DISABLED EMPIRE: RACE, REHABILITATION, AND THE POLITICS OF HEALING NON-WHITE COLONIAL SOLDIERS, 1914-1940

by

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The First World War and its aftermath gave birth to the trauma industry – an intellectual, political, and institutional response to the widespread experiences of disability and “shell shock” among veterans. “Disabled Empire” follows several million non-white colonial subjects from across the British Empire who fought in the War, and their experience of grievous injury, debility, and trauma. Through a comparative analysis of South Asian and West Indian servicemen, it explains how race shaped the character and goals of bodily and psychological treatments that the British wartime and post-war state offered its non-white veterans. It also analyzes the impact non-white veterans had on how white British psychologists, orthopaedists, hospital staff, policy makers and administrators understood trauma. It reveals how colonial subjects’ service in WWI destabilized long-standing ideologies about masculinity and racial difference, even as it produced an uneven system of care.

Throughout the Great War, British officials struggled to resolve the paradox of enacting the Empire’s mission to restore the health of crucial manpower reserves of non-white soldiers, while reinforcing colonial gendered and racial hierarchies. Imperial constructions of race, from the fearless South Asian ‘martial races’ to the
hypersexualized black masculinity of West Indians, shaped the kind of wartime service Indian and Afro-Caribbean soldiers were allowed to perform and the treatment of their psychological and physical injuries. Whether in the form of ethnic-specific diets and rations, the provision of impractical prosthetics, or discounting trauma through racialized stigmas, colonial soldiers navigated a health system whose technologies, diagnostics, and treatments denied them the same quality and level of care as their white counterparts. Yet White British Tommies’, Indian Sepoys’, and West Indian labour corps workers’ concurrent experiences of disease, disability, and trauma disrupted ideologies about colonial difference. Drawing on archives from the United Kingdom, Jamaica, and India, the thesis’s transcolonial framework demonstrates how racial ideologies simultaneously played into and were subverted by the process of offering healthcare to non-white colonial subjects. It demonstrates the war’s lasting effects on the policies and practices of healthcare and welfare throughout the Empire.
Acknowledgments

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This project would not be possible without the archives and librarians who contributed to and enriched it, from the United Kingdom to India and Jamaica. I have never envisioned myself as a military historian. Nonetheless, the archival journeys that this project has enabled me to go on have brought me into contact with a world of postcolonial militaries, many of which are still working out their relationship with their colonial predecessors. In Pune, India, I spent time and shared meals with the differently abled students of the Queen Mary Technical Institute, injured in service with the Indian National Army. At the QMTI, they trained for a new profession in hospitality, engineering, or computer science, on the same grounds that the Institute had re-educated disabled servicemen on since its move from Bombay to Pune in 1922. I watched them take their exams, read their reflective writing to others during the daily flag raising ceremony, and listened to them as they recounted their journey from their often-distant home provinces, to the rehabilitation center next door to the QMTI, where many were able to bring their wives and children to live near them as they recovered. Sunil Panicker, once a student at the Institute and now one of its teachers, was especially generous with his time and insights, and shared with me his own research into the school’s history.

In Kingston, Jamaica, Corporal Harrison of the Jamaica Defense Force gave me a comprehensive tour through their small military history museum and library, describing the ordeals and service of soldiers past and his time in the present JDF. The collection, housed in a small hangar on the grounds of the JDF’s base, sat on the same ground that
arriving Jamaican recruits would have camped and done training exercises on as they awaited deployment. When, at times, I found the voices of their First World War predecessors unreachable, my discussions with these men and their perspectives helped give life to a history I could otherwise only read about in periodic glimpses. They are historians in their own right, and the following thesis would be dramatically different – and all the poorer – for the lack of their insights.

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Table of Contents

Abstract.................................................................................................................. ii

Acknowledgments ................................................................................................. iv

Table of Contents.................................................................................................. vii

Introduction............................................................................................................. 1

Chapter One
Muscles: Raced Labor and the Mobilization of Non-white Colonial Servicemen........ 31

Chapter Two
Stomachs: Food, Nutrition, and Multiracial Rationing............................................. 101

Chapter Three
Nerves: Non-white Trauma and Military Psychiatry............................................ 148

Chapter Four
Bones: Rehabilitation, Re-education, and Re-Membering Colonial Veterans......... 204

Chapter Five
Genitals: Sexual Health, Racial Hygiene, and the Bureaucracy of Repatriation .... 266

Chapter Six
Bodies in the Aftermath: Protest and Pensions in the Interwar Era..................... 302

Conclusion............................................................................................................... 364

Bibliography........................................................................................................... 370
Introduction

From his hospital bed in June, 1915, Sursan Singh mused, “I got wounded in the hand and have been very well treated. They give me very good food and as much as one wants… One is very well looked after.”1 Decent treatment would not give him a long term reprieve from the war encircling the globe. “The wounds get better in a fortnight, and then one is sent back to the trenches,” he continued, “I have no hope of surviving as the war is very severe. The whole world is being sacrificed, and there is no succession… I am not allowed to write more. In England I am driven about a lot in a motor car and see village after village.” Singh’s missive see-saws. He is treated well and healed, only to be thrown back into battle. He tours the English countryside, but his thoughts and feelings are censored.

A letter by Charles Booth, an Acting Corporal with the British West Indies Regiment, echoes Singh’s sentiments. Healing on Ward 6 at the Windsor St. Auxiliary Hospital in Liverpool in December 1918, Booth thanked the philanthropic West Indies Committee for a box of chocolate received at Christmas. “I have had a very fine Xmas,” Booth assured them.2 “I also send my heartest thanks to our committee… I have received a tin of chocolate which was sent from Panama colon I was a liver there for twelve years and after war brake out I ‘Valintery’ joine up I am now helpless. And that Nice Beautiful Country I will never see again which I love so dearly [sic.]” Like Singh, Booth expressed

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2 Charles N. Booth to Lady Mallet, 27 December 1918, in Letters from the Trenches During the Great War, ed. Matilde Mallet (Shipston-on-Stour: King’s Stone Press, c. 1919).
gratitude for the care he received, yet despair filled his thoughts. The wounds of war, he believed, had permanently separated him from his distant homeland.

Even if the “whole world” was not being sacrificed, as Singh alleged, the whole of the British Empire certainly was. Assigned to opposite roles in the war – Singh a combatant soldier and Booth a menial labourer – they nevertheless found themselves in surprisingly similar situations. Both had traversed oceans to fight for the British. Both wrote from British hospital wards as they healed from wounds treated by British physicians. Singh and Booth alike felt grateful for the care they had received. Yet both were convinced that they would never see their former homes again.

The physical and psychological crises of shell-shocked white troops, and the politics of how they sacrificed their bodies and psyches during the first great Global War have come to stand in for the fractured violence of modernity. We know a great deal about the physical and psychological crises of these white troops, and the politics of how they sacrificed their bodies and psyches. We also know that anti-colonial and nationalist leaders in the colonies hoped wartime service would elicit augmented rights, self-sovereignty, and varying levels of independence from imperial states. Historical scholarship narrates their disappointment when these dreams went unfulfilled. Studies of decolonization identify the European powers’ ‘broken promises’ of veteran pensions and expanded rights as fuel for colonial discontent and anti-colonial nationalism. However, we know very little about the intersection of these watershed moments. These two grand narratives – on the one hand, the white historiography of trauma and medicine, and on the other, the historiography of non-white anti-colonialism – meet at the place where non-white soldiers at war came into contact with care providers. It is there, in hospital
archives in Britain, in asylum records in India, and in personal petitions and papers in
Jamaica, that I’ve found the most productive, disturbing, and vocal archives about race,
trauma, and care in the First World War.

This thesis is about the tensions that arose between the dehumanizing and
racializing tendencies of Empire, and the humane responses by individuals to experiences
of disability and trauma during the war. It is also about the men themselves from South
Asia, Africa, and the Caribbean who, like Singh and Booth, answered the call to serve the
British Empire. In particular, this study focuses on servicemen from British territories and
armies in South Asia and the West Indies. Because West Indian and Indian soldiers
enjoyed official status as volunteers, rather than as conscripts like their Egyptian and
African counterparts, they had crucial access to the moral discourses of self-elected
service and duty upon which they made claims on the British state.3

The Great War was the first time that troops and volunteers from nearly all
reaches of the Empire participated in the war effort side by side. As such, army officers,
health officials, and colonial administrators considered racial and ethnic groups not in
isolation, but in concert with each other. Administrations had done so before. They
deliberated which martial races in the Raj were suitable fighters after the 1857 Sepoy
Rebellion, which Indian troops would be imported to South Africa for service in the
Second Anglo-Boer War, and which West Indian troops could serve in the Anglo-Ashanti
Wars in Western Africa from the 1870s to the 1880s. However, during the First World
War Asians, Africans, West Indians, and all manner of colonial subjects fought alongside
or in close proximity to one another. Their assignment to distinct, often segregated units

and regiments seemed to corral them from unregulated communication. Yet the vicissitudes of a catastrophic war gave them opportunities for direct and indirect contact. They met in the trenches, mobile camps, casualty clearing stations, field hospitals, on hospital ships, and in convalescent homes. Just as importantly, many of the officials, clinicians, and ward orderlies organizing their treatment encountered men of different ethnicities, religions, and cultures from across and beyond the British Empire.

To corral them from unregulated communication, officials assigned Asians, Africans, West Indians to distinct, often segregated units and regiments: the Indian Army, the Indian Labour Corps, the British West Indies Regiment, the Cape Boys, the South African Native Labour Corps, and so on. The vicissitudes of a catastrophic war, however, gave them ample opportunities for direct and indirect contact with one another. They met in the trenches, mobile camps, casualty clearing stations, field hospitals, on hospital ships, and in convalescent homes. Just as importantly, many of the officials, clinicians, and ward orderlies organizing treatment encountered men of different ethnicities, religions, and cultures from across and beyond the British Empire. The war, then, brought together new problems and new possibilities for the management of people across the globe. Only by decolonizing the history of the War and military medicine can we understand its long-lasting effects on the farthest corners of that Empire.

This dissertation makes several arguments about the intersecting histories of race, gender, the body, and rehabilitative regimes during the First World War. First, I demonstrate how dominant ideologies and the political economy of race shaped medical care, as well as the development of diagnostic categories. Whether in the form of ethnic-specific diets and rations, the provision of sub-par prosthetics, or the explaining away of
trauma through racialized stigmas, colonial soldiers navigated a health system whose technologies, diagnostics, and treatments denied them the same quality and level of care as their white counterparts. Racial thinking and racism explain a great deal of this story, but not everything. Compassion and sensitivity to cultural differences also produced surprising new insights into the physical and psychological needs of non-white soldiers.

This leads to my second main contribution: the imperatives of care and the interpersonal relationships forged between clinicians and patients challenged raced assumptions about non-white servicemen. Treating an ethnically, religiously, and culturally diverse body of servicemen prompted some colonial administrators and clinical practitioners to break with dominant interests of the Empire by legitimizing and demanding care for non-white servicemen. Experiences of, and responses to, colonial servicemen’s debility underscored the fragility of racial relations and racial ideologies in the British Empire. Crucially, demands of South Asian and West Indian soldiers compelled some physicians and officials to rethink how racial ideologies played into their medical practices. The experience of shared trauma and treatment created a new awareness among patients about the care they received and their entitlement to it.

And third, negotiations between medicine, the military, and colonial troops produced changes to and expectations of healthcare and welfare systems in the colonies. The colonial soldiers’ involvement in the Great War forced the British to acknowledge that healthcare was not just a gift of civilization bestowed by benevolent rulers. Now, it was also an imperial duty towards loyal subjects who volunteered to fight for the Empire alongside British citizen-soldiers. Ongoing debates over what constituted adequate care in the colonies were further inflected by questions of race and ethnicity. Wartime
experiences with the multiethnic British Armies engendered a greater awareness on the part of doctors, policy-makers, and psychologists of the need to provide culturally-informed healthcare. Yet in practice, they struggled to provide care free from bias that met the diverse needs of local populations across the global Empire. Colonial patients and British caregivers, I show, established a dynamic – albeit profoundly unequal -- relationship.

Burbank and Cooper emphasize how empires relied on the management of difference to ensure stability and growth, simultaneously accommodating and perpetuating it. This thesis takes up how another form of “difference” – debility and disability – offered new and different challenges to systems of imperial management. In the wartime world of imperial mobilization and individual mobility, both constructed identities (British configurations of “colonial difference) and cultural difference deeply affected ways in which colonial servicemen were worked, fed, treated, repaired, and aided. Difference could be managed, but it also challenged management. Medicine was not alone in breaking the body apart and putting it together again – often imperfectly. It did so alongside British forms of colonial labor, the military, and the entangled bureaucracy of bodily valuation. Wartime suffering ruptured and reconfigured British understandings of race and labor, at the same time that it shaped colonial servicemen’s self-understanding.

The vast body of scholarship on the First World War makes possible this history of race and trauma, despite the overwhelmingly Eurocentricity of work on health, wounding, and the war. Nevertheless, as the centenary of the War approached, many Western nations ‘rediscovered’ colonial and non-Western contributions to their war
effort. Scholars both initiated and extended these histories. This constituted a sharp divergence from existing narratives about colonial militaries. In the late twentieth century, most historical research about colonial soldiers and their involvement in imperial warfare focused heavily on the political and military history of their engagements and viewed the Great War as yet another conflict in the long history of colonial military action. These colony-specific narratives did not probe what it meant for colonial subjects to fight alongside soldiers from colonies across the Empire. They rarely delved into soldiers’ experiences at war. But over the last fifteen years, a number of valuable social histories have considered the First World War experiences of colonial servicemen of color on a country-by-country basis.

4 In 2002, a Guardian feature told the stories of Indian, African, and West Indian veterans ‘forgotten’ in British history. Simon Rogers, “Soldiers of the Empire: The Heroes Britain Forgot,” The Guardian (6 November 2002). These recovered histories increased over the following decade. The BBC has solicited a series of articles, blogs, and online history features about colonial contributions to the War. In 2015, the National Army Museum blogged features on “Black Soldiers in the First World War” as part of contributions to Black History Month; the Imperial War Museum coordinated an AHRC-sponsored study “Whose Remembrance?” to question whose war stories went untold in 2012. In the process, it collected blogs from those conducting research on non-Western servicemen in their collections, and organized online learning resources on the Empire at war.


https://www.bl.uk/world-war-one/articles/colonial-troops (29 Jan. 2014)

http://www.bbc.co.uk/history/worldwars/wwtwo/colonies_colonials_01.shtml (30 March 2013)


6 On the cross-colonial contributions of non-white servicemen, see John Morrow, The Great War: An Imperial History (New York: Routledge, 2004); Timothy C. Wineguard, Indigenous Peoples of the British
on West Indian servicemen, and Omissi, Das, and Singh on Indian troops take on the social experiences of these diverse soldiers. Das and Ahuja et al’s collected volumes draw history, literary studies, and anthropology together to recount a postcolonial history of war by reconstructing the experiences of colonial troops from across the globe in the First and Second World Wars. Similarly, Guoqi recovers the experience of Chinese laborers hired by the French and British to explore how they understood their encounter with Westerners and war. All argue, to a varying extent, that colonial subjects’ service fundamentally changed their understanding of themselves, their colonial masters, and Empire itself. For Smith and Howe, Afro-Caribbean experience abroad furthered their sense of injustice at racial prejudice and spurred future black radicalism and nationalism. How active black ex-servicemen actually were in these movements is unclear and underdeveloped. Das, Markovits, Omissi and Singh’s studies perform deep readings of

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Dominions and the First World War (Cambridge: Cambridge University Press, 2011); and Kilson, Calling Up the Empire.


Though not focused on the First World War, a number of scholars have expanded on the cultural history of the Indian Army. See Erica Wald, Vice in the Barracks: Medicine, the Military and the Making of Colonial India, 1780-1868 (London: Palgrave Macmillan, 2014); Heather Streets, Martial Races: The Military, Race, and Masculinity in British Imperial Culture, 1857-1914 (Manchester: Manchester University Press, 2010); and Kate Imy, “Queering the Martial Races: Masculinity, Sex and Circumcision in the Twentieth Century British Indian Army,” Gender & History 27, no. 2 (August 2015), 374-396.

Indian soldiers’ writings in order to establish them as active agents whose wartime experiences shifted their understanding of the British and French. Yet these histories refrain from conclusively tracing how wartime experiences impacted their understanding of imperialism, Western medical care, or Empire, just as they leave the question of how the British were changed by Indian service untouched. Furthermore, they rarely continue after 1918 to probe the linkage between colonial veterans, military service, and the imperial state in the later 1920s, 30s, and 40s. How their military service impacted non-white colonial servicemen’s later lives – through debility, disability, or welfare – is undeveloped.

In contrast to the new and growing field of colonial and global histories of the War, scholarship on health, disability, and the military is well established. Historians have narrated in extensive detail the relationship between medicine and the war. Several works recount how medicine was militarized in total war, and how the conflict served as a defining moment in fields ranging from military psychiatry to surgery and orthopaedics, and how soldiers dealt with pain, suffering, and the destruction of their bodies. Mark Harrison, in particular, has designated the First World War “The Medical War.”

Medicine obtained this prominent standing because, Harrison explains, it was both a crucial managerial resource and a symbol of the Britain’s mobilizing humanitarian ideals. Harrison expands at length on the complexity of care across fronts for the

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11 Ibid., 11.
Indian Army and, to a lesser extent, of the “Native Labour Corps.” Yet the personal experiences of these servicemen are absent from this predominantly revisionist medical narrative of the war. The perspectives of his physicians, politicians, and army authorities organizing medical service offer no deeper questions about the role of race in military medical care.

Technical medical histories intermingle with the large body of work that explores the cultural, social, and political dynamics of wounding, illness, and disability. Recently, several historians have pivoted towards examining the nature of caregiving and the perspective of those performing care in the First World War.\textsuperscript{12} Ana Carden-Coyne alters this framework by elaborating on the soldier’s experience of wounding in the context of industrialized warfare.\textsuperscript{13} As she points out, World War One was a contradictory moment: the extreme political demand on soldiers’ bodies stood in tension with the rise of humanitarian focus on individual agency.\textsuperscript{14} This paradox raises even more questions with regards to the mass participation by non-white troops from the colonies – questions which go unanswered in cultural histories of wartime medicine. Subjugated men played a critical role in securing further territories during the war. Their contributions helped bring the British Empire to its geographic zenith in 1919. Did the British public and military authorities believe that their sacrifices also jostled with the British values of liberal humanitarianism? Carden-Coyne at times briefly expands on the differing perspectives and experiences of non-white soldiers from the British colonies. These

\textsuperscript{12} Emily Mayhew does so by following the precise technical transformations and procedures of caregiving. Mayhew, \textit{Wounded: A New History of the Western Front in World War I} (Oxford: Oxford University Press, 2013). See also the forthcoming work of Jessica Meyer on “Masculinity and Medical Care in Britain during the First World War.”


\textsuperscript{14} Ibid., 3.
occasional comparisons, however, serve to emphasize the centrality of the British and Australian soldier, and rarely tap into the larger questions surrounding race, wounds, and care.

The robust literature on trauma and disability, meanwhile, uniformly treats British, American, and European veterans. In the last two decades, accompanying the establishment of trauma studies as an interdisciplinary enterprise, historical studies of war trauma and combat stress have multiplied. Many scholars, notably Leese and Loughran, focused on the wartime responses of clinicians and their patients. These works established that many “shell-shocked” men had never killed an enemy combatant. Their collapse in the trenches led “experts” and the British public to conclude that traumatized men were innately effeminate. Peter Barham expanded on these volumes by taking account of the common soldiers who suffered mental debility, as opposed to the officer class more often officially diagnosed with “neurasthenia” or “shell shock.” Exploring a wider range of soldier-patients and psychotic illnesses, Barham broke ground by tracing their lives and experiences in the aftermath of the War. This work was furthered by Reid’s examination of care apparatuses and social responses to trauma victims in the 1920s. Bourke alone noted how ethnicity was a crucial variable in these studies. She argues that British authorities suspected Irishmen of degeneracy and “primitive” or

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“feminine” reactions on a much larger scale than their English, Scottish, or Welsh counterparts. Expanding on the global impact of war trauma, Kent claims that the collective experience of trauma in the Great War led the British public to generate fantasies of “Others,” leading to acts of imagined or real violence against outsiders in the 1920s. In doing so, Kent, among others, established psychoanalytic categories as a lens through which historians could understand society. Produced in the wake of international conflicts that reintroduced war trauma as a vital concern in American and European societies, these works have helped to establish the legitimacy and power of psychological illness as an object of historical inquiry.

Because these works on trauma and disability emphasize the importance of dislocation in producing psychological upheaval, it is even more compelling to examine colonial veterans, most of whom were transported halfway around the globe before entering an unfamiliar war under unknown commanders. The same questions of governmental obligation to and provision for traumatized British veterans must be asked of non-white colonial servicemen. For them, the stakes of war participation were often even higher.

Anderson, Bourke and Carden-Coyne all note the way in which disabled bodies – particularly those of masculine soldiers – served as metaphors for the functionality and future of the state. The individual health of the nation’s men corresponded directly to conceptions of the nation’s health as a whole. In some cases, disabled white officers were offered the opportunity to migrate to co-operative settlements in British East Africa, where the incapacitating effects of their wartime experience would be offset by their status at the top of a racial hierarchy. Here, fragmented or disturbed white bodies were consistently affirmed as superior to whole black bodies. The soldier body held the same critical meaning in Jarvis’ study of twentieth century America, and in Lerner’s account of WWI Germany. In the latter, psychological healing was just as paramount to soldier rehabilitation and the nation-state’s health as physical therapy. While these studies illustrate the complex power of the disabled body as a representative of the condition of the nation, they remain silent on what the disabled, traumatized, or otherwise damaged body of the non-white soldier meant to the empire and colony.

Disability studies scholarship, concerned with how different societies understand and experience impairment, offers a new avenue for histories of debility and global war. The innovations in this field offer rich accounts of the biosociality of disability. In the

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last decade, as disability studies grappled with their own Western-centric legacy, scholars have increasingly turned to questions of race, ethnicity, and imperialism, to examine how colonial and neo-colonial structures impact the politics and processes of debility, rehabilitation, and re-education. These approaches suggest new questions for a colonial history of debility and trauma in the First World War: How did subaltern sacrifice register on the imperial state? How were mechanisms of care predicated on Western models? And how similarly or differently did British and colonial servicemen conceptualize, experience, and respond to disablement?

Scholars of colonial medicine, meanwhile, have explored the prominent role of psychiatry as a field which reaffirmed colonial difference by pathologizing colonial subjects as alternately criminal, sexually maladjusted, or mentally ill.

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psychiatry was focused on diagnosing and treating clinical assessments of mental disturbance. Conversely, psychology’s perspectives on race and condition were considerably less clinical and more flexible. Linstrum suggests that while imperial officials set the agenda for research in the colonies, studies into the psychologies of the non-white Empire often challenged racialized frameworks. Researchers collected evidence subverting primitivist stereotypes and illustrated the similarity of European and non-white mental aptitude. Yet as in many other new histories of the social and human sciences at the turn of the twentieth century, we rarely hear from or consider the perspective of the non-white or non-Western subjects of study. Linstrum’s analysis investigates officially funded expeditions to study the psychology of colonial civilians after the Great War, noting only in passing how the catastrophic years of battle destabilized imperial claims. The interaction of metropolitan and colonial sciences in WWI, however, repays fuller treatment than Linstrum affords it. It offers a particularly salient example of how expert knowledges like racialized labor theories, ethnography, psychology, reconstructive surgery, and rehabilitative therapies came together alongside medical fields such as orthopedics and psychiatry to determine colonial soldiers’ rights to a whole and healed body. It also provides a site in which expert knowledge changed alongside subaltern servicemens’ experience of suffering.

This study brings together histories of colonial medicine and histories of wartime trauma and disability. Drawing from the former, it asks how colonial frameworks and racial ideologies shaped care for the colonial war wounded, not only back at home but

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during the war in fronts and hospitals from Britain and France to Mesopotamia and East Africa. Building on the latter, it reorients central questions about the symbolic power and experience of the (white) mentally and physically wounded body, asking instead how non-white servicemen’s experiences, presence, and actions transformed and transfigured military medicine and broader ideas about debility at war. In doing so, it illuminates how non-white colonial servicemen shaped the phenomena of trauma, debility, and disability that came to define “the war to end all wars” – and how those phenomena impacted colonial systems of healthcare and welfare long after the last shots were fired.

Ever hungry for manpower after the abolition of slavery in 1833, colonial officials had long contemplated Indians, Africans, and Chinese as units of labor endowed with race-specific capabilities. Some groups, notably Sikhs, Gurkhas, and ethnic groups from the Punjab region of Northern India, were conceptualized as “martial races,” biologically and socially inclined towards the arts of war. Chinese, lower-caste Indians from the Southern reaches of the Raj, and other southeastern Asian groups were allotted menial jobs and various forms of hard labor. So too were Africans, black West Indians, and many black British enlistees. In the case of the latter, British notions of their hypersexualized masculinity cast them as potentially subversive dangers, too threatening to be supplied with arms and loyally serve in British Armies. British officials derived these characterizations from incidents over decades of colonial rule, from slave rebellions on West Indian plantations to the Sepoy Rebellion in 1857 British India. The flexibility of raced ideologies of labor prompted the imperial state to use a variety of colonial subjects as muscle in service of the empire. The Indian Army secured new borders in the

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north and northwest of the Raj, contributed troops in the Anglo-Boer War, and served in policing deployments in Hong Kong. The spottily-deployed West India Regiments, originally drawn from local slave and ex-slave populations in the 1790s, suppressed the Morant Bay Rebellion, and facilitated British conquest of the Gold Coast and Sierra Leone in the 1870s and 90s. In British East Africa, locally-recruited soldiers served in the King’s African Rifles and assorted other rank-and-file battalions both within and outside British territories. Military officials drew on this pre-history of colonial deployment, and on the presumed racial differences that structured it, as they deliberated the location and character of colonial subjects’ wartime service. During the “Great War,” the military’s role as an employer – rather than simply a state or martial apparatus – expanded dramatically.

To discuss ideologies of race and labor in the British imperial world, it is first necessary to question what constituted ‘race’ for British colonizers. There is no definitive answer, largely because British conceptions of ‘race’ in the age of high imperialism were messy, often entangled with notions of what we now think of as ethnicity, religion, caste, and class. One so-called martial race, the Sikhs, were a monotheistic religious group. The martial race category of “Gurkhas,” as Heather Streets-Salter has elaborated, were drawn from a region of Nepal and included men from a variety of culturally distinct traditions.\(^{28}\) The racial distinctions that British officials drew on in organizing colonial labor and governments were constructed identities, shaped by decades, sometimes centuries of colonial interference, migration, and cultural reorganization. In the same way that Western colonial rule helped to produce and harden the system of caste in India,

the British simultaneously constructed and hardened certain groups in central and southern India by designating them “criminal tribes.” These colonial categories, Anupama Rao has argued, along with many others, became an “ethnographic real” when they diffused through imperial society and were taken up in different ways by colonial subjects. The same process is visible across the British Empire. Categories and identities were reworked in the wake of the Middle Passage, where people from a wide variety of African ethnic groups saw difference erased, only to reform in the post-emancipation Caribbean as Jamaicans, Bahamians, Barbadians, and Trinidadians. Ethnic taxonomies were in themselves historical products.

These long-standing yet fluid racial ideologies were constituted in part through a deep history of labor migration and imperial projects, from the horrors of the middle passage and the British Atlantic, to the importation of Chinese and South Asian indentures to the West Indies, to the gold rush on South Africa’s Witwatersrand. These processes created new racial taxonomies among a wide variety of groups – Africans of different ethnicities, white migrants, mixed race people, South and East Asian laborers. The British imperial view – perceiving the world in ethnic and racial terms – seemed effortless and natural, yet it was also part of a divide and rule strategy that used


difference to ground and strengthen Empire. Increasingly in the late nineteenth century, the human sciences of ethnology and anthropology buttressed this imperial project. In the early twentieth century, new sciences and theories – including those of psychology and Taylorism – reinforced it. These technologies of Empire, and the ideologies of difference that provided a framework for them, were essential scaffolding for organizing and managing a massive, multi-racial army, from Fiji to British Honduras.

At the start of the war, the British Empire encompassed some 417 million people, of whom only c. 70 million were white. By 1919, Britain had utilized nearly one hundred percent of their available white manpower, to put just over 5.7 million of these men in combat and labor corps. In India alone, Britain recruited over 1.4 million men for service. Non-white colonial recruits provided an essential but often unwelcome source of manpower, particularly in Europe itself.

The swift introduction of the Indian Army into battle in the European theatre was a direct result of the British admiration for the fighting skills of so-called “martial races” of India, long put to use in conflicts ranging from conflicts on the Afghan border to the Boxer Rebellion. Dispatched in the first month of the war, the War Office sent India’s 1,400,000 men to fronts as diverse as France, Egypt, Western Africa, and Mesopotamia. Yet by 1916, British officials began to articulate fears over the presence of these “brown men” in Europe, citing miscegenation, slackening morale, and anxieties concerning the

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physical and psychological degeneration of Indian troops on Western soil.\textsuperscript{34} By the end of the year, all Indian battalions were removed from Europe to farther fronts, where they played a decisive role in combat and sieges in the Middle East, as well as in Palestine and British East Africa. Historians’ emphasis on fraternal solidarity in the trenches overlooks this rethinking of racial divisions and differences.\textsuperscript{35}

The mobilization of West Indian servicemen followed its own distinct trajectory. When war in Europe broke out in 1914, the governors of Caribbean colonies swiftly pledged British allegiance and offered volunteers. Despite chronic manpower shortages, the British military was hesitant to involve these black colonial subjects in a “European war.” Early black volunteers seeking their own passage to England were frequently turned away at ships due to a color-bar. Men from the Caribbean colonies, however, were eager to enlist: some sought steady employment, while others anticipated rights in exchange for their wartime contributions.\textsuperscript{36}

The War Office finally approved a West Indian contingent (BWIR) in late 1915. Ultimately, over ten thousand men and 243 officers made up the final nine battalions, which mixed men from different islands together while scattered over numerous fronts.\textsuperscript{37} But while West Indians had enthusiastically enlisted for combat, most were used as trench diggers and ammunition carriers. Only two battalions ever saw active combat. Though the War Office consciously removed West Indians from fighting roles, laborers’

\textsuperscript{36} Howe, \textit{Race, War, and Nationalism}, 32.
\textsuperscript{37} Kilson, \textit{Calling Up the Empire}, 224, 228-229.
proximity to the front resulted in extremely high rates of mortality and injury. The War Office deployed them on menial labor duty throughout Europe, Africa, and the Middle East. Throughout the war, many British civilians and officials alike treated the BWIR with Caribbean-specific British racial expectations. War Office officials and British media illustrated West Indians as masculine primitives, strong yet simple, alternately infantilized and hypersexualized.

If having “black” men in imperial armies was crucial to British colonial policy and military strategy, healing them was also necessary. The War Office saw the need to provide basic medical care and attention to wounded colonial soldiers, or risk losing vital units of manpower, and potentially inciting rebellion among agitated laborers. Even before the war, agitation for nationalism and self-determination had begun in many colonies, particularly India, and officials were eager to avoid anti-British sentiment from fomenting during the war. Furthermore, the Great War was the first time that many colonial servicemen visited England. However brief their stay, officials deemed it essential that these troops were impressed by the “mother nation” – including its medical regimes and hospital facilities. Yet during the war, the logic of British liberalism broke down, collapsing a system which had been largely open to colonial collaboration and cooperation. Virtually all non-white servicemen served in segregated units, a practice which extended to medical facilities and hospital ships. Thus, these veterans underwent a fundamentally different medical experience than their white counterparts.

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38 Smith, *Jamaican Volunteers in the First World War*, 90.
39 Ibid., 100-103.
40 Ibid., 143.
At the same time, wounded and traumatized black soldiers were a locus of deep anxiety for colonial policy-makers: in denying most non-white troops the opportunity to serve as active combatants, and by removing them to far-off fronts, British officials denied them the right to be seen as martyrs and dedicated citizens. As Bourke and Mosse have shown, British government and media created a highly complex rhetoric around sacrifice for the nation. For the War Office, media, charity organizations, and the British public, bodily sacrifice in the form of lost limbs was particularly powerful in supporting arguments for state-provided welfare and disability aid in the metropole. It was no accident that the Representation of the People (Fourth Reform) Act of 1918 granted millions of returning British soldiers the right to vote for the first time. In doing so, Parliament verified how their sacrifices for the nation rendered them worthy citizens. Yet while the War Office readily propagandized colonial soldiers as loyal imperial subjects, mass media in Britain remained largely silent about these non-white disabled servicemen. They received no such political boons when they were returned – sometimes forcibly – to the colonies.

**Comparative Dynamics**

Over 1.4 million South Asian servicemen served in the Indian Army and Labour Corps as combatants and non-combatants. Combined with the official count of other non-white colonial troops – Africans, West Indians, Fijians, etc. – over 1,575,000 non-white servicemen from the colonies officially enlisted and fought for the British cause. This was greater than the cumulative contribution of all white soldiers from the settler dominions of Canada, Australia, New Zealand, and South Africa (1,306,512 servicemen).

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Coercion and poor record-keeping, particularly in British East Africa, make it difficult to arrive at an exact figure for total non-white colonial manpower. Historians widely believe the official figure of 1.58 million to be a severe underestimate.¹² This number does not include the 140,000 Chinese laborers used by the Allied Forces. It likely also excludes the masses of North Africans, Egyptians and East Africans who served as laborers, many of whom were conscripted or who were exposed to excessive, often forceful recruiting measures.¹³ Published figures include the official estimate of 44,262 “Native African followers,” or the East African subjects who formed a vital part of army manoeuvring by working supply lines and in transit – a number some historians believe to be up to one million men, women, and children.⁴⁴

The drastically asymmetrical contribution of servicemen from colony to colony, and the different duties they performed, renders even comparison difficult. Army officials widely believed non-combatant laborers – disproportionately non-white men from the Empire – to be of inferior mental health. They often attributed their psychological afflictions to hereditary conditions, rather than new war neuroses caused by the traumas of modern warfare. These diagnostic practices harkened back to earlier European interpretations of mental illness in Africa and among other “undeveloped” societies,

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¹³ Historians quote wildly different figures in reference to the total African mobilization during World War I. Many circuitously cite other scholars, making the process of arriving at a final number a wild and virtually impossible process.

¹⁴ On the difficulty of ascertaining total numbers of participants from British African colonies, see Parsons, “Mobilising Britain’s African Empire for War,” 195-196.

where psychological symptoms hinged on group pathology (instead of individual biography). Studies into and records of non-combatants’ psychiatric experiences, therefore, are rarer than those of critically important combatants, from Indian sepoys (soldiers) to British officers. Conversely, Afro-Caribbean veteran’s literacy and enhanced mobility generated many more direct petitions and entreaties to the colonial and metropolitan government, from both individuals and ex-servicemen’s associations. The range of personal testimonies of struggles to procure welfare and pensions skew towards West Indians. As a result, this dissertation’s treatment of different soldiers’ experiences and medical management varies from chapter to chapter. The first two chapters take place entirely during the war, resulting in sustained comparisons across colonial lines, from West Indian and Indian servicemen to Chinese laborers and African troops. The subsequent four chapters, however, stretch beyond the war into the interwar period, in some cases up to the 1940s. To accommodate this broader temporal range, I have narrowed the colonial scope of these sections.

This study focuses on the care and experiences of South Asian and West Indian servicemen. The two groups offered drastically different contributions to the war: over 1.4 million Indian Army troops vs. a final count of 15,204 members of the British West Indies Regiment. However, their political and military conditions of service render them a fruitful site for comparison. Crucially, both forces were made up almost completely of

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46 Sepoy, the Europeanized term for an Indian soldier, is derived from the Persian sipahi (soldier).
volunteers, unlike the conscripted and coerced labor provided by South African, West African, East African and Egyptian servicemen.

