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Health and Illness in Colonial Malaya, 1870–1940

LENORE MANDERSON

Australian Centre for International and Tropical Health and Nutrition
The University of Queensland

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Spelling and Abbreviations

I have used the contemporary English spelling of most places mentioned in this work, since these are the names of the politico–geographic entities of the colonial state, hence Penang not Pulau Pinang, Malacca not Melaka. Other spelling used for place names in the Indonesian Archipelago and for Malay terms follows the conventional orthography of the period, thus Acheh rather than Aceh or Atjeh, for example.

Abbreviations used in the text, notes, references:

FMS	Federated Malay States
GB	Great Britain
IMR	Institute of Medical Research
LSHTM	London School of Hygiene and Tropical Medicine
SS	Straits Settlements

Sources

BAKed	British Adviser to Kedah
BAKel	British Adviser to Kelantan
BATr	British Adviser to Trengganu
CO	Files of the Colonial Office
FMS	Federated Malay States
GB	Great Britian
GRO	General Register Office
Mss Indian Ocean	Colonial Records Project, Indian Ocean Manuscripts
Sel. Sec.	Files of the Selangor Secretariat
SSR	Straits Settlements Records
ZHCI	Great Britain, Colonial Office, Accounts and Papers, ZHCI

See also Archival Sources, p. 308, for locations

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Publications

AJE	*American Journal of Epidemiology*
ATMP	*Annals of Tropical Medicine and Parasitology*
BDJ	*British Dental Journal*
BHM	*Bulletin of the History of Medicine*
BIMR	*Bulletin of the Institute of Medical Research*
BJA	*British Journal of Anaesthesia*
BMJ	*British Medical Journal*
CMP	*Culture, Medicine and Psychiatry*
EDCC	*Economic Development and Cultural Change*
FMSAR	*Federated Malay States, Colonial Reports, Annual Report*
HTR	*Health Transition Review*
IJHS	*International Journal of Health Services*
JAS	*Journal of Asian Studies*
JBS	*Journal of Biosocial Science*
JMBRAS	*Journal of the Malay Branch of the Royal Asiatic Society*
JMBMA	*Journal of the Malayan Branch, British Medical Association*
JMH	*Journal of Modern History*
JRSA	*Journal of the Royal Society of Arts*
JSP	*Journal of Social Policy*
MH	*Medical History*
MJA	*Medical Journal of Australia*
MJM	*Medical Journal of Malaysia*
MMJ	*Malayan Medical Journal*
MMJES	*Malayan Medical Journal and Estate Sanitation*
SKAR	*State of Kelantan Annual Report*
SSAR	*Straits Settlements Annual Departmental Report*
SSI	*Social Science Information*
SHM	*Social History of Medicine*
SMJ	*Singapore Medical Journal*
SSM	*Social Science and Medicine*
SSS	*Social Studies in Science*
ST	*Straits Times*

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Preface

When I commenced work on this book, a good decade ago, little had been published outside medical journals dealing with health and medicine in Malaysia, either for the colonial period or since independence. Even in recent years as interdisciplinary interest in the field has expanded – spawning anthropological, sociological, historical demographic and social historical studies – a small corpus of writing only has been concerned with death and disease, health and medicine under colonialism.[1] There remains a vacuum in historical epidemiology and the documentation and analysis of changes in morbidity and mortality, the development of health and medical services, the nature of decision-making, and the implementation of subsequent programs, the ideological and pragmatic considerations which determined these programs, and their effects on people's health. The voluminous literature on education and schooling for the colonial period stands in marked contrast to this apparent disinterest in or shying away from issues of health and medicine.

Medical administrative innovations under British colonial rule related to and followed from economic developments, and occurred in response to the perceived political and economic effects of ill health. To date, however, we lack a history of medicine or health services for the colonial period which would provide an overview within a political, economic and social context, which might explore the effects on health of colonialism. We lack too documentation of the ways in which people responded to the broad changes that colonialism brought: changes to the environment and ecology of the Peninsula, the distribution and prevalence of infection, the means of production, subsistence and well-being, and the means provided for the treatment of injuries and illness.

