hospital Reports compiled in Georgetown by Dr. Shier, the Medical Inspector of Estates' Hospitals. It is from these reports and descriptions that a fuller picture of the evolving perspective of immigrant health can be reconstructed. This is one that includes the social, economic and geographical conditions which also shaped the character of plantation medical provision, and helped lead to the reforms discussed in the last chapter.

One aspect of medicine and doctors, which was touched on towards the end of the last chapter, was the importance of collective qualities. The medical profession was particularly interested in how labourers from different parts of the world coped with the Guianan disease environment. As in England, doctors in the colony were keen to identify the relative healthiness of areas and grade them against each other. In Guiana this medical topography was tempered by assumptions about race, acclimatisation, and the susceptibility of different categories of workers to disease. In this chapter I argue that these intellectual commitments formed an important element in medical thinking, helping doctors to understand and explain variations of disease between different groups of workers. In short, doctors were strongly committed to unearthing the fluid and complex relationships between individual, place and disease.

### Plantation hospitals - disease, mortality and race

It should be remembered that these speculations on immigrant and Creole corporeal capacities were not idle musings. Up to 1873 doctors were salaried employees of the estate and therefore worked closely within a framework of costs and efficiencies. The estate doctor did not merely treat disease, but bent his skills towards helping manage and produce a profitable plantation economy. We can see in their accounts of race and acclimatisation how important this rhetoric was for the commercial workings of the colony. What is particularly noticeable is the way doctors refused to confine themselves to narrow observations about disease, but expressed opinions about many diverse aspects of the indentured labour system.

Another objective of this chapter is to provide an understanding of the scope and quality of medical provision, i.e. the number of hospitals, their size, how many labourers were treated, the diseases confronted, and levels of mortality experienced. From this information, something of the character of plantation hospital provision emerges, and the extent of the state's involvement in matters of health. I also attempt to bring out how the health care of labourers moved from the periphery of official colonial thinking to a more prominent position. This is indicated by the steady rise of statistical information, through the multiplication of disease categories in the official record, and by the detailed tabling of morbidity and mortality on estates. The result was that by the early 1870s the administration of immigrant health was an important aspect of colonial governance.

#### 3.2 Plantation hospitals 1848-1870

The vast majority of plantations in British Guiana stretched approximately 60 miles along the low-lying coast each side of the city of Georgetown. A smaller number hugged the river banks of the colony's numerous rivers. The plan of plantation *Uitvlugt*, with the typically regular partitioning of fields for drainage, is shown in appendix V. A map of all of the colony's plantations is included in appendix VI. Squeezed between or sometimes in front of these flat strips of intensely cultivated pieces of land were most of the colony's villages. To the north and west of the colony there were swathes of fertile unworked crown land, bunched in by dense uncultivated savannah, mangrove swamps, and forest. Further west still, hilly lands gave way to mountains and the vast Amazon jungle. Rains from this hinterland region, which comprised ninety-six per cent of

### Plantation hospitals - disease, mortality and race

Guiana's surface area, flowed down to the coast, conveyed by a myriad of streams and rivers.<sup>1</sup>

At high tides much of the coastal plain, for about five or ten miles inland, was below sea level. Plantations were, therefore, constantly threatened by the inflow of sea at the front, and during the rainy seasons, by flood water from behind. A distinctive characteristic of Guianese sugar production was the reliance of estates upon massive earthen banks to protect themselves from floodings, and complicated drainage systems to manage the flows of water through and around the estate. At other times, when the extremes of weather produced extended dry periods, plantations strove to retain water. Either way, in this constantly changing environment, efficient drainage, ditching, maintenance of canals, the management of sluice gates, and repairs to the steadily eroded 'back dam', were crucial for an estate's survival. It has been calculated that each square mile of cultivated land necessitated forty-nine miles of drainage canals and ditches and a further sixteen miles of higher waterways for transport and irrigation.<sup>2</sup> The bulk of work on the plantations was, therefore, not directly related to sugar planting or harvesting. Rather, it was an unrelenting organised struggle of human labour against the proliferation of weed, and the shifting forces of mud, sediment and water.

Drainage of this complex hydraulic world was achieved by an intertidal system. At low tides sluice gates were opened and the excess water allowed to escape. But the combination of high tides and heavy rainfall invariably meant that the defences of estates and the surrounding villages were overcome. Inundated by water on all sides, plantations and villages regularly succumbed to flooding. At this point rotting vegetation, waste from the sugar factory and human excreta floated up from the trenches, spread to the provision grounds, and mingled with the supplies of drinking water from the 'sweet water' trench. In the wake of flooding, estate workers, labourer and manager alike, as well as nearby villagers were vulnerable from outbreaks of diarrhoea and dysentery.

The plantation hospital lay within the grounds of the estate. It was here that doctors arrived to treat slaves, then later after abolition, sick labourers under contract, and towards the end of the nineteenth century, 'free' labourers from the villages. The institution also helped to maintain the plantation's social boundaries. Estate managers

---

1. Adamson, *Sugar* pp. 15-18.

### Plantation hospitals - disease, mortality and race

and other Europeans were invariably treated separately, in their own accommodation at the front of the estate. During the slave era both doctors and managers produced idealised views of the plantation hospital. As the following quotation shows, perceptions of what made for a healthy hospital involved styles of architecture, the proper division of patients, space, light, and nursing management.

With respect to the hospital accommodation, the buildings erected for that purpose, are in general lofty, spacious, and well ventilated. Some hospitals built within the last four or five years are finished in a style equal to a proprietor's dwelling house; the window sashes hung on pulleys to let up and down, the walls and ceilings painted, the apartments well arranged and neatly finished, built on brick pillars seven or eight feet off the ground, two stories high from the pillars, and some are three stories, with airy comfortable apartments in the upper story, for the lying-in women. One room is set apart for the pharmacy, and another for the residence of the head sick nurse, and as a store room for blankets, etc.<sup>3</sup>

This was a place where the orderly care of patients was structured into the architecture and design of the building, in a manner which would have been familiar to many British doctors. This description also demonstrated slave owner paternalism. It is charged with persuasive rhetoric designed for a home audience sceptical of the conditions under which slaves were treated. Doctors' glowing accounts of medical provision pre-emancipation were very much justifications and defences of the status quo, and as such the historian has to treat them, and indeed anti-slavery tracts also, very carefully. The former were produced by doctors who were deeply implicated in, and who often directly benefited from, colonial slave society.<sup>4</sup> It can be argued that post-emancipation this relationship had not substantially altered. However, what had incontrovertibly changed, were the political circumstances within which the production of sugar and the procurement and management of labour, were organised. This, together with the 1847 and 1859 Hospital Ordinances, slowly paved the way for a more critical tone towards medical provision emerging amongst some members of the medical fraternity and the government of the colony.

It is worth pointing out here, that although the sentiments of care implied in the above quotation, bore a resemblance to contemporary thinking about hospitals in

---

2. Walter Rodney, *A History of the Guyanese Working People 1881-1905* (Heinemann 1981), p. 2.

3. Remarks by Dr. Bell, in Alexander M'Donnell, *Considerations on Negro Slavery with Authentic Reports Illustrative of the Actual Condition of the Negroes in Demerara* (London 1824), pp. 178-179.

4. A number of doctors owned slaves as house keepers, and some had plantations worked by slaves. C.O. 114/10. See also *Royal Gazette* 10 January 1807. Dr. P. Cramer owned eighty male and thirty female slaves. Dr. George Gill's estate was worked by ninety-two male and fifty-one female slaves. Eight domestics were also owned by his daughter. The Gladstone papers. T 71/391/74-75. T 71/391/719

### Plantation hospitals - disease, mortality and race

England, the actual design and organisation of plantation hospitals attested far more to local circumstances than metropolitan preconceptions.<sup>5</sup> First of all, like the majority of buildings in the colony, plantation hospitals were constructed out of wood, and, as indicated above, they were ideally raised up on brick pillars to lift them beyond the miasmatic influences of their locality. Secondly, they were generally small buildings catering for no more than the local workforce. During slavery, most plantations employed less than a hundred labourers, often far less. Thirdly, it follows that these hospitals were part of a workplace environment, one that was generally closed to outsiders, and they were managed and supervised privately, by employers' representatives.

It is evident that the quality of care provided in these institutions differed from plantation to plantation, and over time. Properly run hospitals with a sufficiency of medicines and beds were costly, and it was not always evident that hospitals were successful in returning the sick to active work. As we saw in the first chapter, particularly from the descriptions of the *Belle-Vue* hospital by the abolitionist Scoble in 1838, the attitudes and influence of plantation managers were very important as to how labourers were treated. In the post-emancipation period it seems that many managers were indifferent or even hostile to providing hospital treatment. From a managerial point of view 'malingering' in hospital by labourers was a constant concern. Hospitals were potential refuges for rest, and each immigrant in hospital directly depleted the available number of field hands.

The low priority of hospitals is evident in the way that they also served as sites for punishment, imprisonment, or more parochially, for the storage of provisions. In Guiana, as was the case throughout the rest of the West Indies during slavery, it was not unusual to find the plantation stocks in the hospital. Although the stocks were probably used much less widely after abolition, many estates retained them, and some estates, often with the support of doctors, put them to use. As the 1870 Commission of Enquiry showed, labourers could be confined to the stocks by doctors or managers if found drunk, for 'causing ulcers wilfully', breaking hospital rules, absconding from hospital,

---

5. Jeremy Taylor, The Architect and the Pavilion Hospital. Dialogue and Design Creativity in England 1850-1914 (Leicester University Press 1997).

### Plantation hospitals - disease, mortality and race

'insubordination' and 'skulking'.<sup>6</sup> Refusing to take medicine also provided grounds for using the stocks. For example, at plantation *Hamburg* the hospital case-book recorded: '24<sup>th</sup> December 1868: Sowdeen, Dysentery. – The man will not take his medicine, he must be kept under strict restraint [in the stocks] until he does; give half-ounce of brandy four times a day with his sago.'<sup>7</sup> The most apposite comparison for the plantation hospital seems to be the English workhouse, which also had a reputation for the brutal treatment of its inmates.<sup>8</sup>

It has been suggested that any definition of disease is an 'unavoidably political process'.<sup>9</sup> Clinical evaluations imply various therapeutic consequences, and their acceptance or rejection, as the incident with Sowdeen suggests, mark out the different ways that individuals and doctors understand the rituals of diagnosis. Hence, 'having' a disease and being labelled by a doctor as 'ill', and perhaps also, claiming as an immigrant to be 'sick', were each rather different designations. In Guiana, meanings of disease were further complicated as doctors shared neither the social or cultural background of the workforce. Apart from the immediate problem of language translation, the symbolic connotations and metaphoric repertoires that Western doctors used to describe symptoms, discomfort and pain, were likely to differ significantly from those of their patients.<sup>10</sup> Health, disease and sickness, from this perspective, were not neutral, objective, and universally agreed categories. Although the voice of the doctor, and the perspective of the plantation, comes through strongly in the official record, we should remember that the shared world of plantation society with its labourers and managers, administrators and doctors, field labourers, servants and factory hands, contained profoundly different standpoints through which that world could be viewed. The walls of the estate hospital, brought together a potent mix of disease and sickness, but also the disparate priorities of labour, economics, social power and, in time, colonial governance.

---

6. Report of the Commission Appointed to Enquire into the Treatment of Immigrants in British Guiana 1870. P. P. 1871. Vol. XX. pp. 636-638.

7. *Ibid.* p. 638.

8. M. A. Crowther, *The Workhouse System 1834-1929* (Methuen 1983), pp. 160-161.

9. Gerald Markowitz and David Rosner, 'The Illusion of Medical Certainty: Silicosis and the Politics of Industrial Disability, 1930-1960', in Charles E. Rosenberg and Janet Golden (eds.), *Studies in Cultural History. Framing Disease* (Rutgers University Press 1997), p. 185.

10. Cecil G. Helman, *Culture, Health and Illness* (Butterworth Heinemann 2000), pp. 130-131. See also, Edward C. Green, *Indigenous Theories of Contagious Disease* (Altamira Press 1999).

### Plantation hospitals - disease, mortality and race

The traditional European discourse of medical topology which ascribed meaning and significance to place clearly influenced the descriptions of hospitals by the prominent Georgetown practitioner, Dr. Bonyun.<sup>11</sup> Under government patronage, Bonyun set out to evaluate how far plantations had put into effect the 1847 Hospital Ordinance. It is from his accounts of this investigation that we can build up a rich picture of medical care in the colony for this period.

The first point to note, is that from a mid-century medical perspective, little care (from a medical point of view) seems to have been taken in siting plantation hospitals. As hospitals were places of sickness and ill-health, perhaps it is not surprising that Bonyun found them located in the remoter and more inaccessible parts of the estate, far away from the manager's house and sugar factory. This spatial distancing of hospitals from the core of plantation activity reinforces the view that they were not key parts of the estates' organisation, something which required the constant attention of the overseer. Later on, when new hospitals were built, they were invariably nearby the other important plantation buildings at the front of the estate (see plan of plantation *Uitvlugt*). One consequence of being tucked away inland, was that they did not benefit from the full force of the strong coastal winds, and therefore, they possessed little natural protection from 'miasmatic' influences emanating from nearby privies and stagnant pools of water. Hospitals were often encircled by luxuriant vegetation, and were the favourite sites for rooting pigs and other animals. In Bonyun's view, and that of other doctors, hospital grounds appeared more as potential repositories for disease, rather than places best suited for recovery.<sup>12</sup>

Bonyun's 1848 report also revealed the very limited extent to which plantations had moved to comply with the most substantial point of the 1847 Hospital Ordinance, that of providing a hospital. Only ninety-eight of the 220 working sugar plantations had hospitals (forty-five per cent), although another twenty-four estates claimed to have plans for one. Just as importantly the quality of hospital facilities varied enormously between plantations, although overall it appears to have been very poor. Unlike the descriptions of hospitals circulated to the home audience by plantation owners, most

---

11. John D. Thompson and Grace Goldin, The Hospital: A Social and Architectural History (London 1975). Mary J. Dobson, Contours of Death and Disease in Early Modern England (Cambridge University Press 1997), pp. 9-42. Karen Kupperman, 'Fear of Hot Climates in the Anglo-American Experience', William and Mary Quarterly Vol. 41. 1984, pp. 213-240.

12. 2nd Report of the Estates' Hospitals (REH) 21 September 1860. CO. 114/22.

### Plantation hospitals - disease, mortality and race

hospitals were not purpose built, but converted out of old plantation buildings such as storehouses. They were makeshift affairs, varying in size, and bearing little relationship to the number of labourers on the estate. However, on a small number of larger plantations, those which typically employed more than 200 labourers, hospitals capable of housing thirty or more patients were sometimes provided. In these places, according to Bonyun, the facilities were often quite adequate.<sup>13</sup>

The economics of growing sugar seems to have had a direct impact on the quality of care offered. Hospitals on less economically viable estates, those on lease, on the market to be sold, or in the hands of the receiver tended to be very poorly resourced.<sup>14</sup> But even where estates put aside a building for use as a hospital, medical provision was often inconsequential or non-existent. In practice, many hospitals were not fitted out to receive patients, they stocked insufficient quantities of medicines, and were infrequently visited by doctors.<sup>15</sup> Typical of the poor treatment meted out to immigrants was plantation *Annadale*. This estate, which lay about seven miles to the east of Georgetown on the Demerara coast, employed 225 labourers. Although it had hospital accommodation for ten patients, it was not fitted out to take a single sick person. At the time of Bonyun's inspection, there were fifty-five labourers on the estate in need of medical attention, but, as the visiting doctor had earlier remarked in the hospital book: 'There is no quinine'.<sup>16</sup> The lack of medicines was pervasive. Quinine, an expensive but important drug used for treating a wide range of fevers, needed to be given in 'liberal' doses for effect, but was often missing from the estates' medical stores.<sup>17</sup> At plantation *Enterprise* (169 labourers), also on the Demerara coast, Bonyun described the pitiable plight of Madeiran immigrants:

the mortality among the Madeirans is very great, principally from a fatal epidemic of dysentery and the seguelae [sic] fever. These people dwell in decaying buildings which are exceedingly filthy. There is no supervision exercised over them, nor are they prevented from eating garbage when sick. This latter propensity must be the consequence of an inability to procure better food and not a morbid craving as some

---

13. Bonyun's Report. C.O. 111/250. Appendix No. 6. See also plantation *Friendship*. Bonyun's Report. C.O. 111/250/101. Smaller estates could also benefit from proximity to these larger establishments by sending their labourers across for treatment, and for estates near Georgetown or New Amsterdam another alternative presented itself, that of bringing sick labourers to the Colonial Hospital. For example, plantation *Union*, Bonyun's Report. C.O. 111/250/81, 115.

14. 1871 Commission. P.P. 1871. XX. pp. 625.

15. Bonyun's Report. C.O. 111/250/64, 70, 77, 91, 42.

16. *Ibid.* C.O. 111/250/53.

17. *Ibid.* C.O. 111/250/87, 123, 85, 42, 50. At *Batsebas Lust* the estate attorney stated that he had no intention of equipping a hospital in accordance with the Ordinance. Bonyun's Report. C.O. 111/250/113.

## Plantation hospitals - disease, mortality and race

would make it appear... the Madeirans complained that they did not receive either food or wine when ordered for them by the doctor, except in very limited quantities.<sup>18</sup>

Hospital Reports produced after the 1859 Hospital Legislation also contained many disapproving medical observations. From these we can see that many hospitals lacked bathrooms, privies and kitchens. Habits of cleanliness, which were ideally part of the hospital regimen, were therefore difficult to enforce. Patients wore work clothes, often no more than 'filthy tattered rags', thus introducing into hospitals, 'itch, insects and filth'.<sup>19</sup> If beds were provided, they tended to be wooden and therefore awkward to move or clean. Bedding was difficult to keep dry, pillowsacks (generally stuffed with plantain leaves), blankets and sheets all suffered from incessant damp and mildew.<sup>20</sup> Despite these difficulties doctors were keen that hospitals should have brick hearthed kitchens and some sort of facility where inmates could wash. Doctors wanted well ventilated and flushed privies to complement the nutritive and cleansing side of care. After 1859 it is evident that hospitals began providing nurses with night chairs, and patients with cutlery and crockery, but not clothing.<sup>21</sup>

As already suggested, doctors worked in these hospitals with the authority gained from their profession, and as trusted European employees of the estate. They used this power to manage the hospital and discourage unhealthy habits in immigrant behaviour, both inside and outside of the hospital. However, exercising this power was another matter. Ideally doctors visited hospitals at least once every forty-eight hours, but unless residing on the plantation they may have visited the estate only intermittently. Also many hospitals were unfenced and hospital attendants were generally unable to prevent inmates leaving the premises at will, or able to stop those with reputations as 'loungers and hangers on' from entering.<sup>22</sup> Placing male and female patients in the same ward, or allowing grog shops to ply their trade nearby was also frowned upon, but it is not known how successful doctors were in discouraging these practices.

Significant improvements to the number of hospitals do seem to have been ushered in with the 1859 Hospital Ordinance. This can be seen in the second report by Dr. Shier, the newly appointed Medical Inspector. By September 1860 he was able to

---

18. Dr. Bonyun's Report. C.O. 111/250/54.

19. 9<sup>th</sup> REH. February 1864. C.O. 114/22. 11<sup>th</sup> REH. April 1865. C.O. 114/22.

20. 1<sup>st</sup> REH. January 1860. C.O. 114/22.

21. Ibid.

### Plantation hospitals - disease, mortality and race

inform the colony's legislature that seven entirely new 'substantial and commodious' estate hospitals had been constructed, with another five on the way. The slow improvement to the colony's hospitals had begun. Each year Shier charted the number of satisfactory buildings with good internal arrangements, and those hospitals needing improvement, enlargement, or replacement. One new establishment which met official approval was at plantation *Retrieve* on the island of Leguan. It was a 'commodious' building forty feet by eighteen feet, complete with a nine foot gallery to windward, and included all that was needed for self contained care: kitchen, privy and bathroom.<sup>23</sup> With pressing from the government, concessions towards patient comfort were made by most hospitals. Old sloping benches were gradually discarded and replaced with individual iron bedsteads or new wooden frames.<sup>24</sup> Hospitals were remodelled, repaired or underwent enclosure. Perhaps, most significantly of all, the overall number of hospitals greatly increased. By 1862 there were 134 plantation hospitals in existence.<sup>25</sup> At least in theory, medical care was now within reach of the majority of plantation workers.

An examination of all the plantations on the west coast region of Demerara between 1848 and in 1895 usefully underlines the direction of these changes. See Table 3.1 on page 107. In the third column we can see the dramatic fall in the number of working plantations. Over this time many estates went bankrupt, were forced to amalgamate, or were simply abandoned. However, on those plantations still surviving, the workforce had expanded enormously. For example, *Uitvlugt*, with a labour force of 139 in 1848, became a massive enterprise employing 2,304 workers.

On the other hand, although by 1895 all plantations now provided hospitals with separate male and female wards, and employed registered dispensers, the overall the ratio of beds available for the workforce did not significantly improve. Available data for this region of the colony, the average number of beds for labourers in 1848 and 1895 remained virtually unchanged, at just above twenty-five beds per labourer. Arguably, towards the end of the century on some plantations, the situation had actually worsened. On *Philadelphia* for instance, there was a fifteen bed hospital for 105 labourers in 1848

---

22. 2<sup>nd</sup> REH. September 1860. C.O. 114/22.

23. *Ibid.*

24. *Ibid.* 1871 Commission. P.P. 1871. XX. pp. 630-631.

25. 6<sup>th</sup> REH. October 1862. C.O. 114/22. 7<sup>th</sup> REH. April 1863. C.O. 114/22.

25. Walter Rodney, Guyanese Sugar Plantation The Late Nineteenth century A Contemporary Description from the Argosy (Release 1979), p. 34.

**Plantation hospitals – disease, mortality and race**

**Table 3.1 Hospital provision on the West Coast Region of Demerara: 1848-1895**

Plantations 1848	Total no. of labourers		Total no. of hospital beds		Ratio of beds to labourers		Name of attending doctor 1895
	1848	1895	1848	1895	1848	1895	
Philadelphia	105	691	15	29	1:7	1:23	Dr. Ozzard
Vergenoegen	33	1410	10	28	1:3	1:50	Dr. Ozzard
Tuschen De Vrienden	53	1737	No hospital	49	-	1:35	Dr. Ozzard
Zeelught	70	Abandoned	No hospital	-	-	-	-
St. Christopher	-	Abandoned	-	-	-	-	-
De Kinderen	29	602	No hospital	48	-	1:12	Dr. Ozzard
Met en Meerzorg	195	766	20	32	1:9	1:23	Dr. Ozzard
Greenwich Park	-	Abandoned	-	-	-	-	-
De Willem	11	Abandoned	No hospital	-	-	-	-
Zeeburg	43	Abandoned	No hospital	-	-	-	-
Uitvlugt	139	2304	No hospital	84	-	1:27	Dr. Shannon
Edinburgh	15	Abandoned	No hospital	-	-	-	-
Groenweld	71	Abandoned	No hospital	-	-	-	-
Stewartville	142	Abandoned	No hospital	-	-	-	-
Lenora	41	2620	No hospital	104	-	1:25	Dr. Shannon
Anna Catharina	77	Abandoned	No hospital	-	-	-	-
Cornelia Ida	112	483	No hospital	40	-	1:12	Dr. Shannon
Hague	77	694	No hospital	44	-	1:15	Dr. Shannon
Fellowship	Owned by labourers	Became a village	No hospital	-	-	-	-
Blankenburg	209	Abandoned	20	-	1:10	-	-
La Jalouise	62	Abandoned	No hospital	-	1:	-	-
Winsor Forest	158	1812	Hospital not fitted to take patients	60	-	1:30	Dr. Honiball
Haarlem	137	Abandoned	12	-	-	1:11	-
Union	8	Abandoned	No hospital	-	-	-	-
Tourvelle Flanders	144	Abandoned	No hospital	-	-	-	-
Best and Waller	Not available	Abandoned	No hospital	-	-	-	-
Dem Amstel	Owned by labourers	Became a village	No hospital	-	-	-	-

Source: Bonyun Report C. O. 111/250 and RIAG 1895.

### Plantation hospitals - disease, mortality and race

(ratio 1:7), but only a twenty-nine bed hospital for 691 labourers in 1895 (ratio 1:23). One reason for this was that a greater number of labourers were being treated as out-patients on estates. By the turn of the century there were only six plantations still working in this region. However, between them, they treated 1,416 labourers as out-patients. This considerably reduced pressure on the hospital system.<sup>26</sup> Medical care was also assumed to operate with much greater efficiency than before. Nevertheless, it is worth stating that as estates became larger, the size of their hospitals did not keep pace with statutory requirements. The minimum bed to labourer ratio, established in the 1859 Hospital Ordinance (fifteen beds for the first one-hundred labourers, and then just five more beds for each additional hundred labourers) was rarely achieved.<sup>27</sup>

Another feature of the 1859 Hospital Ordinance was that it marked an important intellectual shift amongst some doctors in their approach to the plantation hospital. This is evident in the way that plantation hospitals began to be compared against medical practices at the Georgetown Public Hospital, indicating that medical opinion in the colony was viewing these different institutions as somewhat complementary. For example, the importance of standardisation and centralisation was evident in the long running attempt to improve plantation hospital diets.

From at least the 1860s onwards, officials dispatched to estates guides to the ingredients for 'Ordinary', 'Coolie', 'Spoon' and 'Milk' diets used by doctors in the Public Hospital.<sup>28</sup> More interestingly still, these diet tables were then translated into Portuguese, Hindustani, Tamil or Chinese, and then posted up in the hospitals.<sup>29</sup> The duties, rights and liabilities entailed by indentureship were enormously in favour of employers, yet government officials clearly felt a measure of obligation towards the labourers. In some cases the diet tables were destroyed by 'evilly [sic] disposed patients' (if not also ruined beyond legibility by heat, moisture and insects). 'Coolie' prejudices were seen as 'serious obstacles' preventing the general consumption of fresh beef and pork.<sup>30</sup> However, on other estates, posting up diet tables may have empowered hospital inmates, allowing them to negotiate within the system. In one instance Dr. Shier reported that immigrants acted 'violent and boisterous in hospital because they had

---

26. RIAG. AR 1900-01. p. 4.

27. See 1871 Commission. P.P. 1871. XX. p. 626.

28. Ibid. p. 639.

29. 3<sup>rd</sup> REH. April 1861. C.O. 114/22.

30. 9<sup>th</sup> REH. February 1864. C.O. 114/22.

### Plantation hospitals - disease, mortality and race

nothing to eat out of.’<sup>31</sup> Shier repeatedly drew attention to the ‘very grave’ problem of plantation hospital diets.<sup>32</sup> It should be remembered that plantation managers, who were responsible for procuring the food, were under little compulsion to defer to the doctor prior to the reforms of 1873. Sometimes managers withdrew diets as punishment or simply reduced quantities in order to cut costs. As des Voeux, noted in 1870:

I have strong reason to believe that on some estates the food, at least usually provided in hospital in all but the severer [sic] cases is of a wretched description, and that this fact is well known to the medical men, who dare not make a complaint.<sup>33</sup>

More generally, it is evident that after the 1859 Hospital Ordinance proprietors prevaricated about introducing improvements to their hospitals. The work of the colony’s Medical Inspector, and that of the Immigration Department was frustrated by changes of plantation ownership and the constant postponement of refurbishments. Moreover, the Immigration Department was ultimately very reluctant to take strong action against estates. They relied far more often upon threats and cajoling to achieve their aims, than applying the sanction of forbidding new immigrant allocations.<sup>34</sup> In consequence, refurbishments demanded by the Medical Inspector were sometimes incomplete, and the work shoddily done.<sup>35</sup>

All in all, despite notable improvements, hospital conditions in the early 1870s differed from one estate to the next, just as they had done at the time of Bonyun’s report in 1848. While plantations had gone some way to meet the broad outlines of the 1859 legislation, the internal life of the hospital ward remained poorly monitored. Literacy rates for nurses remained low and ward conditions varied. The proper supply of diets, the type of bed, the provision of sheets or blankets, the dry material for stuffing, utensils, basins, pans and shelving all required the expenditure of time, money and the willing cooperation of plantation officials. This was often lacking. Government attempts to standardise the experience of illness stumbled against the powerful local influences of the plantation manager.

It is notable that the 1873 Immigration Ordinance was much more successful in reforming hospital provision. In 1876 Dr. Watt, on behalf of the Immigration

---

31. 1871 Commission. P.P. 1871. XX. p. 635, 642.

32. 13<sup>th</sup> REH. October 1866. C.O. 114/22.

33. 1870 Commission. P.P. 1871. XX. p. 488.

34. *Ibid.* pp. 629.

35. *Ibid.* p. 631.

## Plantation hospitals - disease, mortality and race

Department, produced a special report for the Colonial Office, which Governor Longden greeted as 'a very satisfactory document.' It revealed that of the 120 estates employing indentured labour, 117 now possessed hospitals in good order, and most importantly of all, had sufficient bed space. Hospital accommodation, the report continued, was 'far beyond the requirements of the law' with over 4,500 beds.<sup>36</sup> In return, the Colonial Office acknowledged the 'very satisfactory condition of the hospital accommodation.'<sup>37</sup> We saw in the last chapter that the 1873 Immigration Ordinance led to the re-organisation of doctors in the colony. That reform, together with the above changes in hospital accommodation, ensured that the political and organisational problems of plantation health were largely resolved to the satisfaction of Whitehall and the Indian government.

### 3.3 Nursing Care

Nursing in the former slave colonies, unlike in Europe, was shorn of any religious, humanitarian or charitable associations.<sup>38</sup> Nevertheless, there were many points of similarity. As in England, and more especially in the English workhouse, prior to the Florence Nightingale reforms, the work of nurses in the colony was characterised by low pay, poor conditions and little or no training.<sup>39</sup> Correspondingly, the status of nursing in the plantation hospital was also low. Traditionally the job of hospital attendant during slavery fell to the older male or female. Initially at least, this arrangement seems to have been continued as immigrants arrived in the colony. Reforms of nursing care on plantations also paralleled developments in England by emphasising trustworthiness, literacy, reliability and later, experience in a medical institution.<sup>40</sup>

One of the problems which faced doctors in the colony was how to bring nurses within the ambit of medical authority rather than leaving their selection to plantation managers. Aside from monitoring patients and cleaning, nurses needed sufficient skill to

---

36. However, as we saw in Table 3.1 the statutory ratio of beds to the number of labourers was not maintained.

37. Colonial Office. 10 January 1876. C.O. 384/111. Governor Longden, 22 November 1876. C.O. 384/111.

38. Roy Porter, 'Religion and Medicine', in Bynum and Porter (eds.), *Companion Encyclopedia* pp. 1449-1468.

39. Guenter B. Risse, *Mending Bodies, Saving Souls. A History of Hospitals* (Oxford University Press 1999), p. 368.

40. Christopher Maggs, 'A General History of Nursing: 1800-1900', in Bynum and Porter, *Companion Encyclopedia* pp. 1320-1322.

### Plantation hospitals - disease, mortality and race

use scales for making up and dispensing the diet to patients.<sup>41</sup> Opinion differed in the colony as to whether it was preferable to attract males or females to these posts. The ‘steady, elderly, well trained female nurses’, were counterposed against the ‘thoughtless and restless young men’, that were increasingly providing much of the care.<sup>42</sup> Training was another issue. Plantation nurses were encouraged to seek certificates of competency from the Surgeon General which allowed them to make up medicines. In 1859 the legislature set aside funding for a ‘limited number of MALE PERSONS’ desirous of being trained for work in estate hospitals.<sup>43</sup> However, only a small number of these nurses found their way to the plantation. A survey of the 140 sick-nurses working in the colony in 1861, revealed that only twenty-three nurses were in possession of the competency certificate, although a further eight nurses held similar certificates from doctors and a small number of estate nurses (eight) had gained some experience working as nurses in one of the public hospitals.<sup>44</sup> By the 1870s the situation seems to have improved – there were sixty-nine sick-nurses with certificates. Nevertheless, not all estates employed nurses, and as the 1870 Commission discovered, it was not unusual for overseers, or even washerwomen or cooks to make up and dispense medicines.<sup>45</sup>

With the reorganisation of medical services in 1873, the quality of nursing care on the plantations once more received attention. New ‘*Rules for Maintaining Discipline and Enforcing Cleanliness in Estates Hospitals*’ were produced and greater stress was laid on the importance of competency certificates. Ideally, the duties of estate nurses were now expected to match the procedures and standards sought after in the Public Hospital of Georgetown, especially those of cleanliness and order. In fact, evidence suggests that the medical authorities in Georgetown struggled to impose suitable forms of behaviour amongst its staff at the Public Hospital. One report from 1859 alluded to murderous threats against doctors at the institution, and a collapse of proper nursing. For example, on visiting the hospital one morning Dr. Johnson discovered:

The female wards without a nurse; the night nurses had gone away, and the day nurses had not come on; the matron did not arrive until half-past 7 o’clock a.m. The

---

41. 11<sup>th</sup> REH. 29 April 1865. C.O. 114/22. 1871 Commission. P.P. 1871. XX. p. 640.

42. 2<sup>nd</sup> REH. 21 September 1860. C.O. 114/22. Royal Gazette 15 February 1859.

43. Official Gazette 26 November 1859. C.O. 115/35.

44. 3<sup>rd</sup> REH. 4 April 1861. C.O. 114/22.

45. 1870 Commission. p. 653, 656.

## Plantation hospitals - disease, mortality and race

wards were in a filthy state. One night, 10 o'clock p.m. I found the nurse in the Seaman's Hospital asleep.<sup>46</sup>

Still, the *Rules for Maintaining Discipline* were a clear statement of intent. Plantation hospitals were no longer seen as medically separate places with their own special ethos and practices. Nurses there, just like their counterparts in the Public Hospital, were expected to fulfil their duties with trust and responsibility. This included monitoring patients' behaviour, sweeping, mopping, dispensing diets and promptly attending to the doctor's wishes. One of the tasks which lay before the re-organised medical services, in the opinion of Dr. Shier, was that of inducing in those of a 'low civilisation' the habits of cleanliness.<sup>47</sup> In just a few years the experience of sickness on the plantation had begun to alter. On those estates which fully complied with regulations the influence of the estate manager on the hospital was indiscernible. Sick labourers were now likely to be stripped of clothing, bathed and handed a ticket representing their property. Guided by the flickering presence of oil lamps and the regulatory influence of the hospital clock the work of nursing was fashioned according to the expectations of doctors.<sup>48</sup> By the end of the century the status of the plantation nurse dispenser was confirmed in wages. While the plantation carpenter and blacksmith could expect about \$220 per annum, dispensers' wages ranged from \$240 to \$420 per annum.<sup>49</sup>

### 3.4 The State and Hospital Registers

Plans to improve the mortality profile of indentured labourers depended first upon the accurate collection of statistics. This task required the bringing together of several different elements: the co-operation of doctors, proper assessments and records of health and better control of the allocation and tracking of immigrants. 'It ought not to be forgotten,' wrote Dr. Shier, 'that till regular statistics are obtained the working of the Estates' Hospital Ordinance can never be said to be complete, neither can the Executive receive the assistance which is necessary in the distribution of immigrants.'<sup>50</sup> This remark went to the core of the thinking behind the 1859 hospital legislation. The centralised collection of information was not conceived primarily as a method of

---

46. Dr. Johnson. Letter to Royal Gazette 12 February 1859.

47. 26<sup>th</sup> REH. 18 August 1873. C.O. 114/26.

48. Dr. Carolan. *Rules*. 30 December 1872. C.O. 114/26.

49. Rodney, History p. 148.

50. 4<sup>th</sup> REH. November 1861. C.O. 114/22.

### Plantation hospitals - disease, mortality and race

anticipating the spread of disease or even as a way of improving curative techniques. Rather it provided government officials with a glimpse of the situation on plantations, and therefore it assisted and rationalised the distribution of immigrants to those estates with better mortality records.

Discovering the parameters of life and death on the plantation required extending in novel ways the legitimate fields of governmental interest. Moves in this direction risked creating conflict and friction. In effect, by furnishing detailed statistics regarding race, morbidity, mortality and the standards of hospital care, the estates were fashioning the very tools which enabled the authorities to patrol conditions on the plantation. The key for success in this reformist programme was the recently launched system of hospital registers. These documents were unsuitable for calculating a general rate of immigrant mortality since they only took account of those who entered hospital. Immigrants outside of the plantation system were not, therefore, part of this new scrutiny. Still, identifying those estates which had a high level of hospital mortality alerted government officials to those places where, in their view, action was most needed.

Responsibility for collecting and tabulating these registers, and indeed, for allocating immigrants, rested with the Immigration Department. These officials produced a range of statistical returns which ultimately found their way back to London, along with similar reports from other colonies, and the returns from various emigration agencies and depots. Once in London all of this material (and the discrepancies therein) underwent appraisal and comment by officials in the Colonial Office.<sup>51</sup> The ability of the home government to comment authoritatively on events far away was greatly enhanced by this flow of material from the periphery to the centre.

The initial reaction of plantations to their new bureaucratic obligations was not favourable. Disease surveillance on this scale was unprecedented. Even in Britain it had only recently become customary to collate records of disease during periods of mortality crisis such as the cholera epidemic of 1832.<sup>52</sup> Although, under the 1859 hospital legislation, estate doctors were expected to forward hospital registers to the government, few did so. Government officials, therefore, found it difficult to tabulate information

---

51. Scott to Kimberley, 19 July 1872. C.O. 111/390.

52. Graham Mooney, 'Infectious diseases in nineteenth century Britain: Notification, diagnosis and medical education', Unpublished paper. Spring 2001.

### Plantation hospitals - disease, mortality and race

about disease, or to glean the age of the patients, the treatments provided and their outcomes. Those registers which did find their way to Georgetown often contained no more than scattered comments about the hospital and patients. Names were frequently miswritten and distinctions between male and female, indentured and free labourer, were not recorded. Dr. Shier discovered that the ages of patients were full of discrepancies. Neither did the estate doctors seem to attach much importance to citing correctly the patients' race or country of origin, for example those from Bengal were sometimes entered as arriving from Madras and *vice versa*. Moreover, doctors rarely distinguished between the 'native negro', the 'native mulatto' or the colony born East Indian. With regard to disease, vague and imprecise terms were used. Symptoms, such as 'indisposition', 'cold', or 'pain in the belly' sufficed to describe illnesses, making it impossible to know under what category the patient's disease should be recorded.<sup>53</sup>

Perhaps even more worryingly, for the proponents of the new hospital register system, doctors tended to merely note in the register the discharge of patients from hospital, but failed to indicate whether they had been cured, relieved of their symptoms, or had died.<sup>54</sup> It was thus impossible to quantify the different causes of mortality on the estate. In a single stroke one of the central aims of the 1859 legislation was annulled. Although the patient may have been admitted with nothing more than a minor injury, they may have died later of consumption, but none of this appeared in registers.

Despite efforts to persuade estate doctors to act in accordance with the new legislation, they continued to ignore entreaties emanating from the colonial government. Writing in the spring of 1861 Dr. Shier commented on the poor quality of information in the Hospital Returns noting that: 'The greater proportion, however, contained errors and defects which rendered them of almost no use; while a few were got up in such a manner as to convey the impression that they were prepared for the occasion.'<sup>55</sup> Later in the same year more than half of the reports from Berbice were returned to estates for correction.<sup>56</sup>

While the colony government, or at least its medical representative Dr. Shier, put great store in accurately recording the nuances of age, race and admission dates, it was apparent that the estate doctor working at the level of the plantation hospital, often

---

53. 11<sup>th</sup> REH. April 1865. C.O. 114/22.

54. 2<sup>nd</sup> REH. September 1860. C.O. 114/22.

55. 3<sup>rd</sup> REH. April 1861. C.O. 114/22

### Plantation hospitals - disease, mortality and race

remained resistant to these new and time consuming bureaucratic responsibilities. A concern for patient confidentiality was hardly an issue in Guiana; more likely doctors were anxious to maintain their autonomy over the diagnostic encounter, or simply intended to resist this irksome bureaucratic encroachment on their duties. After all, they were paid by the plantation to treat estate workers, not by the state to furnish statistics. Moreover, the mid-nineteenth century doctor was not accustomed to having their authority challenged or their professional judgement scrutinised on a systematic basis.<sup>57</sup>

Nevertheless, the authority of the colonial government eventually prevailed. Even though many of the returns and statements contained in the hospital registers left much to be desired, by the autumn of 1862 the government had in its increasingly bureaucratic grasp over 60,000 entries ready for comparison and examination.<sup>58</sup> An example of how this material was eventually tabulated is shown in the section on diseases on page 121. For the first time it was possible to see the total number of immigrants under treatment in the colony's plantation hospitals, the ratio of males to females, and the broad categories of disease they suffered from. It was possible to compare morbidity against mortality and measure both against place.

Changes were also underway in the Immigration Department which made the job of producing this material easier. By the mid 1860s the office was despatching to estates standardised forms every half year to record the movement, presence or absence of labourers between a network of colonial institutions.<sup>59</sup> Managers were expected to document births, deaths and account for desertions, or conversely, transfers to the colonial hospital, alms house, lunatic asylum, or leper asylum. Although estate managers gradually moved to comply with these strictures, suspicions of inaccuracies and errors still plagued the Immigration Department, and in 1870 it sent every plantation a comprehensive guide to filling in the returns.<sup>60</sup>

From the yearly Reports of the Hospitals Registers we can see the total numbers of labourers treated in the colony's plantation hospitals. In 1864 estate hospitals handled 82,025 patients.<sup>61</sup> The number of indentured labourers at this time was around 33,000.<sup>62</sup>

---

56. 4<sup>th</sup> REH. November 1861. C.O. 114/22.

57. Graham Mooney, Infectious diseases Unpublished paper.

58. 6<sup>th</sup> REH. October 1862. C.O. 114/22

59. Ordinance 13. 1866. Immigration Office 19 April 1871. C.O. 111/385

60. Ibid.

61. 11<sup>th</sup> REH. April 1865. C.O. 114/22.

### Plantation hospitals - disease, mortality and race

According to the Seventh Report of Estate Hospitals 'native resident labourers' may have added another 13,000 to this figure.<sup>63</sup> Therefore, a remarkably high percentage of the workforce (including some non-indentured labourers) saw the inside of plantation hospitals and many individuals must have been treated there several times during the year.<sup>64</sup> Length of stay in hospital depended upon the disease and the course of treatment. In 1869, those who died within their first year in the colony spent an average of just eight days in hospital.<sup>65</sup>

This statistical mapping dramatically showed up the seasonal patterns of disease. A typical disease wave is shown in appendix VII. Each year from January to April the number of labourers entering hospital gradually declined until there were between 10,000 and 14,000 labourers under treatment. In most years May was the healthiest month. From then onwards, the levels of sickness rapidly began to rise. The engine which drove this fluctuation was fever. The number of patients increased steadily until a peak was reached in July or August when perhaps 20,000 labourers went through the hospital system. From about September onwards there was a sharp descent until the following year when the cycle was repeated. During this cycle mortality rates often fluctuated. At times, high rates of mortality in the rainy period existed with low levels of sickness. The converse was also possible, in some years very many labourers succumbed to disease, but few died.<sup>66</sup>

In conclusion, it was many years after the 1859 Hospital Ordinance was introduced, before government officials were able to build up an accurate picture of the spread, limits and seasonality of disease in the colony. Only gradually did the endemic nature of ulceration, the ruinous and deadly effects of diarrhoeas and dysentery, and the vulnerability of new arrivals to fever, find expression in the official records of the colony. It is noticeable that estate doctors and estate managers were slow to turn their attention towards bureaucratic form filling and other administrative tasks. However, it seems that by the early 1870s, i.e. prior to the new 1873 Immigration Ordinance, doctors had already become inured to their new responsibilities. At the very least, the collection

---

62. The number of immigrants on the estates was estimated to be 32,376 (including 333 children) on 30 June 1864. See 25 GRCLEC. PP. 1865 XVIII.

63. 7<sup>th</sup> REH. April 1863. C. O. 114/22.

64. 11<sup>th</sup> REH. April 1865. C.O. 114/22.

65. Dr. Shier. 20<sup>th</sup> REH. The number of immigrants on the estates was estimated to be 32,376 (including 333 children) on 30 June 1864. See 25<sup>th</sup> GRCLEC. PP. 1865 XVIII.

66. 18<sup>th</sup> REH. May 1869. C.O. 114/22. Dr. Shier. 20<sup>th</sup> Report of Estates' Hospitals.

### Plantation hospitals - disease, mortality and race

of statistics was deemed sufficiently accurate for the Immigration Department to begin producing year on year comparisons and issuing recommendations. Just as importantly, for the managers of imperial rule in Whitehall, evidence of the progress (or not) of the colony's hospitals in treating disease lay in the official record.

#### 3.5 Disease, mortality and statistics

As Charles Rosenberg has argued, disease is an elusive entity, it is something that has power but evades simple categorisation.<sup>67</sup> Disease not only structures doctor – patient - relationships, but it legitimises actions, and often underpins cultural values. Disease is also a biological event: individuals become ill, they sicken, and die. In British Guiana, as in much of the colonial world occupied by Europeans, the presence of disease, especially its tropical manifestations, was a constant and sometimes special threat. The intermittent and remittent fevers, yellow fever and the disorders of blood brought about by heat, damp and miasmas, were unvarying reminders that the European was a visitor in foreign lands. How did doctors understand this environment? Of great importance was the weight of what Rosenberg has termed 'intellectual and institutional history'.<sup>68</sup>

In other words, doctors brought to the colony their knowledge, opinions, and judgements learnt from their circumstances at home, and from their university education. This would include opinions about the diseases of warm climates and hints on how to 'manage' the climate. By the end of the eighteenth-century there was a substantial body of writing on this subject.<sup>69</sup> However, by the end of nineteenth century the literature was vast, and remarkable for its scope and sophistication. A rich swathe of books, journals, reports, and studies were available to doctors in Guiana, including those working outside the capital. For example, in discussing the treatment for dysentery in 1895 the resident surgeon of the New Amsterdam hospital, E.D. Rowland, cited research

---

67. Charles E. Rosenberg and Janet Golden, 'Introduction', in Rosenberg and Golden (eds.), Framing Disease pp. XIV-XVI.

68. *Ibid.* p. XIII.

69. Mark Harrison, Public Health in British India. Anglo-Indian Preventative Medicine 1859-1914 (Cambridge University Press 1994), pp. 41-43. Mark Harrison, Climates and Constitutions. Health, Race, Environment and British Imperialism in India 1600-1850 (Oxford University Press 1999), p. 58.

### Plantation hospitals - disease, mortality and race

from countries as far apart as India, England, France, Egypt, Japan, the United States and Russia.<sup>70</sup>

Typically, doctors were also imbued with the importance of status and the value of hierarchies.<sup>71</sup> Thus they drew upon contemporary notions about the European urban poor, particularly the reputed links between environment, disease, filth, and moral failure. So it was no accident that when they stepped ashore in the colony they were committed to particular forms of epidemiological categorisation and their preconceptions alerted them to where, even in the distinctiveness of the Guianan environment, disease was most likely to be found, and who was most likely to succumb to it. In the strange and novel world of Guiana, doctors found not the absolute antithesis of European disease topology but associations and comparisons, both epidemiological and social.

But there were also differences, especially in the clinical context. Aside from treating the small European population, and the diseases most associated with field labour, such as ulcers, it should be remembered that doctors routinely had to deal with the results of accidents and the consequences of violence engendered by conditions on the sugar estate. Machinery was used without proper guards, and for the tired, the inexperienced, the young or the unwary, flywheels caught, boilers burst and boiling liquids spilt. Social tensions on plantations led to fights, often leading to mutilations, aggravated by the close proximity of machetes used for hacking down sugar cane. Ultimately, what emerged from this interaction between doctor, disease, and immigrant, were attempts to manage the 'ignorant and thoughtless patients' and their ailments, within a modified model of the European medical corpus.<sup>72</sup>

It is apt to continue this discussion on disease by turning to Dr. Bonyun's 1848 report as this marks the first systematic attempt to map the presence of disease in the colony. As Dr. Bonyun, worked his way up and down the rivers and along the lengthy seaboard of the colony, visiting the estates and recording his impressions, he plotted the presence of important diseases. The dominant causes of mortality emerged as intermittent fever and its associated disorders; dropsy and anasarca (swellings of the limbs). Fever was an

---

70. E. D. Rowland, 'Some Remarks on the Treatment of Dysentery', The British Guiana Medical Annual and Hospital Reports (BGMAHR) Georgetown 1895. p. 43.

71. N. Jewson, 'Medical Knowledge and the Patronage System in Eighteenth-Century England', Sociology 1974. Vol. 8. pp. 369-385. Digby, Making a Medical Living pp. 314-316.

72. Rowland, 'Some Remarks' BGMA 1895. pp. 31-49.

### Plantation hospitals - disease, mortality and race

enduring concern for Europeans in warm climates, so it is unsurprising to find that Bonyun also viewed the health of workers by noting its absence or presence. Fever, it was understood, debilitated the body's constitution, attacking the subject again and again until the 'digestive and assimilating powers' became impaired, thereby inducing dropsy. In the late 1850s immigrants diagnosed with fever were likely to have their heads shaved and have a plaster of ingredients, devised by the late Surgeon General, applied to the head. The administration of brandy, ammonia and camphor followed.<sup>73</sup> Another fatal, but 'unexplained consequence' of feverish attacks, was the enlarged spleen. Later in the century, this symptom came to confirm malarial infection. In the 1850s, however, enlarged spleens seem to have confounded medical expertise. According to Bonyun, it was a disorder which put individuals 'beyond the control of medicine.'<sup>74</sup> Bonyun also noted that labourers were prone to itch and to bouts of diarrhoea and dysentery, but he attached no special significance to their presence, claiming they produced much suffering but far less mortality than fever.<sup>75</sup> However, as Table 3.2 (below) from the 1863 Report on Estate Hospitals shows, by the early 1860s the importance of fever was somewhat displaced as the focus of attention shifted towards ulcers, diarrhoea, and 'other diseases' such as leprosy.<sup>76</sup>

**Table 3.2 Number of patients in the Estates' Hospitals and the categories of disease: 1863**

Counties.	Districts.	No. of Hospitals.	Patients.		Ulcers.		Inter-mittent Fever.		Diarrhoea and Dy-sentery.		Other Diseases		Total.	Severe Ulcers.	
			M.	F.	M.	F.	M.	F.	M.	F.	M.	F.		M.	F.
Barbados.....		23	307	43	181	13	55	10	17	4	54	16	350	7	1
Demerara.....	{ East Coast.....	27	518	82	303	51	105	12	13	6	92	13	600	46	14
	{ River District...	20	370	68	243	42	28	8	11	2	88	16	438	39	11
Essequibo. ....	{ West Coast.....	19	449	81	230	39	84	28	67	6	68	8	530	34	8
	{ Islands.....	21	224	45	178	36	8	3	14	0	24	6	262	21	7
	{ Arabian Coast..	24	197	33	135	20	25	6	24	1	13	6	230	17	5
Total Seventh Inspection....		134	2065	352	1275	201	305	67	146	19	339	65	2417	164	46
Total Sixth Inspection. ....		134	1436	294	721	130	262	54	138	22	315	88	1730	104	28

Source: 7<sup>th</sup> REH 1863. C. O. 144/22.

This Table is interesting for the way officials aggregated diseases by district, and expressed sickness in terms of the total numbers of male and female sufferers. It offers a

73. Dr. R. Johnson. Letter to Royal Gazette 12 February 1859.

74. Bonyun's Report. C.O. 111/250/32.

75. Ibid. C.O. 111/250/63, 76, 82.

76. 7<sup>th</sup> REH. April 1863. C.O. 114/22.

### Plantation hospitals - disease, mortality and race

broad picture but no detail at the level of the estate. The apparatus for a more sophisticated survey was not yet available. Nevertheless, we can see from Table 3.2 that ulcers were recognised as endemic throughout all areas of the colony, and that by 1863 ulcers accounted for more than half of all the incidences of disease amongst all patients in estate hospitals.<sup>77</sup> In subsequent years, in the hospital reports, failed respiratory organs, anaemia and liver complaints were added to the cornucopia of deadly ailments. By the late 1860s an even more detailed catalogue of disorders suffered by labourers was in use. Doctors alluded to incidences of elephantiasis and yaws, and added deaths from fits, apoplexy, paralysis, marasmus, syphilis, jaundice, pneumonia, influenza, congestion of the lungs, disease of the heart and occasionally from opium.<sup>78</sup>

Medical information about diseases was further systematised, expanded, and thereby available for comment and analysis, after the 1873 Immigration Ordinance. The yearly reports on immigrants, compiled by the Immigrant Agent General, produced a complex and detailed picture of disease across the colony and on the individual plantation. These disease tables were then included in the colony's annual Administration Reports which in turn were sent off to Whitehall. To illustrate the profound change in the way doctors routinely mapped ill-health after the 1873 Ordinance, the first page from an Immigrant Agents Report from 1900-01, Table 3.3, is shown on the next page.<sup>79</sup> As can be seen, hospitals were grouped together and then individually listed under one of the colony's three geographical districts: Berbice, Essequibo and Demerara. The categories of disease and injury began with 'Abortion, Abrasion and Abscess' and they ended 148 separate categories later with 'Wounds incised, Wounds lacerated and Wounds punctured'. In these lists, besides disease, there were the hazardous imprints of the plantation world, bites from alligators and snakes, burns, drownings and crushings.

The enormous scale of the bureaucratic enterprise involved in collecting such statistics can be seen from the fact that all of the colony's estates complied with this detailed monthly counting exercise. Included in the yearly summaries, were figures for the number of immigrants (both non-indentured and indentured) entering each of the

---

77. The Comparative figures were: West Coast Demerara 50.76 per cent and islands 79.56 per cent. 7<sup>th</sup> REH. 7 April 1863. C.O. 114/22. See also 20<sup>th</sup> REH. Dr. Shier. April 1870 (Alabaster and Passmore Printers London).

78. Ibid. 1871 Commission. P.P. 1871. XX . pp. 622.

79. RIAG 1900-01. AR 1900-01.



## Plantation hospitals - disease, mortality and race

colony's plantation hospitals, and the numbers and ailments of those treated as out-patients. From these figures GMO's calculated the causes of death and the mortality rates of districts, and those of the individual estate hospital.

Despite the new mechanics of bureaucratic surveillance which the 1859 Ordinance ushered in, assessing the mortality of immigrants initially proved difficult. For many years previously the flow of immigrants into plantations and villages had been only loosely monitored. Although two colony censuses had been taken, the registration of individuals was, as Governor Henry Barkly noted, 'neglected by all but State paid Clergy and too imperfectly performed by them.'<sup>80</sup> The problem was compounded by the steady arrival of new immigrants each year, and an Immigration Department with sparse human resources.<sup>81</sup> Every year a portion of immigrants deserted the plantation, or, if they had completed their contracts, returned to India. Others stayed in the colony and settled in villages, had families, or drifted.<sup>82</sup> Assessing immigrant mortality, was therefore, fraught with obstacles, especially as the bureaucratic reach of colonial officialdom into the villages was limited. Even the best official estimates of mortality were likely to contain significant errors.<sup>83</sup>

It was possible to achieve a narrower view of immigrant mortality by restricting calculations to the plantation population, which after all, was the main focus of government concern. This is what Dr. Bonyun had done in 1848, and the course followed in 1863 by the former magistrate, and now Immigration Agent General, J. Crosby.<sup>84</sup> The broad outlines of Bonyun's and Crosby's reports were remarkably similar. Each showed that low levels of mortality on estates did not always follow from the presence of hospitals, and both emphasised the geographic, racial and seasonal

---

80. Barkly to Grey, 26 July 1852. C.O. 111/290/275.

81. See chapter two page 77.

82. In an attempt to account for the numbers of deaths of immigrants who resided off the estates, i.e. those in the villages, towns and in the remote wood cutting places, an arbitrary ten per cent was routinely added to the number of dead. For the years running up to 1866 the Immigration Office, who provided details of immigrant mortality for parliament, added a further twenty-five per cent to the number of dead. As it was later stated, this was done simply because the numbers arrived at were 'obviously too small.' 1871 Commission. P.P. 1871. XX. p. 611.