Recruiting efforts grew in force over the course of the war, particularly for certain “martial race” ethnic groups in the north of India. Nonetheless, the vast majority of enlistees joined of their own volition. The nature of the Indian and West Indies military forces differed drastically – a massive standing military with roots stretching back to the East India Company, compared to a new patchwork of soldiers that fought to be allowed to enlist. However, both servicemen and officials from the two colonial forces called on their voluntary commitment to the imperial Motherland to emphasize their loyalty, devotion, and sincerity of their wartime contribution. In time, veterans of the BWIR and Indian Army also emphasized the moral weight of their chosen sacrifices in petitions and pleas for augmented care and welfare from both colonial and metropolitan administrations.

Their political circumstances also meant that these veterans received an unusual amount of oversight from metropolitan bureaucracies. The settler colonies that mobilized the majority of other non-white servicemen – the British East African territories, South Africa, Australia and New Zealand – had more independent systems of veteran welfare provision. The metropolitan Ministry of Pensions retained an interest in their affairs, but only to a limited extent. Settler colony governments prioritized white veteran pensions. As Chapter 6 will detail, the Ministry of Pensions was unwilling to involve itself in a debate over “native pensions” with colonial authorities. For East African veterans, for

\footnote{Though the West India Regiment had been recently deployed in the Anglo-Ashanti Wars, Chapter 1 details how the War Office debated their deployment in the Great War, particularly in a European theater.}
instance, Timothy Parsons has detailed, “rehabilitation meant retribalization.”
Furthermore, in British East and Central Africa, coercive recruiting and the resulting poor recordkeeping often rendered it impossible for ex-servicemen to claim further medical and fiscal aid.

In contrast, veterans in the West Indies and the British Raj had significantly more civic avenues to voice complaints and concerns. The Indian Army maintained a large military bureaucracy. It had over fifty years of experience distributing various forms of veteran aid. The metropolitan army of the Government of India, the India Office, maintained close relations with colonial government and frequently interfaced with the Ministry of Pensions and the War Office over the care of its servicemen.

On the other side of the Empire, ex-servicemen in the Caribbean had markedly different, yet still potent possibilities for accessing and asserting veterans’ rights. West Indian veterans were fluent in English and largely concentrated on the island of Jamaica. Their vocal petitions and protests led to an increasing number of metropolitan committees, sent to consider West Indian welfare. Crucially, the BWIR emphasized its voluntary nature. These factors combined granted Afro-Caribbean veterans more avenues to pursue care and welfare – even if it was not regularly provided to them.

The non-settler nature of the West Indies and the British Raj’s colonial governments also provides strong grounds for comparison in the interwar decades. Their ties to metropolitan offices and administrative lack of white veterans combine to make their post-war dealings with non-white ex-servicemen more visible. When representatives

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from the Ministry of Pensions investigated imperial provisions for veterans in the colonies in the 1920s and 30s, their visits to the West Indies and India put a spotlight on non-white care and welfare. In the Dominions, in contrast, local officials elaborated on the condition of white veterans, while obscuring their inadequate and often non-existent efforts to aid black ex-servicemen.

**Structure & Chapter Outline**

This study is organized around various body systems – muscles, stomachs, nerves, bones, and genitals. I adopt this organizing structure for several reasons. First, it troubles wartime clinicians’ understanding of bodies and organ systems as naturalized (and implicitly, abstracted and universal) objects of scientific enquiry. The Twentieth edition of Henry Gray’s *Anatomy of the Human Body*, released in 1918, split its chapters up similarly – myology, neurology, osteology, splanchnology, etc. Yet the practices of colonial medicine made clear that not all bodies were the same. In wartime hospital beds, convalescent homes, and medical journals, clinicians analysed soldier bodies from across the Empire as both unitary and different. For instance, while medical experts saw nutritional science as a field dedicated to the body’s absorption and management of food and nutrients, they simultaneously believed that the bodies they treated were not the same: they conceived of distinct ‘Punjabi stomachs,’ ‘Indian stomachs’ and ‘British stomachs’ (see Chapter 2).

What is gained by putting together these diverse medical fields and issues as part of a single albeit highly differentiated story? First, during the war, military authorities dealt with medical and scientific concerns in diverse disciplines together, as part of the
problem of healing and re-mobilizing colonial manpower. The War, Colonial and India Offices and the Ministry of Pensions consulted and worked with a wide variety of evolving specialists through wartime administrative bureaucracy, from the Army Medical Service to the Directorates of Labour. The exigencies of war prompted some medical sub-specialities – nutritional science, military psychiatry, new orthopaedics – to emerge, at the same time that it required practitioners of diverging disciplines to work together. What’s more, given the contingencies of wartime mobilization and deployment, medical staff were not necessarily deployed in their sphere of expertise. This was particularly true for new medical graduates without established positions in their fields. The physician in charge of the mental health ward at the Kitchener Indian Hospital in Brighton, East Sussex, was trained as a gynaecologist in Edinburgh. In contrast, psychologist Owen Berkeley Hill, who had seen five years with Indian Army regiments as a member of the Indian Medical Service, was deployed in British East Africa with little to no contact with South Asian servicemen. Cultural familiarity and medical specialism did not necessarily correspond to individual’s assignments. As a result, ‘expertise’ was varied, and wartime contributions to medical knowledge haphazard.

Secondly, over the course of the war, servicemen encountered their physical and psychological trials concurrently. Their troubles were systemic. Their hunger defined their pain, their pain their psychological state, and vice versa. Their medical experience of war could not be separated from their corporeal experiences. For servicemen of color from the colonies, their differential mobilization, deployment, and status meant that their medical experience was also deeply entangled with their raced experience. To reclaim
their struggles against an overwhelmingly white narrative, we must consider how their bodies moved through a variety of types of care.

No chapter tells the complete story of medical fields or specialist issues during the war. Rather, what I hope to show in considering these bodily systems and sciences together, is how each produced medical structures and diagnoses which were inflected by race, in ways that operated very differently depending on the subject. The treatment of colonial soldiers was rife with political, medical, and social debates. As officers, scientists, doctors, and administrators confronted colonial subjects, their conscious and unconscious beliefs about their racial, gendered, and classed identities rubbed uncomfortably against the mass experience of trauma and disability.

The first two chapters examine mobilizations and medicines from the outbreak of the war until the armistice of November 11, 1918. “Muscles: Raced Labor and the Mobilization of Non-white Colonial Servicemen” explores how pre-war racial ideologies shaped the mobilization of colonial troops, and the structuring of a healthcare system that would treat the multiracial, multicultural, and multi-ethnic British Armies. From the vantage point of the War Office, colonial peoples were, quite literally, muscle – necessary muscle at that. In mobilizing non-white servicemen from the Empire, they drew directly on long-standing ideologies about race and the kind of labor non-white individuals could perform. Yet ongoing debates around mobilization revealed the lack of a united front of ‘expertise.’ Physicians and officials in charge of organizing non-white servicemen’s welfare could be both agents of racial bias and critics of these attitudes. In many cases, they were both. The confluence of soldiers, officials, and clinicians from
across the colonies, on battlefields and in hospitals, reshaped their understanding of the Empire itself.

Chapter 2 (Stomachs) investigates how the British attempted to feed a multicultural army across diverse fronts and campaigns. If the stomach powered the soldier, the army ration was critical to powering the British forces. Yet rations were the subject of fierce cultural, scientific, and military debate. Preference and access to food depended on an increasingly complex matrix of status, race, and religion. The War Office attempted to delineate ration schemes by race and unit. Their dietetic prescriptions elicited resistance from a mix of officials, clinicians, and soldiers on the ground. These factions critiqued existing ration scales and also demanded change on the basis of personal preference, cultural and religious need, or medical requirement. This chapter, then, tracks how notions of ‘culturally appropriate,’ ‘racially specific’ and ‘nutritionally necessary’ diets became conflated. It also examines how wartime contingency altered diets. Geographic dislocation, transport difficulties, and personal exchange led to the mixing of different diets by choice and necessity. Diets shaped by race and ethnicity simultaneously produced health problems and offered solutions to them.

The following four chapters bridge war and postwar. Chapter 3 (Nerves) addresses the treatment of psychological trauma and illustrates how racial ideologies about martial stoicism and temperament broke down in wartime. In asking who could be labelled a traumatized subject, it explores the continuing tensions between initiatives that attend to illness as a universal, and those which understand it as culturally-specific. Chapter 4 (Bones) looks toward the rehabilitation and re-education of disabled non-white veterans. It investigates how British beliefs concerning raced labor roles infiltrated
colonial policies concerning artificial limb distribution, disability pension allotment, and orthopedic techniques. Faced with ill-suited prosthetics from an imperial system that blamed patients for the inadequacies of their devices, disabled ex-servicemen often modified their prostheses or engaged in their own therapies.

Chapter 5 (Genitals) studies colonial servicemen’s experiences of masculinity and sexuality through the lens of British fears and regulation of venereal disease, miscegenation, and intermarriage. The persistence of interracial relationships in the interwar years both validated the administration’s anxieties and highlighted the way in which colonial mobilization made these relationships possible. A final chapter considers the bodies and minds of colonial ex-servicemen in dialogue with the Empire of military welfare. Chapter 6 (Bodies in the Aftermath) explores veteran protest politics through Ministry of Pensions investigations and individuals’ pension petitions. These seemingly mundane documents reveal the deeply fraught colonial debates over questions of race and responsibility, as ex-servicemen made the case for their moral and bodily worth to the colonial and metropolitan governments.

The technologies of empire controlled colonial subjects’ bodies through racial and gendered hierarchies. Race and ethnicity were constitutive of wartime approaches to nutritional science, military psychiatry, orthopedics and rehabilitation, the treatment of venereal disease, and postwar welfare. The medical treatment of non-white soldiers disrupted the categories upon which the entire enterprise of empire rested. The result was a mixed legacy of therapies and technologies of care, marked by profound inequalities as well as a novel sensitivity to the cultural contexts of medical care that lasted well into the post-colonial period.
“From all over the Seven Seas the Empire’s sons came to illustrate the unanimity of all the King’s subjects in the prosecution of the War. English, Scottish, Irish, and Welsh divisions of good men and true fought side by side with soldiers of varying Indian races and castes. Australia’s valiant sons constituted many brigades of horse and, with New Zealand mounted regiments, became the most hardened campaigners in the Egyptian and Palestine theater of operations…. South Africa contributed many good gunners; our dark-skinned brethren in the West Indies furnished infantry who, when the fierce summer heat made the air in the Jordan Valley like a draught from a furnace, had a bayonet charge which aroused an Anzac brigade to enthusiasm (and Colonial free men can estimate bravery at its true value). From far away Hong Kong and Singapore came mountain gunners equal to any in the world, Kroomen sent from their homes in West Africa, surf boatmen to land stores, Raratongas from the Southern Pacific vied with them in boat-craft and beat them in physique, while Egypt contributed a labour and transport corps running a long way into six figures. The communion of the representatives of the Mother and Daughter nations on the stern field of war brought together peoples with the same ideals, and if there are minor jealousies between them the brotherhood of arms will make the soldiers returning to their homes in all quarters of the globe the best missionaries to spread the Imperial idea. Instead of wrecking the British Empire the German-made war should rebuild it on the soundest of foundations – affection, mutual trust, and common interest.”

- W. T. Massey, How Jerusalem Was Won (1919)

William Thomas Massey’s imperial vision of “the Empire’s sons” rushing to Britain’s side during the First World War is a paean to multiracial cooperation and dedication. The “dark-skinned brethren” of the West Indies bested the Jordan Valley’s summer heat, various “Indian races and castes” fought “side by side” with the English, Scots, Welsh, and Irish of the British isles, and the “Kroomen” of West Africa vied with the Pacific Raratongas to display their maritime talents.49 A war correspondent, Massey’s retrospective picture also highlighted skill, explicitly comparing raced abilities and aptitude. His account of the Palestinian campaign underscored the importance of heat

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49 “Kroomen” or Krumen was an invented term referring to groups living in coastal Côte d’Ivoire and Liberia, often maritime workers and sailors. Originally an unofficial journalist on the Western Front, Massey became a special correspondent in Allenby’s Egyptian Expeditionary Force in Palestine. From 1923 to 1935, he served as the news editor of the Daily Telegraph.

William Thomas Massey, How Jerusalem was Won: Being the Record of Allenby’s Campaign in Palestine (London: Constable, 1919), 17.
endurance, shooting skill, physique, and seafaring. While this brotherhood might bear “minor jealousies” toward one another, Massey insisted that they were all dedicated, loyal fighters.

Colonial subjects’ global experiences in WWI would cement Empire, Massey asserted, not only preventing future erosion, but “rebuilding it on the soundest of foundations.” Yet as historians of empire in the twentieth century have long argued, the failure of France and Britain to reward colonial contributions with self-determination, augmented rights, and welfare produced waves of anti-colonial nationalism. Their very mobilization, predicated on colonial racial ideologies, led to the questioning of imperial ties and loyalty.

The British Government began the war largely opposed to the involvement of any non-white colonial forces as laborers or combatants. The notable exception was its longtime reliance on the standing Indian Army, heavily populated by “martial races.” The manpower crises of 1915 changed their minds. It did not change officials’ race-based assumptions. They initially structured the deployment and mobilization of non-white servicemen around pre-war ideologies about raced labor roles. Developed from centuries of colonial knowledge production, these informed all questions regarding colonial soldiers. Should they serve as active combatants, or be slotted into labor corps? Could they be deployed at the front lines, or would this foment grievances against the War Office for using them for gun fodder? Were their bodies more resistant or sensitive to heat and cold than the white British body? How could army officials preserve the boundaries between colonizer and colonized, the undergirding principles of colonial difference?
As officials in the Colonial and War offices and the Army wrestled with these questions, many saw the War as a unique opportunity to test and remake men’s laboring bodies. The late nineteenth century saw the culmination of European fervor for classifying subjects and identifying racially-determined labor roles. The Great War, driving one of the most diverse labor migrations in modern history, gave colonial officials an immense arena in which to test these prescribed identities. The War also gave colonial subjects an immense arena in which to push at the boundaries of these classifications. Never before had so many different groups of colonial subjects worked in such close proximity and similar conditions to one another.

This situation produced two paradoxical consequences. Administrators’ attempts to maintain colonial hierarchies led them to trade in racist assumptions and promote segregationist treatment. At the same time, however, this moment of multiracial, multicultural comparison frequently undermined and challenged the racial ideologies upon which non-white deployment was based on.

Historians of science and war have demonstrated the Great War’s influence in spurring medical and scientific advances. Yet military and medical technologies were not the only type of knowledge enthusiastically produced by the British war machine. Once the wartime Cabinet accepted the need for non-white manpower, administrators in the War and Colonial Offices believed the war offered vital opportunities to assess the physical and mental capacities of their colonial subjects. Studying, training, and outfitting them for battle, they also sought to assess their propensity for certain types of labor – either as potential future soldiers, or as workers in the imperial economy. Muscles mattered to British officials. The challenge, as they saw it, was to match the
right sort of muscles with those tasks for which they were inherently best suited.

Officials believed that doing so correctly would not only help to win the war, but would

This chapter examines how the mobilization of non-white colonial servicemen both drew from, adapted, and sometimes called into question pre-war ideologies of race and colonial difference. Wartime shortages and labor crises forced the War Office to assign different groups of colonial laborers and servicemen to heretofore untested roles. This threatened to expose as fictions the assumptions about raced labor governing much of colonial administration and economy. At the same time, it reflected the fractured front of authority within the army on the question of race, health, and labor. Within official policy and on the ground, physicians and officials held vastly different opinions about the ways in which non-white servicemen could be deployed and healed.

Imperial classification had both a marginal and paramount effect on soldiers themselves. Servicemen may have had different racial and ethnic classificatory schemes, carried with them from home. They found themselves in a world where treatment was poor, work was perilous, and new forms of injury and illness abounded. They too reworked categories and hierarchies even as they struggled to access necessary forms of treatment and recompense. Amid these efforts, non-white soldiers frequently protested against poor treatment. Others sought non-Western medicines and therapies to carry them through the War.

This chapter charts and analyzes the impact of race and racial thinking on the somatic economies of non-white soldiers in wartime Britain. First, I examine the mobilization of servicemen from the British Raj and the West Indies to illustrate how
recruitment practices, military training regimens, and media responses were inflected with long-standing yet fluid racial typologies. I then analyze arguments over where such regiments ought to be deployed, from discussions of climate suitability to housing and formative studies in raced epidemiology. Seeking to respond to its own racialized understandings of soldiers’ needs, the military warfare state constructed a segregated medical infrastructure. Yet even within this strictly ordered system, cross-cultural exchanges between groups of soldiers, caregivers, and officials produced affective ties and new cultural knowledge. These exchanges across lines of race, ethnicity, region and religion began to break down long-standing ideologies of racial difference.

I. Decisions for Non-white Mobilization

The British Cabinet and War Office debated extensively whether to deploy non-white servicemen, even as insatiable demand for manpower rendered their mobilization almost inevitable. Trench warfare turned hard won inches and feet into weeks and months of fighting. The unexpectedly static nature of the Western Front required an especially high level of manpower and military material. High consumption of supplies demanded a continuously high level of transport – and men to run it. In the Mesopotamian and East African campaigns, which by geographic necessity had to maintain much longer lines of supply, the need for porters and ammunition carriers was already high and continued to grow. From the outset of hostilities, the War Office

50 Numerous factors lead to the multiplication of work and duties which British labor corps had to perform. The lack of modernization in the British army, and its lack of a pre-war mass army, contributed to disorganization and the need for a bloated labor force. Furthermore, as sea shipping became more dangerous and tied up, and British home sources dried up, the Directorate of Works was quickly forced to employ men in the harvesting of raw materials, primarily quarry stone and timber, to complete its projects. On the history of the Directorate of Works during the War, see Robin Wallace Kilson, Calling Up the Empire: The British Military Use of Non-White Labor in France, 1916-1920 (PhD diss., Harvard University, 1990), 16, 41-49, 64.
espoused a policy of refraining, whenever possible, from engaging forward troops in labor duties, to reserve their energies instead for fighting.\textsuperscript{51} Officials strongly opposed non-white subjects serving on the Western Front, where black men would fight white men on European soil. Still, the dire conditions of trench warfare drove the War Office’s eventual decision to import foreign and colonial labor.

Past practices of colonial mobilization offered conflicting precedents. Much of the British Army was deeply imbued with racial thinking, and many officials believed that arming colonial subjects was inherently dangerous.\textsuperscript{52} As the Empire expanded, however, the British abroad regularly yet selectively mobilized non-white colonial subjects as soldiers and laborers. Defeat and extended periods of fighting between the British and various indigenous peoples led some military and colonial officials to respect and value certain group’s martial capabilities. This is most prominent in the case of the vaunted “martial races,” groups thought to be both biologically and culturally predisposed to the arts of war. For the British, the most prominent of these groups in the colonies were the “martial races” of northern India, particularly the Sikhs and Gurkhas.\textsuperscript{53} To varying extents, “martial races” also included Celtic groups in Scotland and Ireland. Parallel ideologies grew around certain ethnic groups in British East Africa, where the colonial

\textsuperscript{51} “Execution of Work: Labour,” The National Archives (TNA), War Office (WO) 161/2.
\textsuperscript{53} Streets, \textit{Martial Races}. 
administration recruited select men to serve in the King’s African Rifles. A similar precedent held in the British Caribbean – though notably, in much smaller numbers after emancipation. The West India Regiment, founded in 1795, sent non-white enlistees to campaigns both in the West Indies and as far as West Africa, where they fought for the Empire during the Anglo-Ashanti Wars. Crucially, the colonial process of assigning and transfiguring racial and ethnic identities was often accompanied by attendant ethnogenesis on the part of colonized groups, whose own identity was in turn changed by their newly configured laboring roles.

Even when official positions rejected black labor – notably in the Boer War – supply troops provided indispensable manpower. Yet the nature of the Great War as a contest fought between mainly European nations and empires, a large part on European soil, greatly complicated outstanding precedents and the anxieties that had produced them.

The only non-white servicemen mobilized for European service at the outbreak of War were Indian sepoys. The War Council deployed three divisions in Egypt. When Lord Hardinge, the Viceroy of India, advocated ending the color ban on European fronts, the King agreed. Less than a month after they set off for Egypt, the ships carrying the Indian battalions were redirected to the shores of southern France. Their speedy and decisive mobilization was largely unquestioned due to their military and cultural status. The vast majority of the Indian Army’s combatant sepoys came from ethnic groups and tribes recognized as superior ‘martial race’ fighters. Practically, their deployment was

enabled by the large and established bureaucracy of the Indian Army, which organized and ordered regiments quickly to France. As the war progressed, they were summoned to nearly every campaign alongside other combatant units of the British Armies.

Martial race ideology undergirded a transformation within colonial armed forces and ideals of masculinity in the late nineteenth and early twentieth centuries. Army rhetoric as well as popular literature constructed these military elites as archetypally stoic, obedient, loyal, and fierce in battle – ideal traits of the superlative masculine soldier. Yet this rhetoric reshaped its Nepalese and Punjabi targets as well as infusing Victorian culture. Heather Streets has illustrated how, as army service grew more typical for certain “martial race” cultures in the northern borders of the British Raj, they in turn embraced both martial race ideology and the Army and Empire which provided for them and their families. As the Army further defined and identified “martial races” from the 1880s to the early 1900s, their idealized masculinity informed late Victorian ideals of manliness. British children in 1900 could collect cigarette playing cards featuring colonial troops, from cards featuring the 5th Punjab Cavalry, the 1st Madras Pioneers, the 45th Sikh Infantry, the 44th Gurkhas, and the Hong Kong Garrison (made up of Sikhs), as well as the Canadian Queen’s Own Rifles, the South Australian Mounted Rifles, and Sierra Leon Frontier Force, among others – a testament to the infusion of martial race discourse into Victorian popular culture. Nonetheless, these trifles also illustrate the

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57 Ideas of sepoy obedience were deeply upset during the 1857 Sepoy Rebellion, in which ten regiments of the Bengal Light Cavalry mutinied against their East India Company leaders. The Rebellion shifted Army recruitment away from Bengal in the East to volunteers from the Punjab in northern India. See Streets, *Martial Races*, 31-35.

58 Several sets of cigarette playing cards featuring numerous imperial forces can be viewed at the National Army Museum, Chelsea, London. “Our Colonial Troops by Faulkner” (1900), National Army Museum (NAM) 8605-5/8404-47; and “Colonial and Foreign Troops Playing Cards” (1902), NAM 8404-51 / 9004-130.
relative fluidity of this ideology. Each collection featured slightly different cards, as new ethnic groups in the Raj were recruited into regiments in the Indian Army.

This expanding discourse acted as the cornerstone rationale for involving South Asian subjects in a ‘Western’ war, fighting against white Europeans. At the start of the Great War in 1914, the War Office and their commanding generals emphasized Indian battalions’ distinctiveness and fitness for battle; James Willcocks, the commanding Lieutenant-General of the Indian Army Corps exhorted troops from the front in October 1914:

You will recall the glories of your race. Hindu and Mahomedan will be fighting side by side with British soldiers and our gallant French Allies… You will be the first Indian soldiers of the King-Emperor who will have the honor of showing in Europe that the sons of India have lost none of their ancient martial instincts and are worthy of the confidence reposed in them.\(^59\)

Men from established “martial races” standing in front of Willcocks, predominantly the Sikhs and Gurkhas, had been the mainstay of the Indian Army since the Sepoy Mutiny of 1857.\(^60\) The Mutiny sent shockwaves through the political and social fabric of the Raj. The widely reported acts of revolt and defiance by regiments of the Bengal Light Cavalry spurred Army administrators to shift recruiting away from Bengal, concentrating on loyal regiments and new groups from the Punjab, Nepal, and the Northwest Frontier – peoples long resistant to being incorporated within the British Empire. The “Punjabization” of the Indian Army proceeded throughout the 1870s, 80s, and 90s. More and more groups

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were added to the roster of “martial races,” attracted to the steady salary, respected status, and promised benefits of Army service.

Yet the British government found it much harder to justify the involvement of other non-white colonial forces, which lacked as storied and established an ethos of martial race – particularly those from outside Asian territories. During the Great War, the struggle to mobilize these non-white servicemen in Europe and the Middle East can largely be put down to a simple dynamic: eagerness on the part of the manpower-hungry War Office, and resistance on the part of the Colonial Office. Colonial officials were eager to use these forces to defend their own colonies. The War Office deployed the King’s African Rifles on the East African Front from the first months of the war and used local labor in Carrier Corps as non-combatants, putting an estimated total of 34,000 men into service. 61 25,000 subjects manned the West African Frontier Force and served the defensive scheme in Nigeria. 62 But the true manpower crisis was on the Western Front, where stalemate led to attritional battles and forced the British War Office to shift to conscription in January 1916.

Many of the formative debates about non-white manpower concerned its appropriateness in European theaters and its overall productivity and fitness. These attitudes drew deeply on preconceptions of racial and hereditary aptitudes. Even as the War Office grew more enthusiastic about the possibility of using non-white labor, officials expressed their anxiety over such servicemen’s capabilities – their skills,

endurance, and value. At the 79th meeting of the War Committee in March 1916, the committee members themselves articulated that the central problem with non-white workers lay not only in their physical capabilities, but in their productivity and pliability:

Prime Minister: asked where it was suggested the labour should be got.
Lloyd George: replied from Africa.
Bonar Law: considered that Egyptians were bests, or Kroo-boys [sic].
Prime Minister: enquired about Malta.
Lord Kitchener: said the Maltese were bad labourers.
Lloyd George: suggested Indian coolies.
Lord Kitchener: said they were bad workers, and would be affected by the climate.63

Comparisons of “races” and ethnicities were part and parcel of the government’s discussions of non-white deployment. In fact, Robin Kilson has aptly demonstrated how the War Committee’s repeated trading of racial comparisons and suggestions for more efficient non-white labor prevented them from settling on any single proposal or plan – despite the fact both the Colonial and War Offices were currently refining their own plans for such labor. Proposals for Egyptian labor was followed by plans for “Cape Boys,” followed by proposals to import Canadian blacks.64 Despite unending comparisons between colonial groups, I have found no occasion on which military or government authorities compared these men’s abilities with those of the white men performing the labor in question in the Royal Engineer Labour Battalions and the Infantry Labour Battalions – regiments predominantly filled with men who were a step – or steps – below the physical qualifications to pass for combative service.

Longstanding ideas about the laboring roles and capacities of colonial populations shaped political discussions of potential and actual troop deployment, as well as the

63 ‘Minutes of the 79th Meeting of the War Committee,’ 23 March, 1916, TNA, Cabinet Papers (CAB) 42/11/9.
64 Kilson, 107-108.
British vision of government itself. When the manpower crisis grew more acute, the Army Council considered conscripting fellahin, impoverished Egyptian peasants, as laborers in Sinai. A committee established to review Egyptian recruitment discouraged them from doing so, partly because they deemed their laboring capacities and minds weak: “Combined with their mental constitution and un-warlike propensities of the fellah, it gives rise to countless vague fears…”\(^{65}\) Nonetheless, the growing emergency spurred the War Office to sanction their enlistment. E. K. Venables, an officer with the Egyptian Labour Corps, wrote of his men, “The best of them were from the Sa-eed, in the far south, and digging trenches was just an enlargement of their work in the soil at home. On completing the day’s allotted portion satisfactorily they were allowed to return to Camp, singing lustily to signify their prowess, not without some opprobrious commends on squads of townies… who where possible were transferred to work more suited to their weakly physique, and lack of perseverance.”\(^{66}\) These debates over Egyptian mobilization illustrate the extent to which pre-existing ethnic assumptions continued to shape deployment, as well as the ways in which wartime service prompted officials to rethink finer divisions within groups.

French policy towards non-white labor differed markedly from the British, but nonetheless influenced British War Office strategy. France’s stunning losses during the

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\(^{65}\) Much of Egyptian labour was conscripted or coerced, though the War Office often turned a blind eye to the “irregular methods” of recruiting. One report of Col. Butler’s labor battalion noted that “while the men seemed on the whole content… Butler found it necessary to surround the camp with barbed wire.” Perhaps as an attempt to stave off corps rebellion – more dangerous abroad than at home – the Committee on Manpower paid conscripted Egyptian Labour Corps members serving in Mesopotamia, Salonika, France, and Mudros slightly more in salary and food and clothing rations than those serving “at home” in Egypt. ‘Committee on Manpower, &c. in Egypt, Report No. 2 to H.E. The High Commissioner: Recruiting for the Egyptian Labour Corps and the Camel Transport Corps,’ TNA, Foreign Office (FO) 371/2932/115861. See Kilson, 280.

\(^{66}\) E. K. Venables, \textit{They Also Served} (Unpublished manuscript, n.d.), IWM P257, Chapter 3, 1.
early stages of the war, its non-growing working-age population, pre-war use of foreign labor, and its longstanding tradition of military participation among colonial subjects in the Maghreb and Senegal, all provided ample reason and precedent to use non-white servicemen as combatants and laborers in its ranks in Europe and abroad. Furthermore, Kilson and Fogarty have argued that France’s position as an invaded territory also supported its use of whatever troops were available to them. Like Britain, France, had a strong popular conception of its own colonial “martial races,” revolving mainly around the tirailleurs senegalais of West Africa and the Zouaves of Algeria. The French recruited various groups of troupes indigenes for decades prior to the outbreak of WWI. Charles Mangin, the wartime French General, was a longtime advocate of their involvement. His 1910 manifesto La force noire encouraged expanding a black African force, identifying the men as born soldiers who would solve France’s demographic military conundrums.

France’s mobilization order at the start of the war included these standing troops, and its continued “recruiting” of African servicemen was largely pressured and coercive. The Ministère de Guerre recruited laborers and soldiers from North and West Africa from the start of the war. By May of 1915, the severe labor crisis prompted the Ministries of the Interior, Agriculture, and Armaments and Munitions to recruit from French Indochina and Madagascar; at the same time, they contracted Chinese indentured

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68 Kilson, 91.
69 Fogarty, Race and War in France, 21.
labor for service in Europe. Until 1917, the bulk of colonial laborers in Europe under French control were only partially segregated from whites – an arrangement most visible in their relatively open access to European prostitutes. Indeed, Richard Fogarty has argued that France’s seemingly liberal position on race relations during the Great War “cemented France’s reputation as a color-blind society” in the eyes of African American soldiers experiencing segregation and prejudice from the United States Army. Studies confirm that this position was less problematic in policy than it was in practice, where day to day relations and negotiations between non-white soldiers and laborers and white French servicemen highlighted racial tensions and prejudices.

British officials eagerly emulated French willingness to deploy their colonial subjects in Europe. In October 1915, frustrated with the Colonial Office’s side-stepping ideas of using non-European labor on European soil, Churchill suggesting consulting with the French to ask how they managed their “recruitment of coloured troops,” whether they took them “by compulsion or voluntarily,” and how they dealt with the related difficulties, “with far less experience of native races than ourselves.” For Churchill, then a member of the War Committee and eager to bolster British ranks, the British were effectively ahead of the French in their accumulated (colonial) knowledge of their colonial subjects. This knowledge and “experience of native races,” Churchill hoped, would allow the British Army to create an informed plan of action for non-white deployment.

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70 Kilson, 96.
71 Fogarty, Race and War in France, 3.
72 Particularly where Chinese indentured labor was stationed, race riots were a common feature in France throughout the late years of the war.
II. Changing Paradigms of Colonial Labour: Restructuring, Training, Mobilizing

Unprecedented losses on the Western Front in early to mid 1916 at the Battles of Verdun and the Somme pushed the War Committee and Colonial Office to authorize West Indian mobilization. Non-European labor battalions did not appear on the Western Front until the very end of 1916. This force was the first two regiments of the British West Indies Regiment (BWIR), 1 battalion of Cape Coloured Labour (CCL), 2 of the South African Native Labour Battalions (SANLC) and 1 of the Bermuda Royal Garrison Artillery (BRGA, a standing force in that colony since 1895). They joined a number of white labor forces, including the RE Labour, the Non-Combatant Corps Companies (NCC), and Prisoner of War Companies. These colonial forces grew in size with further battalions arriving as laborers in the coming years. By June of 1917, colonial and foreign labor corps serving in Europe ranged from Chinese to Egyptians, and Indians. Once the floodgates for colonial labor were opened, they did not close until the United States entered the war and provided fresh replacements.

Mobilizing colonial labor forced colonial administrators and army officials to remake colonial categories of labor, and in turn, to remake the racial ideologies that undergirded those categories. This process has been most thoroughly documented in the British Raj, where drastically widened recruiting practices rendered new groups eligible for martial and non-combatant labor. As the battlefields of the Western Front depleted

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74 WO 107/37, The Work of Labour, 10; WO 107/37, Appendix A; Ivor Lee and John Starling, No Labour, No Battle: Military Labour During the First World War (Stroud: Spellmount, 2009).
76 Kilson, 131.
long-standing battalions of “traditional” martial races, the Indian Army began to consider recruitment in heretofore non-martial areas.

Though martial race designation was constantly in flux, wartime recruiting prompted it to grow to an extent never seen before. By the end of 1916, with standard sourcing areas exhausted of men, recruiters turned to newly eligible groups. Some were associated with those already serving: Tamang Gurkhas, Saini Sikhs, and Khatri Sikhs. Recruiters also revived others previously allowed in service including the Mappilas, Mahars, Coorgs, and some men from Madras. Alternately, some groups were entirely new to service, such as the Kanets and Girths. The Report on Recruiting in India Before and During the War of 1914-18 reveals how older classes of “martial races” were exhausted, and the rapid increase in enlistees from recently recruited groups. Numbers of long-serving classes, primarily Gurkhas, Sikhs, Jats, and Rajputs, remained relatively consistent throughout the war, though for some, numbers began to drop beginning in 1917. Gurkhas went from 17,418 at their peak in July 1916 to 13,208 in the recruiting year ending July 1918, and down to 2,611 in the final 4 months of 1918. The bottom of the chart illustrates just how eagerly the Indian Army absorbed new classes of fighters. Newly defined classes like Kumaonis and Nayars went from supplying no troops in 1914 to nearly 3,000 each by 1918. Central Recruiting Board quotas ensured that the Punjab and Nepal continued to lead in overall numbers, with the Northwest Frontier Province following, but the geographic and ethnic parameters of eligibility for service in the Indian Army had expanded considerably.

78 Report on Recruiting in India Before and During the War of 1914-18, British Library, India Office Records (IOR) L/MIL/7/15052.
Though brought about by the labor shortage, Army authorities and local recruiters saw this process as a valuable opportunity to test “neglected classes.”\(^7^9\) One postwar report on wartime recruiting practices observed that the success of these “experiments varied considerably.” Those noted as “conspicuously successful” included Burmans, Kumaonis, Coors, and Mahars.\(^8^0\) Commanding Officers at local Depots ensured that these new groups received instruction in the ways of the Indian Army by completing elementary drills, physical training, and games for one month before joining their units. The report recommended that going forth, it was “most desirable… that as many classes as possible shall be represented in the Army in time of Peace.”\(^8^1\) Always in flux, the mass expansion of the Army during the war made clear how flexible “martial race” identities were.