Lack of attention by social scientists to matters of health and medicine reflects in part the professional territoriality and epistemological

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tensions that have existed within the field and remain characteristic of the interdisplinary projects seeking to better understand the interface of biology, culture, and society.[2] The practice of medicine was – over a century – to be increasingly confined to a small group of professionals, even in areas traditionally beyond their concern and interest (for instance, childbirth). So too the records of medical practice and policy were to become and remain within their territory, generally uncritical assessments which emphasised the supremacy of biomedicine and the desirability of its structures and institutions. In the context of this work the lack of critical analysis pertaining to colonial Malaya is most significant. However, it is important to note that until the past decade or so little had been written anywhere which located the provision of health and medical services in a political and economic context or which examined them in terms of public policy formulation and practice.[3] Rather, medical history for the most part was concerned with the history of the great men (and rarely women), with the establishment of medical and related welfare institutions, and with clinical advances. Few medical histories until recently have shown much interest in patient perspectives or the population as a whole,[4] or in biomedicine as a cultural system. Finally, in histories of health care in colonial societies, there has been little interest in traditional medicine and its interrelationship with biomedicine.

The first article on health care in colonial Malaya appeared early, in 1913, and related to the establishment of the Tan Tock Seng Hospital in Singapore.[5] Fifty years later, with few intermittent publications, H. C. Chai published a chapter on health and medical research in the Federated Malay States (FMS).[6] From 1972 to 1977, Y. K. Lee published a series of articles on public health and medicine in the Straits Settlements in the nineteenth century;[7] and Ross in 1980 published a paper on medicine in Penang, drawing on the letters of Dr Francis King, the East India Company surgeon posted to the island from 1857 to 1865.[8] Excepting Chai's work, these articles focused on institutions or programs. Lee, for example, details the establishment of pauper and general hospitals and lunatic asylums, programs to reduce the incidence of smallpox and cholera, the development of medical education, forensic medicine, the use of anaesthesia, and the establishment of the municipal health department, but without exposition of the logic that underlined the processes and determined the nature of the developments. Yet these steps in nineteenth-century medicine were far more than simple humanitarian or public health innovations following from the penetration and establishment of colonial rule.[9]

These early histories of colonial medicine have their counterparts in other colonial settings. Baker's history of medicine in Malawi, Bayoumi

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for the Sudan, Beck for German East Africa, Herrmann for British Honduras, provide accounts of the appointment of medical staff and the establishment of hospitals and clinics in the context of colonialism and its economies, providing some of the groundwork on the basis of which we can now interpret the relationship of medicine to colonialism.[10] Baker, for instance, notes that by the 1930s expatriate planters in Nyasaland (present-day Malawi) had begun to see the economic advantages of a healthy workforce, and hence medical services to rural areas increased, despite continued European privilege.[11] Elsewhere, political considerations directly influenced the extension of medical services. Bopegamage, for example, documents the role of the British Indian Army, following the Indian Mutiny in 1857, in initiating public health and medical services: treatment of malaria, innoculation against typhoid fever, sterilisation of water with chlorine, provision of piped water and underground drainage in urban areas, and general improvement of communications.[12] To some extent British Malaya followed this model: the prime focus of medical care was the European population; medicine was most often curative rather than preventive; indigenous populations were usually (although not in Malaya) left to the Christian missions.[13]

In this book, I aim to begin to fill out the picture in Malaya. I begin with a description of the nature of empire, then review political economic approaches to colonial medicine, together with an exegesis of recent discussions of health and empire, colonial capitalism and disease. The introduction also sets the scene in terms of political geography, describing the colonies of the Straits Settlements and Malay States, and discussing issues associated with administrative arrangements, demographic structure, and economic development. It also describes contemporary (1870 onwards) understandings of the etiology of disease, the purported effects of the environment on health outcomes, and the ways in which such vulnerability was understood to be mediated by race. I illustrate too the complex health and healing systems of the region, into which biomedicine was introduced.