83. It became customary to estimate the number of immigrants present on the estates on the last day of the previous year; add the average of the new arrivals over the year; add one third of the number of births during the year; then deduct from this total the number of immigrants who had returned to India over the same period. The mortality figure was then calculated after subtracting from the total numbers of dead, half the numbers who had died in the public hospital, in order to account for those sent directly to the public hospital from on-board ship. Unsurprisingly, the final figures arrived at were recognised as extremely provisional. 1871 Commission. P.P. 1871. XX. p. 611.

84. J. Crosby, Immigration Office. 18 April 1863. C.O. 111/340.

### Plantation hospitals - disease, mortality and race

determinants of sickness. This approach was not surprising because in accordance with traditional medical topology, the colony was likely to possess areas of special and enduring healthiness, and places where the environment exerted a powerful corrosive effect on the body.<sup>85</sup> This idea of 'climatic determinism' shaped the work of British doctors throughout the empire.<sup>86</sup>

Two brief examples from Bonyun's report underscore the tremendous influence attributed to climate and place in Guianan medical topography. The hospital at plantation *Spring Hall* was considered a 'very commodious building with every convenience...they have good houses and were attended daily or oftener.' However, it provided little effective relief for its feverish patients. By the time of Bonyun's visit in 1848, disease on the estate had flared up, devastating the workforce, claiming 54.4 per cent of labourers during the past year.<sup>87</sup> Rather than hospitals, more powerful factors appeared to be at work. The persistently high mortality on the colony's largest plantation, *Houston*, was according to Bonyun, 'convincing proof of the increased insalubrity of the plantations as they are more exposed to the malarious influences of the river.'<sup>88</sup>

However, it was no easy matter to simply read off the presence or absence of disease from the season or from local topographical features such as rivers and creeks. Estates close together could have very different experiences of disease, and few satisfactory explanations were proffered as to why estates near the coast, which were open to the supposedly cooling benefit of trade winds, were not better protected against the ravages of fever.<sup>89</sup> In broad terms the district of Demerara appeared at first glance to be the least salubrious area and Berbice the most. Yet, as Crosby showed, there were also significant differences in the mortality rate *within* districts, such as between the east and west coasts of Demerara. In Crosby's account, there was a subtle but perhaps significant shift away from climatic factors. As we have seen, this was a time when the authorities were attempting to push plantations into improving their hospitals.

---

85. Andrew Wear, 'Making sense of health and the environment in early modern England', in Wear (ed.), *Medicine and Society* pp. 126-137. Andrew Wear, *Knowledge and Practice in English Medicine, 1550-1680* (Cambridge University Press 2000), pp. 184-193.

86. Harrison, *Climates and Constitutions* pp. 113-132.

87. Bonyun's Report. C.O. 111/250/60, 103 and Table A.

88. *Ibid.* C.O. 111/250/69.

89. *Ibid.* C.O. 111/250/109, Table 3. 1871 Commission. P.P. 1871. XX. p. 621.

### Plantation hospitals - disease, mortality and race

Crosby's report brought into focus another key factor shaping colony mortality. This was the presence of 'unseasoned' labourers. The susceptibility of the new arrival to disease was well known – but it was generally unquantifiable. Crosby's figures showed that the glimmerings of disease flickered and flowed along the lines of immigrants as they were distributed to estates, as much as it sprang from the nearby environment. The allotment of new immigrants to a region increased the mortality level there almost immediately, and often quite independently of whether the climate of the district was considered healthy or not. At first sight, in 1862, the salubrity of the Corentyne coast (Berbice) contrasted very favourably against that of west coast Demerara. However, as Crosby showed, in that year, the bulk of new immigrants were sent to Demerara, while estates on the Corentyne coast received no immigrants at all.<sup>90</sup>

This was statistical, and not anecdotal evidence, of the vulnerability of new immigrants. Of the thirty-three estates in the colony in 1862 with mortality rates of four per cent and above, nearly all were in receipt of new immigrants during the preceding year. Equally, those estates which had taken in the largest number of immigrants were often the ones with the highest rates of mortality. On the fourteen estates in the whole colony which had the worst records for mortality, the average intake of new immigrants as a percentage to the old was 66.5 per cent. The clear implication of this work was that the highest levels of mortality occurred amongst the most recent arrivals.<sup>91</sup> Yet, neither did the process of acclimatisation seem to confer complete immunity to disease - long standing labourers were also vulnerable. For example, some twenty-one per cent of all mortality on the estates in 1869 came from this group, mainly ex-immigrants from India, China, Africa, Barbados and Portugal. The young especially suffered. More than half of these deaths arose from children under ten, many of whom were thought to be under one year old.<sup>92</sup>

This detailed analysis of immigrants and the diseases they suffered, was all part of the new emerging language of statistics for describing population, its composition and behaviour. In their own way, Bonyun's and Crosby's reports, and others too, helped transform the nature of political discussion in Guiana. This did not mean that proposals

---

90. The average half-yearly mortality on thirteen west Coast estates was 2.97 per cent, while the average mortality, for the same period, for seventeen east Coast estates ran at 1.99 per cent. Immigration Office. J. Crosby, 18 April 1863. C.O. 111/340.

91. *Ibid.*

92. Dr. Shier. 20<sup>th</sup> REH.

### Plantation hospitals - disease, mortality and race

for reform immediately found their way into government. But they helped to set the basis for discussion about estates. The Governor, Francis Hinks, wrote in 1863 that 'It must...be obvious that much greater care is taken of new immigrants on some estates than on others.' He went on, 'I cannot but think that some rules as to the treatment of new immigrants should be framed.'<sup>93</sup> As we saw in chapter two, it took a political scandal in the form of the des Voeux letter, before Hinks' hopes were turned into a reality.

#### 3.6 Race, acclimatisation, and labour

Discussions about disease and comments about the environment or climate were often woven into the colony's hospital reports. However, as suggested above, there was also a distinctive strand of racial thinking amongst doctors and other Europeans. This also affected ideas and perceptions about how diseases spread and varied in intensity amongst different 'racial' groups. Of course, ideas of race in the colony rested on far more than medical considerations. Both in England and in Guiana, racial discourse was permeated by considerations of social distinction.<sup>94</sup> This can be seen by looking at who attended the colony's social highlights, such as the King's Birthday Ball. This was uniformly a European affair, lavish in food and musically nostalgic.<sup>95</sup> These elite gatherings brought together the colony's opinion formers including members of the government, magistrates, doctors, military men and religious representatives. Together, this influential class of individuals, who were distinct in salary, breeding, accent, education and dress, from most other groups in the colony, and who also held all of the important governmental, administrative, and legal positions in the colony, observed and commented upon the labouring masses of Guiana. Their accounts provide a picture of the European beliefs around race.

Recent literature on colonialism has supported the view that racial knowledge was profoundly informed by the exercise of power.<sup>96</sup> In Guiana, the sinews of rule were manifested on the plantation through a plethora of privileged individuals and officials:

---

93. Hinks to Newcastle. 5 May 1863. C. O. 111/340.

94. Kenan Malik, *The Meaning of Race. Race History and Culture in Western Society* (Macmillan 1996), chapter three. Moore, *Cultural* pp. 12-14.

95. *Argosy* 1 December 1906.

96. Ania Loomba, *Colonialism / Postcolonialism* (Routledge 1998), pp. 43-57. Alexander Butchart, *The Anatomy of Power. European Constructions of the African Body* (Zed Books 1998), pp. 13-33.

### Plantation hospitals - disease, mortality and race

the magistrate and immigration agent, the estate manager and overseer, and not least, by the doctor. Edward Said's comment about '*positional superiority*' seems apposite here. The European, he argued, thought about the 'other' within the shelter of 'Western hegemony over the Orient.'<sup>97</sup> In a sense, the entire social fabric of Guiana, with its enormous disparities of power and stark divisions of labour along lines of colour and place of origin, provided the covering and context for European and medical musings on race.

Doctors in Guiana drew on multi-causal explanations for the high rates of mortality amongst the colony's labourers: season, environment, hospital care, and race. The site for these speculations was the plantation hospital. As we saw earlier, this was generally a small and isolated rural institution which gathered together the estates' sick. Here, doctors assessed and categorised labourers. As a result of their experiences doctors fashioned complex connections between individual and locality, and between racial type and sickness. Together with hospital reports local experiences were generalised and transformed into knowledge. In performing this work doctors in the colony embraced many pre-existing racial norms, and put them to use in order to measure individuals against the supposed attributes of groups.<sup>98</sup> In so doing they turned their intellectual skills towards the better management of the plantation. This was racial categorisation summoned to bolster the existing social and economic order, it stressed the corporeal, it looked at bodies in particular environments, and was concerned with commerce and production.

One factor, which came through strongly, was that individual immigrants and Creoles were always considered to have collective qualities, as well as individual idiosyncrasies. The polarities of racial description were often stark, although they could also overlap: hard working or lazy, intelligent or stupid, honest or crafty. The markers of race also varied. In *Race and Colour in the Caribbean*, the historian Hoetink stresses the importance of skin shading, its lightness or darkness.<sup>99</sup> Whilst this was true, ideas of race could be secured by many other physical attributes, or even by place of origin. More importantly still, race was explicated in a plethora of moral judgements and stereotypes about the 'other'. For example, like children, immigrants were generally held to

---

97. Edward Said, *Orientalism* (Penguin 1995), p. 7.

98. Graham Richards, '*Race*', *Racism and Psychology* (Routledge 1997), p. 4.

## Plantation hospitals - disease, mortality and race

exaggerate, were thought to be excitable, easily provoked, and tending to overdramatic display.<sup>100</sup> Other accounts stressed they were superstitious, devious, and lying. The magistrate Henry Kirke, looked upon his African servants as 'idle, dirty and thoughtless', as well as, 'affectionate and amusing.'<sup>101</sup> As David Arnold and others have remarked, race was rarely used with any technical precision, but deployed in a variety of different ways.<sup>102</sup>

The tenor of the above descriptions pervaded European thinking, they also provided a role for colonial governance. From this perspective the colony's immigrants and Creoles needed mixtures of kindness, management, and discipline. A letter to the *London Telegraph* cited Guiana as:

a wonderful example of the art of government inherent in the Englishmen. Indian Coolies, blacks, Portuguese are kept from flying at each others throats by comparatively a mere handful of Britons, who dwell amongst the motley crowd, none daring to make them afraid.<sup>103</sup>

The markers of race were also, at different times, perceived to be carried in blood, apparent from the size of brains, found in special physiques, dispositions, restorative powers, liabilities and, towards the end of the nineteenth century, in degeneration. Bodily constitutions hastened or retarded the course of disease. In the colony's Lunatic Asylum doctors identified those races most susceptible to 'Nervous diathesis' and those of a 'sanguine lymphatic' temperament.<sup>104</sup> In the immigrant body, which was often perceived to be corrupted or weakened by degenerate social practices, European doctors discerned racialised forms of insanity. Species of mania and dementia rather than melancholia (the mental disease of civilisation) demonstrated the inferiority of non-European cultural and intellectual development.<sup>105</sup> Thus the:

---

99. H. Hoetink, '“Race” and colour in the Caribbean', in Sidney W. Mintz and Sally Price, (eds.), *Caribbean Contours* (Johns Hopkins University Press 1992), pp. 55-84.

100. H. G. Dalton, *History of British Guiana* (Longman). Vol. 2. p. 4. Whereas the European was held to reach maximum intellectual development by the age of forty, the East Indian and Black were held to attain their intellectual maturity much earlier, and then decline. C. W. Daniels, 'Further notes on a series of post-mortems in the Public Hospital Georgetown, April 1893, to March 1895', *BGMAHR*. 1895. p. 56.

101. Henry Kirke, *Twenty Five Years in British Guiana* (London 1898), p. 282.

102. David Arnold, '“An ancient race outworn.” Malaria and race in colonial India, 1860-1930.', in Waltraud Ernst and Bernard Harris (eds.), *Race Science and Medicine 1700-1960* (Routledge 1999). pp. 123-143. For a very useful discussion see Lara Marks and Worboys, 'Introduction', in Marks and Worboys (eds.) *Migrants* pp. 1-7.

103. *London Telegraph* 11 April 1890.

104. W. F. Law, M. D., 'Insanity in British Guiana' *The Georgetown Hospital Reports 1887* (Baldwin & Co. 1888), p. 25.

105. *Ibid.* p. 32.

## Plantation hospitals - disease, mortality and race

negro or the immigrant coolie, living as they do, easy-going lives, with little anxiety, and careless for the future, happy in the present – so long as they have sufficient means to meet their immediate necessities and with no keen struggle for existence, would be much less prone to Melancholia than a race whose conditions of life were the reverse of this; that on the contrary insanity, when it did appear...in the more lowly organised brain, where the emotional predominates over the intellectual, [would] develop itself as Mania rather than Melancholia.<sup>106</sup>

This racialisation of insanity was pervasive throughout the British empire.<sup>107</sup> Similar forms of racial thinking also reached deep into the French, German and Spanish empires.<sup>108</sup> It seems that systems of power and authority automatically generated, during the nineteenth century, the justifications for their own existence and positions in society. In each of these empires, a wide swathe of colonial officials, military personnel, traders and travellers helped fashion the categories of racial distinction. As was the case of the British in India, their own standards of civility, religion, and background provided the starting point for these musings.<sup>109</sup>

Racial thinking, however, was never unified. Agents working outside of British Guiana on behalf of the planters wrote persuasive racial profiles about the benefits of introducing individuals from Africa, India, China and North America. As discussed in chapter one, in the colony itself, the constitution of East Indians or Africans was generally held to possess certain advantages over other types of labourer. Elsewhere, however, British colonial officials were frequently far less impressed. Commenting on the mortality of immigrants travelling to the West Indies, the Colonial Land and Emigration Commissioners suggested that East Indians were ‘at the best of times of feeble constitution’.<sup>110</sup> In England opponents of indentured labour sometimes adopted an

---

106. Ibid. p. 29.

107. Waltraud Ernst, ‘Colonial policies, racial politics and the development of psychiatric institutions in early nineteenth century British India’, in Ernst and Harris (eds.), *Race* pp. 80-100. Harriet Deacon, ‘Racial categories and psychiatry in Africa. The asylum on Robben Island in the nineteenth century’, in Ernst and Harris (eds.), *Race* pp. 101-122.

108. Alice L. Conklin, *A Mission to Civilize. The Republican Idea of Empire in France and West Africa, 1895-1930* (Stanford University Press 1997), p. 9. Lora Wildenthal, ‘Race, Gender and Citizenship in the German Colonial Empire’, in Frederick Cooper and Ann Laura Stoler (eds.), *Tensions of Empire. Colonial Cultures in a Bourgeois World* (University of California Press 1997), pp. 263-283. Peter Wade, *Race and Ethnicity in Latin America* (Pluto Press 1997), pp. 25-30. See for example: *Memorias Sobre la Topografia Medica de la Habana*. Dr. Don Marcial Dupierris. C.O. 318/217.

109. The character of British ideas about their own superiority in India was revealed in James Mill’s influential *History of India*. In this book he examined the visual arts, literature, science, industry, laws, and religion of India. Mill concluded that India was a non-dynamic society which needed reform and British governance. Metcalf, *Ideologies* pp. 30-42. On British attitudes towards the perceived lack of science in India, see Kumar, *Science* p. 57-60.

110. 31<sup>st</sup> GRCLEC. PP. 1871 XX.

## Plantation hospitals - disease, mortality and race

even more sceptical tone. The *Daily News* raised ethical questions over sending Africans to the West Indies due to their perceived inability to adapt to the new climate:

There is a danger of a change in climate, and a change in life of habits and associations. These changes necessarily involve a serious mortality. Have we, the people of England, any moral right to subject Africans, whom we may transport to the West Indies for the advantage of the West Indian proprietors, to this extraordinary mortality.<sup>111</sup>

One of the most important issues for planters in the colony was how well immigrants performed what was termed, 'continuous labour'. Racial ideas and physicality were closely bound up. The distinctions of non-European physical prowess, muscularity and stamina, and also adaptability to the climate, were questions eagerly sought after by various elements of colonial society. Doctors contributed to this question by commenting on and assessing immigrants in their work. As we will see in the example of Chinese labourers, these appraisals and comparisons were not immutable. Racial ranking was rather like the healthiness of the Guianan environment, neither completely stable nor fixed.

Another aspect of European racial thinking lay in the perceived complicity of labourers in their own ill health. For doctors and the colonial state, this underlined the need for medical authority and paternalism. Even amongst the most 'industrious' races there was, in the view of the colonial government, doctor and plantation manager, always a proportion of individuals given to indolence, apathy and its probable consequences: destitution and ill health. Idleness, pauperism and vagrancy was a prolific cause of disease according to one plantation doctor.<sup>112</sup> This problem lay in the 'quality' of immigrants. Amongst planters, it was widely believed that the docks of India and China teemed with 'hordes' of 'useless vagrants' and other devious individuals not suited to field labour, but who managed to fill the ships and set sail for Guiana.<sup>113</sup> In these individuals positive racial pictures were reversed, they were supposedly susceptible to disease, lacked agricultural skills, took to drink, and avoided work.

Not all categorisation was negative. Writing a despatch from China in 1851, Jas White, an agent for the British Guiana and Trinidad Government, for example praised

---

111. Quoted in the *Royal Gazette* 20 August 1857.

112. 9<sup>th</sup> REH. February 1864. C.O. 114/22.

113. Grey. Minutes of the Court of Policy 2 June 1851. C.O. 114/18. In 1858 the West Indian Association Complained about Immigration Agents Caird and Franklin who were responsible for managing East Indian emigration. *Royal Gazette* 16 March 1858. *Royal Gazette* 24 April 1858.

### Plantation hospitals - disease, mortality and race

(with a measure of self interest) the mental and physical attributes of Chinese labourers over East Indians from Bengal. The Chinese were described as a 'strong muscular race, broad shouldered and bony, and capable of enduring great and continuous fatigue.' Their 'intelligence', 'indomitable industry', 'civility' and 'inoffensive' manners were attributes which highly recommended them as emigrants for the West Indian plantations. Moreover, White continued, they were 'fully alive to the necessity of authority for their regulation and control.'<sup>114</sup> These persuasive but impressionistic descriptions outlined the ideal worker for plantation life, physically strong, hard working, uncomplaining, deferential and manageable.

White's communication to planters in the Court of Policy was influential in helping open a new source of labour. However, two years after the arrival of Chinese immigrants, planter dissatisfaction began to emerge. On some plantations sickness prevented the Chinese from performing any work. At plantation *Anna Catharina* the cause of their sickness was attributed to their 'filthy' state. Managing the new immigrants was also proving more problematical than expected. The local magistrate was prompted to assure the governor that 'acts of violence, theft, insubordination, etc., on their part can and will be punished.'<sup>115</sup> Although it had been suggested in the Court of Policy that Chinese labour was precisely 'twenty percent' better than that of East Indians, the persistently high levels of mortality amongst the Chinese gradually transformed judgements about their suitability.

Medical opinion helped frame how Chinese mortality was to be understood. The season of their arrival in the colony, their agricultural background, disposition and moral status were all called into question. Distinctions of character were attached to place of origin. Those from Amoy, it was claimed, were of a far superior quality to the great mass of recent arrivals who had arrived from Canton and were addicted to the 'degrading and destructive vice of opium smoking.'<sup>116</sup> In fact, planter hostility about Chinese immigrants was never unanimous, and by the 1870s the West India Committee

---

114. Jas White. Court of Policy 1 October 1851. C.O. 114/18

115. Minutes of the Court of Policy 14 July 1853. C.O. 114/18

116. 4<sup>th</sup> REH. November 1861. C.O. 114/22.

### Plantation hospitals - disease, mortality and race

was once again lobbying the Secretary of State for the Colonies for access to Chinese labour.<sup>117</sup>

As we can see above, doctors imbued judgements about individual moral character with racial understandings and wove into both elements the assumed trajectories of disease. The significance of pejorative descriptions about immigrant behaviour may have lain in the way they shifted explanations for ill-health onto the habits of the immigrant, pulling attention away from the conditions of labour, the quality of medical provision, and the epidemiology of place. Yet there is little evidence to suggest that doctors used such explanations to absolve themselves from the responsibilities of treatment. Doctors' accounts about disease on plantations rarely highlighted a single causal factor. Immigrant impropriety, if referred to at all, was inevitably only one element in a diverse schema of influences.

Although the theory of acclimatisation predated the eighteenth century it endured into the middle of the nineteenth century, unchallenged in its ability to account for the presence and distribution of disease amongst Europeans working in the colonies.<sup>118</sup> The concept of acclimatisation conveyed more than just a limited capacity of humans, animals or plants to thrive in distant countries. Rather it was a theory of adaptability. The human frame, it was understood, underwent physical transformation as it moved from one type of climate to another. In the eighteenth century writers talked about Europeans in the tropics suffering from softenings, weakenings, and accelerated body fluids leading to deprived body energies.<sup>119</sup> The intensity of these changes or 'seasoning' supposedly related to the severity of the climatic alteration, the peculiarities of individual constitutions and the powers of modification embodied in race. Those who travelled across the world to similar climates were assumed to suffer less severe rigours

---

117. West India Committee to Kimberley, 19 December 1871. C.O. 318/262. Chinese immigrants were also favourably looked upon because they tended not to become shopkeepers, like the Portuguese, and they did not require the expense of a return passage. Royal Gazette 1 January 1857.

118. David N. Livingstone, 'Human acclimatisation: Perspectives on a contested field of enquiry in science, medicine and geography', History of Science Vol. 25 (1987). pp. 359-394. Ludmilla Jordanova, 'Earth science and environmental medicine: the synthesis of the late Enlightenment', in Ludmilla Jordanova and Roy Porter (eds.), Images of the Earth (British Society for the History of Science 1995), pp. 127-151. Mark Harrison, "The Tender Frame of Man": Disease, Climate, and Racial Difference in India and the West Indies, 1760-1860. Bulletin of the History of Medicine Spring 1996. Vol. 70. no. 1. pp. 69-118. Harrison, Climates pp. 88-92.

119. George Pinckard, Notes on the West Indies Written During the Expedition Under the Command of the late Sir Ralph Abercromby (Longman 1806), Vol. 3. pp. 420-422.

## Plantation hospitals - disease, mortality and race

of acclimatisation than those, such as Europeans, who moved from temperate zones to hot climates.

Guiana lay six to eight degrees above the equator. For most of the year it basked in a damp heat (the thermometer rarely dipped below eighty degrees), punctured by occasional droughts and sudden violent storms. The low lying, swampy, coastal geography, criss-crossed by rivers, creeks and canals, the proliferation of exotic and strange flora, the myriads of biting insects and the hissing, whistling, and croaking which filled the night air, all suggested little which could be compared with Europe. The explorer, anthropologist and naturalist Robert Schomburgk drew his readers' attention towards the restless natural 'tropical' energy or 'exuberance' of Guiana compared to Europe.

The fertility of the soil, the humid climate and congenial temperature, insure a succession of flowers and fruits. To a person accustomed to the sleep of nature during winter in the northern regions, that continued luxuriance of vegetation cannot but raise astonishment and admiration.<sup>120</sup>

Yet, if the geography and seasons of the colony were utterly unlike Europe, it did have apparent similarities with many other countries in warm climates. Evidence that specific groups of people were suited to these climates was easily available. The course of yellow fever in the West Indies proffered evidence for the existence of racial immunity and of the positive force of acclimatisation. For many years it had been noted that Black individuals largely enjoyed freedom from the disease. In addition, it was well known that Europeans and East Indians, once struck by yellow fever and surviving the attack, were rarely affected twice.<sup>121</sup> In the late nineteenth century this process of achieving resistance was sometimes expressed in Darwinian terminology. One doctor hoped that once immigrants passed their epidemiological probation, whereby the 'fittest' survived and the 'feeble' were eliminated:

a progeny may be expected which inheriting the characteristics of its parents is likely to prove a valuable addition to the vital resources of the country.<sup>122</sup>

Ideas of race and acclimatisation, therefore, shared assumptions about the affiliations between individual and place. The fitness or vulnerability of the human frame to withstand the effects of heat, moisture and disease was both a racial description

---

120. Robert H. Schomburgk, *The Natural History of the Fishes of Guiana* (Edinburgh 1845-1846), p.88.

121. *The Asylum Journal* "The Asylum Press" Berbice. 16 June 1884. p.33.

122. *Ibid.* p. 19.

### Plantation hospitals - disease, mortality and race

and a measure of a person's affinity to their place in the world. Both race and environment were imbued with deterministic qualities. Race helped shape the range of corporeal responses to the disease environment. Yet, as we have seen, the environment too had a role. As had been typical of medical thinking for centuries, at least from the time of the Hippocratic treatise *Air Water Places*, doctors in the colony continued to attribute great importance to the effect of locality.<sup>123</sup> Thus, while both race and environment were often spliced together in discussions about disease, they also existed in an unstable and dynamic tension with one another. While doctors often prioritised the influences of race over environment, they never forgot that some districts, river banks, or plantations were always more unhealthy for some labourers than for others.

Measuring the daily and monthly fluctuations of temperature and moisture was considered important by doctors. Both of these factors pointed to a compelling association between disease, place and season. In 1891 Dr. Ferguson, the assistant Resident Surgeon at the Public Hospital Georgetown made this comment about malarial fever:

Except in hopelessly unhealthy and unmanageable spots, a knowledge of the factors that make up each local climate, and its effect upon the individual and the race, will enable us to adopt measures that are effectual in warding off this formidable enemy of mankind.<sup>124</sup>

Forty-eight years earlier, on the roof of the Georgetown Public Hospital, the technologies for understanding the minutiae of weather change had been assembled: the sympiesometer, Whewell's anemeter, the electrometer, Howard's evaporometer and pluviometers.<sup>125</sup> Measurements of wind direction, rain tables, temperature charts and speculations about the presence of ozone and atmospheric disturbances were dutifully collected and entered into reports and summaries of disease in the colony.<sup>126</sup> Evidence from plantation hospitals confirmed that in comparatively dry years there was an overall reduction in disease for all inhabitants. Conversely, the greater extremes of heat and moisture found in the rainy season were thought to impair acclimatisation and raise levels of disease. But, climate, like the presence of disease, was sometimes

---

123. See note 85.

124. J. E. A. Ferguson, 'Pathological Studies in British Guiana', *BGMAHR* 1891, p. 60.

125. The sympiesometer was a type of barometer. The anemeter measured wind, the electrometer measured electricity in the atmosphere, the evaporometer measured evaporation, and the pluviometer measured rainfall. Report of the Colonial Hospital, July–December 1843. C.O. 114/16.

126. 21<sup>st</sup> REH. October 1870. C.O. 114/22.

### Plantation hospitals - disease, mortality and race

unpredictable and changeable, even from one district to the next. Heavy unexpected out of season rainfalls in one area existed alongside places experiencing drought. Mortality rates often tracked these local changes and Dr. Shier for one, was keen to gather better information about aberrant rainfalls and local climatic conditions.<sup>127</sup>

Opinion differed as to the length of time it took for an individual to adjust to the Guianan climate, but it was usually considered to take between twelve and eighteen months.<sup>128</sup> During the acclimatising period doctors were aware that newly arrived immigrants showed vulnerability to the effects of disease but that not all immigrants were affected to the same degree. Figures gleaned from estate hospitals supported the view that the intensity of disease, especially 'fever', not only varied from estate to estate, but between racial groups within an estate and between males and females. Women, it was said took longer to acclimatise due to their '*mental and physical inferiority*', the likelihood that they came from a 'low class' and because they were usually of 'advanced age'.<sup>129</sup> [original italics]. Quantifiable data in support of these views was first produced by Dr. Bonyun.

In Table 3.4 (below) the numbers in brackets represent Bonyun's estimated total for the number of indentured workers in each racial category working on the estates in 1848. The percentages of morbidity and mortality represent the proportion who died since arrival, and the proportion who were treated in the estate hospitals. So for instance, 30.6 per cent of all Madeirans (1,791 individuals) had either been treated in hospital or had died at the time of Bonyun's inspection.

**Table 3.4 Morbidity and mortality rates of immigrants: 1848**

Place of Origin	Morbidity	Mortality
Madeira (5853)	16.6%	14%
Calcutta (3403)	5.9%	2.8%
Madras (2736)	9.4%	8.1%
Africa (4319)	1.3%	1.8%

Source: Bonyun's Report. C. O. 111/250

127. Dr. Shier. 20<sup>th</sup> REH. By the 1870s the Royal Gazette was regularly printing meteorological observations from around the Colony. *Royal Gazette* 4 June 1870.

128. Report by J. Caird. For the Colonial Land and Immigration Commissioners. 18 March 1853. C.O. 318/202/160.

129. J. S. Wallbridge. Medical Inspector. RSG 1894-95. C.O. 114/64.

### Plantation hospitals - disease, mortality and race

The low numbers of Africans and Black native workers suffering from fever helped confirm the view they possessed physiques which endowed them with special toughness, vigour and immunity to feverish diseases. Satisfaction and approval with African labourers manifested itself in their appraisal. Amongst many favourable epithets they were noted by Bonyun for being a; 'fine gang and very merry'; as 'healthy and robust'; and as a 'fine and robust people'.<sup>130</sup> Further confirmation that Africans were particularly suited to the colony lay in their perceived virility and the production of 'vigorous children'.<sup>131</sup> This strand of thinking worked on the European imagination well into the twentieth century, particularly with regard to population growth and infant mortality which will be discussed in later chapters. African 'vitality' marked them out for work in those parts of the colony considered dangerous to other workers. They required, according to Bonyun, less medicine and fewer doses of quinine, since the river miasmas, perceived as deadly to the Madeirans, were nothing more than 'a congenial stimulant to the natives of Africa.'<sup>132</sup>

In contrast, planter and medical opinion viewed the bodily constitution of East Indians more equivocally. For example, one official report stated that: 'The Hindu at the best of times is feeble and ill nourished, constitutionally subject to diarrhoea and of a timid disposition, very liable to be affected by changes of climate, food and habits of life.'<sup>133</sup> But not all East Indians were looked upon in a similar manner. In Guiana, Calcutta 'coolies' were described as possessing strong constitutions and a quick ability to acclimatise. Only the African Creoles were understood to have greater powers of resisting the 'marsh miasmas'.<sup>134</sup> Just as importantly, the 'industrious' Calcutta migrant seemed to settle into plantation life more easily than his fellow countryman from the south.<sup>135</sup>

On the other hand, Madras labourers in the colony often drew disapproving moral and corporeal assessments. Bonyun identified in them a tendency towards, 'imperfect digestion and assimilation', and, 'diminished nervous power'.<sup>136</sup> The arrival of Madras immigrants was not regarded as an overwhelming success. They were accused of taking

---

130. Bonyun's Report. C.O. 111/250/61; 62; 69; 73; 83; 101.

131. Ibid. C.O. 111/250/40.

132. Ibid. C.O. 111/250/39; 33.

133. Murdoch. Emigration Board. 30 December 1870. C.O. 318/259.

134. Dr. Bonyun's Report. C.O. 111/250/38.

135. Ibid. C.O. 111/250/36; 48; 52; 60; 92; 93; 95; 102; 106; 117; 38.

### Plantation hospitals - disease, mortality and race

to begging, squatting and 'vagabondage', rather than applying themselves to steady labour.<sup>137</sup> Bonyun alluded to their propensity towards idleness, drinking and sleeping out at night, activities which he believed left them open to fever and which predisposed them to chigoes, sores and ulcers.<sup>138</sup> Although the Madras migrant tended to a large physical frame their general appearance was deemed to be 'very inferior' to that of the 'Calcutta coolies.' They were, according to Bonyun, an 'inferior caste' and a liability to the colony: 'not worth the trouble and expense of acclimatising'.<sup>139</sup> It is difficult to estimate how far these descriptions actually resulted in decisions which altered the patterns of immigration. However, it was the case that after 1855 the vast bulk of Indian immigrants to the colony were obtained through Calcutta rather than Madras.

Adjusting to the norms of the colony meant fitting into the rhythm of sugar production and appreciating the precepts of British colonial rule. In a sense acclimatisation was as much a social process as it was a gradual physical adaptation.<sup>140</sup> To be acclimatised also meant to be educated by doctors about the avoidable causes of disease. The neglect of cuts from the small spines which clustered around the lower part of sugar leaves, the untreated stings of insects and the bites of chigoes and other vermin all required not only medical advice and treatment, but an acceptance of medical superintendence. The British viewed immigrants who failed in this undertaking as morally suspect and therefore particularly vulnerable to suffering and ill health.<sup>141</sup>

On the other hand, although the Madeirans took longer than any other group to acclimatise and suffered the greatest susceptibility to the fatally pervasive influences of 'marsh miasmas', they were seldom the subject of Bonyun's moral interrogation.<sup>142</sup> Disease amongst the Madeirans was endemic and, as we can see from Table 3.4 they contrasted unfavourably against the more healthy African and East Indian immigrant.<sup>143</sup> As Bonyun travelled across the colony visiting plantations, the poor health of Madeirans, particularly those recently arrived, stood out from that of other groups. Bonyun surmised that Madeirans landed in the colony with 'constitutions shattered by

---

136. Ibid. C.O. 111/250/35.

137. Ibid. C.O. 111/250/34.

138. Report by J. Caird. For the Colonial Land and Immigration Commissioners. 18 March 1853. C.O. 318/202/166.

139. Dr. Bonyun's Report. C.O. 111/250/36.

140. Emigration Board. 18 September 1873. C.O. 318/271.

141. Dr. Bonyun's Report. C.O. 111/250/36.

142. Ibid. C.O. 111/250/33;77.

### Plantation hospitals - disease, mortality and race

disease' and were then settled in areas least suitable for acclimatisation.<sup>144</sup> Bonyun's experience visiting estates seemed to confirm this view. On reaching *Hamburg* on Tiger Island, he once more reported that: 'The sad story of Madeiran sickness and mortality must again be repeated.'<sup>145</sup> Even after many months in the colony those Madeirans who survived still looked, 'weak, pale and dejected'.<sup>146</sup>

In summary, the varying morbidity and mortality levels between the different immigrant groups powerfully confirmed the importance of race and acclimatisation. Bonyun argued that the robustness of Africans disposed them for working on plantations near rivers, creeks and islands and in the same manner, he claimed it was better that Madeirans were not allocated to these same estates.<sup>147</sup> Unfortunately, it is difficult to tell how far these aspirations were turned into reality.

Another legacy, built up and developed over the century, were the strong associations between particular races and diseases and other disorders. Leprosy, phthisis, yellow fever, intermittent fever, ulcers, hookworm and insanity were all cited at one time or another as having racial dimensions. Finally, all of these factors were woven into a broader social and cultural discourse on race whose durable legacy can be identified in elite stereotypical descriptions of non-Europeans the twentieth century. The continuing power of the sugar estate to shape racial ideas in Guiana was present in an article from 1919 entitled *Labour and Colonisation – The Outlook* in which the writer praised the East Indian as the 'right man for the plantation'.<sup>148</sup>

### 3.7 Conclusion

This chapter, and the two preceding ones, have argued that the arrival of indentured immigrants into British Guiana brought the plantations under the scrutiny of governmental and non-governmental bodies. One outcome of this interest was legislative reform – particularly with regard to the organisation of medical provision. During the twenty six years which spanned the first Hospital Ordinance of 1847, to the 1873 Immigration Ordinance and the introduction of government salaried doctors, it is

---

143. *Ibid.* C.O. 111/250/63; 69; 70; 77; 82; 83; 85; 86; 95.

144. *Ibid.* C.O. 111/250/30.

145. *Ibid.* C.O. 111/250/96.

146. *Ibid.* C.O. 111/250/75; 104.

147. *Ibid.* C.O. 111/250/31.

148. *Timehri* 3<sup>rd</sup> Series. Vol. VI. September 1919. p. 37.

### Plantation hospitals - disease, mortality and race

evident that the standards of medical provision deemed acceptable for immigrants were raised. It should be remembered that at the time of Bonyun's report the majority of estates failed to provide their workers with a hospital. Over the following years the number of hospitals expanded, until virtually all estates provided one. The government also paid attention to the conditions and the management of these institutions. In this chapter we have seen how nursing, diet, and hygiene in the plantation hospital, as well as the number of beds, concerned official thinking. From 1859 onwards the role of government and its officials in the life of the plantation became steadily more visible. The collection of statistics, the tabling of diseases, and the grading of hospitals along with the reports, registers and returns indicates the way in which the role of the state was extended.

Ultimately however, the 1847 and 1859 Hospital Ordinances once again pointed to the inability of the plantations to manage properly the health care of their labourers. Although economic self interest propelled estates towards introducing a number of technical innovations which were designed to increase productivity and improve the quality of sugar during the 1850s and 1860s, neither self interest nor the existence of legislation seems to have guaranteed better hospitals.<sup>149</sup> As discussed in the last chapter, the political leverage for reform became available once the 1871 Commission of Enquiry was set in motion. The result was a system of government salaried medical officers who were attached to medical districts.

Incorporating medical practitioners as government employees created a distinct type of medical person – one who was working in the 'interests' of the colony and who was in 1886 to receive further symbolic confirmation of this fact in the title of Government Medical Officer. Another measure of this transformation, and a perception of what had been lost can be found in a plea from the West India Committee in 1874, requesting a return to the former medical system. At present, it argued:

...the proprietor has no control over the medical supervision of his people or the management of the hospital which he maintains at great expense on the estate, and no effective check upon any extravagant expenditure that may be authorised by the Doctor.<sup>150</sup>

---

149. The most significant technical advances which plantations adopted included the spread of 'vacuum-pan' sugar, steam engines, and centrifugal pumps. Adamson, *Sugar* pp. 167-173.

150. West India Committee to Carnarvon. 29 July 1874. C.O. 384/104/708.

### **Plantation hospitals - disease, mortality and race**

Thus, the defining features of a doctor's work on the plantation were now established through the precepts of the Immigration Department and the home government rather than from the more immediate influences of estate managers. At one level, doctors continued to apply their skills to treating labourers much as they had done in the past. However, the regimen of accountability, the collection of statistics, and the systematic categorisation of labourers, indicates that doctors were now busy producing new pictures of life and suffering on the colony's plantations. These practices also represented a widening of legitimate medical interest beyond the delivery of medical care in the plantation hospital. Medicine was now speculating upon the efficiencies, orderings and management of labour on the plantation. The conditions of its transportation, the season of its arrival and finally its distribution to the plantation and even tempo of work all had a medical dimension. The ultimate aim of these interventions was the survival and more efficient working of the plantation system. Healthier and more productive immigrants were the means to these ends.

In the following chapter the focus shifts from the world of the plantation to the wider colony. Here too, it will be seen, medicine was beginning to stretch out to categorise and assess the inhabitants of Guiana. The questions which came to interest the medical profession were population, infant mortality, birth rates and death rates. In the next chapter, *Politics and Population 1880-1914*, I examine the transformation of medical provision from a plantation focused system to one which began to address health provision for wider numbers of individuals.

-----

## Chapter 4

### 4.1 Introduction

In 1893, Dr. Robert Grieve, the former Medical Superintendent of Hampstead Hospital, and now Surgeon General of British Guiana, received a novel proposal (source unnamed) for improving the care of infants in the colony. Parents who were unable to look after their young properly, it was suggested, should be induced to relinquish them to a 'baby farm', where they would be brought up as children of the colony under the guidance of government officers.<sup>1</sup> Who these unsuitable parents were, and how their children should be identified and selected was not stated. However, it was taken for granted by the author that standards of 'native' parenthood left much to be desired, and that the scheme would produce large numbers of children.

Grieve dismissed the proposal. He was sceptical that Guiana was 'ripe' for such a wholesale transference of parental responsibilities to officials of the state. He then went on to discuss the issue which lay simmering behind the proposed baby farm. This was the problem of the colony's, and in particular Georgetown's, 'excessive' infant mortality.<sup>2</sup> The question for Grieve, was not whether the government should involve itself in this matter, but the manner of its involvement. Rather than baby farms he pointed to a greater role for the state in modifying the ideas and everyday practices of colony inhabitants. Grieve argued that:

The main remedies are to be found in the improvement of the sanitary conditions of the city and in the moral and social elevation of the people coupled with the spread of knowledge of the elementary principles of hygiene.<sup>3</sup>

Was this comment just a platitude, part of the rhetoric of colonialism, without any further significance? I argue in this chapter that Grieve's statement marked a critical change in official attitudes towards 'the people'. In the 1890s the words 'public health' were increasingly nudging their way into the lexicon of the colony's medical personnel. This chapter introduces a discussion on what this phrase meant in the context of Guiana. Public health is itself essentially an abstraction. What it means is discernible only crudely through morbidity and mortality figures. However, the phrase begins to assume

---

1. Dr. Robert Grieve. Minutes of the Surgeon General, British Guiana. July 1893-4. British Guiana National Archives. AE4. p. 8.

2. Ibid.

### Politics and Population 1880-1914

a more concrete reality when located in given populations, at particular times, and places. Christopher Hamlin also reminds us that neither 'public' nor 'health' are self explanatory categories.<sup>4</sup> How they become connected are political questions, involving relationships between professional bodies, institutions and individuals. Public health also encompasses forms of, administration, legal questions, enforcement, funding, and not least, forms of categorisation i.e. decisions about which aspects of health, and which population group is important. Factors such as whether individuals are young or old, male or female, kinsfolk or strangers, rich or poor, able or disabled shape the boundaries of who is included or excluded from the 'public'. These very same 'social' factors also affect patterns of morbidity and mortality in society. As George Rosen has argued, disease is not a chance phenomena, but the outcome of an interaction between the circumstances of peoples lives and the wider environment – the built and the natural – in all its facets.<sup>5</sup>

The emergence of public health thinking in Guiana, in particular the idea that reducing infant mortality was something which the medical profession and government should seek, was inextricably linked to a broadening medical vision. A medical service designed to cater for the needs of immigrants was slowly transformed into one which sought to intervene directly into the lives of the colony's inhabitants.

To understand what this change meant, it is worth looking at the place of medicine in Guianan society at the time of emancipation. Two strands of thinking in political and medical circles seem significant in this respect. First of all, there was a general acceptance amongst government officials that doctors and town councils, and to a lesser extent village councils, had a role in improving sanitary conditions, providing clean fresh water, and managing epidemic outbreaks. This idea can be traced back to the 1837 Ordinance which established a Mayor and Town Council for Georgetown to oversee these matters. This ordinance was also an early indication of the way that the urban environment, as a place of official interest, was privileged over the rural, plantations excepted. Secondly, outside of the estates, and in the absence of epidemic crises such as cholera or smallpox, a person's health and that of their children were

---

3. Ibid.

4. Christopher Hamlin, Public Health and Social Justice in the Age of Chadwick. Britain 1800-1854 (Cambridge University Press 1998), p.2.

5. George Rosen, 'Social Variables and Health in an Urban Environment: The Case of the Victorian City', Clio Medica 1973 Vol. 8. No. 1. pp. 1-17.

### Politics and Population 1880-1914

largely seen as a matter for individual responsibility, and not of the state. In Georgetown, those who could afford to, paid the doctor a flat fee for attending to them for the year.<sup>6</sup> For most of the nineteenth century, the government did not feel the need to reflect very often, or at any great extent upon the health of Georgetown's inhabitants.

As already suggested, with the growth of public health thinking, this situation changed. The outcome may be seen in the various official exhortations, drives and enforcements designed to alter the activities of the colonial subject according to sanitary models or medical priorities imported from England. These included encouraging individuals and householders to adopt novel sanitary codes, better management of privy pits, covering up of water vats, tending to cattle in special ways, and prohibitions on spitting in the street. At a municipal level, 'public health' sentiment expressed itself through regulations designed to ensure improved standards of hygiene in the markets and bakeries, and in controls on the sale of milk. At the colonial government level it resulted in the establishment of a Mortality Commission in 1905 to examine the general mortality of the colony, and, as the Government Secretary put it 'more especially into the excessive infantile mortality thereof.'<sup>7</sup> The proceedings of this commission were reported in detail in the colony's press, and it provides a valuable insight into how colony officials (town council, government, medical) viewed the urban and rural environment, motherhood, and the administration of government.

Many of the ideas and public health initiatives mentioned above were also occurring in England, and the importance of the English model in providing examples of desirable sanitary practice can not be overestimated. However, as this chapter emphasises, although there were some similarities in how problems were identified, the political, social and economic context for developing public health measures in Guiana were quite distinct from England. This is evident in the manner in which Europeans in the colony successfully resisted pressures for democratic reform, in the privileged but minority status of Europeans, and more generally, in the deeply racialised features of society, such as the way labour was managed and organised. Mass urbanisation and the spread of industrialisation, which historians have often identified as the twin drivers of

---

6. Dr. J. S. Wallbridge, 'Fifty Years' Recollections of British Guiana', *Timehri* 3rd Series Vol. 1. No. 3. p. 266.

7. Report of the Commissioners. *British Guiana Medical Annual* 1906 (BGMA) (The "Argosy" Co. Demerara 1907), p. 2.

## Politics and Population 1880-1914

British public health and welfare thinking, were also largely absent from Guiana.<sup>8</sup> This last statement needs some qualification. Georgetown, which had reached a population of 50,000 by the end of the nineteenth century did assume, in the eyes of its public health guardians, many symptoms of the English pathogenic city: ignorance, filth, and disease.

The guardians of political rule in Guiana and Britain both shared a perception about the importance of population. In Britain, as Dorothy Porter contends, interest in the health of the country's urban and rural inhabitants was 'a product of Enlightenment rationalism created in an effort to calculate the strength of the state in terms of the health of its subjects.'<sup>9</sup> Or, as the nineteenth century statistician of population William Farr succinctly argued: 'The longer men live, and the stronger they are, the more work they can do.'<sup>10</sup> In Guiana, as mentioned in chapter three, the incessant movement of mud and water made plantations particularly vulnerable to the flooding, eroding and dissolving powers of nature. The connections between human physical labour, production, and prosperity were unmistakable, perhaps more so than in many other parts of the world. Without 'constant labour', the colony as a productive site within the British empire, had no viable future.

This chapter begins with a brief exploration of the links between labour and commerce. Population, it will be seen, was considered crucial for economic development, and also as a broader measure of the colony's 'progress'. One of the difficulties which faced officials was estimating the size and health condition of the population. Was it growing, stagnating or falling? Which racial groups had the lowest infant mortality and the highest fertility? During the late nineteenth century doctors in the colony carried out investigations into these questions. The evidence they collected shaped their perceptions of 'mothercraft' and, as we will see in chapter six, stimulated new approaches to the regulation of midwifery.

### 4.2 Population, environment and commerce

During the nineteenth century the British population became the subject of sustained interest for government and social reformers. One influential line of thinking

---

8. Anne Hardy, Health And Medicine in Britain Since 1860 (Palgrave 2001), p. 29. D. Porter, Health pp. 196-197.

9. *Ibid.* p 165.

10. William Farr, in Noel A. Humphrys (ed.), Vital Statistics: Memorial Volume of Selections From The Reports And Writings (London 1885), p. 63.

### Politics and Population 1880-1914

was represented by Malthus, who regarded the burgeoning population as a threat. Others, as the historian Anna Davin has pointed out, saw population as a resource, adding vigour and wealth to the nation, and thereby maintaining civilisation through commercial activity.<sup>11</sup> It was this latter view, population as human capital, which came to dominate elite thinking in British Guiana. More specifically, the two population groups which were seen as crucial to society were the Europeans (defined by place of origin and whiteness) and plantation workers (defined by work and 'otherness'). The former, it was understood was needed in order to manage the latter. This was supposedly for the financial and moral betterment of all. More than this, commercial exchange meant bringing 'civilisation' to non-Europeans especially Africans. Not infrequently, the Court of Policy argued that 'the only practical means to civilise Africa is by sanctioning and establishing frequent and regular intercourse between that continent and the West Indies'.<sup>12</sup> Just as the trade in labour was necessary to spread the benefits of civil society, so too was the presence of Europeans considered crucial for its organisation, management and preservation. In the absence of European influences there was a likelihood of universal ruin. As the *Daily Chronicle* put it as late as 1893:

Withdraw the Anglo Saxon from the West Indies [and] within a very few years things will once more assume their natural course, evidence of civilisation will disappear.<sup>13</sup>

Many similar statements in favour of the European presence in Guiana, had surfaced over the years.<sup>14</sup> For example, the reform minded *Nuggett* newspaper in 1888, colluded in this view: 'Leave the African, or the coloured, or the black to himself and he relapses to his fetish...obeahism, barbarism and cannibalism'.<sup>15</sup> Comments like these hinted at much more than a minor reversal of economic fortune, but a total collapse of *society* to some purposeless pre-European, possibly 'barbaric', state. Mid-Victorian thinking on this matter generally supposed that the 'natural course' of countries in the hands of 'natives', and without the guiding influences of Europeans, was a declining population and the abandonment of the material, religious and moral conditions

---

11. Anna Davin, 'Imperialism and Motherhood', in Frederick Cooper and Ann Laura Stoler (eds.), *Tension of Empire. Colonial Cultures in a Bourgeois World* (University of California Press 1997), pp. 87-88.

12. Reply to the Anti-Slavery Society 22 March 1850. MCP. 11 June 1850. C. O. 111/275/81.

13. *Daily Chronicle* 2 July 1893.

14. Supporters of West Indian sugar interests understood the crucial importance of polemic within government circles, and painted graphic pictures of the Caribbean's economic and moral decline springing from the abandonment of plantations. Rodway. *History* Vol. 2. p. 288.

15. *Nugget* 1 September 1888.

### Politics and Population 1880-1914

necessary for civilised life. In short, any weakening or collapse of the planter system wrought wider changes, supposedly, idleness and debauchery replaced industry and propriety. These anxieties ran through the 1850 Commissioners *Report on the Condition and Prospects of British Guiana*.<sup>16</sup> This document charted the abandonment of estates under the 'hammer' blows of the 1846 Sugar Act. The authors (all with planting interests) attempted to show that where the individual estates no longer existed, whole districts became cut off and isolated as stretches of the coastal road collapsed and bridges were no longer maintained. The fate of individual estates, which were in a sense microcosms of the wider society, hinted at the destiny of the colony should Europeans leave. With the disintegration of commerce and infrastructure the institutions of the state and moral society withered. Along the Corentyne coast for example:

Owing to a want of roads, the magistrates' and sheriffs' courts are very irregularly held, the churches and schools are neglected...There is no police station or stipendiary magistrate resident in this district, and the people are living, as nearly as possible in a state of lawless independence.<sup>17</sup>

There was also a strong ecological dimension to this picture, a sense of wilderness reclaimed and then lost, an almost palpable horror of the encroaching disorder.<sup>18</sup> Europeans and the plantation system they had developed had rapidly transformed West Indian landscapes. Before sugar was planted trees were felled and burnt. For example, on the island of St Croix in the seventeenth-century French sailors had set fire to the whole island in order to make it suitable for human colonisation. Ash from the smouldering remains of former forests supplied a quick, but temporary, boost to productivity. As one planter from Barbados explained, there remained after clearance neither 'wood, nor bark, nor leaf, nor so much as the least grass'.<sup>19</sup> Similar wholesale transformations, which represented enormous investments of time, organisation, finance and labour had been wrought in Guiana. Any disruption to this imposed pattern of carefully managed settled agriculture, threatened the rapid return of pests, pathogens, weeds, bush, and forest in the form of jungle - the antithesis of European notions of

---

16. 'Commissioners Report on the Condition and Prospects of British Guiana 1850', in The Case for Free Labour in British Colonies Submitted to the British Legislature (London: James Maden, 1852).

17. *Ibid.* pp. 119-120.

18. David Arnold, The Problem of Nature. Environment, Culture and European Expansion (Blackwell 1996), pp. 133-135.

19. David Watts, The West Indies: Patterns of Development, Culture and Environmental Change since 1492 (Cambridge University Press 1987), p. 393, 394.

### Politics and Population 1880-1914

desirable pastoralism.<sup>20</sup> Visiting the village of Craig in 1882 a journalist from the planter newspaper the *Argosy* described how a dwindling village population was matched by the slow insistent advance of jungle which ultimately took possession of, and finally demolished, the local religious houses.

...the retrogression in population is nothing compared to the general appearance of the village and its surroundings. Perhaps no part of the colony is a sadder sight than here. The roofs are crumbling off the miserable huts; the drains are choked; the jungle is creeping up and taking possession of the very doorsteps; and the decaying remains of what at one time were large and roomy religious meeting houses add suggestively to the general air of squalor and desolation.<sup>21</sup>

In fact, the villages were rarely a priority for colonial officials, and never seriously featured in planter thinking. Typically, officials routinely decried the 'state of the villages' while simultaneously denying them the financial and technical means to develop. Nevertheless, it is possible to read into the above description a disturbing allegory of British rule, where the absence of power is replaced by the chaotic but inexorable spread of physical disintegration and moral degeneration. 'These people', commented the 1850 Commissioners' Report on 'idle' villagers, 'seem fast retrograding into a savage state, consistent with the wilderness, which is surrounding them.'<sup>22</sup> This imagery and rhetoric was designed for audiences at home, it was an appeal for special consideration, for the lifting of immigration restrictions and economic privileges. It also served a wider ideological purpose by offering a vision of empire. It underlined the duty of Europeans to bring and uphold in the colonies prosperity, harmony, and order under law. Importantly though, these were values some Europeans in Guiana took seriously. For example, in 1888 in *Timehri*, the colony's cultural-intellectual periodical, the author of an article on village health reminded his European audience that as nations became more 'refined', the 'common *health* became regarded as the common *wealth*.'<sup>23</sup> Civilisation, it seems, required medicine as much as commerce. On the other hand, ideas about European duty towards the wider population were unfolding in a rapidly changing colony. The social circumstances of life in Guiana were also pulling official attention towards examining the world outside of the plantation.

---

20. Libby Robin, 'Ecology: a science of empire', in Tom Griffiths and Libby Robin (eds.), *Ecology & Empire. Environmental History of Settler Societies* (Keele University Press 1997), p. 63.

21. Rodney, *Guyanese Sugar Plantations* p. 45.

22. Commissioners' Report 1850. p. 122.

23. C. E. MacNamara, 'The Free Rural Population from a Medical Point of View', *Timehri* II 1888.

#### 4.3 Social context and critiques of immigration

As we saw in chapter one, from the moment of emancipation onwards planters were concerned about securing 'continuous labour' for their commercial enterprises. For the remainder of the century the colony's political administration was unshakably committed to this aim by means of immigration. Nevertheless, over the years planters and their supporters kept up a steady pressure on each of the colony's Governors to maintain and increase the number of immigrant labourers brought into the colony. For example, in 1890 the financial representatives of the Combined Court, the Planters Association and Chamber of Commerce all presented memorials to the Governor stressing the continuing inadequacy of the labour supply. The pro-planter *Daily Chronicle* chimed in to claim that agriculturists, commercial men, producers, importers, parsons and other 'professional men' were all united on the colony's urgent need for extra workers.<sup>24</sup> In London the staunchly pro-planter West India Committee, and its Glasgow and Liverpool associations lobbied Parliament and the Colonial Office to protect the interests of planters.<sup>25</sup>

This high profile political activity reflected the lasting importance of immigration to the Guianan economy. The fifty years from emancipation had seen very little economic diversification take place in the colony. Only in the last decade of the century did gold and diamond mining begin to take on any significant economic importance; an estimated 6,000 men were employed in gold in 1896-97.<sup>26</sup> In fact, the discovery of gold brought its own special problems. The scantiness of the rural population made the permeability of Guiana's border with Brazil and Venezuela a new source of anxiety as both countries pressed their territorial claims.<sup>27</sup> Despite gold, the economic edifice of Guiana continued to rest on the importation of labour and the production of sugar.

As we have seen, by the middle of the century, the relationship between planters and immigrant labour had been secured in law by numerous special legislative enactments, the Immigration Ordinances, each sealed with the approval of Whitehall. Although immigrants lacked direct political influence, their presence pervaded

---

24. *Daily Chronicle* 24 June 1890. See also Adamson, *Sugar* pp. 138-140.