The manpower crisis forced permanent changes to the Indian Army’s recruiting system. Since the 1860s, administrators debated recruiting models based on class (caste or ethnic group) versus territory. Where Class-based systems designated officers to target specific “martial races,” territorial systems allotted geographical areas for officers to recruit from (some with multiple martial race groups resident). Despite countering arguments, the class-based system reigned supreme, on the grounds that it allowed individual Recruitment Officers to become learned scholars of martial race groups, intimately familiar with the “castes whose characteristics and qualifications have been his special study.”\(^8^2\) In doing so, they could continue to monitor their suitability as ‘martial races,’ while also potentially increasing the numbers of recruits. Yet in the manpower-

\(^7^9\) “Recruiting During the War,” c. 1918, IOR L/MIL/7/15052, 30.
\(^8^0\) Ibid, 30-31.
\(^8^1\) Ibid, 31.
\(^8^2\) “Recruiting During the War,” in Army Instruction No. 654, IOR L/MIL/7/15052, 14-15.
hungry first years of war, army administrators admitted its faults. The focus on previously accepted classes made it difficult to “exploit new classes.” Likewise, classes assigned to one specialized Recruiting Officer were spread over large regions, and overlapped with others. Finally, in the Punjab in April 1917, the Army shifted to a territorial system. By the end of the war, Provincial Recruiting Boards replaced Class-specialized Recruiting Officers with territorially-based recruiting in all provinces except Baluchistan, Burma, and Assam.

In addition to loosening definitions of martial race groups and expanding recruitment to non-traditional peoples, wartime expediencies also prompted other changes in recruiting standards. As in Britain, the Indian Army lowered minimum age and height requirements. Alterations in height minimums occurred gradually throughout the war, largely in order of the most valued and established martial races first (See Table 1). Thus, the most valued recruit groups were the first allowed to be shorter.

Table 1: Compilation of Changes in Height Restrictions in the Indian Army

<table>
<thead>
<tr>
<th>Date</th>
<th>Change Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 1916</td>
<td>Height for Mahratta recruits reduced to 5’2’’</td>
</tr>
<tr>
<td>February 1917</td>
<td>Height for Sikh recruits reduced to 5’3’’</td>
</tr>
<tr>
<td>October 1917</td>
<td>Height for Pathans, Punjabi Musalmans, Jats and Rajputs of Rajputana reduced to 5’3’’</td>
</tr>
<tr>
<td>January 1918</td>
<td>Height for Dogras recruits reduced to 5’2’’</td>
</tr>
<tr>
<td>April 1918</td>
<td>Height for all classes of dismounted recruits remaining at 5’4’’ reduced to 5’3’’</td>
</tr>
<tr>
<td>May 1918</td>
<td>Height for all classes of dismounted recruits reduced to 5’2’’</td>
</tr>
</tbody>
</table>

83 Ibid, 25.
84 Ibid, 33.
Furthermore, the ban on enlistment of returned emigrants was overturned. Martial-race theory itself had expanded and adjusted, highlighting its flexibility and ability to adjust to need.

A similar change in ethnic eligibility occurred for non-martial laborers, who filled the ranks of Army followers as cooks (langris), water carriers (bhistis) and sweepers, syces, stretcher carriers, and muleteers (drabis), and entered newly established Indian Labour Corps as porters, diggers, and construction workers. This type of labor was also raced. In contrast to martial race ideology’s emphasis on the rural, village, and typically Northern origins of eligible fighters, followers were set apart by the more urban sites of menial recruitment – the bazaar, construction site, and the port.85 Yet recruiters eager to meet quotas frequently gathered from all areas, encouraging the Indian Army to take steps to ensure that Labour Corps recruiters did not enlist men from traditional martial races in the Punjab and the Himalayas for coolie and porter labor. Still, recruiting standards had to be bent in both directions to meet demand. Frustrated with lagging enrollments in the muleteers, the Army took “the important step” of granting them combatant status, in addition to further concessions in the form of free rations and increased service pay, in March 1917.86 The Mule Corps officers continued to complain about the “quality” of recruits, but never faced shortages again. The tendency toward expansion and flexibility in eligibility for combatant and non-combatant labor began long before 1914, but the catastrophic destruction of ranks and swift need for more manpower meant that these processes sped up drastically during the war.

86 “Recruiting During the War,” 33.
Army administrators highlighted the useful experiment of training new classes of combatants. They saw a similar opportunity to train and remake menial laborers. A series of training camps with varying specialties instructed non-combatant recruits in discipline and drill, teaching them “habits of personal cleanliness,” and holding games of football, running, jumping, wrestling, gymnastics, and tug-of-war. Some were instructed in specialized courses on railway laying, preparing them for a future of postwar productivity. The postwar Report on Recruiting estimated that “the value of these men [was] increased some 50 per cent by this training.” What type of “value” and to whom are unclear, but the report’s authors were certain that the expediencies of war produced a newly industrious crop of workers. From Saharanpur to Jubulpore, Calcutta to Puri, officials proclaimed that laborer instruction made it possible “to take men of the village artisan class and train them in a comparatively short time to work to European standards,” skills they would carry into the postwar working economy. These objectives echoed those in the metropole, where military service was seen to improve men’s – particularly working-class men’s – physique and stamina.

Even when hasty recruiting led to undesirable non-combatants, India Office officials believed their hands-on work during the war could help remake menial laborers. Sir Bruce Seton, in his report on the operation of new Indian hospitals in Brighton, acknowledged that the hasty recruitment of temporary hands at mobilization centres in India resulted in the hiring of many men “attracted by the high pay, engag[ed] for duties

87 Ibid, 47.
88 Ibid, 47.
89 Ibid, 52.
for which they were unqualified,” or worse, unable to perform due to their caste. Yet in spite of this, Seton alleged, “military discipline very soon converted a mob of bazar coolies into an efficient body of men.” In wartime, recruitment operated on a much larger scale, and military discipline was given far greater reign. Seton argued that the experience of serving with the army – limited in peacetime India to a much smaller body of local, “non-martial” natives – had the potential to transform men previously unsuitable for serious labor or military service.

Yet Indian Army officials’ desire for increasing manpower met an unexpected obstacle in the form of the medical examination. Such examinations were standard practice for new recruits, and essential to eliminate “unfit” men before they were paid salaries. Recruiting officers valued quantity, and Regimental Medical Officers receiving recruits often rejected them as unsuited to work. Furthermore, the mobilization of many army medics drained the pool of eligible examiners, creating a backlog of waiting recruits. Many, tired of “hanging about,” simply returned home. Commanders complained that exam standards weren’t strict enough. Provincial governments eager to meet recruiting quotas argued that they were too stringent. In 1917, the Punjab Government convinced the Army to accept recruits suffering from “temporary ailments,” arguing that men with problems treatable within two months could be sent ahead, treated, and put on the field. Instead of bolstering quotas, the move was a disaster, resulting in congested hospitals as recruits remained unfit, or “resolutely refused to be operated.

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91 Bruce Seton, Reports on the Kitchener Indian Hospital, 1916, IOR L/MIL/17/5/2016.
92 Ibid, 32.
Army administration had not anticipated that new recruits, unused to Western medicine practiced in military station hospitals, would refuse treatment.\textsuperscript{94}

In their push for ever more recruits, bureaucratic efficiency in the Raj sabotaged itself. As British officials willingly expanded categories of eligibility, they increasingly came to believe that military training could transform even unpromising men into soldiers and capable workers. This confidence began to destabilize more rigid notions of ethnic, racial, and geographic labor suitability, affirming that certain groups of people could perform duties that the warfare state so desperately needed. It would do the same in the Caribbean, where resistance and enthusiasm for mobilization clashed.

\textbf{Remaking the West Indian Laborer}

When war in Europe broke out in 1914, the governors of Caribbean colonies swiftly pledged British allegiance and offered various forms of support, including the provision of willing volunteers to swell the ranks of the British Army.\textsuperscript{95} Despite their desperate need for manpower, the British military was initially extremely hesitant to involve black West Indian subjects in a “European war” on European soil – military recruiters and naval officers frequently cited the color bar for enlistment and turned away early black volunteers seeking their own passage to England.\textsuperscript{96}

\textsuperscript{93} Ibid, 32.
\textsuperscript{94} Resistance to biomedical initiatives ran throughout civilian medical initiatives as well. Mark Harrison has detailed how British medics struggled to inoculate local populations in Mesopotamia against smallpox. Though vaccination was intended to be a symbol of imperial benevolence in an occupied theater, the Medical Advisory Committee set up to organize inoculation among the Arab population consistently faced locals who resolutely refused their offerings. The British medical officers frequently resorted to compulsion and punished breaches of sanitary law harshly. See Mark Harrison, \textit{The Medical War: British Military Medicine in the First World War} (Oxford: Oxford University Press, 2010), 266-267.
\textsuperscript{95} Trinidad formed a sole exception – it made no plans or efforts to form a local contingent, and only did so months after the War and Colonial Offices approved the venture. Despite vocal public support for a Trinidadian contingent, the Governor, Sir George LeHunte, repeatedly refused to assist in recruitment. A contingent of 1,478 servicemen was formed by LeHunte’s successor, Sir John Chancellor.
\textsuperscript{96} Glenford D. Howe, \textit{Race, War, and Nationalism: A Social History of West Indians in the First World War} (Kingston: Ian Randle Publishers, 2002), 32. White businessmen, planters and civil servants from the
Committee’s reluctance to involve black servicemen from the West Indies revolved around the same fears of enlisting other non-white troops from the colonies discussed above. Men from the colonies, however, readily offered diverse reasons for enlisting. Some were eager for steady employment, while others referenced the longer-term benefits of anticipated rights that the government would grant veterans upon seeing their positive contributions to the war.

In the Caribbean colonies still suffering from long-term economic decline, the War offered a vital opportunity for a respectable salary, and for the potential mobility that came with increased earnings. Peasantry, tenant farmers, and wage laborers across the West Indies had struggled with wage insecurity and circumscribed employment opportunities in the eight decades since emancipation. In Jamaica, the largest British colony in the Caribbean, laborers and cultivators faced high taxes, rents, and difficulty accessing land. With few prospects at home, many Afro-Caribbean workers migrated to Caribbean, on the other hand, paid for their passage to Great Britain more easily and were accepted into Canadian and British forces. West Indian troops had, prior to the First World War, engaged in numerous colonial conflicts, but crucially, they were rarely routed through Britain for training or recovery, never quartered in the metropole, and when abroad, served largely in colonies without a substantial established British population. After beginning as a slaved regiment in 1795 to serve centrally as an island defense force, the Regiments switched to volunteer recruitment, participating in numerous Caribbean conflicts and the War of 1812. Some West Indian soldiers were briefly sent as fighting units to serve in the 43rd Monmouthshire Foot, and the 81st North Lancashire Foot, but these engagements terminated in the early 1800s. After the War of 1812, most Regiments were disbanded. Their only overseas engagement until WWI was on the Gold Coast, participating in limited fighting in the Anglo-Ashanti Wars of 1873–4. At the time of the war, it had been nearly a century since black Caribbean troops fought on European soil. This was not the case for other Allied forces; the French freely used their North African Zouaves, the Chasseurs d’Afrique, and Senegalese and Moroccan soldiers, among others, in Europe. See Roger N. Buckley, *Slaves in Red Coats: The British West India Regiment, 1795-1815* (New Haven: Yale University Press, 1979); and Irving W. Andre and Gabriel J. Christian, *For King and Country: The Service and Sacrifice of the British West Indian Military* (Bowie, MD: Pont Casse Books, 2009), 13-30.

the fruit plantations of Central America, the Panama Canal Zone, Cuban sugar plantations, or further abroad to the United States.\textsuperscript{98}

Governors and civilians of high-standing pressured the Colonial Office to give these men an outlet for their alleged patriotism, to avoid political unrest. Even Marcus Garvey’s recently founded Universal Negro Improvement and Conservation Association and African Communities League wrote expressing their loyalty to the Empire: “being mindful of the great protecting and civilizing influence of the English nation and people.... [we] hereby beg to express our loyalty and devotion to His Majesty the King and Empire… We sincerely pray for the success of British Arms on the battlefields of Europe and Africa, and at Sea, in crushing the ‘common foe,’ the enemy of peace and further civilization.”\textsuperscript{99} Just as W. E. B. DuBois encouraged African American enlistment as a temporary sacrifice in the service of racial progress, so Garvey’s League hoped that enthusiastic enrollment might spur postwar rights.\textsuperscript{100}

In local newspapers, including the Jamaican \textit{Daily Gleaner}, individuals pledged funds for men who wished to go to war: £9,964 in 1915. When an anonymous woman philanthropist urged King George V to accept a WI force, he asked his secretary to learn from the Colonial Office whether such a contingent would be possible. Overcoming earlier resistance, the resulting Colonial Office and War Office correspondence approved a contingent – on May 10\textsuperscript{th}, the War Office rubber stamped an order to enlist at least one hundred Jamaicans, with “a larger number if they are forthcoming.”\textsuperscript{101} On October 26\textsuperscript{th},

\textsuperscript{98} Smith, \textit{Jamaican Volunteers in the First World War}, 35.

\textsuperscript{99} Marcus Garvey, Universal Negro Improvement and Conservation Association and African Communities League to RT Hon. Lewis Harcourt, MP, SSC, 16 September 1914, TNA, CO 137/705, in Smith, 43.

\textsuperscript{100} Chad L. Williams, \textit{Torchbearers of Democracy: African American Soldiers in the World War I Era} (Chapel Hill: University of North Carolina Press, 2010), 41.

\textsuperscript{101} CO 137/712/2343, War Office to Under-Secretary of State May 10, 1915.
1915, a King’s warrant for formation of British West Indies Regiment (BWIR) officially approved the new contingents and opened an unexpected flood of recruits.

An estimated 10,168 men and 243 officers made up the final 9 battalions, which mixed men from different islands together during their extensive deployment. Originally, the War Office agreed to grant recruits British rates of pay, to provide equipment, and to pay separation allowances for the men’s families. The West Indies governments pledged to pay for troops’ transport to England. However, realizing that far more men than expected signed up, the War Office clarified that BWIR contingents were an auxiliary corps rather than an official arm of the British Army – a distinction which allowed them to differentiate benefits and deployment. The War Office exerted increasing pressure on the colonial governors to assume the cost for the BWIR. They eventually submitted. On 8 March, 1916, Jamaica’s Legislative Council agreed to pay all costs of Jamaica’s contingents, including pay, pensions, separation allowances, transport, and equipment – adding up to £60,000 per year for forty years. As the island suffered severe hurricanes for three years of the war, the War Office agreed to pay immediate costs themselves.

Recruiting officers emphasized two narratives of the West Indian soldier to encourage recruitment: first, that all were volunteers, and second, that all would be “fighting” for Great Britain. Enlisting troops believed that they could claim privileges on account of their willing sacrifice and duty - an opportunity unavailable to troops coerced into service. Nearly all servicemen recruited in the British Caribbean were trained in

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102 Kilson, 224, 228-229.
103 CO 318/348 Amery Minute on Pay of the British West Indies Regiment. (Kilson 223)
combat, some in training camps in the colonies and some once the contingents reached their destination.

Despite this training, arriving BWIR troops were surprised that they were not allowed to fight, but limited to labor corps duties. The First, Second, and Fifth BWIR battalions, who were stationed with the Egyptian Expeditionary Force for the duration of the war, saw small bouts of active service in Palestine against Turkish forces from July 1917 to 1918, while the smaller West India Regiment (WIR) were involved in periodic combat in Cameroon.105 The handful of instances of active fighting became a narrative to rally around in both liberal and conservative West Indian presses and postwar accounts, but their designation as non-combatants never changed.

Despite anxiety and uncertainty in the metropole over the presence of West Indian servicemen in Europe, many in the West Indies saw the War as a grand effort to remake the black West Indian labor force. Colonial administrators relayed conflicting representations of the post-emancipation black laborer, from the overtly racist figure of the “Quashee,” lazy and infantile, to abolitionists’ and missionaries’ notion of the childlike yet eager to learn black Christian subject.106 As Catherine Hall has detailed, the mission to remake the Jamaican civilian laborer was an ongoing yet ever conflicted project. This mission grew more complicated during post-emancipation labor crises, as former slaves were loath to perform plantation work. Colonial officials in the larger Caribbean islands, particularly Jamaica and Trinidad, answered the labor shortage

105 Smith, 90-91.
problem by instituting a new system of indentured labor. From the 1840s to the end of the Great War, they replaced Afro-Caribbean workers with men and women from India and East Asia - sidestepping the question of West Indian labor.

The War seemed to offer a prospect for reconfiguring West Indian laborers once again, particularly to administrators in Jamaica. J. H. W. Park, the Chairman of the Central Recruiting Committee in Kingston, argued that men of the BWIR “profited by their experience both physically and mentally.” What’s more, he insisted that the ex-servicemen would “in future prove a real source of strength to the island… their energy… will be an example to others.” Disciplined by military training, Park envisioned masses of transformed young black Jamaicans revitalizing a stagnant, depressed economy – not because of economic reform and fair labor practices, but because their time in the Imperial army would turn them into trainable, reinvigorated subjects.

The demand for manpower opened up army service to virtually any subject who wanted to enlist. Originally, illiterate recruits could be excluded from overseas service; this changed in November 1916, in order to open further opportunities for enlistees. The Parochial Recruiting Committees on Jamaica advocated strongly for the ability to coerce able men into service. Their efforts culminated in a March 1917 bill granting authorities the power to conscript every male in Jamaica from ages 16 to 41. Approved on June 1st, Jamaica became the first colony after New Zealand to institute Conscription. However, the massive influx of recruits registering for service (over

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110 Cundall, *Jamaica’s Part*, 25. For more on the public and political reception of conscription in the West Indies, see Howe, *Race, War and Nationalism*, 86-90.
135,000), meant that officials never instituted the draft. Colonial authorities, particularly Governor Manning of Jamaica, placed great emphasis on the fact that all Jamaicans going to the front were volunteers, not conscripts.

When recruits arrived in Up Park Camp, the central recruiting depot for the West Indian Regiment, they were drilled in martial techniques and performed regular training exercises and daily calisthenics. Park’s hopes for a revitalized labor force in Jamaica seemed confirmed in the reactions of the local press. As recruiting efforts ramped up in November 1915, the Gleaner quoted an anonymous army medical officer to emphasize to its readers how “military training” was “training for citizenship.”¹¹¹ In a published excerpt from a sermon delivered at the Holy Trinity Cathedral in downtown Kingston, the Gleaner reported, “When some men join the army their hands are soft, their muscles flabby, and so they are put through hard drills, exercises, long marches, watching, fightings….” Returning BWIR servicemen would come back “a purer, nobler race,” via the “discipline of suffering.”¹¹² Martial discipline and the physical exertions of war, military officials and medical officers argued, would render the average Jamaican fit and productive. The rhetoric of the “discipline of suffering,” and their acute attention to the corporeal and mental effects of hard labor, echo the inspections and discourse of the pre-emancipation slave market. In 1915, military service would make them suitable laborers, and only willing workers could transform into potential citizens.

Yet mobilization and its ensuing medical exams exacerbated fears over the general unfitness of the West Indian population. Similar concerns abounded in the British Isles. In the metropole, the recruiting crises of the Boer Wars sparked serious

¹¹² Ibid, 4.
alarm over the physique, health, and masculinity of British working class. Anxieties about the inadequacies of the average British male grew to reflect intensifying concerns about national fitness. During the Great War, however, this crisis extended well beyond the island borders of the metropole and the settler dominion. Informed by local recruiters in the colony, the manpower hungry War Office reckoned with an imperial health crisis as well. The August 1917 Recruiting Committee Report claimed that in the first months of recruiting, West Indian applicants were chiefly waiters, grooms, mechanics and artisans. Agricultural laborers arrived later. The Committee noted that they had gotten all the men they required, or rather, that the metropolitan government would allow. Yet physical and mental testing weeded a significant number of recruits out from service. In August, 1917, the Barbados Recruiting Committee reported that of the 2,130 registered men (1,500 of whom were actually called in for medical examination), only 1,000 men passed as physically fit for army service – 47% of the men who registered for service, and 66% of those who had a medical examination. The Committee alleged that the majority of rejections were due to “insufficient chest measurement and expansion” and “cases of flat-foot.” What’s more, despite the intense drilling and training exercises, the Committee reported that a number of recruits who had passed the physical medical had to be let go during training, “from a lack of sufficient intelligence to acquire the drill.” In the same way that the Boer Wars exacerbated concerns over the physical and mental condition of the white working class, WWI recruitment dredged up longstanding

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anxieties over the economic development of the British West Indies – and the corresponding fitness of the Afro-Caribbean laborer.\footnote{114}

Though West Indian soldiers in the metropole were observed less frequently than their colonial Indian counterparts, they were the subject of much reporting throughout London and in assorted colonies. Many of these reports, particularly those in the white settler dominions, retained the same patriarchal, exoticizing tendencies of metropolitan press. Other accounts attempted to further infantilize the “strange” figures of West Indian men by painting them as jolly, immature sources of entertainment. One article accompanied by photos in the *Natal Witness* in 1916, headlined “Happy Darkies at the Front: No Bad Teeth in that Lot!,” went on to note how their faces “Bear a remarkable resemblance to the African type… They are splendid soldiers; and all speak English fluently. They have taken with them to Europe the manners and customs of the plantations, and their merry dispositions make them great favorites with the neighborhood while in camp.”\footnote{115} These media depictions sinisterly mingled admiration and approbation with grotesque and degrading stereotypes. The *Witness*, published in South Africa, included a photo of a game of cards, with the caption, “One ‘cute darkey… lucky enough to hold three aces.”\footnote{116} Not only did news of the BWIR troops cross quickly between colonies, but individuals in the Dominions actively drew connections between men of the colonies and men of the metropole. The *Witness* seems to have shared a


\footnote{116} Ibid.
common attitude. While praising their “civilized manners” and command of English, they harken back to obsolete references of plantation customs, reminding readers of the soldiers’ origins in the African slave trade, implicitly tempering admiration with patriarchal imperialism. The political agenda of the government focused on keeping colonial subjects subjects and limiting extensions of political rights and the franchise. These motives fed indirectly into popular anxieties about the infiltration of a colonial Other into the metropole. The press, in turn, endlessly reproduced these worries. The gifts and donations of West Indian colonies played into other stereotypes of Empire. In addition to 6,500 cases of fruit from Dominica, Jamaica, and Trinidad, the West India Committee donated 40 imperial gallons of Trinidadian coconut oil “for our Sikh’s hair.” These narratives of gifts and colonial sacrifice allowed for a polyglot recycling of sundry stereotypes about black and brown men and their status as combatants.

The metropolitan media also abetted these distortions of the West Indian soldier by often carelessly homogenizing men from distinct islands into a single group. One British sporting journal, *The Field*, featured BWIR troops in a July 1917 issue. The article included a photograph featuring line of volunteers, described as “Some stalwart Bahamians,” with a white officer, Captain Cole, in the center, “ Introduced for the sake of comparison, … himself over 6 feet high, and it will be seen that each of the men is taller than he is.” Setting the black subject body apart from the white citizen body, the purpose of these sketches lies uneasily on the border between curiosity and morbid fascination, always in danger of tumbling into the realms of the monstrous. Despite identifying the featured soldiers as Bahamians, the article goes on to refer to the men as

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117 “Some Stalwart Bahamians: Each of these men is over 6 feet in height,” *The Field*, July 7 1917, SOAS ICS West Indian Contingent Committee Records, File 96/2/3.
“Jamaica boy scouts.” This careless elision of one Caribbean identity with another is illustrative of the general disconnect between British understanding of the “West Indians” as a relatively homogenous group, and the soldier’s own complex identity as Jamaican, Bahamian, Barbadian – identities which themselves effaced earlier African ethnic categories.

At the same time, these references were accompanied by a strong dose of reminders about the soldier’s heritage. In an issue of the War Budget newsletter in October of 1915, a reporter headlined a piece on BWIR servicemen “From the Plantation to the Battlefield.” The correspondent outlined the virtues of the volunteers: “They are soldiers of sterling quality and they speak English fluently.” The article was accompanied by photos of soldiers, some featuring them fake-sparring or standing in rank and file, and one depiction of troops engaging in “rag time dancing.” These descriptors explicitly tie the BWIR volunteers back to a broader history of the black Atlantic slave trade – including the elision of contemporary African American culture and ragtime music with Caribbean dance music – but they also paint them as distinct from many other Commonwealth fighting forces. The need to establish that the troops were, indeed, fluent in English, speaks the ways in which media coverage disrupted possible assumptions about West Indian servicemen.

Nonetheless, the creation of a massed West Indian force invited opportunities to rethink the racial division of labor. Should non-white servicemen always be restricted to non-combatant duties? Were they fit enough to lead? And perhaps most crucial - in a

118 Ibid.
119 “From the Plantation to the Battlefield,” War Budget, Oct. 28 1915, SOAS ICS West Indian Contingent Committee Records, File 96/2/3.
120 Ibid.
force that combined men from eight colonies, dozens of islands, and varying racial and ethnic backgrounds, where did mixed-race individuals fit?

These questions came to the forefront when recruiters considered the numbers of mixed-race individuals applying to fight. In October 1917, Governor Probyn of Barbados asked the Colonial Office whether he could grant commissions to BWIR men who wished to serve as officers but were “not of pure European descent.” The Governor assured the Colonial Office that, if granted, he would exercise this power with “rigid discretion.” The War Office replied that they had no objection to granting “slightly coloured gentlemen” temporary commissions – provided the candidates were British subjects suitable “in every other respect… to undertake the leadership of men.” What qualified as “slightly coloured” went unsaid. Nonetheless, Colonial Office officials fretted over Probyn’s inquiry and the War Office’s decision. They decided to inform Probyn of the War Office’s wishes, but to express that, “unless he has very strong reasons for making such an appt.,” the Colonial Office would prefer that he hold off. Though they agreed that the allure of such commissions would increase enlistment, by late 1917, recruitment of further BWIR contingents was put on hold. Furthermore, the Colonial Office concurred, “the whole question is singularly difficult and embarrassing.” This “embarrassing” question of mixed-race appointments and commissions continued to challenge colonial administration throughout the remainder of the war. It reflected the conflict between the Colonial Office’s continued hesitancy regarding non-white mobilization, and the War Office’s eagerness for manpower regardless of potential racial

121 Governor of Barbados to Colonial Secretary, October 13, 1917, CO 28/292/37
122 Colonial Secretary to Governor of Barbados, October 20, 1917, CO 28/292/37.
mixing. More generally, it was a perpetual debate for a force made up of the multiracial compendium of the British West Indies that brought up uncomfortable questions about racial parity and status in a society that could not be reduced to black and white.

The same restructuring of colonial labor categories pervaded the War Office’s organization of armed forces in the East African campaigns. As in the Indian Army, the makeup of the King’s African Rifles, the major armed force in British East Africa, was predicated on colonial notions of the martial races. For military authorities, martial race in East Africa operated much like in the subcontinent. They pervasively identified rural, less “developed” groups with a history of resisting British rule as martial “tribes,” particularly the Nandi and Maasai of Kenya. From its formation in 1902, British officers selected these men for service in combat battalions, relying on “non-martial” groups for service as military specialists and laborers. These recruiting practices effectively encouraged British officials to create ethnic identities, bringing together disparate populations, modifying cultural practices, and inventing martial traditions for the enlisted. Tim Parsons has extensively illustrated how the Great War’s demands on manpower resulted in the multiplication of East African “martial race” groups, and the blurring of distinctions between combatant and non-combatant.125 As supposedly “non-martial” enlistees and conscripts in the Carrier Corps, men from the Kamba and Kavirondo groups were elevated as combat troops with the KAR, allowing the non-martial Kikuyu and Mijikenda to fill out spots in the Carrier Corps. The ideology of

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martial race expanded and became more flexible with the manpower crisis, loosening categories and increasing opportunities for mobility for aspiring *askaris*, albeit at the risk of mortal danger. The shakeup over raced labor roles continued in the aftermath of the war. Parsons identifies how these changes heightened conflict between the imperial government and European farmers, as the military drew increasingly from groups of men formerly hired for meager wages as farm laborers.

In analyzing British deployment of non-white colonial forces as laborers, Robin Kilson argued that the Army espoused an ethos of “scientific management” for colonial labor. Based on raced knowledge gathered over decades of colonial rule, this strategy sought to continue the segregation of servicemen from different colonies, races, and labor roles, combining and justifying it with an ethos of efficient management. Most available labor was work on transportation lines – railway and road building – which took serious physical effort. Permanent base (“P. B.”) men, wounded or sick soldiers who were not ill enough to invalid to Britain, and over-age civilian recruits would not be able to perform this work. Non-white colonial labor bore the brunt of heavy tasks, an assignment which the British Labour Directorate justified through their calculations of worker productivity and suitability.

The organization of non-combatant labor was an intricate web of restrictions and segregation. Army authorities created “zones” for non-combatant labor, defined by their proximity to the front line. Officers considered various factors and contractual stipulations when assigning different colonial labor forces to these zones, particularly those close to the front line. Ethnic conflict and British beliefs about various groups stamina and propensity for work also prescribed where different battalions could be
stationed. Kilson ascribes the decision to keep most colonial labor corps away from the front line to two separate motivations. First, to maintain the prestige of Europeans in the eyes of colonial subjects, second, in the case of the foreign battalions of Chinese and Egyptians, to encourage their governments’ continued “neutrality.” Members of the British Non-Combatant Corps and the Indian Labour Corps filled roles in the front lines, while the Chinese, Egyptians, and Prisoners of War worked further behind in the Lines of Communication. BWIR battalions moved between Line of Communication areas and the front lines. SANLC and Fijian workers, among others, worked mainly in ports and in transport.

Furthermore, labor assignments were constricted by a desire to hinder colonial servicemen’s contact with others colonial subjects, as well as with local women. General Gibb’s November 1917 Report to the War Office noted that men from the Northwest Frontier in India, as well as Burmese troops, should be kept away from other Indians. Likewise, he noted, Basutos could not be employed near Zulus, nor should Chinese recruits be placed near SANLC servicemen. He advised keeping units recruited from specific regions together, in part to cut down on conflict or interchange between subjects – and no colonial troops should be employed “where French women work,” when it could be avoided.

Beyond political considerations, organizers assigned tasks based on beliefs about physical fitness, skill, and worker mentality. The Labour Directorate (later known as Labour Control) issued specific instructions for different tasks, often ordering that British

127 Ibid., 4-6.
“B” men (on permanent base) perform less work than colonial laborers. One such
discrepancy is visible in instructions on the task of “Entrenching”:129

<table>
<thead>
<tr>
<th>Task</th>
<th>British “B” Men</th>
<th>Chinese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soft Sand</td>
<td>190</td>
<td>300</td>
</tr>
<tr>
<td>Loam</td>
<td>160</td>
<td>260</td>
</tr>
<tr>
<td>Chalk, Soft</td>
<td>120</td>
<td>180</td>
</tr>
<tr>
<td>Chalk, Medium</td>
<td>100</td>
<td>150</td>
</tr>
<tr>
<td>Chalk, Hard</td>
<td>80</td>
<td>120</td>
</tr>
</tbody>
</table>

Kilson ties these discrepancies to British beliefs about non-white labor. In accordance
with long-established patterns of colonial labor, “coolie” workers were frequently
dehumanized and set apart from white men, and expected to assume a greater share of
difficult back-breaking labor. But the Labor Directorate did not assign Chinese workers
far more cubic feet of earth to entrench per day solely based on the belief that they could
physically bear more. They also believed that native laborers were both lazy and
experienced fakers. In continuity with longstanding practices of colonial labor
management, officers thus had to assign them more tasks to ensure that they did not shirk
their work. This self-fulfilling logic, extended to South Asian lascars, indentured
servants, and assorted other colonial laborers throughout the nineteenth century,
simultaneously served to protect white masculinity. As Colonel Edward G. Wace,
promoted to run the Labor Directorate in 1916, observed, “Unless [the native laborer]
saw you knew his capacity and intended to get the work out of him he would not exert
himself to the full. For this reason tasks should always be set by the labour officer who
knows his men, their capacity, and the work for which they are best suited.”130

129 WO 95/83, Appendix X, Schedule of Tasks, Sheet 11.
130 WO 107/37, The Work of Labour, Chapter VI, 120.
Pune, India, and educated in England, Wace had over ten years of experience with the Indian Army before the War.  He called on his knowledge and familiarity with South Asian workers and soldiers in judging their characters and, during the war, their labor assignments. The war was a time to study these labor sources in concert with each other. The Directorate of Labour noted in November 1917 that there was “no noticeable difference in the efficiency, physical fitness, etc., of Coolies recruited at Wei-Hai-Wei and Tsingtas.”

Wace, with his interest in data and maximizing efficiency, sought to use precise calculations and formulas to best organize the enormous, disparate, and multiracial body of laborers. Yet as Kilson notes, military labor never reached the level of organizational sophistication he envisioned – their resources were too lacking, and time too short. Nonetheless, interest in identifying and training suitable workers, and maximizing productivity, ran throughout the war, from recruiters in Jamaica and the uplands of the Raj to officers in the Labour Directorate and the War Office. Their enthusiasm for remaking colonial labor was hindered by another factor, at once the most anticipated and the least prepared for - health and disease.

IV. Segregated Healthcare: Tall Fences & Porous Boundaries

Given the widespread debates over whether to mobilize various units of non-white colonial labor in the first place, segregation of their different regiments and battalions was de facto official policy. However, policy was not always practiced. Even when it was, wartime healthcare offered more avenues for exchange than forceful

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131 For a full account of Wace’s role in the Directorate during the war, see Kilson, 193-204.
132 War Diary, Directorate of Labour, November 31, 1917, WO 95/83.
segregation. Despite a hard line against various groups of colonial subjects and citizens mixing, British officials structuring medical systems for these troops found that the necessities of healthcare refused these boundaries. Time spent on the front lines and in hospital offered numerous opportunities for soldiers, civilians, and clinicians to interact. These exchanges often served to erode the geographic and ideological borders that separated colonizers and the colonized as well as different groups of non-white soldiers from one another.

The government bureaucracies structuring the deployment of colonial troops saw segregation as an answer to a number of problems of mass mobilization. It could help officials attend to the cultural and religious needs of specific groups, potentially promote morale and group solidarity, and allowed for close supervision and surveillance of the divisions in question. Furthermore, some official surmised that mixing groups – especially labor corps – would decrease productivity. Brigadier General E. Gibb, the Director of Labour at General Headquarters in France, emphasized in February 1917 that it was important to concentrate “Kaffir labour away from White as far as possible, for the benefit of discipline and efficiency.” These measures were supported and considered necessary by the government of South Africa, which organized the two battalions of non-white laborers from its Dominion, the Cape Coloured Labour (CCL, colloquially known as the “Cape Boys”) and the South African Native Labour Corps (S.A.N.L.C.) The chaos of war and changing demands of labor meant that various battalions of colonizer and colonized mixed more frequently than War Office officials would have liked. As always, segregation was easier to effect in words than in practice.

133 War Diary: Director of Labour, General Headquarters, February 13, 1917, WO 95/83.
While the War Office took advantage of the British force’s melting pot to compare their different subjects, wartime granted colonial subjects a similar opportunity. Cross-colonial interactions not only imparted to non-white colonial subjects a greater understanding of the makeup of the Empire, it also notably spurred some instances of cross-colonial solidarity and understanding. Etienne Dupuch, the future Bahamian legislator, recalled encountering a Sikh battalion on a transport ship from Egypt to France, declaring them the “handsomest people” he had ever set eyes on.  

Dupuch was surprised that British discrimination extended to South Asians. “It was then for the first time that I realized that the lowest, dirtiest, scrubbiest Englishman was considered superior to the finest Indian. I was painfully aware of prejudices that existed in the Bahamas, but this could not have happened to one of our men, despite the consciousness of discrimination one felt in the British Army against ‘native troops.’”

One night in France when Dupuch was working in the Quartermaster’s Stores, he chanced upon a stray Indian soldier, possibly a deserter, who wandered into his tent. Dupuch recalled that he fed and clothed him, and talked throughout the night, trading stories of life under British rule. Dupuch isolated this chance meeting as a turning point that awakened him to a broader, transcolonial anti-imperialism. He observed:

> It was then that I began to realize that Britain was out of touch with undercurrents that were festering underground in India. And so it was that on my return to Nassau I predicted that Britain would lose India. This was a ridiculous prediction for an inexperienced youth of 20 years to make, but I could not see how a fine race of people like the Sikhs would forever endure an inferior position in their own country…. It was then that I became interested in humanity’s movements… It was then that I began to dream of the time when I might be instrumental in helping to break down racial barriers in the Bahamas.

