Contagion and Enclaves
Nandini Bhattacharya

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CHAPTER 8

Habitation and Health in Colonial Enclaves: The Hill-station and the Tea Plantations

So far we have discussed the impact of colonization and consequently medical policies in two different, contiguous enclaves: the hill-station of Darjeeling and the tea estates in its adjoining regions of northern Bengal. The town of Darjeeling, originally conceived of as a European sanitary enclave, invited from the very beginning traders, immigrant labourers and Indian civil officials and servants; and with its development came the greater colonization of the entire Terai and Duars areas. As we have seen, the town of Darjeeling was neither an indisputably healthy hill-station, nor was it a white enclave. Certain areas within Darjeeling were marked out for the exclusive use of the European population and the Eden Sanitarium was one of them. The hill-station signified an enclave because the British perceived it as a secluded site, more salubrious and scenic than the dreaded hot and dusty Indian plains. The town itself, controlled directly by the colonial administration, provided a space for medicalized leisure to the European population; and the Eden Sanitarium provided an exclusive space unavailable in the plains for the rejuvenation of white bodies. Through these various institutions the British population in India sustained a socially exclusive site for themselves in some parts of Darjeeling. As a consequence, the medical facilities within the urban space of Darjeeling were of a much higher standard in the colonial period than in the surrounding areas. These places were kept relatively free from encroachment from local Indian influences. In that sense, the town of Darjeeling was an enclave of particular, privileged medical infrastructure. This medical infrastructure was not merely about clinical medicine, doctors and hospitals, but was an enclaved privilege in a medical paradigm defined in terms of colonial ideas of tropical heat, filth and human habitation.

The tea plantations in the Darjeeling district and in the adjoining Duars that were established in the same phase of colonization as Darjeeling were enclaves of a different sort. First, their management mostly comprised of European personnel whose social world and medical requirements corresponded with those of the
Europeans in Darjeeling; therefore the provisions for their health care constituted their own doctors with British qualifications as well as the option to go to the privileged site of Darjeeling in cases of emergency. Second, the identity of the plantations as enclaves was embedded within the structure of the tea plantation economy in colonial northern Bengal. As we have seen, the system of free labour and the necessity for a working population that provided seasonal labour was achieved through the gradual settling of ex-tea garden labourers in bastis outside the plantations. Simultaneously, planters kept an eye on encroachment by other agencies, including the government and political parties.

Although situated in relatively remote areas, with vast tracts of land allocated to tea plantation, the isolation of the tea estates was not entirely due to geographical factors. Mines and plantations represented special sites, the habitations of the workers being placed together – very different from the chawls or hatas inhabited by the industrial workers in the mills of Kanpur or Bombay, for instance, where labourers lived in equally crowded and unsanitary habitations, which were rented to them by private landlords and were contiguous to the mills, not remote and cut off from the respective cities.¹

In that sense, the plantations, too, had a dual identity: they were porous and yet were enclaves. The provisions of health care for the labourers in the plantations were located within the system of production of the plantation; paternalistic and individualistic. At the same time, the labourers and their bodies within the plantations provided a unique site for the testing of medical techniques and theories in the expanding specialization of Tropical Medicine in the twentieth century. The plantation management used the symbiotic relationship between the plantation and the bastis to engage in a continuous negotiation with the government over the responsibility for the health care of workers within the bastis. In this context, the bastis and the sites outside the plantations emerged as the sites of disease in managerial and often official discourse. Much like the healthy–unhealthy dichotomy of the hill-town of Darjeeling vis-à-vis the 'plains', such a duality was not sustainable. The discourse, however, enabled the managerial element within the plantations, much like the European population in Darjeeling, to sustain the myth of the healthy–unhealthy duality vis-à-vis the plantations and the bastis and more importantly to retain administrative and political control over the labourers in the hands of the planters.

After the Second World War and in the post-Independence era, the two coterminous enclaves met with different fates. The aspect of rejuvenation for

¹ For a vivid description of working-class habitations, the overcrowded hatas where street life merged in many ways with the workers’ lives within their homes in colonial Kanpur, see Chitra Joshi, Lost Worlds: Indian Labour and Its Forgotten Histories (Delhi, Permanent Black, 2005), pp. 121–26. Prashant Kidambi has argued that in early twentieth century Bombay, the Bombay Improvement Trust which was intended originally to provide sanitary and cheap accommodation for workers failed in its project, and instead of in the Trust’s tenements, the working classes lived in the over-crowded private chawls near the mills and docks in the heart of the city. See Kidambi, ‘Housing the Poor in a Colonial City: The Bombay Improvement Trust, 1898–1918’, Studies in History, 17 (2001), pp. 57–79.
white bodies in Darjeeling became irrelevant in this period. The British presence in the entire northern Bengal area was represented mostly by the planters. The exclusive and elite aspect of medical services in the Darjeeling was now represented by the Dooars and Darjeeling Home, a specialized hospital that the planters’ associations of northern Bengal established within the premises of the old Planters’ Club. The plantations themselves, on the other hand, by the very nature of their isolated circumstance and the labour habitations within the tea estates, remained the focus of government health policies, thereby accentuating the differences, especially at the level of government policy, from the surrounding countryside.