25. *Daily Chronicle* 11 July 1890.

26. Adamson, *Sugar* p. 93.

27. For appointment of Boundary Commission see CO/111/520/321, CO/111/521 9 and 18 October 1900. For border incursions see *Daily Chronicle* 13 June 1890 and various issues to 15 July 1890. For seizure of vessels see *Argosy* 14 August 1903.

### Politics and Population 1880-1914

discussions about the colony's political, educational, welfare, and policing arrangements. Customs' revenue and levels of colony taxation were directly affected by the cost of immigration. The presence of imported labour also shaped thinking about the health status of non-Europeans. Crucially, as we saw in chapter one, due to the overriding importance of immigration, colonial policies focused on indentured immigrants and the estate environment, rather than the free labourer or urban dweller. However, the political repercussions of the state driven immigration policy were not confined to the colony's government.

Outside of government and planting circles, it is clear that the assumptions, goals and priorities described above were not always shared by other colony inhabitants, especially in times of economic difficulty. Evidence of a changing mind-set on the question of immigration and its cost emerged towards the end of the nineteenth century. At this time, despite the ethos of free trade, Britain had begun to feel a tightening of international competition for export markets with the rise and rivalry of European empires and America.<sup>28</sup> It responded by gradually erecting a complex web of trade treaties, tariffs, duties, subsidies, and bounties. Increasingly, these arrangements, in Britain and elsewhere, were seen as necessary in order to funnel commodities around the world. Amongst British manufacturers, the 1880s saw the cry of 'fair trade' (protectionism by another name), begin to supplant that of 'free trade'.<sup>29</sup> But what looked like fair trade from the metropole was often a handicap from the periphery. As cheap sugar beet from Europe steadily squeezed out from the home market West Indian sugar, Guianan planters scrambled to find alternative outlets for their produce, and were at once embroiled in the contentious and uncertain world of trade diplomacy. In brief, the British desire to maintain their trading privileges in Guiana, had the effect of repeatedly choking off the efforts of planters to export sugar to America and elsewhere.<sup>30</sup> In the matter of trade, the imperial connection seemed injurious, not beneficial. Tellingly, in 1886 a member of the West India Committee told the government he would 'rather be a rich Yankee than a ruined Englishman.'<sup>31</sup>

---

28. C. C. Eldridge, England's Mission. The Imperial Idea in the Age of Gladstone and Disraeli 1868-1880 (Macmillan 1973), pp. 244-251.

29. Cain and Hopkins, British Imperialism pp. 202-214. Helen Mercer, Constructing a Competitive Order. The Hidden History of British Anti-trust Policies (Cambridge University Press 1995), pp. 8-11.

30. Adamson, Sugar pp. 224-235.

31. Quoted by Adamson, Sugar p. 228.

### Politics and Population 1880-1914

The uncertain economic outlook for the colony was matched by the beginnings of organised political discontent as sections of the colony's inhabitants, in particular the growing urban commercial class, but also artisans and villagers, pushed themselves into active political life.<sup>32</sup> They were aided by the publication of reform minded newspapers e.g. *The People* and the *Nugget*, which were critical of the colonial order. Reform clubs and associations sprang up and provided new forums for discussion about taxation, the need for constitutional reform, and other grievances such as the running of the Georgetown Public Hospital, or more generally the cost of the medical service provided to immigrants. At one meeting in 1892 a member of the audience railed against the rule which 'prevented Creoles and other deserving persons' from joining the Colonial Medical Service.<sup>33</sup> The *Nugget* newspaper prided itself for its dedication to the 'cause of the people.' In this campaigning capacity it sometimes criticised the colony's medical profession, thus indicating the way that Western medicine was already firmly embedded in a wider social discourse. There were, claimed the *Nugget*, a 'long list' of cases carelessly treated by hospital staff.<sup>34</sup> In fact, accusations had already surfaced in the Court of Policy that doctors in the Georgetown Public Hospital were 'over familiar' with nurses, that they routinely drank the hospital's brandy, stole food and arbitrarily handed out fines.<sup>35</sup> The paper also turned its attention to the sanitary state of Georgetown, pointing out the way that the poor in dry periods, were reduced to fighting over access to stand pipes.<sup>36</sup>

Around this time there is also evidence that some rural communities saw the attendance of the doctor as a right. For example in 1883, R. Daniel, a sick nurse complained about the reluctance of Dr. Pollard to treat his wife. In a letter published by the *Daily Chronicle*, Daniel claimed that they were 'morally entitled to a share of his professional generosity', and questioned whether the lack of treatment 'had much to do with my colour'.<sup>37</sup> Medicine, imported to support the colonial regime, was now furnishing the means for a critique of that same society.

---

32. James G. Rose, 'The Coming of Crown Colony Government in 1928', in McGowan, Rose, and Granger, (eds.) *Themes in African-Guyanese History* p. 300.

33. *Daily Chronicle* 9 January 1892.

34. *Nugget* 15 and 22 September 1888

35. John Walsh. Encl. Despatch 9 July 1886. Henry Irving. C. O. 111/436.

36. *Nugget* 5 October 1889.

37. *Daily Chronicle* 14 July 1883.

### Politics and Population 1880-1914

Support for these reforming organisations and papers mainly came from outside of European circles. The individuals involved included artisans, lawyers, schoolteachers, businessmen and later from non-conformist churches in rural areas.<sup>38</sup> However, at least three doctors in private practice, Dr. J. Rohler, M.D. Master of Surgery, University Bishop's College Montreal; Dr. J. London, Licensed Royal College of Physicians, London 1883; and Dr. F. Willis, M.B. Master of Surgery, Edinburgh 1895, spoke at Reform Club meetings and were involved in radical publications such as the *People*.<sup>39</sup> Other organisations, which indicate the strength of the growing social and political solidarity amongst a strata of colony inhabitants, also came into existence around this time. These included Beneficial Societies, Friendly Societies and Lodges which provided benefits in times of unemployment, sickness and death, and the establishment of various worker's and farmer's associations, as well as a Young People's Improvement Society.<sup>40</sup>

Early evidence of a mood for change is apparent from a petition in 1871 from the 'coloured' inhabitants of the East Coast. They complained about the 'privileged proprietor class who deprive the poorer classes of a just command of the necessaries of life by oppressive taxation designed for their own benefit.'<sup>41</sup> The colony's legislature routinely dismissed such complaints, and it was not until 1896 that the first non-white stepped into the legislative chamber and ended the unchallenged dominance of the planter class.<sup>42</sup> Claims that the 'general community' shouldered too high a burden in taxes grew in force.<sup>43</sup> Village opposition to taxes was often directly linked with planter influence in government.<sup>44</sup> A memorial to the Secretary of State for the Colonies, signed by 3,952 mainly Black villagers, stated their objections to the 'exorbitant' cost of immigration thus:

An adequate conception of the injustice of state aided immigration as it obtains in British Guiana might be gained by imagining the British workman on a strike for

---

38. Rodney, *History of the Guyanese Working People* p.142; 146; 148.

39. *Ibid.* p. 172.

40. *Ibid.* p. 162; 172.

41. Memorial to Her Majesty, November 1871. CO/111/387.

42. Brian L. Moore, 'African-Guyanese Political Disempowerment during the Nineteenth Century', in McGowan, Rose, and Granger, (eds.), *Themes in African-Guyanese History* p. 235.

43. Letter. *Daily Chronicle* 31 January 1890. Also report of Reform Club meeting Berbice. Indentured immigration was compared to a form of serfdom, and the taxes levied on the 'whole community' characterised as: 'a political injustice and national wrong.' *Daily Chronicle* 7 February 1890 and also 5 July 1890. See also articles in the *Argosy* headed "Anti-Immigration Controversy" 3 and 6 June 1903.

44. See anti taxation meetings at *Plaisance*. *Argosy* 8, 11, 22 April 1903.

## Politics and Population 1880-1914

higher and fairer wages being taxed to pay for the introduction of *foreign* cheap labour, and the Government justifying it on the ground that what would in such cases be essentially a grant to capitalists was merely a grant to increase the population of the country.<sup>45</sup>

Attempting to swell the colony population with expensive imported labour while infant mortality went ‘unchecked’ was, according to a comment from the recently formed Children’s Protection Society in a letter to the *Daily Chronicle*, like filling a leaky cask, both irrational and wasteful.<sup>46</sup> Those who sought reform wanted less government concern shown for the financial welfare of planters, and more regard for matters of universal interest. Interestingly, the planter friendly *Daily Chronicle* responded positively to this opinion, and argued in 1890 that a measure of change was necessary in order to ‘create a healthier public opinion and some real interest in colonial affairs.’<sup>47</sup> The paper went on: ‘Once people begin to think about matters of common concern they will not rest content with a policy of *laissez faire*.’<sup>48</sup> The Children’s Protection Society drew attention to those issues which it felt confronted society. These were the colony’s high infant mortality rate and the ‘overcrowded, unwholesome, filthy, ill-drained houses’ in which infants were expected to ‘strike shoots’ and grow.<sup>49</sup>

It is difficult to see how far these ideas had an impact amongst government or medical people. Perhaps the first point to make is that the 1880s saw the institutional spread of medicine beyond its urban and plantation boundaries. Ironically, a gathering critique of the cost of medicine was matched by its extension. In 1880 a small Public Hospital was opened at Suddie in the district of Essequibo. Another one was opened at Massaruni (eight beds) in 1887 to cater for gold diggers. In 1886, when the Medical Service officially became a Government Medical Service, medical practitioners were given the explicit duty of attending to villagers, even if they did not work upon the estate.

By the early twentieth century the justification for medical expenditures had also altered. The criteria for judging medicine, according to some of its practitioners, now lay in how far the medical services met the needs of the wider population. As the *Argosy* newspaper stated in 1905: ‘Whatever may have been the origin of the present [medical]

---

45. Quoted by Sir J.A. Swettenham Secretary of State for the Colonies. *Official Gazette* 7 July 1906.

46. Letter from member of the Childrens Protection Society. *Daily Chronicle* 3 January 1890.

47. Leader. *Daily Chronicle* 3 January 1890.

48. *Ibid.*

49. Letter. *Daily Chronicle* 3 January 1890.

service, the *raison d'être* now is unquestionably the general need of the colony.<sup>50</sup> In the same year, when the GMO, Dr. von Winckler, was asked what motivated him, he replied: 'To attend the public.' In a further indication of the shift in attitude from a plantation focus to the wider colony, he went on to assert that: 'You must have a Government medical service even though you may not have immigration.'<sup>51</sup> A point again emphasised by the *Argosy* three years later.<sup>52</sup>

In addition, we can see that as the medical profession began to examine more systematically the causes of mortality amongst the wider population, they adopted forms of language which articulated the widening scope of their medical gaze. Phrases such as 'the people', 'community', and 'citizenship' entered into medical and administrative parlance. The use of these inclusive terms suggests that a new medical vision for the future of the colony was being fashioned. It is arguable that the linguistic move from colonial subject to individual citizen revealed a considerable change in attitude. Citizenship, after all, implied obligation and duty as well as rights. We can see what this means by examining the tensions around the endeavours of Georgetown's Town Council to improve their management of the city, local sanitation and the quality of milk. This is discussed more fully in chapter seven. For now, it is worth noting that amongst the medical profession and much of the colonial administration there emerged at the beginning of the twentieth century a remarkable level of agreement over the tasks of government in promoting health and extending medical provision in the colony. Doctors constructed a rhetoric of health around the meaning of progress, which increasingly meant reducing the mortality of the 'community'. This was measured by birth rates, death rates, and infant mortality rates. How doctors collected, analysed and used this material is examined next.

#### 4.4 Studies in Life and Death

Information about the state of the colony's population, its size, racial composition, and the occupations of its inhabitants was compiled for each of the colony's ten yearly censuses which began in 1841. In general, these were not viewed as providing particularly accurate pictures of the colony, they were exercises in number

---

50. *Argosy* 14 October 1905.

51. Dr. von Winckler. *Argosy* 14 October 1905.

52. *Argosy* 25 January 1908.

### Politics and Population 1880-1914

counting and did not have significant political impact. While officials strove for accuracy, it was nevertheless understood that much of the information was at best 'partial' or 'one sided'.<sup>53</sup> Although individuals were encouraged to register births and deaths, the system was haphazard and voluntary. The colony's Commissary of Population, J. Hadfield, complained in 1848 that the 'higher orders of the community' had little interest in pursuing matters of non-compliance.<sup>54</sup> It was not until 1868 (thirty-one years after similar legislation had been passed in England) that the colony passed a Registration of Births and Deaths Ordinance and began assembling the proper administrative mechanisms for calculating population.

Although the accuracy of the colony's birth and death rates may have been questionable, (one doctor described the system of registration in 1893 as 'worthless') to many members of the administration and medical profession, the colony's statistical data was persuasive and a cause for alarm.<sup>55</sup> This can be seen when Mr. Dalton, the 'well known and popular head of the Registrar's Office' published the numbers of still births in Georgetown for 1882. Numbering 206, they were of 'shocking significance' according to the *Argosy*. Was infanticide to blame? Apparently so, the *Argosy*, in a revealing phrase, said this was 'a most repellent feature of our boasted civilisation'.<sup>56</sup> These suspicions led to a change in the law relating to the burial of still-born infants, namely the introduction of mandatory medical certificates. The new law also represented a significant administrative turn towards the 'native' family, culminating in various investigations and surveys by doctors designed to show fertility rates and causes of infant mortality.

Birth rates and death rates were often finely balanced in official statistics. For example, in 1882 they were 32.29 per thousand and 32.1 per thousand population respectively. At best this gave the colony the slenderest of population increases, one which was easily reversed by the indiscriminate vagaries of disease. Dr. Grieve, the Surgeon General, pointed out as editor of the new *Asylum Journal* that 'No one who has the true interests of the Colony at heart can view this state of things with indifference.'<sup>57</sup> More worryingly still, about a third of all deaths were children, most of whom died

---

53. J. Hadfield. Commissioner of Population, 1847. C.O. 111/256/311.

54. Ibid.

55. *BGMA* 1893, p. 163.

56. *Argosy* 8 September 1883.

57. *The Asylum Journal* "Asylum Press", 15 September 1882. p. 57.

#### Politics and Population 1880-1914

within their first year of life. Data such as this had a perceptible political impact within the colony's ruling circles. For example, when the Registrar General in 1883 announced that the total annual rise of the colony's population was no more than 654, an alarmed member of the Court of Policy, Mr. Russell, exclaimed that: 'unless the rate be considerably accelerated, it will be impossible to develop the resources of the colony as quickly as desirable.'<sup>58</sup>

Exploring this state of affairs gradually occupied greater amounts of time for the colony's medical profession. One of the crucial questions they became keen to answer concerned fertility rates. Doctors suspected that birth rates for Blacks were lower than previously thought. In 1890 Dr. Rowland, Resident Surgeon to New Amsterdam Public Hospital, and a former pupil of Sir. J. Halliday Croom, Professor of Midwifery at the University of Edinburgh, began collecting together data to test out these speculations. The Public Hospital, which seems to have attracted mainly Black women, made it possible to gather information on the ages of mothers, the frequency of pregnancy, miscarriage, and still-birth.<sup>59</sup> Although the numbers of women surveyed in his work were modest, just 283, the results challenged received knowledge about racial fertility, gave substance to the view that the colony's Black population was declining, and set the intellectual direction that future investigations would take.

By careful questioning of mothers under his care Rowland estimated that only forty-eight per cent of live births finally made it to adulthood.<sup>60</sup> Evidence appeared to confirm that Black women were far less fertile than doctors had previously believed. To help interpret and evaluate these figures Rowland drew upon the British experience. The statistical work of Farr, and medical luminaries who were steeped in the culture of British medicine, such as Sir J. Y. Simpson of Edinburgh (famous for using chloroform anaesthesia) and J. Matthews Duncan, of the Royal Maternity Hospital, were thus the unwitting architects of medical knowledge in the colonial world. They helped to provide the intellectual framework and the statistical detail necessary for making comparisons and judgements.<sup>61</sup> Table 4.1 where Rowland set out his data about English women from a poor area of East London, and Black women in Guiana, is shown on the next page.

---

58. Mr. Russell. *Argosy* 8 September 1883.

59. Rowland, 'Some Remarks on the Fertility of Negro Women, and its Influence on the Population of the Colony of British Guiana', *BGMAHR* 1891. p. 27.

60. *Ibid.* p. 32.

61. Rowland, 'Some Remarks', *BGMA* 1891. p. 20.

## Politics and Population 1880-1914

**Table 4.1 England and British Guiana compared: age of marriage, rate of illegitimacy, still birth and birth rates 1891**

ENGLAND.	BRITISH GUIANA—BLACKS.
1. Average Age at marriage of women— 24.3 (Farr). 23 per cent. marry under 21 (Newsholm).	Average Age at first pregnancy 19.7 yrs. 27.2 p.c. at 15 and under. 50.9 „ between 16 & 20 (incl.) 22.1 „ between 21 & 25.
2. Illegitimacy 6.5 per cent. (Farr).	61.8 (Reg. General) p.c.
3. Still births 4.0 per cent. (?) (Farr).	The Reg. General gives 8 to 10 per cent. 4.3 per cent.
4. Children to all marriages 4.63 (Farr)	To all (83) women 2.7 per cent.
5. To all fertile marriages 5.3 (Mat. Duncan)	To all fertile (11) women 3.5 „
6. To married state over 10 years' duration 9.12 (Mathews Duncan)	6. „
7. Birth-rate 35 (Farr)	Birth-rate for all races (3.2 for 9 years) 29 to 30 (R. Gen.) for Coolies 33.9 (R. Gen.)
8. 100 women living 49.6 married (Farr).	
9. 100 wives 2.2 children annually (Farr).	118,082 females of all races at all ages bear 7,869 children. (R. G.)
10. 100 unmarried 1.7 „ „ (Farr).	100 Coolie women have 18 children an- nually. (Imm. Ag. Report.)
11. 100 women 12 „ „ (Farr).	Children alive now 49 per cent.
12. Children alive now 57.46 (Duncan) p.c.	Sterile women for all ages (14 and onwards) 1 in 4.3.
13. Sterile wives (all ages) 1 in 6.6 or 15 p.c. (Duncan).	Sterile women for 21 and onwards 1 in 6.7 or 15 p.c.

One of the striking points that emerged out of the wealth of information that was poured into the above table was that Black fertility *was* lower than for white women. Rowland identified three principal factors involved. Black women had earlier pregnancies than women in England; they had fewer children; and a higher proportion had no children at all.<sup>62</sup> Establishing the age of first pregnancy was important since early pregnancies meant a longer period for childbearing and ordinarily would suggest a higher fertility rate. Rowland found that first pregnancies among Black women began around the age of twelve, and rose quickly from the age of fifteen onwards, before beginning to decline rapidly from the age of twenty-one. But early pregnancies did not come without problems, and were commonly associated with puerperal fevers, child-bed mortality and with social difficulties connected with parental immaturity.<sup>63</sup> Such problems with early pregnancy, however, were insignificant by comparison with the effect of an early cessation of pregnancy. In other words, while Black women were having their children at a young age, it seems that they were also limiting the number of children, although doctors offered no thoughts on how women might do this.<sup>64</sup>

62. Ibid. p. 20, 21, 30.

63. Ibid. p. 30.

64. An insight later confirmed Dr. Daniels in 'Negro Fertility and Infantile Mortality', BGMAHR 1898. p. 10.

## Politics and Population 1880-1914

Rowland was not the only doctor with this interest in examining fertility rates and the causes of infant mortality. In fact, a special meeting of the British Guiana Medical Association was convened in 1893 specifically to discuss this matter.<sup>65</sup> Another prominent colony doctor was C. W. Daniels, an Edinburgh trained surgeon and GMO, who was later to serve on the Royal Commission on Malaria and write extensively on the medical laboratory in the tropics.<sup>66</sup> In *Negro Fertility and Infant Mortality* Daniels emphasised that, 'In our under populated Colony, any facts bearing on the causes of the want of natural increase of the inhabitants are important.'<sup>67</sup> Like Rowland, Daniels' work was set in the hospital where he could question women under his care and trace the life histories of infants. Besides once again, demonstrating the high rate of infant mortality in the colony, Daniels also showed that childhood and young adulthood provided no refuge from disease. As the Table 4.2 below shows, doctors in Guiana estimated that the mortality rates for Guianan children at the end of the nineteenth century were substantially worse than for English children.

**Table 4.2 Mortality rates between England and British Guiana compared: 1898**

	2-5 Years	6-10 Years	11-15 Years	16-20 Years
Mortality rate per 1000 England	38	6.43	5.33	7
Mortality rate per 1000 Guiana	47	16	6.9	14

Source: Daniels, 'Negro Fertility', BGMAHR 1898. p. 13, 14.

As we will see later, doctors offered a range of opinion as to why mortality in the colony remained so high for infants and children. For the moment it is worth noting that doctors were pessimistic about the prospect of the Black population increasing. Rowland commented that:

There seems to be some reason to believe that the blacks are slowly dying out in this Colony. If this is so, surely we have a beautiful example of the survival of the fittest.<sup>68</sup>

The implications of such a view were ominous. The 1881 census had put Blacks at just over fifty-six per cent of the entire population.<sup>69</sup> Therefore, a low or falling birth

---

65. Ferguson, 'Infant Mortality viewed from the records of the Maternity Ward of the Public Hospital', Georgetown, BGMAHR 1893. p. 173.

66. Dr. Daniels and A.T. Stanton, *Laboratory Studies in Tropical Medicine* (London: John Bale, Sons & Danielsson, 1907).

67. Daniels, 'Negro Fertility', BGMAHR 1898. p. 8.

68. Rowland, 'Some Remarks', BGMAHR 1891. p. 33.

69. 1881 Census. Moore, *Race* p. 274.

### Politics and Population 1880-1914

rate amongst Black people signalled the stalling of colony population. Looking back over the past decade Rowland described the colony's rate of population growth as 'absurd', and a 'grave concern', estimating that it would take Guiana 233 years to double its numbers.<sup>70</sup> Two years later this view was elaborated by Dr. Castor, a GMO, who put the argument for an increased population in distinctly racial terms:

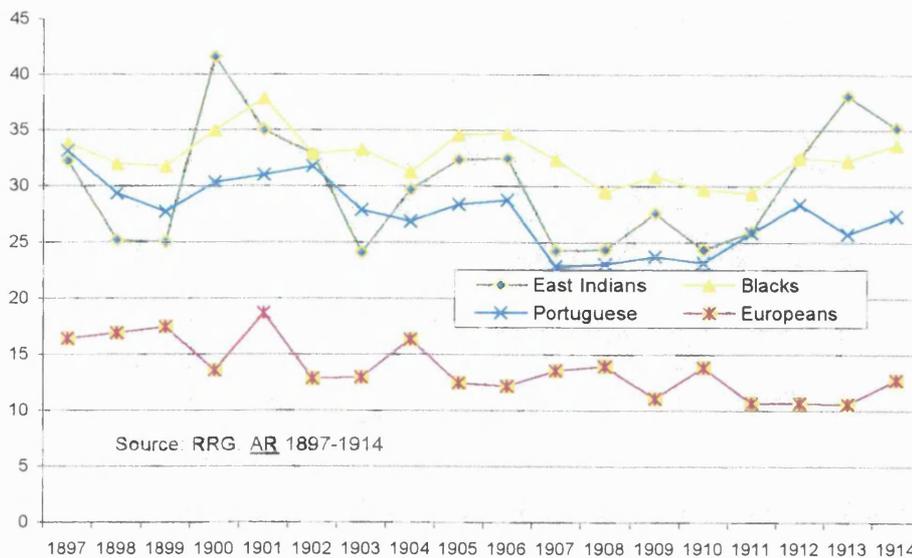
In all sparsely populated countries the growth of population is an element of prosperity and even of existence, more so with us with our imported labour, and where the suitability of particular races to its special climate is a question of great interest as a matter of anthropology and practical politics.<sup>71</sup>

The 'matter of anthropology' referred to East Indians. Amongst this group the colony's medical profession found encouraging signs of higher birth rates. Although the general birth rate for the colony in the late 1880s lagged behind England, (32.2 per 1000 births compared to 35 per 1000) there was a perception amongst some doctors that East Indians had a high birth rate. The Immigration Agent General, according to Rowland:

Gives figures which result in apportioning 18 live births to 100 coolie women annually, whilst Farr states that 12 children are born to 100 women married and unmarried annually at home.<sup>72</sup>

In fact, the overall birth rate of East Indians was calculated in most years as below that of Blacks. This can be seen in the Fig. 4.1 set out below.

**Fig. 4.1 Birth rates per 1000 according to racial category: 1897-1914**



70. Rowland, 'Some Remarks', *BGMAHR* 1891. p. 34.

71. Castor, *British Guiana Medical Annual and Hospital Reports* (Georgetown 1893), p. 167.

72. Rowland, 'Some remarks', *BGMAHR* 1891. p. 31.

### Politics and Population 1880-1914

However, the figures for the East Indian birth rate were complicated by disproportionality between the sexes. Rowland estimated that there were only fifty-four women to every hundred East Indian men.<sup>73</sup> For the colony as a whole there were an estimated eighty-one females to every hundred males. This compared to a ratio of 94.84 males to every hundred females in England. The planters long standing preference for males over females reverberated in the colony's vital statistics. Even when the indentured labour system was finally ended in 1917, less than forty-five females to every hundred males were travelling out to Guiana.<sup>74</sup> Only by taking this imbalance into account did the East Indian birth rate push itself above that of Blacks. But the effects of this adjustment was seen as significant. As Rowland went on to comment 'It would almost seem as if the height of the birth rate depends on the fertility of the Coolie women'<sup>75</sup>

Aside from being associated with higher rates of fertility, East Indians also seemed to have lower rates of infant mortality. For the 1893 meeting of the Guianan Medical Association, Rowland listed (see Table 4.3 below) each race according to infant mortality per 1000 live births calculated over seven years. As this data stretched over a long period the results were not easily dismissable. At the head of this list, with the lowest rate of mortality were the East Indians, and at the other end, with the highest rates of infant mortality were the Portuguese. All of these figures substantially worsened if the influenza epidemic, which reached the shores of Guiana in the middle of 1890, was taken into account. This is shown in the third column.

**Table 4.3 Average infant mortality rates by race 1883-1890**

Race	1883-89	1883-90 (influenza)
East Indians	143	154
Chinese	137	165
European	161	174
Aborigines (native inhabitants)	171	179
Blacks	202	206
Mixed	215	222
Portuguese	220	233

Source: BGMAHR 1983. p. 190.

73. Ibid. p. 35.

74. Laurence, *Question of Labour* p. 368.

75. Rowland, 'Some remarks', *BGMAHR* 1891. p. 36.

### Politics and Population 1880-1914

Statistically, the infant mortality rates of the Chinese and Aboriginal people were not considered reliable as they were compiled from very small numbers. Still, the remaining figures were considered sufficiently accurate to indicate unambiguously the 'excessive' level of infant mortality.<sup>76</sup> Interestingly, the favourable position achieved by East Indians in the infant mortality stakes began to change as the age categories were extended. If the death rates of Blacks and East Indians were divided into three stages; i.e. all under one year, from one year to ten years, and all above ten years, then the order of mortality was gradually reversed. This may be seen from Table 4.4 below. The figures represent the mean percentage of total mortality for each racial class for the years 1887 to 1896.

**Table 4.4 Average rate of mortality by age and race compared (1887-1896)**

Category	East Indians	Blacks
Deaths under 1 year	14.7%	23.1%
Deaths from 1 to 10 years	15.1%	17.1%
Deaths above 10 years	69.9%	59.6%

Source: BGMA 1898. pp. ix - x.

Thus, East Indians, if compared against Blacks had lower rates of infant mortality, but had markedly higher rates of adult mortality. In accounting for this difference the colony's medical profession resorted to vague assertions about race, culture and the environment, implicitly implicating racial classes with different susceptibilities to disease. At the turn of the century, ideas of acclimatisation were still very strong in the medical thinking. High Black infant mortality was put down to poor upbringing, bad feeding and the effects of overcrowding. For those Blacks who survived infancy it was a case of 'survival of the fittest'. However, once they had survived childhood, doctors speculated that Blacks benefited from being 'almost' indigenous to the colony and therefore likely to resist disease. East Indians, as immigrants, were categorised rather differently. As Godfrey put it (marking a reversal of earlier attitudes), they were 'to a considerable extent not natives' and therefore more susceptible to the colony's disease environment. On the other hand, it was widely assumed in medical circles that East Indian mothers breastfed their infants, temporarily conferring upon their children a measure of protection from disease.<sup>77</sup>

76. Ferguson, 'Infant Mortality', BGMAHR 1893. p. 173.

77. *Ibid.* p. V.

### Politics and Population 1880-1914

Taken together, all of these surveys and investigations helped to build up a complex and detailed picture of infant mortality and fertility amongst the colony's various races, especially the Blacks and East Indians. An additional dimension which appeared out of this work was the significance of place, particularly the contrast in infant mortality rates between the countryside and the towns of Georgetown and New Amsterdam. The importance of place was a long held observation in English public health thinking, and typically expressed by William Farr: 'Nature, however, does much for its inhabitants. The fresh air dilutes the emanations from their nuisances; and infectious diseases are not easily transmitted from person to person.'<sup>78</sup> So too in Guiana. The residential location of individual mothers significantly affected the life expectancy of their infant, regardless of race classification.

For each year from 1881 to 1890 infant mortality, for all classes, was dramatically higher in the towns than for the inhabitants of the countryside. For these nine years the mean rate of infant mortality for Georgetown and New Amsterdam was calculated at 307.49 per 1000 births, compared to 168.87 per 1000 for the countryside.<sup>79</sup> See Table 4.5 below. The stark contrast between town and countryside was taken as evidence of the overcrowding and unsanitary conditions in which communities lived.<sup>80</sup>

**Table 4.5 Infant mortality between town and country compared 1880-1890**

Year	Georgetown and New Amsterdam	Georgetown	The Country
1880	-	382.8	-
1881	291.28	-	179.21
1882	298.15	356.0	190.89
1883	291.04	-	162.86
1884	383.62	-	150.37
1885	311.02	-	158.98
1886	276.83	-	137.82
1887	306.69	-	189.62
1888	283.39	-	146.59
1889	289.39	-	159.25
1890	343.52	-	213.14

Source: BGMAHR 1893. p. 193.

78. Farr, Vital Statistics p. 146.

79. For table see Wallbridge, BGMAHR 1893. p. 193. Wishart, BGMA 1898. p. xxi.

80. Wallbridge, BGMAHR 1893. p. 193.

## Politics and Population 1880-1914

In Georgetown the high levels of urban infant mortality also dramatically skewed the entire city's mortality rate upwards. The recently qualified Edinburgh surgeon, Dr. Wishart, writing in 1898, identified two principal factors which pushed up Georgetown's high death rate: tuberculosis and infant mortality. With regard to the latter, and excluding deaths in the public hospital, Wishart estimated that a quarter of all children born in Georgetown died within their first year, thus contributing to the city's general death rate of 34.6 per 1000.<sup>81</sup> Georgetown also had a very poor record of infant mortality rate when compared to the average level of infant mortality in thirty-three of the largest English towns. The relative rates being 270 per 1000 births and 151 per 1000. It was, as Wishart explained 'a serious matter, especially for the capital city of a Colony whose chief need is population.'<sup>82</sup>

### 4.5 Conclusion

By the end of the nineteenth century the question of securing sufficient labour for the plantations still exercised a decisive influence over the politics of government. Nevertheless, the wider colony, in the form of its social composition, its 'progress' and its economic activity, was increasingly becoming a factor for consideration in elite circles. This is illustrated in the rising concern for Guiana's population growth. The gaze of the medical profession was now not only fixed on the estate – but on the wider colony also. In a similar manner, the medical profession was itself coming under scrutiny from elements of the colony's population.

Doctors in Guiana brought compelling evidence of the enormous amount of infant mortality amongst all classes of the population to the attention of government authorities. The emerging medical consensus was that of a stagnating or declining Black population, but of a slowly increasing East Indian population. Secondly, it had been firmly established in official minds that the city of Georgetown, rather than the countryside, had the highest rates of infant mortality. Although immigration was capable of refreshing the colony's labouring force, and indeed was still considered vital, the high levels of infant mortality amongst the rest of the population were no longer seen as acceptable. The next chapter continues this discussion, but also introduces some of the broader but interrelated contexts for official thinking about infant mortality in the

---

81. Wishart, *BGMA* 1898, p. XXI.

### Politics and Population 1880-1914

colony. These were: disease, motherhood, the 'problem' of illegitimacy and breastfeeding.

---

## Chapter 5

### 5.1 Introduction

Research into the level of infant mortality in Guiana took place at the same time that the germ theory of disease was becoming known and accepted in Europe. In February of 1878 Pasteur argued his case that micro organisms were responsible for disease, putrefaction, and fermentation before the French Academy of Medicine.<sup>1</sup> Just four years later in Guiana, the colony's *Asylum Journal* produced a series of articles in support of this theory, gauging it to have already 'revolutionised' the practice of surgery, and predicting its leading role in preventative medicine. Dr. R. Grieve argued that germ theory had important implications for medicine in the colony, not least because it showed that the prevention of disease was as important as its cure. In other words, 'the health of the community ought to be cared for as much as the health of the individual.'<sup>2</sup>

As discussed in the last chapter, a growing perception about the importance of the colony's wider population drew the medical profession into examining closely questions of fertility, birth-rates and infant mortality. Far from restricting their work to treating individuals in Public Hospitals, on plantations, or the surrounding villages, doctors began trying to comprehend and produce a broader picture of life and death in the colony. Another side to this work exhibited itself through a commitment to public health and an interest in 'native' mothercraft. It is to these issues that we now turn.

### 5.2 Disease theory and public health in the colony

Historians of public health have shown how bacteriology subtly shifted medical preoccupations from local environments as a *source* of disease, to an emphasis on the individual and their behaviour, as the *bearer* of disease.<sup>3</sup> We can see these ideas at work in Guiana. In 1903 in an editorial piece in the *Argosy* about 'unhealthy persons' hauling meat in Georgetown's market, it was stated that 'people seldom if ever realise that they

---

1. Porter, *Greatest Benefit* p. 433.

2. *The Asylum Journal* 15 March 1882. p. 10.

3. Dorothy Porter, "Enemies of the Race": Biologism, Environmentalism, and Public Health in Edwardian England', *Victorian Studies* Vol. 34. Number 1.1990. p. 170. See also Michael Worboys, *Spreading Germs: Disease Theories and Medical Practice in Britain, 1865-1900* (Cambridge University Press, 2000).

### Disease, infant mortality and colonial perceptions of 'native' motherhood

are endangering the health of the community at large.'<sup>4</sup> In other words, social practices which in the past may not have sparked comment became imbued with new meanings.

As doctors left universities in Britain and took up their posts in Guiana, they brought these new notions of public health with them. Spitting in the street, illegitimacy, ignorance over the feeding of infants and personal sanitary practices, all came under consideration by health professionals for their perceived impact on mortality rates and the overall health of the colony. As we will see, freedom from disease depended, amongst other things, upon good sanitation, clean water, safe food, pure milk, and fresh air, as well as on eliminating illegitimacy, ignorance, and immorality amongst the colony's poor. Drawing together municipal and government policy and individuals into desirable civic practices became a prime task for the colony's medical profession, and for forward thinking town council officials. Some of these individuals took notable pride in their achievements. This can be seen, for example, in the activities and rhetoric of Georgetown's long standing Town Superintendent, Luke M. Hill who served from 1878 to 1910. Looking back on the extension of foot pavements and lining of street drains in Georgetown during 1906, he stated that they were embarked upon 'without reference to any particular ward or district, treating the entire city as one large community working for the general good, unaffected by any narrow limitation or mere ward boundaries.'<sup>5</sup> In Hill's description there is also an echo of imperial ideology. After all, the British presence in Guiana, just like the enlightened Town Superintendent's work, was supposedly for the 'common good' of all, and unaffected by narrow sectional interests.

English public health initiatives impressed Hill, and where possible appropriate elements were quickly translated into policy in Guiana. In 1903 and then in 1908 Hill briefly left the colony for England so that he could keep 'in touch with modern improvements and advances in municipal and sanitary engineering.'<sup>6</sup> One result was that by 1907 Georgetown streets were bedecked with anti-spitting notices and some 10,000 to 12,000 educational cards were prepared and printed by the government on the subject of *Tuberculosis*, the *Feeding of Infants*, and the *Destruction of Mosquitos*.<sup>7</sup> (see appendix VIII, IX, X). These cards were printed in English. It is not clear how the cards

---

4. Editorial. *Argosy* 16 December 1903.

5. Luke M. Hill. Town Superintendent's Annual Report 1906. p. 2.

6. Ibid. Annual Report 1908. p. 1.

7. Ibid. Annual Report 1907. p. 2.

### **Disease, infant mortality and colonial perceptions of 'native' motherhood**

were distributed, probably through schools, dispensaries and churches. Either way it is difficult to know how they were received by colony inhabitants, many of whom were illiterate or did not speak English. On the other hand, the intentions of the authorities seems clear. As well as offering practical advice, the cards stressed individual responsibility to community. The mother, by implication, was accountable to the wider society for bringing up her child properly. The householder or 'citizen of the community' was duty bound to kill mosquitoes in their own yard or house, and the tuberculosis sufferer entreated not to 'spit about the place', because this endangered 'the lives of others.'<sup>8</sup>

Dr. Wishart, Georgetown's Medical Officer of Health provides another example of how some officials adopted and promoted the rhetoric of public health. Wishart left the colony in 1909 to study for a Diploma in Public Health in England. Upon his return he headed a new enlarged department of Public Health for Georgetown, additionally taking responsibility for the city's sanitation. In his 1911 report he reprinted a short piece about the purpose of public health from an English journal which he felt was applicable to the conditions of the colony:

Public Health in its later developments has realised that it could never hope to satisfy its aspirations by the prolongation of the existence of the more favoured members of the community. Its greatest justification lies in increasing the health of the workers and especially of the industrial classes those less able to help themselves. It is distinctly socialistic in its tendencies as distinguished from individualistic; it is in the widest sense, humanitarian.<sup>9</sup>

The industrial classes did not exist in Guiana in any meaningful way (although the technology of the industrial world such as the steam train, electricity and telephones were well established in the colony by the end of the century) however, the sentiment that public health should ideally reach and benefit all sections of the population clearly impressed Wishart. Elsewhere in his 1911 report he turned to the question of milk purity. Here too his language was imbued with collectivist thinking. The 'citizens' he claimed, 'demand pure milk, and if the private capitalist cannot or will not provide it, then it becomes the duty of the State or Municipality to see that they get what they ask for.'<sup>10</sup>

---

8. See appendix X.

9. Wishart, Report of the Medical Officer of Health Georgetown 1911. p. 40.

10. *Ibid.* p. 18.

### Disease, infant mortality and colonial perceptions of 'native' motherhood

The views of Hill and Wishart regarding the aims of public health were not accepted by every municipal or government official. However, the prominence of these individuals in the colonial order do suggest that their ideas were widespread and characteristic of governmental thinking in the early twentieth century. The other side of public health sentiment was that of individual, and especially maternal, responsibility. Before looking at this aspect of health thinking, it is important to bring into the picture how doctors understood the diseases which particularly affected the young.

#### 5.3 Disease and infant mortality

One reason why doctors perceived parental behaviour to be an important cause of the colony's high infant mortality lay in the belief amongst many European residents that the colony enjoyed a salubrious and healthy climate. We saw in chapter three, in line with environmentalist thinking, that doctors pathologised the landscape. Those parts of the colony which were thought to foster disease, such as the swampy back-lands, as well as places with dense undergrowth, and some creeks and rivers, were believed to be particularly dangerous for habitation and were to be avoided if at all possible.

Counterbalancing the deficiencies of place, doctors identified in the normally steady temperature, and absence of dramatic seasonal changes, and the availability of cheap food and abundant water, conditions favourable to the health of children and the poor. According to Grieve: 'It may be repeated that there is nothing peculiar to the climate or the necessary conditions of life here to give rise to this great mortality amongst infants.'<sup>11</sup> The colony's pure air, quality of light, and freedom from zymotic diseases (those diseases said to be caused by a process analogous to fermentation such as smallpox, plague and cholera), supposedly gave the inhabitants certain health advantages over many Londoners.<sup>12</sup>

Of particular importance was the apparent absence in the colony of many diseases associated with childhood. This included various epidemiological scourges of Victorian society: measles, scarlet fever, whooping cough, and diphtheria.<sup>13</sup> Another notable rarity in Guiana was rickets. Although this disease was not associated with infant mortality, it

---

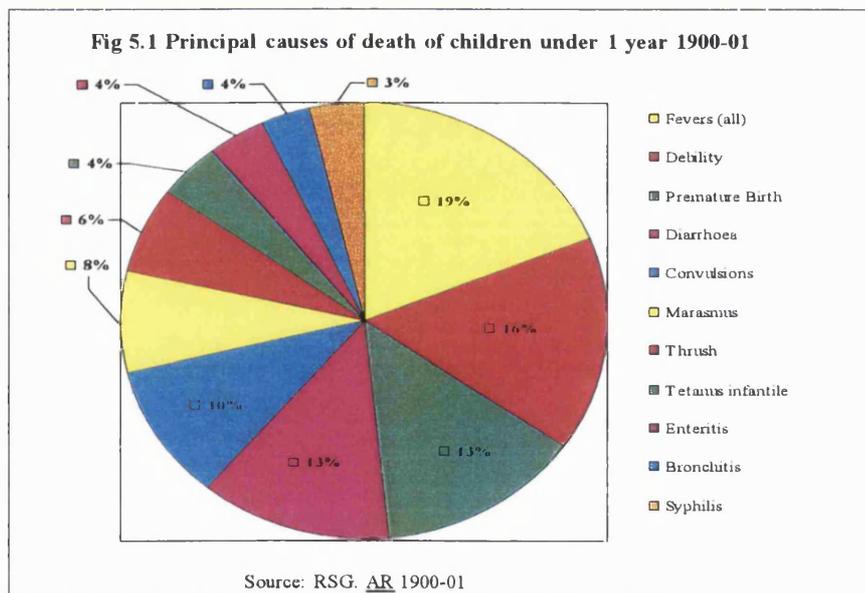
11. Grieve. *The Asylum Journal* 15 September 1882. p. 58.

12. Wallbridge, *BGMAHR* 1893. p. 166.

### Disease, infant mortality and colonial perceptions of 'native' motherhood

was prominent amongst urban children in England, and so its absence in the colony was commented upon.<sup>14</sup>

On the other hand, medical practitioners recorded many diseases and disorders which seemed more prevalent amongst infants in the tropics. These included: convulsions, parasites, worms, malarial influences, and febrile attacks.<sup>15</sup> Diseases associated with inheritance such as tuberculosis, leprosy, and syphilis were also identified, but their influence on infant mortality was difficult to measure, and doctors disagreed about their spread in the colony's population. Of all the inherited diseases, perhaps syphilis prompted most disagreement. Although it was not generally considered a prominent cause of death, some doctors argued that its presence almost entirely accounted for infant mortality amongst the Black population.<sup>16</sup> Closely associated with syphilis, was the moral question of illegitimacy, a subject which drew a wide range of comment and speculation from the government, the church and newspapers. The main causes of deaths amongst infants at the turn of the twentieth century in Guiana, according to the Surgeon General, is set out below in Fig. 5.1.



13. Ibid. See also E. D. Rowland, 'A Contribution to the Study of Bright's Disease, as Seen in Malarious Countries', BGMAHR 1892, p. 55.

14. Dr. Barnes, 'Notes on the Absence of Trismus Neonatorum and Rickets in the Children of the Colony', BGMAHR 1894. pp. 37-43.

15. Wallbridge. BGMAHR 1893. p. 167. Also Law, p. 177; Ozzard, p. 183; and Wallbridge, p. 192.

### Disease, infant mortality and colonial perceptions of 'native' motherhood

In order of declining magnitude fevers, debility, premature birth and diarrhoea together accounted for more than half of all infant mortality. Diarrhoea was frequently combined with other opportunist infections, such as thrush, and also associated with debility. These problems were often seen as consequences of filthy conditions and poor feeding by mothers. In the case of convulsions, which also accounted for large numbers of infant deaths, parasitical infections of the intestine were implicated. In these cases doctors recommended a dose of *Sanotin* or other intestinal antiseptics.<sup>17</sup> However, as doctors recognised, new-borns were unlikely to suffer from dietic errors or have had sufficient time to encounter parasitical infections if breastfed.

In other parts of the West Indies more than half of infant mortality within the first two weeks of life was put down to *tetanus neonatorum*.<sup>18</sup> *Tetanus* in new-born infants almost certainly indicated an infection had been introduced through the open wound of the severed umbilical cord.<sup>19</sup> As the GMO Daniels commented, the disease was 'easily preventable as the Hospital experience shows.'<sup>20</sup> Midwives, therefore, bore the brunt of criticism for the continued presence of *tetanus*. Nevertheless, in Guiana *tetanus* infection seems to have been lower than in the rest of the Caribbean. All the stranger, according to one doctor, in view of his perception of local midwifery practices, since: 'The separation of the umbilical cord takes place as elsewhere and the average negress is remarkable for her intense ignorance and neglect of even the most ordinary measures of cleanliness.'<sup>21</sup> By 1910 incidences of neonatal deaths from *tetanus* were rare in Georgetown, indicating the possible influence of government trained nurse-midwives.<sup>22</sup>

Another major concern of doctors was the physical condition of infants at birth, especially those with 'feeble vitality.'<sup>23</sup> Two diseases were especially blamed: malaria (associated with anaemia or debility), and syphilis. Malaria in pregnancy can cause premature births or intra uterine growth retardation leading to a low birth weight baby. This child is also more likely to die during the neonatal period. Those that survive will

---

16. Ferguson. BGMAHR 1893. p. 176. Also Law p. 178; Wallbridge, p. 192; and Ozzard, p. 183.

17. Ozzard. BGMAHR 1893. p. 183.

18. Barnes, 'Notes on the Absence of Trismus Neonatorum', BGMAHR 1894. p. 38.

19. Udwardia Farokh Erach, Tetanus (Oxford University Press 1994).

20. Daniels, 'Negro Fertility', BGMA 1898. p.13.

21. Barnes, 'Notes on the Absence of Trismus Neonatorum' BGMAHR 1894. p. 38.

22. Dr. Wishart. Report of the Medical Officer of Health. 1911. p. 30.

23. Daniels, 'Negro Fertility', BGMA 1898. p. 13.

### Disease, infant mortality and colonial perceptions of 'native' motherhood

have a higher incidence of morbid events during infancy.<sup>24</sup> The presence of malaria and syphilis seemed to surface unevenly amongst the colony's population. Malarial fever, it was understood, disproportionately affected the unacclimatised, while syphilis, notably a disease associated in the colony with low standards of civilisation, seemed particularly widespread amongst Blacks. Evidence of syphilis was derived from the increasing percentage of still births that occurred in mothers after their first pregnancy. Ordinarily, the likelihood of a still birth decreased with each pregnancy. In Guiana the reverse was the case. Dr. Ferguson estimated that over thirty-one per cent of third pregnancies ended with a still birth.<sup>25</sup> The pathological symptoms which accompanied these deaths were classic indications of inherited syphilis: the fatty degeneration of the placenta and the malnourished wasted appearance of the foetus.<sup>26</sup>

Daniels charted the way that infantile disease profiles altered with age. In summary, early deaths from constitutional disease (syphilis) gave way to dysentery in infants. Typically, from about the age of two years children started to show signs of Bright's disease (pigmented spleens) and to die from malarial infection. By early adulthood, tuberculosis was an important cause of death.<sup>27</sup> Many infants, claimed Daniels, survived poor midwifery and 'bush remedies' into infancy, only to subsequently perish from other preventable diseases.<sup>28</sup>

#### 5.4 Women, the medical profession and infant mortality

The organisational reach and influence of western biomedicine ran most forcefully through its institutional arenas, those places directly under the control of European doctors: the asylum and jails, dispensaries, plantation hospitals and Public Hospitals. Beyond these confines, in Georgetown and out in the country, in the villages, and later, in the mines of the colony, medical authority had no automatic remit. Moreover, for most of the nineteenth century doctors showed little inclination to spread the good effects of their medicine to the wider rural population. Private medical practices were

---

24. Christine Luxemburger, Effects of Malaria and Anaemia During Pregnancy on Survival and Morbidity of Infants Living in an Area of Low Malaria Transmission (University of London thesis 1999). p. 16; 189.

25. Ferguson. BGMAHR 1893. p. 175.

26. *Ibid.* p. 176.

27. Daniels, 'Negro Fertility', BGMA 1898. pp. 13-14.

28. *Ibid.*

### Disease, infant mortality and colonial perceptions of 'native' motherhood

orientated towards those who could pay, rather than those who required medical assistance.

Towards the end of the century this situation changed. A government circular published in 1897 reminded Government Medical Officers of their duty to visit at least once a week the important villages in their district.<sup>29</sup> This notice was symptomatic of the way that the institution of the family was emerging as a site for critical attention, and indeed of administrative anxiety. As doctors and reform minded individuals studied East Indian and Black families they found, in their character and customs, the failures and imperfections of race, gender, and class.

One expression of this scrutiny was the establishment by European women of a *Child Protection Society* in Georgetown in 1888. Amongst Europeans the 'native' family was often portrayed as a place of instability, violence and sexual laxity, and the beatings and cruelties supposedly carried out by men on women were assumed to include children.<sup>30</sup> The new *Society* sought to police this situation by bringing cases of mistreatment before the courts. However, in the event there seems to have been few prosecutions. Reports of cruelty to children sometimes appeared in the press, but they remained rare.<sup>31</sup> In the absence of sufficient overt cases of child cruelty, the *Society* gradually turned its attention towards other matters. It metamorphosed into an organisation more concerned with promoting better nutrition and improving standards of accommodation. By the end of the century it had produced a number of pamphlets explaining the best methods for raising a child.<sup>32</sup> It also began a soup and food kitchen in Georgetown. Whether or not this venture was means tested is not known, but the service seems to have been used widely. For example, in 1904 the *Society* sold 58,686 full portions at two cents each of which 2,013 were purchased by school children, hinting at the existence of widespread levels of poverty in the city.<sup>33</sup>

The *Society's* activities were imbued with a language of civilising paternalism. Its President, Sir Charles Bruce, announced that it was important for 'Western countries –

---

29. Godfrey, Surgeon General. *Daily Argosy* 25 February 1910.

30. Moore, *Cultural Power* pp. 104-106; 172-173.

31. For example, in 1900 just 37 cases of alleged cruelty were brought to the notice of the committee, but only one of these was forwarded to the police. A case where a mother was accused of burning her child's arm resulted in her imprisonment for 3 months. *Argosy* 17 January 1903.

32. Report of the Society for the Protection of Children (RSPC) *Daily Chronicle* 30 January 1900. *Argosy* 23 September 1905.

### Disease, infant mortality and colonial perceptions of 'native' motherhood

for Europe – to show that true civilisation existed, and that was by the protection of men, women and children.<sup>34</sup> As with Ladies Health Societies in England, the education of the mother had a key role in this enlightening process.<sup>35</sup> One woman wrote:

Let purity and cleanliness of life be preached in our churches, taught in our schools: social purity be brought forward by the Press, and in our drawing-rooms, in our daily life; let the highest set the example for the lowest to follow, that the child in our midst may be given a start in the right direction, a chance of health and strength, that our colony may have cause to glory in the manhood and womanhood of the future instead of the deplorable disgrace of our excessive infantile mortality.<sup>36</sup>

Promulgating the correct methods of child hygiene and feeding became one of the central themes of the colonial intervention into the family. In view of the Victorian aphorism that 'cleanliness was next to Godliness', perhaps it is not surprising to find that the church too was involved in this activity.<sup>37</sup> The spread of Christianity in the colony amongst ex-slaves and their descendants brought each week substantial numbers of parishioners into church where they could be regaled with the teachings of Christ and the principles of cleanliness. For example, at Saint Stephens Church in 1905, after a rendition of 'Christ on the Rock', the audience were treated to a lecture on personal and domestic hygiene, the ideal diet, and the importance of fresh air.<sup>38</sup>

These didactic initiatives later found their way into the colony's school curriculum. In 1908 arrangements were made to give lectures on hygiene to teachers in Georgetown and New Amsterdam.<sup>39</sup> Subsequently, the colony's teaching certificate contained a strong public health/hygiene component. For example, in 1911 candidates were asked: 'What impurities are sometimes found in milk and why is it of the greatest importance that a pure milk supply should be maintained?'<sup>40</sup> In other papers they were expected to explain the dangers of the 'Sweet Water Trench', of walking barefooted over the ground in Tropical Countries, and the diseases conveyed by dirt and mosquitoes.

It is uncertain how widely these endeavours to transmit the tenets of hygiene and the essentials of modern disease theory to colony inhabitants actually went. The world of

---

33. RSPC. *Argosy* 1 February 1905.

34. RSPC. *Daily Chronicle* 22 July 1893.

35. Celia Davies, 'The Health Visitor as Mother's Friend: A woman's place in public health, 1900-14', *Social History of Medicine* Vol. 1. 1988. pp. 39-59.

36. Letter to *Argosy* by K. *Argosy* 23 September 1905.

37. Leader. *Argosy* 23 March 1903.

38. *Argosy* 4 February. 1905. For lecture on importance of good sanitation see *Argosy* 20 May 1905.

39. *Daily Argosy* 11 November 1908.

40. RIS. *AR* 1911-12. p. 73.

### Disease, infant mortality and colonial perceptions of 'native' motherhood

work rather than leisured education filled most non-European women's lives in the colony. Short term work, the effects of age, sickness or injury, and most of all poverty, were the material conditions which shaped working lives and the social setting within which children were brought up. The physical conditions of employment were frequently harsh, hours were long, and remuneration low. Young girls often began full time work on the plantation by the age of thirteen. Sometimes this involved heavy physical labour. Before harvest it was the custom on the estate to muster Creole gangs of young women from different villages for the purpose of shovelling manure across the fields. At other times women were employed in carrying materials for sugar making, or cleaning buildings, perhaps earning twenty-four cents per day, sufficient for about three pounds of dried fish, or a gallon of rice in Georgetown.<sup>41</sup> If in a weeding gang women may have earned \$1-96 cents for three and a half days work.<sup>42</sup>

Women also performed an important role as rice field labourers on family owned land. The GMO Dr. Castor described the harvest period as a time of 'feverish haste'.<sup>43</sup> During this critical moment the young, the old, and the pregnant worked in all weathers to bring in the crop. At night villagers spread lights across the swampy fields to continue working. The physical cost of this intensive labour was high and it was noted that many villagers seemed to suffer from diminished 'natural resistance.'<sup>44</sup> Another area of employment for women was stitching. In 1890 women stitchers were being paid eighty cents per dozen trousers. Yet, a full week's labour generally produced no more than three or four dozen completed garments, forcing women to work from 'morn till night to earn the barest subsistence.'<sup>45</sup> By 1905 there was high unemployment amongst seamstresses 'even at the sweating wages paid.'<sup>46</sup> Women also worked at washing and hawking milk. Stories abounded at the inferior treatment meted out to infants by mothers employed in these areas.<sup>47</sup> Many women also worked as servants, which was a notoriously badly paid trade with long hours. The Mayor of Georgetown recalled that:

---

41. Bronkhurst, The Colony of British Guiana and its Labouring Population 1883. p. 95. 12 Essays on the Cultivation, Drainage and Manufacture of the Sugar Cane ("The Colonist" 1876), p. 72.