I bring to my use of the term 'colonial capitalism' not only an understanding of the way in which specific political and economic conditions shaped and gave meaning to material life in Malaya, but also the fact that in this context, biology, ecology, the circumstances of material life and knowledge interacted and produced health and illness. I include therefore not only the specific conditions and circumstances of capitalist penetration and relations of production, and the disruptions that colonialism created in terms of social and material life, but also colonial perceptions of territory and space, order and control, and ideas of moral authority and cultural difference that saturated state policies and programs.

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This use of political economy provides a framework within which to view an eclectic and disparate range of epidemiological, demographic, and historical data. The approach provides a mechanism for the interrogation of state initiatives in the areas of health and medicine, forcing us to question the nature, direction, structure, and outcomes of health interventions in terms both of their epidemiological impact and their ability to serve the interests of the state. In addition to my use of political economy, I am concerned also with the significance of the introduction of biomedicine as a cultural system, in terms of practice, institution and belief,[14] and with the role of gender within the state and with respect to health and illness, as in all aspects of social life.

To take these points, briefly, in turn. Edward Said, following the early work of Eric Stokes, draws attention to the significance of nineteenth-century English philosophy in legitimating colonialism – in Stokes' example, British dominion of India. Said argues that the entire history of nineteenth-century European thought is predicated on presumptions of them/us, inferior/superior, upper/lower, hence also ruler/ruled.[15] This apparently crude binarism underpinned much nineteenth and early twentieth-century colonial discourse in Malaya (and in the Colonial Office in London), and provided the intellectual arguments to justify the colonial enterprise; it introduced 'superior' cultural trappings (ideas and beliefs, methods and technologies, structures and institutions) to 'primitive' peoples, and established systems of Western science through schools and medical services. The development of a hospital system, the provision of British doctors and assistant doctors and apothecaries trained in biomedicine, and the availability of a pharmacopoeia derived from this (without acknowledging the debts owed to other systems with prior presence in Malaya) established, in the context of the colonial polity, the primacy of Western science, and the need to maintain a political system to ensure the continuing advantages of its technical offerings. Tropical medicine was 'invented' in this light.

I have implied, above, the importance of gender in understanding health and illness. I do not propose here to demonstrate the ways in which many histories, gender-blind, have represented the realities of men as if they were all people, nor to spell out why gender matters. But colonial Malayan history provides a nice case study of gender at work: the structure of the colonial population, the distribution of power, the sexual divisions of labour and the concomitant varying risks of infection, and access to medical care, are all as much matters of gender as they are of class and race. Less easily documented are the variations in meaning, knowledge and treatment between women and men, and by ethnicity, although as I describe later, state understandings of the sexual distribution of disease and salience of various ailments is relatively straightforward. Colonial

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understandings of gender and the colonial construction of sex and sexuality pervade the epidemiology of disease and its interventions whilst informing also colonial demography. In official accounts, men not women suffer from malaria and beri-beri, cholera and tuberculosis, not because women were protected from such infections but because the sexual division of labour and the demographic disequilibrium of the sexes created a series of hierarchies that affected exposure, infection, illness and its treatment. Ideas about women and their health derive from the segregation of women and men, and women from each other; and women's sexual roles divide into recreational and procreational roles that subsume colonial women, their biology, functions and behaviour. Whilst in general health services collapsed the categories of woman and reproduction (women's health was of interest only in the context of reproductive health),[16] in Malaya the population of women was bifurcated into essentialist categories – mother and whore – and their health needs defined in terms of antenatal care for the former, venereal disease for the latter. For mothers, women's health services concentrated on ensuring their ability to reproduce. For sex workers, the focus was on preventing others from being infected by them; these women were vectors rather than victims of disease.