As we have seen in Chapter 1, Darjeeling was incorporated in the wider colonial polity and economy of northern Bengal over the nineteenth century. Simultaneously, the town of Darjeeling stretched to accommodate various demands on its multiple identities – as a European social enclave and seasonal administrative centre, as well as the hub for the planters of the hill area, and as an aspirational social site of rejuvenation for the Bengali elites.

In the early part of the twentieth century the town of Darjeeling accommodated the settlement of diverse social and economic interests within itself. After Independence, its characteristic changed at a more fundamental level. With the transfer of power in 1947, the numbers of British/European civil servants within the Indian administration dwindled to a very small minority. The European character of the hill-station was then mostly defined by the British planters. The ‘Sterling companies’, that is, the British-owned tea companies (the Indian-owned companies were invariably registered in India and were called ‘Rupee companies’) and their British recruits stayed on in India after Independence.

The question here is, what transformations occurred in Darjeeling after the Indian Independence, bereft of its special status as the summer seat of government and the chosen leisure site of the ruling classes? The tea industry in northern Bengal also accommodated large-scale changes in its structures of functioning after the Second World War and the transfer of power. The newly emergent nation-state positioned itself, too, as the arbiter between labour and industry, borrowing some of the rhetoric from its predecessor, the colonial state. However, the nature of structural changes initiated by the independent nation-state was of a more interventionist nature. In this chapter I shall examine some of these structural changes which affected the medical infrastructure of Darjeeling and the plantations in the immediate post-Independence India.

**Darjeeling after Independence**

Like all former colonial hill-stations, Darjeeling refashioned itself as a tourist town, famed for its scenic view of the Kanchenjunga, its charming colonial architecture and quaint ambience. The Indian nationalists including Gandhi himself had frequently criticized the transfer of government administration to the ‘hills’
for up to eight months in the year. In postcolonial India, the seat of the central and Bengal governments remained in Delhi and Calcutta permanently. While Simla remained a state capital of the newly formed Himachal Pradesh state, the status of Darjeeling and Ootacamund changed drastically, reduced as they were to being mere district headquarters and provincial towns. As in other hill-stations, the British gradually left, only a few remaining to the last, owing their tenacity to nostalgia, the lethargy of age, and often, an inadequate pension that would further reduce after conversion to the British pound.

The changed character of Darjeeling was reflected in the fact that there was no longer a racially exclusive town, or indeed, medical institutions. The government took over the management of the Eden Sanitarium after 1950, and amalgamated it with the main public hospital of the town, Victoria Hospital. At the time of amalgamation the Eden Hospital, ‘subscribed mainly by the Planters’ Associations’, was the best-equipped hospital in the area, with its ‘major X-ray set, Electric Diathermy, and Electric Vibrator Apparatus’, and carried out X-ray work for other hospitals in the district.² The European planters, deprived of an exclusive medical institution, established the Dooars and Darjeeling Medical Association, a private hospital mainly for the use of the planters. For that purpose they relinquished part of the Planters’ Club, a gracious building overlooking a ridge with views of the mountains.³ Its chief medical supervisors were British, initially an ex-army man.⁴ The respective Planters’ Associations in Darjeeling, Terai and the Duars subscribed to it, which enabled British planters and their families to use it as their principal medical establishment.⁵ The appropriation of the Eden Sanitarium and hospital by government merely led to the establishment of another exclusive medical institution in Darjeeling. The town itself maintained its own hospitals, with a few charitable dispensaries in the remote tahsils. Yet, the appropriation by the Indian elite of the climatic theories of health continued, sustaining the status of Darjeeling as a health resort. A Bengali philanthropist, S.B. Dey, donated a substantial sum of money for a TB hospital in Jadavpur near Calcutta. The TB hospital built a branch in Kurseong, the smaller hill-station near Darjeeling, to facilitate convalescence for its TB patients.⁶ Therefore, long after the Germ theory of TB was established and ‘phthisis’ no longer remained a disease category, the presumption of well-being for a respiratory patient in a cool hilly climate survived in Indian medical discourse and practice.