42. J. C. King. Immigration Agent General. Argosy 25 August 1906.

43. AR 1909-10. RSG. P. 102.

44. Dr. Kennard. RIAG. AR 1909-10. p. 21.

45. Argosy 23 August 1890.

46. Evidence before the Mortality Commission. Argosy 7 October 1905.

47. K. Letter to Argosy. Argosy 23 September 1905.

## Disease, infant mortality and colonial perceptions of 'native' motherhood

I know of several cases where they get \$4 a month, out of which they have to support themselves and find a house, and I do not know how they can live at all.<sup>48</sup>

Although the authorities were keen to play down any suggestions of chronic malnutrition in the colony, the undernourished mother was sometimes commented upon in the press.<sup>49</sup> In 1908 Georgetown's Sanitary Inspector attributed infant mortality to the unpredictable and insecure living achieved by women: 'The consequence is that their bodies are so poorly nourished that when they get ill they have no strength to fight the disease.'<sup>50</sup> The poverty of the mother thus directly contributed to the poor care of the child. As the *Argosy* later explained there was:

abundant evidence that the mortality was largely increased by the poor nourishment of some of the people, especially women of the poorer respectable classes who earn a very precarious living, insufficient to enable them to obtain more than the barest necessities of life, and who owing to malnutrition have no stamina to resist the onslaughts of disease.<sup>51</sup>

In order to survive it was necessary to labour. But this brought problems with regard to childcare as work often involved long absences from the home.<sup>52</sup> Family networks sometimes provided the care needed, but this too could lead to accusations of maternal 'callous indifference'.<sup>53</sup> For women working on the estates the situation was rather different, by 1900 the majority of them had crèches.<sup>54</sup>

### 5.5 The problem of illegitimacy

The above comments indicate that in medical circles and amongst concerned individuals knowledge about motherhood and infant health were grounded in an economic and political understanding. To this we should add a cultural dimension. While Victorian notions of motherhood were capable of evoking a multiplicity of meanings, it was essentially seen as a moral state, imbued with ideas of feminine

---

48. Mr. E. A. V. Abraham. Mayor of Georgetown. *Argosy* 16 December 1905.

49. *Argosy* 8 November 1905.

50. Mr. W. B. St. Aubyn. Town Overseer and Sanitary Inspector. *Argosy* 7 October 1905.

51. *Argosy* 28 July 1906.

52. Report of the Mortality Commission (RMC). *The British Guiana Medical Annual for 1906*. "The *Argosy*" 1907. p. 22.

53. *BGMAHR* 1893. p. 167.

54. Wallbridge, *BGMAHR* 1893. p. 197. RSPC. *Daily Chronicle*, 30 January 1900.

### Disease, infant mortality and colonial perceptions of 'native' motherhood

nurtureship.<sup>55</sup> From this emerged a concern for illegitimacy, or as Judith R. Walkowitz more broadly argues, there developed 'narratives of sexual danger' which fastened upon prostitution, sexual diseases and vice.<sup>56</sup> Unsurprisingly then, as in Britain, illegitimacy in the colony drew a great deal of pejorative comment from the medical practitioners, although it should be noted that from the perspective of the colony's employers, illegitimacy carried little stigma.<sup>57</sup>

But it was not simply a question of applying the ideals of late Victorian morality to the colonial arena. Rates of infant mortality and illegitimacy were thought to be directly related.<sup>58</sup> In a colony where the issue of population was uppermost, this lent added force to official views about the desirability of marriage over 'concubinage'. The state of marriage marked by Christian rites, was considered the best testament to civilised and cultured behaviour both in Britain and in the colony.<sup>59</sup> However, marriage rates were low. Each year the Surgeon General duly recorded the numbers of births attributed to married couples, and to those united under the Heathen Marriage Ordinance of 1860, whose offspring were classed as 'illegitimate'. In 1882, according to this system of categorisation, illegitimacy rates ran at about seventy per cent.<sup>60</sup> Comparisons were also made with other West Indian islands. There too colonial administrations had an interest in 'social progress'. However, whether it was a question of 'resistance', or because of the official encumbrances attached to legal marriage, or simply the irrelevance of marriage rules, illegitimacy in Guiana (and elsewhere in the West Indies) remained stubbornly high.<sup>61</sup> By 1914 the Guianan rate hovered at just under sixty per cent.<sup>62</sup> The dominant British attitude may be summed up in this comment from Dr. Ozzard: 'Are we', he asked his fellow doctors, 'to abandon our most cherished principles for the sake of the few

---

55. This idea comes from Jan Lewis, 'Mother's Love: The Construction of Emotion in Nineteenth-Century America', in Rima D. Apple and Janet Golden (eds.), Mothers and Motherhood (Ohio State University Press 1997), pp.52-71.

56. Judith R. Walkowitz, City of Dreadful Delight (University of Chicago 1992), p. 6. See also Susan Groag Bell and Karen M. Offen (eds.), Women, the Family, and Freedom Vol. 2. 1880-1950. (Stanford University Press 1984), pp. 10-11.

57. Dr. Barnes. BGMAHR 1893. p.167.

58. Dr. Wallbridge quoted English figures which suggested that nine tenths of illegitimate children born never reached maturity. BGMAHR 1893. p. 196. See also Rowland. BGMAHR 1893. p. 191. Leader comment. Argosy 8 November 1905.

59. F. M. L. Thompson, The Rise of Respectable Society. A Social History of Victorian Britain, 1830-1900 (Fontana 1988), p. 85.

60. The Asylum Journal 15 September 1882.

61. Moore, Cultural Power pp.102-104, 174-175.

### Disease, infant mortality and colonial perceptions of 'native' motherhood

uncivilised who cannot be brought to appreciate those principles?' He went on: 'or are we compelled to educate the half-civilised to what we consider a more civilised state of affairs?'<sup>63</sup> Profligacy, Ozzard insisted, increased infant mortality, and those nations that 'live most in illegitimacy, have and will always have the largest infantile mortality.'<sup>64</sup>

Nevertheless, it is clear that Victorian ideas of morality were tempered for the colonial world. Some colony officials had little criticism of the stable relationships they associated with 'ordinary concubinage' or 'concubinage of the West India type'. On the other hand, 'promiscuous illegitimacy' (temporary sexual relationships), which more directly challenged core Victorian values about 'domestic respectability'<sup>65</sup> seems to have been uniformly condemned.<sup>66</sup> The absence of fathers from the family unit was considered particularly disadvantageous to women, who invariably had to meet the burden of bringing up the child themselves.<sup>67</sup> In these circumstances, the arrival of disease and sickness were perceived to exert a terrible price. They prevented mothers from working and thus cast families into poverty and destitution.<sup>68</sup> This anxiety over the collapse of the family unit is evident in Dr. Law's comment that there was in the colony 'no proper home life in our English sense of the word, and the children are not unfrequently looked on as a burden rather than as a blessing.'<sup>69</sup>

The term illegitimacy then, had a number of shaded meanings. There were legalistic definitions, and there were various overlapping grades of pejorative social classification. In each of these cases the label 'illegitimacy' had a distinctly ideological role, in that it helped differentiate individuals within classes, to mark out the poor and respectable from the dissolute.<sup>70</sup> These ideas were reinforced by the assumed connections between illegitimacy and infant mortality. The *Argosy* summed up this view for its readers

---

62. Report of the General Registers Office, *AR* 1915 p. 6.

63. Ozzard, *BGMAHR* 1893. p. 185.

64. *Ibid.* p. 186.

65. Michael Manson, *The Making of Victorian Sexuality* (Oxford University Press 1994), p. 139.

66. The Mayor of Georgetown Mr. Abraham. *Argosy* 7 October 1905. Dr. Wishart, Medical Officer of Health. *Argosy* 23 December 1905. Godfrey, Surgeon General. *Argosy* 2 December 1905. Abraham, *Argosy* 16 December 1905. Report of the Mortality Commission. *BGMA* 1906, p. 22.

67. Castor, *BGMAHR* 1893. p. 171. Barnes, *Argosy* 27 September 1905. Leader. *Argosy* 30 September 1905.

68. Rowland, 'Some Remarks', *BGMAHR* 1891. Law, *BGMAHR* 1893. p. 171, 177.

69. Law, *BGMAHR* 1893. p. 177.

70. Rowland, 'Some Remarks', *BGMAHR* 1891. p. 28.

## Disease, infant mortality and colonial perceptions of 'native' motherhood

in 1905 by stating that: 'It has been abundantly proved that the chief factor in immorality and infantile mortality is the large class of unmarried people.'<sup>71</sup>

### 5.6 The problem of breastfeeding and infant nutrition

Disease and illegitimacy were not the only factors considered in relation to infant mortality, so too were questions about maternal child rearing practices, especially the perceived reluctance to breastfeed amongst urban Black women.<sup>72</sup> Not uncommonly, witnesses who testified to the Mortality Commission made disparaging remarks about Black motherhood.<sup>73</sup> Both 'ignorance' and 'laziness' were cited as possible reasons why Black mothers appeared to breastfeed less than East Indian mothers.<sup>74</sup> Another factor was disease. Syphilis, anchylostomiasis and malaria seemed to have a morally corroding effect on the mother's willpower. The GMO, Dr. Ferguson, argued that the absence of breastfeeding amongst 'native' women was 'partly from inability due to physical degeneration of malarial origin, [and] partly from indifference and weak maternal feeling due to malarial causes.'<sup>75</sup> By comparison, newly arrived immigrants were, according to another account 'stronger people, and able to nurse their infants.'<sup>76</sup> With regard to European women, high temperatures and humidity were believed to diminish the efficacy of breastfeeding. However, these climatic factors were not thought to operate on the 'tropical races'.<sup>77</sup>

Many within Victorian society viewed milk as having positive properties for promoting health, and these assumptions surfaced strongly in the language and administrative actions of Guianan officials. We have already seen that 'milk diets' formed part of the treatment for hospital inmates. Officials were also concerned to improve the quality of cows' milk on sale in Georgetown. The administrative implications for this are discussed in more detail in chapter seven. However, it is worth noting here that the 1905

---

71. *Argosy* 8 November 1905.

72. *Argosy* 28 October 1905. Mr. Wood Davis. *Argosy* 28 October 1905. Law, *Argosy* 23 September 1905. Mr. A. J. Patterson. Town Overseer and Sanitary Inspector. *Argosy* 7 October 1905. *Argosy* 28 July 1906.

73. Mr. A. J. Patterson. Town Overseer and Sanitary Inspector. *Argosy* 7 October 1905. Rev. R. L. Macnie. *Argosy* 11 November 1905.

74. Law. *Argosy* 23 September 1905.

75. *Argosy* 28 October 1905.

76. Mr. Hill. *Argosy* 28 October 1905.

77. RMC. *BGMA* 1906. p. 22.

### Disease, infant mortality and colonial perceptions of 'native' motherhood

Mortality Commission specifically devoted time to the discussion of milk and the feeding of infants, concluding that the 'Neglect or inability for breast-feeding is more or less universal among the people.'<sup>78</sup> Doctors were thus frustrated that women did not accord to the practice the importance they felt it was due. As Dr. Castor, a member of the British Guianan Medical Association argued, in 1893:

It seems almost impossible...to instil into the minds of our working classes that milk, and milk alone, should be the only food for the first few months of an infant's life. Mother's milk stands incomparable in this respect, a child suckled by a healthy mother requires no treatment and is plump and happy.<sup>79</sup>

Dr. Castor was not alone in this view.<sup>80</sup> On the other hand, the medical profession recognised that some women were unable to breastfeed due to ill health, an insufficiency of milk, or due to the obligations of work. In these cases mothers were recommended tinned condensed milk, cows' milk, or more preferably asses' or goats' milk.<sup>81</sup> Using these substances required bottles or cups, accurate measurements, and the regular task of procuring boiled water. Here we are able to glimpse some of the assumptions made by doctors about the scale of hygienic practice they thought was achievable amongst colony inhabitants. Dr. Ozzard extolled 'scrupulous cleanliness' in the preparation of feeds: 'The food should be prepared fresh each time of feeding; bottle tube and nipple should be carefully cleansed and kept in water when not in use.'<sup>82</sup> In practice, these were time consuming procedures. Mothers without easy access to clean water, and surrounded by the effects of poor sanitation, were unlikely to meet Ozzard's hygienic ideals.

The price of milk was another issue. The *Asylum Journal* noted that although cows' milk was expensive in the towns, most poor rural families were able to support a few goats. However, it is not clear that cost alone determined whether a mother breastfed or not. In rural districts Dr. Barnes noted that 'more black children were fed on milk than in the towns, where breast-feeding was almost unknown.'<sup>83</sup> In Georgetown Black mothers questioned the nutritive value and safety of cow's milk. Mr. St. Aubyn, the Town

---

78. Ibid. p. 22.

79. Castor, *BGMAHR* 1893. p.169.

80. Ibid. Ozzard p.179.

81. Godfrey. *Argosy* 2 December 1905.

82. Ozzard. *BGMAHR* 1893. p. 181.

83. Barnes, *Argosy* 27 October 1905. See also *Argosy* 27 September 1905. Mr. T. H. Outram. Town Overseer. *Argosy* 14 October 1905.

### Disease, infant mortality and colonial perceptions of 'native' motherhood

Overseer and Sanitary Inspector, recalled that when he had advised mothers to use nothing but milk for feeding infants 'they had laughed and told him it was nonsense.'<sup>84</sup>

In contrast to Black mothers, the East Indian immigrant was often cited as a paragon of good breast-feeding habits.<sup>85</sup> The Mortality Commissioners singled her out as an exception to the general picture of maternal neglect.<sup>86</sup> In many ways this was analogous to the way metropolitan officials identified Jewish immigrant mothers as models for other mothers in East London.<sup>87</sup> In Guiana, the practice of breast-feeding was said to reward East Indians with a lower rate of infant mortality than Blacks.<sup>88</sup> Doctors were consistently impressed by the East Indian mother, and she was celebrated for demonstrating affection and care for their children, even under adversity.<sup>89</sup>

The unspoilt coolie mother is beyond praise for her devoted care in rearing her infant at the breast. It is an inspiring sight to see her, even in the throes of sickness and suffering, continue to supply it with its only perfect food.<sup>90</sup>

The positive benefits attributed to breastfeeding had its negative counterpart in the way Black mothers allegedly fed their infants wrong foods, namely 'pap' and 'foo foo'. These were culinary formations which had survived the passage from Africa and the West Indian islands.<sup>91</sup> After slavery they had been handed down through community and family, and as such they were remarkably resistant to rapid change, and continued to provide the diet for infants well into the twentieth century.<sup>92</sup> Pap was a generic name for a wide range of food mixtures, usually crushed biscuit, oatmeal, sago, cassava or corn flour, which were sweetened with water, a little milk, and then flavoured with cinnamon or other spices. Now and then spirits were added. Foo foo was a Creole dish consisting of boiled and pounded plantain, sometimes with added salt fish.<sup>93</sup> Doctors claimed that these starchy foods passed into the bowels causing irritations which gave rise to diarrhoea, and

---

84. Mr. St. Aubyn. Argosy 7 October 1905.

85. Argosy 28 July 1906.

86. RMC. BGMA 1906. p. 22.

87. Lara Marks, Model Mothers Jewish Mothers and Maternity Provision in East London, 1870-1939 (Clarendon Press Oxford 1994), p. 1.

88. Argosy 27 September 1905.

89. BGMAHR 1893. p. 167. Moore, Cultural Power p. 106.

90. RSG. AR 1912-13. p. 586.

91. Moore, Cultural Power p. 100-101.

92. Argosy 25 July 1906.

93. Mr. W. B. St. Aubyn. Town Overseer and Sanitary Inspector. Argosy 7 October 1905. Dr. J. S. Wallbridge. A Doctor's Memories in the Argosy 13 October 1906.

### Disease, infant mortality and colonial perceptions of 'native' motherhood

malnourishment.<sup>94</sup> Gradually, the weakened child wasted away, exhibiting signs of 'marasmus' or general atrophy, before suffering convulsions and finally dying.

Aside from 'pap' and 'foo foo', there were a wide range of food and drinks available to the mother for her infant. They included: 'sweet oil', 'barley water', various 'teas', 'arrowroot', and 'cornstarch'.<sup>95</sup> However, few of these items accorded with medical views about the proper requirements of nutrition. The drink 'tea', a food born of poverty, was often nothing more than a piece of bread and sweetened warm water with a little milk, usually shared around the whole household.<sup>96</sup> Doctors recounted that bread, beef, and salt-fish were also given to infants. In themselves, these were not seen as dangerous foods. What chiefly concerned the colony's medical profession was the time in the infant's life when the mother administered them, particularly if she had shunned the use of breast milk. The London trained Dr. von Winckler gave this description of feeding practices amongst Black mothers:

...for the first week...the infant is fed on sweet oil, honey and hot water; as often as not gin is added. Even if the mother nurses her infant, some busy body is ever ready to suggest additions in the shape of farinaceous food, locally made if too poor. After a month, it is not an uncommon thing to try and make infants digest plantain and other paps.<sup>97</sup>

In contrast, Portuguese mothers seemed more likely to breastfeed their infants. The Rev. Victorine, a minister to the Portuguese population described mothers giving infants breast milk or 'tea made with weeds' to which a certain amount of milk was added. Later, when the child was about eight months old it was given bread soaked in milk and tea. Victorine noted that the use of starchy substances was at one time very common, but appeared to be in decline. With regard to solids, he said it was the rule of mothers 'never [to] give them plantain before they can bite it.'<sup>98</sup>

Such was the positive power credited to breastfeeding that members on the Mortality Commission were unprepared to find that Portuguese infant mortality was consistently the highest amongst all races in the colony. Characteristically, although there was already evidence showing them to have high infant mortality, the Portuguese and their children were looked upon as representing some of the most healthy and prolific in the

---

94. Law. BGMAHR 1893. p. 177.

95. Argosy 28 July 1906. Argosy 2 December 1905.

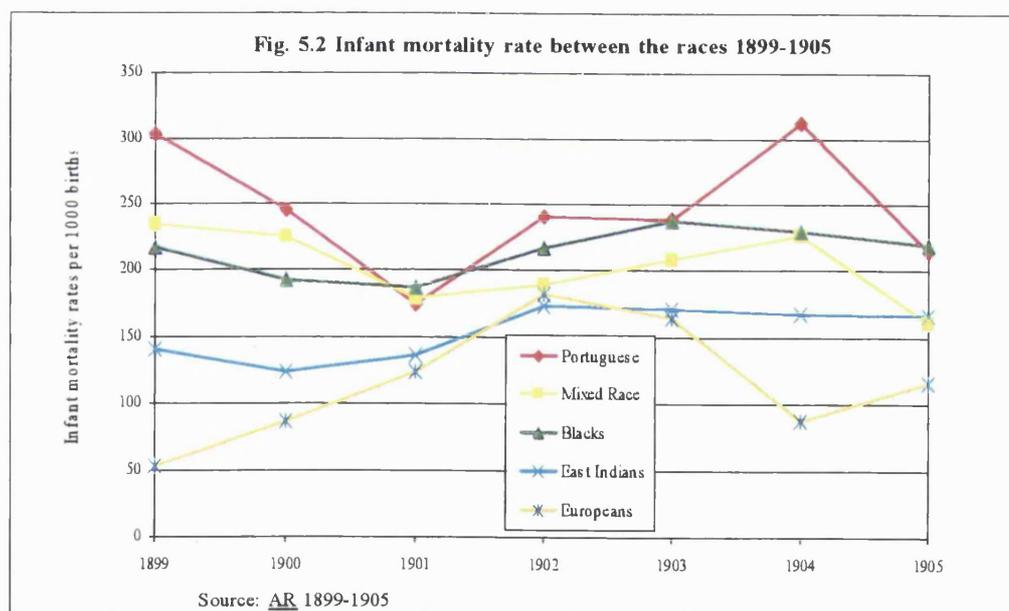
96. Gomes. Argosy 11 October 1905.

97. von Winckler. Argosy 11 October 1905.

### Disease, infant mortality and colonial perceptions of 'native' motherhood

colony. Figures released before the Mortality Commission and published in the *Argosy* estimated the Portuguese rate of infant mortality to be 313 per 1000 for 1904. This extraordinarily high rate was met with open disbelief. 'The only reasonable explanations of the disturbing disclosures are that the figures are wrong', asserted one report. The question was raised over the registration of Portuguese births and whether 'mixed parentage' had been used to calculate the mortality.<sup>99</sup>

Clearly the Registration of births remained a problem for the colonial authorities, the poor especially were seen as shirking their legal duties in this respect.<sup>100</sup> But under-representation of births seems unlikely given the consistency of the figures from one year to the next. In Fig. 5.2 below, the infant mortality per 1000 live births between five categories of race are given for the years 1899 to 1905. Note that European infant mortality was nearly always significantly lower than other categories of population. This helps explain why discussions about infant mortality in Guiana did not centre on the maternal practices of British women.



Filth, ignorance, and poverty were also assumed to explain the perplexing incidences of Portuguese mortality. Far from being an example of sanitary correctness,

98. Rev. Father Victorine. *Argosy* 11 October 1905.

99. *Argosy* 25 October 1905.

100. *Ibid.*

### Disease, infant mortality and colonial perceptions of 'native' motherhood

the Portuguese were, according to Dr. Law 'dirtier in their habits than any other race in the city.'<sup>101</sup> Over the following years the high rates of mortality amongst the Portuguese continued to surprise doctors, particularly, as can be seen in the infant mortality chart, in the way that it generally remained higher than for other groups. By 1912 both racial considerations and poor sanitary conditions were proffered as reasons for high Portuguese infant mortality. As one doctor explained, they were a 'transplanted' race, and had less resistance to disease than those around them.<sup>102</sup>

As the discussion above shows doctors in the colony were particularly concerned that mothers should adopt breastfeeding as the preferred method for feeding infants. Another related concern of doctors was over rituals of birth and more generally, in lay medical practices. Doctors filtered their knowledge about non-European birthing culture through the categories of knowledge (ideas of hygiene, skill, and therapeutics) they had learnt in their London or Edinburgh medical schools. The influence of 'old women' on nursing mothers was particularly disparaged, especially if the infant became ill. Dr. von Winckler claimed that mothers often turned to ineffectual patent medicines for their sick children or had recourse to 'herbs'.<sup>103</sup> According to Dr. Rowland new-borns were given all sorts of harmful compounds of drugs and 'messes'. These ranged from a local concoctions of 'bush tea', to vinegar and oil, and to the child's own urine.<sup>104</sup> When Mrs. Minett M. D. (the partner of E. P. Minett D. P. H., one of the Medical Officers of Health) spoke to the 1921 West Indian Medical Conference she outlined some of the 'deep rooted' customs which she thought flourished in the undergrowth of society:

The bathing of a new-born child's eyes with lochial (or other) discharge from the mother, the dressing of sore eyes with milk or with urine, of the cord likewise; the mixing of butter mixed with lamp-black around, and into the eyes in East Indians; the rectal injections of a decoction of hot peppers, "to strengthen the back;" the tying of tight strings around the mother's abdomen, and of amulets and assafoetida around the baby.<sup>105</sup>

There is very little evidence to suggest how widespread any of these practices may have been in the population. In some ways this was not the crucial factor for colony doctors, since the acceptance of their occurrence, and the way they transgressed hygienic

---

101. *Argosy* 28 October 1905.

102. Craigen, *BGMA* 1913. p. 135.

103. von Winckler, *Argosy* 14 October 1905.

104. Rowland, *BGMAHR* 1893. p.167. 'K'. Letter to the *Argosy*. *Argosy* 23 September 1905.

### Disease, infant mortality and colonial perceptions of 'native' motherhood

understanding, provided more than sufficient reason for medical intervention into birthing and nursing practices. Discovering these practices helped lever into place elite western notions of medicine. In the examples given above bodily products had quite different meanings, roles and uses than those prescribed under western medical orthodoxy, and hint at deeper levels of culture hidden from western eyes. This was explicitly commented upon by Minett who told her audience that it was only through ' a certain amount of "bluff" that one learns what is really done by the people'.<sup>106</sup>

Enlightening the inhabitants of the colony, and encouraging women in particular to abandon seemingly dangerous traditions and adopt new rituals of hygiene was fashioned into a task for the colony's medical profession in the 1890s. The rate at which this new hygienic knowledge spread was taken to bear some relation to the proportion of doctors amongst the poor. This raised concerns over the fate of communities in remote and scattered villages where doctors rarely visited.<sup>107</sup> After all, it was, according to Dr. Ozzard 'for us to teach the people what to do and how to do it.'<sup>108</sup> At the same time, another of the colony's Government Medical Officers, Dr. Wallbridge, argued for a 'crusade' against the practices of improper feeding, claiming that its success would quickly check mortality amongst the young.<sup>109</sup> Later, in Dr. Ferguson's evidence before the Mortality Commission he explained that 'medical men are the best educators of the people in the knowledge of personal and general hygiene, as well as their best helpers in disease.'<sup>110</sup>

## 5.7 Conclusion

We saw in the last chapter that a concern over infant mortality had entered the colony's political arena. Amongst doctors this interest resulted in meetings, surveys, and investigations. From the statistical mapping of the plantation population doctors gradually turned their attention towards the less regimented social world which existed beyond the estate, and in particular towards the problematic urban environment. As they

---

105. Mrs. E. P. Minett. M.D. Medical Officer of the Baby Saving League, Report of the Proceedings of the West Indian Medical Conference 1921 (WIMC) ("The Argosy" Printers 1921), p. 58.

106. Ibid.

107. Ferguson. Argosy 28 October 1905. von Winckler. Evidence before the Mortality Commission. Argosy 14 October 1905.

108. Ozzard, BGMAHR 1893. p. 182.

109. Ibid. Wallbridge. p. 167.

### Disease, infant mortality and colonial perceptions of 'native' motherhood

embarked on this scrutinising project doctors were able to draw upon rich sources of data, and upon sanitary and demographic norms that had been established in the metropolitan centre. Indeed, to a significant extent the measuring sticks of the colony's progress lay with the cultural and administrative standards being produced in England. But this was not entirely the case. Although Victorian views on the pivotal role of women in the upbringing of the infant powerfully influenced the colony's medical profession, the character of deliberations in British Guiana were also shaped by its colonial circumstances. This included the presence or absence of specific diseases, especially syphilis and malaria, and by firmly held racial considerations which often saw in the mother various 'backward' practices. Few contributions by doctors on the subject of infant mortality failed to weave in comments about how race affected the likelihood of an infant's survival. There was also a sense, amongst some doctors, that the very conditions of the colony, disease, heat and water, and the insanitary state of the villages and parts of Georgetown, all conspired to weaken and sap the vigour of the offspring of new immigrants. As the GMO, Dr. Ferguson stated in 1911:

The effect of local rearing on the race tends, therefore, to physical deterioration, to the production of a light weighing, thin boned and delicate-featured man, having less capacity for prolonged, hard muscular effort...many such are being reared in the villages of the colony – a menace to its future vital interests.<sup>111</sup>

Ferguson expressed a hope for 'virile and desirable citizens'.<sup>112</sup> By the time Ferguson wrote these words it was already accepted within the Government, municipal administration, and the colony's medical profession that the key to achieving this aim rested with efforts to improve the circumstances surrounding childbirth, such as the training of midwives, with better urban and village sanitation, and the provision of higher standards of food, particularly milk.

One of the themes of this chapter has been to show how colonial officials and doctors turned their knowledge about the natural world towards gauging the social practices of non-Europeans, in particular the 'native' mother. Developing alongside this intellectual activity there were also practical steps taken to improve the sanitation and supply of fresh water to Georgetown. These matters of 'public health' increasingly came

---

110. Ferguson. *Argosy* 28 October 1905.

111. Ferguson. RSG. *AR* 1911-12, p. 92.

112. *Ibid.* p. 92.

### **Disease, infant mortality and colonial perceptions of 'native' motherhood**

to occupy an important place in local affairs and in colony administration. Another strand of activity which emerged in the early twentieth century was around attempts to reduce the spread of malarial infection and other diseases – again, especially in Georgetown. However, the two issues which had the most direct and immediate bearing on infant mortality were those of midwifery and the quality of milk. The next two chapters, while not entirely losing sight of the range of public health initiatives embarked upon in the colony, will concentrate firstly on the state and questions of midwifery, and then turn to examine how the authorities attempted to improve the quality of the colony's milk supply.

-----

## Chapter 6

### 6.1 Introduction

When in 1898 the magistrate Henry Kirke wrote his memoirs, *Twenty-Five Years in British Guiana*, he included a short piece to illustrate the character of 'native' midwifery. Kirke had presided over an inquest into the body of a young pregnant woman named Hope whose death was allegedly due to the activities of the attending midwife, Amsterdam. Kirke was told how the mother, who experienced difficulties with her labour, was tied to a tree with a rope and stretched by the midwife. Then, after this procedure failed Amsterdam began pushing and pulling the woman in a 'violent' manner. Hope's suffering finally ended two days later, on March 30<sup>th</sup> 1874 when both she and her unborn child died.<sup>1</sup> For Kirke, the manner of Hope's death represented far more than an isolated personal tragedy. It dramatically pointed to what Kirke believed to be the 'utter stupidity and barbarity of the midwife'.<sup>2</sup> Kirke's allusion to 'barbarism', at the time a quasi scientific category, was particularly evocative for the Victorian reading public, especially in its colonial setting. It was a counterpoint to everything civilised, it hinted at dark forces, ignorance, and primitivism.

It is evident that Kirke's views were shared by other members of the colonial administration. This is not surprising since in England the medical profession had long represented women midwives as dangerous combinations of ignorance and dirt.<sup>3</sup> It was merely a sharper racialised echo of these sentiments about gender, class and culture that Kirke expressed in British Guiana. In 1886 legislation had been introduced to regulate the practices of 'native' midwives, but this seems to have done little to reverse the unflattering opinion of European doctors.<sup>4</sup> Certainly, by the 1890s 'native' midwifery was thoroughly discredited in official eyes. Why should Kirke's pejorative rhetoric about midwives surface in British Guiana? One reason was that concern over the colony's slow population growth had gathered pace. Infant mortality, as we saw in the last chapter, was fast becoming a central issue for doctors. Constructing a 'problem'

---

1. Henry Kirke. *Twenty Five Years in British Guiana*. London 1898. p. 269.

2. *Ibid.*

3. Irvine Loudon, 'Midwives and the Quality of Maternal Care' in Hilary Marland & Anne Marie Rafferty (eds), *Midwives, Society and Childbirth* (Routledge 1997), p. 180.

around midwifery therefore gave doctors and the government an incentive to introduce various reforming measures.

This chapter also brings back into focus the central importance of the Public Hospitals at New Amsterdam and Georgetown. In chapter one we saw how the character of these hospitals was transformed by the mass arrival of immigrants and the political imperatives associated with their care. As the goals of colonial medicine once again expanded, this time towards reducing infant mortality in the wider population, so too did the organisation of these hospitals. Maternity wards were introduced, and special measures were taken to encourage women to have their children under the supervisory eye of Western medical expertise.

Here the discussion is dominated by the Georgetown Hospital. Due to its size and therefore its importance, the workings of this institution generally received greater prominence in the official record than the neighbouring New Amsterdam Hospital. By looking at the Georgetown Hospital we can see that in many ways medicine was tracing European developments. At least from the late eighteenth century onwards both pregnancy and childbirth in Europe had been gradually detached from their 'natural' origins, transformed into medical conditions, and seen as suitable subjects for medical diagnosis and treatment. One of the aims of this chapter is to try to judge how far doctors in Guiana were successful in this enterprise.

I am also going to look at what steps were taken by the colonial authorities to alter the midwifery practices of colony inhabitants. How were Western notions of birth culture, with its shared systems of thought, concepts, and rules, transmitted to Guianan women? In the main, I think this happened in three ways. Doctors encouraged women to use the maternity ward at the Georgetown Public Hospital, training for midwives was introduced, and thirdly, they attempted to regulate already existing midwives. One way of looking at the development of the medical services for plantation workers, which was discussed in chapter three, is to see it as a programme which sought the categorisation, assessment and supervision of labourers. Similar elements were present in the government's attempt to promote new standards of midwifery and mothercraft. The

---

4. Medical Ordinance No. 9 of 1886.

midwifery programme, by reaching out to Guianan women, represented a significant extension of the 'officialising' procedures seen earlier on the plantations.<sup>5</sup>

The main focus of these educative and administrative initiatives was the population of the capital, rather than the rural population. It was here that doctors considered infant mortality to be the highest and where they deployed most resources to reduce it. In the final part of this chapter I look at the organisation of midwifery and the pro-natalist policies developed by the medical profession for Georgetown inhabitants. These included similar measures already established in parts of Britain, such as infant clinics and health visitors. I argue that midwifery in British Guiana, by the end of the first decade of the twentieth century, had been stamped indelibly by the presence of English and Scottish trained doctors in the colony.

## 6.2 'Native' midwifery and the medical profession

As a class, midwives in Guiana were women who shouldered the pivotal responsibility for assisting in childbirth some of the poorest, weakest, and most vulnerable members of society.<sup>6</sup> At the same time, for most of the nineteenth century, they were largely peripheral to the concerns of the plantation economy, and remained beyond the gaze of European doctors and absent from the administrative record. This changed in the latter half of the nineteenth century as the colony's medical administration became anxious about infant mortality. For the most part European doctors regarded the 'native' midwife as someone who required altering, regulating, or educating in the ways of European medical standards.

Doctors claimed that many midwives were nothing more than 'old grannies', perhaps no more skilled than washers or cooks, essentially dirty of habit, untrained, brutal, and incompetent.<sup>7</sup> Midwives were frequently referred to as 'so-called midwives'. For example, a report from the Bellfield medical district in 1900 claimed that still births were 'out of all proportion to the number of normal births...largely due to the profound

---

5. The useful phrase 'officialising' comes from Bernard S. Cohn, Colonialism and its Forms of Knowledge. The British in India (Princeton University Press 1996), p. 3.

6. This point is made by with regard to midwives in the American South at the turn of the century by Gertrude Jacinta Fraser, African American Midwifery in the South. Dialogues of Birth, Race, and Memory. (Harvard University Press 1998), p. 27.

7. Dr. J. E. Godfrey. President of the British Guiana Medical Association. BGMA 1898. p. vii.

ignorance of the so-called midwives who abound in the villages.’<sup>8</sup> Officials continued to use the epithet ‘so-called midwives’ well into the twentieth century.<sup>9</sup> Midwives were also often referred to as ‘gamps’, or ‘gon-gons’.<sup>10</sup> The term ‘gamp’ was a powerful cultural signifier. Sarah Gamp was a notorious midwife drawn from Charles Dickens’ *Martin Chuzzlewit*. She was portrayed as a self-serving female, someone who was often drunk, who was both corrupt and corrupting, of those around her.<sup>11</sup> ‘Gamp’ was therefore a useful stereotype which contrasted how doctors saw themselves (educated, professional, regulated, and humanitarian), with their view of midwives (ignorant, unskilled, unregulated, and selfish).<sup>12</sup>

The colonial critique of the Guianan midwife thus bore many similarities to medical attitudes in Europe. In Guiana doctors also strongly suspected that the work of the ‘gamps’ was not restricted to help at birth, but that they colluded with mothers and assisted in procuring abortions.<sup>13</sup> Whether or not this was the case, the profession was agreed that midwives were an important proximate cause of infant mortality.<sup>14</sup> In submissions before the colony’s 1905 Mortality Commission, some of the foremost obstacles to reducing infant mortality were cited as the old age of midwives, their ignorant attachment to poor birthing traditions and their misplaced views about infant feeding.<sup>15</sup> This view was summarised in the *Argosy*.

...improper attention during delivery and...inefficiency of untrained midwives, tetanus resulting from long exposure or from septic instrument used, bad feeding and neglect of cleanliness. There was no adequate knowledge of the kind of food that the child should be fed with, and food which the stomach was not prepared to digest was given, thereby disordering the stomach, intestines and liver and culminating in death.<sup>16</sup>

One of the difficulties which faced the colony’s medical profession was that midwives were not an easily identified group. Unlike some forms of employment, such as field work, its visibility was low, and few women worked exclusively as midwives.

---

8. RSG. *AR* 1900-01. p.53.

9. RSG. *AR* 1908-09, p.34; *BGMA* 1913. p. 147.

10. Minett, *WIMC*. p. 59.

11. Ann Summers, ‘The mysterious demise of Sarah Gamp: The domiciliary nurse and her detractors 1830-1860’, *Victorian Studies* 1988-89 Vol. 32. pp. 365-386.

12. ‘Introduction’, in Hilary Marland and Anne Marie Rafferty (eds.), *Midwives, Society and Childbirth Debates and Controversies in the Modern Period* (Routledge 1997), p. 3.

13. Dr. Ozzard, *BGMAHR* 1893. p. 184.

14. Dr. Rohlehr, *BGMAHR* 1893. p. 187. Dr. Wallbridge. *Ibid.* p. 197. Dr. von Winckler. Evidence before the Mortality Commission. *Argosy* 14 October 1905.

15. Report of the Mortality Commission. *BGMA* 1906. p. 22, 37.

### Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

Moreover, women who had themselves successfully given birth often acted as midwives, indicating its fluid and intermittent nature, perhaps more akin to mutual aid than an organised income producing activity.<sup>17</sup> At the same time, midwifery was associated with a remarkably resilient body of ideas handed down from generation to generation. As a writer to the *Argosy* explained, the excessive death rate of children was primarily due to the:

crass ignorance on the part of the mothers, whose only knowledge is derived from those so-called nurses the old women who deal with superstitious faith cures, composed principally by dabbling with weeds and their supposed curative properties.<sup>18</sup>

Thus, the ignorant and misguided, according to medical opinion, transferred their prejudices and superstitions from one generation to the next.<sup>19</sup> These pejorative descriptions of midwives did far more than simply bolster the standing of Western medicine amongst Europeans in the colony. They operated to open the legislative doors of change. What the colony most needed, in this view, was training and the implementation of simple hygienic reforms. As Dr. Castor urged at the quarterly meeting of the colony's medical association in 1898:

Something should be done to at least teach the so-called midwives cleanliness. At present the only qualification seems to be that the midwife should have arrived at such an age – when instead of assisting others into the world she should be considering her latter end and preparing for her own exit.<sup>20</sup>

Hence, it was with the intention of increasing the numbers of trained midwives in the colony, and raising the standards of those already practising, that fresh legislation was proposed. As discussed below, doctors also embarked on a programme to raise the profile of the Georgetown Public Hospital amongst pregnant women. The Surgeon General also arranged for the hospital to select and train nurses in the skills of midwifery and took steps to encourage practising midwives to undergo training at the hospital. Subsequently, in 1908 Georgetown saw the introduction of health visitors and infant clinics. Downgrading the older midwives, encouraging new midwives, and (in contrast to England) attempting to attract women into the public hospitals to give birth, became central elements in the colony's attempts to reduce the level of infant mortality.

---

16. *Argosy* 23 September 1905.

17. Charlotte G. Borst, *Catching Babies* (Harvard Press 1995), p. 5.

18. Letter by K. *Argosy* 23 September 1905.

19. Dr. Godfrey. *BGMA* 1898. p. vii.

20. Dr. Castor. *Ibid* p. 172.

### 6.3 Georgetown Public Hospital

We saw in the last chapter that the colony's two main public hospitals were pivotal in the way they gathered together 'native' women and allowed doctors to examine questions of infant mortality and fertility. This work was made possible by the existence of maternity wards which dated back to at least 1873. It is clear that by the end of the century doctors favoured hospital births over home births, and saw in these wards one of the most effective ways of managing and supervising expectant women. The colonial hospital (as did its metropolitan counterpart) stood, in the eyes of the medical profession, in stark contrast to conditions in most homes by bringing together trained medical staff, hygienic conditions, and the technologies of health (instrumentation, drugs, space, light and ventilation) under one roof.

One indication of the rising status of the Georgetown maternity ward can be seen in the improvements undertaken after 1894. First of all, the ward was moved away from the hospital laundry with its 'hazardous' cleaning fumes. Secondly, in its new brighter and airier location the floor space was increased.<sup>21</sup> Its sixteen maternity beds, and two-bed delivery room, occupied a generous 2,849 square feet. This amounted to 158 square feet per bed.<sup>22</sup> This was the built environment in which the culture of Western medicine unfolded. Doctors endeavoured to examine women in this ward following the strict aseptic and antiseptic principles that had gained favour in Europe.<sup>23</sup> European forms of knowledge were symbolised by the use of sterilised gowns and sheets which were provided for the mother, and the washing of attendants' hands in antiseptic solutions such as Lysol. The ward also possessed its own steriliser for instruments. After the birth, care of the mother and infant continued. Newborns had their eyes bathed in solutions of silver nitrate to prevent ophthalmia neonatorum, and mothers were required to remain in the hospital ward under observation for a further nine days.<sup>24</sup> Later, as a result of charitable contributions, a special Children's Ward was added to the hospital. Each of

---

21. RSG AR 1896-97. p. 19.

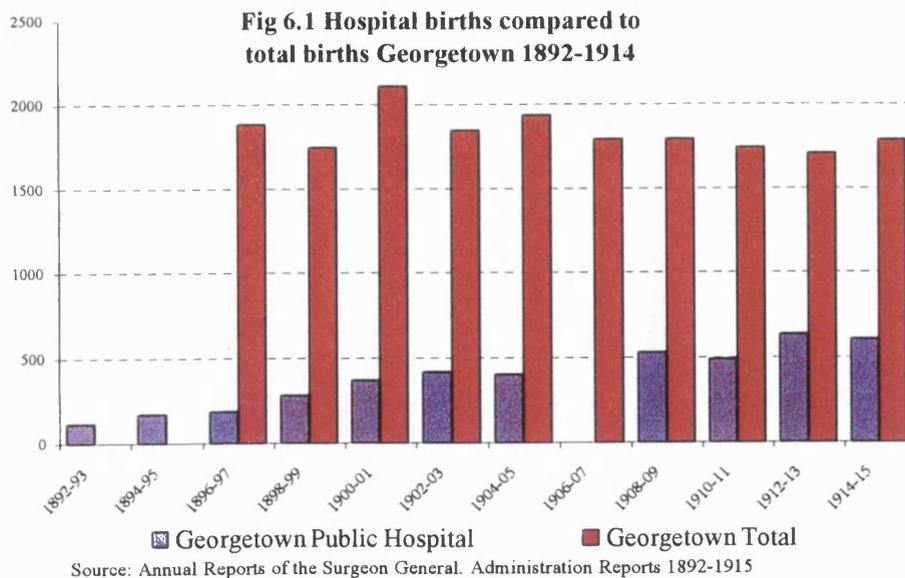
22. *Argosy* 27 September 1905. *BGMA* 1910. p. 25. By comparison, the new sick ward at Amsterdam Public Hospital provided for only 96 square feet per bed. Rowland, 'A Description', *BGMAHR* 1894. p. 70

23. Ulrich Trohler, 'Surgery (Modern)', *Companion Encyclopedia* Bynum and Porter (eds.), pp. 987-982.

24. *BGMA* 1910. p. 25

the thirty cots in this ward had a mosquito net and was described in 1908 as 'comfortable and up-to date'.<sup>25</sup>

These developments were a sign of the increasing importance attached to infant mortality and motherhood. Another indication of this lay in the hospital's fees policy. Whereas ordinary patients were obliged to produce a certificate of poverty in order to receive free hospital care, expectant mothers were excused this requirement.<sup>26</sup> The accessibility of the hospital is again emphasised if it is compared against the admission criteria for expectant mothers in English hospitals during the same period. In contrast to Guiana, proof of 'respectability' via a marriage certificate was often essential in England, while many establishments only admitted exceptional cases or those who could prove it was their first confinement.<sup>27</sup> As we saw in the last chapter, colonial doctors were preoccupied with illegitimacy and its effects, but this seems not to have translated into a restrictive hospital admissions policy. In practice then, the overriding concern of the authorities lay with the colony's low birth rate and high infant mortality more than with its morals. The figures given below in Fig. 6.1 indicate the increasing numbers of women entering the Georgetown hospital.<sup>28</sup>



25. RSG. AR 1908-09. p. 40.

26. RSG. AR 1894-95. p. 8.

27. Lara Marks, 'Mothers Babies and Hospitals', in Valerie Fields, Lara Marks and Hilary Marland (eds.), Women and Children First. International Maternal and Infant Welfare 1870-1945 (Routledge 1992), pp. 54-55.

28. These figures are compiled from Administration Reports 1892-93 to 1915.

### Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

The significance of these figures is further underlined when compared against the total number of registered births in the city. As can be seen from the red column these remained relatively steady throughout the period.<sup>29</sup> What changes dramatically, is the proportion of women (indicated by the blue column) entering hospital to give birth. In 1896-97 births in hospital accounted for 9.9 per cent of total births in Georgetown. This figure gradually increases until in 1912-13 hospital births accounted for 37.3 per cent of all births in Georgetown.

Elsewhere in the Empire similar efforts were also being made to tackle infant mortality and make provision for non-Europeans to give birth in hospital.<sup>30</sup> Historical studies of this phenomena outside the settler colonies remains a relatively unexplored area, particularly so with regard to the Caribbean. However, it does seem that throughout the British West Indies in the late nineteenth century the authorities were keen to have maternity facilities in colonial hospitals. For example, in Jamaica there was the Victoria Jubilee Lying-in Hospital. By 1905 over 400 women a year were going through its doors.<sup>31</sup> The colonial hospital at Port-of-Spain Trinidad also supported a maternity ward. The Georgetown Hospital, therefore, fits into this Caribbean pattern of development.

Much more difficult to assess is the impact of these hospitals amongst the local population. The apparent popularity of the Jamaica institution suggests that doctors in Guiana were not alone in successfully persuading women to enter hospital. However, in other parts of the empire, such as India and elsewhere, it is clear that local communities remained unimpressed with the benefits of the hospital for giving birth.<sup>32</sup> For example, despite providing a sixteen-bed maternity ward for Malay women in Singapore from 1888, very few women used these facilities. As Lenore Manderson comments, until well into the twentieth century the 'ritual demands of pregnancy were managed by the *bidan*, who provided the expectant mother with dietary advice and massage as well as

---

29. Some caution has to be exercised here. The catchment area that the hospital served was Georgetown, but women from the surrounding districts did arrive at the hospital seeking treatment, and may also have given birth there.

30. Judith Richell, 'Ephemeral lives: the unremitting infant mortality of colonial Burma, 1891-1941', in Fields, Marks and Marland (eds.), *Women and Children First* pp. 133-153. Lenore Manderson, 'Women and the state: maternal and child welfare in colonial Malaya, 1900-1940', in Fields, Marks and Marland (eds.), *Women and Children First* pp. 154-177. For a useful bibliography see Fields, Marks and Marland (eds.), *Women and Children First* pp. 281-298.

31. Annual Report of the Superintending Medical Officer. *AR* 1910. p.14-15.

32. Arnold, *Colonizing* pp. 257-258.

ceremonial supervision.<sup>33</sup> This last point is particularly interesting as it demonstrates the resilience of the powerful cultural associations which surrounded pregnancy and childbirth. It also leads on to the question, what did going to the hospital to give birth signify in Guiana?

The first point to make is that not all women looked equally favourably on the Georgetown Hospital. Of particular concern for doctors were those women where 'complications' were detected. However, even in these cases women sometimes proved very reluctant to place themselves under the care of doctors in hospital. The following comment by Dr. Wishart, the Georgetown Health Officer, indicates a tone of paternal firmness born of expertise.

Of course if you are firm with them, and tell them straightforwardly that you cannot look after them at home they are sometimes induced to go. In several cases I have experienced a great deal of trouble in persuading them to go; others have gone cheerfully.<sup>34</sup>

Another crucial factor which seems to have shaped attitudes was race. East Indian women rarely entered the Georgetown Hospital for their confinements. This pattern of behaviour was repeated on other islands and points to the integrity of cultural practices brought over from India.<sup>35</sup> When the weights of 1000 babies born alive in the maternity ward were averaged in 1913, only one-hundred were from East Indian women.<sup>36</sup> Thus, the birthing culture of East Indians appears to have been largely resistant to the institutionalisation of birth.

Entering the hospital represented an important change in where women gave birth. The significance of this was more than a neutral change of place. The home was the usual site for birth. Traditionally, this was a privileged social space where the autonomy of the family ran strongly. The connotations of leaving the home for such an important event as birth should not, therefore, be underestimated. Although there are no accounts of the procedures or arrangements undertaken in the maternity ward which can illuminate the character of the mother-doctor relationship, to cross the threshold of the hospital entrance was to place the supervision of birthing care in the hands of European

---

33. Lenore Manderson, Sickness and the State. Health and Illness in Colonial Malaya, 1870-1940 (Cambridge University Press 1996), p. 206.

34. Dr. Wishart, Mortality Commission. Argosy 23 December 1905.

35. The Georgetown Hospital Reports for 1887 (Georgetown 1888), p. 83. See also Island Medical Department Report for Jamaica. AR 1910.

doctors and the administrative systems of the institution. For those women who entered hospital, birth and its meaning were subsumed by Western medical orthodoxy which attached its own meanings to the role of food and drink, the place of sleep, air and water, and the proper movement, exercise, and rest of mothers.<sup>37</sup> One immediate effect of this was that parturition was no longer a family episode circumscribed by the usual cultural traditions, but an experience structured by European, and male, doctors.<sup>38</sup>

The historians Andrew Cunningham and Bridie Andrews have elsewhere forcefully argued 'Western medicine was imposed as an alien form of knowledge and an alien practice...it took no account of the cultures and medical systems already present.'<sup>39</sup> There is a good deal of merit in Cunningham and Andrew's argument. No doubt doctors sought absolute supremacy in their hospitals. However, their control was not total. Birth in Guiana was not just being transformed into a medical event by doctors, but by both women and medical practitioners who shared, to an extent at least, a similar outlook on the role of doctors and hospital medicine. It is important to remember that women could walk away from the hospital. As David Harley has recently put it: 'The presentation of medical ideas in an open market requires them to connect with the core beliefs of a substantial group of potential patients.'<sup>40</sup> This holds true, he goes on to suggest, even though the symmetries of power and knowledge may be far from equal.<sup>41</sup> It is clear then, that amongst some women, doctors had gained a high measure of plausibility or legitimacy, which influenced the women's decision about where to give birth.<sup>42</sup> The mandatory rest period after birth, and the perceived effectiveness of hospital therapeutics

---

36. Dr. Craigen. BGMA 1913. p. 134.

37. Margarita A. Kay, Anthropology of Human Birth (F. A. Davis Co. 1982), pp.1-24.

38. However, a comment by Dr. Craigen in 1914 suggests that doctors may have been sensitive to some of the anxieties and wishes of women and family members when it came to birth. One of the reasons they preferred not to perform caesarean deliveries was because of the 'alarm' it caused to the patient's friends. This raises the possibility that friends or relatives were in close proximity or contact with the mother at the hospital. Caesarean section also had wider implications in terms of the hospital's reputation. Craigen argued that for mothers returning from hospital, in the colony's 'small and ignorant communities [caesarean section] has a bad effect.' A. J. Craigen, 'Puerperal Eclampsia or Toxaemia of Later Pregnancy in British Guiana', BGMA 1915. p. 5.

39. Andrew Cunningham and Bridie Andrews (eds.), Western Medicine as Contested Knowledge (Manchester University Press 1997), pp. 2-3.

40. David Harley, 'Rhetoric and the Social Construction of Sickness and Healing', Social History of Medicine Vol. 12. Number 3. 1999. p.414. See also Borst, Catching Babies pp. 2-3.

41. *Ibid.* p. 423.

42. Steven Shapin, 'Cordelia's love: credibility and the social studies of science', Perspectives on Science Vol. 3, no. 3 (Fall 1995). See also Carol P. MacCormack, 'Health Care and the Concept of Legitimacy in

## Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

may have been an important factor in the mother's thinking. The following remark by Dr. E. D. Rowland of the New Amsterdam hospital shows that morphine was regularly administered. (*Italics added*).

A primipara lady was seen at 6.30 p.m. with early pains and slight show; at 3 a.m., nine hours later, membranes ruptured, head was fully engaged in first position, and *as she wished it*, I gave hypodermically Burroughs and Wellcome's tabloid of 1/4 grain Morphia and 1/200 grain Hyoscine Hydrobromide with another 1/4 grain of Morphia.<sup>43</sup>

Thus, a monopoly on dispensing strong opiates may have given the hospital doctor a reputation for alleviating pain, underlining the point that therapeutic credibility, and other confidence giving strategies, was a bulwark of Western medicine in Guiana.<sup>44</sup> Similarly in Britain, and elsewhere in the empire, the 'Twilight Sleep' and other forms of pain control were an attraction for mothers.<sup>45</sup>

In the previous chapter the high rates of infant mortality were discussed. Another concern of doctors was maternal mortality. For the Georgetown hospital, between the years of 1886 to 1910, the maternal death rate was 292 per 10,000 births.<sup>46</sup> This was extremely high, especially if compared to some hospitals in England where the rate was often below fifty. However, it should be remembered that in English hospitals maternal mortality rates differed enormously from one institution to the next, making comparisons very difficult. Irvine Loudon provides tentative data which shows that in some English provincial lying-in hospitals which admitted emergencies and cases from outlying districts, the maternal mortality rate could rise to 296 or even much higher.<sup>47</sup> As shown below, a large proportion of women entering the Georgetown hospital were suffering from chronic levels of disease. Despite this, the figures from Guiana point to the exceptionally hazardous nature of birth in the colony hospital. Unfortunately, for

---

Sierra Leone', in Steven Feirman and John M. Janzen (eds.), The Social Basis of Health and Healing in Africa (University of California Press 1992), pp. 429-430.

43. Dr. Rowland, 'Notes on Painless Childbirth by Scopolamine Morphine', BGMA 1915. p 13.

44. John Harley Warner, The Therapeutic Perspective (Princeton 1997), pp. 1-7.

45. Hanna Rion, Painless Childbirth in Twilight Sleep: a Complete History of Twilight Sleep from its Beginning in 1903 to its Present Development in 1915, Including its Successful use in Great Britain to-day (London. T. Werner Laurie, 1915). Helen R. Woolcock, M John Thearle, and Kay Saunders, "'My Beloved Chloroform" Attitudes to Childbearing in Colonial Queensland: A Case Study', Social History of Medicine Vol. 10. No. 3. 1997. pp 437-457.

46. During this period there were 6,862 births and 201 deaths. Dr. Craigen, 'Practice of Midwifery at the Public Hospital Georgetown', BGMA 1910. p. 32.

47. Irvine Loudon, Death in Childbirth. An International Study of Maternal Care and Maternal Mortality 1800-1950 (Clarendon Press 1992), pp. 224-266.

purposes of comparison it is quite impossible to tell how many maternal deaths occurred among home births in the colony.

We can glimpse something of the dangers women faced on giving birth in the hospital by looking at the type of diseases they were diagnosed with. They arrived showing evidence of chronic Bright's disease, anaemia, anchylostomiasis, and pneumonia. They died from haemorrhage, septicaemia, puerperal convulsions, and eclampsia, the 'disease of theories'.<sup>48</sup> Unfortunately, we do not know the proportions of women who entered hospital with these problems. What is more certain is that the risk of death from haemorrhage was greatly worsened with severe anaemia. Equally, women who suffered from nutritional deficiencies were also likely to have increased maternal deaths.<sup>49</sup>

However, the most life threatening condition, with a mortality rate of about thirty-eight per cent, was eclampsia, on which doctors blamed the 'Malarious Climate'. The onset of eclampsia was usually signalled by headaches and the presence of albumen in the urine, proceeding to rapid pulse, convulsions, and coma.<sup>50</sup> By 1908 urine testing was part of the hospital midwifery course.<sup>51</sup> Recent research has shown that incidences of this condition are higher in Black populations than among whites.<sup>52</sup> This is borne out by the experience of doctors in the colony who estimated eclampsia affected one in forty-four hospital deliveries, compared to about one in 440 deliveries in England.<sup>53</sup> Eclampsia was supposedly susceptible to prevention through antenatal care and it is clear that doctors in the colony, like their colleagues at home, strove to mitigate the effects of this disorder by experimenting widely with different methods of treatment. Caesarean section, bleeding, morphia and purgation, milk diets and laxatives, and new drugs such as Veratrone were all tried at one time or another.

#### 6.4 Midwifery nursing and training

---

48. Irvine Loudon, *The Tragedy of Childbed Fever* (Oxford University Press, 2000).

49. David Rush, 'Nutrition and maternal mortality in the developing world', *American Journal of Clinical Nutrition* Vol. 72, No. 1, July 2000. pp. 212-240.