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135 Ibid, 54.
136 Ibid, 55.
Whether Dupuch’s revelations were stronger in his autobiographical reminiscences than at the time, the war granted these opportunities of exchange to many colonial subjects. Their fundamental experiences of fighting alongside troops of all races, from all reaches of the empire, tied them in a way that simple unit segregation could not deny. At the same time, Dupuch illustrates how pervasive martial race ideology and its ideals of masculinity were in late imperial Britain. His nighttime encounter depicts his supposedly “Sikh” visitor as strong and superior, part of a “fine race of people.”

Medical services on the front line were largely segregated. Indian General and Stationary Hospitals, transferred from India, were staffed by a mixed body of IMS officers and metropolitan-based RAMC MOs. But what was more difficult to effect on the front was easier in the army hospitals set farther behind the front lines and back in the United Kingdom. Still, in the first weeks and months of war, when Indian soldiers were deployed in the catastrophic battles of Neuve Chappelle and the First Battle of Ypres, the War Office lacked fully separate facilities for the many Indian wounded. As a stop-gap, the Royal Victoria Hospital at Netley was opened to Indians, Maoris, black South Africans, and Aboriginal Australians, the latter of whom were working in Labor Corps on the front. Convinced, however, of the inappropriateness of housing fighting Indian sepoys together with non-white laborers, officials developed an alternate network of healing sites for soldiers from the subcontinent. Closing Netley to Indians in February 1915, they commandeered public buildings and reassigned civic spaces to create a string of Indian-only hospitals and convalescent homes.

Thus, most soldiers requiring medical aid were shipped from the Western Front to sites on the southern coast of England, boarding hospital trains in Southampton to their
destination. Indian General Hospitals were set up across the south. The Lady Hardinge Hospital was founded with 500 beds in Brockenhurst as early as September of 1914, funded by the Indian Soldiers’ Fund, a private initiative by the Order of St. John of Jerusalem. Indian-only convalescent homes were set up at New Milton and Milford-on-Sea in Hampshire, with a larger convalescent depot at a group of former hotels in Barton-on-Sea. The biggest complex of hospitals for soldiers from the subcontinent was formed in Brighton, whose ocean access made it a prime location for transfers from France. There, the Royal Pavilion estate was converted to accommodate 724 beds, and the War Office adapted a number of other buildings in Brighton into hospitals exclusively for the Indian wounded. Secondary council schools at York Place were transformed into a hospital intended for difficult cases, and the Elm Grove workhouse grew to house the largest number of Indian troops on European soil. Renamed the Kitchener Hospital after the famed commander and newly appointed Secretary of State for War, Lord Horatio Herbert Kitchener, York Place and Elm Grove housed over two thousand servicemen. The hospitals were staffed by a mixture of R.A.M.C. officers and I.M.S. officials, both British and Indian.

The war represented a new mode of medical treatment for sepoys. For much of the late nineteenth century, Indian Army administrators prioritized the careful balance between providing Western biomedical care and accommodating sepoys’ “habits, peculiarities, and prejudices.” Believing sepoys to be averse to hospitals, they perpetuated a regimental system, where each regiment had its own medical officer and small hospital, as opposed to creating larger, more advanced, well-staffed and well-

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funded station hospitals. Numerous army committees reproduced the idea that by mixing
regiments, station hospitals would facilitate the violation of ethnic and caste taboos,
increasing troops’ rebelliousness and shrinking recruitment. Critically examining these
beliefs, Samiksha Sehrawat has made a strong case for the opposite. Numerous studies
and officers testified that sepoys expressed a desire for British-provided medical care, not
only for themselves, but for their families resident in military cantonments. Despite this
evidence, Sehrawat illustrates how a combination of economic anxieties (the short term
costs of converting to the station system, IMS officers’ fears of losing status and
employment) and supposedly caste-centered beliefs (the lasting relationship between
ethnicity and regimental organization) allowed the Indian Army to reject the station
system. Thus, though many long-serving sepoys indicated their acceptance of British
medicine despite its potential dangers, the gap in standards between care for British and
Indian soldiers in the Army grew from the 1870s to the 1910s.

Yet with Indian regiments’ mobilization to France came medicine that was both
mixed and segregating. Despite efforts to limit interaction between British regiments and
Indian regiments on the front, the first line of care after battle necessarily found sepoys
mixing with Tommies. Similarly, in the Indian General Hospitals that the Indian
wounded were moved to after treatment at field hospitals and dressing stations, men from
the 47th Sikhs were treated alongside those from the 40th Pathans and 2nd Gurkhas.

The hospitals saw sepoys of various ethnicities healed side by side, yet they were
constructed and organized around an ethos of extreme accommodation. Preserving

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138 Samiksha Sehrawat, “Prejudices clung to by the natives’: Ethnicity in the Indian army and hospitals for
sepoys, c. 19870s-1980s,” in The Social History of Health and Medicine on Colonial India, eds. Mark
Harrison and Biswamoy Pati (London: Routledge, 2007), 151-172.
custom and caste were the highest priority. Sweepers were housed in separate buildings on hospital grounds. All Indian hospitals and convalescent homes created a separate kitchen for Hindu and Muslim soldiers, often with a separate facility for Sikh cooking. Two different dining halls catered to patients well enough to leave their wards. At Brockenhurst, the cook houses were situated on opposite sides of the camp, with separate slaughterhouses. Hospital organizers thought proper burial especially important to retain soldier loyalty. At Brockenhurst and Brighton, a crematorium was constructed close to the hospitals for the Hindu dead. Deceased who practiced Islam were taken to the Muslim burial ground in Woking. These measures also attempted to maintain traditional army hierarchies of officer and sepoy. The Lady Hardinge Hospital retained a separate ward for native Indian officers to set them apart from lower ranking soldiers.

Even when spiritual customs were accommodated, they remained a source of frustration and suspicion for some medical officers. Facing an outbreak of influenza harrying men with particularly high fevers, the DDMS for Indian Troops in the European Expeditionary Force, Col. Westropp White, identified Muslim religious accouterments as vectors of disease. Noting that the afflicted members of the mounted brigades and infantry had attended the same prayers, he judged, “it seems feasible therefore that the disease has been contracted by inhalation from the prayer carpets.” He pulled evidence from his own orderly, “an Indian Mahommedan” who also attended the prayers at the El Aksa Mosque, observing that he too had contracted the disease.139 Nonetheless, Indian Army officers continued to emphasize the importance of allowing soldiers to practice

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139 War Diary, DDMS Indian Soldiers EEF, March 20, 1918, WO 95/4387.
religion in accordance with their own customs, particularly those who were in the process of healing.

Recreation was both common yet differentiated. Soldiers of different regiments and ethnicities played cards and football together, while maintaining their distinct religious traditions. At the Hardinge Hospital, one end of the recreation room was reserved for the Garanth Sahib, the sacred scripture for Sikh soldiers. A separate room was furnished with Korans for Muslim patients. The careful attention to soldiers’ caste and religious differences was accompanied by somewhat awkward attempts to imagine what furnishings might appeal to patients. Sir Charles Havelock observed that the “commodious recreation room” of the Lady Hardinge Hospital was “furnished in the Oriental style.” What constituted “Oriental style” was unclear, though subsequent reports made notice of the “bright colored cushions.”

As in the case of British soldiers, Indian Medical Service officials thought it imperative to strictly order healing sepoys’ activities during recovery. “As soon as he is fit for light work he should be drilled and have physical exercises, to get back to the martial spirit,” Lawrence mused. Once the recovering were moved to Convalescent Homes and Depots, they were encouraged to engage in even more physical activity. Combatant officers were attached to each Depot to lead specific drills aimed at priming convalescents for the front lines as soon as possible. Soldiers recovering at Netley and other hospitals in early 1915 were photographed playing football, playing cards, and

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141 “The Lady Hardinge Hospital for Indian Soldiers,” British Medical Journal 1, no. 2827 (March 6, 1915): 438.
listening to music – as well as performing calisthenics and daily exercises. Many of the recently-healed or still healing residents at the convalescent homes were insulted by this push. Ram Singh, recovering at the Kitchener Indian Hospital in October 1915, wrote to a friend in France, “The rule these doctors follow is to put on some duty here any man who is lame or has a useless hand, and then, after a month, write him down a malingerer and pack him off to France.” Singh felt that the practice of drilling the healing and putting them to work was part of a wider scheme to send as many men as possible back to the firing line. This initiative at times reinforced rumors that the wounded were indiscriminately sent back to the front before they had fully recovered.

Controlling sepoys beyond the walls of the hospital complexes was another matter. The India Office liaised with local government and established regulations to prevent “too free intercourse between Indian patients and attendants” at the Brighton hospitals and the civilian population. Furthermore, desire for contact with the “Other” went both ways. Much of the local populace, consuming news articles and press releases about the esteemed Indian Army, sought to view and meet the arriving wounded. At Brockenhurst, Sir Charles observed that the entire hospital was surrounded by barbed wire fencing, “not so much with a view to preventing inmates from getting out as to prevent outsiders from getting in.”

While Indian patients were already separated from the civilian population, the administration introduced a second level of segregation by housing all doctors and non-

142 Photographs of Indian Patients and some Indian Medical Staff, at the Royal Victoria Hospital, Netley and other Hospitals, c. 1915, MSS EUR F143/100.
143 Ram Singh to Jam Dhola Singh, October 21, 1915, IOR L/MIL/5/825/7.
144 India Office Minute, March 22, 1915, IOR L/MIL/7/18920.
Indian hospital staff outside the boundaries of the hospitals, putting them up in hotels in town. This brewed deep resentment in many of the site workers and soldiers being treated. Baghi Shah, a patient at the Kitchener Hospital, wrote to a friend from the 129th Baluchis who was being treated at the Milford-on-Sea Convalescent Home, “Here there is great tyranny on the part of the doctor… No one is allowed outside – to the bazaar or elsewhere, altogether the treatment is harsh. I hear that at your place everything is well… If I were in some other hospital I would have some hope of being passed by a committee for a return to India. But this is a very bad hospital.”\textsuperscript{146} Of course, not all soldiers shared these opinions; in the same month, Sursan Singh claimed that the Kitchener Hospital gave him “very good food and as much as one wants… One is very well looked after.”\textsuperscript{147} Many other soldiers praised their care and the skill of the resident doctors in letters home and to friends on the front.

However, officials tightened controls on Indians’ freedom of movement further in response to the more mobile Indian personnel repeatedly wandering into the city outside the hospitals’ gates. Writing to a friend in Peshawar, Tulsi Ram, an Assistant Storekeeper at the Kitchener, described how Indian laborers access to the town had been restricted due to men misbehaving. Anyone caught climbing the walls, he claimed, received a dozen lashes. Lamenting that he was only let out into Brighton once a month, he blamed his fellow mischievous compatriots. At the Kitchener Hospital, administrators added barbed wire palings to the walls as a precaution against further breakouts and created a Military Police Guard to monitor the soldiers.\textsuperscript{148}

\textsuperscript{147} Sursan Singh to Atra Chand, June 1915, IOR L/MIL/5/825/4.
\textsuperscript{148} These officers dealt with misdemeanors that included smoking in huts, gambling, and quarrelling, most often occurring among hospital staff, not patients. The only serious case of violence occurred when a sub-
Soldiers’ outings were strictly monitored but promoted in the hopes that they would both encourage their movement and recovery, all whilst extolling the history and monuments of the imperial motherland. Seton at the Kitchener Hospital arranged daily drives in motor ambulances, and occasional visits to the Brighton cinemas. The India Office organized closely supervised tours of London. Circumscribing patient and personnel mobility prompted hospital officials to create further avenues for recreation inside complex walls. The Kitchener Hospital added a rifle gallery and held frequent competitions, and established a sports ground for able personnel to participate in hockey, football and cricket. Despite these arrangements, Seton observed that “it must be admitted that the men were never reconciled to the limitation of their movements.” At the Kitchener, walls were “supplemented” by barbed wire palings, and Seton established a Military Police Guard as a further precaution against patient and worker break outs.

Sepoys and Indian workers alike were frustrated with restrictions on their mobility. Ghulam Haidar of the 40th Pathans complained to a friend in his regiment back at the front, “Here all the patients are treated like prisoners. In the evening they are allowed to go outside but ‘Sahib log’ accompany them. They are not allowed to go into the City.” Nonetheless, others relayed their happiness with the opportunities for travel and recreation afforded to them. The Subedar Major Gugan Sirdar Bahadur, convalescing at the Milford-on-Sea Depot, informed a fellow Subedar back in Uttar Pradesh of a prize he won in a race for the recovering officers. He also relayed tales of assistant surgeon, newly arrived in Brighton, attempted to shoot the Commander of the Kitchener, as a protest against the personnel’s confinement. Having failed to wound anyone, the perpetrator was court martialled and received 7 years rigorous imprisonment for his protest.

150 Ghulam Haidar to Hashmat Khan, June 8, 1915, IOR L/MIL/5/825/4.
his pleasurable experiences travelling in the region: “I have seen London and England. England is a very fine place. The English people are delightful and treat us well.”

While official policy sought to contain South Asian servicemen within their locales, largely to curtail possibilities of sexual relations or longer-term relationships between soldiers and nearby women, this was paired with official outings to see sights, intended to entertain, boost morale, and cultivate admiration and affection for their English hosts. Containment mixed with controlled forms of pleasure and leisure as part of a single therapeutic disciplinary regime.

Despite soldiers’ isolation, administrators emphasized to them and those in the surrounding community that the fundamental level of care which Indians received was equal in all ways to that of British soldiers. Captions accompanying photographs of the hospital affirmed that they received the best and most modern care possible. In his annual report on the Kitchener Hospital, Seton emphasized that “It must be remembered that the patients were dressed exactly like British sick, that they had the same bedding and hospital equipment, and that the whole internal administration of the Hospital was carried on exactly on the lines of a British station hospital.” Indeed, Seton contended that Indians received far better treatment and less discrimination on British soil than in their home colony.

Why did Seton feel the need to equate Indian care with that provided to the British? In her recent study of global democracy and its roots in the Indo-British colonial encounter, Leela Gandhi identifies two moral virtues that evolved during WWI and played an important role in the subsequent history of decolonization: generosity and

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While non-Westerners praised Westerners for their generosity in housing and healing them, Westerners praised non-Westerners for their sacrifice in service. Taken together, these virtues allowed both the colonized and the colonizer to appeal to a sense of “exacting reciprocity” between each other, pushing both toward a transnational, anticolonial community. Exploring the contradictions of this relationship, Gandhi characterizes it as one of “intimate enmity,” where both parties engaged somewhat reluctantly, and where this solidarity could be fractured and challenged. Nonetheless, for Seton, medical care was the primary grounds by which the British could thank Indian troops for their sacrifice.

Access to “the most modern care” did not necessitate indiscriminate or unbiased therapies, as we will see in Chapters 3 and 4. However, officials like Seton emphasized that they provided the most up to date and emerging medical treatments to British and Indian soldier alike. Central among these developments were radiology and electrical therapy. Sepoys described these technologies to their families and friends in letters. Recovering at Brighton, Hirnam Singh of the 9th Bhopal Infantry wrote to a friend in Hoshiapur, “There are fine glasses which enable one to count the bones in one’s body, even when dressed.”  

Others related new treatments whose methods could be confusing and indeterminate. One Lance Naik with the 40th Pathans, Sher Muhammad Khan, wrote to a fellow friend in his regiment, “I expect I shall see you soon, because the Doctor Sahib gives me great pain… The Doctor gave me electrical treatment.”

152 Gandhi is interested in how these co-dependent “virtues” produced an anticolonial ethical system which pre-dated and helped produce later conceptions of human rights, and her identification of the values of generosity and sacrifice personifies the atmosphere of healing in WWI and post-WWI British India. Leela Gandhi, The Common Cause: Postcolonial Ethics and the Practice of Democracy, 1900-1955 (Chicago: University of Chicago Press, 2014).
likely that Khan was treated at the Dowsing Electrical Institute at the Pavilion Hospital for rheumatism or sciatica, as he later related his continuing lack of flexibility: “My foot is very bad. It will not reach the ground and is very frightened of the ground.”

While basic lines of segregation enabled army officials to control sepoys’ movement and communication, they were not intended to cut the Indian wounded off from contact with the British entirely. Visits from esteemed persons, particularly those with a presence or reputation in India, were part and parcel of Seton’s emphasis on affording the best care possible. Queen Alexandra, Lord Kitchener, and Mr. Austen Chamberlain, then the Secretary of State for India, visited the Brighton Hospitals – events which, Walter Lawrence observed, had “useful political results.”

The attention paid to the Indian wounded – whether in the outfitting of their front-line stationary hospitals or convalescent homes in Britain, in the trips arranged for them and visits received, or the attention to customizing their care – prompted some accusations that they were better provided for than British soldiers.

Indeed, War and Colonial Office officials believed caretaking and healing to be a pacifying practice which would strengthen ties between Indians and the British. This extended to non-combatant volunteers and ward orderlies as well as fighting sepoys (but notably only to higher caste, educated, and typically young South Asians – those seen as the vanguard of the nationalist movement). Sir Walter Lawrence, a former colonial administrator made Commissioner for the Indian Sick and Wounded in France and England, praised the Indian students studying in Britain who came forward to form the

155 | Ibid.
157 | Mark Harrison expands on the development of front-line care and reactions toward Indian treatment in the early years of the war. Harrison, *The Medical War*, 58.
Indian Volunteer Ambulance Corps. Lawrence asserted that their nationalist, revolutionary tendencies – fostered by the atmosphere of political exchange in the metropole – were thrown off in the process of healing Indian soldiers for Britain’s war. The 198 participants, mostly students of law, medicine, engineering, and business, “Set to work in the finest spirit, and though many of them had been infected by the fever of youth and revolt they threw this off and rendered most useful and loyal service, as dressers, dispensers, clerks and superintendents of kitchens. They did work which in India they would have scorned. They were full of genuine love for England… and their conduct suggests the thought that with opportunities and generous ideals the revolutionary youth of India may be guided into safe and honourable paths.”

Thus, their time in service would do more than to eliminate their nationalist tendencies. By exposing the intellectual Indian students to low-level work, it would also potentially rework the systems of caste and class which the Raj’s administration found so difficult. Consciously or not, it also exposed groups of colonial subjects to each other. Martial race sepoys, predominantly Muslims or Sikhs, had been isolated on the Northwestern and eastern frontiers, and would have rarely, if ever, had contact with educated Indians from professional or upper-class families. This agenda was short-lived. Most student workers were discharged as laborers from India arrived in 1915.

Lawrence believed that caretaking by British personnel would help to patch up the wounds of racial tension and colonial violence between the colonizer and colonized. He professed that he could not speak too highly of the white British ward orderlies, who “took at once to the Indians, and the Indians responded to their kindness…

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Unconsciously [the British hospital orderly] has helped towards bridging the gulf of color.” This would, Lawrence hoped, help to quash the murmurings of Indian nationalism, as it built bridges of transcolonial racial understanding.

Lawrence’s hopes concerning British caretaking and camaraderie did not extend to British women. As early as October 1914, Lt. General Willcocks telegraphed the War Office to voice his strong objection to employing women in any capacity in Indian hospitals. The War Office modified their policy accordingly. Women could supervise wards in matters of cleanliness and sanitation, they concluded, but would not be employed in medical or nursing duties requiring close contact with Indian troops and non-combatants. Sir Havelock Charles, Serjeant Surgeon to the King and former IMS official, fought against the new regulations, reasoning that women nurses were employed in many civil hospitals in India. Furthermore, the women nurses at the Lady Hardinge Hospital were specially selected for their knowledge of various Indian vernaculars and their varying experience and knowledge of the Raj. Representatives from the Indian Soldiers’ Fund joined with Charles in requesting an exception for the Lady Hardinge institution.

Lawrence sided against allowing women nurses one-on-one contact with Indian patients, yet he did not altogether reject the opportunity for comparing wards with British nurses caring for Indian patients and those that did not. In the first months at the Netley Hospital, Lawrence reported to Lord Kitchener that “The English nurses all said that they liked the work and that the Indians were fine gentlemen. The Indians salaamed the

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159 Barrow to War Office, October 29, 1914, IOR L/MIL/7/17316.
160 Ibid.
161 Havelock Charles to India Office, undated telegram c. 1915, IOR L/MIL/7/17316.
162 J. P. Hewett to Medical Secretary, War Office, June 7, 1915, IOR L/MIL/7/17316.
nurses and told me that it was an honour to them to ‘be supervised by
Englishwomen.’” Conversely, “At Brockenhurst the medical officers asked for
English nurses, but I would not” – a policy he advised keeping at the Brighton hospitals.
Nonetheless, he confided to Kitchener that he thought it “well” to study patients in “the
two systems and to watch results.” It is unclear whether sepoys’ persistently positive
interactions with the supervising nurses impacted further decisions about their
mobilization. Nonetheless, by July 1915, the India Office insisted on removing all
female staff from institutions treating Indian patients.164

This segregation cut both ways. Australian wounded brought on hospital ships to
Southampton objected strongly to being treated by Indian members of the Indian Medical
Service. Major Dunn, IMS, and the Officers Commanding of the Indian Hospital ships
advocating removing all Indians on medical duty on the ships “to avoid the racial
question becoming acute.”165 Like Indian Army servicemen, native Indian orderlies, sub-
assistant surgeons, and surgeons trained with the IMS went West to help the war effort.
Most were attached to Indian units and hospitals. Some, however, were assigned to
hospital ships, which catered to different groups of wounded servicemen depending on
their route and allocation. Walter Lawrence objected to the Australians’ bias and tartly
observed that there “was no such feeling on the part of British soldiers.”166 However, he
agreed to consider removing Indian orderlies, “who regarded it as an honor to tend
British soldiers,” from ships carrying the Australian wounded.

163 Walter Lawrence to Lord Kitchener, November 28, 1914, MSS EUR F143/65.
164 Walter Lawrence to Lord Kitchener, July 21, 1915, MSS EUR F143/65.
165 Major Dunn to Walter Lawrence, Reports on the Working of Indian Hospitals, WO 32/5110.
166 Walter Lawrence to Lord Kitchener, October 2, 1915, WO 32/5110.
The Australian complaint highlights another dynamic in imperial military healthcare: that of the colonizer as the healer, and the colonized as the grateful healed. Despite Lawrence’s belief in the healthy relationship between Indian ward orderly and British soldier, Indian men, whether orderly or physician, rarely healed the white wounded. Instead, images circulating in the metropole and the colony almost universally depicted the white Briton as medical master and care-giver. This dynamic applied to fundraising initiatives and propaganda posters as well. In a poster for the “Our Day” Red Cross fundraising event in India in 1917, British officers tend to fallen sepoys, made distinct by their headware.167 Similarly, another “Our Day” poster depicted a wounded sepoy carried off the front lines by Indian stretcher-bearers, watched over – yet comfortingly separated – from the Madonna-like Red Cross nurse.168

Despite British efforts to emphasize the excellent care available for wounded Indians, not all Indian troops readily accepted British medical treatment. The mass influx of recruits meant that many new sepoys were unused to military healthcare. War diaries of Indian General Hospitals in Europe indicate that some refused treatment. On 18 September, 1915, doctors at the Kitchener Hospital asked the Deputy Adjutant General for his legal opinion on whether a patient could be operated on against his will in order to make him fit for duty.169 Indian soldiers’ resistance to the Western medical surgery indicates that not all docilely handed their bodies over to unfamiliar doctors.

Likewise, sepoys’ correspondence illustrates how many sought healing therapies as well as substances to render them temporarily sick from home. Soldiers requested

169 War Diary of Kitchener Indian Hospital, Brighton, September 18, 1915, WO 95/5465.
amulets and drugs to protect themselves and self-medicate. Nizam-ud-Din, serving with the 129th Baluchis, begged a friend to request a replacement amulet for his comrade Bagh Ali. “Send word to his home,” Nizam elaborated, “A few days ago he lost his ‘tawiz’ (amulet) and now he has begun to be possessed and subject to seizure at intervals.”

Others requested opium and cannabis. Letters requesting packages of drugs rarely passed beyond the military censors, and most soldiers had trouble obtaining them. In January 1916, Bir Singh dictated mailing instructions to his family to help substances bypass postal inspection: “You say that the parcel came back from Bombay… If you wrote ‘opium’ on it, do not do so again, but put ‘sweets’ or ‘dainties’ on it, and send off the opium.” Whether desired as customary habit or as a coping mechanism with the stresses of war, sepoys continued to seek therapies and remedies from home. These healing objects resembled the English, Irish, and Scottish soldiers’ accoutrements of war, from St. George and Christopher medals to dried flowers and hair cuttings – items described by Paul Fussell as British Tommies’ “talismans,” in which “every tunic pocket became a reliquary.”

Likewise, they also wrote home for remedies to release them from service. Abdul Aziz Khan, recovering at the Convalescent Homes at New Milton, wrote to a friend in Madras with a specific request and plan to return him home:

Please get an amulet for me from badruddin, which will have the effect of making me ill, so that I shall be sent back to India. The amulet should be made of such a nature as to cause slight fever and general debility, so that, when I appear before the Medical board, the doctors will find me suffering from fever and general debility, with all the outward signs of illness. Try and get for me an amulet of this sort, and when sending it to me, write and tell me the properties of the amulet.

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170 Nizam-ud-Din to friend, April 26, 1915, IOR L/MIL/5/825/3.
From the confines of the Convalescence Home, Khan attempted to draw on a popular subaltern therapy, an amulet, from across the globe, in an attempt to subvert Western biomedical examinations and return home. This information was likely passed on from soldier to soldier and laborer to laborer, in full understanding of the medico-bureaucratic processes they confronted. Khan thus prepared for his own strategy to deceive members of the Medical board using subaltern medical techniques. Another resident at the Milford-on-Sea depot, Ullah Khan, relayed to a friend in Peshawar that a friend had asked him to arrange for some rattis, for “they are not to be had in this country and he wants some.” Censors noted that ratti seeds, from the jequirity plant, while commonly used as a weight of measurement by jewelers, could also be juiced in the eye to produce inflammation. Here was yet another attempt to use local medico-botanical knowledge to undermine British military officials’ finely calibrated ethnographies of bodily strength and avoid military service.

Both Khans’ use of subaltern therapies was accompanied by what Ellen Samuels has termed the “disability con.” In her discussion of the popular anxieties around disability imposture, Samuels highlights the ways in which disability constitutes a fourth category of identity – alongside race, gender and class. The “disability con,” like other forms of passing, prompted such anxieties because it revealed these categories of identification to be fantasies, ever in tension with reliance on the “visual knowability of


175 Sher Ullah Khan to Ata Muhammad Swabi, November 24, 1915, IOR L/MIL/5/825/7.
bodily identity” and the possibility that this was a misrepresentation. What neither letter writer seems to have been aware of was the scope of the military warfare state’s surveillance, where oversight extended from formal interview by medical boards to everyday correspondence home. Censors attempted to bypass visual evidence and make Sepoys’ bodily condition legible and known. Yet their attempts, as in their bid to recategorize and rate laboring capacities by race, were periodically frustrated by the servicemen in question, who consciously and unconsciously foiled officials’ endeavor to know their minds and bodies.

When the first BWIR contingent arrived in Europe in 1916, they met a very different system from those receiving wounded Sepoys. Designated as a “native” unit, West Indians were assigned to “native hospitals” alongside non-white battalions from South Africa, Egypt, Fiji, and China. With less governmental support and aid, individual volunteers and philanthropists played a very prominent role in BWIR healthcare and provisioning. At the encouragement of the Colonial Secretary Andrew Balfour, ex-civil servants and political figures from the Caribbean founded the West India Contingent Committee in London. Its mission was advocating for the comparatively silenced soldiers. Along with separate Ladies’ Committees formed locally in Panama, Jamaica,

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177 The lines between substances intended to heal and those meant to sicken were sometimes blurred. In February 1916, military censors apprehended several packages of drugs sent to sepoys at the front. Though the interceptors did not identify the drugs, they withheld them on the grounds that they were “probably intended for [the] purpose” of malingering. Given the antipathy of censors toward substances that did not originate with British physicians, as well as towards sepoys’ use of opium or marijuana, they may have been restricting substances which families had sent to help ailing soldiers. As many sepoys gradually became aware that their correspondence was being monitored, however, we have no way to know how much mail – and medication – did manage to slip through censors into the hands of its intended. The blurred lines between malingering and self-medicating will be discussed further in Chapter 3. Censor Report, February 15, 1916, IOR L/MIL/5/826/2.
and nearly every West Indian colony, the groups raised funds to provide both basic services and creature comforts for the active and convalescent troops. England-based members visited the sick and wounded in hospital, organized the provision of tobacco and cigarettes, and arranged for the forwarding of the deceased’s personal effects to their families back home. They organized “Flag Days” to collect funds back in the colonies, and used the proceeds to provide musical instruments and games for soldiers convalescing, typewriters, stationary, and postage to allow the enlisted to write to their families, Christmas gifts, and cap badges to set BWIR members apart.178 Women members of the local Ladies’ Committees sent hand-knit gloves, mittens, and “woolen helmets,” and the Antiguan Ladies’ Committee collected money for hampers and parcels for men at the front and in hospital.179

Run largely by the white elites across the colonies, much of this philanthropy was an exclusive affair. There is no evidence of whom else Mrs. Popham Lobb, the wife of the St. Vincent and Grenadines colonial officer and president of the St. Lucia Flag Day Committee, or Mrs. Dyett, wife of the Montserrat Commissioner and President of the island’s Women’s War Committee, invited into organizational meetings. They likely did not extend to local workers and laborers across the British Caribbean, who nonetheless contributed to these organizations. Several groups of canal laborers in Panama and Costa Rican banana plantation workers authorized their Paymasters to send a small percentage of their salary each month to a collection organized by a Ladies’ Committee. Ironically, while their contributions were significant, they did not always go to aid West Indians in the war effort. Instead, they eventually funded the Lady Mallet Panama room and the

179 Ibid.
Costa Rica Memorial Reading Room at the Star and Garter Hospital in Richmond, London – a facility established and run for white soldiers only.  

BWIR servicemen happily accepted gifts and assistance. Lady Matilde Mallet, head of the Panamanian committee which distributed chocolate boxes to BWIR soldiers at Christmas of 1917, collected some of their missives. Many expressed gratitude and a sense that the gifts validated their important service. Silburns C. Coy, of the 11th BWIR Battalion in Italy, thanked her in solidarity. They would “continue such a fight until victory by the Layindown [sp.] of our common foe.” “Madam,” he assured her, “your labour was equal to our [sp.].”

Other integral parts of military medicine for colonial servicemen showed divisions in standards for “native” patients and white ones. When the War Office decided to shift some hospital ships from serving Indian servicemen to British troops in late 1915, they developed a list of “proposed alterations” to fit the ships “for use of Europeans.” The catalogue of necessary improvements illustrates just how substandard “native” transport ships could be. In addition to standard transitions like refitting squat toilets with seated wash closets, the Indian ships had no hot water and required new taps, wash basins, and galley fittings.

These divisions persisted throughout the war, even as standards of military medicine rose in nearly all theaters. Yet units stationed away from large forces or at occupied outposts sometimes found themselves prone to lax care at the hands of negligent individuals. In some cases, visiting medical officers reprimanded the officers

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180 On the Star and Garter Hospital, see Deborah Cohen, *The War Come Home*, 133-140.
181 *Letters from the Trenches During the Great War*, ed. Matilde Mallet (Shipston-on-Stour: King’s Stone Press, c. 1919).
182 Silburns C. Coy to Lady Mallet, December 25, 1918, *Letters from the Trenches During the Great War*. 
in charge and attempted to restructure medical arrangements. In late 1918, one such MO, Capt. W. R. Mathewson RAMC, submitted a series of reports lambasting the condition of the native Indian laborers working in the town of Iman Hamza on the Euphrates. Mathewson blamed the “quite inadequate” conditions on the physician assigned to the Labour Corps – “who had been the doctor to a tea-garden, in Assam or thereabouts, and who took things very easily and did not quarrel.” European brutality on these plantations, notorious in India, prompted powerful protest movements throughout the 1900s. Mathewson’s complaints appeared to link this legacy of mistreatment to the meager care which non-white laborers encountered during the war. He prepared critical reports, which he submitted to his superiors. Much review of colonial servicemen’s conditions arose from conflicts like these, where medical supervisors clashed with doctors imbued with indifference to human life (conditioned through the ‘normal’ conditions of the late nineteenth century tea plantation). The physicians and officials in charge of laborers’ welfare were both agents of cruelty, neglect, racism, and bias, as well as vociferous critics of deeper structures of through, feeling, and behavior toward South Asians. Despite the segregated infrastructure of care designed for West Indian servicemen, the chaos of war produced moments of cross-cultural healing. On the

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183 Harrison, *The Medical War*, 278-79.
184 W. R. Mathewson, “Iman Hamza,” 1, Liddle Collection, University of Leeds, Liddle/WWI/MES/066.
186 On the history of plantation health care in colonial India, see Bhattacharya, *Contagion and Enclaves*, “Chapter 6: The Plantation Enclave, the Colonial State and Labour Health Care.”
evening of the 8th of September, 1918, only two months before the signing of the
Armistice, a minor battle broke out on British soil: a dispute between patients at the
Belmont Road Auxiliary Hospital in Liverpool, many of whom were single or double
amputees, escalated into a full-scale brawl.\textsuperscript{187} With hospitals overrun with patients in the
last months of the war, Belmont had shifted to treat black and white troops in the same
facility. In the fight’s confusing aftermath, reports identified the factions as a group of
West Indian soldiers against a variety of white troops. About the cause of the conflict,
there was no agreement. Black interest newspapers, activists, and the West Indian
Contingent Committee, set up in London to help advocate for troops of the British West
Indies Regiment (BWIR), blamed racial taunts from white South African soldiers and
misunderstandings about room access and equal treatment between the troops. The
Times and other Liverpool-area local publications attacked the West Indians and
emphasized their supposed aggression and uncontrollable violent tendencies. In contrast
with the paragraph-long report of the Times, the African Telegraph, an anti-colonial
platform for the black community in England, devoted a two-page spread to the issue,
complete with photographs of soldiers involved in the fracas, including their white
supporters.\textsuperscript{188} Unlike the Times, which pitted black soldier against wounded white
soldier, the African Telegraph described the attack on BWIR troops as unprovoked, while
also emphasizing their reduced agency due to their physical condition. The reporter
approvingly noted that many white soldiers who had fought alongside the BWIR troops
stood over them to protect them from their attackers. In the published images, the
wounded soldiers sit cross-legged, the stumps of their amputated feet and lower legs

\textsuperscript{187} “Disturbance by Black Troops, Army Nurses Death,” The Times, September 26, 1918, 3.
\textsuperscript{188} “The Belmont Hospital Affair,” The African Telegraph, December 1918, 85.
bandaged and openly displayed for consumption by the Telegraph’s readership. This image of cross-racial solidarity in the face of disability and discrimination is particularly powerful, and differs sharply from the patronizing, whole-bodied images of West Indian soldiers in British and other colonial newspapers. The African Telegraph recognized the potency of highlighting the interracial alignment of the disabled soldiers, who in fighting and healing together, had bonded to the point of defending each other while wounded. For Afro-Caribbean servicemen, then, wartime military rehabilitative institutions could be both plantation and hospital. Their treatment was rife with racialized standards, hierarchy, and exploitation, but it also offered opportunities for interracial connection and care.