The Writing on the Wall: Privilege and ‘Industrial’ Labour

At the moment of Indian Independence, the racial/sanitary enclave of Darjeeling and the structural enclave of the tea plantations got conflated, for a brief period. The planters, unlike the British missionaries in neighbouring Sikkim, had depended directly on their social status as ‘Europeans’ in British India for a number of informal advantages from government. Immediately after the war and the Indian Independence, the special status of Darjeeling as a European sanatorium diminished with the exodus of the British civil and military officials. At this time, the British planters comprised mostly the European population of the region. A contemporary reminiscence by a woman who belonged to a planter family recounted Christmas in 1947, the year of Independence. In the sodden early hours of the next morning a few of the planters fantastically plotted for a separatist movement – for a ‘British Sikkim’ – which was to be an island of Britishness in the tea estates. The planters in the Duars, Terai, as well as in Darjeeling petitioned the newly instituted office of the high commissioner of Britain in India that the British component of the entire region represented by the planters, was prominent enough to deserve a separate consul or, as the deputy high commissioner described it, ‘a small outpost’ in the northern Bengal region. The high commission did not pursue this, because the deputy high commissioner who toured the northern Bengal tea districts reported that such an enclave of a British outpost was impossible. The tea plantations were scattered and isolated from each other, and the establishment of a consulate would be difficult. For the planters, an emotional sense of loss at the dismantling of the British Empire was overlaid with more urgent tones, following the new resolve of the emergent nation-state to act as the arbiter between the tea industry and the interests of the labourers. The reality was that it was a process that had begun from the 1940s, when the tea plantation enclaves were being threatened in various ways.

This breach was different in character from the fissures within the enclaves in the colonial period when the district officials were generally respectful of the authority of the tea estate managers, and scattered labour recalcitrance was kept a close secret except in times of overspill. Previously, we have seen that such changes occurred immediately after the Second World War, when the railway workers unionized and in turn mobilized tea workers. The Tebhaga movement, in which many tea garden workers participated with their kin among the ex-tea workers who were sharecroppers, also contributed to the sense of impending, fundamental changes among the planters.

7 For an account of missionary activity in education and medicine in Kalimpong see Alex Mackay, *Their Footprints Remain: Biomedical Beginnings across the Indo–Tibetan Frontier* (Amsterdam, Amsterdam University Press, 2007).
Other factors simultaneously contributed to the crumbling autonomy of the plantations. The mobilization of labour for the Second World War, particularly on the eastern frontier, absorbed labour from the plantations and their catchment areas. During the hard years of the Bengal famine, the tea estates procured rice, the staple food, and some other essentials such as jaggery and oil – sometimes from the local markets, often from outside, to feed their labourers, both permanent and _faltu_. The district officials as well as the provincial government assisted the planters’ associations in the procurement of rice. The wages were calculated partly in kind. During the war years the tea estates, European- and Indian-owned, competed among themselves to obtain _basti_ labour.

From the early 1940s, the plantations were no longer isolated, virtually sovereign estates. When the government of India instituted enquiries into the conditions of the plantation workers in 1946, they were unmoved by the planters’ protests that the time was not convenient for such an enquiry. The reports, examined to some extent in Chapter 4, made wide-ranging recommendations. These included the establishment of a pyramid of large ‘group hospitals’ and better-stocked and well-attended dispensaries at the individual tea gardens. Griffiths, an ICS officer who was later employed as adviser to the ITA during the 1950s, commented that ‘In his study of the medical organization of the tea industry, Jones revealed himself as something of a theorist with a bureaucratic desire for uniformity.’ Jones recommended a three-tier system of hospitals within the plantations (regional hospitals/group hospitals/garden dispensaries). However, he principally emphasized the need for preventive health and health care at the level of the garden dispensaries:

> the fact remains that the vast bulk of the mortality, and even more of the morbidity of the tea gardens … is the result of conditions arising from poor diet, inefficient sanitation, contaminated and insufficient drinking water, the ignorance of the workers, which are easy to recognise, and do not ordinarily require elaborate facilities for diagnosis, or highly specialised treatment.