50. Dr. Craigen. *BGMA* 1915. p. 2.

51. RSG. *AR* 1907-08. p.40.

52. A. M. Davies, 'Geographical epidemiology of the toxemias of pregnancy', *Journal of Medical Science* 1971 Vol 7. cited in Rush, 'Nutrition'.

53. Dr. Craigen. *BGMA* 1915. p. 1.

### Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

The successful workings of the colonial infrastructure (administration, transport, sanitation, police) required the recruitment of many non-European subjects. This unavoidable undertaking sometimes caused tension within ruling circles. A reliance upon non-Europeans in the administrative structures of society emphasised the dependency of the state upon social classes whose values were often different, and whose loyalty was uncertain. A measure of deep underlying levels of anxiety present in governing circles over the bulk of the population can be seen in the care taken to maintain and fund the semi-militarised colony police force.<sup>54</sup>

However, for the most part, transmitting the imperatives of authority required little more than the elaboration of bureaucratic mechanisms through layers of collaborators, combined with a determination to avoid alienating any large mass of the population. As in many other parts of the world, supervision in the form of a chain of command, and a measure of accountability, was sufficient to achieve most bureaucratic goals.<sup>55</sup> In the case of medicine, as already stated, European domination was expressed through the institution of the hospital and the colony's medical service. Outside of these institutional spheres doctors experienced far more difficulty inculcating colonial subjects with the premises of medical or 'public health' thinking. In the urban or rural environment the structures of support for Western medicine were relatively weak. In these places the disciplines and orderings of the colonial hospital or estate hospital were not replicable. This was particularly so with regard to childbirth and midwifery.

In country districts, in villages along river banks, and in the towns and settlements, midwives worked independently of the medical profession, and in locations where it was impossible for them to be supervised. Gaining a foothold in the practices of these women, changing the way they worked, and making them the bearers of Western biomedical thought, became a key aim of the colony's medical establishment in the early twentieth century. The colonial strategy for increasing its medical authority in these urban and rural areas involved four important interrelated elements. Namely: the training of nurses already employed at the Public Hospital in midwifery; certification;

---

54. In 1900 the government secretly re-equipped them with the latest armaments. This included importing 1500 point 303 rifles, three maxim guns and nearly a million rounds of ammunition. The cost of this expenditure was hidden from the public and press in a 'loan account'. 4 January 1900. C.O. 111/517.

55. Peter Burroughs, 'Imperial Institutions and the Government of Empire', Porter, (ed.), *Oxford History* pp. 170-197.

### Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

registration of existing midwives with the Medical Board; and finally, attempts to raise the standard of midwifery for those already practising in the colony.

In Britain in the late-nineteenth century midwifery training for women was not obligatory but was increasingly recognised as desirable within the medical profession.<sup>56</sup> By 1895, and perhaps earlier, this idea had been taken up in Guiana. In the first place, potential midwives were selected from small numbers of 'respectable women' between the ages of twenty-one and forty taken from amongst the ranks of the hospital's nursing probationers.<sup>57</sup> They then underwent six months of training and attended a series of lectures in midwifery, pharmacy, general nursing, and the care of infants. After this training midwives took an examination set by the Medical Board. Success at this stage was rewarded by certification which allowed nurse-midwives to attend women in cases of 'simple or natural labour.'<sup>58</sup> A sign that doctors were keen that midwives should remain medically and administratively subordinate to the professionally trained medical practitioner, especially those in possession of a Licentiate in Midwifery was that midwifery certificates were initially stamped with the following in red lettering: 'This Certificate Does Not Entitle The Holder To Practice Midwifery.'<sup>59</sup> This legally distinguished the midwife's work from the midwifery practised by the colony's medical profession, most of whom did not in fact possess any special midwifery qualifications, although those trained in Edinburgh or Glasgow would have attended a midwifery course.<sup>60</sup> Before the turn of the century most women trained in the hospital continued to work there, although a small proportion went out into the towns or attempted to find work in the villages. By 1914 a total of 138 nurse-midwives had trained and qualified in this way.<sup>61</sup>

In 1897 the government and medical service also decided to begin a colony-wide system of certification for women already practising as midwives. This simple measure of competency was achievable through an oral examination in front of a

---

56. Lara V. Marks Model Mothers Jewish Mothers and Maternity Provision in East London 1870-1939 (Clarendon Press 1994), p. 98.

57. RSG. AR 1895-96. p. 8.

58. *Ibid.*

59. RSG. AR 1895-96. p. 8.

60. Alison Nuttall, 'A preliminary survey of midwifery training in Edinburgh, 1844 to 1870', International History of Nursing Journal Vol. 4. No. 2. 1988/1999. p. 5. Johanna Geyer-Kordesch and Fiona MacDonald, Physicians and Surgeons in Glasgow: The History of the Royal College of Physicians in Glasgow, 1599-1858 (Hambledon Press 1999), p. 343.

### Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

Medical Practitioner or a Justice of the Peace or Poor Law Guardian.<sup>62</sup> In other words, it was probably not an exacting test. However, further efforts to control the activities of midwives began in 1900 when compulsory registration was introduced. This not only allowed for the fixing of fees, but also provided for fines and the cancellation of certificates should midwives be shown as 'incompetent, addicted to intemperance, or negligent in her midwifery duties, or guilty of any misconduct in connection therewith.'<sup>63</sup> Registration began slowly, although by 1905 the *Argosy* newspaper was able to print the names of 521 officially accredited midwives. It is important to note that the names of these women indicate that all of the colony's different races were represented. Despite this apparent success strong suspicions remained amongst the colony's doctors that unregistered midwives without certificates continued to ply their trade.<sup>64</sup> This is very likely. In England too, where supervisory systems were much more developed, unlicensed midwives were known to continue their work in 'blissful ignorance' for many years after the implementation of the 1902 Midwives Act.<sup>65</sup>

The new century also saw an attempt to extend the benefits of a formal training to 'native' midwives. This too bore parallels with some European countries where, as Hilary Marland explains: 'The midwife was to be lifted out of society, reformed and transformed, and put back amongst people of her own class, ready to work as a childbirth missionary'.<sup>66</sup> In 1903 the Georgetown hospital adopted a policy of offering a limited number of places to 'intelligent women' outside the ranks of nursing probationers.<sup>67</sup> In addition to the core midwifery curriculum these women were instructed in the feeding of infants, indicating that midwifery was already seen in a wider context than help with birth. This initiative was helped by the arrival of Miss I. M. Cowie (formerly of the Western Infirmary in Glasgow) as Superintendent of Nurses in the colony. Under her guidance the nursing and midwifery regimes in the hospital began

---

61. RSG. AR 1915. p. 16.

62. RSG. AR 1897-98. p. 6-7.

63. Medical Ordinance No. 9. Of 1886, Amendment Ordinance No. 32 of 1900.

64. *Argosy* 1 March 1905. *Argosy* 25 February 1910. Minett, WIMC p. 56.

65. Enid Fox, 'Midwifery in England and Wales before 1936: handywomen and doctors', International History of Nursing Journal Vol. 1. No. 2 1995. pp. 17-18.

66. Hilary Marland, 'The Midwife as Health Missionary. The Reform of Dutch childbirth practices in the early twentieth century', in Hilary Marland & Anne Marie Rafferty (eds), Midwives, Society and Childbirth (Routledge 1997), p. 153. See also regarding Sheffield, England, Tania McIntosh, 'Profession, Skill or Domestic Duty?', Social History of Medicine Vol. 11. No. 3 1998. p.418.

67. RSG. AR 1903-04. p. 15.

### Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

to be shaped more towards the lines of a metropolitan hospital. One sign of this was the provision of distinctive uniforms and caps for charge nurses, assistant nurses, probationers, and ward maids.<sup>68</sup>

The extension of midwifery training to rural women was significant. Dr. J. E. Godfrey, President of the British Guiana Branch of the British Medical Association, perceived the problem of infant mortality as essentially one of education.

Before any marked success can be attained in this direction it is absolutely necessary to get into close communication with the people, and this can best be done by providing and scattering, more especially throughout the villages, well trained and educated women who are competent to teach.<sup>69</sup>

Village midwives were now being targeted as the conduit through which hygienic influences could be introduced into the villages.<sup>70</sup> The training of local women as midwives was also a practical recognition of their important position and status in rural communities by the medical authorities. In order to encourage women from the more remote districts to take advantage of this training, small maintenance grants were introduced.<sup>71</sup> However, these payments were insufficient to cover an individual's living expenses, particularly after the length of training was increased from six months to eight months.<sup>72</sup> That there were sufficient women in the colony who considered formal midwifery training deserving of such personal and financial investments, goes some way towards indicating the spread of European medical influence at this time. The year 1905 saw this initiative get underway, and with notable pride the Surgeon General recorded that an illiterate Arawak Indian woman had entered the midwifery course.<sup>73</sup> Her training was, according to the Surgeon General 'naturally a purely practical one'. But he was confident she would prove to be of 'great assistance to her own people amongst whom she will practise.'<sup>74</sup> By 1920 the Georgetown hospital was training about forty women from rural districts each year.<sup>75</sup>

---

68. RSG. AR 1905-06. p. 14.

69. Dr. Godfrey. BGMA p. vii.

70. Mortality Commission. Argosy 2 December 1905.

71. Four students received subsidies amounting to \$112.02. RSG AR 1909-10, p. 16.

72. I. M. Cowie. Nurse Superintendent. RSG. AR 1907-08. p. 41. Miss Clapham, 'The Training of Native Hospital Nurses in the Tropics', WIMC p. 13. RSG. AR 1905-06. p. 15.

73. Clapham, 'Training'.

74. *Ibid.*

75. Clapham, 'Training', p. 13.

### Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

The policy of training Guianan women as nurses and midwives, and certifying village midwives, was not implemented without some misgivings. In particular, doctors levelled complaints that it was too easy for village women to gain midwifery certification.<sup>76</sup> Hospital authorities, for their part, were also sceptical about the quality of intake onto their courses. Turnover was high, and there were problems maintaining discipline, particularly since nursing accommodation at Georgetown hospital was not provided until 1905.<sup>77</sup> Finding those with the proper character and attitude, increasingly deemed necessary for nursing, proved difficult.<sup>78</sup> As in England, hospital officials were constantly frustrated by the way promising individuals turned out to be 'bad characters.'<sup>79</sup> For example, in 1907 there were over 370 applications for vacancies on the Nursing Staff, but only 157 were considered eligible.<sup>80</sup> Of each year's intake a proportion of women 'absconded', turned out to be physically unfit, or were found 'unsuitable' after a trial.<sup>81</sup> Hospital officers appeared disappointed that many requests to join the hospital staff were prompted by little more than a desire for a wage.<sup>82</sup> At Georgetown hospital, Miss Cowie complained that:

It is impossible to realise the difficulty that is experienced in obtaining a suitable class of applicants and even of those who are put on the list as eligible, and taken on as vacancies occur, the result is disappointing.<sup>83</sup>

Complaints about the quality of work performed by nurses continued, even after completion of training. The nature of midwifery, where women worked alone and unsupervised, supposedly in a manner approved of by colonial officials, provoked even greater concern. After all, according to Cowie:

A fair standard of education and a certain amount of intelligence are required from those who are sent out to work on their own responsibility and who are expected in some measure to educate the people in modern ideas of asepsis and hygiene.<sup>84</sup>

This observation echoed similar opinions expressed by the Surgeon General. Even within the confines of the hospital, where close supervision was possible, it was

---

76. RSG. AR 1903-04. p. 15.

77. RSG. AR 1905-06 p. 14-15.

78. Anne Marie Rafferty, The Politics of Nursing Knowledge (Routledge 1996), pp.23-41.

79. Argosy 12 November 1908.

80. RSG. AR 1907-08. p. 41.

81. *Ibid.*

82. Ethel A. H. Bridge. Nurse Superintendent. RSG. AR 1913-14. p. 47.

83. RSG. AR 1907-08. p. 41.

84. RSG. AR 1908-09. p. 39.

considered difficult to get adequate work done.<sup>85</sup> How much greater the problem when women worked independently of direct medical supervision in Georgetown or the countryside? Anne Marie Rafferty has drawn attention to the way that doctors in England saw a threat to their authority in the independence of the domiciliary nurse (hence the popularity of the Gamp stereotype amongst the medical profession), especially in the way she tended to sideline official medicine by identifying with working class culture.<sup>86</sup> It seems that similar worries fuelled attempts to improve the standard of midwifery training in Guiana.<sup>87</sup> Training, Rafferty argues, provided the ideal means for bringing nurses under medical control.<sup>88</sup> In Guiana, first of all, basic education entry levels for all nurses were raised in 1908, and course requirements were tightened. Secondly, nursing examinations were extended to cover questions of practical surgery and instruments, drugs and poisons, as well as general nursing.<sup>89</sup> Midwifery nurses in the Public Hospital were further expected to deliver personally nine cases under supervision, and attend a special series of lectures about the administration of simple drugs and feeding. Finally, only after successfully completing these tasks were they allowed to sit the midwifery examination and go out into the outside world having been reshaped and 'Europeanised'.<sup>90</sup>

## 6.5 Midwives, doctors and duties

As already stated, an important aspect of the nurse-midwife's duties was to educate the mother in hygiene and feeding. This was not merely a didactic role. In her behaviour and appearance she was expected to embody good practice by conforming to established standards of propriety, hygienic procedures, tidiness and orderliness. The midwife's equipment was basic: vaginal tube, flexible catheter, blunt-pointed scissors, clinical thermometer, nail brush and three ounces of Carbolic acid.<sup>91</sup> This last substance embodied for European doctors a special identity and status in the cornucopia of disinfecting materials. In England also, health visitors were carrying carbolics into the

---

85. *Argosy* 12 November 1908.

86. Anne Marie Rafferty, 'The anomaly of autonomy: Space and status in early nursing reform', *International History of Nursing Journal* Vol. 1. No. 1. 1995. p. 48.

87. RSG. *AR* 1915. p. 4.

88. Rafferty, 'The anomaly of autonomy' p. 48.

89. RSG. *AR* 1909-10. p. 54.

90. Clapham, 'Training', p. 13.

### Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

homes of the poor.<sup>92</sup> These notions of cleanliness, also served to underline another facet of colonialism: a perception of non-westerners, like the poor at home, as menacingly dirty.<sup>93</sup> Segregationist thinking by European elites was informed by this idea.<sup>94</sup> However, for the colony's medical profession the symbols of proficient rule, as well as the markers of competent midwifery, did not lie in secluded enclaves. On the contrary, they were to be found in the use of disinfectant, and in the clean hands and short nails of government trained 'native' midwives.

The midwife's other duties included seeing to proper ventilation in the lying-in room and keeping the bedding and clothing of the mother and child in a thorough state of cleanliness. As was the case with English midwives, comprehensive instructions were compiled indicating the many conditions where it was necessary to summon a doctor (in all cases of maternal death, any threat of bleeding, the presence of any disease, abnormal position of child, ruptures, and still births).<sup>95</sup> Under the direction of European doctors the culture of midwifery became increasingly bureaucratic. As well as formal training stress was laid on accountability. Names, addresses, fees, and an account of the delivery, type of presentation, sex, dates of attendance, and numbers of confinements were kept in Day Books for ready inspection by Government Medical Officers.<sup>96</sup>

Remuneration for this work was ostensibly decided according to tariffs set by the Medical Board, although in practice midwives had plenty of opportunity to negotiate their own rates. For attending to the confinement and the woman and child morning and evening for nine days after the confinement, the midwife was permitted a fee of \$4.<sup>97</sup> This was \$1 and forty cents less than that charged by doctors. Nevertheless, it was still a substantial sum of money for many poorer women. Recognition of this in government circles led, by 1903, to the introduction of poverty certificates whereby mothers received the benefits of trained midwives for free. This represented another small but significant encroachment of officialdom into the formerly private world of maternity. Poverty

---

91. RSG. AR 1903-04. p. 24.

92. Celia Davies, 'The Health Visitor as Mother's Friend: A woman's place in public health, 1900-1914', Social History of Medicine Vol. 1. 1988. p.43.

93. A. Wear, 'A History of Personal Hygiene', in Bynum and Porter (eds.), Companion Encyclopedia p.1302. For example, see Shang-Jen Li, British Imperial Medicine in the Late Nineteenth-Century China and the Early Career of Patrick Manson (University of London Ph. D thesis 1999). p. 91.

94. Headrick, 'Cities, Sanitation and Segregation' in Headrick Tentacles pp. 145-170.

95. RSG. AR 1903-04. p. 27.

96. *Ibid.* p. 26.

### Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

certificates were only available from accredited agents of the colony: District Medical Officers, managers of estates, Ministers of Religion, chairman of Village Councils, or Poor Law Commissioners.<sup>98</sup>

The official status of nurse-midwives was further enhanced in 1907 and 1909 when extra funds were made available to the colony's medical department to increase the subsidy to midwives to \$16 a month. In addition, they were provided with a free uniform and cloak (shipped to the colony by the Medical Supply Association), given a transport allowance, and supplied with a sign plate for display.<sup>99</sup> In doing this the administration carefully weighed up the costs and benefits of such schemes. Conflicts sometimes arose over the financial expenditure on nurses and midwives, and over the supposed benefits of subsidising midwives.<sup>100</sup> More generally, the overall cost of the colony's medical services drew criticism from elected representatives. For example, in 1908 an editorial by the *Daily Chronicle* described the money spent on hospitals as 'fabulous and extravagant'.<sup>101</sup>

Outside of these bureaucratic and governmental wranglings the government midwife was now clothed to signal her colonial accreditation, her education, and her training. How successful were they? It seems that the experiment in subsidised midwives did not prosper at the outset. Competition from local women who were more thoroughly part of the workings of local culture proved difficult to overcome.<sup>102</sup> The Surgeon General saw in the close bonds which existed between village midwives and expectant mothers one of the main obstacles to better midwifery.

The class of persons on whom these women practise are themselves steeped in the grossest ignorance, and seem to prefer the ignorant and incompetent so-called midwives to those who have been properly trained and qualified.<sup>103</sup>

However, perhaps even more pertinently, the village midwife risked losing her fee, and therefore a part of her livelihood, if the mother chose a government midwife, or used the hospital. In the face of these difficulties, state trained midwives were often unable to sustain a living and resigned. Typical of this was Mrs. C. J. Adamson who was

---

97. *Ibid.* p. 24.

98. *Ibid.* p. 24.

99. RSG. *AR* 1909-10. p. 16. RSG. *AR* 1907-08. p. 15-16.

100. *Daily Chronicle* 26 February 1909. *Argosy* 26 March 1909. *Argosy* 12 November 1908. District midwives were estimated to earn \$40 per month in 1921. Miss Clapham, 'Training', p. 16.

101. *Daily Chronicle* 25 February 1908.

102. Dr. Wallbridge. Mortality Commission. *Argosy* 4 November 1905.

### Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

assigned to Plaisance Village on 1<sup>st</sup> May 1900, but resigned just seven months later, citing competition from existing midwives as the reason. Ironically, it was also revealed that 'a large number of women well known in the district had claimed and been granted certificates under the Ordinance, thus practically reducing her practice to nothing.'<sup>104</sup> The certification and registration of village midwives had strengthened their role in the community making it harder for newcomers to make a living. The experiment was, according to the Surgeon General: 'a failure', although, as I discuss later, nurse-midwives did have more of an impact in Georgetown.<sup>105</sup>

Government attempts to settle nurse-midwives in rural districts continued, but thereafter enthusiasm seems to have waned, and the level of funding was not increased. In 1914 there were only five of these women working outside of Georgetown.<sup>106</sup> On the other hand, as already mentioned, many more village midwives were undergoing training at the Georgetown hospital. This approach was more successful in establishing trained women in rural communities. In 1914 the cause of midwifery was also taken up by a new organisation, the Baby Saving League. Founded with a grant from colonial funds by Lady Egerton, the wife of the colony's Governor, the League aimed to supplement government attempts to educate mothers in mothercraft. One of their first initiatives was to pay for the training of midwives for work in the country districts.

#### 6.6 Georgetown, midwifery, and health visitors

The problem of providing proper midwifery services to the inhabitants of Georgetown also occupied colonial thinking. Georgetown, with an estimated population of over 49,000 in 1903, suffered higher rates of infant mortality compared to the countryside, and as the colony's capital city and seat of government it had a special importance in colonial society. Here, in contrast to the rural districts, the impact of government policy was much more marked. Over a five-year period the authorities adopted many of the municipal strategies of English towns including outdoor nurse-midwives, health visitors, and infant clinics.

---

103. RSG. AR 1903-04. p. 15.

104. Official Gazette 8 June 1901. C.O. 115/92/1380. RSG. AR 1903-04. p. 14.

105. Only nineteen cases were attended by government midwives in 1901-02, at a total cost of \$110, 08 cents, according to the RSG. AR 1903-04. p. 15.

106. RSG. AR 1912-13. p. 18.

### Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

The plan of providing nurse-midwives to mothers in Georgetown originated with the recommendations of the colony's 1905 Mortality Commission. However, it was another three years before the idea was turned into a reality. First it had to be filtered through the colony's various political structures and interest groups. Georgetown's Town Council, while not hostile to the scheme, was reluctant to provide funding.<sup>107</sup> Likewise, the acting Surgeon General, W. F. Law. He wished to run the scheme through 'private charity', or even better, through one of the 'sisterhoods at home' who had experience of working in the slums. In this way, Law argued, 'the question of supervision would not come in'.<sup>108</sup> For the government's part, they too adopted a parsimonious stance. F. M. Hodgson, the Government Secretary questioned Law as to whether it was really 'necessary to pay as much as \$16 a month to each nurse.'<sup>109</sup>

In the event, agreement was reached that just two midwives were to be funded by the government for attending lying-in women within the city of Georgetown, and on the 1<sup>st</sup> August 1908 the midwifery scheme was finally introduced. Godfrey, the current Surgeon General wrote to religious ministers outlining the new service. It was not intended, he emphasised, 'to interfere with women going to the Maternity Ward of the Public Hospital...on the contrary they should be encouraged to go there in preference to calling in one of the nurse-midwives.'<sup>110</sup> The prioritising of hospital births continued. However, those women in 'poor or destitute circumstances' who wished to avoid the hospital could now call upon a qualified midwife. But for those who could afford to pay (judgement of this was often decided by the minister of religion) there was a sliding scale of fees up to five dollars.<sup>111</sup> Further assistance, in the form of maternity bags, was made available for those women with poverty certificates. These bags contained the basic necessities for looking after an infant: sheets, draw-sheets, pillowcases, towels, bedgowns, cotton binders, infant gowns, flannel binders, a number of napkins, and a flannel square. For premature or weak infants, 3 flannel gowns were additionally provided.<sup>112</sup>

---

107. H. D. Belgrave. Acting Town Clerk. Letter to Government Secretary. Argosy 12 November 1908.

108. Law to Gov. Secretary D. Bailey 3 June 1907. Argosy 12 November 1908.

109. Governor to Hodgson 10 March 1908, Argosy 12 November 1908.

110. Circular to ministers of religion 24 July 1908. See Argosy 12 November 1908.

111. *Ibid.*

112. Ada A. Brown. Acting Nurse-Superintendent. RSG. AR 1911-12. p. 41.

### Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

The role fashioned for these outdoor midwives was much wider than providing assistance of the mother at birth. In line with the importance doctors in the colony attached to maternal education, they were also expected to give advice on hygiene and feeding. Their skills seem to have been sought after. By 1909, after the scheme's first full year of operation, Georgetown's two nurse-midwives had directly assisted in seventy home deliveries and undertaken 1,172 visits to pregnant women. (see second column, Table 6.2 on page 210).<sup>113</sup> Nurse Superintendent Cowie considered the arrangements had 'prospered beyond our hopes.' The work of these midwives seems also to have impressed the government, and as a consequence funding was found for two further outdoor nurse-midwife posts.<sup>114</sup>

In 1911 two infant clinics were also established. These ran fortnightly and then, due to their success, twice weekly.<sup>115</sup> Initially, these clinics only provided infant care for women who had given birth at the hospital, however, those born with the assistance of nurse midwives in Georgetown were later included. Therefore, not all women and their children were seen in these clinics, but only those who had fully embraced 'official' midwifery. The clinics were staffed by volunteers, who after 1914, included European women from the Baby Saving League. Mothers were encouraged to bring their infants to the clinic for weighing and to receive instructions on care, feeding, and rearing. The Finsbury authorities of north London provided the formulae for feeds (boiled milk and water with a little sugar, delivered in corked and scalded bottles) in cases where mothers were unable to provide breast milk.<sup>116</sup> By 1913 both of these clinics saw an average of about one hundred children a week.<sup>117</sup> Additional clinics were eventually opened with the help of the Baby Saving League in New Amsterdam and in several of the larger villages and sugar estates.<sup>118</sup> By the 1940s these numbered sixty.

In July 1913, municipal health visitors were introduced into Georgetown. This was shortly after the city adopted an Early Notification of Births Ordinance which allowed a maximum of just thirty-six hours for recording births with the Medical Officer

---

113. RSG. AR 1909-10. p. 16.

114. Ibid. p. 55.

115. Dr. Craigen. BGMA 1913. p. 139.

116. Ibid. p. 140.

117. Ibid. p. 139.

118. Dr. De Freitas, 'Review of the Salient Stages in the Medical History of the Colony from 1900-1944' Timehri p. 63.

### Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

of Health.<sup>119</sup> As with the infant clinics, health visitors, with their card indexes and systems for dividing up the city into districts, were a metropolitan initiative lifted wholesale and transported to the colony. In a similar vein to England (and other European countries) the emphasis was on advice and education, and not on alleviating the material circumstances of the mother.<sup>120</sup> Thus, their chief role was primarily educative, centred around the management of infant care and issues of cleanliness.<sup>121</sup>

The mother's perception of these matters is hard to discern. Was the health visitor an 'intruder' into the household?<sup>122</sup> From an official point of view the visiting went well. For example, in 1914 there were 1,676 live births notified in Georgetown and 1,519 'first visits' to mothers. Therefore, over ninety per cent of mothers saw a trained member of the government's medical staff.<sup>123</sup> What of the 157 births not visited? This is explained, according to the 1914 Public Health Department report, 'by the fact that some parents expressly state that the attentions of Health Visitors are not desired.'<sup>124</sup> Who these mothers (or fathers) were is not stated. However, there may have been an element of discretion due to class and perhaps race, as the following comment from the same report suggests: 'a visit to an infant born of parents who can afford to call a Medical Practitioner whenever necessary would probably be resented.'<sup>125</sup>

What comes through more clearly than the view of mothers is the positive perception of doctors about the role of health visitors. According to Dr. Wishart, who now acted as Georgetown Municipal Health Officer, health visitors were successfully, 'carrying sanitation into the homes of the people.'<sup>126</sup> From this medical perspective the crucial elements of the programme were to combat 'ignorance', encourage the mother to breastfeed, and to see that the infant was properly fed on suitable artificial food. 'The main object', stated Wishart, 'of this visiting and re-visiting is to see that the infant is, if possible, naturally or breast fed.'<sup>127</sup>

---

119. Annual report of the Public Health Department Georgetown 1914. p. 24.

120. See for instance Hilary Marland, 'The Medicalization of Motherhood', in Fildes, Marks, Marland (eds.), *Women and Children First* pp.79-80.

121. Dr. Wishart, 'Infant Welfare in Georgetown: Past Present and Future', *WIMC*. p. 54.

122. For a discussion on London boroughs see L. Marks, *Metropolitan Maternity: Maternal and Infant Welfare Services in Early Twentieth Century London* (Rodopi 1996), chapter 8.

123. Report of the Public Health Department of Georgetown 1914. p. 24.

124. *Ibid.* p. 25.

125. *Ibid.*

126. Dr. Wishart, 'Infant Welfare', p. 54.

127. *Ibid.*

### Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

Ideally, infants were re-visited fortnightly, or more often in cases of illness. Given the ratio of health visitors to births this was quite achievable. In fact, the ratio of health visitors to births was very favourable, even if compared to some London boroughs (see Table 6.1 on page 210). Health visitors also encouraged mothers to attend infant clinics, and pointed out to expectant mothers the advantages of using a certified nurse-midwife from the hospital for assistance during delivery.<sup>128</sup> They also acted as a point of referral, urging women to attend hospital in cases of suspected sickness.<sup>129</sup> Later, when a municipal crèche was established in Georgetown, health visitors recommended to it children of mothers who worked during the day.<sup>130</sup> Another area of work related to illegitimate infants. If the father was ill, absent, or deceased, health visitors contacted the Poor Law Authorities, who had within their power the choice of supporting the child.<sup>131</sup>

These 'public health' measures represented another extension of officialdom into the lives of Georgetown inhabitants. Interestingly, however, health visitors were not English trained nurses (they helped to supervise the scheme) but locally trained nurses drawn from the Georgetown hospital. As with the hospital trained midwife who was sent out into the countryside, this further encroachment of Western medicine into non-European society came in the guise of a colony-born inhabitant. The home visits also complemented a more interventionist stance regarding the city's sanitation. This is looked at more closely in the next chapter but included regular yard inspections, and the handing out of cautions and notices for improvement. Thus, sanitary practices both inside and outside of the home were slowly drawn into a broader vision of public health.

Table 6.2 on the next page shows the expansion of work undertaken by government trained nurse-midwives in Georgetown. In the second column in brackets are the numbers of visits paid to pregnant women in Georgetown.<sup>132</sup> As can be seen in the sixth column the percentage of births in Georgetown associated with the Public Hospital or a nurse-midwife working in the city steadily increased. By 1913-14 more

---

128. *Ibid.* p. 54, 55.

129. Dr. Craigen. *BGMA* 1913. p. 131, 139.

130. Dr. W. Wishart. 'Infant welfare', p. 55.

131. *Ibid.* p. 55.

132. RSG. *AR* 1914-15. p. 16.

**Table. 6.1 Ratio of health visitors to total births**

Place	Date	Number of health visitors	Total births	Per health visitor
Stepney	1911	1	8,464	8,464
Woolwich	1911	3	2,814	938
Hampstead	1921	3	1,342	447
Georgetown	1915	4	1,464	366

Source: Marks Metropolitan p. 172. Annual Report of the Georgetown Public Health Department for 1915.

**Table. 6.2 Percentage of births assisted by government midwives**

Year	No. of deliveries attended by outdoor nurse-midwives	No. of births: Georgetown Public Hospital	Total no. of births in hospital or attended by government nurse-midwife.	Total no. of births registered in Georgetown	Percentage of births associated with Georgetown Public Hospital or outdoor nurse-midwife.
1909-10	70 (1,172)	475	545	1796	30.3%
1910-11	134 (2,872)	492	626	1622	38.5%
1911-12	170 (4,208)	582	752	1746	43.0%
1912-13	256 (5,273)	638	894	1825	48.9%
1913-14	259 (6,225)	615	874	1708	51.1%

Source: Administration reports 1910-11 to 1914-15.

than half of all women in Georgetown were assisted by government trained midwives either at their home or in the hospital.

From these figures we cannot tell whether there was a racial dimension to the use of nurse-midwives. However, a report from 1913-14 suggests that this was likely. In this year there were 295 applications for out-door midwives from Blacks and just eighteen from East Indian women.<sup>133</sup> To put this in context, the ratio of Blacks to East Indians in Georgetown in 1911 was 4.5 to 1.<sup>134</sup> Also Black women certainly used the hospital more than East Indian women, and, therefore, it seems very probable that in Georgetown Black mothers were more receptive to using the nurse-midwife. Possibly, the long enforced experience of adapting to European cultural values and institutions may have meant that Black mothers looked to Western medicine more favourably than the East Indian mother. Either way medical opinion saw the introduction of nurse-midwives, health clinics, and health visitors as a success.<sup>135</sup> Wishart claimed they were now welcomed as 'friends of the home'.<sup>136</sup> The place of medicine in the wider society seemed more secure. Moreover, there appeared to be a significant difference in the infant mortality rate between those infants visited, and those who were not. The general infant mortality rate in Georgetown for 1915 was 228 per 1000, but for those visited the figure was as low as 156.<sup>137</sup> This was still much higher than the worst infant mortality rate for many English metropolitan urban boroughs. For example, by this time London infant mortality rates had declined to below 120 per 1000.<sup>138</sup> Still, it marked a dramatic step in the right direction. Doctors now considered that the British Guiana infant mortality rates compared favourably with other tropical countries. Doctors in the colony hoped that even better results would be soon achieved, although it was doubted that their figures would ever reach those of New Zealand and Australia 'situated as they were in more temperate and healthy localities, and populated with more intelligent and educated people.'<sup>139</sup>

---

133. RSG. AR 1913-14. p. 43.

134. Census of British Guiana for 1911 ("The Argosy" Co. Demerara 1912).

135. Dr. Wishart, 'Infant welfare', p. 53.

136. *Ibid.* p. 55.

137. Dr. Wishart. 'Infant welfare', p. 56.

138. Lara Marks, Metropolitan Maternity p. 90.

139. Dr. Craigen. BGMA 1913. p. 132.

## 6.7 Conclusion

This chapter has attempted to uncover the steps taken by the colonial authorities and doctors to intervene in and alter the management of childbirth in the colony. As we saw in the last chapter discussion about the need for these measures arose in the context of heightened concern about the high rates of infant mortality in the colony. The colony's medical profession offered multicausal explanations for the high infant mortality: disease, poor feeding, maternal ignorance, poverty, and the consequences of immorality. Some or all of these factors were blamed on midwives, who it was said, fostered ignorant and dangerous ante and postnatal practices. Limiting their activities thus became a key aim of administrative policy. To this end, efforts were made to encourage women from Georgetown and New Amsterdam to have their children in the public hospitals. Likewise, the formal training of midwives was initiated, and as in England, a system for registration and certification was instituted.

How successful were these policies? One way of answering this question is to look at the distribution of trained midwives in the colony. In 1893 it was understood that, apart from those working in the Georgetown hospital, there were none in British Guiana.<sup>140</sup> It is also clear that the hospital trained midwives who were sent out to work in rural communities were generally not well received. On the other hand, the number of village midwives who underwent training at the Public Hospital steadily increased, until by 1920 about forty women from country districts were being trained each year in modern English midwifery practices.<sup>141</sup> Perhaps unexpectedly, given the efforts put into training, little direct evidence exists to indicate how these women fared with their new found skills. The extent to which women already practising midwifery may have been influenced by their better trained competitors is also hard to estimate. However, from an official point of view, the problem of the village "Sarah Gamp" remained. Doctors complained that in the smaller and more remote villages it was impossible to stop her activities.<sup>142</sup>

In Georgetown, with its large Public Hospital and maternity ward, the situation was rather different. As Table 6.2 on page 210 shows, a steadily increasing number of women used its facilities. Then, from 1908 onwards two hospital trained nurse-

---

140. *Minutes of the Surgeon General 1893*. p.12.

141. Miss Clapham, 'Training', p. 13.

### Training the Servant Class: Colonial Midwifery in British Guiana 1890-1914

midwives were also deployed to visit mothers in Georgetown to assist in birth. Their activities seem to have met approval – unlike those initially sent from the hospital directly to rural communities. It was also in Georgetown that the initiative for the colony's first Health Clinics and health visitors was started. Therefore, it was the capital, rather than rural communities, which received most administrative and institutional investments in medicine. Nevertheless, despite the influence and presence of European medicine in the capital, some doctors believed that 'Gamps' and 'her vile methods' were still popular amongst some residents.<sup>143</sup> Usually though, there was a sense of medical optimism. According to the GMO Dr. Craigen the 'public' of Georgetown were 'realising that good results can be obtained by rearing children in a proper, scientific and hygienic manner.'<sup>144</sup>

In the colony's discourse of health, practitioners such as Craigen closely associated poverty with ignorance, and by implication, rural life with backwardness. But the connections may have been more imaginary than just. In Georgetown, the 'credibility' of Western bio-medicine, especially amongst Afro-Creole women, seems to have been widespread and growing. In fact, one of the problems faced by the colony was the burgeoning cost of the medical services, partly brought about by the expense of providing free medicines to the city's poor from the colony's dispensaries.<sup>145</sup> Already by the turn of the century it was not uncommon for 200 people to crowd each day around the out-patients' department at the Public Hospital waiting to be seen.<sup>146</sup> Craigen himself relates that the medical profession was somewhat sceptical over the benefits of establishing an infant clinic, and expressed doubts as to whether mothers would bring their children to it. However, after its commencement, he wrote:

We have been agreeably surprised, and each week has seen an increase in the numbers, and now we have 800 on our list and a weekly average of almost a 100 children who are brought to see the doctor.<sup>147</sup>

These urban initiatives were not made available to rural communities on any great scale. Although, mainly through the efforts of the Baby Saving League, infant

---

142. Dr. De Freitas, 'Difficulties of medical practice in country districts', *WIMC* p. 21.

143. Dr. Craigen. *BGMA* 1913. p. 139.

144. Dr. Craigen. *Ibid.* p. 131.

145. *Argosy* 9 December 1909.

146. *Argosy* 21 October 1905.

147. Dr. Craigen. *BGMA* 1913. p. 131, 139.

clinics were gradually opened up in country districts with success. In summary, where facilities were available many women were prepared take advantage of them.

Finally, the development of government midwifery represented a marked widening of the scope of medical provision in the colony. But it is worth noting that this was not unique to British colonialism. For example, in the Dutch East Indies European modes of training and knowledge were also being imported, and a School for Indigenous Midwives was opened in 1898.<sup>148</sup> There too the expansion of 'official' midwifery represented an attempt to orientate mothers towards a Western biosystem of health. In British Guiana this intellectual stance was additionally matched by the privileging of the maternity ward of the Public Hospital, and a particularly vigorous urban campaign to prohibit some and encourage other practices in the home. In short, the officialising and categorising potential of colonial rule was brought in to aid the spread of Western medical power. Ultimately, by reaching into the formerly private sphere of the family, medicine strove to establish a new normative status amongst the colony's inhabitants, and helped push domestic life into the political world. One important aspect of this development lay in contemporary conceptions of colonial society. Fifty years earlier the measure of health in the colony primarily meant the state of fitness of indentured workers on the estates. In 1914 the health of the colony and 'progress' was also measured by an estimation of an infant's chance for survival in the city of Georgetown.

In the next chapter the discussion moves into another area which colony doctors thought had a direct bearing on the rate of infant mortality. This is milk – and its purity. As with the midwifery question European efforts to control and regulate the sale of milk rested upon their power in society and their knowledge about the world. Once again, both of these factors were marshalled to intervene and change the habits and practices of colonial subjects.

-----

---

148. Rosalia Sciortino, 'The multifariousness of nursing in the Netherlands Indies', in Peter Boomgaard, Rosalia Sciortino & Ines Smyth (eds.), Health Care in Java Past and Present (KITLV Press 1996), pp.30-31.

## Chapter 7

### 7.1 Introduction

In the last chapter I showed how Victorian notions of hygiene and cleanliness shaped colonial discussions about midwifery. These ideas were gradually translated into new forms of practice. Evidence of this was to be found in the washed hands and starched uniforms of nurses in the colonial hospital, and by the first decade of the twentieth century, in the bottles of carbolic carried by midwives into the homes of mothers. An important theme of this discourse of cleanliness was the transfer of elite European notions of dirt to non-Europeans.<sup>1</sup> For the colony's medical profession the re-clothing, training and 'disciplining' of midwives was intended to produce a transformation amongst 'native' women about the underlying rules and assumptions concerning matter and bodies, and the appropriate rituals needed to deal with each of these factors. In this chapter the themes of colonial power, cleanliness and the transmission of knowledge is explored by looking at the provision and regulation of milk in Georgetown, and the wider dimensions of developments in public health.

As with midwifery, milk united European and colony inhabitant. Milk brought together diverse perceptions about the nature of the world, the meaning of dirt and the role of washing, scrubbing, isolating, and disinfecting. With midwifery the authorities set about fortifying new normative standards of behaviour by introducing registration and certification. For those women who failed to meet the emerging Western standard of midwifery there were fines and the threat of exclusion. These same bureaucratic measures were brought to bear on the question of milk. But while it seems that by and large the 'bona fide' midwife, having complied with her duty to register was allowed to continue her trade relatively untouched by officialdom, milk sellers were never free from their entanglement with authority.

One reason for this was that milk was easily testable. Milk sellers with their ladles, pots and churns were a visible presence on the streets and plied their trade

---

1. See Mary Douglas, *Purity and Danger. An Analysis of Concepts of Pollution and Taboo* (Routledge 1966), p. 36.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

openly. Yet, this does not entirely explain the persistence with which the authorities in Guiana tackled poor quality milk. The gathering concern in government and amongst the medical profession over Georgetown's high infant mortality rate undoubtedly fuelled official interest in this subject. Milk always had a dual character, it was at once both nourishing and threatening, a wholesome food and the potential conveyer of disease. In addition, unlike midwifery, milk touched many people's lives, the old and the young alike, especially those of the European community. In 1891 sixty-two percent of Europeans resided in Georgetown. The quality and purity of milk was therefore of direct relevance and interest to the most powerful social group in the city.

As examined in chapter five, the Government's interest in mothercraft and the role of milk in infant feeding coincided with similar concerns in Britain and Europe.<sup>2</sup> Elsewhere in the empire where there were other territories with low or recently settled European populations, the question of milk provision also came to occupy colonial thinking, for example Malaya, Australia, and Canada.<sup>3</sup> It is beyond the bounds of this thesis to examine how far the metropolitan centre stimulated this concern in these countries, although it seems that local concerns over population and an 'emerging enthusiasm for public health measures' were a common theme.<sup>4</sup>

Such preoccupations similarly occurred in British Guiana. However, as I go on to argue, the scientific and legislative frameworks which were assembled in England to control milk, also provided suitable models of scientific practice and administrative action for Guianan officials. Notwithstanding this, and although opinions over the purity of milk in Guiana, especially with respect to tubercular cows, were shaped by the state of the scientific debate in Europe, the implementation of legislation was set within the specific social and economic conditions of the colony.

In an article by the historian Juanita de Barros, "To Milk or Not to Milk?", the argument is set out that the authorities in Guiana, prompted by fears to health, attempted

---

2. See Jorg Peter Vogle, Wolfgang Woelk and Silke Fehlemann, 'Decline of the urban penalty: milk supply and infant welfare centres in Germany, 1890s to 1920s', in Sally Sheard and Helen Power, (eds.), *Body and City. Histories of Urban Public Health* (Ashgate 2000).

3. Lenore Manderson, *Sickness* pp. 214-15. Philippa Mein Smith, "'That welfare warfare': sectarianism in infant welfare in Australia, 1918-1939', in Fildes, Marks and Marland (eds.), *Women and Children First* p. 233. Cynthia R. Comacchio. "'The infant soldier': early child welfare efforts in Ontario'. *Ibid.* p. 100, 113.

#### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

to control the milk industry through a sanitarian and racist discourse, the outcome of which was a body of 'repressive legislation' designed to circumscribe the activities of milk vendors.<sup>5</sup> In this chapter I take this valuable idea further by looking at the political and social dynamics of milk regulation, and bring into the picture the 'official presence' on the streets. Here, I want to emphasise that milk legislation was not simply 'handed down' to a pliant population by the authorities (although de Barros does not suggest this) but was the outcome of a series of struggles, sometimes hidden sometimes open, between colony officials and milk producers over the character of the milk trade. The stakes were high, money, profits and livelihoods were involved. Perhaps too, so was governmental and town council prestige.

Milk regulation in early twentieth century Guiana should also be seen as part of a raft of public health initiatives which were developed around this time. These included improvements to water supplies and campaigns against filth and disease. In this chapter I place the administrative actions regarding milk within this expanded framework of public health thinking. Curiously, by bringing forward this larger picture for analysis, and by keeping the focus on milk, the spatial parameters of investigation narrow, and it will become immediately noticeable that the authorities were most concerned about Georgetown, rather than elsewhere. This reflected the urban focus of Europeans. I emphasise this at the beginning of the chapter by looking at the way colonial authorities adjusted to the uncertain political environment after emancipation by gradually refashioning public and private spaces in the city.

Foucault has suggested the importance of architecture in bringing people together and separating them in particular ways, structuring the human world seemingly naturally, and normalising certain sorts of behaviour.<sup>6</sup> In Georgetown, the markets, streets and wharves, and the people and activities associated with them, came under increasing scrutiny towards the end of the nineteenth century. I argue that with

---

4. Smith, 'That welfare warfare', *Ibid.* p. 232.

5. Juanita De Barros, "To Milk or Not to Milk?" Regulation of the Milk Industry in Colonial Georgetown. *The Journal of Caribbean History* Vol. 31. 1997. p. 191.

6. M. Foucault, 'Space, Knowledge and Power', in Paul Rabinow (ed.), *The Foucault Reader* (Penguin 1991). p. 242, 253. See also H. Lefebvre *The Production of Space* (Basil Blackwell, Oxford. 1991), p.73. James A. Delle, *An Archaeology of Social Space. Analyzing Coffee Plantations in Jamaica's Blue Mountains* (Plenum Press 1998).

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

improved sanitation, more systematic street cleaning, pavement laying, lighting and drainage, the sanitary culture of the city was gradually altered, even if, as seems to have been the case, these reforms to the built environment were carried out inconsistently. Moreover, new public spaces were created in the form of public baths and parks. These too, I argue, were established with a view to eliciting specific social responses in keeping with the developing importance of 'public health' and 'civilised' values.

These adjustments to the built environment were matched by equally important legislative changes, such as market regulations and 'no spitting' rules, which sought to secure in law the standards of appropriate civic behaviour. This legislation also helped define the relationship between colonial authority and subject. Thus, in the commercial intersects of Georgetown's streets, municipal authorities and police were garnered with powers to oversee the conditions of trade, exchange, and consumption.

The boundaries of Georgetown were even expanded on occasions to bring within the orbit of the municipal authorities, communities which existed on its physical margins. One such village, which I examine in this chapter, is Albouystown. Lying on the edge of Georgetown it came to represent to municipal authorities a source of sanitary and social disorder. In 1913 Albouystown was incorporated under the city ordinances, whereupon officialdom embarked on a programme of sanitary reform.

These spatial reorganisations and legalistic resources were supported by a range of political, administrative and financial investments, the scale of which was not available to village communities. These also affected how the municipal authorities dealt with milk regulation. By 1904 the production of milk had largely moved from Georgetown to the countryside, well beyond the inspecting powers of the local authority. This chapter explores how municipal officials gradually extended the regulatory regimes they had developed in Georgetown to the countryside. In short, amidst the chronically unsanitary conditions of the village, they attempted to build islands of good sanitary practice in the village dairies that provided milk for Georgetown.

## 7.2 Georgetown and urban reform

The interest in Georgetown (formerly Stabroek under the Dutch) lies not just in the place itself, but in its relationship to the wider world, and to the plantations and the country districts which surrounded it, and were linked to it. Throughout its existence in the nineteenth century, Georgetown was closely associated with networks of trade and information which went well beyond the immediate West Indian island region. The pull of Britain and empire had a significant and lasting impact on Georgetown's development. As the town was the most important point of entry into the colony, the flow of labour and commodities into Guiana, as well as the export of sugar, all took place through its port. However, in taking on this role Georgetown became much more than a junction to the empire and outside world. It was also a site from which people were distributed. The town also collected together, and concentrated into one place, the financial, political, and commercial interests of the colony. The geographers Hohenberg and Lees have theorized cities as:

a central place, supplying its surrounding [areas] with special services – economic, administrative, or cultural – that call for concentration at a point in space.<sup>7</sup>

With regard to Georgetown and the plantations, this analysis draws our attention to the town's vital function in creating, sustaining, and (attempting) to control the diverse social, political, legal, and bureaucratic structures which arched over the colony.

The town itself was built at the point where the Demerara river met the sea. From a small settlement at the turn of the century it grew in population and size until in 1843 it was raised to the rank of city.<sup>8</sup> This growth was haphazard and unplanned, and little attention was paid to the 'look' of the city. Despite the civilising presence of Saint George's Cathedral Church, the settlement attracted few compliments from visitors, being generally deemed rough, squalid, gaudy and commercial.<sup>9</sup> The novelist and traveller, Anthony Trollope, in an otherwise favourable report of the colony from 1860 described the 'best' hotel as a 'rickety, ruined tumbledown wooden house, into which at

---

7. Paul H. Hohenberg and Lyn Hollen Lees, 'The Making of Urban Europe, 1000-1950', (Harvard University Press 1985) in J. Kalala Ngalamulume, City Growth, Health Problems, and Colonial Government Response: Saint-Louis (Senegal), From Mid-Nineteenth Century to the First World War (Michigan State University Ph.D. 1996).

8. James Rodway, The Story of Georgetown (Demerara 1920), p. 56.

#### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

first one absolutely dreads to enter.’<sup>10</sup> For the most part, Georgetown was built out of slavery, and the export of sugar, not civic pride.

Many different types of urban culture existed within the confines of the city. The narrow streets around the wharves, where the ice-house, slaughter-house, market and spirit shops clustered, drew crowds of traders, black servants, immigrants, hawkers, ‘coolie’ porters, clerks, sailors, fruit girls, ginger-beer women, and milk sellers. Loosely arrayed behind this turbulent market and mercantile area were the political, administrative, banking and insurance centres of the colony, run by and for Europeans. This included the old Court House, which in 1806 was ‘an old tottering building, supported by poles’, with ‘decayed’ and ‘rotten’ flooring.<sup>11</sup>

The decrepitude of civic buildings was characteristic of the period under slavery when there were no police or magistrates. At this time, the administration of justice was for the most part carried out in the plantation, the basic unit of social structure in the colony, the plantation. With emancipation this changed, and so too did the attitude towards administrative buildings. Notably, some of the first significant post-emancipation buildings erected in Georgetown were those concerned with maintaining order: the police magistrates office, the police station, and new law courts.<sup>12</sup> Later in the century church building began in earnest, a proper post office building was established, and a town hall and Government House were built. As each of these layers of colonial rule and bureaucratic organisation were added to Georgetown, the city emerged as a distinctly Victorian enterprise, but one situated in the tropics with special topographical features. This can be seen in the unique way that the city’s buildings were plotted along a grid-like design.

Georgetown’s regular street pattern was due to the requirements of drainage, rather than from any aesthetic legacy derived from its former masters, the Dutch. Rich and poor alike had to take account of these matters. The galleried and pillared residences of Europeans and merchants, and the ‘shanties’ of the colony poor, were thus

---

9. Rodway, *Story* pp. 3-4.

10. Anthony Trollope, *The West Indies and the Spanish Main* (Dawsons of Pall Mall 1968), p. 66.

11. Rodway, *Story* p. 103.

12. *Ibid.* p. 113.

#### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

shuffled in between the dams and open trenches, and along the lines of river canals which crossed back and forth through Georgetown on their way to the sea.

As with plantations, these hydraulic mechanisms were necessary to protect the city from flooding, since at high tides Georgetown was some four feet below sea level, and like the rest of the colony was subject to high rainfalls. Canals served dual purposes, they brought fresh but 'peaty water with a slight inky flavour' into the city, and carried away the city's waste and storm waters.<sup>13</sup> Needless to say, they gained a reputation for being choked with refuse and flooding.<sup>14</sup>

Canals also provided water for fighting fire. In dry seasons Georgetown's wooden construction was particularly vulnerable to the accidental upsetting of a lamp, or from ignited spirits. Besides wider political questions, it was the sudden destructive eruption of fire more than anything else which seems to have animated most discussion amongst town officials. Two fires, one in 1828 and 1864, laid waste to large areas of the mercantile district.<sup>15</sup> The fear of fire, as much as the need for fresh water, spurred efforts to improve the city's water supply.

Over the years, as plantations adjacent to Georgetown fell into disuse, they too were colonised by the poor who steadily migrated to the city attracted by the possibilities of work. The criss-cross patterns of drainage established for growing sugar seemingly provided an ideal way for property owners to parcel out land on lease. On occasions the fourteen member Town Council was prompted to 'incorporate' into the city these surrounding villages in the making. There was good reason for this. James Rodway, writing at the turn of the century cited fears about poor sanitation, the threat of disease and flooding from these outlying areas.<sup>16</sup> In fact, anecdotal descriptions indicate that habits of sanitation were barely any better within city limits.<sup>17</sup> The Town Council was not unaware of this. In 1848 it initiated, for example, a commission to enquire into the sanitary state of Georgetown. One contentious issue, revealing of contemporary priorities, was whether Lot (a parcel of land) owners should be obliged to pay for the

---

13. 'Water Supply of Georgetown', West Indian Quarterly No. 4. April 1888.

14. Rodway, Story. p. 3.

15. *Ibid.* pp. 62-68.

16. *Ibid.* pp. 219, 220.

17. Dr. Daniel Blair, Some Account of the last Yellow Fever Epidemic of British Guiana (Longman 1850). Preface.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

maintenance of their drainage in a similar way to which they had to fund precautions against fire.<sup>18</sup>

From the mid 1860s onwards Georgetown began acquiring many of the features which Victorian 'progress' and civic pride demanded. This included new legislation providing for the sanitary superintendence of the city, and a much expanded town administration. The posts of Civil Engineer, Overseer of Public Works, Sanitary Inspector (later the Town Superintendent), Inspectors of Nuisances and city Health Officer were permanently established. The Town Superintendent's annual report began charting the 'material progress' and 'improvement' of Georgetown. One practical outcome of these changes is evident in the provision of public water tanks in 1860 (issued at half cent per gallon)<sup>19</sup> and the laying of street mains in 1866, closely followed by the appearance of public baths and drinking fountains. By 1915 there were an estimated fifty miles of piped water in the city.<sup>20</sup>

Although the modernising vision of town officials should not be exaggerated, other technological innovations were also quickly adapted for the colony. In 1871 gas arrived, at which time the old kerosene street lamps were superseded. Electric light then replaced gas in the early 1890s. Just after the turn of the century the first electric trams started running along Main Street.<sup>21</sup>

With the Town Superintendent's post firmly established, the 1870s saw greater attention being paid to matters of sanitation. In many ways, Town Council officials mirrored medical and public health sentiment at home in Britain. Thus, in the offensive smells of drains and trenches they discovered the causes of ill-health. This, in itself was not new, bad smells or miasmas were long associated with ill-health. What was changing was that within the burgeoning population of Georgetown, the sanitary practices of individuals increasingly drew opprobrium from European elites. The 'stench' of Georgetown became a suitable subject for complaint and discussion. By all accounts it was the habit of individuals to 'creep out' at night to empty their slops into

---

18. C.O. 111/254/354.

19. 'Water Supply of Georgetown', *West Indian Quarterly* No. 4. April 1888.

20. Luke M. Hill, 'The Municipality of Georgetown', *Timehri*. 1915. Vol. III. p.230.

21. *Ibid.* p. 233.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

the nearest drain or canal instead of using cesspools or specially built privies.<sup>22</sup> For example, one letter to the *Daily Chronicle* in 1883 objected that:

Excretal matter...is regularly thrown into one of the main trenches in Charleston to such an extent as to create, at certain times of the day a 'knock-down' stench which cannot but be detrimental to the health of the residents.<sup>23</sup>

Besides overseeing drainage there were other difficulties that the Sanitary Department faced. The number of animal and bird carcasses that clogged up ditches, decomposed under the sun, and needed to be quickly dragged out and eliminated seemed to increase every year. In 1881 the sanitary department offered a precise breakdown of what it had collected for disposal: 4,470 fowls, 1,032 dogs, 716 cats, 482 ducks, 244 pigeons, 90 goats, 67 turkeys, 28 parrots, 20 pigs, 11 cows, 9 sheep, 6 Guinea pigs, 5 Guinea birds, 3 rabbits, 2 carrion crows, 1 accourie (opossum), 1 alligator, 1 mule and 1 horse.<sup>24</sup>

The problem of drainage, largely brought about by the city's steadily growing population, led to demands that the city's sanitary department undertake a more interventionist role. As a leader in the *Daily Chronicle* argued in 1882, 'the disposal of excremental matter, which is at present obligatory on the lot owner, should be undertaken by the municipal authorities, the same as is done in all the large cities and towns of the United Kingdom.' It went on to attack the Council for its 'apathy'.<sup>25</sup> Apathy aside, disagreements over policy, and a lack of funds blunted the effectiveness of the council's work, and each year proposed improvements were abandoned or left incomplete. Nevertheless, by the turn of the century the city was making constant use of a furnace to burn rubbish, had embarked on a programme of concreting drains, and deployed four 'Odourless Excavators' to drain cesspools. In addition, Government institutions, a number of private dwellings and the Werk-en-Rust district used the 'pail' system for which a special rate was levied.<sup>26</sup>

There were other significant areas of change in the built environment, for example the erection of a new market building, and just as importantly, new regulations designed

---

22. Leader. *Daily Chronicle* 14 September 1883.

23. Ibid.

24. Town Superintendent's Report 1882. *Argosy* 4 March 1882.

25. *Daily Chronicle* 19 September 1883.