**Responsibility and Reform: Changing Landscapes of Colonial Military Medicine**

Scandals eroded the reputation of British army hospitals throughout the war and prompted outrage and calls for reform both from the colonies and the metropole. The most consequential of these occurred on the Middle Eastern fronts where a high percentage of Indian troops had been removed and relocated from the Western Front towards the end of 1915. The Dardanelles Commission, charged with examining the Gallipoli campaign, identified shortcomings related to medicine and sanitation, from the failure of GHQ to heed medical advice and liaise with MOs, to a lack of inter-officer communication resulting in insufficient sanitary apparatuses, transport, and latrines. It claimed that this ill-planning centrally contributed to the campaign’s failures.\(^{189}\) The accompanying Mesopotamia Commission, directed to investigate the eponymous

\(^{189}\) Harrison, *The Medical War*, 173, 176-78.
campaign, was more damning. Even before the disastrous siege of Kut, the campaign was marked by severe lack of foresight in transportation for medical supplies and the wounded, under-provisioning, and understaffing. Officials in charge were notably lax in enforcing sanitary regulation, leading to outbreaks of malaria and dysentery in the resident British and Indian forces. These problems were exacerbated by the self-protectionist attitudes of commanding officers like General Nixon, who was charged with misleading the Secretary of State, parliament, and the public about the “true situation” in Mesopotamia.  

The conclusions drawn from the Mesopotamia Commission directly impacted not only military medicine in general, but Indian hospitals at home. This was largely because of the outsize role of Indian administration in structuring treatment for the war wounded. The Indian Government, through the Indian Medical Service, had a large hand in organizing staffing and provisioning (and the lack of). The Colaba Station Hospital in Bombay was the only military hospital designated to receive the sick and wounded British from the Mesopotamian campaign. As the hospital flooded with patients in the summer of 1915, its lack of equipment, staff, and poor infrastructure grew critical. Rather than reprimanding the ill-preparedness and tactics of superior officers like General Nixon, the Commission’s report laid most blame at the feet of the Government of India. It charged them with failing to adapt and fund their medical resources in the early years of the war.

191 Harrison, 208.
Healthcare provisioning for British imperial troops was marked by varying forms of inequality and difference, sometimes grounded in well-intentioned efforts to mold care to British perceptions of the distinct medico-cultural needs of diverse populations. It also provided impetus for progressive improvement in medical services in general. The medical failures of campaigns in Salonika and East Africa, in particular, spurred change. These fronts, and to some extent Mesopotamia and Palestine, had increased difficulties with epidemiology and sanitation. The commissions set up to investigate these poor standards and systems established the central role of public oversight and official scrutiny in the effort to improve conditions.\(^{192}\)

Other medical ‘experts’ and authorities pointed to wartime failures to push the restructuring and reform of Indian medical systems. In 1917, the home Government formed a Committee to conduct an inquiry into the state of military hospitals in India. The *British Medical Journal* asserted that the metropolitan public felt strongly about British responsibility for Indian medical care. They alleged, “Public opinion in [Britain] is outraged by the inference that Indian soldiers are to suffer death by disease and wounds in order to provide the Finance Minister with a larger surplus.” Yet the *BMJ* was quick to note that the burden was not solely that of the metropole: “But whatever the extent of the responsibility of the home Government, the main responsibility rests upon the Government of India; its duty is clear, and we may well hope that the objections of the finance department will at last be overridden by the Viceroy and the Secretary of State.”\(^{193}\)

\(^{192}\) Harrison, 300-302.

These reports, combined with internal and external scrutiny, prompted the Government of India to overhaul Indian military medicine. Indian Army administrators introduced the station hospital system which they had repeatedly rejected before the war. This allowed medical officers both to economize and provide more specialist care to the wounded. Colonial administrators in India paired reforms in military medicine with reforms in the structure and expenditure of the Army. In 1917, the imperial government established that Indians could receive King’s commissions which came with valuable education, salary, and prestige. This effort, a concession to the burgeoning numbers of Indian soldiers serving abroad, was expanded in the 1920s with the Indianization of the Army and Medical Service. At the end of the war, the Montagu-Chelmsford Report enshrined the process of Indianization in the Government of India Act of 1919, supposedly setting the Raj on a reform-filled path to Dominion Status.\textsuperscript{194}

Not all changes in wartime labor policy carried through into the interwar period. The 1920 Report of the Esher Committee, established to review the Indian Army in the war’s aftermath, carried forward some wartime development and new imperatives while rolling back others.\textsuperscript{195} It attempted to marginally improve the status of menial laborers by abolishing the terms “follower” and “sweeper,” and advocating that they be taught basic defense. Yet the processes of demobilization and its accompanying budget slashing meant that low-caste individuals and some ethnic groups admitted as combatants during the war were once again restricted to non-combatant roles.\textsuperscript{196} Indian Army combatants


\textsuperscript{195} For a thorough review of the Esher Committee’s studies and conclusions, see Deshpande, “Military Reform in the Aftermath of the Great War,” 45-97.

\textsuperscript{196} Singha, “Front Lines and Status Lines,” 102-103.
did not receive augmented political rights or self-sovereignty, but colonial administrators accelerated the process of Indianization. In the interwar years, they replaced white civil servants and officers with native men in more senior positions. This effort extended both to the Indian Army and the Indian Medical Service, though it did not reduce disparities in pay, rights, and respect between white and native officers.\textsuperscript{197} Indian Army administrators lowered recruitment quotas for combatants outside the Northwest Frontier and the Punjab, and once again set their focus on the most vaunted martial races of the late nineteenth century – Sikhs and Gurkhas.

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Colonial and War Office officials drew deeply on long-standing ideologies about race and race-specific work as they organized deployment, labor, and healthcare for colonial servicemen. Yet putting ideology into practice highlighted how ‘race’ was not necessarily synonymous with ‘difference.’ Varying conceptions of the ethnic, geographic, class, and gender divisions also shaped how the Indian Army and BWIR were mobilized. Healthcare provisioning for these laborers was marked by varying forms of inequality as well as difference. Policies that structured this segregated system were grounded both in fears of miscegenation and anti-colonial sentiment, as well as in well-intentioned efforts to mold care to British perceptions of the distinct medico-cultural needs of diverse populations.

At the same time, war forced permanent changes to practices and systems of labor in the British Raj and the West Indian colonies. Martial race ideologies expanded and

\textsuperscript{197} Waltraud Ernst, “The Indianization of Colonial Medicine: The Case of Psychiatry in Early-Twentieth Century British India,” \textit{NTM Zeitschrift für Geschichte der Wissenschaften, Technik und Medizin} 20, no. 2 (June 2012), 61-89.
contracted to fit need. Government of India administrators and British officials in the Caribbean hoped that new combatants and menial laborers alike would take the skills and discipline learned during the war and transform themselves into more productive colonial subjects. As this vast assembly of diverse colonial subjects trained, served, and fought under British commanders and discipline – they participated in the remaking of themselves and broadened their understanding of their place in the British imperial world. The cross-cultural exchanges performed through labor and care accentuated both structural inequalities and groundbreaking empathy across the Empire.
Chapter 2: Stomachs
Food, Nutrition, and Multiracial Rationing

On Monday, 30th November, 1914, King George V and the Prince of Wales embarked on a five-day tour of the front in France. The Times of India detailed the pair’s visit to station hospitals for the Indian sick and wounded, the divisional headquarters of the Indian Army, and various commanding points where the battlefield could be best observed. After a parade inspection of British and Indian troops the next day, they made one more stop: “A halt was called at a Field Ambulance, where the preparation of the native food was watched with interest, his Majesty tasting a chapatti which had just been cooked.”198 The King’s taste of this “native food” marked a moment of intercultural solidarity and imperial gratitude. It was also an opportunity to illustrate the warfare state’s commitment to proper provisioning of Indian servicemen. This encounter between George V and his chapatti illustrates the wider constellation of meaning surrounding food provisioning during the war. The apparently mundane tasks of eating, offering, and structuring nourishment for a multicultural military force were rife with opportunities for camaraderie and contestation, and as well as cultural and scientific knowledge building.

Soldiers’ stomachs have always mattered, especially in times of war. Experts, from War Office officials to RAMC medics and nutrition scientists knew this only too well. They engaged in fraught debate over the provision of food to non-white colonial servicemen. This chapter analyzes how colonial experts and colonial servicemen made food the centerpiece of an ongoing negotiation over health, culture, and fitness. Far from

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198 “King at the Front,” The Times of India, January 4, 1915, 9.
a simplified narrative of control and resistance, preference and access to food was determined by a highly complex matrix of status, race, and religion. Imbued with colonial beliefs about Indian Army religious taboos, army administrators prioritized Indian sepoys’ access to suitable food as bona fide “needs.” They often overlooked groups whose food preferences they deemed cultural rather than “spiritual.” Furthermore, as the War Office attempted to designate rations by race and unit, they constantly debated and redefined what was “culturally appropriate” food – based on their changing perception of spiritual taboos, religious preferences, and social traditions.

British officials were also in conflict with each other. Nutritional scientists and dieticians fought for professional recognition and increased influence over food policy; colonial officials sought to influence or accommodate the rationing of their subjects; medical officers attached to colonial units sometimes altered rations of their own accord against official policy to provide what they believed necessary for the health or wellbeing of their servicemen. Colonial servicemen frustrated some of their efforts and made their own case for input on their diets, whether through vocal debate or physical refusal of food. Culturally-sensitive, traditional diets were frequently nutritionally deficient, particularly as the strictures of war decreased the quality and availability of certain foodstuffs., and calorific science did not reign supreme. Reviewing studies of deficiency diseases, a number of army officials held strong against the advice of nutritionists to diversify soldier diets. They argued instead that soldier obedience and morale (through retaining culturally appropriate diets) was more important than soldier health (improved by diversifying diets).
This chapter tracks the mixing of notions of culturally appropriate, racially specific and scientifically necessary diets. It analyzes how official policy determined food provisions for colonial troops, and the debates – among colonial servicemen, army officers, and medical professionals – that these policies engendered. How did Great Britain go about feeding its vast, multiethnic force? How did officials structure and order the distribution and nutritional content of food alongside considerations of science, health, race, culture, and religion? And how did particular conceptions of what the British Empire stood for – its polities and colonial subjects – get encoded in the formation of a food ration system?

Improper or insufficient rationing had devastating medical consequences for British and colonial soldiers alike. Food consumption was a site of fervent negotiation and compromise, given the intensely personal, physical, and cultural implications of eating. British officials’ attempts to differentiate diets and adhere to cultural and religious prescriptions all too often failed. The contingencies and connections forged by war resulted in both necessary and happenstance mixing of different diets, as the servicemen mingled far away from their respective homes and hearths.

**Food as Feeling, Food as Reason: Incentives to Eat and Enlist**

Army recruitment was intimately bound up with promises of food. Recruiters urged – and the enlisted appeared to believe – that joining up promised them adequate provisioning as well as a decent salary. In the metropole, where the Boer War-spurred crisis of fitness shed light on working-class malnutrition, the offer of free and regular
food incentivized volunteers. Recruiting posters and songs put diet front and center in their plea for enlistment. “Come on and join Lord Kitchener’s army, Ten bob a week, plenty grub to eat, Bloody great boots make blisters on your feet,” sounded the popular jingle throughout England. The boons of uniform, pay, and at the onset of war, a promised 4,200 calories a day supplemented patriotism as inducements to enlist.

Similar overtures were made throughout the Empire. From colony to colony, recruiters made edibles part of a complex case for enlistment: enlistees would receive enough to eat, and their dietary customs would be respected – but, furthermore, an army diet would grant them more sustenance and a healthier body and life than most enjoyed as civilians. One handbill issued in Antigua listed height and age requirements for troops, pay rates, and the assurance that “Free quarters, good food, free clothing and medical attendance are given, and men are well looked after.” Posters in the Raj also emphasized enhanced health and wellbeing through the joining the army. One such call pictured “Scenes in the early life of a recruit,” noting “These Young Men Enjoy Good Food, Good Pay, Good Treatment, and a Healthy Life. Follow Their Example.” Other materials sought to visually enforce the transformation of soldiers’ bodies: one recruitment poster set the thin, slight figure of the agricultural laborer – his “Condition upon being recruited,” against the visibly bulkier and groomed body of the sepoy, only

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201 Hand Bill issued in Antigua calling for Volunteers for Contingent of the British W.I. Regiment, National Army Museum (NAM) C FO NWS 5469, Ex. 352.

“Ten days after recruitment.” The new recruit highlights his speedy growth by holding a measuring stick that emphasizes the divide between soldier and non-soldier. Food supply and health acted as potent rationales for enlistment across the colonies, and they were felt particularly keenly in the British Raj. Well-documented famines of the late 19th century devastated Southern India and the Central Provinces, as well as the soldier bastions of the Punjab and the North Western Provinces. These regions constituted areas of moderate to high sepoy recruitment, where returning soldiers often returned to agriculture.

British officials in the Raj were preoccupied with food policy long before 1914. David Arnold argues for a deep genealogy of British interest in the Indian dietary from the 1870s. Food policy in the Raj was shaped by issues of caste and class, as well as by British experience with regulating – or failing to regulate – food distribution during the famines of the 1870s, and their attempts to regulate diets in provincial prisons. In moments of crisis or places of punishment, colonial officials debated whether and how to respect social differences and caste taboos. Studies into the chemical content of foodstuffs in the late nineteenth century also produced a new, seemingly scientific, rhetoric of Western superiority: various authorities on diet argued that the more nutritious wheat-eaters of the West were clearly more robust than the starchy, nutritionally lacking Oriental rice-eaters.

203 Untitled Recruitment Poster (Hindi Text), Imperial War Museum, Art.IWM PST 12583.
204 Arnold’s claims contrast with earlier colonial medical histories, which identified the 1920s as the moment when imperial officials became interested in malnutrition in the colonies. David Arnold, “The ‘Discovery’ of Malnutrition and Diet in Colonial India,” The Indian Economic and Social History Review 31, no. 1 (1994), 11-12.
205 Ibid, 11-12.
These rationalizations of racial superiority constituted just one part of a long history of hypersensitivity to and manipulation of the relationship between Indian Army soldiers and their food. Notions of Northern wheat eaters as martial races stretched back into the early nineteenth century, even when the pre-mutiny army was populated by non-“martial race” sepoys of the Bengal and Madras Armies. In the mixed army, manned by Hindus, Sikhs, and Muslims, among others, food took on central importance in pacifying and controlling soldiers. This impetus was based both on practical truth and historical myth - particularly in light of the 1857 Mutiny. Interpreting the causes of the uprising, British officials glossed over a panoply of soldiers’ complaints. Instead, they emphasized the role of gun cartridges purportedly greased with animal fats and argued that the alleged betrayal of Hindu and Muslim customs was at the core of the mutiny. This explanation came to dominate British debates over political instability in the Raj, and spurred new recruitment patterns and preferences. Kate Imy has observed how officials espoused changing beliefs about the nature and centrality of religious customs in sepoys' lives in order to justify their increased recruitment of Sikhs, Punjabis, Muslims from the Northwest Frontier, and (nonetheless Hindu) Gurkhas. At the same time they drastically reduced the number of Bengalis and high-caste Brahman soldiers.

The findings of nutritional science seemed to affirm British beliefs in the physical superiority and masculinity of peoples of Northern India, who ate more wheat-based foodstuffs than Bengalis and southern Indians. D. McCay, Professor of Physiology at the Medical College in Calcutta, cemented these distinctions in his studies on jail

206 Kate Imy, “Spiritual Soldiers and the Politics of Difference in the British India Army” (PhD diss., Rutgers University, 2016), 31-32.
dietaries in 1912. McCay’s work, Arnold has observed, effectively provided a
“scientific, nutrition-based rationale for the martial races theory.” Instead of arguing for
a biological or climactic rationale for martial inclinations, McCay claimed that diet, not
race, separated Punjabis and Gurkhas from Bengalis and Madrasis. This rendered martial
race ideology surprisingly flexible: McCay promoted the idea that altering diets would
physically transform non-martial peoples, to the benefit of the state and the economy.208
This radical notion was not widely spread within the Indian Army or IMS at the start of
the war. Yet as nutritional science gained credibility and insinuated itself in army
medicine, it simultaneously affirmed long-standing recruiting traditions and army
structuring, and encouraged the enlistment of even more wheat-eating soldiers from non-
traditional martial race groups. The complicated relationship between sepoys and food
continued to dominate discussions of rationing South Asian servicemen over the course
of the Great War.

Food was more than a recruiting device and political obligation. It was also a
potent device of memory, comfort, and moral and physical sustenance during the war.
The well-developed literature on British troops argues that edibles offered both an
opportunity for comradeship and an emotional tie to home. Meal and parcel sharing both
cemented bonds between rankers and offered an opportunity to preserve relationships
with their families.209

208 Ibid, 15.
209 Food and its role in everyday soldier life has been widely studied, most notably in Rachel Duffett, The
Stomach for Fighting: Food and the Soldiers of the Great War (Manchester: Manchester University Press,
2012); and Michael Roper, The Secret Battle: Emotional Survival in the Great War (Manchester:
Manchester University Press, 2009), 125-133.
Yet food could be contentious and divisive. British soldiers often lamented the monotony of standard rations. Some protested against food that was excessively unfamiliar or unappetizing. (insert further examples for both sections)\textsuperscript{210} The poor dental health of working-class recruits made chewing hardtack biscuits uncomfortable and painful.\textsuperscript{211} British rankers sometimes refused unfamiliar foods, such as tinned rather than their preferred smoked herrings. At other times, they rejected substitutes for their meat ration, from sardines to rabbit, widely regarded as a poor man’s food.\textsuperscript{212}

The War Office believed traditional food from home brought the best benefits in morale to white Tommies, as well as colonial troops from across the Empire. BWIR advocates attempted to supplement West Indians’ diets accordingly. While line cooks shuttled makeshift sausages and chocolate to British privates on the front lines, the philanthropic West Indian Contingent Committee (see Chapter 1) similarly sought to channel familiar products to men of the B.W.I.R.. from guava jelly, ginger, and hot sauces to salmagundi and briar pipes.\textsuperscript{213} Individual colonial governments joined in the effort: the Leeward Islands contributed 1,248 lbs of guava jelly for forces in hospitals and the field.\textsuperscript{214} West Indian servicemen, like their British counterparts, eagerly accepted gifts from family and the WICC. Lady Matilda Mallet, wife of the British resident Minister Sir Claude Mallet, organized a philanthropic Ladies’ Committee in Panama to distribute chocolate boxes to BWIR soldiers during the 1917 Christmas. Several soldiers wrote to her in thanks. One, Corporal Charles N. Booth, healing at the Windsor Street Auxiliary

\textsuperscript{210} Duffett, \textit{The Stomach for Fighting}, 11, 73-75.
\textsuperscript{211} Ibid, 153.
\textsuperscript{212} Ibid, 80, 92, 151.
\textsuperscript{213} Roper, \textit{The Secret Battle}, 132-133.
\textsuperscript{214} G. A. Natesan, \textit{All About the War: The Indian Review War Book} (Madras: G. A. Natesan and Co., c. 1915), 336.
Hospital in Liverpool, observed how the token reawakened memories of his time working in Panama: “I have received a tin of chocolate which was sent from Panama colon. I was a liver there for twelve years and after war brake out I ‘Valintery’ joine up I am now helpless. And that Nice Beautiful Country I will never see again which I love so dearly [sic].”\(^\text{215}\) Familiar images and foods had the power to bring a literal taste of home to troops in the unfamiliar setting of the front.

Rations were also the subject of many soldiers’ letters and writings. Before he became an educator and well-known poet in Jamaica, Henry Benjamin Montieth honed his poetic practice at war. Promoted as a Warrant Officer Class 2, Montieth often sent his poems back to his home colony where they were published in local papers, particularly the Kingston periodical the *Jamaica Times*. Though most of these works concerned the role of the B.W.I.R., he also memorialized the standard rations of the British Army in a 1919 poem “Bully Beef and Cigarettes”:

\[
\begin{align*}
\text{This is not an empty story.} \\
\text{Not a bit of fame or glory} \\
\text{By someone too ambitious} \\
\text{Makes even truth appear fictitious} \\
\text{What I here narrate is true-} \\
\text{Sights presented to my view} \\
\text{When Taranto’s days were ended,} \\
\text{And our way to Havre we wended….} \\
\text{Now before the train had started,} \\
\text{Every one was gay, light-hearted;} \\
\text{Each possessed the soldiers’ pets,} \\
\text{Bully-beef and Cigarettes! ….} \\
\text{So with glad anticipation} \\
\text{Gleded we from out the station} \\
\text{On the first day all went merry} \\
\text{But we left good luck at Bati} \\
\text{For at Foggia, troubles waited}
\end{align*}
\]

\(^{215}\) Charles N. Booth to Lady Matilde Mallet, December 27, 1918, in *Letters from the Trenches During the Great War*, ed. Matilde Mallet (Shipston-on-Stour: King’s Stone Press, c. 1919).
And in truth it must be stated
I was taken by surprise
There I saw before my eyes
What I never had seen before
Women, boys and girls galore
All with eggs and wine-plus-water,
(Curious mixture) which they barter
For the soldiers dearest pets
Bully-Beef and Cigarettes! …

By far the most straightforward and unromantic of his war poems, its simple, doggerel-like rhymes mirrored the repetitiveness of the unsavory edible. The poem was his sole narration of his voyage from Taranto to Britain, when regiments of the B.W.I.R. were transported via train after their hard labor at the Italian port. Their work at Taranto embodied West Indian servicemen’s central wartime complaint – that despite their enlistment and training as combat troops, they were routinely kept from battle and used for unpleasant tasks behind the lines. These tensions boiled over into a December 1918 mutiny in the port city by several factions of the BWIR (see Chapter 6). It is unclear whether Montieth was present in Taranto during the Mutiny, but his poem affirms that the West Indian servicemen found “not a bit of fame or glory” in their work digging latrines as other white soldiers celebrated the end of hostilities. Nonetheless happy to finally be on their way home, the “gay, light-hearted” servicemen began their journey.

Montieth chose to narrate this voyage – the first time most of the B.W.I.R. men travelled through Europe, and their first en mass encounter with everyday Europeans – through the interactions around the notoriously unpleasant and monotonous ration of Bully Beef. Montieth’s poem may have been partly inspired by the many popular verses that circulated through the British Army. On his train through Italy, he may have heard a

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216 Henry Benjamin Montieth, First Manuscript of Poems, National Library of Jamaica (henceforth NLJ), MS 2255.
number of drinking songs popularized in the trenches, including the famous “Sing Me to Sleep”: “Sing me to sleep where bullets fall, let me forget the war and all; Damp is my dug-out, cold my feet, Nothing but bully and biscuits to eat.” Montieth’s own verse betrays his incredulousness at the everyday Italian’s vociferous desire to taste the slimy bane of many British and West Indian soldiers’ nutritional sustenance, their eager bartering growing ever more feverish the deeper they passed into Italy. Furthermore, he dedicates an entire stanza to their interactions with local women:

> “Women! Well you should have seen them! Some with little clothes to screen them, Some so nice you try to win them, Some with devils laughing in them, Some with smiles like Eve or Venus Some we wished had never seen us Some that any man could bribe Others that I won’t describe Swarmed around with one intention; What they wanted need I mention? Well twas but the soldiers pets, - Bully-Beef and Cigarettes!

British officials – particularly those who worked to prevent the BWIR from mingling with white women – may have been unsettled at this account of West Indian servicemen interacting with women from all walks of life. Nonetheless, the hated Bully-Beef is at the crux of West Indians’ wartime relationships. Montieth writes the ration into his core experiences of war: it embodies his physical reliance on the British food for nutritional sustenance, it serves as a familiar continuity during his trip through alien lands, and it is the means through which he socializes with white European civilians. Like in the case of British Tommies, soldiers were united in their mutual dislike and experience of bully-

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beef. But for West Indians, it also constituted a strangely foreign and yet essentially ‘British’ facet of their wartime dislocation.

As in the case of British and West Indian troops, philanthropists sought to bring more specific pleasures of home to Indian troops, particularly during the Christmas holiday. A Mr. Mitra, likely Siddha Mohana Mitra, the author of a number of English-language books on India and member of the Royal Asiatic Society, wrote of one company that began to sell “Indian comforts” in portable boxes at the suggestion of “two interested ladies” in London.218 Generous individuals could purchase the boxes and send them as gifts. Mitra learned of these efforts when Lord Roberts, the famous Field Marshal, solicited his opinion on whether Indian soldiers would enjoy their contents. Recalling his conversations with troops convalescing at Netley and in the New Forest hospitals, Mitra suggested adding prepared tobacco (Tembaku or Gurakhu) for hookah smoking, as well as specially prepared ghee. Though the specific company remains unknown, Mitra noted that organizers took account of the different preferences of varying groups in the Army, organizing shipments of both chaalia, chikni supari, and supari (ready-to-chew pouches) – all various types of betelnut or paan, a mild stimulant – “to suit the tastes of the different races forming the sepoy army in Europe.”219 Though most South Asian troops served too far from home for their families to send edibles, the War Office cooperated with philanthropists to send on gifts organized for their “dear Indians.” Despite these efforts, everyday provisioning in the form of Army-mandated rationing proved far more complicated, particularly where the War Office attempted to balance “tasting home” with nutritional sustenance, food shortages, and religious dietary customs.

219 Ibid, 11.
Racing Rations: The Development of Ration Scales during the War

Nutrition and food sciences occupied a tenuous position at the start of the war in 1914. Interest had expanded dramatically over the previous decades, yet the government provided little to no funding to back new studies. Prompted by renewed interest in soldier fitness during the Boer Wars, the British Army funded several experiments in energy requirements throughout the first decade of the twentieth century. These studies focused largely on calorific expenditure and protein consumption. In 1912, F. G. Hopkins introduced the controversial idea of “accessory food factors,” alternatively labeled “vitamines” by Casimir Funk. Both tied “vitamin” deficiency to certain diseases, from beri-beri and rickets to scurvy and pellagra.220 Yet this science held little sway with military authorities. At the start of the war, many British medical and army officials were unconvinced. Some rejected dietary theories of diseases altogether.

Though controversial, nutritional studies grew in number and importance in the military during the war. The Royal Society, the British national academy of science, designated a wartime Food Committee to advise the government on matters of food supply.221 The War Office funded studies in energy expenditure and nutritional value in an effort to economize rations and power their soldiers and laborers. Nation-wide rationing in 1918 extended the problem to the civilian population of Britain, spurring further interest.222 However, attention to nutrition and vitamins varied sporadically

221 Ibid, 146-7.
during the war. While rations attempted to meet standards for daily calorie consumption, arguments ensued over their balance of food groups and their effectiveness in preventing disease.\textsuperscript{223} The Ministry of War only began cooperating fully with the Food Committee in mid-1917 after criticism over the lack of scientist involvement in formulating food policies.\textsuperscript{224}

As Rachel Duffett has established, the exact path of development of wartime ration policy is difficult to construct due to a lack of in-the-moment documentation.\textsuperscript{225} In this absence, postwar studies and reports, brief mentions in administrative war diaries, and individuals’ own letters, poetry, and accounts provide a glimpse into the construction of a provisioning system. This incomplete record applies to the feeding of colonial forces as well as the comparably well-studied case of British troops. However, the War Office’s attempt to feed unique diets to diverse colonial servicemen did generate archival evidence of the debates over their rations.

From the first days of the war, administrators set about constructing different ration scales for servicemen of different races and roles based on cultural tradition, religious practice, and food science. In the postwar review of military medicine, \textit{The Medical History of the War}, Sir William Macpherson opened his chapter on rations by highlighting ration differentiation: “The rations issued to troops in the several theatres of war varied considerably to meet the special requirements of locality and climate as well as the needs of the different nationalities and races employed in auxiliary services.”\textsuperscript{226}

\textsuperscript{223} On conflicting opinions of scientists and statesmen, see Mikuláš Teich, “Science and Food During the Great War: Britain and Germany,” in \textit{The Science and Culture of Nutrition, 1840-1940}, eds. Harmke Kamminga and Andrew Cunningham (Amsterdam: Rodopi, 1995), 213-234.
\textsuperscript{224} Smith, “Nutrition Science and the Two World Wars,” 148-149.
\textsuperscript{225} Duffett, “British Army Provisioning on the Western Front, 1914-1918,” 27.
But varying rations by “nationalities and races” often depended on a fuzzy combination of nutrition science, colonial knowledge, and cultural understanding. When army organization changed, or transport issues and shortfalls cut off food supplies, Directors of Supplies and Directors of Medical Services had to quickly rethink ration scales. This invited even more juggling and disorder.

Though ration allotment changed over the course of the conflict, categories almost never shifted. For most of the war, Directors of Supplies for the Western Front distributed field rations in seven different categories, largely bounded by race: British and Dominion Troops, Indian, Chinese, Egyptian, Fijian, Naga Hill (Burmese), and Kaffir (South African Native Labour Corps) servicemen.227 This trend continued in other theatres: Command in Egypt set rations for five categories, Egyptian Expeditionary Force, Indian, Egyptian, the separate Arab legion, and West Africa; In Macedonia four categories, British and Dominion troops, Indian, Macedonian Labourers, and a separate ration for the Serbian Army; East Africa six categories, ‘Europeans and men of the West India Regiment,’ Indian, Nigerian and West African, Arab, East African, Cape Boys (South African Native Labour), and Somalis; In Mesopotamia, British, Indian, Chinese, and Arab and Persian Labour Corps. Men from the BWIR, the small Mauritius Labour Corps serving in Mesopotamia, and the small Maltese contingent drew the same ration scale as British troops, with certain substitutions (e.g., replacing part of their meat ration with bread).228 Several of these categories developed modified ration scales for servicemen working at the Line of Command, or on mobile columns in Egypt,

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228 Ibid.
Mesopotamia, and East Africa, or added extra issues of certain rations for transport personnel, or as substitutes in times of scarcity.

The War Office also treated certain servicemen’s diets as a rationale for refusing to enlist them. Army officials expressed their unwillingness to further complicate ration provisions for non-white battalions. Administrators were highly attentive to the dietary requirements and desires of many sepoys of the Indian Army, yet they refused to enlist South Asian subjects living in the West Indies into the BWIR. When forty-one “East Indians” arrived at a recruiting station in Kingston, officers rejected them on the grounds that they could not speak proper English and required different ration scales on religious grounds. After some back and forth with the West India Committee, the War Office agreed that it was happy to enlist “creoles of Indian descent” – provided that they were British subjects born in the colonies, were fluent in English, and were willing to receive ‘standard’ rations provided to West Indians troops.\footnote{Proposal for Repatriation, 25 October 1915, CO 318/336/17. See also Reports on Seaford Camp, October 11, 1915, CO 318/337/66; and August 16, 1915, CO 318/336/6.} Thus, while the War Office was happy to accommodate the spiritually determined diets of martial race servicemen in the Indian Army, they did not deem their non-martial, migrant counterparts outside the Raj worth the same trouble. Just as they struggled to ‘fit’ British and Canadian non-white and mixed-race individuals into regiments (see Chapter 1), imperial migrants and minority groups similarly did not appear to ‘fit’ into the racially-bounded colonial regiments.

Administrators complained about the multiple scales and the complications they engendered, but accepted them as part and parcel of accelerated local and colonial mobilization. Macpherson noted that the East African campaign worked through “the
problem of feeding not only the European, the Indian, and the Africa, but of catering for
the peculiar dietaries of half-a-dozen African races; and now and again for imported
labourers wholly unused to African food conditions.”

In East Africa, where reports throughout the war observed severe mismanagement and ill treatment, the diversity of troops could become a foil for internal criticisms. In his postwar summary of ration scales, Macpherson agreed with General Pike’s Report, noting that rations for the Nigerian Brigade, the Gold Coast Regiment, Arab porters, Indian troops, East African carriers, Somalis, and South Africans were partially or wholly inadequate, with severe insufficiencies of certain foodstuffs. Yet he defended the administration as a whole, reasoning that they had done their best: “The mere perusal of the rations issued in East Africa show how complex was the problem of feeding troops and followers. The diet question was a physiological and economic problem, and it could not be expected that any supply department… could unaided solve the problems with which it was confronted.”

For Macpherson, servicemen’s diversity rendered proper rationing a costly endeavor. These complications justified the disorganization and nutritional failures of the East African Campaign.

White troops from Britain and the Dominions were allotted the same rates of ration, differing only in exceptional circumstances. One such case was the employment of forestry personnel: Canadian laborers, whose “work was arduous and prolonged,” and were “of fine physique,” received a ration calculated at 5,681 calories, while the British forestry units collected a ration equivalent to 4,852 calories.

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231 Ibid, 66.
232 Ibid, 50.
Bulgarian prisoners of war were combined into a single category and given the same ration rate across fronts. Army Regulations differentiated Turkish prisoners who received markedly less calories per day than white POWs (see table for Egypt Field Rations below). Rationing authorities also drew an overarching divide between combatants and non-combatants. The former was generally considered more deserving and in need of rations for both physical labor and positive morale. An extension of ration policy for civilians on the home front, ration scales nearly always privileged full-time combatants over full-time laborers.\textsuperscript{233}

<table>
<thead>
<tr>
<th>Ration Category</th>
<th>Calorific Content of Field Rations, Egypt</th>
</tr>
</thead>
<tbody>
<tr>
<td>European Troops</td>
<td>3,610 (Protein: 124.8 gm.)</td>
</tr>
<tr>
<td>Indian Troops</td>
<td>3,810 (Protein: 120.4 gm.)</td>
</tr>
<tr>
<td>German, Austrian, &amp; Bulgarian Prisoners of War</td>
<td>2,900 (Protein: N/A)\textsuperscript{234}</td>
</tr>
<tr>
<td>Turkish Prisoners of War, Non-Labour</td>
<td>2,684 (Protein: 90.5 gm.)</td>
</tr>
<tr>
<td>Turkish Prisoners of War, Labour</td>
<td>3,026 (Protein: 102.4 gm.)</td>
</tr>
</tbody>
</table>

Differentiating rations between combatants and non-combatants brought other problems, particularly on fronts or in forces where the line between the two were blurred.

In British East Africa, where porters and carriers were continually promoted as \textit{askari} soldiers and given weapons (see Chapter 1), the Deputy Adjutant and Quartermaster General of the East African Force, R. H. Ewart, noted the “the difficulty of determining which Africans should receive the ‘troops’, and which, the ‘followers’ ration.”\textsuperscript{235} This problem lasted several months in 1917. The Assistant Director of (Ordinance) Supplies


\textsuperscript{234} Compiled from German, Austrian, and Bulgarian Prisoners of War ration scale and Percentage Composition and Food Value data in Table II, Macpherson, \textit{Medical History of the War Vol. 2}, 55-59.

appears to have sidestepped the problem by continually combining the standard rates, giving African servicemen on the front a mixed ration averaged between the standard for non-combatant and combatant. Ewart, made this practice official in September of 1917, mandating a “combined scale for all East Africans.”

Indian Army officials were especially reluctant to make large changes or reductions in the diet of Indian sepoys, an extension of nutritionists’ pre-war validation of their diet. A number of doctors and supply officers, from East Africa to Mesopotamia, advocated reducing their ration of atta, an Indian wheat flour. The set amount was more than enough to fill a sepoy’s stomach, they insisted. Excess chuppaties (unleavened flatbreads) were regularly thrown away. Other officials met these suggestions with strong disapproval. In Dar-es-Salaam in 1918, Col. W. Johns, Director of Railways, expressed shock at one reduction plan. The suggestion “is not a little astonishing,” he claimed, as the “Indian ration studied as a whole is simple, well balanced… and is, on the whole, composed of articles which the Punjabi stomach has been accustomed to digest.” If any changes had to be made, Johns argued, ghi could be increased and meat decreased. The only Indians for whom atta could be mildly decreased were those on light duties or serving as orderlies. Nonetheless, gathering his experience with Indian combatants and laborers in Africa and South Asia, Johns argued that atta was primary and essential: “The Indian stomach is a wonderfully responsible machine, the more you can fill it with atta and ghi the more work will the man do.” For Johns, first-hand experience during the war verified the physical and nutritional dominance of the atta-eating Indian serviceman.