The focus by government on labour health was part of a larger concern for the lives of the plantation workers; this included a move for minimum wage, paid holidays and other benefits. This was the time when the tea estates were unionized, and the planters participated in the unionization by patronizing the ‘moderate’ Congress unions rather than the more radical Communist ones. The unionization of the tea estate workers in northern Bengal was a complex phenomenon, beyond the scope of this work. For our purposes it suffices to point out that the nature of relations between labour and management changed to a great extent. For instance, after 1948, the Indian Tea Association handbooks

10 Of the two reports, one focused on the standards of living of the plantation workers (Rege, _Labour Investigation Committee_). The second concentrated specifically on medical infrastructure in the plantations (Jones, _Standards of Medical Care_).

11 Griffiths, _History_, p. 361.

12 Jones, _Standards of Medical Care_, p. 20.

13 The point has been made by Ray, _Transformations_, p. 196.
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always provided statistics on the number of strikes in each tea district in India. The mai–baap (paternalistic) relationship between the planter and his workers did not disappear overnight, but had to accommodate intermediaries such as trade unionists and labour officers.¹⁴

The negotiations for all-India legislation began with a tripartite meeting between the government, labour representatives and the industry held on 31 March 1948. Wage increases were high on the agenda. The chairman of the DPA reported to the members of his association,

at the outset it was made clear that an agreement would have to be made for some increase not necessarily because labour was as it was often stated underpaid, but that the standard of living of tea garden labour had to be raised and that there was ample room for improvement on both counts. So that was the writing, quite plain on the wall.¹⁵

The negotiations were long and often acrimonious. Apart from the abolishing of the piece wage, the settlement for a minimum wage and other benefits, the workers also demanded medical facilities that, they insisted, should be controlled by the government rather than the plantations. The government’s intent to intervene within the plantations, however, did not extend to such lengths. The chairman explained to his members that

Labour wanted the whole thing under Government including the appointing of Dr. Babus, nurses and the whole shooting match at of course our expense. This we would not agree to and Government accepted our views that control over Estate Medical arrangements should be in our own hands.¹⁶

The new government insisted on the ‘conception of labour’s partnership in industry’, and the agenda for the meeting included the fixing of new wages, standards of medical care and discussion of outline of legislation covering all plantations.¹⁷ After several rounds of negotiations, the Plantation Labour Act (PLA) of 1951 was passed by the government of India. The Act specified the numbers of hospitals and doctors, maternity benefits and crèches, as well as the abolition of piece rate (wage paid by amount of work done, namely the hazira and the ticca and the introduction of minimum wages, the construction of pucca houses and provisions for clean water and conservancy facilities for the workers. The measures were to be at the expense of the tea industry, which were to be provided with some government concessions on quotas of steel and cement, which were rationed in the post-Second World War years. The PLA represented a significant degree of state intervention within the plantations.¹⁸

¹⁴ Ray has pointed out that in the process of unionization the workers were left with little autonomy or agency in the actual negotiations with the government. The long-term impact of the war and the Tebhaga movement was that it ‘strengthened the hand of the government vis a vis the planters’. Ray, Transformations, pp. 196–97.
¹⁷ Summary of Proceedings of the Second Session of the Industrial Committee on Plantations Held at New Delhi on 31st March and 1st and 2nd April, 1948, IOR/N/26/670/73 (APAC).
¹⁸ Mss Eur F174/1022 (APAC).
The planters negotiated to a great extent, claiming, for instance, that large ‘group hospitals’ need not be provided by the plantations and should instead be the responsibility of the government:

It is considered that the Plantation Industry can no longer be described as working in undeveloped areas, and that, by reason of their substantial contributions to general revenues they should not be expected to provide these facilities which are in other industries provided by the State.  

They pointed out also that the industry was expected to provide ten hospital beds for every thousand workers, whereas the national average of hospital beds in India was 0.24 per thousand. The planters’ desire to make the government responsible for the health care of its workers was, as we have seen, hardly a new phenomenon, nor was the comparison between the facilities provided by the tea industry with those enjoyed by other agricultural labourers.

However, the new government viewed the tea plantations as enclaves where, through legislation, medical facilities not available elsewhere in rural India might be enforced. In principle, this was similar to the colonial government’s legislation, in the JLA. The provisions of the PLA far exceeded any recommendations made by the Royal Commission of India, 1931, many of which had not been implemented until then. In the immediate aftermath of the war and Independence, the Indian state and the newly established trade unions pushed through the PLA under the principle of the ‘partnership between labour and industry’ where the labourers were conceived to have a share in the profits of the companies. Although the provisions of the PLA were never implemented fully, they nevertheless demarcated a new relationship between the planter and labourer, where the planter was no longer to be the provider and the protector of the labourer.