26. Town Superintendent's Annual Report 1904.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

to safeguard the quality of food on sale there. The replaced market was designed as a model of hygienic efficiency, complete with gutters, discharge pipes and concrete paving. Under its vast awning twenty-six Bray Patent Globe lanterns lit the activities of the assembled meat, fish and vegetable sellers.<sup>27</sup> These lights were another tangible (and perhaps metaphoric) expression of how the colonial Government and Town Council was nudging its way into the lives of ordinary people.

However, the market was only one of a number of architectural initiatives from around this time. Earlier projects, which indicate that colonial authorities were thinking about the management of urban space, and indeed were striving to materialise their vision of what a city should be from early on, included opening a museum to the public (1870), and the building of an Alms House (1874).<sup>28</sup> The Alms house in particular proved to be a heavy financial burden. By the early twentieth century, according to the Surgeon General, Godfrey, it was a ‘huge incurable hospital, a home for “the dying”’.<sup>29</sup> However, there was no sense of irony when in 1908 it was announced with a view to economising, that the inmates were to be employed in coffin making.<sup>30</sup>

Arguably, both the Alms House and Museum were not just functional institutions, but served to promote a particular view of colonial society as something that was ideally in the image of the metropole. In this sense they had a moral purpose. They were proper institutions for a modern society. So too were the gardens, fountains, bandstands and statues that the authorities (like many of their colonial counterparts) set about providing.<sup>31</sup> A promenade garden for contemplating nature had been established in 1853, but it was not until 1870 that the ornamental planting of streets began. Seven years later the recreational spaces of Georgetown were further extended with the establishment of an ‘Ideal Wild Garden’ or botanical garden.<sup>32</sup>

What did these changes to Georgetown mean? For a clue we can turn to *Timehri*, a journal dedicated to examining the cultural and natural products of the colony. In an article on Georgetown’s architecture the Reverend Scoles explained how important is

---

27. Luke Hill, *Argosy* 4 March 1882.

28. Rodway, *Story* p. 197, 111.

29. Leader, *Argosy* 9 December 1908.

30. *Ibid.*

31. Drayton, *Nature’s Government* pp. 180-183.

32. Rodway, *Story* p. 234, 238.

## Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

was to 'raise the mob', to help them 'look up, learn and admire.'<sup>33</sup> Public spaces were thus carefully crafted to foster admiration of European culture and motivate improving forms of behaviour. The special place of the capital city in colonial life was stressed by Luke Hill, the Town Superintendent:

The principal port and capital of a tropical colony stands upon a somewhat different footing from other towns. Most of the imports and exports pass through it. It is the main inlet and outlet of the trade of the colony, the chief seat of revenue as well as the headquarters of Government. Its local concerns are more than local interest, and the well being of *the capital* is largely identical with the well being of *the colony as a whole*.<sup>34</sup>

It is through this 'improving' background of urban reform, sanitary action and 'public health', which I have set out above, that I want to locate the regulation of milk.

### 7.3 Food adulteration, testing and the Government Laboratory

In Britain in the 1850s the powers of the microscope and chemistry were turned towards the examination of food. Several 'exposés' and Parliamentary Committees later, the 1875 Sale of Food and Drugs Act was introduced.<sup>35</sup> In Guiana official concern over the quality of food did not find expression in specific legislation until 1882.<sup>36</sup> The key sections of Guiana's Sale of Food and Drugs Ordinance dealt with the mixing, colouring and staining of food substances. These were simply lifted from the British Act and transferred wholesale to the colony. However, initially at least, the sight of city officials seizing goods at the market must have been most unusual as prosecutions were rare.

Proof of the Ordinance's ineffectiveness was revealed in 1890 when the Town Council and Police Department briefly collaborated to seize and examine milk, butter and ghee. The majority of items tested turned out to be adulterated in one form or another. There was no consistency to this action, and a return to more routine matters followed these short-lived bursts of municipal activity. The legislation surrounding the

---

33. The Reverend Scales, 'The Architecture of Georgetown', *Timehri*. Vol. 4. 1886. p. 85.

34. Original italics. Annual Report 1906. p. 3.

35. Arthur Hill Hassall, *Food: Its Adulterations, and the Methods for their Detection* (Longmans 1876), p. 833, 873. See also Anne Hardy, 'Food, Hygiene, and the Laboratory. A Short History of Food Poisoning in Britain, circa 1850-1950', *Social History of Medicine* Vol. 12. No. 2 1999. pp. 293-311.

36. C. O. 113/7. Ordinance No. 11. 1882. To make provision for the Sale of Food and Drugs in a Pure State.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

sale of food was refined in 1892, but again, the practical effects of this were not sustained.<sup>37</sup> The colony's analytical chemist and head of the Government Laboratory complained of the 'spasmodic' way that legislation was applied by the municipal authorities.<sup>38</sup> In the new century the purchase of food was guided, as it had been in the past, by individual judgement (*caveat emptor*) rather than by official regulation.

This gap between legislative intent and practical activity was characteristic of colonial rule in Guiana. One of the stumbling blocks which hampered an effective approach to milk regulation was the lack of co-ordination between official bodies. The bureaucratic arrangements which were set up to test the quality of imported food stuffs (this was crucial in order to levy duty and provide a stream of revenue for government) seem not to have been extended to the city administration. Within the colonial order 'European rule' covered a considerable diversity of interests, and, for example, the relationship between the Town Council and the colony Government was not always cordial. The new century saw both of these parties embroiled in complex and acrimonious court proceedings over the power to appoint city personnel, land titles and rate setting.<sup>39</sup> Council officials, for their part, complained that the services of the laboratory, which was increasingly having to meet the needs of the Government Botanist and mining interests, were not made available to them.<sup>40</sup> This lack of co-ordination at a higher level was reflected on the streets of Georgetown by fewer and fewer prosecutions for adulterated milk.<sup>41</sup> By 1904 the *Argosy* newspaper described the Town Council and laboratory as at 'loggerheads'.<sup>42</sup> It was not until 1905, after the direct intervention of the Governor, that the laboratory and Town Council established a proper working relationship.

However, the paralysis over milk regulation had deeper roots. In addition to co-ordination between the Town Council and government bodies, the proper regulation of milk required extensive human resources, such as city officers, police and the courts.

---

37. Ordinance No. 11. 1892. Initially though the legislation seems to have boosted the activity of town officials. See *Daily Chronicle* 5, 18 October 1892.

38. Report of the Government laboratory. *AR* 1892-93.

39. Hill, 'Municipality', p. 229.

40. *Argosy* 26 July 1905.

41. Between 1903-04 and 1900-01 fines for adulterated milk plummeted from \$901 to \$564. Report of the Government Analyst. *AR* 1903-04. p. 5. Report of the Government Analyst. *AR* 1900-01. p. 5.

#### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

Prosecution was also an expensive and time consuming business, not least because milk-sellers sometimes hired lawyers to defend themselves.<sup>43</sup> As late as 1909 the Town Superintendent was complaining that over half of all prosecutions were unsuccessful due to failures of service by bailiffs and police.<sup>44</sup>

More importantly still, the Town Council had no authority beyond the city, as was the case in England.<sup>45</sup> This factor became increasingly important after 1900, when it became mandatory for city dairies to register with the Town Council.<sup>46</sup> Unfortunately for city officials, this registry requirement unintentionally resulted in many dairies moving to new areas, just outside of city limits, and beyond the interference of prying officials.<sup>47</sup> In the summer of 1905, when the Mortality Commission started to examine the causes of general and infant mortality, the control of the milk trade by Town Council officials was still a long way off.

#### 7.4 Production and consumption: milk, the countryside and Georgetown

To discuss the production of milk is to shift the focus from Georgetown to the villages. In doing this we not only enlarge the geographical scope for analysing milk, but move from one social and political space to another. In many ways villages shared the same physical environment as plantations and towns. However, there the similarities end. Although villages provided a ready pool of labour to the plantations, and were, therefore, active players in the larger economy, they were nevertheless profoundly disadvantaged economically. Village society was not a place where great wealth accumulated. Politically too, villages carried little weight in colonial society. The contrast with neighbouring plantations, for whom the political structures of the colony were designed to favour, could not, therefore, have been more stark.

Although successive governing administrations professed the need to 'develop' the rural economy, and were particularly keen to encourage the settlement of East

---

42. *Argosy* 11 October 1905.

43. *Argosy* 26 March 1904, 15 November 1908, 12 December 1908.

44. *Daily Chronicle* 11 March 1909.

45. P. J. Atkins, 'White Poison? The Social Consequences of Milk Consumption, 1850-1930', *Social History of Medicine* 1992 Vol. 5. p. 211.

46. *Official Gazette* August 1900.

47. *Argosy* 12 March 1904, 14 October 1905, 25 October 1905.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

Indians, the policies adopted frustrated rather than nurtured village endeavour. First of all, ruinous rates of interest prevented capital flowing into villages. Secondly, the system of land sales encouraged the fragmentation of production in small individual plots rather than jointly run enterprises. For example, in 1871 the village of Bagotville contained 37½ acre plots and 400 quarter acre plots.<sup>48</sup> Drainage of this patchwork system required the involvement and co-operation of each landowner, which was often impossible to achieve. Also, providing proper sea defences and maintenance of kokers and sluices required time, knowledge, capital, and just as importantly, the existence of local political structures to oversee these necessities. However, the growth of politically independent communities was not something any government was prepared to counter.<sup>49</sup>

The 'collapse' of villagers into apathy and despair was noticed by officials and produced much hand wringing, but little in the way of practical help. In 1879 the attorney general pointed out that the colony was more than just a 'sugar factory', and went on to express the Government's commitment to villagers by promising to undertake ambitious 'large scale' land drainage along the sea coast.<sup>50</sup> Typically, very little came of this reforming enthusiasm, primarily due to the continued and determined opposition of planters, who frustrated attempts to devote public funds to what they considered private responsibilities.

The organisation responsible for supervising public works in the villages was the Central Board of Health (later the Local Government Board). This body oversaw the administrative compartmentalisation of the colony into three distinct sanitary categories: town, village and country. It had powers to compel district bodies and individual owners to improve drainage, construct dams and maintain roads.<sup>51</sup> Village improvements were meant to take place through the collection of rates and from government loans (at preferential rates). However, the capital raised was rarely enough to benefit more than a fortunate few villages. According to one historian: 'The balance

---

48. Adamson, *Sugar* p. 63.

49. Moore, *Race* pp. 118-120

50. Adamson, *Sugar* p. 88.

51. Moore, *Race* pp. 93-107.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

of evidence suggests that most villages continued to exist in the miasmal stagnancy they had endured for decades.<sup>52</sup>

In the villages themselves, throughout the latter half of the nineteenth century, conditions of life remained difficult, and from a health perspective dangerous, although there was some significant population growth.<sup>53</sup> As discussed in chapter four, the rate of infant mortality in the countryside was estimated to be considerably lower than that of Georgetown or New Amsterdam. This was despite the fact that many villages suffered from chronic flooding, that malaria was endemic, and sanitation was poor. The quality of sanitation can be inferred from the high rates of ankylostomiasis infection amongst villagers. In 1915, when the International Health Commission undertook a project to eradicate the disease in the rural *Belle Vue* district, they examined the faeces of the entire village population of 11,943 people. Over sixty-three percent were found to be infected with *Ankylostomum Duodenale*.<sup>54</sup>

Obtaining safe drinking water was another problem. Unlike on the estates, village drinking water was usually hauled out of the nearest 'sweet water' trench, and was thus always liable to fouling from humans and animals. In the twentieth century, Local Authority regulations elaborately detailed the responsibility of building owners to erect tanks for water storage, but as Dr. Ozzard commented in 1910, 'I know of none.'<sup>55</sup> He went on to remark that government initiatives for improving villages tended to founder due to a lack of political drive. 'Laws', he said, 'become a matter of a few days wonder, and are then allowed to sink into oblivion.'<sup>56</sup> Elite perceptions of village life are well summarised by this description from a 'country curate' from 1866, 'everywhere dirt, filth and neglect.'<sup>57</sup>

It was from villages like these, strung out along the coast and by the side of rivers, that each day dozens of hawkers set off to Georgetown on foot or by boat with their

---

52. Adamson, *Sugar* p. 92.

53. The 1891 census gave a total village population of 125, 757 compared to 59, 601 in 1861. Adamson, *Sugar* p. 59. Carl A. Braithwaite, 'The African-Guyanese Demographic Transition: An Analysis of Growth Trends, 1838-1988', in McGowan, Rose and Granger (eds.), *Themes in African-Guyanese History* pp. 206-207.

54. F. E. Field, 'Report on the Amelioration and Control of Ankylostomiasis', *BGMA* 1915. p. 56.

55. Dr. Ozzard, 'Village sanitation in British Guiana', *BGMA* 1910. p. 36.

56. *Ibid.* p. 39.

57. *Colonist* 30 May 1866, in Moore, *Culture* p. 6, 86.

#### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

milk supplies.<sup>58</sup> Most milk producers were small family traders, mainly East Indian families with one or two cows which, 'roamed the rough pastures and abandoned estates in a practically wild manner.'<sup>59</sup> Of 213 byres inspected in various rural districts in 1911, the vast majority, 197, had four cows or less. Amidst these small producers some larger scale milk production took place. Estates managers sometimes kept a small herd of cows from which they supplied surrounding plantations and hospitals.<sup>60</sup> Milk generally arrived in Georgetown at around six am each morning along with other provisions brought in for the markets.<sup>61</sup> The colony's veterinary surgeon estimated that well over 1,000 gallons of milk per day were supplied to the city from nearby localities and from outlying districts.<sup>62</sup>

Once in the town, hawkers moved from street to street selling their milk or delivered it directly to homes. This work was often carried out by East Indian women, and as De Barros has shown, it was a profitable trade shared out amongst close-knit kin networks. Although these social connections were largely invisible, it is clear that underneath European rule traditional forms of family and communal loyalty ran strongly in some communities. Milk usually sold for between three and four cents a pint on the street, or was sold in the form of 'Bub', which was milk mixed with a little nutmeg, syrup and ice.<sup>63</sup> Either way, returns were enormously enhanced if scoops of trench water were added.<sup>64</sup>

Milk sellers were also known as prominent money lenders, with a reputation for bribery, and for securing appointments from local officials for relatives in areas such as scavenging, water cart driving, and night soil conservancy.<sup>65</sup> The powerful effect of this influence may be seen in the racial composition of street cleaning gangs. In 1906, not a

---

58. Report of the Mortality Commission (RMC). BGMA 1906. p.31. See also Argosy 26 September 1906. E. P. Minett, 'Protection of the Milk Supply in British Guiana', The Journal of the London School of Tropical Medicine Vol. 1. 1911-12. p. 217.

59. Ibid.

60. K.S. Wise, 'Review of the Milk Question in British Guiana', Journal of the Royal Sanitary Institute. Colonial Supplement October 1912. p. 75.

61. K. S. Wise, and E. P. Minette, 'Review of the Milk Question in British Guiana', BGMA 1911. p.48. See also Daily Chronicle 25 November 1905. Argosy 7, 8 January 1913.

62. Argosy 17 November 1906.

63. Georgetown Vignettes (Daily Chronicle 1917), p. 9.

64. Argosy 25 January 1905. See also Daily Chronicle 25 November 1905, 28 January 1908. Argosy 27 September 1905.

65. Georgetown Vignettes. p. 91. Juanita De Barros, Purity and Filth. See also Argosy 14 March 1906.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

single Black labourer was employed in any of the city's sanitary gangs, despite the fact that they made up the majority of Georgetown's population.<sup>66</sup> The police were also suspected of colluding with milk sellers by skimming the richer surface milk for analysis in return for small payments.<sup>67</sup> Even a small amount of money would have made a significant monetary difference to a 'third class' ordinary constable who earned little more than \$4 per week.<sup>68</sup> Amongst the upper echelons of society, appointments were guided by favouritism, family connections and social standing.<sup>69</sup> So perhaps it is not surprising that despite the promoted ethics of 'public service' the corrosive effects of low wages made poorly paid officials extremely vulnerable to the corrupting practices of city traders, milk sellers, and the 'profiteering' 'wily coolie'.<sup>70</sup>

Thus, through a combination of systemic low level corruption, and administrative inaction, milk adulteration proliferated in Georgetown. In February 1905 the Central Board of Health claimed that 'the standards of purity of milk - especially in Georgetown - have continued to fall and have never been so low since the half year ended in June 1901.'<sup>71</sup> Similarly, Luke Hill, the Town Superintendent, estimated that fifty-nine percent of milk sold in Georgetown was adulterated.<sup>72</sup>

Alongside this commercial activity there was also anxiety about Georgetown's infant mortality rate. The year 1905 saw levels of infant mortality in the city once again reach 300 per 1000 registered births. And once again the general death rate of the city exceeded the birth rate, as it had done for each of the past five years. The Health Officer, Dr. W. Wishart commented that the colony should, 'face the possibility of its population some day reaching vanishing point.'<sup>73</sup> The Report of the 1905 Mortality Commission hammered home the 'paramount importance' of achieving supplies of unadulterated and *uncontaminated* milk for Georgetown residents.<sup>74</sup> High infant mortality, the Report repeated, was not unconnected with, '...the difficulty and expense

---

66. Leader. *Argosy* 14 March 1906.

67. *Argosy* 7, 11, 21 October 1905.

68. Georgetown Town Council Meeting. *Daily Chronicle* 24 March 1908.

69. Moore, *Race* p. 124.

70. *Argosy* 11 October 1905.

71. Report of the Central Board of Health. *Argosy* 18 February 1905. See also *Argosy* 14 June 1905.

72. *Argosy* 26 July 1905.

73. Dr. Wishart. Health Officers Report 1906. p. 4.

74. RMC. *BGMA* 1906. p. 31.

## Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

attendant on obtaining supplies of pure milk',<sup>75</sup> a stance which also reflected the official position on milk in England.<sup>76</sup>

### 7.5 The politics of disease management: Georgetown and plantations

One of the effects of the Commission seems to have been to stimulate a number of reforming moves designed to lessen the impact of disease in the city. First of all, in 1905, the colony's administration (perhaps belatedly) sought out the services of a bacteriologist, and opened up a properly equipped bacteriological laboratory.<sup>77</sup> Secondly, officials began to discuss the possibility of widening the extraordinarily narrow city franchise. Less than one per-cent of city inhabitants were entitled to vote in 1907.<sup>78</sup> The *Argosy* hoped that a move in this direction would produce a 'more lively interest' by property owners in their responsibilities.<sup>79</sup> In the same year the Surgeon General helped to establish a *Society for the Prevention and Treatment of Tuberculosis* and a dispensary for treating the disease.<sup>80</sup> The public health campaigns were shaped by their location and the historical context in which they were undertaken. The campaign to eradicate malaria exemplifies this, and shows that public health action was far more effectively carried out in the plantations than in Georgetown.

Earlier in the century canals had been laboriously dug by slave labour to improve the city's health, and for the same reasons many of them were now filled in.<sup>81</sup> They were now seen as reservoirs for transmitting malarial infection. Filling in the canals reflected the impressive influence of the new malarial theory, transforming it from a disease of the soil and bad air, to something spread through the bite of a mosquito.<sup>82</sup> Acceptance of the theory also lent new meanings to dirt, disorder and, with regard to the crowded environs of Georgetown, to elite ideas of social responsibility. Untended flower beds, spilt water, pools, broken bottles and discarded tin pots became not only

---

75. *Ibid.* p. 30.

76. Atkins, 'White Poison', p. 219.

77. RSG. *AR* 1905-06, p. 28.

78. Clementi, *Constitutional* p. 132.

79. *Argosy* 14 March 1906.

80. Town Superintendent's Annual Report 1907. p. 3.

81. Dr. Wishart, 'Some Aspects of the Sanitary and Public Health Problems of Georgetown', *WIMC* p.65.

#### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

recognised as opportunities for mosquitoes to breed, but also as signs of household ignorance.

Safety from malaria, from a European point of view, seemed to lie in separation. The houses of Europeans, Dr. Ozzard had advised some years earlier, 'should be as far as possible away from native huts.'<sup>83</sup> However, in the confines of Georgetown, forming exclusive social enclaves was never a practical solution to avoiding disease. The patterns of drainage and sanitation traversing the city brought the effluent from one area through to the next. Although Georgetown had distinctive racial contours it was still a shared space, thus diminishing the role of individual solutions to the spread of disease or the management of waste. As Ozzard also observed: 'In a crowded community obviously the co-operation of the people is necessary.'<sup>84</sup>

Co-operation or not, new legislation soon emerged. With respect to malaria the screening of water storage vats was made compulsory in 1907 for Georgetown residents. Yet subsequent reports suggest that this seemingly simple task was fraught with problems, pointing to the uneven way that doctors realised their medical goals, and the absence of a uniform 'official' view over the Georgetown environment. Not all councillors, and presumably others too, subscribed to the mosquito theory of malarial infection. On the contrary, and as late as 1910, mosquito larvae were still seen as desirable for their ability to purify water.<sup>85</sup> Wishart, the Medical Officer of Health, complained that the screening of vats was ineffective, inspections were infrequent, and prosecutions of householders few. A similar situation, as De Barros has shown, dogged the sanitary department. Each month officials inspected buildings and privies. These visits were duly recorded in the official statistics (48,002 inspections in 1907) and suggest a department of great energy, but as with the malaria ordinance, few

---

82. M. Worboys, 'From miasmas to germs: malaria 1850-1879', *Parassitologia* August 1994. Vol. 36. pp. 61-68.

83. Dr. Ozzard, 'The Mosquito and Malaria', *BGMA* 1902. pp. 37-38.

84. *Ibid.* p. 37. See also Philip D. Curtin, 'Medical Knowledge and Urban Planning in Tropical Africa', *American Historical Review* Vol. 90 (1985), pp. 594-613.

85. Leader. *The Weekly Argosy* 25 April 1908. Leader. *Argosy* 10 March 1910.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

prosecutions resulted.<sup>86</sup> This was despite the council receiving petitions about overflowing privies.<sup>87</sup>

Beyond the rhetoric of sanitary improvement action was inconsistent and municipal politicians sometimes showed indifference to the issue. In 1910 the *Argosy* attacked the council for its 'smug satisfaction' over the 'stink-holes' of Georgetown.<sup>88</sup> Wishart, for his part, urged an 'anti-mosquito campaign' for the 'common good' and for the 'benefit of the whole community', but was constantly thwarted by the machinations of local politics and financial parsimony.<sup>89</sup> It was not until 1911 that the numbers of deaths from malaria in Georgetown began to show a consistent decline from the disease.<sup>90</sup>

Wishart's Georgetown experience usefully underlines the different possibilities of action that were created according to *where* medicine was located. The advantages of 'indenture and discipline' to 'freedom and no indenture' were commented upon by doctors and seemed to be reflected in the mortality statistics which consistently showed a lower death rate for indentured labourers.<sup>91</sup> The institutional framework of plantation life provided an ideal environment for disease reduction 'programmes', although here too in practice, the ambition of doctors was often frustrated by the power wielded by managers, and by the realities of financial stringency. Nevertheless, the contrast between the campaign against malaria which unfolded on the plantations to the situation in Georgetown is plain.

As we saw in chapter three, malaria was the cause of very high numbers of labourers attending the plantation hospital. The following statistics show the extent to which the disease was diagnosed, and by implication the level of mosquito infestation on estates and nearby villages. In 1900 the estate population was just under 69,000. In the same year 44,076 cases of malarial fever were treated in the estates' hospitals.<sup>92</sup>

---

86. There were only five prosecutions in 1907. *The Weekly Argosy* 16 June 1908.

87. Juanita De Barros, 'Colonialism and Public Health in the Tropics' Unpublished paper presented at 'Colonialism and Public Health in the Tropics' York University June 18-19 1999.

88. Leader. *Argosy* 2 March 1910.

89. Dr. Wishart. Report of the Medical Officer of Health. 1911. pp. 37-38.

90. Report of the Public Health Department. p.34.

91. In fact, the population groups were different and not strictly comparable. Leader. *Argosy* 9 December 1908.

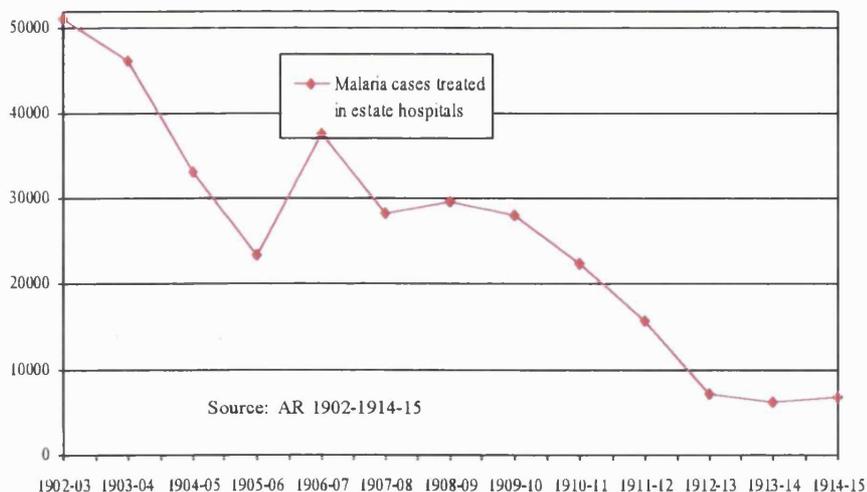
92. RIAG. *AR* 1901-02. p. 20.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

When the Government Medical Officer, Dr. Von Winckler examined the spleens of children on the *Ogle* estates, he estimated that ninety-five percent were distended, pointing to chronic levels of malarial infection. Doctors at the turn of the century had a bleak view about their chances of reversing this situation, as Winkler himself commented, ‘to try and stamp out malaria in this colony by either medicine or sanitary measures is almost as hopeless as has been proved to be the case in Africa.’<sup>93</sup>

Initial efforts to combat malarial infection on the estates centred on identifying the breeding grounds believed suitable for *Anopholes*. In accordance with the recommendations which Ronald Ross had publicised in *Mosquito Brigades*, managers of estates were encouraged to embark upon drainage schemes, oiling water, and general clearances of rubbish. The graph below (Fig. 7.1) suggests that these measures were effective. From 1902-03 there was a steady decline in admissions to estate hospitals for malaria (apart from 1906-07), until by 1912 when the number of cases began to flatten out.<sup>94</sup> The year 1909 also saw most estates adopt the prophylactic use of quinine.

**Fig. 7.1 Malarial infection in estates’ hospitals 1902-1914**



Quinine was supplied to estates by the government at cost, indicating the continued close involvement of government with the workings and organisation of the plantation system. The GMO Dr. Ferguson described how the ‘machinery’ of the estate

93. RSG. AR 1900-01. p.55.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

hierarchy was made available and marshalled to distribute quinine. First managers divided the accommodation ranges in their 'nigger yards' among the drivers. Each driver was then supplied with two lists, one containing the names of those with normal spleens, the other, those with enlarged spleens. The former were given a weekly dose of five grains and the latter were given a daily dose. Drivers were supervised by the plantation sick-nurse. As Ferguson then commented: 'the results of the periodic splenic censuses show which of the drivers distribute the quinine carefully, and which of them shirk their work.'<sup>95</sup>

In fact, the pink quinine tablets given out on the estate were the same as those given to public employees such as the police and other public employees. As we have seen throughout this thesis, the state, medicine and the organisation of labour were closely allied, and in the relatively controlled world of the plantation doctors were able to muster considerable amounts of influence. Milk regulation, on the other hand, unfolded within a politically diverse, administratively complex, and socially heterogeneous space. There was also uncertainty about the diseases milk supposedly carried, and connected to this, there were changing perceptions about the meaning of clean milk.

#### 7.6 Rhetoric, persuasion, and the bacteriological laboratory

In Britain testing the quality of milk had never been a straightforward matter as it naturally varied from one breed of cow to another. However, the percentage of fat and non-fat solids was considered crucial. By 1901 the legal minimum for non-fat solids had been established at 11.5 per cent.<sup>96</sup> These levels were not expected to be reached in the tropics. As the Government Bacteriologist later explained, the inhabitants of the colony were, 'devoid of any ideas on high farming' and therefore lower standards were set.<sup>97</sup> Milk with more than 8.5 per cent non-fat solids was thus deemed satisfactory.<sup>98</sup> Yet

---

94. The numbers of labourers declined over this period' from 65,716 to 58,111. See RIAG 1902-03 p. 17 and RIAG 1914-15 p. 6.

95. Dr. Ferguson. RSG. AR 1911-12. p. 92.

96. P. J. Atkins, 'Sophistication detected: or the adulteration of the milk supply, 1850-1914', Social History 1991 Vol. 16. No. 3. p. 325.

97. Wise & Minett, 'Review', BGMA 1911. p. 45.

98. Central Board of Health Meeting. Samples with 8.6 per cent and above were returned as genuine. Those between 8.6 per cent and 8.3 per cent were considered of doubtful purity, and those below 8.3 as adulterated. Argosy 11 February 1903. The authorities in Guiana seem not to have tested for butterfat,

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

adulteration with water and the diminished nutritional value of milk formed only one part of official concern. Anxieties over adulteration were gradually supplanted by concerns over contamination.

For some years in Britain it had been recognised that milk was a possible carrier of disease.<sup>99</sup> So too in the tropics.<sup>100</sup> We can see from the colony's Surgeon General Reports that milk was implicated in disorders such as: diarrhoea, infective enteritis, dysentery, gastritis, dyspepsia, and diphtheria.<sup>101</sup> However, opinions differed how far the boiling of milk reduced the likelihood of these diseases.<sup>102</sup> Another crucial disease question, but one which European scientists disagreed over, was the role of milk in spreading tuberculosis, otherwise known as phthisis or consumption.<sup>103</sup> By 1904 a degree of unanimity was reached amongst British medical opinion, the British Royal Commission having firmly linked milk with tuberculosis.<sup>104</sup> This judgement seemed to fit the experience of doctors in Guiana where the issue had also been widely discussed. Dr. J. H. Conyers, one of the colony's leading medical practitioners, and president of the British Guiana branch of the British Medical Association, described tuberculosis as, 'the scourge of the Colony.'<sup>105</sup> More accurately, it could have been described as the scourge of Georgetown, for it was here that the disease was most concentrated. The Surgeon General's Report for 1906-07 put deaths from tuberculosis in Georgetown (but not necessarily linking them directly to milk) at just over twenty-four per cent of the city's entire mortality.<sup>106</sup>

The spectre of disease, and the sight and smells of dirt, provided a repertoire of potent images for describing poverty and the attendant problems of lawlessness in colonial society. It was these combinations of 'disorder' that Town Council officials

---

something that was considered important in England. In 1901 the Sale of Milk and Cream Regulations made the legal minimum three per cent butterfat, and 11.5 per cent solids non-fat. Standards which lasted until today. See Atkins, 'Sophistication detected', p. 325.

99. Jim Phillips and Michael French, 'State Regulation and the Hazards of Milk, 1900-1939', Social History of Medicine Vol. 12. Number 3 December 1999. p. 371.

100. Andrew Davidson, Hygiene & Diseases of Warm Climates (Edinburgh 1893), p. 230, 406, 997.

101. RSG. AR 1906-07. p. 54. RSG. AR 1909-10. p. 28.

102. Leader. Argosy 10 March 1910.

103. Deborah Dwork, War is Good for Babies and Other Young Children. A History of the Infant and Child Welfare Movement in England 1898-1918 (Tavistock Publications 1987), p. 74.

104. Argosy 25 June 1904.

105. Dr. Conyers. BGMA 1904. p. x. RMC. BGMA 1906. p. 27.

106. RSG. AR 1906-07. p. 44.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

claimed to find in the villages, dairies and cow sheds which bordered Georgetown.<sup>107</sup> Two places repeatedly surfaced in official accounts: Kitty and Albouystown. Town officials claimed that dairies in the village of Kitty were worked by lepers and that consumptive individuals lived amongst the cows.<sup>108</sup> Kitty, according to a 1905 report in the *Daily Chronicle* was, 'reeking with leprous matter.'<sup>109</sup> The uncertain epidemiology of leprosy with its reputation for producing gross deformities was certainly calculated to raise alarm amongst Georgetown residents. In a similar manner the inhabitants of Albouystown were denigrated in the colony's press.<sup>110</sup> According to the *Daily Chronicle* the area was populated by, 'a motley crowd of coolies, cows, the off scourings of the city, blind beggars, and variously afflicted sick people'.<sup>111</sup> Like Kitty, Albouystown was also perceived as a place that fostered disease, posing to the authorities of Georgetown a dual threat, both social and epidemiological.<sup>112</sup>

Despite the supposed associations between dirt, the cleanliness of milkers and contaminated milk, not all officials were persuaded that milk was regularly tainted or spoiled. Amongst Town Council and Government officials divergent views existed. Some of the medical profession viewed milk production in terms of 'natural' cultural and racial attributes. The putative East Indian 'veneration' of the cow supposedly ensured that cattle were well cared for and that milk was produced in clean conditions.<sup>113</sup> However, with the arrival of the bacteriological laboratory a new form of authoritative knowledge was brought to bear on the question of milk, and this stance weakened.<sup>114</sup>

In 1906 the colony's veterinary surgeon, and the recently appointed Government bacteriologist, K. S. Wise, visited the Bel Air District milk farms which lay just to the west of the city. This district was responsible for a large proportion of milk supplied to

---

107. *Argosy* 14 October 1905.

108. *Daily Chronicle* 25 October 1905. *Argosy* 14, 25 October 1905.

109. *Daily Chronicle* 25 October 1905

110. *Argosy* 11 February 1903. Mr. Davis. Evidence presented before the Mortality Commission. *Argosy* 23 September 1905.

111. *Daily Chronicle* 26 October 1905.

112. *Ibid.*

113. *Argosy* 25 October 1905. *Daily Chronicle* 25 October 1905. *Argosy* 29 November 1905.

114. RSG. *AR* 1905-06. p. 28. For the laboratory in the colonial context, and as a site for new knowledge see Andrew Cunningham, 'Transforming Plague. The laboratory and the identity of infectious disease', in

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

Georgetown. At the commencement of milking, Wise noted that milkers spat into their hands. Other sights also gave grounds for concern, 'filthy' cows, and dislodged faecal matter in milking pails.<sup>115</sup> The laboratory results were equally unambiguous. Only three of the fifteen samples taken approached the English average for bacteria per cubic centimetre. The remainder teemed with streptococci, sporogenes, and coli. communis. All these bacteria were known to inhabit cow intestines, and therefore seen as proof that milk produced at Bel Air had been invaded by faeces. Tests on laboratory guinea-pigs (these were injected with milk which had been centrifuged) furthermore demonstrated that the bacillus tuberculosis was present.<sup>116</sup> Wise's laboratory supplied proof that the colony's milk, particularly that produced in the countryside, was far from being an agency for health. On the contrary, it appeared to be a means for distributing disease. In his subsequent report to the Surgeon General, Wise exclaimed, 'I regard the milk supplied to Georgetown as little short of sewage.'<sup>117</sup>

#### 7.7 Milk legislation and the politics of discontent

From the point of origin to the point of sale, milk had become the focus of intense interest by members of the colony's Town Council and Government administration. The question of its purity, its regulation and the role of official bodies, also raised wider questions about the organisation of 'public health', highlighting the divisions of power and the disagreements over policy which sometimes arose between the Surgeon General and city officials.<sup>118</sup>

Disputes over how to regulate the milk trade soon led to a wider critique of the city fathers.<sup>119</sup> Godfrey, the Surgeon General, demanded a greater say in the supervision of the city's sanitation, and the creation of a new full-time post, a Medical Officer of Health for Georgetown.<sup>120</sup> The Town Council opposed this proposed dilution of its

---

Andrew Cunningham & Perry Williams, (eds.), The Laboratory Revolution in Medicine (Cambridge University Press 1992), pp. 209-244.

115. Official Gazette 22 September 1906. p. 587.

116. RSG. AR 1906-07. p. 55.

117. *Ibid.*

118. Argosy 14 March 1906.

119. The New Amsterdam council also came in for criticism. Dr. Rowland attacked its 'extravagance', 'waste' and 'bad financing'. Argosy 14 March 1906.

120. Official Gazette 22 September 1906.

#### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

powers, and it was not until 1909 that Godfrey finally got his own way in this matter. Other subjects of disagreement were tuberculosis (Godfrey, who tracked metropolitan changes of opinion on this subject, now disputed the link with milk),<sup>121</sup> and municipalisation (Godfrey sought an improvement in overall standards rather than the sterilisation of milk once it had arrived in Georgetown which was favoured by some members of the council).<sup>122</sup>

In the discussions about milk, questions of health were often secondary, more often they were dominated by queries over costs, estimates and prices.<sup>123</sup> For the Town Council milk regulation offered an opportunity to *raise* revenue through the sale of licences.<sup>124</sup> On the other hand, the Surgeon General seemed more concerned to squeeze out of business the small milk trader with whom he associated the most unsanitary practices.<sup>125</sup> Quite simply, according to Godfrey, ‘a poor person should not sell milk.’<sup>126</sup> As to whether this would result in more expensive milk Godfrey was equally clear. It was better entirely to cease using milk than to, ‘drink the poison and filth that is being sold to them daily.’<sup>127</sup>

New regulations about milk finally came into force on the 1<sup>st</sup> January 1908. A description of this event from the *Daily Chronicle* arguably reflected the ambition and easy assured confidence of the colonial regime.

The Council have approved of by-laws – operative from today – which afford the municipality efficient control over the sanitary conditions of the cow-sheds and of the animals and attendants employed in the handling of milk. The by-laws also deal with the regulations of dairies and milk-shops, the construction and cleansing of cow-houses, byres, etc. It is expected that as a result of the new regulations the business of vending milk will pass into the hands of a more responsible class.<sup>128</sup>

References to the ‘construction and cleansing’ of byres included alterations to ventilation and the introduction of expensive sloping concrete floors, bricking and

---

121. *Daily Chronicle* 10 April 1908. *The Weekly Argosy* 18 April 1908. *Argosy* 8 September 1912.

122. *Argosy* 17 November 1906.

123. *Argosy* 14 March 1908. See also Luke M. Hill. Long standing proponent of milk depots. *Argosy* 1 February 1905, 29 September 1906, 23 May 1912.

124. *Daily Chronicle* 23 March 1909.

125. *Official Gazette* 22 September 1906.

126. *Argosy* 17 November 1906

127. *Argosy* 24 November 1908.

128. *Daily Chronicle* 1 January 1908.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

tiling, all to be paid for by the (most often small) farmer. It is worth noting that far more attention was being devoted towards the accommodation of cows than that of villagers.

Resistance to these measures was swift in coming. Far from bringing forward a better class of vendor, someone who was anxious to conform to new laws of sanitation, the authorities ignited sustained opposition from milk-traders. The year 1908 saw 'monster' deputations of East Indians protesting against the new regulations, as well as an effective strike which quickly forced up the price of condensed milk in Georgetown.<sup>129</sup> The authorities had mobilised a significant section of the colony's population against their rule. In the face of this opposition the Town Council adopted a policy of leniency towards unlicensed milk traders, reduced the cost of licences, and it back-pedalled on the number and scale of sanitary improvements required for the licensing of byres.<sup>130</sup> This conciliatory approach may also have arisen as a consequence of the strikes and riots which swept through Georgetown in November and December of 1905.<sup>131</sup> We cannot know whether these events lingered in the minds of Town Council officials. What is more certain is that united action by a section of the colony's population clearly had potential to spark off disturbingly wide levels of protest, and that the Town Council trod cautiously in its dealings with milk traders.

At the same time the Town Clerk maintained that it was, 'essential there should be an improvement in the milk supply, and the present by-laws are such as we think can achieve it; and we are determined to see that they are carried out.'<sup>132</sup> Ultimately the course of compromise adopted showed results.

By the beginning of 1909 the majority of Demerara's milk producers and sellers were registered, licensed, and badged. In short, the milk trade had been bureaucratised. Milk containers were adorned with a metal tablet bearing the licence number of the person offering milk for sale, and vendors sported a badge on their left arm indicating they were licensed by the Town Council to hawk milk. The Town Clerk's register

---

129. Daily Chronicle 2 October 1908. Argosy 3 October 1908.

Argosy 24 November 1908.

130. Daily Chronicle 3 October 1908, 10 October 1908.

131. Kimani S. Nehusi. 'The Causes of the Protest of 1905', in Winston F. Mc. Gowan, James G. Rose, David Granger, (eds.), Themes in African-Guyanese History Free press 1998. pp251-276. Rodney, History pp. 190-200.

132. Daily Chronicle 3 October 1908.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

showed the number of people who kept cows, who ran milk shops, who sold milk in Georgetown, and who supplied milk. A sliding scale of penalties was introduced for those convicted of milk adulteration.

How did these regulations work in practice? First of all, it should be remembered, milk was a profitable substance, and there were always more than enough people ready to sell it without applying for a licence.<sup>133</sup>

There were also other practical difficulties which surfaced. The town's veterinary surgeon was unable to examine cows systematically, as municipal farms often pastured their animals outside the city area where they roamed at will.<sup>134</sup> In addition, not all milk originated from a single farm. Farmers habitually bought milk from several sources, sometimes from individuals without licences, and then mixed the milk with their own or even scalded the milk of the previous day for reselling. Milk thus 'fathered' was then sold in Georgetown in the normal manner.<sup>135</sup> In countryside districts local authorities rarely had sufficient funds to appoint an inspector of cow-pens. GMOs were only empowered to advise local authorities on the state of disease in cattle, and sometimes they gave conflicting opinions.<sup>136</sup> Neither were milk producers or hawkers particularly disposed to cooperate with officials, and the suspicion of corrupt practices was never far away.<sup>137</sup> The local

**Fig. 7.2 Fish in Milk. Comment on the milk trade in the *Daily Argosy* 15 January 1910**



133. *Argosy* 17 May 1912.

134. *Argosy* 15 August 1906.

135. Wise & Minnett, 'Review', *BGMA* p. 51. *Argosy* 12 May 1912.

136. *Argosy* 20 August 1912.

137. *Argosy* 23 May 1912.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

authority in the district of Kitty pointed out that even when sanitary notices were complied with, the cow-pens swiftly returned to their former filthy state.<sup>138</sup>

The sudden outbreak of disease, such as the epidemic of enteric fever, which appeared in Georgetown in April 1909, was a reminder that milk was an unstable substance. It required constant supervision, and municipal inspecting procedures needed to be re-enacted daily, and not on an intermittent basis. Doctors were also sceptical that milk producers really understood the tenets of cleanliness:

In our opinion the milk supply of the city is the chief agent responsible for the entry of the enteric bacillus into the inhabitants affected with this fever. The infection of the milk may arise from contaminated water used for washing out the cans or diluting the milk or may come directly from the handling of vessels, etc., by infected persons, or from milch cows which have swallowed in some pond or trench containing enteric bacilli.<sup>139</sup>

The work of the Government Bacteriologist continued to raise doubt about any claims that the colony's milk was consistently pure. Although milk taken for testing from various hawkers generally showed that tuberculosis was rare, there were inevitably always small quantities of *bacillus coli*, *enteriditis*, *sporogenes*, and *streptococcus*. All were organisms which pointed to the washing of milk cans and milking implements in trench water. Doctors Wise and Minett in the conclusion of their 'Review of the milk question' in 1911, stated that: 'milk as at present supplied is open to very serious suspicion and certainly unfit for human consumption in its present condition especially for children and invalids.'<sup>140</sup> Boiling milk, which was customary, continued to receive official approval.<sup>141</sup>

This state of affairs may have persisted if it had not been for the daughter of the Attorney General who was incapacitated in 1912 after drinking milk recently delivered to her father's house. The milk's origin was traced to Kitty, a place long associated in official minds with unsanitary practices. The practical weaknesses of municipal control over the milk trade was revealed in the way the accused dairy owner had apparently carried on his trade unchecked and without a licence.<sup>142</sup> The *Argosy* printed a number of

---

138. *Argosy* 22 May 1912.

139. RSG. *AR* 1909-10. p. 29.

140. Wise & Minett, 'Review', *BGMA* 1911. p. 57.

141. *Argosy* 10 March 1910, 11 January 1912.

142. *Argosy* 22 May 1912, 1 August 1912.

#### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

revelatory articles variously entitled: 'Deadly Milk', 'Filthy Cows In Filthy Pens' and 'Milk Danger'.<sup>143</sup> These provocative articles once again highlighted for Georgetown residents their vulnerability to practices carried out in the countryside.<sup>144</sup>

More than this, the regulation of milk raised far reaching questions about colonial governance and the organisation, or disorganisation, of public bodies. Better, in view of the *Argosy* to entirely remove the milk control from the hands of Georgetown officials.

It remains then for the Government to realise the necessity of taking over the entire control of the public health department by the appointment of a supreme official who would be held responsible for and see to the prevention of such scandals as this milk business.<sup>145</sup>

The demand for a 'supreme official' eventually found an expression in the establishment of a countryside Medical Officer of Health and an assistant. Like their urban counterpart, these officials were expected to advise villagers on matters of sanitation, and help organise the inspection milk dairies and cow byres.<sup>146</sup> Uniformity of approach, regulation and administration was slowly being achieved.

Meanwhile in May 1912, a Joint Committee set about the task of reviewing and rewriting milk regulations for Demerara dairies. Once again the characteristic stamp marks of bureaucratic rule were apparent in the complex system of assessment, registration, badges and licensing. Many of the objectives previously abandoned as impractical now returned, such as concrete floors, special receptacles for excreta, and waterproof roofing. Concern even extended to the management of household waste and family accommodation. The troolie (leaf) roofs that both animal and human commonly coexisted under were a particular cause of alarm, and decried as breeding places for, 'bugs, fleas, ticks, and lice.'<sup>147</sup> Section thirty of the new 'By-Laws for Regulation of the Sale of Milk' declared that dairies were no longer, 'to be used as a sleeping apartment'.<sup>148</sup> The cow was also to be protected from noxious 'effluvia'. This entailed

---

143. *Argosy* 11 January 1912.

144. This point is made by Juanita De Barros, Purity and Filth.

145. *Argosy* 12 May 1912.

146. *Argosy* 24 May 1912.

147. *Argosy* 3 January 1913.

148. By-laws For Regulating The Sale Of Milk. *Argosy* 5 September 1912.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

the removal of the, 'water closet, earth closet, privy, cess-pool or urinal' from any 'communication' with the dairy.<sup>149</sup>

Just as health visitors were carrying carbolic disinfecting fluids into the home of Georgetown residents, the Medical Officer of Health in the country district was making sure it was applied to the insides of dairies. Thus, in the insalubrious conditions of rural life the sanitary bureaucracy of Georgetown stretched out and reached into villages in order to create islands of good sanitary practice, the main beneficiary of which, in the first instance, were cows.

In the regulations concerning milk a new thread of medical supervision emerges. Each milk producer and seller now required certification (and by implication examination by medical personnel) that they were free from infectious diseases. The privileges of private enterprise were, therefore, becoming conditional on the physical health of the individual, and also on their willingness to accede to bureaucratic monitoring. We saw in chapter three how the state gradually assumed responsibility for the 'body' of the plantation labourer through the controlling mechanism of indentured law and the plantation hospital. In chapter six I showed how in the context of midwifery the state then slowly intruded itself into the wider population, attempting to change and organise birthing practices. We can see here in the licensing of 'healthy' milk sellers another dimension of this expanding medicalisation of society, another moment where the state and medicine pushed out beyond its former boundaries.

Perhaps unsurprisingly, given the recent history of milk regulation in Guiana, official ambitions were tempered by the realities of implementing these latest controls. Once again the increasingly confident class of milk sellers refused to supply milk to the city. This time milk sellers not only made their presence felt on the streets through pickets, but announced their strike with an advertisement in the press.<sup>150</sup> And once again the authorities attempted to mollify these traders reducing the price of licenses and by simplifying procedures.<sup>151</sup> A sign that these concessions eventually worked, and that

---

149. Ibid.

150. *Argosy* 7 January 1913.

151. *Argosy* 8 January 1913, 9 January 1913, 14 January 1913.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

new costs were simply passed on to the customer, was another increase in the price of milk which rose to six cents a pint.<sup>152</sup>

In the country districts the government and Town Council set about 'winning over' the farmer. In Georgetown a full sized demonstration cow byre was constructed. In addition, Doctors Minett and Wise, the Medical Officer of Health and assistant respectively for the country districts, constructed a model byre, an 'ideal sanitary structure' for carrying onto farms. With this, and with printed instructions, estimations of cost, and interpreters, they began a painstaking programme of visiting each of the colony's dairy farms.<sup>153</sup> This strategy seems to have paid off. By the end of 1913 these officials had registered 510 cattle pens, if nothing else, this was an indication of the enormous energy being devoted to the milk question.<sup>154</sup> In Georgetown the scope of medical surveillance may be grasped from the fact that the town authorities issued over 300 certificates to milkers and attendants. Another 471 licences were granted to sell milk. The authorities were unquestionably successful in their attempts to embroil the milk trade and its participants in a web of bureaucratic procedures. Earlier in this chapter we saw that this did not necessarily mean a better quality of milk. What was the result of this latest regulatory turn?

As Table 7.1 below shows municipal vigilance, indicated by the numbers of samples of milk taken, increased over the years.

**Table 7.1 Number of milk samples and percentage of adulteration 1890-1914**

Year	Milk samples	Number adulterated	Percentage
1890	22	19	85.5
1899-1900	864	237	27.4
1905-1906	1990	333	16.6
1913-1914	1952	247	12.6

Source: AR 1890-1913-14.

Although these figures represent only snapshots from particular moments it looks as though the authorities did manage to improve the quality of milk. The contrast between 1890 and 1913-14 is enormous. At the earlier date only very few samples were being taken, but most of these were adulterated. Over a twenty year period, adulteration,

---

152. *Argosy* 11 January 1913.

153. *Argosy* 3 January 1913, 7 January 1913, 8 January 1913.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

from a practice which seems to have been almost universally performed by milk sellers, was transformed into a minority activity.

Undoubtedly many milk hawkers continued to make calculations about whether adding water to their milk was likely to fall foul of the municipal authorities. But, other hygienic considerations may also have been at work. A better gauge of the way milk was produced is found in the number and type of bacteria present. Cleaner conditions of production and better handling techniques all helped to keep levels of bacteria low. Figures suggest that this was the case after 1913, indicating that East Indian farmers and colony officials increasingly shared ideas of 'cleanliness'. The number of samples of milk containing over 500,000 bacteria per cubic centimetre was fifty-five in 1912. In 1913 there were only nine samples with this rate of bacteria. Faecal contamination also declined. In 1912 there were seventy-two samples of milk with over 10,000 faecal organisms per cubic centimetre. This dropped to fourteen in 1913.<sup>155</sup>

Although caution is needed in interpreting these figures because we only have them for the year 1913-14, they do suggest that the sanitary reach of officialdom had entered into the lives of milk traders. In doing this however, it should be stressed that the authorities remained narrowly focused on the conditions under which milk was produced, and that villagers did not directly benefit from this interest. Closer to Georgetown the situation was rather different. There the authorities were more determined to order the wider environment according to their sanitary ideals. The concluding part of this chapter returns us to Albouystown on the edge of Georgetown.

#### 7.8 Albouystown revisited

One way of understanding the struggle to control the milk industry is to see it as an attempt to loop the supervisory powers which existed within Georgetown around the milk farmer living in the country district. Another strategy for bringing sanitary reform to individuals was to simply extend the city boundaries to envelop whole areas. This was done with Albouystown on the 21<sup>st</sup> February 1913. From that moment, under a

---

154. Report of the Public Health Department of the Local Government Board. AR 1913-14. p. 69.

155. *Ibid.* p. 70.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

little used by-law dating from 1878, the Georgetown Medical Officer of Health was empowered to inspect properties in Albouystown used for human habitation. City officials, long alarmed by the insanitary threat posed by this area immediately began preparations to explore its yards, streets, drains, and tenements. Their subsequent 'shocking discoveries' were reported in the *Argosy* in a series of articles which fulsomely described the 'human warrens' and 'slums' in almost tangible detail.<sup>156</sup>

However, if Albouystown represented a squalid 'native' urbanness, the antithesis of proper order, municipal regulation and cleanliness, it also became a symbol of redemption, testimony to the transforming powers of whitewashing, floor scrubbing and good governance. In the pages of the *Argosy* the threatening social potential of Albouystown soon disappeared to be replaced by an image which stressed the grateful attitude of individuals there towards improvements. The justification of colonial governance, reform, order, good sanitation and not least clean milk, apparently found an enthusiastic echo from the residents of Albouystown.

Work began properly in May 1913 when three city of Georgetown sanitary inspectors and their assistants started house to house searches of the area. As they slowly trawled through the district, they issued notices to owners of properties warning them to clear up rubbish from the yards, clean parapets, unblock and fix drains, and to break down decayed closets, especially those, 'reeking with green slimy water and mud'. Barrels and water vats not covered with netting contravened the Georgetown Mosquito Ordinance, and now required covering. Within days they had served over 1,300 notices.<sup>157</sup> Something of the manner in which these officials approached their work is indicated in the following brief incident. On discovering a dead consumptive, the Portuguese De Souza, the sanitary inspectors removed his body for burial then immediately sprayed the room with formalin. Fumigation then followed, and the bed on which he had breathed his last was finally taken away for burning, watched by a large crowd.<sup>158</sup> Meanwhile, work in the street continued as the twelve strong council gang

---

156. *Argosy* 18 May 1913.

157. *Ibid.*

158. *Argosy* 21 May 1913.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

collected and carted off rubbish for destruction. Within days 220 cartloads of rubbish were cleared.<sup>159</sup>

The *Argosy* descriptions of Albouystown offer a glimpse of the appalling conditions that some individuals lived in. Typically, rooms were small, ramshackle wooden constructions, perhaps no more than 225 cubic feet, and badly ventilated, if at all. To enter properties inspectors were often forced to crawl on their knees.<sup>160</sup> Absolute levels of poverty seem to have somewhat dissolved racial segregation and collapsed the desired boundaries between the healthy and the sick. In Albouystown, the poorest of Georgetown huddled together, Blacks and East Indians alike. The Salvation Army hostel fared little better. Seventeen porters, the ‘Salvation Army Sardines’ were discovered sleeping in the single room that the mission provided. Neither was it uncommon for whole families and a medley of animals to crowd into one dilapidated space. At Lot C in Hogg street the sanitary inspectors discovered:

a troolie [leaf] covered shed in which there was a collection of filthy kennels – called rooms – 4 1/2 feet in height, each occupied by men and women of the East Indian and negroid races. Dogs, cats, pigs, donkeys, and cows were found housed in these kennels – the stench that emanated from them being unspeakable.<sup>161</sup>

The condition of the yards were deemed to be no better. As suggested above they were frequently occupied by animals, and inspectors found them filled with manure and other accumulated foul smelling rubbish. Drains were blocked, and cesspits overflowed. The district overseer pointed out that many of the drains were unable to discharge their waste into trenches, creating year round swamps, ideal conditions for harbouring disease and breeding mosquitoes.<sup>162</sup> All the cow byres in Albouystown failed to meet the conditions imposed by the new by-laws. As described in one instance:

A Chinese owner of a cow-pen when remonstrated with over the state of things existing in his yard, argued that his byre under the old regime when Albouystown was not incorporated in the city of Georgetown, had been passed as correct. He failed entirely to appreciate the changed order of things.<sup>163</sup>

---

159. *Argosy* 28 May 1913.

160. *Argosy* 18 May 1913.