The distribution of disease by race and sex, and changes over time due to economic and demographic changes, is documented in Chapter 2. Colonial Malaya was characterised in the late nineteenth century by rapid changes in morbidity, mortality and demographic structure. Whilst there was a dramatic decline in the incidence of some epidemic infectious diseases through simple controls (for example, smallpox through vaccination), for other diseases the etiology was more complex, treatment was unavailable or offered varied success, and control was problematic. Health statistics are unreliable, but even so, it is apparent that health status was equivocal for many, and the incidence of a number of endemic ailments, including diarrhoeal diseases, respiratory infections and malaria, continued to take a major toll of the population. Although the infant mortality rate as well as adult mortality declined from the early twentieth century, several major factors contributed to this and morbidity statistics for the period to 1940 suggest that improved health was sometimes illusory.

For many Malays colonial capitalism resulted in changes in the mode of production from peasant subsistence farming and fishing to wage labour. However most labour was provided by immigrant Indian and Chinese men. Chapter 3 is concerned with understandings of illness and race, and the way in which this was played out in the context of particular diseases. It considers the incidence of various ailments as influenced by material circumstances of everyday life, and dominant

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beliefs and actions consequent upon the etiology of illness, diagnostic categories, and available treatments. Economic changes resulted in disruptions to the environment, affecting particularly the epidemiology of malaria and resulting in changes in food supply, in turn affecting the nutritional status of peasants and fisherfolk as well as agricultural labourers. In addition, specific conditions which prevailed in parts of Malaya resulted in the prevalence of particular diseases: beri-beri among Chinese miners was the most notable and best documented. The chapter discusses government interventions in malaria and beri-beri, the impact of which was harshest among immigrant workers, as pursued for estate works in Chapter 5; these public health programs were accorded high priority in an effort to minimise the cost (and exploit the potentiality) of the colonial economy.

In Chapter 4, the focus shifts from the country to city. For evidential reasons I focus on Kuala Lumpur and Singapore, where health risks and outcomes were calqued onto the social geography of the towns, reflecting colonial social and racial categories. Hygiene and sanitation were poor, visibly so with open sewers, drains, and refuse in the streets. Dry and wet waste disposal presented one problem to public health officials, so too did the pace of urbanisation. Towns expanded rapidly, resulting in overcrowding and spread of disease. Coffee houses, bars and brothels, markets, food stalls and dairies, and residential cubicles were all sites of contagion; this chapter describes the management of urban space that was based on this understanding.

Chapters 5 and 6 concentrate on two populations that might be considered exemplary or indexical of the colonial setting. In Chapter 5, the setting is rural, the workers estate labourers; the chapter details the organisation of labour, health conditions on estates and the health status of the labourers, and the provision of medical care, potable water and sanitation. Poor health from infectious disease was compounded by conditions of deprivation and cruelty. Malaria was a major risk to estate workers and death rates at the turn of the century were especially high. Malaria control measures were implemented variously on the estates, with continual tension between state and capital, as represented by the malaria control boards and town councils on the one hand, and estate owners on the other – one seeking to reduce mortality and the other to expend as little as possible on a labour force which it regarded as replaceable.

Chapter 6 focuses on working women: the commercial sex workers of the colonies. The colonial economy relied on immigrant labour, mostly men. Around the turn of the century the sex ratio was some 12 men to 1 woman, a significant number of whom were involved in prostitution. Most lived and worked in oppressive conditions, in substandard and

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overcrowded housing, their mobility limited, their money strictly controlled. From the late nineteenth century their health needs were partly met by private medical clubs and lock hospitals, driven by a wider interest to control venereal disease. Shifts in morality and political pressure from outside the colony led to government movements to 'rescue' the women by encouraging them into commercial sewing, domestic service, or marriage and, as a result of growing international pressure in the 1920s, by steps taken to close down the brothels.