‘The Measure of a Sahib’

A tea garden in Darjeeling hills is run on tradition; the whole structure is founded on the ideals laid down by the pioneer planters who set out the estates … Once they are convinced … that the new Sahib is a sound and strong character, they accept his authority without question … Because the manufacture of tea at remunerative prices is largely dependent upon cheap, unskilled labour, the relations between garden coolies and estate managers is the single most important factor in the production of tea.

In spite government legislation to systematize and streamline the availability of basic medical care for the labourers, the extent to which medical care within the plantations was dependent upon the idiosyncrasies of individual planters is

20 'Draft Model Rules for Plantation Labour Act, 1951', p. 3.
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evident from David Fletcher’s reminiscences. He relates an anecdote when Tuli, a woman worker in the plantation where he was an assistant, was injured. She came to his bungalow and was attended by his wife, who cleaned her wound and then asked him if Tuli would be able to stand the sting of iodine. He replied, ‘To the coolie mind, a medicine that doesn’t have some immediate effect is not potent enough … Iodine will at least convince this woman of its potency’.

This was of course the legacy of ‘heroic medicine’ for the labourers in planters’ folklore, unchanged from its nineteenth-century form. So little is known of workers’ perceptions of their own illnesses, or indeed of their own world of ojhas and healers who existed side by side with the doctor babus (and in all probability provided a major part of the health care to the working population of the estates), that we cannot surmise what Tuli herself made of the iodine on her wound.

Change in health care, or indeed any structural changes in the tea plantations, was gradual and slow despite government legislation and intervention. The actual implementation of the PLA took several years, indeed even in the 1970s many tea companies had not complied with its various regulations. The important factor in the postwar and Independence years was that the enclaves of the tea plantations was encroached upon on a more systematic scale than ever before. In the post-PLA years the planters continued to cite labourers’ cultural values as justification for the lack of basic sanitary facilities in the plantations. The tea plantations by their very enclaved nature were expected by the state and the trade unions to provide for health services in a way that was not available to ordinary residents of the district.

Tropicality, Postcoloniality and Enclaves

This book has studied the interaction between Tropical Medicine, colonial enclaves and the colonial state. With decolonization within the British Empire, the organic links between colonialism and Tropical Medicine and the colonized states were severed. The medical speciality of Tropical Medicine has survived through its clinical and research institutions, but through negotiations of a different order. Its practitioners in Britain are engaged more closely with

22 Fletcher, The Children of Kanchenjunga, p. 46.
23 A government inspector’s report in 1972 noted that on an average there was one medical practitioner for 1750 workers and makes a comment that is familiar to us: ‘the workload of the individual doctor has been heavy’. Annual Report of the Administration of the Plantation Labour Act 1951, for the Year Ending 1972 (Alipore, n.d.), pp. 3–4. Two years later the annual report recorded 105 cases of prosecution against employers, generally for ‘violation of welfare provisions’. Annual Report of the Administration of the Plantation Labour Act 1951, for the Year Ending 1974 (Alipore, n.d.), p. 3.
international health organizations such as the WHO, for instance, are funded by several international medical charities and have formulated strategies that continue to sustain its legitimacy as an academic discipline. But if the tropics still provide the contexts for medical research and international health programmes for myriad diseases, it is through a model of development that was distinct from the triumphant imperialism at the turn of the nineteenth century. ‘Tropical disease’ continues to be a medical category; presently, it comprises of diseases prevalent in exotic and under-developed parts of the world, and may include a spectrum of infectious diseases, from HIV/AIDS to trachoma, onchocerciasis, as well as the more familiar malaria and filariasis.\(^{25}\)

In postcolonial India, therefore, the sites of what were formerly colonial enclaves became irrelevant. This moment of rupture between colonialism and racialized, exclusive medical and political enclaves came when the British high commission declined to establish a British consulate at Darjeeling to cater to the British planters and retired civilian and military personnel in the region. Darjeeling is now a mere district capital and one hill-station among several, and like them is trading the vestiges of its colonial past to compete for domestic and international tourists. It is also the site of a long-standing regional and ethnic separatist dispute in West Bengal because the Gurkhas, the dominant majority, as well as other indigenous people of the region, believe that they have been short-changed in the development stakes of independent India.\(^{26}\)

The tea plantations have survived as well; but as we have seen, with their autonomy severely curtailed. This is not to suggest, of course, that sites of privilege disappeared in postcolonial India; if anything, privilege and social space were even more entrenched at multiple sites, those of ethnicity, caste, gender, class and the urban–rural inequalities. But the era of tropical enclaves ended with colonialism.

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