161. *Argosy* 20 May 1913.

162. *Argosy* 21 May 1913.

163. *Ibid.*

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

While the inspectors continued to serve improvement notices, other properties were completely torn down. The individuals inside often proved to be sick and old. The *Argosy* reported that one woman was 'sent to the Alms House', while a consumptive 'will be sent to the Public Hospital'.<sup>164</sup> Despite the vigour of this activity and the disruption to lives, officials noted with satisfaction that, 'although the slum-dwellers in Albouystown are considered a lawless lot, yet not one has interfered with or tried to interrupt the sanitary officers when carrying out their duties.'<sup>165</sup> This observation was repeated as the clearance continued. As 'foul' latrines came down, and 'old rags, bags, old beds, and other household refuse' were chucked out for collection, the *Argosy* drew attention to the 'gratifying manner' in which the people of Albouystown complied with the sanitary officers' notices.<sup>166</sup>

As reported, the compliant behaviour of local inhabitants to these changes supplied a superb justification for extending the spatial reach of municipal power. Incorporating Albouystown and tackling the 'filthy' conditions there, brought not just its cow-pens and drains under the influence of city officials, but its inhabitants also. By bringing them all into line with the rest of Georgetown, the authorities widened the municipal and environmental uniformity to the city. Their activities also evoked a particular vision of colonial society, one of reform and improvement, of grateful subjects and paternalistic administrators.

## 7.9 Conclusion

In this chapter I have tried to locate the whole question of milk regulation by Town Council and Government in Guiana within a wider framework of metropolitan and local social change, science and politics. In Guiana it is clear that elite ideas about urban spaces, and their approval and disapproval over what sort of activities should take place within them, altered significantly over the fifty years between 1830 and 1880. As discussed at the beginning of the chapter, by the twentieth century the sanitary practices of Georgetown's inhabitants had become a major subject for debate at Town Council

---

164. *Argosy* 18 May 1913.

165. *Ibid.*

166. *Argosy* 21 May 1913, 28 May 1913.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

meetings. It is noticeable that there was also a distinct strand of civic pride surfacing amongst city administrators, seen for example in the establishment of the Promenade Gardens, and the tree planting of trees in streets.

These changing sentiments towards civic duty bore many similarities with the enthusiasm for municipality amongst some politicians in urban Britain.<sup>167</sup> However, it is difficult to estimate to what extent the city authorities in Georgetown took their cue from practices and events in the metropole. Certainly, it is important not to underestimate the way that ideas and 'ways of doing things' flowed from Britain to Guiana. The local historian of British Guiana described the reading rooms of the Agricultural and Commercial Society as a place where a man could: 'keep himself up to date, and not feel that he is quite out of the world.'<sup>168</sup> Inevitably though, ideas were adapted to account for the tropical situation of the colony, for the topographical features of towns and villages, and for social circumstances. For example, the role of parks in the urban landscape is particularly interesting. In Britain they were primarily a response to industrialisation and the problem of smoke pollution. The working classes, it was felt, needed to 'taste the breath of nature'.<sup>169</sup> Parks were morally improving places, but they functioned as the city's 'lungs'. This was hardly the case in Georgetown, with its flat, open, sea-breezed location. The garden park in tropical Guiana appears to be much more a statement about the ordering of nature, a distinctive counterpoint to the hinterland wilderness. Arguably, the park was also a self-conscious demonstration of good governance and another mark of imperial beneficence. As with science and medicine, which Europeans had 'brought' to the colony, the park demonstrated the civilising influence of colonial rule.

This reading of public space, as something which the authorities consciously addressed, seems particularly appropriate for the changing, unstable, and uncertain circumstances of post-emancipation Georgetown. After 1838 the social position of Blacks altered dramatically. They became free to enter and leave Georgetown at will, and within the constraints of economic conditions, pursue livelihoods of their own

---

167. Asa Briggs, *Victorian Cities* (University of California Press 1993), p. 201.

168. Rodway, *Story* p. 199.

169. Briggs, *Victorian* p. 135. See also H. Conway, *Peoples Parks. The Design and Development of Victorian Parks in Britain* (Cambridge University Press, 1991).

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

choosing. Other socially transforming forces were also at work. The city was the recipient of large numbers of Portuguese and East Indian immigrants as well as significant numbers of Chinese. Each of these groups had their own histories, understandings about the world, language and culture, besides a measure of shared migratory experience. To a large extent British political rule had fed off these differences, and indeed helped to cultivate them. As we have seen throughout this thesis, British Guiana was a country saturated by racial discourse. The result was that by the late nineteenth century all manner of class, gender, and racial divisions had been firmly implanted into the geographical, social, and political landscape of Guiana.

Such a view is supported by the historian Brian Moore who has claimed the colony's, '...constituent social categories were sharply differentiated by race and culture.'<sup>170</sup> He goes on to argue that in British Guiana there was, '...no social will or value system shared by *all* segments of society.'<sup>171</sup> Moore's analysis seems particularly apposite for Georgetown, at least until the late nineteenth century. It was undoubtedly a city of racial enclaves, rather than a 'melting pot'. In a sense, the attempts of the Town Council and Government to introduce 'public health' measures (this could include the parks) were designed to bring about a shared system of values to the inhabitants of this fragmented world. One of the effects of colonialism had been to differentiate between races, and structure these putative differences into society at various levels, for example in the allocation of labour. At the same time, and in order to achieve political and economic goals, a countervailing dynamic of colonial rule had been to imbue in individuals a common understanding about the world. This was particularly so with regard to those matters which the authorities felt touched on the problem of the colony's low population growth and high infant mortality: sanitation, midwifery and milk. However, it would be wrong to think that the colony's political powers uniformly ascribed to a single point of view about sanitation, its importance, or the value of better milk quality.

The successive failure of the authorities to reduce milk adulteration shows that there were considerable divisions within and between the various parts of the colonial

---

170. Moore, *Race* p. 213.

171. *Ibid.* p. 215.

### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

bureaucracy. The role of the Government Laboratory in testing milk was not clearly defined until 1905, and the Town Council and the Central Board of Health, each of whom was responsible for sanitary matters in different geographical areas, found it difficult to work in conjunction with each other. This did not begin to change until 1907 when the Central Board of Health was abolished and replaced by the Local Government Board.

There was also the ultimately flawed policy of trying to push aside the poorer class of milk producer and seller by raising income from the sale of licences. As council officials slowly began to recognise, the profits available from the sale of milk were sufficient to encourage the non-compliance or evasion of expensive regulations. In addition, the responsibility for implementing and policing milk by-laws in Georgetown lay with poorly paid police and council inspectors who were subject to corrupting inducements from milk traders. However, by comparison, in the country districts the administrative infrastructure was even weaker – except with regard to plantations. Another important factor was that both milk producers and milk-sellers were generally East Indians, often with a shared linguistic and cultural experience. Communal solidarity in the face of administrative attempts to restrict their commercial activities was, therefore, important in shaping the manner in which regulatory control of the milk trade was introduced. Administrative endeavours to improve the milk supply to Georgetown were consequently always much more a process of negotiation rather than decree.

It remains unclear whether the poorer inhabitants were able to take advantage of the improved milk quality. The price of milk rose steadily during the first decade of the twentieth century, but wages, as the social upheavals of 1905 dramatically underlined, generally remained static or falling.<sup>172</sup> For many of the poorest individuals, fresh milk remained an expensive product. Taking into account the substantial expansion in the population of Georgetown between 1906 and 1912, (it rose from 48,550 to 53,877), it would be expected that the amount of milk entering the city would have increased if

---

172. For instance, the salary of a Georgetown tram car conductor which was a 'respectable' position started at the rate of five cents per hour, giving perhaps \$2 50 a week. Kimani S. Nehusi, 'The Causes of the Protest of 1905', in McGowan, Rose and Granger (eds.), *Themes in African-Guyanese History* p. 264.

#### Georgetown, Sanitary Spaces, and the Provision of Milk, 1890-1914

more individuals were using the product. In fact it declined slightly.<sup>173</sup> Milk may have been purer and safer, but fewer individuals were using it. On the other hand, there was a massive increase in the use of condensed milks. At the turn of the century over 85,000 lbs. a year were being imported. Within a few more years this amount had increased to over 700,000 lbs. pointing to an important and dramatic shift in colony purchasing habits, perhaps due to an impression that artificially produced foods were better or lasted longer in the tropics.<sup>174</sup>

Milk also brought to the forefront another dimension of colonial rule. Whereas the provision of fresh water and sanitation in Georgetown was never conceived on an individualistic basis, but as part of the province of local Government, the provision of milk was a private business activity. Regulating milk, therefore, indicates that the colonial administration was increasingly determined and capable of intervening in the commercial market place in the cause of promoting health. In the same spirit, new regulations on the sale of meat, the baking of bread, and the supply of patent medicines were also brought in during this time.

Thus, the emergence of cleaner milk in the streets of Georgetown was part of a broader shift in administrative thinking. It involved new moves over the provision of clean water, sanitation, refuse collection, and changing attitudes towards the presence of disease in the city. This was signalled by the creation of new administrative posts to organise the city's sanitation, the extension of various public works, and by investigations and commissions into tenements and the extent of disease in the city. In addition, as we saw in the last chapter, public-health thinking was also marked by more direct attempts to improve the levels of infant mortality by introducing community midwives, and improving facilities for birth at the public hospital. Finally, these initiatives should not be mistaken as indicating political reform. The widened franchise which took place in 1909 only added a small number of Georgetown residents to the electorate. In 1914 there were just 519 registered voters out of a population of 52,000.<sup>175</sup> Reforms in matters of health were not extended to the political arena.

---

173. Wise & Minett, 'Review', Journal of the Royal Sanitary Institute p. 77.

174. The Weekly Argosy 25 July 1908.

175. Clementi, Constitutional History pp. 132-133.

## Conclusion

A British traveller surveying the social and political institutions in British Guiana in the early twentieth century would have found many similarities with home. Aside from the apparel of law, police, courts and prisons, many of the other distinctive marks of Victorian society were present in this colonial outpost. Evidence of care for the old and the insane was represented by the Alms House and Lunatic Asylum, and there were hospitals for the sick. Like Britain there was also an 'elite' school and an institution for the correction of juveniles.

The bureaucracy of political life also had their British counterparts. Through the familiarly titled Town Councils and Mayors, Local Boards, Officers of Health, Town Clerks and 'departments', the functions of local government were carried out. As indicated in the last chapter, the capital of the colony, Georgetown, with its promenade walks, red post-boxes, and Hackney carriages was in many ways a distinctly Victorian city, replicating forms of administration and many features of city life (hierarchy, inequalities, poverty and privileges) found at home. In short the Britishness of British Guiana should not be underestimated. Plausibly, as David Cannadine recently argued, empire (and by inference, the small outpost of empire that was British Guiana) was at some level about 'replication and sameness originating from home'.<sup>1</sup>

However, at a deeper level Guiana was far from being simply a smaller 'tropical' version of Britain. Profound differences lay in its linguistic and religious diversity, in its heterogeneous social makeup, its racial stratification, and in the structure of its political features. The recent past of Guiana was characterised by slavery, rule by plantocracy and monoculture rather than free labour, political plurality and economic diversity. Moreover, the plantations of Guiana, which provided the economic core and driving force for the colony, only survived due to the ability of planters to import immigrants. Unlike today in Britain, where immigration is often seen problematically, and as a measure of cultural decline, immigration to Guiana in the nineteenth-century was

---

1. David Cannadine, *Ornamentalism. How the British Saw Their Empire* (The Penguin Press 2001), p. XIX.

## Conclusion

eagerly sought after, indeed championed by the colony's officials and commercial class, as the colony's only route to prosperity and moral salvation,.

All this aside, the terms of labour, the form of politics, and the tempo of commerce, were never purely Guianan affairs. But neither were they entirely shaped by Britain. The colony was the beneficiary of, and also subordinate to, a vast interconnected network of exchange whereby capital, labour, commodities, information and knowledge flowed back and forth between the different sites of the global market place. The vagaries of the financial markets constantly imprinted themselves on the activities of producers, and the economic impulses from Britain were by no means always dominant. For example, by the turn of the century it was not Britain but America which was the main recipient of Guianan sugar.<sup>2</sup>

On the other hand, with the global expansion of empire and growth in the scale of political activity, the colony's political life was increasingly overlaid by wider imperial interests. As discussed in chapter one, the political corridors of power ran not just between Guiana and Whitehall, but between the colony, India, and other parts of the world. The manifestation and expansion of state enforced 'plantation medicine' and the rules of immigration and indenture represented far more than just a local response to problems of labour organisation.

Apart from Guiana's labouring force, the colony also saw the arrival of various managers, administrators and professionals. They too were imported into the colony, and set to work to create the developing infrastructure of colonial rule. As was typical for the colonies few of these people were tempted to remain in Guiana. The *Daily Chronicle* complained in 1909 that: 'As soon as a man has earned a competence or is entitled to a pension, he takes himself to pastures new or old.'<sup>3</sup> Temporary presence or a 'stretch' of service, rather than permanence characterised the European abroad.

For the colonial official, Guiana was often no more than another posting in the empire. The career of Sir David Palmer Ross, Surgeon General to the colony between 1895 and 1904 illustrates this point. Born in Penang, the Straits Settlement in 1842, he was educated at home, like many sons of British officials living abroad. After studying

---

2. Adamson. *Sugar*. p. 228.

3. *Daily Chronicle* 29 December 1909.

## Conclusion

medicine at Edinburgh University he entered the Army Medical Staff, later joining the Colonial Civil Service as a medical officer in Jamaica. Subsequently he was appointed as Colonial Surgeon General of Sierra Leone in West Africa, and then in 1895, he was appointed Surgeon General for Guiana.<sup>4</sup>

Did Sir Palmer Ross's move from West Africa to Guiana represent a qualitative transformation of situation and circumstance? Unlikely, under the empire's wide cloak of political power there was considerable uniformity to British bureaucratic structures and departments of government. The world of European medicine also bore the imprints of an increasingly standardised university education and all the hall marks of a distinct 'community' informed by a body of scientific knowledge.<sup>5</sup>

It should be noted that in Guiana, as was the case elsewhere, diverse and bitter differences of opinion could arise on certain issues. Life for officials was also occasionally characterised by petty jealousies, personal enmities, competition for posts, and manoeuvring for influence. Nonetheless, there was more often than not, especially within the official structures of colonial government, a shared system of values, attitudes and beliefs expressed through honours, ritual and spectacle.<sup>6</sup> Governors, magistrates, and administrators, and (perhaps to a lesser extent) doctors too, slipped easily between one site of the empire and another.

It is clear that the British in Guiana rarely had their rule seriously threatened. As suggested above, in a large part they benefited from their own shared sense of purpose. Neither did the government ever have to deal with any of the 'great Victorian famines' and the ensuing social instabilities which afflicted many other parts of the empire.<sup>7</sup> But perhaps more importantly, the British benefited from the social and political divisions produced by the system of immigration and racial stratification. The historian Brian Moore quotes from the 1870 Commission, signalling the way in which elites cynically

---

4. *Argosy* 1 June 1904.

5. Marjaana Niemi, 'Public health discourses in Birmingham and Gothenburg, 1890-1920', in Sally Sheard and Helen Power, (eds.), *Body and City. Histories of Urban Public Health* (Ashgate 2000), p. 126.

6. For a discussion on the outlook and mindset of the Indian civil service see Clive Dewey, *Anglo-Indian Attitudes: The Mind of the Indian Civil Service* (Hambledon, 1994). See also John M. Mackenzie, 'Empire and Metropolitan Cultures', in Porter (ed.), *Oxford History* pp. 270-293.

7. Mike Davis, *Late Victorian Holocausts. El Nino Famines and the Making of the Third World* (Verso 2001), pp. 1-16.

## Conclusion

perceived advantage in this state of affairs, 'there will never be much danger of seditious disturbances among the East Indian immigrants ... so long as large numbers of negroes continue to be employed with them.'<sup>8</sup> This description of disunity between racial groups in Guiana was an oft repeated assertion amongst Europeans.

The idea of African racial inferiority also provided ideological legitimacy for the continued presence and rule of whites. E. Thurn, M. A., C. M. G., and a colony resident, spoke to the Royal Colonial Institute in the following terms in 1892.

It is all very well to say that a man is a man whether his skin is white or black; but it is certain that the vast majority of West Indian blacks – are not men but children, great, strong, generally good tempered children, but almost always fickle and essentially, through mere thoughtlessness, cruel. It seems *possible* to educate individuals of this class to the grown up stage; but this does not alter the fact that the great mass of them remain children'.<sup>9</sup>

Thurn continued, by arguing for the continuation of a, 'just, strong and kind' power over Blacks. As we saw in chapter one, in some of the comments sent by Governors to the colonial office, the view that Europeans should act in *loco parentis* also pervaded official thinking, suggesting that the grip of these ideas went very deep and wide in the European community.

However, beneath the apparent confidence and arrogance of these racialised polemics, there lurked anxieties. The social power of Europeans rested upon far more than racial division, and self confidence giving articulations of their own racial superiority. As Moore goes on to argue, there were also formal structures of power which helped secure British rule. Most importantly the authorities placed great emphasis on the show and actual use of armed force. The large crowds which moved between the docks and the main market at Stabroek, Georgetown, made the area an ideal site for the ritualistic enactment of official punishments. It was here for instance, that obeah men, i.e. those convicted of practising sorcery or enchantment, were flogged.<sup>10</sup> The procession of prisoners to the market area for punishment continued until 1877. Interestingly, the police force was itself primarily drawn from 'only one section of the population, that of

---

8. Moore, *Race* p. 193.

9. E. Thurn, 'Notes on British Guiana', *Journal of the Royal Colonial Institute* No. 2. 1892-93. p. 85.

10. Moore, *Culture* p. 146.

## Conclusion

Black Creoles.<sup>11</sup> As in other areas of colony life, race and occupation were seemingly synonymous. The colony simultaneously aggregated and differentiated, by drawing on cultural distinctions, religious beliefs, and gender relations. In summary, the fragmenting possibilities of racial identity were carefully crafted into the structure and fabric of society by Europeans in order to bolster their rule.<sup>12</sup>

Where did European medicine fit into this picture? In this thesis I have argued that the place of medicine in the colony was shaped and changed through a number of dynamic relationships. Essentially these were between Whitehall and the empire, the colonial state, and the planters and inhabitants of the colony. At the risk of oversimplifying, there were two distinct phases to medicine in Guiana. In the first phase, which begins after the ending of slavery, medicine had a highly specific character – the treatment of labourers. The spatial spread of medicine was therefore coterminous with the economic sinews of the colony. As I discussed in chapters one and two, during this phase, the presence of political forces which existed outside of the colony, (governmental and non-governmental) exerted a significant influence on the development of medical provision in Guiana.

The second phase becomes apparent from the 1880s onwards. At this time local concerns, primarily the colony's supposedly stagnating population and high infant mortality rates, which was discussed in chapter four and five, prompted the further expansion of medical provision. Both of these issues helped orientate the state and medicine towards examining the wider population, although as we saw earlier, the main focus of European attention was the urban rather than the rural environment. It was during this phase of medical development that the influence of metropolitan public health measures (which in many parts of England were still rudimentary) made their presence felt in the colony.<sup>13</sup>

Clearly, medicine in British Guiana, as with the rest of the empire, was never 'just' medicine, a system for healing the sick and coping with disease. On the contrary, medicine (as many historians have argued elsewhere) was an intensely ideological set of

---

11. Ibid. p. 205.

12. This insight comes from David Harvey, *Spaces of Hope* (Edinburgh University Press 2000), p. 40.

## Conclusion

ideas and practices.<sup>14</sup> More so since the putative neutrality and scientific rationality of medicine was itself a source of power for the colonial state. As I have shown, in Guiana the categories of civilised and uncivilised, of European and the 'other', and the manifold refinements of racial distinction were given added force and weight by the activities of doctors as they measured, counted, documented and deliberated over the immigrant labourer East Indian and Creole Black. Although medicine was much less concerned with coercion and enforcement than the disciplinary powers of the state, it was nevertheless part and parcel of this wider system of plantation 'government' over the labourer. In other words, medicine was part of an informal system of authority which, aside from helping to enhance the utility and productivity of labour, gave rationale and justification for preserving white dominance.

If medicine helped anchor the plantation system, and thereby the colonial government, the reverse was also true. State patronage of medicine (unlike in Britain) pushed medicine into a prominent political position in the colony. As already discussed in chapter three, one sign of this was that after 1893 the colony's Surgeon General received a seat in the legislature. At the centre of political power, medicine now had a voice. The social place of medicine amongst the British was correspondingly high. Mingling with government officials, the judiciary, and religious representatives at the King's Birthday Ball in 1906 were doctors and their families.<sup>15</sup>

Clearly though, as we saw in chapter seven, these privileges were not always or easily translated into practical reforming initiatives. In Georgetown, in the thicket of competing demands for local government and colonial funds, the cost of general sanitation and health provision for inhabitants had to be considered against, for example, the imperative of maintaining the sea wall and the fire brigade. That said, for every year from 1900 onwards, labour and sanitary superintendence was the largest single item of expenditure for the Georgetown Town Council.<sup>16</sup> In this manner Georgetown was not so

---

13. John M. Eyler, *Sir Arthur Newsholme and State Medicine 1885-1935* (Cambridge University Press 1997), p. XI.

14. See Biswamoy Pati and Mark Harrison, 'Introduction' in Biswamoy Pati and Mark Harrison (eds.), *Health Medicine and Empire: Perspectives on Colonial India* (Sangam Books 2001), pp. 11-22.

15. *Argosy* 1 December 1906.

16. See Town Superintendent Reports.

## Conclusion

different from many local authorities in England. There too, public health spending witnessed an enormous increase.<sup>17</sup>

It is more difficult to assess precisely the influence of Western medicine on those who were its prime object of work – plantation labourers – given the absence of any direct records from estates. Nevertheless, some issues stand out. On the plantation itself medicine was part of a regime of management, and it arguably helped to make the non-European receptive to Western assumptions about the world and of their supposed place in it. How far medicine went beyond this position and nudged into life new subjectivities or shaped new awarenesses about individual corporeality and disease is difficult to assess. Megan Vaughan makes the insightful comment that ‘subjectivities are made, not given’.<sup>18</sup> This reading of medicine gives space to the creative agency of human subjects which I briefly touched on in chapter six when discussing women and Georgetown’s Public Hospital maternity ward.

While more research on Guiana is needed, the evidence available so far suggests that the response of non-Europeans living outside of the plantation was uneven, but that East Indians were far more circumspect than the Creole Blacks about accepting the tenets of Western medicine. Caution is required here since aside from ‘belief’, care seeking strategies are always constrained by objective factors such as availability and cost. The poverty of rural communities undoubtedly meant less demands were put upon local doctors. It is impressive, therefore, that by 1901 the colony supported 191 registered druggists and chemists.<sup>19</sup> A high proportion of these businesses, which traded in the official medicine i.e. Western therapeutics, resided in Georgetown and New Amsterdam, but the rest were spread along the coast in different village communities or were attached to plantations. This suggests that communities increasingly looked to Western medicine for their health needs. In addition, there are also examples which show that on occasions estate labourers demanded western medicine. The GMO, Dr. Law, reported that in the context of providing quinine for malaria (East Indian)

---

17. Robert Millward and Frances Bell, ‘Choices for town councillors in nineteenth-century Britain: investment in public health and its impact on mortality’, in Sheard and Power, (eds.), *Body and City* p. 163.

18. Vaughan, *Curing* p.13.

19. *Official Gazette* 13 February 1901. C. O. 115/92.

## Conclusion

labourers on some estates refused to set out for work until they had received their morning dose of quinine.<sup>20</sup> We can also infer from the supposedly high (but never quantified) rates of ‘malingering’ or ‘loafing’, that labourers actively sought the regime of rest, medication and diet provided by the plantation hospital<sup>21</sup>

In summary, the insistent *presence* and *visibility* of Western medicine, whether it was in the form of the doctor riding between plantations and villages on his horse, the village midwives who underwent training at the Georgetown public hospital, the plantation hospitals, and local drug shops, are all suggestive of a measure of social support or at the very least, acquiescence to its practices.

Certainly, the British authorities sought to encourage a favourable view of their medicine. This factor seems particularly important as medicine moved out from beyond the confines of the plantation into the colony at large where the relationship of medicine to non-Europeans was for the most part more tenuous. One way of looking at the ‘public health’, ‘cleanliness’ and ‘proper feeding’ rhetoric which emerged during the 1880s, and which later expressed itself in the midwifery and milk initiatives, is to see it as a specifically public discourse designed to communicate the ideas of Western medicine more widely. The winning of hearts and minds, and not just bodies were its characteristic features.

However, another aspect of this discourse around public health was a drive to increase control and supervision over public and private spaces. The domination of Europeans over others went hand in hand with their command over nature, their ability to successfully craft the environment (whether plantation or city or cow byre) according to their requirements. This aspiration is suggested by the following quotation from the Reverend L. Crookall, who expresses in strikingly gendered metaphors, his satisfaction and approval, of the way Georgetown’s vast botanical garden had tamed nature.

Standing there, drinking in the perfume, and soothed by the soft and silent breeze, your eye gazing upon the flowers and lawns trimmed neat and in order, you begin to realise that the ‘luxuriance’ of tropical life has been brought within the bounds of law and order. Nature here is no longer wild and wanton, but civilised and chaste. Her long tresses have been cut and

---

20. Dr. Law. RIAG. AR 1909-10. p. 19.

21. Dr. Wallbridge. RSG. AR 1901-02. p. 67.

## Conclusion

trimmed, her exuberance directed into channels and kept with proper bounds - in short, Nature has been beautified by Art.<sup>22</sup>

The European striving for 'law and order' over nature may be taken as applying with equal force to the social world. Society too needed to be channelled along correct lines. Here the laws of sanitation and hygiene provided compelling reasons for regulating milk traders and midwives.

Finally, evidence of an enthusiasm for 'public health' in medical and government thinking is found in the re-building of the New Amsterdam hospital in the 1880s. The new hospital was in many ways symbolic of British power and of their organising and self promoting presence in the colony. Upon the hospital's completion there was a note of pride in the way Dr. Rowland, its Resident Surgeon, reeled off the statistical parameters of the buildings size and scale in the colony's medical journal.<sup>23</sup> Significantly, the chosen material for building the hospital was, besides concrete, Greenheart and Bullet, two of the world's hardest woods. Although available locally, they were expensive and difficult for carpenters to manipulate. A more important consideration for the government was that they were immune to the rotting effects of rain and heat. The hospital was therefore built to last. It thus represented more than a place of medicine, it celebrated the presence of the British, and pointed to a perspective of political and cultural permanence.

The pavilion design of the hospital also shows something of the durability and adaptability of this type of architecture, which had become the dominant style for new hospitals in England. With suitable changes, notably the raising of wards high off the ground on pillars, the design, like many other British institutions carried to Guiana, was considered equally good for tropical climes. The hospital's spacious wards, the emphasis on light and the free flow of air, and on training and procedure, signalled the way that doctors, who sometimes saw themselves on 'the edge of civilization', were committed to modern sanitary codes.<sup>24</sup> In a sense, the hospital directly connected medicine in the metropole with the periphery. Just as significantly, the hospital was designed in a style

---

22. Rev. Crookall, Wanderings Among the Creoles and Coolies, the Africans and Indians (London, Unwin 1898), p. 50.

23. Dr. Rowland. BGMAHR. 1894. p. 66.

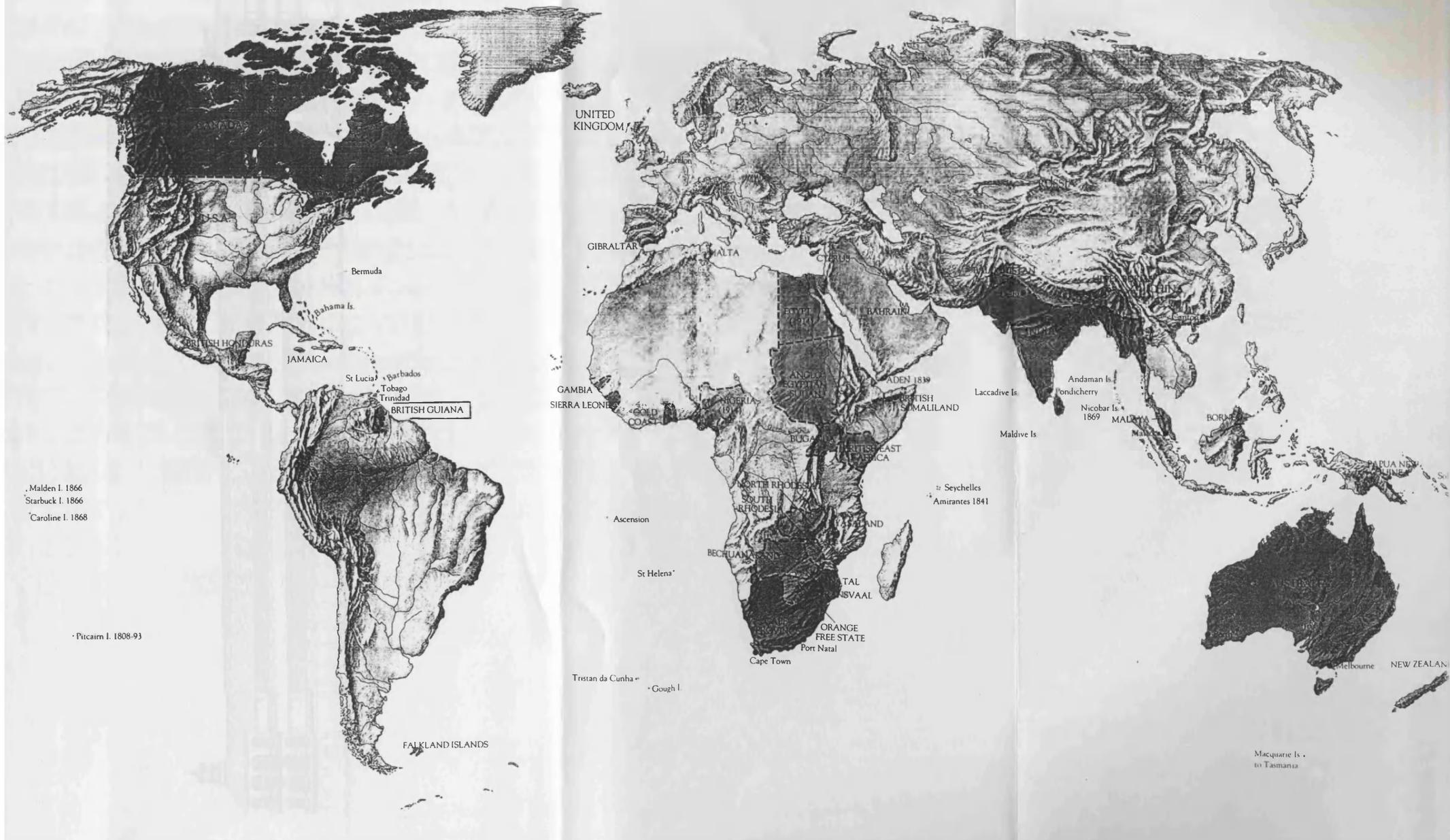
24. Dr. J. S. Douglas, 'Methods and Difficulties of Medicine on the Edge of Civilisation', BGMA 1906, pp. XXVII-XXIX.

### Conclusion

calculated to convey through its balanced proportions certain aesthetic ideas, that of enlightened rationality, order and reason. This was exactly how the British rulers and administrators in Guiana liked to think of themselves. Medicine was thus participating in the expansion and consolidation of political rule. In many ways, therefore, the hospital was emblematic of the supposed relationship between colonial rule, medicine and the wider society. The hospital and the medicine practised within it, like the British, were there to be admired and to an extent emulated.

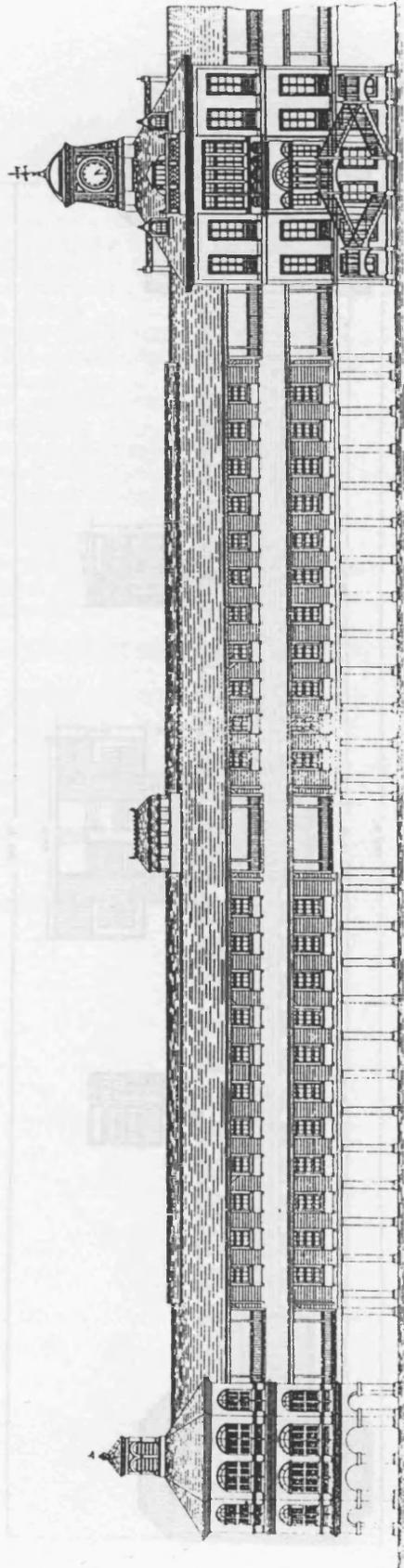
.....

Appendix I  
British Guiana in relation to the world



Appendix II

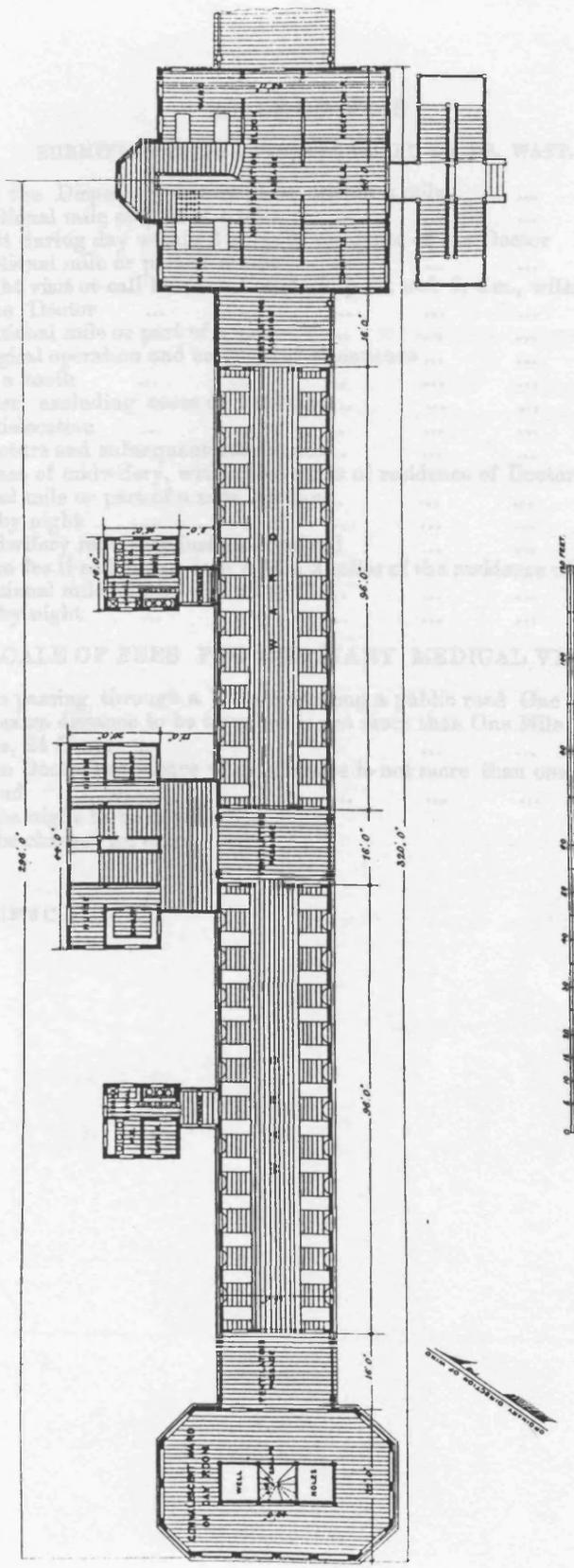
Berbice New Hospital - front elevation



Appendix III

Berbice New Hospital – plan of 1<sup>st</sup> floor

1. For a call from the Doctor
2. For every additional call
3. For special visits during day
4. For every additional call
5. For special night visits or call
6. For every additional call or parking
7. For minor surgical operations and
8. For extracting teeth
9. For minor operations including
10. For minor operations
11. For minor operations and subsequent
12. For ordinary cases of medicine, surgery
13. For every additional call or parking
14. For every additional call
15. For every additional call
16. For each of medicine
17. For consultation
18. For every additional call



Scale 1 Inch = 32 Feet.

## Appendix IV

### Scale of fees adopted for rural districts in 1878

#### SCALE OF FEES

##### SUBMITTED TO THE VILLAGE BOARD BY DR. WATT.

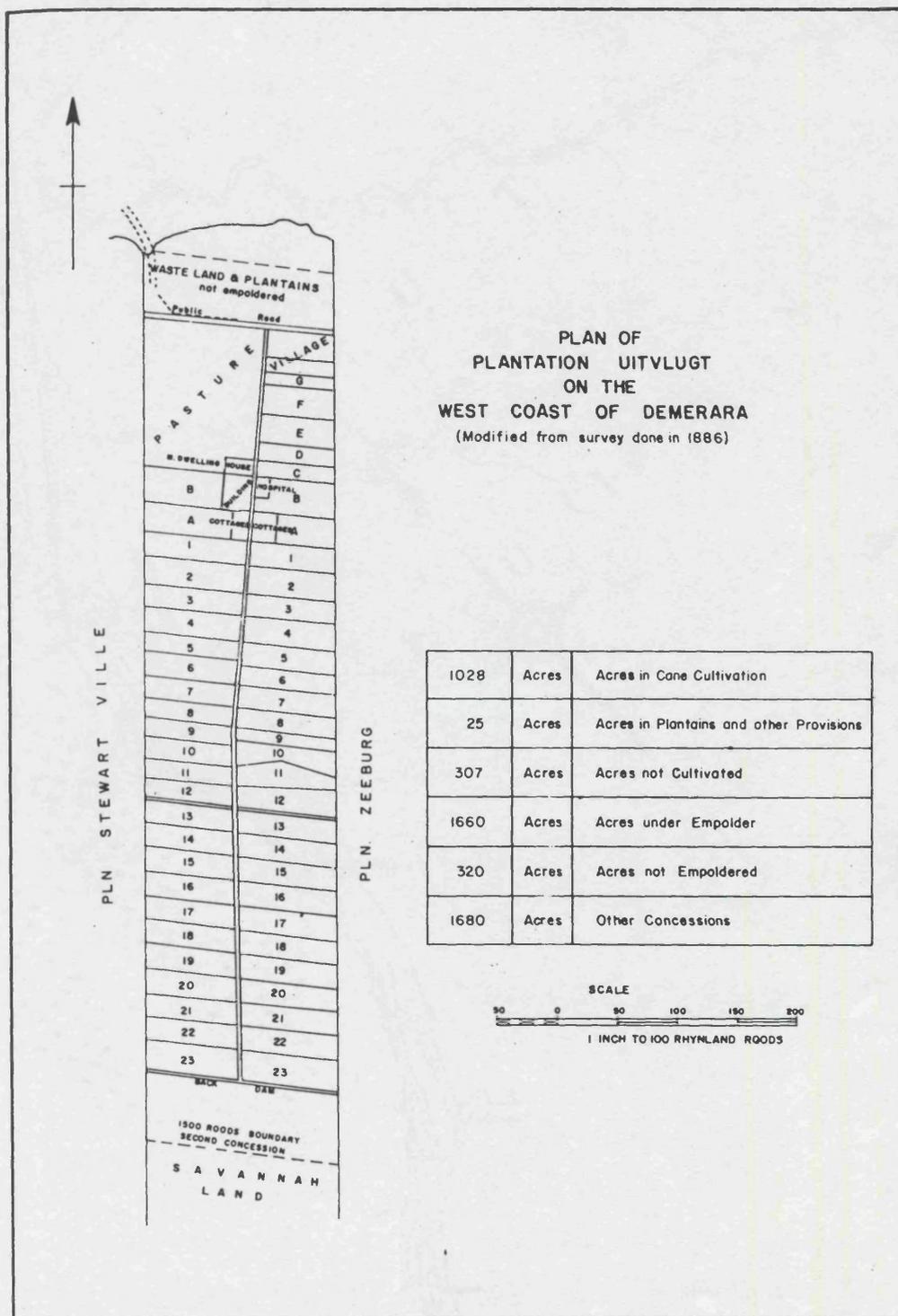
1. For a call from the Dispensary to any place within a mile	...\$	1 00
2. For every additional mile or part of a mile	...	0 48
3. For special visit during day within 2 miles of residence of the Doctor	...	2 00
4. For every additional mile or part of a mile	...	0 48
5. For special night visit or call between 6 o'clock, p.m., and 6, a.m., within 2 miles of residence of the Doctor	...	4 00
6. For every additional mile or part of a mile	...	0 96
7. For minor Surgical operation and subsequent attendance	...	5 00
8. For extracting a tooth	...	1 00
9. Passing Catheter, excluding cases of Stricture...	...	2 00
10. For reducing dislocation	...	5 00
11. For setting fracture and subsequent attendance...	...	10 00
12. For ordinary case of midwifery, within two miles of residence of Doctor	...	5 40
13. Every additional mile or part of a mile, by day...	...	0 80
Ditto ditto, by night	...	0 96
14. For case of midwifery requiring instrumental aid	...	10 00
15. For consultation fee if called to a case within 2 miles of the residence of the Doctor	...	5 00
16. For every additional mile or part of a mile	...	0 48
Ditto ditto, by night	...	0 96

#### SCALE OF FEES FOR ORDINARY MEDICAL VISITS.

When the Doctor is passing through a Village or along a public road	One Dollar a visit	
whenever the extra distance to be travelled is not more than One Mile	...\$	1 00
For each extra mile, 24 Cents	...	0 24
For special call from Doctor's residence when distance is not more than one mile	...	1 00
For each mile beyond	...	0 48
Calls during the night to be double.		
Operations to be charged for extra.		

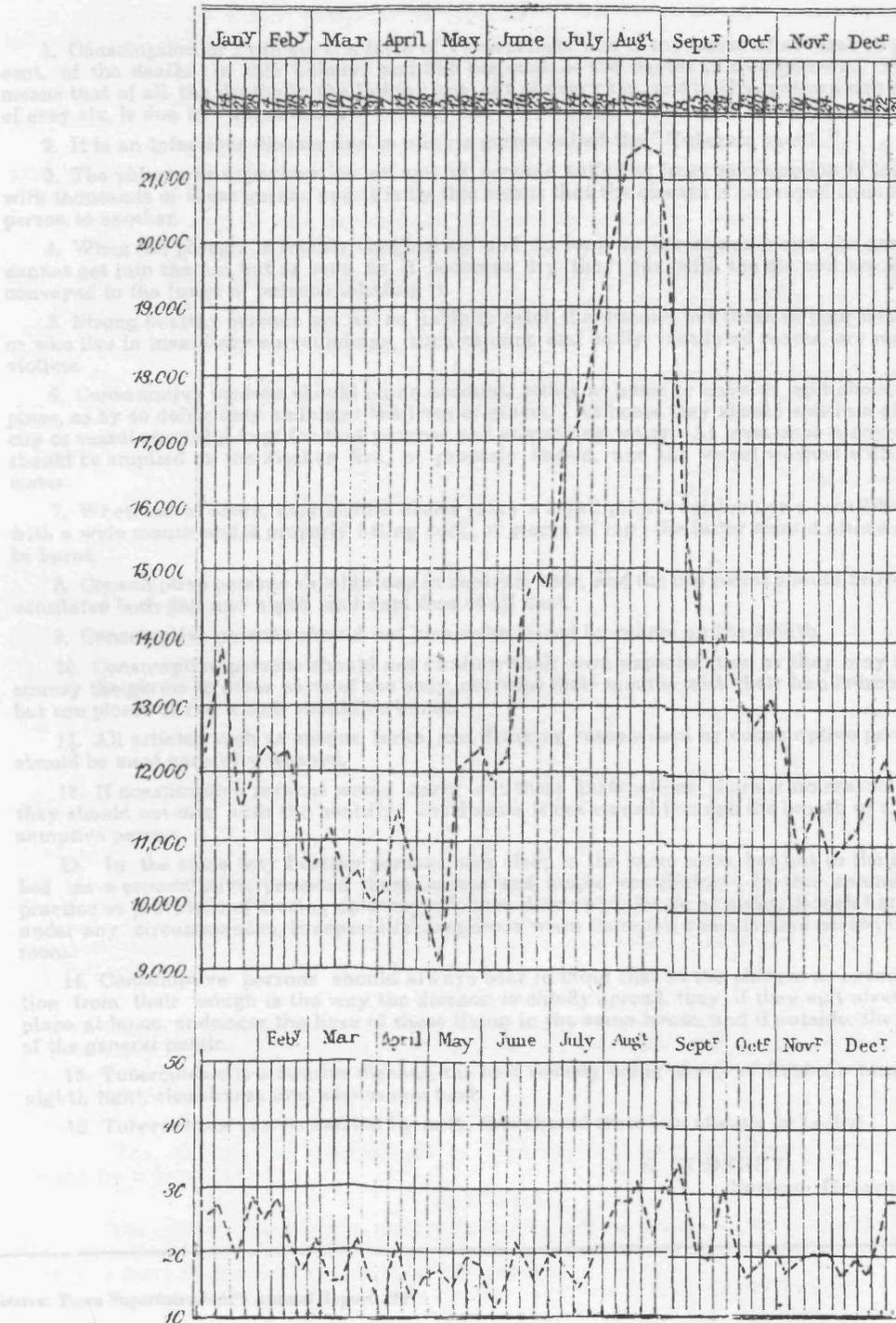
Source: MCP. 8 March 1878 C. O. 114/127

Appendix V



Appendix VII

Chart showing the number of weekly admissions to the Estates' Hospitals for the year 1868 (top chart) and the weekly number of deaths in the Estates' Hospitals (bottom chart)



Source: The Twentieth Report of the Estates' Hospitals 1870

## Appendix VIII

### *TUBERCULOSIS.*

#### HINTS AND SUGGESTIONS FOR THE PREVENTION OF CONSUMPTION AND OTHER FORMS OF TUBERCULOSIS.

1. Consumption or Phthisis is a form of Tuberculosis and is the cause of at least 10 per cent. of the deaths in this Colony, and 15.6 per cent. of the deaths in Georgetown. This means that of all the deaths in the Colony one out of every ten, and in Georgetown one out of every six, is due to Tuberculosis.
2. It is an infectious disease due to minute germs called the "Tubercle bacilli."
3. The phlegm or expectoration or spit of persons suffering from consumption is laden with thousands of these germs, and it is by this means that the disease is conveyed from one person to another.
4. When the phlegm is freshly coughed up and so long as it remains moist, the germs cannot get into the air, but as soon as it becomes dry they mix with the air and are thus conveyed to the lungs of persons inhaling it.
5. Strong healthy persons are not so liable to catch the disease, but those in poor health, or who live in insanitary surroundings, such as dark and badly ventilated rooms, are ready victims.
6. Consumptive persons should on no account, either at home or out-side, spit about the place, as by so doing they endanger the lives of others. At home they should spit in a glass cup or vessel specially kept for that purpose and containing water. At least once a day this should be emptied on the kitchen fire, or properly buried, and the vessel washed with hot water.
7. When out of doors, they should either carry a small pocket spittoon or a small bottle with a wide mouth and a properly fitting cork, or pieces of rag; the latter should afterwards be burnt.
8. Consumptive persons should sleep in separate beds, and the bed rooms should be freely ventilated both day and night, and kept free of all dust.
9. Consumptive persons should not kiss or be-kissed by others on the mouth.
10. Consumptive persons should not swallow their own expectoration as they may thus convey the germs to other parts of the body, nor wipe their mouths with their handkerchiefs, but use pieces of rag which should be burnt.
11. All articles such as spoons, forks, and drinking vessels used by consumptive persons should be most carefully washed.
12. If consumptive persons would carry out these instructions there is no reason why they should not mix with the healthy; the disease is not spread through the breath of a consumptive person.
13. In the same way healthy persons may sleep in the same room, but not in the same bed as a consumptive, provided there is free and ample ventilation. In this colony the practice so prevalent of closing up every window, door and jalousie at night, though harmful under any circumstances, is especially dangerous when there is a consumptive person in the room.
14. Consumptive persons should always bear in mind that as the phlegm or expectoration from their cough is the way the disease is chiefly spread, they, if they spit about the place at home, endanger the lives of those living in the same house, and if outside, the lives of the general public.
15. Tuberculosis is a curable disease, the best remedy being plenty of fresh air (day and night), light, cleanliness and wholesome food.
16. Tuberculosis can be carried by milk, this should therefore always be boiled.

J. E. GODFREY,  
Surgeon General.

## Appendix IX

### HOW TO FEED YOUR INFANTS.

1. The only food for Infants is milk; and no other food should be given for the first nine months of its life.
2. Every mother should endeavour to nurse her child, as breast milk is the best and safest food for infants.
3. The newly-born baby should be put to the breast as soon as it is washed and dressed.
4. During the first nine months all starchy foods, such as paps are most harmful. The child cannot digest them and they cause indigestion, "thrush," diarrhœa and other ailments.
5. For the first six weeks the infant should be fed every second hour during the day, and less frequently as it grows older. During the night it requires to be fed less often—regular habits should be cultivated from the very beginning.
6. When the child is nine months old it should be gradually weaned.
7. If the mother cannot nurse her child, then use pure fresh milk of the cow or goat; in the proportion of two-parts of milk to one of hot water, with a little sugar.
8. If, unfortunately, the mother cannot nurse her child or fresh milk from any cause cannot be obtained, then the next best thing is condensed milk which should be used in accordance with the directions on the tin.
9. The following table is a guide as to the time and number of feeds for both breast and bottle feeding, and as to the quantity to be given when other milk but the mother's is used:—

Age.	No. of feed-ings in 24 hours.	Interval between feeding.	Night feed- ing—10 p.m. to 7 a.m.	Quantity to be given at each feed.	Quantity for 24 hours.
		Hours.		Ounces	Ounces.
1st month ... ..	10	2	2	1 to 2½	10 to 25
2nd month ... ..	8	2½	2	3 to 3½	24 to 28
3rd to 5th month ... ..	7	3	1	4 to 5	28 to 35
6th to 9th month ... ..	7	3	—	5 to 6	35 to 42

10. The bottle and rubber teat with which the cow's milk is given should be well washed after feeding, and when not in use should be left lying in clean boiled water.
11. It is a good thing to give the infant a little water occasionally between feeds; at first only a teaspoonful or two. The water should be boiled.
12. The above table applies as regards hours and number of feeds, to breast as well as bottle feeding. The infant should never be allowed to remain at the breast more than 20 minutes. It must be remembered that at birth the infant's stomach is very small and does not hold more than one ounce of fluid (that is half a wine glass); and if an infant brings up its food this is a sign that the stomach is too full.

#### FRESH AIR.

13. Fresh air is necessary for even the youngest infant. After the first three or four days the child should be taken out every morning and afternoon; and when in the house the windows should be kept open even at night. This will help greatly to make the baby grow strong and sturdy.

#### SLEEP.

14. The infant should sleep in a cot by itself and should always be most carefully protected from mosquitoes.

#### CLOTHING.

15. The young infant is very easily affected by cold and damp winds. It should therefore be carefully clothed with thin soft flannel both by night and during the day, and when this gets damp with perspiration it should be changed.

J. E. GODFREY,  
Surgeon General.

## Appendix X

### *MOSQUITOES.*

*You are responsible for the Mosquitoes in Your Own House and Yard.*

READ THIS CAREFULLY.

1. Mosquitoes frequent the house and yard in which they are bred. They do not fly far to other houses.

2. Mosquitoes live in weeds, grass and bush, sheltering there during the day.

3. The young Mosquito or "Wiggler" lives in water at least 8 to 10 days. They must come often to the surface to breathe. Oil on the surface prevents the "wiggler" obtaining air.

#### TO DESTROY MOSQUITOES.

4. Empty the water from all tubs, buckets, cans, flowerpots, vases; and change the water in Chickencoops and Kennels at least once a week.

5. Treat with oil all standing water which cannot be screened or drained. Two table-spoonfuls of kerosine oil required to every 10 square feet of surface and it must be renewed at least once a week.

6. Put wire-netting (or covers fitting tightly with netted ventilation holes) over cisterns, wells and tanks of water in daily use. The netting must have at least 18 meshes to the inch.

7. Places such as watering troughs, ponds, trenches, etc., which cannot be drained, screened or oiled, may be kept free by putting in them gold fish, millions, etc.

8. Fill in or drain all pools, ditches and excavation holes.

9. Prevent leakage of pipes or clogging of eaves.

10. Clean away all weeds, grass and bush, old tins, calabashes and broken crockery as far as possible.

#### REMEMBER.

11. That Mosquitoes are responsible for Malaria, Yellow Fever and the "Rose."

12. That as a citizen of the community you should feel a personal responsibility for the destruction of Mosquitoes in your district, and should co-operate with your neighbours in destroying breeding places.

13. That relief from Mosquitoes and their diseases in any community is readily obtained and depends upon simultaneous action of all the individuals.

K. S. WISE,  
Govt. Bacteriologist.

## Archives and bibliography

### Primary Sources

#### British Colonial Office Records (Public Record Office)

- C.O. 111 British Guiana: Original correspondence.  
C.O. 112 British Guiana: letters from the Secretary of State.  
C.O. 113 British Guiana: acts/ordinances.  
C.O. 114 British Guiana: sessional papers and Administration Reports. These contain the Reports of the Surgeon General, the Registrar General, and the Reports of the Immigration Agent General.  
C.O. 116 British Guiana: stipendary magistrates reports and blue books.  
C.O. 318 West Indies: original correspondence.  
C.O. 115 Official Gazette.

#### Great Britain – Parliamentary Papers

- P.P. 1839 Vol. XXXIX Correspondence relative to the condition of Hill Coolies.  
P.P. 1840 Vol. XXXIV Copies of reports or despatches to the Governor of British Guiana respecting the Hill Coolies introduced into that Colony.  
P.P. 1841 (I) Vol. XVI Papers relative to the West Indies (British Guiana).  
P.P. 1842 Vol. XXV Colonial Land and Emigration Commissioners.  
P.P. 1844 Vol. XXXV Correspondence relative to the emigration of labour to the West Indies (British Guiana).  
P.P. 1846 Vol. XXX Copies or extracts of despatches and correspondence between the Colonial Office and the Authorities in each of the *West India* Colonies.  
P.P. 1847-48 Vol. XXVI Eight General Report of the Colonial Land and Emigration Commissioners.  
P.P. 1859 (II) Vol. XIV Nineteenth General Report of the Colonial Land and Emigration Commissioners.  
P.P. 1860 Vol. XXIX Twentieth General Report of the Emigration Commissioners.  
P.P. 1865 Vol. XVII Twenty-fifth General Report of the Emigration Commissioners.  
P.P. 1868-69 Vol. XVII Twenty-ninth General Report of the Emigration Commissioners.  
P.P. 1871. Vol. XX Report of the Commissioners Appointed to Enquire into the Treatment of Immigrants in British Guiana. June 1871.

#### Bristol University Archives. West Indies hand-list part 3.

#### Flintshire Record Office, The Old Rectory, Hawarden John Gladstone Papers 2774, 2796, 2798

#### Guiana National Archives

Minutes of the Surgeon General. AE4.