236 Macpherson, Medical History Vol. 2, 64.
237 W. Johns to Deputy Adjutant and Quartermaster General, February 9, 1918, WO 141/29.
238 Ibid.
This enshrined McCay’s earlier observations as doctrine. Johns singled out strong martial races as “Punjabi,” and asserted the importance of wheat in maintaining a martial race. At the same time, his observations both generalized and abstracted the Indian Army soldier. His praises for the “Indian stomach” and the “Punjabi stomach” condensed a hugely diverse group of predominantly northern South Asian troops into a singular entity, while reducing them to efficient organs – or “machine[s]” of labor.

While ration scales privileged combatants over laborers, African combatants found themselves markedly disadvantaged compared to white and Indian soldiers. As early as 1916, the current Surgeon-General of the East African Force, G. D. Hunter, lamented that the “African Troop ration is a very poor one,” conducive to outbreaks of survey and similar diseases. “The ration authorised for the King’s African Rifles compares very unfavourably with those issued to other fighting units in this force, and requires revision.”

 Authorities were well aware of the insufficiencies of diets for “African natives” serving on the front. Furthermore, review of wartime diets also revealed the paucity of food supply for native laborers in peacetime. Reporting on the diet of East African porters and carriers, Major G. D. Maynard made explicit comparisons. Although their ration of 2 lbs of mealie meal (a ground, often coarse maize cooked into a porridge) a day was considered better than the rations of workers employed by the Uganda Railway (1 ½ lbs rice per day), he observed that it was “obviously an improper diet.” He advocated immediate changes to improve and increase their rations. Maynard emphasized that this was a practical measure: “Apart from any humanitarian aspect of the question it is economically unsound to underfeed a labourer.”

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239 G. D. Hunter to Deputy Adjutant and Quartermaster General, October 22, 1916, WO 141/29.
Nonetheless, change was at best slow in the East African Force. As late as 1918, the campaign suffered serious problems with ration amounts and distribution on the German East African front. One commissioned report on “Medical and Sanitary Matters” noted that African Porters were overburdened, not only by the loads they were required to carry, but by their rations, which they were forced to transport on top of their carrier assignments: “Their hardships were increased owing to the way in which they were worked, for it was often physically impossible for the porter to carry both his load and his full ration. The exigencies of war demanded that the former should reach its destination, but too often neither it or its carrier did so, or if the latter arrived it was only to die of exhaustion.”

Surgeon General W. W. Pike’s 1918 Report of Medical and Sanitary Matters in German East Africa singled out many of these failures. General Ewart later came under intense criticism for misleading reports about the appropriateness of the various ration scales, and his failures to review or amend the ration scales for South African natives, West Africans, West Indians, and Indian servicemen in East Africa.

Servicemen consuming and officers regulating rations struggled over the quality as well as the quantity of food. Certain ration foodstuffs provided to non-white laborers were of notably low quality. Laborers eligible for rations in British East Africa had traditionally been given rice or mealie meal. Mealie meal, far cheaper and plentiful, was the ration of choice for East African workers during the war. Yet rushed production for mass consumption led to shortcuts and missteps with grave results for the East African laborer. Major Maynard, visiting a hospital for Carriers at Kilwa in July 1917, reported

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241 Report on Medical and Sanitary Matters in German East Africa 1917 (Nairobi: Swift Press, 1918), 59.
242 Staff Captain A. G., June 12, 1918, WO 141/29.
that many porters grew sick from diarrhea and dysentery, caused by “bad quality” mealie meal. Maynard inspected the wares of the local hospital store and supply depot. He found it was far too coarsely ground with an excessive percentage of bran in it, rendering it difficult for the porters to digest. Maynard railed against forcing “the African native… to eat such irritant diet.” He immediately ordered the supply depot to stop issuing all of the coarser yellow meal, and mandated that all white East African meal be sifted before issuing.²⁴³ Concern over potentially damaging edibles prompted change, but also intertwined with debates over food preparation. Wartime eating grew all the more contested when confronted with issues around cooking habits and traditions.

**Food Preparation: Habit, Hygiene, and Hybridity**

The cultural practices around food consumption rendered diets and rationing a complicated business, highly customized to individual groups. Concerns around hygiene and preparation were especially rife when dictated by religion and customary habit – or rather, what the British officials in charge interpreted as dictated by religious law. The War Office attempted to preserve certain social conventions around food consumption – with varying levels of dedication, depending on the group in question. However, the upheaval of war meant that these could not always be maintained, which engendered further transmutations and negotiations around edibles. The contingencies of war hybridized diets in unexpected ways: either in preparation or content, servicemen were exposed to different styles of cooking and different foods.

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Convinced of the vital importance of Indian soldiery, British officials privileged aspects of their nutrition and feeding over that of other non-white troops. Ever conscious of the allegations of taboo breaking that spurred the infamous 1857 mutiny, administrators believed that the primary way to prevent unrest was to ensure that food preparation adhered strictly to ethnic and caste rituals and regulations. They hired staff and constructed special facilities to these ends. At the four-hospital complex in Brighton for Indian soldiers, administrators dedicated themselves to providing recovering sepoys with caste-appropriate food and drink. Under the guidance of Bruce Seton, the Kitchener Hospital set up five kitchens, all of which had three separate compartments: one for “Musulmans,” one for meat-eating Hindus, and a third for all other Hindus. The Royal Engineers built a new slaughterhouse for halal preparation of meat.

During Ramadan, a committee of Muslim Indian officers decided which wounded Muslim sepoys were fit enough to keep the fast, and distributed all rations after sunset and before sunrise during the festival. Recovering soldiers expressed their satisfaction with these arrangements in their letters. Bir Singh, a Sikh with the 55th Rifles, happily declared during a hospital stay in July 1915 that “the arrangements for our food are very good, because men have been selected from the regiments to look after it and every man is served by his caste-fellows.”

Beyond religious taboo, the army also considered religious tradition. When the first shots of the war broke out in August 1914, many Muslim servicemen were observing Ramzan (Ramadan), the month-long fasting period constituting one of the five pillars of

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244 Bir Singh to Gunga Singh, July 17, 1915, IOR L/MIL/5/825/4.
Islam. As Kate Imy has detailed, this coincidence immediately forced British commanders to debate the priority of religious custom versus food and health. Though observant soldiers could eat light food and water from sundown to sunrise, some British officers considered the day-long intermittent fasting poor for soldiers’ health, especially as they headed to war on a foreign front.245 But anxieties over mass revolt won out over concerns about sepoy fitness: officials rubber stamped Muslims’ observance and considered Ramzan when scheduling troop movements. Besides allowing them to practice, Imy argues, the fast could also empower soldiers through its “‘biomoral’ value”, by granting them the choice to subject their bodies to divine authority rather than governmental dependence.246

Despite sharp attention to providing proper foodstuffs, Walter Lawrence admitted that protocol was not always followed: “It was reported that in the absence of ghee, margarine was being supplied… I also asked [the India Office] whether any of the margarine manufacturers would guarantee margarine free of beef and pigs’ fat. Sir Alfred Keogh promptly gave orders that no margarine was to be served out.”247 Even after the new directives, Lawrence feared that their misstep might have catastrophic consequences on the combined Indian-British war effort: “If it got about that we were using margarine, there might be an explosion similar to the old cartridge trouble of the mutiny.” With the Mutiny’s legacy ever-present in the back of their mind, the India Office took extensive measures to ensure that Indian Army servicemen were fed their

246 Ibid, 53-54.
247 Walter Lawrence, Reports on the Working of Indian Hospitals, December 15, 1914, WO 32/5110.
desired diet, even where it required extra work, and detracted from the men’s dietary fitness.

While the Indian Army strove to accommodate cultural & religious taboos and preserve caste boundaries, food preparation (if not food itself) had to adapt to changing wartime locations and circumstances. Seton was strict about hygiene in food preparation. He demanded cleanliness not only in the kitchens, but especially “of the persons of the cooks themselves.” This meant that British authorities expected cooks to meet British standards of bodily cleanliness. For all of his emphasis on sanitizing the Indian caterer, Seton did not anticipate that their dislocation might prompt self-directed technical changes. He recalled “one noticeable point,” that the cooks took “to using the English rolling-pin and board, and gave up the indigenous method of making chuppaties almost entirely.” This must have pleased Seton, since the “indigenous method,” called for cooks to use their bare hands to shape the dough into discs. Wartime contingencies prompted deviations in cooking techniques, and demanded simultaneous changes in those preparing food.

What’s more, adherence to religious law and traditional diets varied between regiments. Bir Singh, the Rifleman who praised hospital arrangements with regard to caste-appropriate cooking, proudly claimed that his regiment received better rations because of their refusal to deviate from their expected diet. The other regiments “agreed to eat biscuits and European bread…. So now we get “ata” [sic], and the other regiments get babies’ biscuits and bad [ones] at that.” Conversely, rather than always acquiescing to British nutritional advice or custom, some Indian Army servicemen self-imposed

further restrictions on their diets in solidarity with their fellow soldiers. In East Africa, where sheep and goat meat was difficult to obtain, Sikhs and Hindus were given a supplementary ration of ghee. Despite religious divides, T. E. Scott, a Lt. General with the Indian Army in East Africa, noted that some soldiers displayed sensitivity to others’ food customs. He claimed that while the “Muhammedan fared better” due to the greater availability of beef, “in some instances Muhammedans refused to eat beef rather than risk hurting the susceptibilities of their comrades of the other religions.”

British hospitals and army barracks did their best to uphold religious prescriptions on food preparation. This grew more complicated on the front, particularly in France, where Indian soldiers were occasionally billeted with or invited into the homes of French families. As David Omissi has observed, such encounters could prompt both intercultural understanding and cultural anxieties. Some Muslim soldiers refused to eat with the French and commented on “unclean” habits such as feeding animals from people’s plates. Others described sharing enjoyable meals. One even praised a farmers’ halal style slaughtering of a fowl. Hospital feeding also created opportunities for cross-cultural conversation. Brigadier General C. P. Fendall, an A. A. G in British East Africa, was surprised that the Indian wounded treated in the non-European hospitals enjoyed their food and bonded with the locals who cooked it: “The Indians in these hospitals strange to say, thoroughly appreciate these women – African bibis, locally employed – who are most cheery, and very clean.”

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250 David Omissi, “Europe through Indian Eyes,” English Historical Review 122, no. 496 (April 2007), 386-7.
251 Diary of Brigadier General Fendall, October 20, 1918, National Archives, London, Cabinet Office (CAB) 45/44.
exchange and experiences as well as opportunities for the shoring up or erosion of
cultural food practices.

The War and India Offices invested deeply in maintaining proper provisioning in
the Indian Army. However, Directors of Medical Services did not always accommodate
other indigenous methods of preparation – particularly when they took too much time and
materials. In British East Africa, issues with native askari soldiers and porter cooking
often prompted British officials to disparage them as unhygienic or unhealthy.
Aforementioned recognition of the poor quality of mealie meal did not always produce
change, particularly where the servicemen involved constituted a labor force widely seen
as replaceable. Despite ample evidence of the poor quality of mealie meal rations,
Surgeon General W. W. Pike claimed that it was of fine quality, arguing that the problem
lay with the carriers themselves, “due to their eating it unsufficiently cooked [sic].”

Food preparation remained a site of negotiation and appeasement. Responding to
Pike, Major G. D. Maynard, SAC DADMS, advocated that at least one of the porters’
daily meals be cooked “under European supervision,” but encouraged that they be
allowed to cook the others by themselves. Maynard reasoned that this approach would
help balance the porters’ customs with his office’s emphasis on biomedical hygiene. He
acknowledged the benefits of compromise, “Undoubtedly the natives like to potter over
the fire cooking his food, and to debar him from this would no doubt occasion a certain
amount of discontent which it is desirable to avoid, if their health and efficiency are to
remain unimpaired.” Communal cooking provided African carriers with precious
opportunities for comradeship and camaraderie, but it was never a standard activity for

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252 Administration of Medical Services in German East Africa, 11, WO 141/29.
253 Ibid.
them. As another officer reviewing the ration scheme in East Africa noted, the men were accustomed to their wives cooking for them.\footnote{Comments on Surgeon General Pike’s Report, 10, WO 141/29.}

Food distribution grew more complicated with distance, and particularly on fronts with notably diverse groups of servicemen. Prioritizing the needs of some groups over others – notably combatants over non-combatants – produced serious friction. Conflicts over rations sometimes produced direct backlash in the form of protests and riots. One such case arose in the East Africa campaign. To conserve their stores of rice for valued Indian troops, the War Office tried to feed all black servicemen with the mealie meal eaten by East African laborers.\footnote{Ibid, 12.} West Africans and West Indians rebelled and demanded rice, much to the chagrin of the ADS. Similar trials occurred in the Sinai and Palestine campaign: The 1/70th Burma Rifles protested that the ration scales granted them far too little rice, insufficient to sustain them during campaigns. Instead, they requested that they be allowed to draw larger British Rations in place of their Indian ration.\footnote{War Diary G.H.Q., July 1, 1918, WO 95/4387.} Deputy Assistant Directors of Supplies (DADS) mostly accommodated requests to switch types of rations, as long as substitutes were available and did not exceed the quantity of the former diet. Some groups negotiated for British rations. In the early days of the East African Campaign, the 2nd West Indian Regiment and the BWI Regiment were allotted distinct rations from the standard European ration they received on service in Europe. The 2nd West Indian Regiment requested certain changes, and the BWI Regiment requested to be placed on the European ration. Two months later, in December 1916, the War Office agreed to shift both to the European ration.\footnote{R. H. Ewart, Comments on Surgeon General Pike’s Report, 13, WO 141/29.} Reports on the management of
rations for East Africa Force prompted R. H. Ewart, the D.A. & Q.M.S. in Dar es Salam, to identify ration modification as a key outcome of the war. He cited examples where “even the officials who have had long experience of feeding a particular class of native change their views.” The successful management of food for Britain’s multicultural armies required flexibility and adaptability, not rigid adherence either to bureaucratic guidelines or religio-cultural norms.

Requests did not always end in capitulation. The outcome depended both on the status of the subject, and the nature of the request: complaints about type versus amount of ration. In April 1918, the Deputy Assistant Director of Labour (DADL) stationed at Abancourt recorded that 2½ platoons of the 154th Coloured Labour Corps refused to work “on account of misunderstanding the Rations.” Instead of acceding their demands, the DADL took away their allotted rest period as punishment. It is unclear what the CLC servicemen objected to, however, they may well have asked for increased rations. These laborers were by and large underfed compared to their fighting counterparts.

South African non-combatants in particular ate diets far lower in nutrients and calories than other groups. This system arose out of the deep ties between army management and pre-war industry authorities. Rather than basing their ration on standard rates for British Army non-combatants, the local Director of Labour determined the “Cape Boy” and CLC ration rates after a consultation with authorities from the Union of South Africa. The DADL expert, Lt. Col. Maynard, “never questioned” their judgments. Reports noted that the set ration was supported by South African officers, whose War Office-validated

258 Ibid, 12.
259 War Diary, DADL Abancourt, April 2018, WO 95/4007.
expertise was based on their “great experience in feeding natives on the mines.”

Further tying wartime labor to the interests and authorities of South African industry, the Controller of Union Native Labour, Major Liefeldt, was also a representative of the Native Labour Bureau of South Africa. This same board oversaw (and frequently overlooked) marked exploitation and devastating poor health among native workers in the South African mines. The shoddy pre-war standards of feeding for South African labor were thus imported into wartime paradigms. Ration negotiations and concessions to cultural customs only went so far.

Race & Deficiency Disease: Nutrition under Siege in the Mesopotamian Campaign

The privations of WWI proved fertile ground for clinical studies of soldier nutrition and energy expenditure. Here, questions of cultural custom and scientific expertise came to a head. The deepening crisis of so-called “dietary deficiency disease” grew out of and made visible conflicting imperatives over traditional food practices and the desire to improve troop nutrition through medical study.

Deficiency diseases were a particular problem in the Mesopotamian campaign, where distance, fighting, and siege clogged up distribution of diverse foodstuffs. During the siege of Kut, from 7 December 1915 to 29 April 1916, dysentery and diarrhea were rampant. Scurvy and beri-beri, among other diseases, devastated the ranks of British, Indian, and other assorted servicemen trapped inside the city walls. Well-known and pervasively studied in nineteenth century military medicine, scurvy cases originated with

260 Comments on Surgeon General Pike’s Report, 12, WO 141/29.
trouble procuring adequate amounts of Vitamin C for servicemen upriver.\textsuperscript{262} Fresh fruit and vegetables were plentiful at Basra and Amara, but production ceased further up the Tigris. Without irrigation, attempts to grow vegetables for troops further inland failed. When river transport stalled or was clogged by shipments of supplies and troops upstream or the wounded and sick downstream – as it often was in the first years of the campaign – the Army’s only option was to purchase produce from local Arabs.\textsuperscript{263} Furthermore, attempts to preserve sources of anti-scorbutics often failed: lime juice shipped from India (a solution of fresh limes, 5\% alcohol, and 2 grams salicylic acid) was often over six months old by the time it reached troops in Mesopotamia. This vastly reduced its vitamin reserves.\textsuperscript{264}

Less studied and understood was beri-beri. Afflicted patients developed sudden weakness and pain in the legs, followed by dropsy, which in severe cases could lead to heart failure. It first came to the attention of British colonial officials in Southeast Asia over the course of colonial expansion in the nineteenth century, but its cause remained a mystery. In European colonies, cases appeared to rise with the expanded cultivation and consumption of milled rice. Physicians suspected the culprit was a fungus or toxin. Although its root cause, deficiency of thiamin, vitamin B1, was not identified until the 1920s, research presented at the Far Eastern Association of Tropical Medicine in 1910 established that the disease could be prevented by substituting unmilled or minimally


\textsuperscript{263} Willcox, “The Treatment and Management of Diseases Due to Deficiency of Diet: Scurvy and Beri-Beri,” \textit{British Medical Journal} 1, no. 3081 (January 17, 1920), 73.

\textsuperscript{264} Macpherson, \textit{The Medical History of the War, Vol. 2}, 101.
polished rice for white rice. During wartime, cases arose less in South Asian subjects, instead increasing among British troops, whose bread and biscuit rations were made from white flour. Over the course of the Mesopotamian campaign, medical administration calculated the following numbers of troops laid ill with deficiency diseases, brought about by troubles with transport and siege conditions in certain cities.

Table 2: Deficiency Diseases in the Mesopotamian Campaign

<table>
<thead>
<tr>
<th>Year</th>
<th>Scurvy</th>
<th>Beri-Beri</th>
</tr>
</thead>
<tbody>
<tr>
<td>1915</td>
<td>Unknown</td>
<td>&gt; 300 British</td>
</tr>
<tr>
<td>1916</td>
<td>11,445 Indians</td>
<td>104 British</td>
</tr>
<tr>
<td>1917</td>
<td>2,199 Indians</td>
<td>84 British</td>
</tr>
<tr>
<td>1918</td>
<td>825 Indians</td>
<td>51 British</td>
</tr>
</tbody>
</table>

For some medical students, the chance to scientifically study men subjected to continued nutritional deprivation was too good to pass up. Patrick Hehir, an A.D.M.S. with the Indian Medical Service, noted that the siege of Kut “afforded opportunities for studying the morbid state of the body brought about by long-continued deprivation of an adequate quantity of suitable food which seldom present themselves.” Despite the gravity of the situation, “it would have been almost criminal to have disregarded them.” Hehir observed differences between British and Indian bodies behind the walls of the embattled city. During the siege, Indian troops reached an advanced stage of chronic starvation sooner than the British. They were “less resistant to disease and less capable of severe physical strain,” he argued.

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267 Patrick Hehir, “Effects of Chronic Starvation during the Siege of Kut,” *The British Medical Journal* 1, no. 3205 (June 3, 1922): 865; 1915 statistics provided from Willcox, 75.
Hehir did not tie these results directly to the markedly lower calories that Indian’s rations afforded them. During the initial stages of the siege, British servicemen received 1,975 calories per day in rations, Indians 1,550, and Indian vegetarians 1,045 kcal. In the later stages of the siege, rations were reduced to 1,850 kcal for the British and 1,110 for Indians. In the dire last days of the siege, the British were allotted 24 oz. of horseflesh, while meat-eating Indians received 12 oz. Not only did more Indian soldiers reach advance starvation sooner than their white counterparts, they lost far more body weight, on average 17 lb. (or 14%) for Indians versus 12.5 lb (10% of body weight) for British. Not surprisingly, Hehir observed that Indians reached a level of chronic starvation debility faster than Europeans. It must have required some intellectual effort for him not to link this to their reduced rations. Starvation, he alleged, “assumed graver forms in Indians than in Europeans. We noticed in hundreds of Indians that there is a stage in the downward path in chronic starvation from which recuperation cannot take place.”  

Hehir’s interest in studying the differences between British and Indian bodies – and in identifying the point of no return for starving Indians – is indicative of the long-standing colonial interest in understanding the physical capacity of laborers. It also demonstrates how even careful and apparently objective medical and scientific research remained blinkered by race- and ethnic-based assumptions. Hehir simply could not see what his data so obviously told him. More Indians starved sooner than their white counterparts because they consumed substantially fewer calories.  

Physicians continually observed that differences between British and Indian diets resulted in each groups’ clear-cut prevalence towards certain nutritional diseases. British
servicemen on strict ration diets in Mesopotamia suffered overwhelmingly from beri-beri. Indian troops, on the other hand, had virtually no cases of beri-beri, but came down resoundingly with scurvy from deficiencies in Vitamin C (ascorbic acid). Medical officials quickly attributed this to variations in their diets. Indian troops ate thiamin-rich daal (lentils) while the British did not. They used atta (a coarse wheat flour) in baking while British used refined white flours, and Indians ate little to no horseflesh compared to the British. The whole grains and legumes in a typical sepoy diet provided plentiful Vitamin D1, lacking in British rations. Similar dietary deficiencies meant that the Chinese rations of white rice led to many cases of beri-beri among the Chinese Labour Corps (CLC). Conversely, vegetable and fruit sources of Vitamin C deteriorated by the time they reached Indian servicemen, spiking scurvy cases in the vegetable-heavy diets of Indian Army and Labour units. From the vantage of nutritional science, culturally-sensitive diets for all soldiers, white and non-white, sometimes compromised health.

Two Baghdad hospitals were devoted to managing nutritional diseases, one for scurvy-afflicted Indians and one for British sufferers of beri-beri. It is unknown where CLC members suffering from beri-beri were directed. In this case, the ethnically distinct diets and ensuing deficiency diseases of Indians and British made their medical segregation seem natural and practical. The separate hospitals also offered the chance for a special medical officer, attached to each hospital, to make special registers to observe and record the cases for further study. Cases abated somewhat after the summer of 1916, when the army commander General Maude mandated changes in rations. He added lime juice, fresh fruit, tamarind or cocum, and more meat and potatoes/vegetables

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269 Willcox, “The Treatment and Management of Diseases Due to Deficiency of Diet,” 76.
to the Indian ration; for British troops, adding oatmeal, marmite, greater amounts of potatoes and fresh vegetables, and a small amount of daal.\textsuperscript{270} As a further measure, a 1916 order established that Indian troops should have the “first call on the fresh vegetables and fruit available,” given numbers of scurvy cases and the proportion of these foodstuffs in their rations.

Medical officials undoubtedly exhibited a growing recognition of the role of ration type and vitamin sources in the respective epidemics of beri-beri and scurvy, but some practitioners still insisted that Indians exacerbated their own poor health. The demographic distribution of scurvy and beri-beri led W. H. Willcox, Colonel and Consulting Physician to the Mesopotamian Expeditionary Force, to blame habits developed in the Indian Army around rationing. The traditional practice of granting Indian Army troops an allowance to purchase additional rations with led to their general worse health. “The Indian has the instinct of saving money for his family very firmly implanted in his mind,” Willcox claimed, and “he no doubt often starved himself to save a few annas.” This practice led to many Indian recruits arriving in Mesopotamia already “anemic and debilitated, and suffering from pyorrhea [periodontitis],” and hence more susceptible to illness. In contrast, the British soldier arrived to the campaign well nourished, “with a good balance in his bank against deficiency disease.” Though sympathetic, Willcox recommended abolishing the practice of the ration allowance in favor of straightforward food. His concern for the sepoys’ health and fighting fitness overrode their need to aid their families’ wellbeing.

\textsuperscript{270} Ibid, 74.
Willcox affirmed that other contributing causes were beyond the patient’s control. Citing the Oxford Regius Chair physician William Osler’s work, he agreed that mental depression could be a predisposing cause in scurvy: “undoubtedly in Mesopotamia the depressing influences associated with the campaign in 1916 were factors in the causation of the high incidence.” Additionally, he argued, patients recovering from jaundice, dysentery, and other enteric diseases were more likely to fall victim to scurvy. Hospital medics added antiscorbutics such as lemons, limes, and oranges to the diets of all hospital patients to prevent scurvy. Yet Willcox still referenced Indian habits around rationing, as well as their physical appearance, in rationalizing why scurvy could be more difficult to treat in Indian patients. Physicians often noted the presence of purpuric rashes (reddish or purplish skin discoloration due to small blood vessels bursting) in white British scurvy sufferers. However, Willcox claimed that it was more difficult to note the presence of the telltale patches in Indian patients, whose “skin manifestations were very difficult to determine owing to the natural pigmentation of the skin.”

As British physicians like Willcox took notice of these nutritional chasms, he advocated action through diversifying diets and mixing different groups’ rations. Willcox observed the divisions in sufferers of deficiency disease during the campaign, and correctly tied the cause of the epidemics to diet. Indian troops’ field service rations had few antiscorbutics, while British and Chinese servicemen’s rations lacked thiamine. At Amara, Willcox experimented with adding atta to bread baked for British troops – one prototype made with 100% atta flour, 75%, 50%, and 25%. Eventually, he perfected a recipe that combined Indian flours with refined British white flour. After testing it with

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271 Ibid, 76.
272 Ibid, 76.
local units, the GOC mandated that it be provided three times a week in lieu of white bread rations for British troops. Though there are no testaments to how British troops felt about their newly prescribed edibles, numerous metropolitan newspapers reported the new rations as part of their accounts of the Mesopotamian campaign. Willcox attributed much of the decline in beri-beri cases among British soldiers to the provision of the new hybrid bread. Likewise, to address the rise in beri-beri cases among the Chinese Labour Corps, Willcox and the GOC substituted part of their white rice ration with atta. This quickly ended the outbreak.\textsuperscript{273} Hybridizing certain aspects of servicemen’s diets was crucial to stemming deficiency diseases. The Mesopotamian warfront plainly transformed into a laboratory to advance nutritional science, medicine, and food provisioning and preparation. Diets shaped by race and ethnicity simultaneously produced health problems and suggested solutions to them.

With the fall of Baghdad to the combined Indian and British Mesopotamian Expeditionary Force in March of 1917, trade routes reopened and transport strains were alleviated. This drastically lowered the number of soldiers suffering from nutrition-related illness. Though experiments conducted from 1916-17 by staff at the Lister Institute for Preventive Medicine also proved the efficacy of wheat germ or bran in preventing beri-beri, Willcox’s observations of Indian and British diets in Mesopotamia lead him to mix diets and institute a new British ration earlier. These breakthroughs staved off a further rise in deficiency diseases among British troops.\textsuperscript{274} In some small measure, Willcox’s tenacity and ingenuity extracted both useful scientific knowledge and measurable health gains for all British soldiers across lines of race and ethnicity.

\textsuperscript{273} Ibid, 75.
\textsuperscript{274} Macpherson, \textit{Medical History of the War Vol. 2}, 92-5.
British officials and physicians were reluctant to continue these hybrid rations when transport and ration availability improved. At the Lister Institute, Dr. Harriet Chick and Margaret Hume concluded that cultivated, evaporated yeasts like marmite were especially potent in preventing beri-beri, though scientists had not yet identified the vitamin thiamine as its active ingredient. Researchers reported that marmite tasted akin to beef, which made it suitable for and welcomed by white British soldiers. Other Medical and Supply Officers did not adopt Willcox’s mixed atta bread, and in Willcox’s own area of oversight, marmite gradually replaced the hybrid baked good. Culturally traditional diets correlated directly to the types of deficiency diseases servicemen suffered during the war. They also determined the type of preventative and curative medicines that patients received.

Even marmite proved contentious. It became a standard addition to the British ration, but conditions of its manufacture meant that it could not be distributed to all imperial servicemen. In order to provide the marmite in an edible form on its own, the marmite ration mixed plain marmite with cane sugar, pea flour, and a separate ‘S2’ extract containing essence of onion, carrot, herbs, and a “small percentage” of garlic and bacon extract.275 This substance was sent to Basra from August 1916, but in September, Sir Charles Monro, the Commander-in-Chief of the Indian Army, pointed out that its meat content meant it could not be issued to Indian Army troops. It is unclear whether there was a gap before this notification and marmite’s arrival in Mesopotamia, during which servicemen may have been given the mildly meaty ration.276 Though beri-beri was virtually non-existent among Indians in the Mesopotamian campaign, the Lister Institute

275 Ibid, 84.
276 Ibid, 85.
nonetheless developed a vegetable, cottonseed oil-based tablet alternative. Officials authorized it for general use. With cases low to begin with, it is unclear how effective it was. Conversely, in 1917, Chick and Hume discovered that germinated lentils (daal) also contained antiscorbutics, making it a useful scurvy-preventative where soldiers could not access fresh vegetables and fruits. This breakthrough came too late to aid soldiers through the difficult months in Mesopotamia from 1915 to 1916, and rationing officials in districts and hospitals gave it only to Indian servicemen accustomed to eating lentils.  

Resistance to altering traditional diets clearly came from multiple directions – in some cases from servicemen with specific dietary restrictions, but more often, from government officials reluctant to introduce foreign and unfamiliar foodstuffs to active soldiers. Rationing authorities took action on beri-beri by prescribing British troops daal and atta-bread, but only for so long, and they were even less willing to introduce innovations or changes to the Indian diet.

Officials were sensitive to the religious provisions restricting servicemen’s consumption of various meats, but their acceptance of certain group’s dietary restrictions was tempered with grumbling, frustrations, and reservations. Despite their wholesale attempts to lessen the effects of deficiency diseases among troops of all races, scientific professionals repeatedly tied Indians’ nutritional maladies to their religion and customs, rather than the quality and availability of army rations. In a paper given at the July 1917 meeting of the Society of Tropical Medicine and Hygiene, Chick and Hume blamed Indian’s scurvy on their rejection of sound medical advice: Sepoys “failed… to obtain a sufficient supply of anti-scorbutic vitamine, owing to their refusal to eat fresh meat, in

277 Willcox, “The Treatment and Management of Diseases Due to Deficiency of Diet,” 75-76.
spite of the admirable and persuasive manifesto issued by Colonel Hehir upon the
subject.”278 British soldiers, on the other hand, were accommodating and understanding:
their propensity towards beri-beri was remedied once they “were obliged to share in the
more coarsely milled… grain of their Indian fellow-soldiers.” Chick and Hume
characterized sepoys’ scurvy as self-inflicted, despite their own admission in the same
paper that “animal tissues are distinctly inferior in anti-scorbutic properties to those of
fresh fruit or vegetables,” referencing the Artic Expedition of 1875 where liberal meat
rations did not prevent scurvy.279 Despite the widely held conclusion that meat was not
highly effective in warding off scurvy and other deficiency diseases, ‘experts’ continued
to press it as a nutritional necessity.

Willcox fiercely protested against the Government’s penchant for enforcing
rationing practices without considering contingency and new medical research. He
complained that as late as February of 1917, the Government of India sanctioned a ration
which “repeat[ed] the field service ration which was responsible for the enormous
outbreak of scurvy in the Indian troops in Mesopotamia.” It lacked any significant
antiscorbutic value and increased the chance of “great wastage owing to the incidence of
scurvy” among Indian troops in the Indian Army.280 “Rationing of this kind may appear
to those without special knowledge economical,” Willcox protested, “but… it is a false
economy. It seems incomprehensible that after the tragic experiences of Mesopotamia
the same mistakes should be repeated.”281 The peacetime Indian Army must effect

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278 Harriet Chick and Margaret Hume, “The Distribution Among Foodstuffs (Especially those Suitable for
the Rationing of Armies) of the Substances Required for the Prevention of (A) Beriberi and (B) Scurvy,”
Transactions of the Society of Tropical Medicine and Hygiene 10, no. 8 (July 1917): 166.
279 Chick and Hume, 171.
280 Willcox, “The Treatment and Management of Diseases Due to Deficiency of Diet,” 73-77.
281 Ibid., 77.
changes, he insisted, in rations to prevent scurvy. Those in charge of British army rations should take note of the wartime changes to introduce more diverse foodstuffs into the British diet.

If Willcox could not always convince administrators to diversify servicemen’s diets, his research succeeded in making headway on improving the types of rations they received. The 1923 review of wartime military medicine, *The Medical History of the War*, emphasized that the Mesopotamian experience provided two primary lessons for future engagements: first, that troops – particularly Indians – must be physically fit and nourished before taking to the field, and second, “that the quality of the field service ration is even of more importance than the quantity. If the necessary food substances are not properly represented in the diet the health of the troops becomes slowly undermined and much preventable sickness then results.”

The presence of a mass multiracial force in the war effort spurred a wide range of innovations and clinical studies. The trajectory of wartime debates over food and nutrition illustrate the way in which medical conditions endemic to colonial populations come to light during the war. In many cases these conditions were the result of colonial management and laboring conditions, rather than traditional dietaries. Wilcox, for example, continued to disparage the Government of India for its interwar reversion to old insufficient rationing system, and implored them to make permanent changes. The nutritional crises of the Great War produced comparison between races, but also called attention to the serious inadequacies in the preparation and administration of colonial governments. Many nutritionists and army officials made the case for changes and further

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studies into colonial nutrition and army provisions. They urged diversifying the diet of both British and colonial servicemen. The scientific approach toward rationing propelled by wartime deficiency disease fed into an ongoing debate over the importance of spiritually, culturally, and nutritionally-appropriate food in the soldier dietary.

**Conclusions: Cooking, Calories, and Changes in the Interwar Years**

The nutritional crises of the First World War spurred research into dietary health and nutritional deficiency that expanded in authority and scope throughout the interwar years. The wartime trials cemented lasting changes in army rationing, most visible in alterations to sanitary regulations and nutrition policy during the Second World War. Their impact on the lives of ex-servicemen back in the colonies varied greatly in nature and scope. This depended largely on whether a standing army was retained to continue implementing wartime changes.

For standing colonial forces like the Indian Army, the nutritional crises of the First World War permanently transformed systems of food distribution. New additions to the emergency ration rates made an appearance in rations back in India, and the creation of separate Winter and Summer ration rates were also carried through to the post-war rationing systems. New ration scales were introduced again in 1925, along with prescriptive advice to alter the consumption habits and customs of various servicemen. Responding to a

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283 The combined British Army had a lower sickness rate in the Western Desert Campaign due to improvements in sanitation, food preparation, and increased regulations on hygiene since WWI. See Mark Harrison, *Medicine and Victory: British Military Medicine in the Second World War* (Oxford: Oxford University Press, 2004), 91.

recent Ration Committee Report, Medical Adviser I. Smith advocated that “rice eaters should be trained to eat atta,” given its superior amount of protein (then calculated as 13.4% to rice’s 6.9%). Northern-based wheat-eaters already outnumbered those who predominantly ate rice, but the measures once again stressed the health and superior consumption habits of the northern “martial races” over soldiers from Madras and Bengal. These prescriptions were extended from army rations to jail rations, after Captain David McCay, a Professor of Physiology at the Calcutta Medical College observed that rice-eating prisoners ended up in hospital – and cost the government more – than wheat-eaters.

Other modernizing efforts ushered in by the war sought to improve soldier health and reduce waste. The Army’s Medical Advisor convincingly argued for using wastewater from cooking preparation to irrigate vegetable gardens in garrisons and cantonments. This effort boosted consumption of fresh vegetables. Replacing the pre-war emphasis on individual food preparation, the Army also reduced soldiers’ fuel ration by gradually implementing “combined messing.” Like the move away from single-regiment care to station hospitals (treated in Chapter 1), the war stimulated measures to improve efficiency, prompted by wartime health and food practices which spurred increasingly multi-ethnic and multi-regimental initiatives. Further measures attempted to improve the health of the soldier by ensuring that he did not spend his own ration allowance on his family: the 1920 Esher Committee Report (see Chapter 1) stipulated that soldiers’ wives and children should receive free rations.