State accommodation and regulation of prostitution reveals one aspect of its understanding of gender. Midwifery and child welfare, as discussed in Chapter 7, provides a further vehicle for the engendering of colonial subjects. State interest in mothers and children, infant mortality, child welfare and the control of midwifery date from the early twentieth century. Female medical officers ('lady doctors') provided a means of surveillance of mothers, midwives were trained and registered, and infant welfare clinics were established so that babies could be weighed and measured. Babies who performed poorly were proof of maternal incompetence, and the ability of native and immigrant women to be 'good' mothers was constantly in question. A growing concern that initiatives with adults be consolidated led to the development of curricula for young women (future mothers), and this chapter explores the development and content of the curriculum and the perceived role of women as gatekeepers of their families' health.

The concluding chapter documents the shifts in logic that occurred towards the end of the British empire. Growing sensitivities at criticism of the health and wellbeing of subject people in British colonies (from the USA as well as from international organisations and agencies), led to considerable reflection within the Colonial Office about colonialism and the moral responsibility of the state. Enquiries in the 1930s and the development of post-war plans for the colonies reflect a growing concern with a 'moral economy' of colonialism. The foreshadowed end of colonialism pushed government awareness of the need for 'social' development, and for social services that addressed the inequalities created by economic development. It is on this note that the book closes.

If the work were to begin now – in the 1990s – it might be difficult to start from archival sources and to remain so embedded in those records that the work could proceed without matching alternative documentation, the provision of moderating voices of those Chinese, Indians and Malays who left textual records through the 'vernacular' press, for example, or through oral history interviews with those who might still recall the end days of the empire. But this is a work commenced a

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decade earlier, and the excavations of archives in Malaysia, Singapore and the United Kingdom proved far more complex and compelling than might have been imagined; the source material is eclectic and voluminous. This work brings together part of that data, and presents a starting point for a continuing project that seeks to better understand the diverse and pervasive impact of colonial rule on a society, a biosphere, a people, and their everyday life.

Much of the research for this book was undertaken whilst I was a Research Fellow with the Department of Southeast Asian and Pacific History, in the Research School of Pacific Studies, the Australian National University, although the theoretical and thematic interests of the book reflect also the very disparate environments of the School of Sociology, the University of New South Wales, and the Tropical Health Program of the Faculty of Medicine, the University of Queensland. Financial support was provided from a grant from the Australian Research Council;[17] the Faculty of Arts, the University of New South Wales; the Research School of Pacific Studies, the Australian National University; and the Tropical Health Program, the University of Queensland. In addition, I benefited from the hospitality and colleagiality of the University of Oxford as a Visitor to the Department of Biological Anthropology in 1984, and to the Wellcome Unit for the History of Medicine in 1992. The Wellcome Unit especially provided me with a lively intellectual environment and a tranquil haven from routine academic life that enabled me to make the first good draft of this book.

The book draws on diverse holdings. In London, I used the libraries of the London School of Hygiene and Tropical Medicine, the Wellcome Institute, the Royal Commonwealth Society, and the Foreign and Commonwealth Office, in addition to the Public Records Office in Kew and its India Office holdings in South London. In Oxford I used the Rhodes House Library and the library of the Wellcome Unit for the History of Medicine; in Singapore the National Archives of Singapore and the library of the National University of Singapore; in Kuala Lumpur the libraries of the University of Malaysia and the Institute of Medical Research, together with Arkib Negara Malaysia. In Canberra, I worked primarily in the National Library of Australia. I have used the libraries of the Australian National University, the University of Oxford, the University of New South Wales and the University of Queensland for supplementary material.

Institutions I can name; individuals are more difficult. I have scored up many personal debts over the lengthy period when I worked, intermittently, on this book, and I risk omitting or undervaluing the role of some were I to name those who might now first come to mind. Four exceptions are in order: Leanne Kerr, Alyson Stibbard and Kiruba

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