#### Newspapers

##### Argosy

##### British Emancipator

##### Creole

## Archives and bibliography

Daily Chronicle  
Liverpool Standard  
London Telegraph  
London Times  
Nugget  
Royal Gazette  
Weekly Argosy

## Secondary Sources

### Contemporary 1838-1914

The Asylum Journal / conducted by the Medical Superintendent of the Public Lunatic Asylum for British Guiana (Berbice, British Guiana: Asylum Press).

Barnes, W. S. 'Notes on the Absence of *Trismus Neonatorum* and Rickets in the Children of the Colony'. The British Guiana Medical Annual and Hospital Reports (Georgetown: Baldwin and Co., 1894) pp. 37-43.

Blair, Daniel. M. D., Some Account of the Last Yellow Fever Epidemic of British Guiana (London: Longman, Brown, Green, and Longmans, 1850).

Bronkhurst H.V.P. The Colony of British Guiana and its Labouring Population (London: T. Woolmer, 1883).

Census of British Guiana for 1911 (Georgetown: "The Argosy" Co., 1912).

Clapham, Miss. 'The Training of Native Hospital Nurses in the Tropics', West Indian Medical Conference 1921 (Georgetown: "The Argosy" Co., 1921) pp. 13-16.

Craigen, A. J. 'Practice of Midwifery at the Public Hospital Georgetown', The British Guiana Medical Annual for 1910 (Georgetown: "The Argosy" Co., 1912) pp. 25-33.

Craigen, A. J. 'Puerperal Eclampsia or Toxaemia of Later Pregnancy in British Guiana', The British Guiana Medical Annual for 1915 (Georgetown: "The Argosy" Co., 1916) pp. 1-6.

Crookall, L. Wanderings Among the Creoles and Coolies, the Africans and Indians (London: T. F. Unwin, 1898).

Dalton, Henry G. History of British Guiana (London: Longman, Brown, Green, and Longmans, 1855).

Daniels, C. W. 'Further Notes on a Series of Post-Mortems in the Public Hospital Georgetown, April 1893, to March 1895', The British Guiana Medical Annual and Hospital Reports (Georgetown: Baldwin and Co., 1895) pp. 50-79.

Daniels, C.W. 'Negro Fertility and Infantile Mortality', The British Guiana Medical Annual and Hospital Reports (Georgetown: Baldwin and Co., 1898) pp. 8-17.

Daniels, C.W. and Stanton, A.T. Laboratory studies in tropical medicine (London: John Bale, Sons & Danielson, 1907).

## Archives and bibliography

Davidson, Andrew. Hygiene & Diseases of Warm Climates (Edinburgh; London: Young J. Pentland, 1893).

De Freitas, Q. B. 'Difficulties of medical practice in country districts'. West Indian Medical Conference 1921 (Georgetown: "The Argosy" Co., 1921) pp. 20-24.

De Freitas, Q. B. Review of the Salient Stages in the Medical History of the Colony from 1900-1944. Timehri number 26, November 1944, pp. 61-65.

Demerara after Fifteen years of Freedom. By a landowner (London: T. Bosworth, 1853).

Demerara and Essequibo Vade-mecum: Containing the Principal Laws and Regulations of the United Colony and a Variety of Miscellaneous Articles of Local Importance (Georgetown: Stevenson, 1825).

Douglas, J. S. 'Methods and Difficulties of Medicine on the Edge of Civilisation', The British Guiana Medical Annual for 1906 (Georgetown: "The Argosy" Co., 1907) pp. XXVII-XXIX.

Duncan J. Mathews. Fecundity Fertility Sterility and Allied Topics (Edinburgh: Adam and Charles Black, 1871).

Duncan, W. J., M. B., C. M., 'The Public Health Statistics of the Colony', The British Guiana Medical Annual for 1915 (Georgetown: "The Argosy" Co., 1916) pp. 173-179.

Extracts from papers relative to the West Indies (London: Printed by W. Clowes & Sons, for H. M. Stationery office, 1840).

Farr, William. Vital Statistics: Memorial Volume of Selections From The Reports And Writings in Noel A. Humphrys (ed.), (London: The Sanitary Institute, 1885).

Ferguson, J. E. A. 'Pathological Studies in British Guiana', British Guiana Medical Annual and Hospital Reports (Georgetown: Baldwin and Co., 1891) pp. 61-80.

Ferguson, J. E. A. 'Infant Mortality viewed from the records of the Maternity Ward of the Public Hospital', Georgetown. British Guiana Medical Annual and Hospital Reports 1893 (Georgetown: Baldwin and Co., 1893) pp. 173-176.

Field, F. E. 'Report on the Amelioration and Control of Ankylostomiasis', British Guiana Medical Annual 1915 (Georgetown: "The Argosy" Co., 1916) pp. 49-95.

Georgetown Vignettes (Georgetown: Daily Chronicle, 1917).

Hassall, Arthur Hill. Food: Its Adulterations, and the Methods for their Detection (London: Longmans, Green, 1876).

Hill, Luke M. 'Water Supply of Georgetown', West Indian Quarterly number 4, April 1888, pp. 402-418.

Hill, Luke M. 'The Municipality of Georgetown', Timehri 1915. Vol. III. (Georgetown: "The Argosy" Co. Ltd.) pp. 227-235.

## Archives and bibliography

Innes, John. Letter to Lord Glenelg, Secretary of State for the colonies containing a report from the personal observation on The Working of the New System in the British West Indian Colonies (London: Longman, 1835).

Kirke, Henry. Twenty Five Years in British Guiana (London: Sampson Low, Marston, 1898).

Law, W. F. 'Insanity in British Guiana', The Georgetown Hospital Reports for 1887 (Georgetown: Baldwin & Co., 1888) pp. 19-34.

Law, W. F. 'Dysentery in the Gold Diggings, and its Cause', British Guiana Medical Annual and Hospital Reports (Georgetown: Baldwin and Co., 1891) pp. 37-60.

M'Donnell, Alexander. Considerations on Negro Slavery with authentic reports illustrative of the actual condition of the Negroes in Demerara (London: Longman, Hurst, Rees, Orme, Brown, and Green, 1824).

Macnamara, C. E. 'The Free Rural Population from a Medical Point of View', Timehri 2<sup>nd</sup> Series (Demerara, 1888) pp. 285-297.

Minett, E. P. & Wise, K. S. 'Review of the Milk Question in British Guiana', The British Guiana Medical Annual for 1911 (Georgetown: "The Argosy Co., 1913) pp. 47-59.

Minett, E. P. 'Protection of the Milk Supply in British Guiana', The Journal of the London School of Tropical Medicine Vol. 1. 1911-12. (London: Taylor and Francis, 1911-12) pp 217-220.

Minett, E. P. 'Infant Mortality', West Indian Medical Conference 1921 (Georgetown: "The Argosy" Co., 1921) pp. 56-64.

Ozzard, A.T. 'The Mosquito and Malaria', British Guiana Medical Annual (Georgetown: Baldwin and Co., 1902) pp. 26-39.

Ozzard, A. T. 'Village sanitation in British Guiana', British Guiana Medical Annual 1910 (Georgetown: "The Argosy" Co., 1912) pp. 34-42.

Pinckard, George. Notes on the West Indies Written During the Expedition Under the Command of the late Sir Ralph Abercromby Vol. 3. (London: Longman, Hurst, Rees, and Orme, 1806).

Report of the Mortality Commission. The British Guiana Medical Annual 1906 (Georgetown: "The Argosy" Co., 1907) pp. 1-42.

Ridgeway, J. An Abstract of the British West Indian Statutes for the Protection and Government of Slaves (London: J. Ridgeway, 1830).

Rion, Hanna. Painless childbirth in twilight sleep: a complete history of twilight sleep from its beginning in 1903 to its present development in 1915, including its successful use in Great Britain to-day (London: T. Werner Laurie, 1915).

Rodney, W. Ed. Guyanese Sugar Plantations in the Nineteenth Century. A Contemporary Description from the Argosy (Georgetown Guyana: Release Publishers, 1979).

## Archives and bibliography

- Rodway, James. History of British Guiana, from the year 1668 to the present time (Georgetown, Demerara: J. Thomson, 1891-1894).
- Rodway, James. The Story of Georgetown (Georgetown Guyana: Guyana Heritage Society, 1997).
- Rowland, E. D. 'A Contribution to the Study of Bright's Disease, as Seen in Malarious Countries', The British Guiana Medical Annual and Hospital Reports (Georgetown: Baldwin and Co., 1892) pp. 41-73.
- Rowland, E. D. 'Description of the Public Hospital New Amsterdam', The British Guiana Medical Annual and Hospital Reports (Georgetown: Baldwin and Co., 1894) pp. 66-78.
- Rowland, E. D. 'Some Remarks on the Treatment of Dysentery', The British Guiana Medical Annual and Hospital Reports (Georgetown: Baldwin and Co., 1895) pp. 31-49.
- Rowland, E.D. 'Notes on Painless Childbirth by Scopolamine Morphine', The British Guiana Medical Annual for 1915 (Georgetown: "The Argosy" Co., 1916) pp. 12-16.
- Schomburgk, Robert H. The Natural History of the Fishes of Guiana (Edinburgh: W.H. Lizars, ... S. Highley, ... London; and W. Curry, jun. and Co., 1841-1843).
- Scoble, John. HILL COOLIES. A Brief exposure of the Deplorable Condition of the Hill Coolies in British Guiana and Mauritius and of the Nefarious Means by which they were Induced to Resort to these Colonies (London: Harvey and Darton, Gracechurch St., 1840).
- Scoles, Ignatius. 'The Architecture of Georgetown', Timehri. Vol. 4. (Demerara, 1886) pp. 82-121.
- Shier, Dr. The Twentieth Report of the Estates' Hospitals (London: Alabaster and Passmore Printers).
- Thurn, E. 'Notes on British Guiana', Journal of the Royal Colonial Institute number 2, (London: 1892-93) p. 85.
- Trollope, Anthony. The West Indies and the Spanish Main (London: Dawsons of Pall Mall, 1968).
- Royal Agricultural and Commercial Society of British Guiana. Twelve Essays on the Cultivation, Drainage and Manufacture of the Sugar Cane (Georgetown: "The Colonist", 1876).
- Wallbridge, J. S. 'Fifty Years' Recollections of British Guiana', Timehri 3<sup>rd</sup> Series, Vol. 1, number 3, 1911, pp. 260-267.
- Wise, K. S. and Minett, E. P. 'Review of the Milk Question in British Guiana', The British Guiana Medical Annual 1911 (Georgetown: "The Argosy" Co., 1913) pp. 47-59.
- Wise, K.S. 'Review of the Milk Question in British Guiana', Journal of the Royal Sanitary Institute (London: Colonial Supplement October, Edward Stanford Ltd., 1912) pp. 75-84.

## Archives and bibliography

Wishart, W. 'Infant Welfare in Georgetown: Past Present and Future', West Indian Medical Conference 1921 (Georgetown: "The Argosy" Co., 1921) pp. 53-56.

Wishart, W. 'Some Aspects of the Sanitary and Public Health Problems of Georgetown', West Indian Medical Conference 1921 (Georgetown: "The Argosy" Co., 1921) pp. 64-69.

### Modern - Theses and Papers

Barros, Juanita De. Purity and Filth: Views of Indo-Guianese Labour in Colonial Georgetown, 1890-1924. Unpublished paper (Association of Caribbean Historians Conference Surinam, 1998).

Barros, Juanita De. Colonialism and Public Health in the Tropics Unpublished paper presented at 'Colonialism and Public Health in the Tropics', (York University June 18-19 1999).

Carroll, William Edward. The End of Slavery: Imperial Policy and Colonial Reaction in British Guiana (Ann Arbor, Michigan: University Microfilms International. University of Michigan Thesis (PhD), 1970).

Li, Shang-Jen. British Imperial Medicine in the Late Nineteenth-Century China and the Early Career of Patrick Manson (Thesis, (PhD) Imperial College, 1999).

Luxemburger, Christine. Effects of malaria and anaemia during pregnancy on survival and morbidity of infants living in an area of low malaria transmission (Thesis, (PhD) University of London, 1999).

Mooney, Graham. Infectious diseases in nineteenth-century Britain: Notification, diagnosis and medical education (Unpublished paper presented at Wellcome Work in Progress, 2000).

Ngalamulume, J. Kalala. City Growth, Health Problems, and Colonial Government Response: Saint-Louis (Senegal), From Mid-Nineteenth Century to the First World War (Ann Arbor, Michigan, University Microfilms International 1999. Thesis, (PhD) Michigan State University, 1996).

### Modern - Secondary texts

Adamson, Alan H. Sugar Without Slaves The Political Economy of British Guiana, 1838-1904 (New Haven; London: Yale U.P., 1972).

Adas, Michael. Machines as the Measure of Man. Science, Technology, and Ideologies of Western Dominance (Ithaca, N.Y.; London: Cornell University Press, 1989).

Albert, Bill. 'The Labour Force on Peru's Sugar Plantations 1820-1930: A Survey', in Bill Albert and Adrian Graves (eds.), Crisis and Change in the International Sugar Economy 1860-1914 (Norwich: ISC Press, 1984) pp.199-215.

## Archives and bibliography

Arnold, David. 'Disease, Medicine and Empire', in David Arnold (ed.), Imperial Medicine and Indigenous Societies. Disease, Medicine, and Empire in the Nineteenth and Twentieth Centuries (Manchester; New York: Manchester University Press; New York: Distributed exclusively in the USA and Canada by St. Martin's Press, c1988) pp. 1-26.

Arnold, David. Colonising the Body. State Medicine and Epidemic Disease in Nineteenth-Century India (Berkeley: University of California Press, 1993).

Arnold, David. The Problem of Nature. Environment, Culture and European Expansion (Oxford: Blackwell, 1996).

Arnold, David. ' 'An ancient race outworn.' Malaria and Race in Colonial India, 1860-1930', in Waltraud Ernst and Bernard Harris (eds.), Race, Science and Medicine 1700-1960 (London: Routledge, 1999) pp. 123-143.

Atkins, P. J. 'Sophistication Detected: or the Adulteration of the Milk Supply, 1850-1914', Social History of Medicine Vol. 16, number 3, 1991, pp. 317-339.

Atkins, P. J. 'White Poison? The Social Consequences of Milk Consumption, 1850-1930', Social History of Medicine Vol. 5, 1992, pp. 207-227.

Banton, Michael. Racial Theories (Cambridge: Cambridge University Press, 1987).

Barber, William J. British Economic Thought and India 1600-1858 (Oxford: Clarendon Press, 1975).

Barros, Juanita De. ' "To Milk or Not to Milk?" Regulation of the Milk Industry in Colonial Georgetown', The Journal of Caribbean History Vol. 31, 1997, pp. 185-208.

Beechert, Ed. 'Labour Relations in the Hawaiian Sugar Industry 1850-1937', in Bill Albert and Adrian Graves (eds.), Crisis and Change in the International Sugar Economy 1860-1914 (Norwich: ISC Press, c1984) pp. 281-290.

Bell, Susan Groag and Offen Karen M. (eds.), Women, the Family, and Freedom Vol. 2. 1880-1950. (Stanford California: Stanford University Press, 1984).

Bhadra, Gautam. 'The Mentality of Subalternity: Kantanama or Rajdharm', in Ranajit Guha (ed.), Subaltern Studies VI (New Delhi: Oxford University Press, 1989) pp. 54-91.

Briggs, Asa. Victorian Cities (Berkeley and Los Angeles: California University of California Press, 1993).

Blackburn, Robin. The Overthrow of Colonial Slavery 1776-1848 (London; New York: Verso, 1988).

Bolland, Nigel. 'Systems of Domination after Slavery: The Control of Land and Labour in the British West Indies after 1838', in Hilary Beckles and Verene Shepherd (eds.), Caribbean Freedom. Economy and Society from Emancipation to the Present (Kingston, Jamaica: Randle London: James Curry, 1993) pp. 107-123.

Borst, Charlotte G. Catching Babies The Professionalization of Childbirth, 1870-1920 (Cambridge, Mass: Harvard University Press, 1995).

## Archives and bibliography

- Braithwaite, Carl A. 'The African-Guyanese Demographic Transition: An Analysis of Growth Trends, 1838-1988', in Winston F. McGowan, James G. Rose, David A. Granger (eds.), Themes in African-Guyanese History (Georgetown: Free Press, 1998) pp. 201-234.
- Bryder, Linda. 'A New World? Two Hundred Years of Public Health in Australia and New Zealand' in D. Porter (ed.), The History of Public Health and the Modern State (Amsterdam – Atlanta: GA Rodopi, 1994) pp 313-334.
- Burroughs, Peter. 'Imperial Institutions and the Government of Empire', in Andrew Porter (ed.), The Oxford History of the British Empire. The Nineteenth Century (Oxford: Oxford University Press, 1999) pp. 170-197.
- Butchart, Alexander. The Anatomy of Power. European Constructions of the African Body (London: Zed Books, 1998).
- Cain P. J. and Hopkins A. G. British Imperialism Innovation and Expansion 1688-1914 (London and New York: Longman, 1993).
- Cannadine, David. Ornamentalism. How the British Saw Their Empire (London: Allen Lane, 2001).
- Carter, Marina. Voices from Indenture. Experiences of Indian Migrants in the British Empire (London: Leicester University Press, 1996).
- Cassel, Jay. 'Public Health in Canada', in D. Porter (ed.), The History of Public Health and the Modern State (Amsterdam – Atlanta, GA Rodopi, 1994) pp. 276-312.
- Catanach, I. J. 'Plague and Tensions of Empire', in D. Arnold (ed.), Imperial Medicine and Indigenous Societies disease, medicine, and empire in the nineteenth and twentieth centuries (Manchester; New York: Manchester University Press; New York: Distributed exclusively in the USA and Canada by St. Martin's Press, c1988) pp. 149-171.
- Clementi, Cecil. A Constitutional History of Guiana (London: Macmillan and Co. Ltd., 1937).
- Cohn, Bernard S. Colonialism and its Forms of Knowledge. The British in India (Princeton: Princeton University Press, 1996).
- Cole, Joshua. The Power of Large Numbers, Population, Politics and Gender in Nineteenth-Century France (Ithaca: Cornell University Press, 2000).
- Comacchio, Cynthia R. 'The Infant Soldier': Early Child Welfare Efforts in Ontario', in Valerie Fildes, Lara Marks and Hilary Marland (eds.), Women and Children First. International Maternal and Infant Welfare 1870-1945 (London; New York: Routledge, 1992) 97-120.
- Conklin, Alice L. A Mission to Civilize. The Republican Idea of Empire in France and West Africa, 1895-1930 (Stanford, California: Stanford University Press, 1997).
- Conway, H. Peoples Parks. The Design and Development of Victorian Parks in Britain (Cambridge: Cambridge University Press, 1991).

## Archives and bibliography

- Cook, Harold J. 'Physical Methods', in W. Bynum and R. Porter (eds.), Companion Encyclopedia of the History of Medicine Vol. 2. (London; New York: Routledge, 1993) pp. 939-960.
- Crouzet, F. The Victorian Economy (London: Methuen, 1982).
- Crowther, M. A. The Workhouse System 1834-1929 (London: Methuen, 1983).
- Cunningham, Andrew. 'Transforming Plague. The Laboratory and the Identity of Infectious Disease.', in Andrew Cunningham & Perry Williams (eds.), The Laboratory Revolution in Medicine (Cambridge: Cambridge University Press, 1992) pp. 209-244
- Cunningham, Andrew and Andrews, Bridie, 'Introduction', in Andrew Cunningham and Bridie Andrews (eds.), Western Medicine as Contested Knowledge (New York: Manchester University Press: Distributed exclusively in the USA by St. Martin's Press, 1997) pp. 1-21.
- Curtin, Philip D. 'Medical Knowledge and Urban Planning in Tropical Africa', American Historical Review Vol. 90, June 1985, pp. 594-613.
- Curtin, Philip D. 'The British Sugar Duties and West Indian Prosperity', in Hilary Beckles and Verene Shepherd (eds.), Caribbean Freedom. Economy and Society from Emancipation to the Present (Kingston, Jamaica: Randle London: James Curry, 1993) pp. 314-318.
- Curtin, Philip D. 'Africa and Global Patterns of Migration', in Wang Gungwu (ed.), Global History and Migrations (Oxford: Westview Press, 1997) pp. 63-94.
- Curtin, Philip D. The Rise and Fall of the Plantation Complex: Essays in Atlantic History (Cambridge, U.K.; New York: Cambridge University Press, 1998).
- Dalziel, Raewyn. 'Southern Islands: New Zealand and Polynesia', in Andrew Porter (ed.), The Oxford History of the British Empire. The Nineteenth Century (Oxford: Oxford University Press, 1999) pp. 573-596.
- Davies, A. M. 'Geographical epidemiology of the toxemias of pregnancy', Journal of Medical Science 1971 Vol 7. cited in Rush, David. 'Nutrition and maternal mortality in the developing world', American Journal of Clinical Nutrition Vol. 72, number 1 (supplement); July 2000, pp. 212-214.
- Davies, Celia. 'The Health Visitor as Mother's Friend: A Woman's Place in Public Health, 1900-14', Social History of Medicine Vol. 1, 1988, pp. 39-59.
- Davin, Anna. 'Imperialism and Motherhood', in Frederick Cooper and Ann Laura Stoler (eds.), Tension of Empire Colonial Cultures in a Bourgeois World. Tension of Empire Colonial Cultures in a Bourgeois World (Berkeley, California; London: University of California Press, 1997) pp. 87-151.
- Davis, Mike. Late Victorian Holocausts. El Nino Famines and the Making of the Third World (London; New York: Verso, 2001).
- De Clercq, Francine and Legassick, Martin. 'Capitalism and Migrant Labour in Southern Africa: The Origins and Nature of the System', in Shula Marks and Peter Richardson (eds.),

## Archives and bibliography

International Labour Migration Historical Perspectives (Hounslow, Middlesex: Published for the Institute of Commonwealth Studies by M. Temple Smith, 1984) pp. 140-166.

Deacon, Harriet. 'Racial Categories and Psychiatry in Africa. The Asylum on Robben Island in the Nineteenth Century', in Waltraud Ernst and Bernard Harris (eds.), Race, Science and Medicine 1700-1960 (London: Routledge, 1999) pp. 101-122.

Delle, James A. An Archaeology of Social Space. Analyzing Coffee Plantations in Jamaica's Blue Mountains (New York; London: Plenum Press, 1998).

Denoon, Donald with Wyndham, Marivic. 'Australia and the Western Pacific', in Andrew Porter (ed.), The Oxford History of the British Empire. The Nineteenth Century (Oxford: Oxford University Press, 1999) pp. 546-572.

Despres, Leo A. Cultural Pluralism and Nationalist Politics in British Guiana (Chicago: Rand McNally, 1967).

Dewey, Clive. Anglo-Indian Attitudes: The Mind of the Indian Civil Service (London; Rio Grande: Hambledon Press, 1993).

Digby, Anne. Making a Medical Living. Doctors and Patients in the English Market for Medicine, 1720-1911 (Cambridge; New York: Cambridge University Press, 1994).

Dobson, Mary J. Contours of Death and Disease in Early Modern England (Cambridge: Cambridge University Press, 1997).

Douglas Mary. Purity and Danger. An Analysis of Concepts of Pollution and Taboo (London; New York: Routledge, 2000).

Dow, Derek A. Maori Health & Government Policy 1840-1940 (Wellington: Victoria University Press, 1999).

Drayton, Richard. Nature's Government. Science, Imperial Britain, and the 'Improvement' of the World (New Haven, CT: Yale University Press, 2000).

Dwork, Deborah. War is Good for Babies and Other Young Children. A History of the Infant Child Welfare Movement in England 1898-1918 (London; New York: Tavistock Publications, 1987).

Eekelen, Annemarie De Knecht-Van. 'The Debate about Acclimatisation in the Dutch East Indies (1840-1860)', in Nicolaas A Rupke, Medical Geography in Historical Perspective (London: The Wellcome Trust Centre for the History of Medicine at UCL, 2000) pp. 70-85.

Eldridge, C.C. England's Mission The Imperial Idea in the Age of Gladstone and Disraeli 1868-1880 (London: Macmillan Press, 1973).

Erach, Udawadia Farokh. Tetanus (Oxford: Oxford University Press, 1994).

Ernst, Waltraud. 'Colonial Policies, Racial Politics and the Development of Psychiatric Institutions in Early Nineteenth-century British India', in Waltraud Ernst and Bernard Harris (eds.), Race, Science and Medicine 1700-1960 (London: Routledge, 1999) pp. 80-100.

## Archives and bibliography

Evans, Eric J. The Forging of the Modern State. Early Industrial Britain 1783-1870 (London: Longman, 1983).

Eyler, John M. Victorian Social Medicine. The Ideas and Methods of William Farr (Baltimore: Johns Hopkins University Press, 1979).

Eyler, John M. Sir Arthur Newsholme and State Medicine 1885-1935 (Cambridge; New York: Cambridge University Press, 1997).

Fee Elizabeth and Porter Dorothy. 'Public health, Preventative Medicine and Professionalism: England and America in the Nineteenth Century', in Andrew Wear (ed.), Medicine in Society (Cambridge: Cambridge University Press, 1992) pp. 249-275.

Fladeland, Betty. 'Our Cause Being One and the Same': Abolitionists and Chartism', in J. Walvin (ed.), Slavery and British Society 1776-1846 (Baton Rouge: Louisiana State University Press, c1982) pp. 69-99.

Foucault, M. 'Space Knowledge and Power', in Paul Rabinow (ed.), The Foucault Reader (London: Penguin, 1991) pp. 239-256.

Fox, Enid. 'Midwifery in England and Wales before 1936: Handywomen and Doctors', International History of Nursing Journal Vol. 1, number 2, 1995, pp. 17-27.

Fraser, Gertrude Jacinta. African American Midwifery in the South. Dialogues of Birth Race and Memory (Cambridge [Mass.]; London: Harvard University Press, 1998).

French, Michael and Phillips, Jim. 'State Regulation and the Hazards of Milk, 1900-1939', Social History of Medicine Vol. 12, number 3, December 1999, pp. 371-388.

Geyer-Kordesch, Johanna and MacDonald, Fiona. Physicians and Surgeons in Glasgow: The history of the Royal College of Physicians in Glasgow, 1599-1858 (London: Hambledon Press, 1999).

Ghai, Yash. 'Migrant Workers, Markets, and the Law', in Wang Gungwu (ed.), Global History and Migrations (Oxford: Westview Press, 1997) pp. 145-182.

Good, Byron J. Medicine Rationality and Experience. An Anthropological Perspective (Cambridge; New York: Cambridge University Press, 1994).

Grace, Wendy and McHoul, Alec. A Foucault Primer. Discourse, Power and the Subject (London: UCL Press, 1995).

Granshaw, Lindsay 'The Rise of the Modern Hospital in Britain', in Andrew Wear (ed.), Medicine and Society (Cambridge: Cambridge University Press, 1998) pp. 197-218.

Graves, Adrian. 'The Nature and Origins of Pacific Islands Labour Migration to Queensland, 1863-1906', in Shula Marks and Peter Richardson (eds.), International Labour Migration Historical Perspectives (Hounslow, Middlesex: Published for the Institute of Commonwealth Studies by M. Temple Smith, 1984) pp. 112-139.

Green, Edward C. Indigenous Theories of Contagious Disease (Walnut Creek; London: AltaMira Press, 1999).

## Archives and bibliography

Green, William. A. British Slave Emancipation The Sugar Colonies and the Great Experiment 1830-1865 (Oxford: Clarendon Press, 1991).

Guha, Ranajit. 'Dominance Without Hegemony And Its Historiography', Subaltern Studies VI (New Delhi: Oxford University Press, 1989) pp. 210-309.

Haines, Robin and Shlomowitz, Ralph, 'Explaining the Modern Mortality Decline: What can we Learn from Sea Voyages?', Social History of Medicine Vol. 11, number 1, 1998, pp. 15-48.

Hacking, Ian. 'Biopower and the Avalanche of Printed Numbers', Humanities in Society Vol. 5, Summer 1982, pp. 279-295.

Hamilton, David. The Healers A History of Medicine in Scotland (Edinburgh: Canongate, 1987).

Hamlin, Christopher. Public Health and Social Justice in the Age of Chadwick. Britain 1800-1854 (Cambridge: Cambridge University Press, 1998).

Hardy, Anne. 'Food, Hygiene, and the Laboratory. A Short History of Food Poisoning in Britain, circa 1850-1950', Social History of Medicine Vol. 12, number 2, August 1999, pp. 293-311.

Hardy, Anne. Health And Medicine in Britain Since 1860 (Basingstoke: Macmillan, 2000).

Harley, David. 'Rhetoric and the Social Construction of Sickness and Healing', Social History of Medicine Vol. 12, number 3, December 1999, pp. 407-435.

Harper, Marjory. 'British Migration and the Peopling of the Empire', in Andrew Porter (ed.), The Oxford History of the British Empire. The Nineteenth Century (Oxford: Oxford University Press, 1999) pp. 75-87.

Harrison, Brian. 'Philanthropy and the Victorians', in Brian Harrison, Peaceable Kingdom: Stability and Change in Modern Britain (Oxford 1982) pp. 217-259.

Harrison, Lindsey. 'Government Policy and the Health Status of Aboriginal Australians in the Northern Territory, 1945-72', in Lara Marks and Michael Worboys (eds.), Migrants, Minorities and Health (London: Routledge, 1997) pp. 125-146.

Harrison, Mark. Public Health in British India. Anglo-Indian Preventative Medicine 1859-1914 (Cambridge: Cambridge University Press, 1994).

Harrison, Mark. "'The Tender Frame of Man": Disease, Climate, and Racial Difference in India and the West Indies, 1760-1860' Bulletin of the History of Medicine Vol. 70, number 1, Spring 1996, pp. 68-93.

Harrison, Mark. Climates and Constitutions. Health, Race, Environment and British Imperialism in India 1600-1850 (New Delhi; Oxford: Oxford University Press, 1999).

Harvey, David. Spaces of Hope (Edinburgh: Edinburgh University Press, 2000).

## Archives and bibliography

- Havinden, Michael and Meredith, David. Colonialism and Development. Britain and its Tropical Colonies, 1850-1960 (London; New York: Routledge, 1993).
- Headrick, D. R. The Tentacles of Progress: Technology Transfer in the Age of Imperialism, 1850-1940 (New York; Oxford: Oxford University Press, 1988).
- Headrick Rita. Colonialism, Health and Illness in French Equatorial Africa 1885-1935 (Atlanta, Ga.: African Studies Association Press, 1994).
- Helman, Cecil G. Culture, Health and Illness (Oxford: Butterworth Heinemann, 2000).
- Henriques, Ursula R. Q. Before the Welfare State: Social Administration in Early Industrial Britain (London: Longman, 1979).
- Hewa, Soma. Colonialism, Tropical Disease and Imperial Medicine Rockefeller Philanthropy in Sri Lanka (Lanham, MD: University Press of America, 1995).
- Higman, B. W. Slave Populations of the British Caribbean 1807-1834 (Kingston, Jamaica: The Press University of the West Indies, 1995).
- Hobsbawm, E. J. The Age of Revolution 1789-1848 (London: Abacus, 1977).
- Hobsbawm, E. J. The Age of Capital 1848-1875 (London: Abacus, 1977).
- Hoefte, Rosemarijn. In Place of slavery. A Social History of British Indian and Javanese laborers in Suriname (Gainesville: University Press of Florida, 1998).
- Hoetink, H. "‘Race’ and Colour in the Caribbean", in Sidney W. Mintz and Sally Price (eds.), Caribbean Contours (Johns Hopkins University Press, 1992) pp. 55-84.
- Hohenberg, Paul H and Hollen Lees, Lyn. The Making of Urban Europe, 1000-1950 (Cambridge, Mass.: Harvard University Press, 1985).
- Hyam, Ronald. Britain’s Imperial Century 1815-1914. A Study of Empire and Expansion (London: Macmillan Press, 1976).
- Jewson, N. 'Medical Knowledge and the Patronage System in Eighteenth-Century England', Sociology Vol. 8, 1974, pp. 369-85.
- John, A. Meredith. 'Plantation slave mortality in Trinidad' Population Studies Vol. 42, 1988, pp. 161-182.
- Jordanova, Ludmilla. 'Earth science and environmental medicine: the synthesis of the late Enlightenment', in Ludmilla Jordanova and Roy Porter (eds.), Images of the Earth. Essays in the History of the Environmental Sciences (Oxford: British Society for the History of Science, 1997) pp. 127-152.
- Kay, Margarita Artschwager. Anthropology of Human Birth (Philadelphia: F.A. Davis, 1982).
- Kiple, Kenneth F. The Caribbean Slave: a biological history (Cambridge; New York: Cambridge University Press, 1984).

## Archives and bibliography

- Kumar, Deepak. Science and the Raj 1857-1905 (Delhi: Oxford University Press, 1995).
- Kupermann, Karen Ordahl. 'Fear of Hot Climates in the Anglo-American Experience', William and Mary Quarterly Vol. 41, 1984, pp. 213-240.
- Laurence, K. O. 'The Evolution of Long-Term Labour Contracts in Trinidad and British Guiana 1834-1863', in Hilary Beckles and Verene Shepherd (eds.), Caribbean Freedom. Economy and Society from Emancipation to the Present (Kingston, Jamaica: Randle London: James Curry, 1993) pp. 141-151.
- Laurence, K. O. 'The Development of Medical services in British Guiana and Trinidad 1841-1873', in Hilary Beckles and Verene Shepherd (eds.), Caribbean Freedom. Economy and Society from Emancipation to the Present (Kingston, Jamaica: Randle London: James Curry, 1993) pp. 269-273.
- Laurence, K. O. A Question of Labour. Indentured Immigration into Trinidad and British Guiana 1875-1917 (London: James Curry Kingston: Ian Randle, 1994).
- Lawrence, Christopher. 'Disciplining disease: scurvy, the navy, and imperial expansion. 1750-1825', in D. Miller and P. Reill (eds.), Visions of Empire (Cambridge: Cambridge University Press, 1994) pp. 81-106.
- Lefebvre, H. The Production of Space (Oxford: Basil Blackwell, 1991).
- Levy, Claude. Emancipation, Sugar, and Federalism. Barbados and the West Indies, 1833-1876 (Gainesville: University Presses of Florida, 1979).
- Lewis, Jan. 'Mother's Love: The Construction of Emotion in Nineteenth-Century America', in Rima D. Apple and Janet Golden (eds.), Mothers and Motherhood Readings in American History (Columbus: Ohio State University Press, 1997) pp. 52-71.
- Livingstone, David N. 'Human acclimatisation: Perspectives on a contested field of enquiry in science, medicine and geography', History of Science Vol. 25, 1987, pp. 359-394.
- Livingstone, David N. 'Tropical climate and moral Hygiene: the Anatomy of a Victorian Debate', British Journal for the History of Science Vol. 32, pt. 1:112, March 1999, pp. 93-110.
- Lobdell, Richard A. 'Patterns of Investment and Sources of Credit in the British West Indian Sugar Industry, 1838-1897', in Hilary Beckles and Verene Shepherd (eds.), Caribbean Freedom. Economy and Society from Emancipation to the Present (Kingston, Jamaica: Randle London: James Curry, 1993) pp. 319-329.
- Loomba, Ania. Colonialism / Postcolonialism (London: Routledge, 1998).
- Lorimer, Douglas A. Colour Class and the Victorians. English attitudes to the Negro in the mid-nineteenth century (Leicester, Eng.]: Leicester University Press; New York: Holmes & Meier, 1978).
- Loudon, Irvine. 'Some international features of maternal mortality, 1880-1950', in Valerie Fildes, Lara Marks and Hilary Marland (eds.), Women and Children First. International Maternal and Infant Welfare 1870-1945 (London; New York: Routledge, 1992) pp. 5-28.

## Archives and bibliography

Loudon, Irvine. Death in Childbirth. An International Study of Maternal Care and Maternal Mortality 1800-1950 (Oxford: Clarendon Press; Oxford; New York: Oxford University Press, 1992).

Loudon, Irvine. The Tragedy of Childbed Fever (Oxford: Oxford University Press, 2000).

Loudon, Irvine. 'Midwives and the Quality of Maternal Care', in Hilary Marland & Anne Marie Rafferty (eds.), Midwives, Society and Childbirth: Debates and Controversies in the Modern Period (London: Routledge, 1997) pp. 180-200.

MacCormack, Carol P. 'Health Care and the Concept of Legitimacy in Sierra Leone', in Steven Feierman and John M. Janzen (eds.), The Social Basis of Health and Healing in Africa (Berkeley; Los Angeles; Oxford: University of California Press, 1992) pp. 426-436.

Mackenzie, John M. 'Empire and Metropolitan Cultures', in A. Porter (ed.), The Oxford History of the British Empire. The Nineteenth Century (Oxford: Oxford University Press, 1999) pp. 270-293.

MacLeod, Roy. 'Introduction', in Roy MacLeod and Milton Lewis (eds.), Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion (London; New York: Routledge, 1988) pp. 1-18.

Maggs, Christopher. 'A General History of Nursing: 1800-1900', in W. Bynum and R. Porter (eds.), Companion Encyclopedia of the History of Medicine Vol. 2. (London; New York: Routledge, 1993) pp. 1309-1328.

Malik, Kenan. The Meaning of Race. Race History and Culture in Western Society (Basingstoke, England: Macmillan, 1996).

Manderson, Lenore. 'Women and the state: maternal and child welfare in colonial Malaya, 1900-1940', in Valerie Fields, Lara Marks and Hilary Marland (eds.), Women and Children First. International Maternal and Infant Welfare 1870-1945 (London; New York: Routledge, 1992) pp. 154-177.

Manderson, Lenore. Sickness and the State. Health and Illness in Colonial Malaya, 1870-1940 (New York: Cambridge University Press, 1996).

Mangru, Basedo. Benevolent Neutrality. Indian Government Policy and Labour Migration to British Guiana 1854-1884 (London: Hansib Pub. Ltd., 1987).

Mann, Michael. The Sources of Social Power. Vol. 1. A History of Power from the Beginning to A.D. 1760 (Cambridge: Cambridge University Press, 1986).

Manson, Michael. The Making of Victorian Sexuality (Oxford: Clarendon Press; New York: Oxford University Press, 1994)

Markowitz, Gerald and Rosner, David. 'The Illusion of Medical Certainty: Silicosis and the Politics of Industrial Disability, 1930-1960', in Charles E. Rosenberg and Janet Golden (eds.), Studies in Cultural History. Framing Disease (New Brunswick, N.J.: Rutgers University Press, 1992) pp. 185-205.

## Archives and bibliography

Marks, Lara V. 'Mothers Babies and Hospitals', in Valerie Fields, Lara Marks and Hilary Marland (eds.), Women and Children First. International Maternal and Infant Welfare 1870-1945 (London; New York: Routledge, 1992) pp. 48-73.

Marks, Lara V. Model Mothers Jewish Mothers and Maternity Provision in East London 1870-1939 (Oxford: Clarendon Press; New York: Oxford University Press, 1994).

Marks, Lara V. Metropolitan Maternity: Maternal and Infant Welfare Services in Early Twentieth Century London (Amsterdam; Atlanta, Ga.: Rodopi, 1996).

Marks, Lara and Worboys, Michael. 'Introduction', in Lara Marks and Michael Worboys (eds.), Migrants, Minorities and Health (London: Routledge, 1997) pp. 1-21.

Marks, Shula. What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health? Social History of Medicine. Vol. 10, number 2, August 1997, pp. 205-219.

Marland Hilary, and Rafferty, Anne Marie. 'Introduction', in Hilary Marland and Anne Marie Rafferty (eds.), Midwives, Society and Childbirth. Debates and Controversies in the Modern Period (London: Routledge, 1997) pp. 1-13.

Marland, Hilary. 'The Midwife as Health Missionary. The Reform of Dutch Childbirth Practices in the Early Twentieth Century', in Hilary Marland & Anne Marie Rafferty (eds.), Midwives, Society and Childbirth. Debates and Controversies in the Modern Period (London: Routledge, 1997) pp. 153-179.

Marshall, P. J. 'An Expanding Trade', in P. J. Marshall (ed.), Cambridge Illustrated History of the British Empire (Cambridge: Cambridge University Press, 1996) pp. 24-51.

Marx, Karl. The Communist Manifesto (Beijing: Foreign Language Press, 1973).

McGowan, Winston F. 'The Demerara Revolt, 1823', in Winston F. McGowan, James G. Rose, David A. Granger (eds.), Themes in African-Guyanese History (Georgetown: Free Press, 1998) pp. 107-140.

McIntosh, Tania. 'Profession, Skill or Domestic Duty?', Social History of Medicine Vol. 11, number 3, December 1998, pp. 403-420.

Mercer, Helen. Constructing a Competitive Order. The Hidden History of British Anti-trust Policies (Cambridge; New York: Cambridge University Press, 1995).

Metcalf, Thomas R. Ideologies of the Raj (Cambridge: Cambridge University Press, 1994).

Midgley, Claire. Women Against Slavery. The British Campaigns 1780-1870 (London; New York: Routledge, 1992).

Millward Robert and Bell, Frances. 'Choices for town councillors in nineteenth-century Britain: investment in public health and its impact on mortality' in Sally Sheard and Helen Power (eds.), Body and City. Histories of Urban Public Health (Aldershot: Ashgate, 2000) pp. 143-165.

## Archives and bibliography

- Mintz, Sidney. Sweetness and Power: The Place of Sugar in Modern History (New York: Viking, 1985).
- Monteith, Kathleen E. A. 'Emancipation and Labour on Jamaica Coffee Plantations, 1838-48', Slavery and Abolition Vol. 21, number 3, December 2000, pp. 125-135.
- Moore, Brian L. Race, Power and Social Segmentation in Colonial Society. Guyana After Slavery 1838-1891 (New York: Gordon and Breach Science, 1987).
- Moore, Brian L. Culture Power Resistance and Pluralism. Colonial Guyana 1838-1900 (Montreal: McGill-Queen's University Press, 1995).
- Moore, Brian L. 'African-Guyanese Political Disempowerment During the Nineteenth Century', in W. F. McGowan, J. G. Rose, D. A. Granger (eds.), Themes in African-Guyanese History (Georgetown: Free Press, 1998) pp. 235-250.
- Morrison, Ken. Marx, Durkheim, Weber, Formations of Modern Social Thought (London – Thousand Oaks – New Delhi: Sage publications, 1995).
- Nath, Dwarka. A History of Indians in Guyana (London: The Author, 1970).
- Nehaul, B. 'Influence of Indian Immigration', Timehri number, 34, 1955, pp. 35-40.
- Nehusi, Kimani S. 'The Causes of the Protest of 1905', in Winston F. Mc. Gowan, James G. Rose, David Granger (eds.), Themes in African-Guyanese History (Georgetown: Free Press, 1998) pp. 251-276.
- Neocleous, Mark. The Fabrication of Social Order. A Critical Theory of Police Power (London: Pluto Press, 2000).
- Niemi, Marjaana. 'Public health discourses in Birmingham and Gothenburg, 1890-1920', in Sally Sheard and Helen Power (eds.), Body and City. Histories of Urban Public Health (Aldershot: Ashgate, 2000) pp. 123-142.
- Northrup, David. Indentured Labour in the Age of Imperialism 1834-1922 (Cambridge: Cambridge University Press, 1995).
- Nuttall, Alison. 'A preliminary survey of midwifery training in Edinburgh, 1844 to 1870', International History of Nursing Journal Vol. 4, number 2, 1998/1999, pp. 4-14.
- Pati, Biswamoy and Harrison, Mark. 'Introduction' in Biswamoy Pati and Mark Harrison (eds.), Health Medicine and Empire: Perspectives on Colonial India (London: Sangam Books, 2001).
- Parsons, Timothy H. The British Imperial Century 1815-1914 (Lanham, Md.; Oxford: Rowman & Littlefield, 1999).
- Perkin, Harold. The Rise of Professional Society. England Since 1880 (London; New York: Routledge, 1989).

## Archives and bibliography

- Porter, Andrew. 'Trusteeship and Humanitarianism', in A. Porter (ed.), The Oxford History of the British Empire. The Nineteenth Century (Oxford: Oxford University Press, 1999) pp. 198-221.
- Porter, A. N. (ed.), Atlas of British Overseas Expansion (London: Routledge, 1991).
- Porter, Dorothy. "'Enemies of the Race": Biologism, Environmentalism, and Public Health in Edwardian England', Victorian Studies Vol. 34, number 1, 1990, pp. 159-178.
- Porter, Dorothy. 'Public Health', in W. Bynum and R. Porter (eds.), Companion Encyclopedia of the History of Medicine Vol. 2. (London; New York: Routledge, 1993) pp. 1232-1261.
- Porter, Dorothy. (ed.), The History of Public Health and the Modern State (Amsterdam – Atlanta: GA Rodopi, 1994).
- Porter, Dorothy. Health, Civilization and the State (London; New York: Routledge, 1999).
- Porter, Roy. 'Religion and Medicine', in W. Bynum and R. Porter (eds.), Companion Encyclopedia of the History of Medicine Vol. 2. (London; New York: Routledge, 1993) pp. 1449-1468.
- Porter, Roy. The Greatest Benefit to Mankind (New York: Norton & Co., 1998).
- Porter, Roy. 'Medical futures', see The Wilkins Lecture 2000: medical futures / by Roy S. Porter (Notes and records of the Royal Society of London). Vol. 55, number 2, May 2001, pp. 309-323.
- Power, Helen. 'The Calcutta School of Tropical Medicine: Institutionalizing Medical Research in the Periphery', Medical history Vol. 40, 1996, pp. 197-214.
- Power, Helen and Wilkinson, Lise. 'The London and Liverpool Schools of Tropical Medicine 1898-1988', British Medical Bulletin Vol. 54, number 2, 1998, pp. 281-292.
- Power, Helen. Tropical Medicine in the 20th Century: a history of the Liverpool school (London; New York: Kegan Paul International; New York, 1998).
- Rafferty, Anne Marie. 'The Anomaly of Autonomy: Space and Status in Early Nursing Reform', International History of Nursing Journal Vol. 1, number 1, 1995, pp. 43-56.
- Rafferty, Anne Marie. The Politics of Nursing Knowledge (London: Routledge, 1996).
- Ramasubban, Radhika. 'Imperial Health in British India, 1857-1900', in Roy McLeod and Lewis (eds.), Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion (London; New York: Routledge, 1988) pp. 38-60.
- Richards, Graham. 'Race', Racism and Psychology. Towards a Reflexive History (London: Routledge, 1997).
- Richell, Judith. 'Ephemeral lives: the unremitting infant mortality of colonial Burma, 1891-1941', in Valerie Fields, Lara Marks and Hilary Marland (eds.), Women and Children First.

## Archives and bibliography

International Maternal and Infant Welfare 1870-1945 (London; New York: Routledge, 1992) pp. 133-153.

Risse, Guenter B. Mending Bodies, Saving Souls. A History of Hospitals (New York; Oxford: Oxford University Press, 1999).

Robin, Libby. 'Ecology: a science of empire', in, Tom Griffiths and Libby Robin (eds.), Ecology & Empire. Environmental History of Settler Societies (Edinburgh: Keele University Press, 1997) pp. 63-75.

Rodney, Walter. Guyanese Sugar Plantation The Late Nineteenth Century A Contemporary Description from the Argosy (Georgetown, Guyana: Release Publishers, c1979).

Rodney, Walter. A History of the Guyanese Working People 1881-1905 (Baltimore, Md.: The Johns Hopkins University, c1981).

Rose, James G. 'The Strikes of 1842 and 1848', in Winston F. McGowan, James G. Rose, David A. Granger (eds.), Themes in Africa-Guyanese History (Georgetown: Free Press, 1998) pp. 158-200.

Rose, James G. 'The Coming of Crown Colony Government in 1928', in Winston F. McGowan, James G. Rose, David A. Granger (eds.), Themes in Africa-Guyanese History (Georgetown: Free Press, 1998) pp. 296-326.

Rosen, George. 'Social Variables and Health in an Urban Environment: The Case of the Victorian City', Clio Medica Vol. 8, number 1, 1973, pp. 1-18.

Rosenberg Charles E., 'Introduction', in Charles E. Rosenberg and Janet Golden (eds.), Framing Disease. Studies in Cultural History (New Brunswick, N.J.: Rutgers University Press, c1992) pp. XIII-XXVI.

Ruhomon, Peter. History of the East Indians in British Guiana (Georgetown: Daily Chronicle 1947).

Rush, David. 'Nutrition and maternal mortality in the developing world', American Journal of Clinical Nutrition Vol. 72, number 1, July 2000, pp. 212-214.

Said, Edward W. Orientalism (London: Penguin, 1995).

Schaffer, Simon. 'Self Evidence', in James Chandler, Arnold Davidson and Harry Harootunian (eds.), Questions of Evidence Proof, Practice, and Persuasion across the disciplines (Chicago: University of Chicago Press, 1994) pp. 56-91.

Sciortino, Rosalia. 'The multifariousness of nursing in the Netherlands Indies', in Peter Boomgaard, Rosalia Sciortino & Ines Smyth (eds.), Health care in Java past and present (Leiden: KITLV Press, 1996) pp. 23-50.

Searle, G. R. Morality and the Market in Victorian Britain (Oxford: Clarendon Press, 1998).

Shapin, Steven. 'Cordelia's love: credibility and the social studies of science', Perspectives on Science Vol. 3, number 3, 1995, pp. 255-275.

## Archives and bibliography

Sheridan, Richard B. Doctors and Slaves. A Medical and Demographic History of Slavery in the British West Indies, 1680-1834 (Cambridge [Cambridgeshire]; New York: Cambridge University Press, 1985).

Smith, Philippa Mein. ‘‘That welfare warefare’’: sectarianism in infant welfare in Australia, 1918-1939’, in Valerie Fildes, Lara Marks and Hilary Marland (eds.), Women and Children First. International Maternal and Infant Welfare 1870-1945 (London; New York: Routledge, 1992) pp. 230-256.

Stokes, Eric. English Utilitarians and India (Delhi; Oxford: Oxford University Press, 1982, c1959).

Stoler, Ann Laura. Capitalism and Confrontation in Sumatra’s Plantation Belt, 1870-1979 (Ann Arbor, Mich: The University of Michigan Press, c1995.).

Summers, Ann. ‘The mysterious demise of Sarah Gamp: The domiciliary nurse and her detractors 1830-1860’, Victorian Studies Vol. 32, 1988-89, pp. 365-386.

Swaisland, Charles. ‘The Aborigines Protection Society, 1837-1909’, Slavery and Abolition Vol. 21, number 2, August 2000, pp. 265-280.

Taylor, Jeremy. The Rebirth of the Norfolk and Norwich Hospital 11874-1883 (Norwich: Wellcome Unit for the History of Medicine. University of East Anglia 2000).

Temperley, Howard. ‘The Delegalisation of Slavery in British India,’ Slavery and Abolition Vol. 21, number 2, August 2000, pp. 169-187.

Thomas, Clive Y. Plantations, Peasants, and State (Los Angeles: Center for Afro-American Studies, University of California; Mona, Jamaica: Institute of Social and Economic Research, University of the West Indies, c1984).

Thompson, F. M. L. The Rise of Respectable Society. A Social History of Victorian Britain, 1830-1900 (London: Fontana 1988).

Thompson, John D and Goldin, Grace. The Hospital: A Social and Architectural History (New Haven: Yale University Press, 1975).

Tinker, Hugh. ‘Into Servitude: Indian Labour in the Sugar Industry, 1833-1970’, in Shula Marks and Peter Richardson (eds.), International Labour Migration Historical Perspectives (Hounslow, Middlesex: Published for the Institute of Commonwealth Studies by M. Temple Smith, 1984) pp. 76-89.

Tinker, Hugh. A New System of Slavery. The Export of Indian Labour Overseas 1830-1920 (London: Hansib Publications, 1993).

Trohler, Ulrich. ‘Surgery (Modern)’, in W. F. Bynum and Roy Porter (eds.), Companion Encyclopedia of the History of Medicine Vol. 2. (London; New York: Routledge, 1993) pp. 984-1028.

Turley, David. The Culture of English Antislavery, 1780-1860 (London: Routledge, 1991).

## Archives and bibliography

- Turner, Bryan S. The Body and Society (London; Thousand Oaks – New Delhi: Sage Publications, 1996).
- Vaughan, Megan. Curing their Ills. Colonial Power and African Illness (Oxford: Polity Press, 1991).
- Vaughan, Megan. 'Healing and Curing: Issues in the Social History and Anthropology of Medicine in Africa' Social History of Medicine Vol. 7, 1994, pp. 283-295.
- Vogle, Jorg Peter; Woelk, Wolfgang; and Fehleemann, Silke. 'Decline of the Urban Penalty: Milk Supply and Infant Welfare Centres in Germany, 1890s to 1920s', in Sally Sheard and Helen Power (eds.), Body and City. Histories of Urban Public Health (Aldershot: Ashgate, 2000) pp. 194-214.
- Wade, Peter. Race and Ethnicity in Latin America (London: Pluto Press, 1997).
- Walkowitz, Judith R. City of Dreadful Delight (Chicago: University of Chicago, 1992).
- Walvin, J. 'The Propaganda of Anti-Slavery', in J. Walvin (ed.), Slavery and British Society 1776-1846 (Baton Rouge: Louisiana State University Press, c1982) pp. 49-68.
- Warman, Arturo. 'The Cauldron of the Revolution: Agrarian Capitalism and Sugar Industry in Morelos. Mexico 1880-1910', in Bill Albert and Adrian Graves (eds.), Crisis and Change in the International Sugar Economy 1860-1914 (Norwich: ISC Press, 1984) pp. 165-180.
- Warner, John Harley. The Therapeutic Perspective Medical Practice, Knowledge, and Identity in America, 1820-1885 (New Jersey: Princeton University Press, 1997).
- Watts, David. The West Indies: Patterns of Development, Culture and Environmental Change since 1492 (Cambridge; New York: Cambridge University Press, 1987).
- Wear, Andrew. 'A History of Personal Hygiene', in W. F. Bynum and Roy Porter (eds.), Companion Encyclopedia of the History of Medicine Vol. 2. (London; New York: Routledge, 1993) pp. 1238-1308.
- Wear, Andrew. 'Making Sense of Health and the Environment in Early Modern England', in A. Wear (ed.), Medicine and Society (Cambridge: Cambridge University Press, 1998) pp. 119-147.
- Wear, Andrew. Knowledge and Practice in English Medicine, 1550-1680 (Cambridge: Cambridge University Press, 2000).
- Weber, Max. In Guenther Roth and Claus Wittich (eds.), Economy and Society (Berkeley; London: University of California Press, c1978).
- Wildenthal, Lora. 'Race, Gender and Citizenship in the German Colonial Empire', in Frederick Cooper and Ann Laura Stoler (eds.), Tensions of Empire. Colonial Cultures in a Bourgeois World (Berkeley, California; London: University of California Press, 1997) pp. 263-283.

### Archives and bibliography

Woolcock, Helen R., M. John Thearle, and Kay Saunders, ‘ “My Beloved Chloroform” Attitudes to Childbearing in Colonial Queensland: A Case Study’, Social History of Medicine Vol. 10, number 3, 1997, pp. 437-457.

Worboys, M. ‘Manson, Ross and Colonial Medical Policy: Tropical Medicine in London and Liverpool, 1899-1914’, in Roy Macleod and Milton Lewis (eds.), Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion (London; New York: Routledge, 1988) pp. 21-37.

Worboys M. ‘From Miasmas to Germs: Malaria 1850-1879’, Parassitologia. Vol. 36, number 1-2, August 1994, pp. 61-68.

Worboys, M. Spreading Germs: Disease Theories and Medical Practice in Britain, 1865-1900 (Cambridge; New York: Cambridge University Press, 2000).

Wyatt-Brown, Bertram. ‘The Mask of Obedience. Male Slave Psychology in the Old South’, in J. Williams Harris (ed.), Society and Culture in the Slave South (London; New York: Routledge, 1992) pp. 128-161.