285 Note by Medical Adviser on Ration Committee’s Report, April 2, 1925, 2-3, IOR L/MIL/7/18281.
287 Note by Medical Adviser on Ration Committee’s Report, April 2, 1925, 4-5, IOR L/MIL/7/18281.
Wartime deficiency disease and conflict over ration types and amounts drove both deeper studies into nutrition and race, and encouraged the reform of Indian Army rations well into the 1930s. The committees convened to report on army rations had differing conclusions about the adequacy of current scales, prompting a number of investigations into the calorific expenditure of sepoys engaged in different activities. If the war brought about incidental studies into nutrition and energy consumption of different soldiers, it also provided the impetus for further studies in the coming years. Officials were explicit about their mission to understand racial differences in nutritional contexts, citing the American endocrinologist Eugene F. Du Bois’ ruminations that “we know rather little about the difference in the metabolism of the different races.”

These studies were not conducted in isolation, but included details and results from similar research into calories and nutritional fitness of British Army soldiers in India. The organizers of the Indian Army study explicitly arranged it in a manner that rendered results comparable, to understand how the Indian body differed from the British. The Military Food Laboratory carried out the experiments at Jubbulpore in the Central Provinces — “the same climactic conditions” as the 1926-27 Study on British soldiers by RAMC officers Major D. T. Richardson and Major W. Campbell. Men were chosen to represent both the three army unit types: cavalry, artillery, and infantry, and to represent different ‘martial races’ – Sikhs, Pathans, United Province Rajputs, Gujars, Punjabi Muslims, Dogras, Gurkhas, and one Madrasi. Officials chose men who represented the

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‘average’ of their ethnic class, measuring this by soldiers’ “average surface area.” 290 But even under the constraints of a peacetime scientific study, religion intruded: the Pathans involved in the study participated in Ramadan, necessitating a change in their designated eating times, and groups which generally avoided meat (the one Madrasi subject, the Rajputs, and the Gujars) continued to abstain. The organizers recognized that there were other unavoidable, functional differences in the study, namely concerning bodily performance. “As is well known,” their final report concluded, “the movements of the lower limbs of an Indian soldier while marching are quite different from those of a British soldier. He is no doubt taught to march according to the instructions in the drill book, but it is an unnatural mode of progression for him and the skill acquired must vary in different individuals.” 291 The study deduced that on the whole, the Indian Army ration was deficient, though not as badly as originally thought – 21.5% instead of 30%. 292 It urged an increase in daily-allotted calories for artillerymen and cavalrymen in particular, and advocated further studies into the calorific values of Indian foods.

This expansion of nutritional science within colonial militaries was accompanied by an increase in nutritional studies in colonial civilian populations. Historians of colonial medicine identify this burgeoning interest as the “discovery of colonial malnutrition.” 293 Michael Worboys argues that colonial food science was spurred by increasing interest in the linkages between diet and economic productivity. 294 Yet as this

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290 Ibid, 3.
291 Ibid, 16.
292 Anderson to Thomkins, December 28, 1928, IOR L/MIL/7/18282
chapter has illustrated, this interest did not arise out of interwar concerns alone. It was vitally preempted by the wartime drive for knowledge about colonial populations and their laboring capacities. The debate over the relationship between ethnicity, culture, and nutritional health laid the groundwork for a new and vital field of medico-scientific enquiry in the interwar decades.

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The mobilization of forces from all reaches of the British Empire constituted an unprecedented challenge: the feeding and nourishment of a multiracial, multireligious, and multicultural body of over eight million servicemen. War Office officials, army officers, nutritionists, and line cooks, all attempted to sustain both men’s physiological health and their psychological well-being. They took on this mission by preparing fare with varying aims. Food could fuel the body with nutritional value, fit cultural and religion customs, and take away, however briefly, the strangeness of the war that soldiers found themselves in. Yet as this chapter has shown, these efforts were complicated with practical impediments, occasional dissent, and moments of cross-cultural mixing and connection. These fractious discussions brought about changes in soldiers’ experience of diet and cultural tradition, as well as military and medical experts’ understandings about what servicemen from varying backgrounds and ethnicities would consume.

This multicultural army demanded flexibility. British soldiers began to consume atta, West African and West Indian servicemen insisted on rice, meat-eating sepoys went vegetarian, and King George ate chuppatis. Neither military guidelines, nutritional prescription, nor religio-cultural norms reigned supreme. Colonial and metropolitan soldiers alike could not be distilled down to “Indian stomachs,” “Jamaican stomachs,” or
“English stomachs” – they transformed official knowledge by alternately contesting, hybridizing/sharing, and remaking their relationship with food.
Chapter 3: Nerves
Non-white Trauma and Military Psychiatry

On Tuesday, 4 February 1930, the Royal Medico-Psychological Association held its regular quarterly meeting in Alderley Edge, Cheshire. After a paper delivered by Major J. E. Dhunjibhoy of the Indian Medical Service (IMS), the subject of Indian soldiers and “shell shock” arose. It was the first time that the Association had addressed the issue. Dhunjibhoy, Superintendent of the Indian Mental Hospital in Ranchi and one of the first Indians accepted into the IMS, was not in Cheshire to talk about soldiers. His lecture focused on mental disorders found in India, including the then-popular subject of “hemp insanity.” However, the talk turned from cannabis to war neuroses. Dr. Donald Ross recalled his own service with an Indian cavalry division during the war, among whose fine units, he claimed, “‘shell shock’ was practically nonexistent.” Dhunjibhoy agreed. He too had found “very little insanity” in the Indian Army. Most Indian cases of supposed insanity, he alleged, were nothing more than dishonest malingering.

The numerous troops from the subcontinent admitted to British and Indian institutions for psychological symptoms during WWI contradict these claims. At Brighton, the site of the largest complex of war hospitals for Indian casualties in Europe, demand compelled organizers to set up a two-ward asylum by 1915. Mental hospitals in the Bombay Presidency, including the Central Lunatic Asylums at Yeravda and Naupáda, where many soldiers from the Mesopotamian campaigns were shipped, admitted over 570

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295 Dhunjibhoy’s time as Superintendent at Ranchi has been well documented by Waltraud Ernst. See Ernst, *Colonialism and Transnational Psychiatry: The Development of an Indian Mental Hospital in British India, c. 1925–1940* (London: Anthem Press, 2013).

“military insanes” from 1915-22. Superintendents of asylums from Bombay to Bengal reported overcrowding and tight resources due to the influx of soldier-patients. The problem extended to other British colonies whose soldiers served in the Great War. The Kingston Asylum in Jamaica accepted a multitude of “military insanes” from the Caribbean, and psychiatrists repeatedly referenced West Indians in cases of mental neuroses in wartime Labour Corps. The rising psychological crisis was clearly not limited to white troops.

It hardly seems possible that Maj. Dhunjibhoy was unaware of war-connected trauma among Indian soldiers. From 1923-5, he served as Superintendent of the mental hospital at Berhampore, West Bengal, which treated 143 “military insanes” at the height of the overpopulation crisis in 1919. Four years later, during Dhunjibhoy’s tenure as chief, nineteen of these soldier-patients still remained, for whose maintenance costs the Asylum debited the Military Department. What can account for Dr. Ross and Dhunjibhoy’s claims in light of the substantial number of non-white servicemen suffering the psychological effects of war in mental hospitals in Britain and India, some of whom they must have encountered? At a time when a global health system based on difference was emerging in the British empire, what were the stakes for British and Indian physicians and psychiatrists in recognizing – and, just as crucially, not recognizing – psychological trauma among non-white soldiers? And was it possible for physicians to

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297 See n. 76 below.
provide culturally informed healthcare for non-white troops without reproducing the racist assumptions that perpetuated starkly uneven distribution of medical resources?

Officials and colonial physicians responded to non-white servicemen’s mental health crises in diverse ways. Some refused to acknowledge them; others attended closely to their understanding of soldiers’ culturally-specific needs. Their assumptions had profound and enduring implications for the diagnoses, care, treatment, and aftercare of soldiers in Britain, South Asia, and the British West Indies. Examples of officials’ and doctors’ blatant racism abound. At the same time, I’ve also found stories of doctors’ and officials’ solidarity with and sensitivity to non-white troops as they struggled to meet the challenges of providing mental health care for one of the world’s most ethnically, racially, and religiously diverse labour forces – the combined British Army.

Historians of colonial medicine and psychiatry have built an extensive, if variable picture of what mental healthcare looked like in the British Empire, particularly since the rise of psychiatry in the 1920s. Waltraud Ernst, Sloan Mahone, and Meghan Vaughan, among others, tracked colonial emergence of the psychiatric and psychoanalytic subject, and probed the strange relationship between the Fanon-inspired “madness of colonialism” and the “madness of the mad.” Their work often grapples with questions of culture and universalism: to what extent does cultural practice and ethnicity impact how treatment

should be provided, are mental illnesses expressed in culturally-specific or universal ways. At the same time, the last two decades have seen a surge of interest in the colonial servicemen who, in part, rendered the Great War the first global war.  

This defining moment of imperial mobilization is paralleled by the War’s status as a watershed for military psychiatry. The legacy of “shell shock” is firmly embedded in historical memory of the war, in part because of historians’ treatment of traumatic war neuroses as both a medical and cultural phenomenon. Several interrogate how class and ethnicity, notably Irishness, affected soldiers’ diagnosis and treatment. Yet this robust historiography remains overwhelmingly white and European. In studying how colonial subjects interacted with psychiatric regimes outside of the colony – in an arena where white civilian soldiers also suffered abrupt psychological crises – this chapter prompts new questions about how mental illness, race, and imperial ideologies inflected and shaped

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one another. The war’s effects on the politics and practice of healthcare elucidates the challenges of – and to – imperial governance posed by the treatment of patients situated between military and colonial administrations.

The wartime environment put pressure on well-established racial ideologies – from the stoicism and blind obedience of the so-called martial races of northern India, to the childlike primitivism of Afro-Caribbean men. Mental health treatment in the Great War served as a site in which monitoring the morale of “men of different races” revealed the flexibility of racial categories. I do so by examining the cultures of care and treatment largely for South Asian soldiers, or sepoys, in the Indian Army. The demands these men made on the British military state prompted a number of British officials and physicians to legitimize and demand culturally specific care for mentally wounded colonial servicemen. In contrast, British clinicians frequently diagnosed non-combatant servicemen like the British West Indies Regiment with hereditary disorders and “feeblemindedness.” Like non-combatant white British laborers, their illnesses were distanced from “shell shock” and the new array of war-induced traumatic neuroses. Yet disputes over the validity and treatment of non-white mental illness continued into the interwar period. By the mid-1920s, medical and military establishments alike preferred to avoid rather than confront both white and non-white trauma. Amnesia around non-white “shell shock” pervaded interwar psychiatry.

The historiographical gap about the impact of race on psychological trauma is a testament to this amnesia. This chapter points to problems systemic to imperial governance and global healthcare within and beyond the British empire: the persistent

paradoxes of (colonial) difference. At first, officials perceived race as the master category determining whether, and how, to treat soldiers. Yet as they treated colonial servicemen, officials increasingly confronted just how much ideas about racial difference intersected and entwined with ideas about class, caste, and deservingness. Intermittent denial of non-white trauma led to stark disparities in care as the suffering were kept on duty. However, soldiers sometimes were better served by care accessed through their families and treatments back at home than by the experimental, uneven treatments developed by British psychiatrists. Likewise, the cultural amnesia surrounding Indian war trauma served both colonizer and colonized alike, albeit for quite different reasons. For British officials, it preserved the imperial order by maintaining ideals of colonial difference—between white and non-white and between different ethnicities that made up the Indian Army. For some of the colonized—Indian soldiers, officers, and clinicians—it silenced fears that the stigma of mental illness might damage the prestige and standing of the Army and, in some cases, their own anti-colonial, nationalist cause.

I. South Asian “Martial Races” and Trauma in the West

When the War Office began mobilizing British forces, they swiftly agreed to order sepoys of Great Britain’s Indian Army to the front. In the aftermath of the perceived disloyalty of sepoy troops in the 1857 Indian Mutiny, British officials shifted recruitment away from Bengal in the East to the Punjab and Nepal in the North. They believed that such men, predominantly rural Sikhs and Gurkhas, were members of the “martial races,” preternaturally disposed to the arts of war. This would make them loyal “model soldiers” when guided by British officers. Dispatched to France shortly after the
German invasion in mid-August 1914, they arrived by ship via Marseilles, in late September and October. By March 1915, two Indian Army infantry and two cavalry divisions – some 28,500 Indian and 16,000 British troops – served in action at the catastrophic battle of Neuve Chapelle.\textsuperscript{305} Many already presented symptoms of psychological decline. From the moment of their deployment, the India Office analyzed and compared sepoys by martial race, which in turn affected soldiers’ medical treatment.\textsuperscript{306}

The wartime demand for manpower widened recruiting for combat regiments to men from outside the traditional ethnic martial races. Still, the majority of these troops were from the northern provinces of the Punjab and the North-West Frontier and across the Raj’s border in Nepal, with relatively few from the south and east.\textsuperscript{307} This continued the deliberate categorization and ranking of eligible martial races, the definition of which expanded to lower caste and urban groups as casualties mounted among the established orders of “fighting classes.”\textsuperscript{308} Wartime demand for soldiers encouraged flexibility about which groups constituted martial races, but the race-based theory itself remained.\textsuperscript{309}

Monitoring Indian soldiers’ moods and morale was primarily the job of the Army’s censors, who carried out an intense, double-layered review of the copious flow of

\textsuperscript{305} John Morrow, \textit{The Great War: An Imperial History} (New York: Routledge, 2004), 81.
\textsuperscript{309} Streets, \textit{Martial Races}, 4–5.
South Asian servicemen’s correspondence. Even illiterate sepoys sent letters home by enlisting fellow soldiers, orderlies, or followers to transcribe their messages. British officials monitored this correspondence as early as December 1914. The first level of censorship took place in the regiment, where officers crossed out sensitive information (geography, village names). The Indian Mails Censor Office comprised a second level, which weeded out subversive or anti-British material. In contrast, the British Army did not begin detailed, individual censorship of British soldiers’ correspondence until early 1918. Expanded conscription and poor morale on the home and battle fronts pushed the War Office to full-scale perlustration.

The Indian Mail Censor Office, established in November 1914 and based out of Rouen and later Boulogne, was headed by Evelyn Berkeley Howell, a long-serving officer of the Indian Civil Service. From the start, Howell probed the letters for clinical insights and evidence of loyalty and spirit. “The letters from France,” he declared, “are an interesting psychological study and throw light on the morale of the troops.” His reports show that he understood the mental as well as physical impact of war. Discussing

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310 Murray to War Office, November 30, 1914, IOR L/MIL/7/17347.
311 India Office officials found it more difficult to enforce broad surveillance as the war went on: combat and illness progressively shrunk the already limited pool of officers and staff with knowledge of the soldiers’ vernaculars. Furthermore, servicemen grew increasingly aware that their correspondence was examined. On the Indian Censor Archive, see Claude Markovits, ‘Indian Soldiers Experiences in France During World War I: Seeing Europe from the Rear of the Front’, in The World in World Wars: Experiences, Perceptions and Perspectives from Africa and Asia, eds. Ravi Ahuja et al, (Boston: Brill, 2010).
some troubled letters, he observed that the writers, “have apparently been in the trenches, and their nerves have been affected.”

Censors understood the psychological dimension of morale. Howell’s superiors also saw his work as a window into Indian psychology, and hoped to use its unique insights to guide future military policy. In February 1915, the India Office called on Howell’s censors to “[give] us some work of analysis of the classes and regiments from which the more despondent views [are reported].” The memo added, “We all are aware of the great differences that exist in the soldierly qualities of the various classes comprising the Indian Army, not only in courage which is common to most of these, but in grit and endurance, which latter virtues have been severely tested by this present war.”

Howell diligently categorized letters by martial race. One month later, he “note[d] the different behaviour of men of different races under pressure of despair.” Howell’s clinical stance towards the suffering of soldiers is emblematic of the India Office’s approach towards Indian involvement in the war. By focusing on psychological attitudes, censors engaged in a scheme of classification and codification of mental stability according to ethnicity and tribal groups.

Howell brought to his reports an extensive knowledge of Indian language and culture. Born in Calcutta and schooled in England, he returned to join the Indian Civil Service. In 1906, he become Political Assistant in the North-West Frontier Province, and in 1910, Deputy Commissioner of the frontier city of Kohat, a longstanding area of political contention, resistance, and violence between the British and independent tribal

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315 India Office to Evelyn Berkeley Howell, February 15, 1915, IOR L/MIL/5/825/1.
316 Censor Report, March 27, 1915, IOR L/MIL/5/825/2.
populations. Kohat and its surroundings were populated largely by different Pathan tribes, from Afridis and Wazirs to Mahsuds. In an attempt to control these “ungovernable” groups, the British administration operated largely through local chieftains, meeting them with swift violence when indirect governance failed. In these posts, Howell had extensive contact with the sepoys of the Indian Army – predominantly middling peasantry and minor gentry from the rural north of India – as well as with other frontier tribes from which the Raj’s Indian Army began recruiting as early as the 1880s. Army recruiters organized men into regiments by martial race. Howell borrowed these categories and their embedded logics for his censor work.

In censors’ reports, observations on the attitudes of caste-clusters or regional groups followed short paragraphs of general reactions and reflections. Reports typically ended with a table of contents of notable features, along with a notation as to whether the letter was passed on or destroyed. The transcribed letters, organized by ethnic group, were attached. Howell’s 28 August report, for instance, listed correspondence under categories of “Pathan (Orakzai),” “Pathan (Mahsud),” “Pathan (Afridi),” “Pathan (Swati),” and “Punjabi Musalman,” followed by “Sikh,” “Hindu of West Punjab,” “Dogra,” “Jat,” “Rajput,” “Hindustani Musalman,” “Gurkha,” and “Maratha,” among others.

Howell applied racial categories to desirable and undesirable qualities. During the week ending on 23 January 1915, “despair” was not “confined to any one class;” he

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qualified this with the observation that “the Pathans are least affected as might have been anticipated.” In other reports, Howell attempted to quantify morale. On 12 February 1915, he recorded that “Of the Garhwalis 3 are soldierly and 1 despondent. Of 2 dogras [sic] 1 is very despondent and one soldierly. 3 of the Punjabi Mahomedans are soldierly while the 4th and the Gurkha are despondent. The Pathan, the 2 Jats, and the Muhamedan are soldierly.” Designating certain groups of men as “soldierly” cemented the understanding of high morale and steadfastness as an indicator of robust mental health.

However, in Howell’s review of the letters, war trauma and mental disturbance clearly resisted neat ethnic differentiation. He found it difficult to pin down a consistent profile of individual groups. On 16 January 1915, he claimed that “the Dogras seem to be the class which gives way to despondency most,” yet later reports identify melancholia in other groups. On 27 March, he reported that the “Muhammadan of the Punjab wails and prays;” on 24 April he recorded that Sikhs were the most downcast group. Various descriptors – “melancholic,” “devious,” “despondent,” and the prized “soldierly” – were repeatedly attributed to different ethnic groups. His use of the word “seem” marks his recognition that his empirical data refused to fall into orderly race-based categories and patterns.

Joanna Bourke has identified similar debates about the heightened levels of war neuroses seen amongst “martial race” Irish soldiers during the Great War. The War

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320 Censor Report, March 27, 1915, IOR L/MIL/5/825/2; Censor Report, April 24, 1915, IOR L/MIL/5/825/3.
321 Likewise, Gerard Oram’s work on military execution and court martials during WWI has established that colonial troops, including the Irish, were executed at proportionately higher rates than white British troops. Military punishment was tied to psychological health in the sense that shell shock was often configured as a disciplinary issue, rather than as a legitimate medical problem. Oram observes that ethnic minorities or “colonial”-figured troops, like Serbs, Croats, and Poles in the Hapsburg and German armies also suffered harsher forms of discipline. See Joanna Bourke, “Shell-shock, Psychiatry and the Irish soldier
Office and Ministry of Pensions officials commonly claimed that Irish fighters were more prone to madness, a contention seemingly supported by the disproportionate numbers of servicemen from “Ireland (South)” in receipt of pensions for neurasthenia. Psychiatrists and army medics attributed high levels of “lunacy” to ethnic weaknesses and ill-development – alternately explained by the “inferior” place of the Irish in the progress of civilization, “mental weakness” from the famine generations, or a supposedly infantile state as imagined “children.” Physicians and pension authorities meted out different treatment to different people in the so-called martial races. Some Irish soldiers were considered malingerers, while others attracted varying degrees of therapy.

In comparison to the Irish, the “martial race theory” surrounding Indians was far more developed and differentiated: each ethnic group was associated with specific characteristics and traits. Different characterizations of mental conditions produced different findings. Indian Army officers and censors spent more time comparing Indian regiments to each other than in searching for parallels and connections to British servicemen.

In many of these reports, Howell categorized soldiers only by their martial-race identifier and not by their regimental battle or deployment experience. This approach was explicitly colonial. No military censor of British troops supposed that men from the rural Pennines suffered from war neuroses more frequently than the Londoners and Mancunians. Analyzing colonial soldiers by ethnic groups and generalities, rather than the specific experiences of their regiments, led both to the identification of conflicting

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and contradictory “ethnic” traits – and to the first official detection of non-white war trauma.322

While soldiers rarely wrote from their hospital beds or post-diagnosis of their psychological troubles, the dislocation of the front clearly affected them. Some relayed their struggle in their letters. In December 1915, Lance Naik Phina Ram declared to a friend in Kangra, “Since I joined the regiment I have always been having shocks.”323 The environment of the front and the horrors of mechanical war produced “shocks,” but so too did the long journey and foreignness of Ram’s new surroundings. These feelings were echoed in other letters. Sant Singh lamented to his wife in September 1915, “We perish in the desert: you wash yourself and lie in bed. We are trapped in a net of woe, while you go free. Our life is a living death… We are slaves of masters who can show no mercy. The bullets fall on us like rain, but dry are our bodies.”324 When friends and family noted or complained about their lack of spirit, some sepoys rejected their encouragement to stay positive. Writing to the Zemindar Dhani Ram in Rohtak from his Cavalry Brigade in France, the Sowar Nawal Singh protested, “You say to me ‘Do not write to me in a disturbed manner,’ and you accuse me of having become troubled in the mind. No, the fact is that you asked me to say truly how things were here, and so I wrote plainly and

322 Joanna Bourke has identified similar debates about the heightened levels of war neuroses seen amongst “martial race” Irish soldiers during the Great War. The War Office and Ministry of Pensions officials commonly claimed that Irish fighters were more prone to madness, a contention seemingly supported by the disproportionate numbers of servicemen from “Ireland (South)” in receipt of pensions for neurasthenia. Psychiatrists and army medics attributed high levels of “lunacy” to ethnic weaknesses and ill-development – alternately explained by the “inferior” place of the Irish in the progress of civilization, “mental weakness” from the famine generations, or a supposedly infantile state as imagined “children.” Some Irish soldiers were considered malingerers, while others attracted varying degrees of therapy. See Bourke, “Shell-shock, Psychiatry and the Irish soldier during the First World War,” 158.
323 Phina Ram to Lachman Brahman, December 28, 1915, IOR L/MIL/826/1.
324 Sant Singh to his wife, September 18, 1915, IOR L/MIL/825/6.
told you.” These reports diminished soldiers’ acute suffering and reduced their accounts to tallies of moods and dispositions, their letters provide emotive evidence of the daily agonies and horrors they witnessed, and of some soldiers’ refusal to sanitize their experiences for their readers back home.

As Howell constructed failing racial typologies of trauma, he and other wartime administrators in the India Office invoked Orientalist stereotypes, from deviousness to cowardice, to back accusations of Indian’s disloyalty and deception. They interpreted displays of weakness, anxiety or unwillingness to go into battle as malingering, rather than as legitimate conditions for treatment. To account for the number of Sikh men invalided to hospital in March 1915, Howell noted that, “The Sikh either grows sulky or tries to malinger.” Suspicions of fakery led to a heightened scrutiny of suspected self-wounding, non-life threatening gunshot injuries often on the fingers or hands. Officials suggested that Indian soldiers in particular were prone to these acts. As early as 1915, the Indian Medical Service commissioned a study on self-mutilation in the Indian Army, part of an effort to discover potential signs of Indian disloyalty. Records indicate no other ethnic-specific study of self-mutilation conducted during the War.

A 1915 study, directed by Col. Bruce Seton, the commander of the Indian hospitals clustered in Brighton, analyzed one thousand wounds received in action, with the stated goal of “clearing up, if possible, the question of the degree of prevalence, if any, of self-in infliction of wounds among Indian troops.” Seton methodically conducted a detailed, retrospective study of medical injuries which focused on wound location.

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325 Nawal Singh to Dhani Ram, December 29, 1915, IOR L/MIL/826/1.
326 Censor Report, March 27, 1915, IOR L/MIL/5/825/2.
cause of wound, and handedness. His findings seemed to contradict British officials’ suspicions. Although there was “an extraordinarily well marked preponderance of wounds of the hand in certain classes of fighting” (i.e. certain ethnic groups over others), statistics indicated that there was no strong evidence of self-infliction. “It would appear to be fairer… to seek some other explanation,” he concluded, before making broad judgments about invalided Indians.\(^{328}\) The army marked Seton’s report “Top Secret.” His exculpatory findings never circulated during the war. Perhaps the India Office feared that long-loyal groups of sepoys would be outraged by the mere existence of a study that doubted their character. Or possibly, the India Office itself was reluctant to exonerate Indian soldiers from accusations of malingering.

As the war progressed, military and colonial authorities continued to debate Indian malingering. Sir John Collie, a chief advisor to the military, saw matters quite differently from Seton. In 1917, he revised his 1913 workmen’s compensation manual for pension tribunal physicians. The first case of “malingering” he cited in his revised volume was “K. P., a Sepoy,” whose hand injury he deemed faked. Collie argued that K. P.’s condition had been purposefully aggravated by “deliberately and constantly sitting on his thumb” – a practice “quite easy for an Indian to do… as squatting is his normal attitude.”\(^{329}\) He thus deployed the physical culture of Indian soldiers against them. The same prejudices brought to the treatment of physically injured troops were invoked in censors’ perceptions of sepoys’ psychological ailments, which were even more difficult to “prove.”\(^{330}\)

\(^{328}\) Ibid., 8.
\(^{330}\) As court martial records for the Indian Army in WWI have not survived, it is impossible to judge the
Treatment of suspected malingers could be harsh even if they did not face military charges. Ram Singh, a ward attendant at the Kitchener Hospital in Brighton, lamented that doctors put lame men on duty, labeled them malingerers, and sent them back to France. Despairing, Singh wrote to Jam Dhola Singh of the 47th Sikhs, “The very dust of which we made is corrupted. They even punish a man for going lame. My brother, I cannot get rid of my lameness.”\(^{331}\) Indian troops’ letters betray their frustration at accusations of playing truant. The Indian Commissioner for the Sick and Wounded, Walter Lawrence, sympathized. “It is an unfortunate thing,” Lawrence acknowledged, “that persons should have jumped to the conclusion that self-infliction of wounds was a common practice, and I know that the Sepoys felt this.”\(^{332}\) The role of race in soldier pain and trauma divided the British wartime bureaucracy, at once reinforcing and challenging older preconceptions about the supposedly inherent qualities of martial races.

II. From Doubt to Diagnosis: Treating Indian War Trauma

Treating the thousands of wounded Indian troops necessitated the creation of an entirely new network of hospitals and medical auxiliary facilities in Britain. The biggest complex was in Brighton, whose port made it a prime location for transfers from France. Brighton’s Royal Pavilion estate was converted from a public city venue to accommodate 724 beds. At York Place, council schools were transformed into a hospital intended for difficult cases, while the Elm Grove workhouse housed Europe’s largest number of

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\(^{331}\) Ram Singh to Jam Dhola Singh, October 21, 1915, IOR L/MIL/5/825/7.  
\(^{332}\) Walter Lawrence to Lord Kitchener, December 27, 1915, TNA, War Office (hereafter WO) 32/5110.
Indian casualties. Renamed the Kitchener Hospital after the Boer War hero recently appointed Secretary of War, York Place and Elm Grove held over two thousand soldier-patients.

The India Office carefully designed facilities for both medical and ethnic differentiation, to accommodate soldiers of numerous faiths and medical needs. In addition to rooms for surgery and physical rehabilitation, they also included spaces for psychological care and confinement. The Kitchener Hospital opened a separate building for “mental cases,” outfitted with twenty beds, four padded cells, and “every modern provision,” from wire-gauze windows (in place of bars) to protected radiators. Organizers took every precaution to prevent inmates from self-harm. Windows were fitted with special locks, hot pipes and Tobin ventilation tubes were enclosed in perforated iron sheeting, and toilets were flushed by taps, with tank chains removed.

This ward received “mental cases” amongst Indian troops in France who were thought serious enough to warrant hospitalization. Though individual case files do not survive, the 1915 Asylum report documents the general course of treatment in the ward. Neurological and psychological diagnoses were nearly always accompanied by qualifications and explanations involving race. Indeed the 1915 report cast official suspicion on the genuine nature of many cases. Admitting that one Baluchi patient out of six had “undoubted hysterical fits in addition to his mental disturbance,” it charged the rest with malingering and claimed that the fellow Baluchis “copied these [fits] with more or less accuracy.”

J. B. de Winter Molony, the IMS officer in charge of the Kitchener Asylum, did recognize mental illness. “The strains to which all these men had been submitted… would try any man who had any tendency towards mental weakness,” he asserted. Yet despite invoking the universal “any man” – suggesting that he too may have suffered – he divided his cases into three distinct categories. He attributed only the first set to “trauma.” Molony diagnosed these four cases – out of a total twenty nine in the ward – with a combination of traumatic hysteria and head injury. The second category suffered from “acute mental disease” and mania notable for their “unusual physical disturbance.” Molony designated the remaining two cases as individuals of “obviously low mentality.” These patients, he alleged, “would have been thrown off their balance by any slight mental strain.” Molony made no suggestions as to the latter conditions’ cause, nor any observations on the results of treatment, since all mental cases were dispatched to India as soon as they were physically fit and could be found accommodation on a hospital ship.

Molony had no background in psychology or nervous disorders. Trained in Edinburgh after serving two years with the Calcutta Light Horses, he joined the IMS as a specialist in gynecology and pediatrics. Nonetheless, Molony seems to have followed new professional diagnoses and debates concerning “shell shocked” white soldiers. He identified two cases as “Not Yet Diagnosed” (N.Y.D.) Mental cases, a fuzzy label applied to sufferers of war neuroses. He sympathetically aligned two patients suffering from “hysteria” with white victims of industrial accidents. Their hysterics “were typical traumatic hysteria,” he argued, “such as one finds among coal miners and quarry men, after severe accidents.”

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336 Ibid.
337 Ibid.
nor racially-differentiate their condition. Yet while he equated Indian hysteria with white hysteria, it was perhaps no coincidence that his NYD and “hysteria” cases were soldiers rather than labourers. This suggests that Molony, like many of his contemporaries, believed that only fighting men could suffer war induced trauma, not those who served beside them doing menial work.

Despite the focus on race, the Kitchener Hospital’s treatment of Indian soldier-patients resembled that accorded to whites. Both reflected the era’s lack of medical answers to psychiatric trauma and disturbance. The Asylum’s 1915 Report explains, “The chief treatment adopted was exercise, fresh air, and plenty of light food,” with hot water baths employed as “the most efficacious way of quieting the violent.” Only one drug trial was conducted, treating one Mahsud daily with ninety grains of Bromide. Potassium Bromide was fairly standard treatment at the time, used as a sedative and anticonvulsant on epileptics and in mental hospitals. Molony abandoned it after a month when the patient showed no signs of improvement.

The few established psychologists interested in experimental treatments for war neuroses were stationed with and preoccupied by the flood of ill white soldiers. For a time, W. H. Rivers’ Freudian psychotherapies predominated at the British hospitals of Maghull and Craiglockhart, and Lewis Yealland’s controversial cures, produced by shocking mute or traumatized soldiers with cigarette burns or locking them in dark rooms, were practiced only on white soldiers. The Brighton Hospitals were equipped with radio electrical equipment and an Electrical and Galvanic Treatment Room, but there is

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338 Ibid.
no record of their use on cases from the mental ward. Their racial identity may have spared Indian casualties from some of the invasive, pain-oriented therapies that white soldiers endured.

Likewise, sepoys’ correspondence illustrates how many sought healing therapies – and sometimes substances to render them sick – from home. Soldiers asked for amulets and drugs to protect themselves and self-medicate. Nizam-ud-Din, serving with the 129th Baluchis, requested a replacement amulet for his comrade Bagh Ali. “Send word to his home,” Nizam wrote, “A few days ago he lost his ‘tawiz’ (amulet) and now he has begun to be possessed and subject to seizure at intervals.”340 Others sought opium and cannabis. Letters requesting packages of drugs rarely passed beyond the military censors, and most soldiers had trouble obtaining them. Bir Singh wrote home in January 1916 with mailing instructions to help substances bypass postal inspection: “You say that the parcel came back from Bombay… If you wrote ‘opium’ on it, do not do so again, but put ‘sweets’ or ‘dainties’ on it, and send off the opium.”341 Whether desired as customary habit or as a coping mechanism with the stresses of war, sepoys continued to seek remedies from traditional medicine at home. They refused to put all their faith in colonial medicine alone.

The recognition that some Indian soldiers suffered “genuine” nervous collapse did not diminish officials’ enthusiasm for seeking patterns rooted in ethnic groups and inherited categories. White soldiers buried by collapsing trenches or dug-outs suffered “buried alive neurosis;” the same diagnosis for Indian troops was “trench-back” or “hysterical spine.” Commissioner Lawrence recognized that these victims seemed

340 Nizam-ud-Din to friend, April 26, 1915, IOR L/MIL/5/825/3.
“crushed both physically and mentally,” and reported that sepoys could suffer “from the shock caused by the explosion of bombs,” producing “madness and epilepsy.” Yet Lawrence still saw these patients through the lens of a clinical ethnography. Despite the apparent randomness of cases, he wrote to Kitchener, “It has been noticed that the Pathans seem most liable to these mental shocks.”

In December 1915, Lawrence noted the prevalence of severe depression and phthisis (pulmonary tuberculosis) among Gurkha troops, including a case in the York Place Hospital that resulted in suicide. One Gurkha officer relayed to Lawrence that the victim, Lachman Rai, “was depressed by reason of the loss of his officers and his friends.” Lawrence acknowledged the potential role of psychological trauma, yet noted that the suicide case was “From a very peculiar class” in Darjeeling, and a “Rai Linbi,” a caste group that was introduced to the Nepali military comparatively late (although a standard part of the Indian Army by the 1860s). By assigning the soldiers’ suicide-inducing melancholia to ethnic class and “caste” identity – as in his singling out of Pathans with “trench-back,” – Lawrence implied that larger collective identities predisposed colonial soldiers to psychological disturbance.

Men like Lawrence were well-informed about studies documenting growing concerns about the British armies’ mental health. In May 1915, Lawrence mused “some

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342 Lawrence drew on his own accumulating colonial knowledge when analyzing soldiers’ health. A longstanding member of the Indian Civil Service, Lawrence had served as the settlement commissioner of Kashmir and a member of the Council of India. These experiences on the northern borderlands of the Raj culminated in his 1895 ethnographic history *The Valley of Kashmir*, establishing him as an authority on the Indian frontier and its martial peoples. Walter R. Lawrence to Horatio Herbert Kitchener, July 21, 1915, BL Mss Eur F143/65.
344 Walter R. Lawrence to Horatio Herbert Kitchener, December 14, 1915, Mss Eur F143/65.
345 *Ibid.*; Inquisition taken on the view of the body of Luckman Rai at the York Place Indian Hospital, October 23, 1915, East Sussex Record Office, Brighton, UK.
of these cases [of trench-back] are not genuine.” By July, he acknowledged the research at the Pavilion Hospital, Brighton, observing that “the general opinion seems to be that the majority of these cases are genuine.”346 This revised understanding was echoed by John Drummond Sandes, the IMS officer in charge of the Kitchener’s Electro-Therapeutic Institute. Drummond Sandes believed trench-back was a physical rather than psychological ailment, but he did not differentiate between different races or tribes of sepoys as others like Lawrence did. Instead, he aligned his cases with white traumatic cases of industrial accidents. Indian patients who displayed a “psychical factor,” presented features “similar in many respects to the condition known as ‘railway spine.’”347

Traumatized soldiers were rarely in a condition to write home, but the Censor Archive provides rare glimpses of their wartime encounters. In October 1916, the signaller Nur Mohamed Khan recounted the mental breakdown of fellow soldier Lal Khan to a friend back in India. After his commanding officer threatened to send the unresponsive Lal Khan to the Andaman prison colony, Khan “got fever through fright” and was sent to a nearby hospital. Upon entering, he “was screaming and crying and the patients were astonished at the sight of this new arrival with his pale face and hair turned white. He said he was dying. The next day the patients all said to the doctor sahib ‘Either take this man away or remove us from the hospital.’”348 Lal Khan’s nervous episode disturbed other Indian patients, who viewed his collapse with anxiety. Lawrence noted that traumatized

346 Lawrence to Kitchener, May 27, 1915, Mss Eur F143/65; Lawrence to Kitchener, July 21, 1915, Mss Eur F143/65.
soldiers were known in the New Milton Convalescent Home as “lungra-lulus.” Lawrence likely mis-transcribed the term. It seems to correspond to the Hindi phrase \textit{langra-lula}, meaning disabled or handicapped. Convalescent sepoys’ use of this phrase to describe these soldiers indicates their awareness of the growing problem of wartime mental illness.

Lal Khan, Nur Mohamed Khan recalled, was eventually removed to India and branded unfit for service. Poor morale was considered contagious and grounds for sending a patient home immediately. Officials at the Indian-only convalescent homes and depots dotting the Hampshire countryside and coastline were similarly pessimistic about the persistence of psychological problems amongst recovering soldiers. At the convalescent home at Barton-on-Sea in October 1915, Lawrence observed that there was “no spirit” in any of the 210 patients in the facility, who were unresponsive to a wealth of therapies, from massage to walks and drills outside:

\begin{quote}
They represent the remnants in England of the Indian wounded of one year’s war, and to look at them I should say that not one of them would be any use for fighting purposes in Europe. There is no spirit left in them, and I am afraid that they will contaminate the new arrivals at the Convalescent Home. The best thing to do would be to ship them off as soon as a boat can be obtained.\end{quote}

Their morale, rather than their physical injuries, was contagious, grounds for sending them home immediately. Indeed, Lawrence and Seton’s validation of Indian trauma in mid-1915 came amid increasing concern over the dangers of Indians’ presence in Europe.

\begin{footnotes}
\item[349] Lawrence to Kitchener, July 21, 1915, Mss Eur F143/65.
\item[350] This phrase may have designated a sort of double-handicap – at once mental and physical. It may have its roots in the Hindustani term \textit{langra}, “limp” or “lame,” while Lawrence likely confused \textit{lulu} with \textit{lalu}, “blood,” or \textit{lalu}, crazy or stupid. By 1883, British dictionaries identified \textit{langra lula} as crippled. Duncan Forbes, \textit{A Dictionary, Hindustani and English} (London, 1848), 469; S. W. Fallon, \textit{A New English-Hindustani Dictionary} (London: 1883), 372. Thanks to Satyasikha Chakraborty for consulting on alternate translations.
\item[351] Lawrence to Kitchener, October 2, 1915, Eur Mss F143/65: 1914-1916.
\end{footnotes}
Beyond whispered fears of miscegenation, the War Office vocalized the concern that slackening morale among soldiers – represented in cases of war trauma and general lack of “spirit” – was a serious danger to the British Army as a whole. This anxiety is clear in Lawrence’s repeated instructions to isolate low-morale soldiers from their comrades.

Anxious over how these experiences could detract from the martial quality of the Indian Army and its effectiveness in Europe, the War Office removed the bulk of South Asian troops from the Western Front by the end of 1916. Only two cavalry divisions, with an estimated 13-14,000 men, remained in France through to the end of the war, where they saw relatively little fighting. The rest were moved to fronts in the Middle East and, to a lesser extent, Africa. British investigations into psychological trauma and shell shock were still in their infancy when Indian troops were shifted into non-European theaters of war. As such, Indian soldiers never figured as more than brief anecdotes in the vast array of British studies that proliferated from 1916-22, heavily focused on trauma on the Western Front. Nonetheless, their time under study by censors and physicians in France provided ample opportunities for expanding colonial knowledge. As Lawrence concluded in his final report on the Indian hospitals in southern England, “[I] have learned more of the psychology of Indians during this last year and a half than I learned in 21 years in India.”

Needless to say, sepoys suffered mental illness alongside their officers. Captain L. F. Bevington, assigned to the 121st Pioneers and attached to the Egypt Expeditionary Force in 1916, repeatedly came under scrutiny for his “nervous state.” Reports from the

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352 Reid, Broken Men, 46.
battalion’s attached medical officer note that he suffered from insomnia and a depressed condition: “his mind is never at rest nor free from anxiety and to continue in such a state is liable to bring on a serious breakdown.”\textsuperscript{354} While his fellow officers frequently recommended that he be taken off duty or transferred to a more junior position, the Corps Commander repeatedly affirmed that after short rests, Bevington was cleared to return to his battalion. Matters came to a head over a year later – in June 1918, he was arrested and subjected to an Enquiry on his Conduct on the grounds that he did not perform his duty. Captain M. Sucholson of the 8th Gurkha Rifles gave evidence that he found Bevington smoking cigarettes with some of his men while supervising a wiring party who improperly completed their tasks.\textsuperscript{355} Bevington related that he had been having “a rough time,” and was recently caught in a barrage, “during which a heavy shell had pitched quite close to him and knocked him out, and… he had suffered from the effects of it ever since.” This, combined with the prior complaints and reports, prompted the Commanding Officer to release the distressed Captain from arrest. Instead of sending him to hospital or on rest, he ruled that Bevington should be permanently released from army duties after the war and reassigned him to a desk position far removed from the front line. The acute shortage of British Indian Army officers with a knowledge of their regiments, or of South Asian servicemen more generally, may have encouraged his superiors to keep Bevington on even after repeated absence of leaves and convalescent stays. Like many British soldiers and officers in the first years of the war, the lack of physical trauma prompted his

\textsuperscript{354} Medical Officer attached to 121st Pioneers to Adjutant General, December 12, 1916, IOR L/MIL/7/17119.

\textsuperscript{355} Cross-Witness Examination by Captain M. Sucholson, IOR L/MIL/7/17119.
superiors to doubt and overlook his mental state. Yet unlike the Sepoys serving under him, Bevington was never analyzed by his ethnicity or regiment. 

Removing Indians from trench warfare did nothing to stem the rising tide of psychologically troubled servicemen. In 1916, Dr. John Warnock, superintendent of the Government Hospital for the Insane at Abassia, Cairo, was appointed consultant to the British Army in Egypt, where he needed to arrange an additional hospital for military cases, 17 per cent of whom were Indian troops. While the lack of diagnosis and formal data prevents statistical comparisons of mental illness rates between white British soldiers and South Asian servicemen, officials organizing mental healthcare clearly felt overwhelmed by the continuous stream of Indian patients. The DDMS for the Indian Expeditionary Force E in Egypt, Col. W. H. Robinson, noted the perpetual presence of “lunatics,” commenting that “the proportion of Indian Insanes has been high.” Frustrated at the costs and resources necessary to transport them, he lamented, “we never get clear of them; always 10 or more awaiting transport.”

Likewise, in letters from the German East Africa front, Major A. M. Webber RAMC, a surgeon, recounted treating numerous mentally traumatized Indian soldiers. The geographic spread of these cases, far removed from the Western front where nearly all medical investigations into psychological trauma occurred, meant these ill soldiers received little specialist care. Examining the 5 Indian General Hospital in the Sidi Bishr neighborhood of Alexandria, the D. D. M. S. Col. W. Westropp White commented on the paltry provisions for the

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357 War Diary, DDMS Suez, January 2, 1916, WO 95/4387.

overflow of mentally ill Indian troops: “There were 16 Mental cases accommodated in a
tent; no hut for insanes being erected in the hospital compound, a much needed
requirement. The Officer Commanding informed me that the H. S. ‘Glengorn Castle’
brings on an average 8 to 10 mental cases, each voyage from France.”359 White later
reported eleven cases of suicide at the Hospital in the five months from April to
September of 1918, each from a different regiment and martial race group.360
Faced with Mesopotamian and East African campaigns in medical crisis, the War Office
made no overtures to look into the continuing rise of “nervous” cases in the Indian Army.
Care of these cases fell to practitioners in the patients’ home provinces, challenging the
mental health infrastructure of the British Raj.

III. Weak Hearts: Figuring Disordered Action of the Heart among Indian
Servicemen

Alongside accusations of malingering and the various ethnically-specific
diagnoses of mental illness, there remained another diagnosis applied to both white and
colonial troops. These soldiers were not identified as mentally ill: instead, they
purportedly suffered from disorders of the heart. This type of complaint had a long
history in the British medico-military establishment. The first recorded cases of
seemingly unexplainable heart ailments date from around Crimean War and the
American Civil War.361 By the time of the Boer War, military medics regularly
diagnosed soldiers with Disordered action of the heart (DAH), also known as “soldier’s

359 War Diary by Colonel W. Westropp White, May 5, 1918, WO 95/4387.
360 War Diary by Colonel W. Westropp White, October 2, 1918, WO 95/4387.
361 Edgar Jones and Simon Wessely. *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War*
heart” or “irritable heart.” Edgar Jones and Simon Wessely identify the common diagnosis of DAH, along with that of rheumatism, as an essential precursor to the military handling of psychiatric injuries in WWI: physicians widely debated whether the cause of DAH’s inexplicable somatic complaints was physiological or psychological.362

Medics identified DAH’s physical symptoms – a periodically racing orb fluttering pulse, shortness of breath, or tachycardia – in soldiers who were typically listless, constantly fatigued, and apathetic. These symptoms, and a patient’s lack of improvement over time, placed it in a diagnostic limbo between body and mind. In contrast to the ongoing debates over the validity of Indians’ psychological trauma, military medics appeared more willing to diagnose soldier’s heart among Indian troops, likely due to its tangible physical symptoms. IMA physicians readily diagnosed DAH-like illnesses before the war, though not on the same scale found post-1914.363 Historically like patients at all of the established teaching hospitals in Britain, caring for Indian soldiers during the war became inextricably linked with using them as involuntary subjects of psycho-medical observation and study.

Throughout the war, mystery illnesses like DAH caused great consternation to physicians who tried to diagnose them, and to distinguish between Indian and British versions of the illness. Between 1915 and 1916, army physicians debated the root cause of these cardiac ailments. In October 1915, T. Knowles Boney, a Captain of the RAMC, conducted a study on twenty Indians drawn from various units of the Indian Expeditionary Force in Flanders. All the patients had been suffering with symptoms

362 Ibid., 11-12.
363 Major F. W. Cotton’s study on “Soldier’s Heart,” discussed below, is based on the only figures Cotton could access: the 1913 Annual Report of the Sanitary Commissioner with the Government of India.
characteristic of DAH: they had periodic rapid pulse changes, were constantly exhausted, and did not seem to improve after extended periods of convalescence. Knowles Boney isolated these cases, who were “of all races and castes.” This was seriously problematic: their varying cultural and religious practices ensured that there was no common factor to investigate. “Mohammedans” smoked but did not drink alcohol; Sikhs drank alcohol but did not smoke; and “Hindus and Gurkhas” typically did both. None had any debilitating diseases – in fact, very few had been engaged in prolonged periods of fighting. Most had been digging trenches on the front for the ten months they had been in France. The RAMC physician determinedly orchestrated their hospitalization to detect cases of malingering, removing all their clothes and belongings, giving them food and drink prepared in isolation, and restricting them to closely monitored latrines. He closely examined his patients’ things for spare cordite, the explosive used in standard British rifle cartridges, mindful of malingering soldiers in the Boer War who ingested the powder to upset their hearts. There were no traces to be found.

Physical defects could not explain their rapid pulse changes: Knowles Boney tested his subjects for dilatation of the heart, hypertrophy, abnormal heart sounds, and intermittent albuminuria, comparing the data and bodies of the sick to those of a dozen healthy Indian soldiers. Nothing stood out. Unable to identify an underlying cause, and despite the fact that the symptoms matched those of DAH, Knowles Boney nevertheless concluded that his Indian patients were afflicted not with “soldier’s heart” as suffered by

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365 Ibid, 639.
366 For close analysis on the problem of cordite and malingering in the Boer War, see Jones & Wessely, Shell Shock to PTSD, 36-37.
British soldiers, but with a similar, unlabeled cardiac problem. Knowles Boney claimed that traditional (white) “soldier’s heart” was characterized by “more or less permanent myocardial damage… too often incurable.” In his cases, he argued that “there is no evidence of any such damage, and in this Sir John Rose Bradford, who also saw the cases, agreed; consequently they cannot fall into this category.” Here Knowles Boney’s analysis falters: it is unclear how he and Bradford determined that none of his patients suffered myocardial damage, given that none of them underwent surgery or died (and that autopsies were the only way to confirm myocardial damage without doubt). What’s more, there was no certain conviction among physicians that “soldier’s heart” necessitated myocardial damage – many believed that this symptom only became evident near death.367

Knowles Boney thought that the illness afflicting his Indian patients was more akin to, though still fundamentally different from, “irritable heart of adolescents,” “occurring chiefly in growing boys.”368 In this type, “a psychical element was often prominent.” Knowles Boney recognized this psychological component in his own cases; however, the Indians in his charge did not recover as the adolescents did. Thus, he advised, the Indians’ cardiac problems were distinct: he proposed that they suffered a disease which was set apart by their racial and environmental conditioning. The cause, he surmised, was “probably to be found in a great complexity of factors, into which the psychology of the Indian, the exposure, shock, and fatigue of the campaign in a climate to

368 Knowles Boney, “Rapidity of the Pulse Dependent Upon Persistent Disturbance of the Vasomotor Mechanism,” 639-640.
which he is unaccustomed, all enter.”  

While acknowledging the physical similarities between Indian and British soldiers, Knowles Boney nevertheless maintained their psychological distinctiveness.

Other physicians disagreed with Knowles Boney, and believed that Indian soldiers fell victim to the same form of “soldier’s heart” as British soldiers, often deploying cases of Indians suffering “irritable heart” as a foil against claims that DAH was caused by more organic, tangible causes. In April 1916, the retired IMS Captain R. D. MacGregor wrote in to the *British Medical Journal* to disprove claims that all cases of “soldier’s heart” were synonymous with “tobacco heart” or “strained heart,” associated with athletics in boyhood. Instead, MacGregor pointed to “the frequent occurrence of ‘irritable heart’ among the Indian soldiers who have been in hospital in this country,” noting that tobacco use and youth exercise were not practiced amongst a variety of the “races composing the Indian Army.” Data on DAH amongst Indian soldiers was used again seven months later by Major F. W. Cotton, RAMC. Interpreting figures for the occurrence of DAH in the 1913 Report of the Sanitary Commissioner, Cotton argued that the cause of soldier’s heart was “to be found in the diet;” the smaller proportion of Indian DAH-cases could be attributed to their predominantly vegetarian diet and consumption of “natural,” rather than processed, foods. Thus, for MacGregor and Cotton, Indian’s biological race did not render their cardiac disorders fundamentally different: they

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369 Ibid, 640.
371 Ibid, 504.
contracted the same “soldier’s heart” as white troops, but for potentially dissimilar environmental and cultural reasons.

All of these physicians presented various knowledge and understandings which, framed against each other, were differing and confused; however, their contradicting studies progressively challenged ideas that Indians were fundamentally physically or psychologically different from Europeans. Even Knowles Boney, who asserted that a distinctly “Indian” element of South Asians’ psychology was to blame for soldiers’ cardiac ailments, aligned their illness with that of white, British “adolescent irritable heart.” Physicians studying Indian “soldier’s heart” recognized that medical understandings of race progressively failed to provide the answers that they sought.

Coming up against this obstacle during the war, Knowles Boney, MacGregor, and Cotton pondered the implications of a medical system of knowledge that was color-blind. By the end of the war, physicians treating white servicemen’s “soldiers heart” generally agreed that it appeared to be a psychological illness.

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373 Cotton, for example, believed that the majority of Indians were inherently septic and could expel pus from between the teeth of their lower jaws.

374 This, however, did not preclude authorities in India from treating it as a physical ailment after the war: The Indian Government’s dedication to healing martial race soldiers shines through in the cases of two veterans housed and educated in the first class of students at the rehabilitative Queen Mary Technical School in Bombay (to be discussed in the following chapter). Abdul Cadir Khan, a Lance Duffedar with the 2nd Lancers, suffered from “heart disease,” while Mahmed Galub, a Havildar in the 75th Carnatic Infantry, was simply diagnosed with a “weak chest.” Both Galub and Khan’s cardiac afflictions were clearly synonymous or similar to DAH: military tribunals granted invalid pensions provided that a soldier’s injuries were attributable to war service, and would not have done so if a veteran’s heart problems could be identified as hereditary or pre-existing. At the QMTS, Galub studied in the mechanical workshop and Khan trained as a Chauffeur. Their case was clearly unique – excessively few Sepoys appear in the historical record receiving pensions for cardiac issues – yet it marks a distinct liberalization in Indian military pension policy. Like the 44,000 British soldiers who received pensions for DAH (by then officially designated “Effort Syndrome”), Galub and Khan were fortunate to be granted some form of aid for veterans, even in a school for the physically disabled. See An Indian Tribute to the Indian Disabled: A Brief Account of the Queen Mary’s Technical School, Bombay, and its Work (Bombay: The Times Press, 1919), IOR L/MIL/17/5/2316.

375 Shepard, War of Nerves, 66.
IV. Feeble-mindedness and Non-Combatants

Some medical professionals treating Indian combatants in Europe built racial typologies of psychological disorder based on increasingly fine ethnic distinctions. Others associated mental illness among troops in broader terms of class and race. In particular, physicians treating members of the Labour Corps, both white British men and non-white servicemen from the colonies, tended to label them as “mental defectives,” or “feeble-minded,” a legal category formalized in the 1913 Mental Deficiency Act.³⁷⁶

In the case of South Asian laborers or “followers” – all from non-martial race groups, often from the South or urban areas – stereotypes of their primitiveness or simplemindedness abetted such diagnoses. Indeed, journalist Edmund Candler concluded his war account The Sepoy with two chapters on the Santal Labour Corps and Indian Army followers, emphasizing their primitive state of mind. The Santal laborers, he recalled, “Were like happy, black, golly-wogs… Evolution has spared them; they have even escaped the unkindness of war… Once an aeroplane bomb fell near the corps. They looked up like a frightened herd.”³⁷⁷ The same went for army followers, from bhistis (water carriers), cooks, sweepers, porters, to syces (grooms): “in the follower’s honest, slow brain, the processes which complicate decision in subtler minds are clotted into one.”³⁷⁸

Opinions about non-combatant’s simplemindedness bled over into the front, where they were rarely diagnosed with “shock” or “neurasthenia” of any form. W. D. Chambers, the Mental Specialist at Boulogne, studied the patients of his base’s mental

³⁷⁸ Candler, 234.
wards from March 1918 to January 1919. Alongside Indian troops in the sample (likely from the small leftover cavalry divisions), his wards also included men from other Dominions. The bulk of his Labour Corps patients were white British men, likely conscientious objectors, working class men, or those who failed their army medical exam. Out of the 966 cases in his study, Chambers calculated even more “feeble-mindedness” (153 cases) than “psychoneurosis” attributable to war stress (134 cases).379 The high incidence of feeble-mindedness, Chambers explained, was likely due to the low-class and racial make-up of the ill servicemen. Half of these “defectives” were members of the Labour Corps. Most, he asserted, had only been in France for a few weeks, yet in many cases they “showed already early signs of psychosis, usually confusion or depression.” Rather than diagnosing these cases as nervous debility, confusional insanity, exhaustion psychosis, or melancholia – all disorders for which confusion or depression were apt symptoms – Chambers reinforced the alignment of feeble-mindedness with members of the Labour Corps. These servicemen were largely lower-class white men or black colonial workers from the Caribbean or South Africa. Chambers believed that their psychological disorders were due to heredity and environment. “I have great sympathy with the units which are compelled to retain such types,” Chambers wrote. These men might be able to hold down jobs in civilian life, he grudgingly admitted, but the stresses of war would always prove too much for them. During air-rafts, when light was restricted to three hurricane lamps, Chambers observed that “defectives and hysterical cases and the negroes were most alarmed… and needed encouragement.” He drew no further conclusions about their mental state at war.

Chambers reinforced stereotypes about black men – whether South African or Afro-Caribbean – as primitive and simple. Their psychology was too simplistic to lead to the weighty wartime disorders suffered by fighting British men.

Physicians overwhelmingly diagnosed mentally ill labour corps servicemen from the Caribbean as feeble-minded. Henry Yellowlees, a Freudian psychologist, drew on his wartime experience as an RAMC mental specialist in France in his postwar writings on psychotherapy and medical psychology. In 1932, two years after Dhunjibhoy and Ross asserted the absence of “shell-shock” amongst Indian troops, Yellowlees told the Royal Medico-Psychological Society that he had seen “more hysterical fits during one day spent among ‘insane’ British West Indian Regiment (BWIR) soldiers than in the rest of his experience put together.”

This “hysterical paraplegia,” he argued, was produced by the conflict between the soldier’s repressed desires to stay out of danger, while loyalty and discipline urged him into it. Yet events during the war indicate that Yellowlees believed BWIR servicemen’s mental condition to be racially determined. On 5 August 1919, he examined a group of twelve BWIR soldiers who had rebelled when handcuffed to their beds in the Mental Compound of the Marseilles Stationary Hospital. Yellowlees reported that, “With a few exceptions all the histories and symptoms show a remarkable similarity. The exceptions are clear cases of well-defined mental diseases. Most of the remainder are not truly insane in our sense of the term, but are cases of severe hysteria of a type unfamiliar amongst white men.”

Yellowlees argued that they were psychologically disturbed, yet for unstated reasons, he differentiated their hysteria from white mental

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381 War Diary, Director of Medical Services, Entries for August 5, 16, and 25, 1919, TNA WO 95/3981.
illness.\textsuperscript{382} No psychiatrists explicitly linked displacement from home as a potential cause or accelerator of mental illness for non-white labourers, yet Yellowlees advised the DMS that the men be repatriated as soon as possible to the West Indies. This echoed Lawrence’s recommendations for dejected Indians at British convalescent homes. Aware of a serious problem, yet unwilling to organize a treatment regimen, army physicians and administrators counseled that repatriation was the only thing to do for mentally ill non-white servicemen.

\textbf{V. The Return of the Mentally Wounded: Psychiatric Care for Veterans in the Colonies}

In British India, the question of whether soldiers were genuinely ill or malingering could not be avoided. There were simply too many patients flooding the psychiatric facilities of Bombay. The Raj had a large, ever-expanding network of psychiatric institutions for both the colonizer and the colonized; however, even it was unprepared for the wave of patients arriving from overseas. Both British and Indian troops were shipped to the port city from the Mesopotamian and African campaigns, along with troops from the Indian hospitals in Europe. Servicemen institutionalized in Indian mental hospitals for war neuroses were not subject to the same level of racial scrutiny as their counterparts on the Western Front. Local and state government officials were far more concerned with treating them and returning them to their home provinces.

\textsuperscript{382} Whether these men were genuinely ill is unclear. Richard Smith has observed that authorities occasionally used diagnoses of mental illness as a means of detaining men who posed a threat to military order. Smith, \textit{Jamaican Volunteers in the First World War}, 123.
In Bombay, the number of mentally ill soldiers arriving in 1916 put such a strain on the Presidency’s institutions that they were forced to request government intervention to deal with overcrowding. The Surgeon-General of Bombay, R. W. S. Lyons, asked to transfer patients from Bombay to other asylums. The Government of India approved this request under the Indian Lunacy Act of 1912, which permitted institutional transfers so long as the receiving asylum agreed to the move. Many Medical Department authorities wanted to transfer patients to their home regions, in part to cut down on costs of having to pay for a later move, and “in the interest of the insanes themselves,” who were thought to be “more comfortable among their own countrymen.” Bringing ill servicemen home also meant that their “difference” could be attended to more closely and easily. However, it also physically removed the problematic subjects from centres of empire and administration, precluding the possibility of further study of the troubling phenomenon.

Relocating the men proved anything but simple. When P.W. Monie, the Secretary to the Government of Bombay, solicited funds from the Home Department to cover the costs of new patients, he complained that many of their places of residence were unknown, “because the Military authorities have failed to give the information, and the men themselves are incapable of doing so.” IMS officers faced further challenges about how to move Indian and non-Indian patients, including British and other mixed-race troops. The 1912 Lunacy Act only approved transfers between institutions in regions

383 James Mills argues that this period of increased demand forced the Government of India to recognize the need to expand the psychiatric health infrastructure, preempting the ambitious plans for development from 1918–47. Mills, “Modern Psychiatry in India, 1858–1947,” History of Psychiatry 12, no. 431 (2001): 431-458.
384 P. W. Monie to Home Department, July 22, 1916, National Archives of India (hereafter NAI), New Delhi, Government of India (hereafter GOI), Home (Medical) Department Proceedings, October 1916, No. 16.
385 Ibid.
under direct British rule, and not necessarily to hospitals in princely states under British suzerainty such as Jammu and Kashmir and Hyderabad.\textsuperscript{386} This complicated the daunting logistical and administrative situation faced by the medical establishment. The jurisdictional boundaries of empire were narrower than the informal imperial recruitment catchment area. So keen to attach fine-grained ethnographic labels to its men, the bureaucratic Indian Army had now lost the capacity to identify who they were and where they belonged.

The Annual Reports of Lunatic Asylums of the Government of Bombay document a massive influx of “military insanes” into the port of Bombay from 1915-18, with numbers finally dropping off from 1919-21 (See chart below).\textsuperscript{387} Over an eight-year period, local networks of mental hospitals treated 590 patients attached to the Army. The Bombay Presidency hospitals were the first to receive “military insanes” returning from abroad, thus, the fewer numbers and slower rise in patient numbers in other provinces may be accounted for by soldiers who recovered or not did not seek further care upon returning home.

Asylum reports indicate that both Sspoys and followers (non-combatants: labourers, cooks, bhistis or water carriers, etc.) were admitted as “military insanes,” suggesting that both martial race soldiers and non-combatant labourers were regarded as susceptible to trauma. Discounting Bombay, the provinces treating the highest numbers of “military insanes” were also those which contributed the largest numbers of

\textsuperscript{386} H. M. Smith to A. P. Muddiman, September 19, 1916, NAI, GOI, Home (Medical) Department Proceedings, October 1916, No. 18.

\textsuperscript{387} The term “military insane” to identify soldiers and followers resident in mental hospitals had been in use, though infrequently, since at least the 1820s, when the Governor of Bombay issued a general order to prescribe where military patients should be treated. Regulations throughout the rest of the nineteenth century established that these cases should be treated in civil asylums.
combatants to the war: 364 patients went through mental hospitals in the United Provinces of Agra and Oudh, whose soldiers formed 23.94 per cent of the wartime Indian Army, and 327 cases arrived in the Punjab, which contributed 51.19 per cent of combatants.\textsuperscript{388} Notably, the martial race-concentrated Punjab was the only region to admit “military insanes” consistently throughout the rest of the decade.\textsuperscript{389} Hospitals in regions contributing a higher percentage of active soldiers – typically the Northwest Provinces and other areas associated with martial race groups – admitted more soldiers than followers; the opposite is true in regions contributing workers for labour corps, such as Assam.

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|c|c|c|c|c|c|c|c|}
\hline
 & 1914 & '15 & '16 & '17 & '18 & '19 & '20 & '21 & '22 & '23 & 24-'33 & Total \\
\hline
Agra/Oudh & 13 & 76 & 143 & 55 & 44 & 28 & 5 & & & & & 364 \\
Bombay & 15 & 35 & 115 & 224 & 65 & 92 & 34 & 8 & 2 & 5 & & 590 \\
Central Provinces & 6 & 10 & 8 & & & & & & & & & 24 \\
Madras & 1 & 1 & 45-7 & 79 & 47 & 15 & 28 & 6 & & & & 222 \\
Punjab & & & & & & & & & & & & 327 \\
Assam & 3 & 18 & 3 & 2 & & & & & & & & 26 \\
Bengal & 55 & 74 & 18 & ? & 2 & & & & & & & 149 \\
Bihar and Orissa & 2 & 2 & & & & & & & & & & 4 \\
Burma & 1 & 4 & & & & & & & & & & 5 \\
\hline
\end{tabular}
\caption{Admissions of Overseas “Military Insanes” to Mental Hospitals in India (By Province)}\textsuperscript{390}
\end{table}

Lacking patient records or physicians’ notes, we cannot know how soldiers’ trauma manifested itself. Wartime asylum reports indicate that doctors diagnosed military patients with mania or melancholia, and described “mental stress” as the most common

\textsuperscript{388} Data compiled from the Annual and Triennial Reports of the Lunatic Asylums of the Government of Bombay, the Province of Oudh, the Central Provinces, the Madras Presidency, Punjab, Assam, Bengal, the Patna Lunatic Asylum in Bihar and Orissa, and Burma, (India: Superintendent of Government Printing), 1914-1933.

\textsuperscript{389} Ibid.

\textsuperscript{390} Ibid.
predisposing cause. In the Punjab Asylum, psychiatrists most commonly diagnosed “military insanes” with exhaustion psychosis and acute dementia. “Military insanes” considered to be violent presented another complication. Major R. E. Dutton of IMS, head of medical service distribution in Bombay, noted that these men could not be accommodated in ordinary hospitals, but required special ambulance cars with guards and new housing.391

As for treatment, the India Office Military Department and the Indian Medical Service were both plainly conscious of the phenomenon of “shell shock” in European and South Asian soldiers, and attempted to learn from metropolitan methods of treatment. In 1918, the Military Department sent their newly appointed orthopedic expert, Captain Sidney Milverton Hepworth, back to England. He visited numerous hospitals for recovering veterans, primarily to examine the spaces and workshops for disabled soldiers, but also to study the methods of treatment for psychoneuroses. Hepworth toured the Maghull Hospital in Liverpool, where he observed therapies for neurasthenic cases.392 As in Indian military hospitals in England, mental hospital physicians encouraged physical activity amongst mentally ill soldiers. Both European and South Asian soldier-patients enthusiastically used gymnastic equipment, while the former also accessed premium treatments, such as parlor games, tennis, and even trips to the cinema for “the better behaved military insanes.”393

392 Hepworth’s 1918 visit coincided with the British Army’s decision to expand medical officer education at the Maghull Hospital, based on its rare success in “curing” soldiers with psychoneuroses. Hepworth would have experienced a uniquely Freudian education there, in contrast to the vast array of hospitals and recovery homes offering a less experimental course of treatment using massage and electric therapies. Military Despatch No. 30, 1919, IOR L/MIL/7/16093; See Shepard, A War of Nerves, 110.
For those patients able to return to their home provinces, the change appeared to expedite recuperation. In his report on the Punjab Lunatic Asylum in April 1918, the Inspector-General of Civil Hospitals called attention to the influx of military patients from “various expeditionary forces.” Those only “mildly affected” by shell shock “made a rapid recovery.” Doubtless, the homesickness felt by many soldiers thwarted healing. As one sepoy Talib Husain wrote to Havildar Maula Bakhsh Khan, “And I, in my separation from you … remain palpitating like a fish day and night, in the hope that God, in his mercy, will ... let us go away to our own homes.”394 Back in Europe, Commissioner for the Indian Sick and Wounded Lawrence affirmed the detrimental effects of homesickness in June 1915, observing, “The further the Sepoy gets from his regiment, the more he longs for his native home.”395

We know nothing about psychological therapies for servicemen after they left the field or the mental hospital, even less about those who never received any recognition or treatment. This points to the urgent need for future scholarship about the kinds of treatment these soldiers received in their local communities. Returning sepoys suffering war-related trauma must have sought local forms of healthcare, though little evidence has survived to document this. Some may have turned to religious remedies and ayurvedic medicine. Many sepoys may have felt that these therapies, familiar long before their deployment west, offered the easiest and most comfortable path to wellness, rather than a European regimen which at times prioritized medical ethnography as much as actual treatment. Others, particularly those experiencing the late onset of psychological complications from their time at war, may have interpreted their symptoms as a spiritual

394 Talib Husain to Havildar Maula Bakhsh Khan, April 26, 1915, IOR L/MIL/5/825/3.
395 Lawrence to Kitchener, June 1915, Mss Eur F143/65.
problem rather than a medical one. They may have sought treatment in the form of religious rituals and participation in communal shrine activities.\textsuperscript{396} Though the late nineteenth and early twentieth centuries saw a notable rise in the number of sepoys seeking Western medical care, many may have perceived mental health problems as damaging to their regiments’ or their own reputation, and avoided asking for aid.\textsuperscript{397} And while the presence of combatant servicemen in the mental wards of the northern Raj is well documented, harder to identify are the hundreds of thousands of non-combatant labourers whose psychological troubles were more ignored or deemed hereditary.

For a variety of reasons, the psychological troubles of West Indian Contingent soldiers are far more difficult to track than those of their white and South Asian counterparts. The BWIR was not a standing army like the Indian Army, and Caribbean soldiers were no longer registered as “soldiers” or “ex-soldiers” after the war. While mentally ill West Indian military patients were treated during the war, after 1918 the Kingston Asylum ceased to use these categories, making it difficult to estimate how many Jamaican veterans were admitted in the postwar years. Psychiatrists continued to ascribe most West Indian patients’ disorders to inferior heredity. In his annual report for 1917–18, D. J. Williams, the director of the Kingston Asylum, noted that of sixteen admitted mental cases invalided from overseas, “some… were suffering from shell-shock,” while others “were of unstable mental organization and should never have been sent to the front.”\textsuperscript{398} Despite this, in tables documenting the cause of patients’ insanity,

Williams registered no cases as the result of “fright and nervous shock,” “grief,” or “war excitement”; instead, he reported that virtually all men’s cases under the categories of “previous attacks,” “hereditary influence,” or “epilepsy.” While he acknowledged that some Jamaicans’ symptoms were like those of “shell-shock,” he persisted in attributing their causes to genetic weakness and congenital predisposition.

Despite a lack of specialized care, some servicemen recovered. Living with his mother on St. Vincent after his return from service with the B.W.I.R. in 1919, Private Henry Kirby struck his sisters with a stone and an intervening police officer with a razor. Local paper *The West Indian* noted that Kirby had “sometime ago showed signs of mental derangement.” The local magistrate sentenced him to three years of penal servitude for striking a superior officer, yet simultaneously pronounced him insane with “recurrent mania.” After months in the lunatic asylum at Grenada, the resident Medical Officer relayed that Kirby had recovered. George Haddon-Smith, Governor of the Windward Islands, telegrammed the Colonial Office in March 1920 asking for permission to remit his sentence. The Colonial Office refused. Judged as mentally-fit, Kirby performed his years of hard labor.

For others, incarceration in West Indian asylums offered no cures or comforts. In his memoir of serving with the B.W.I.R., Etienne Dupuch, the future Bahamian legislator, recalled his encounter with an old friend at the mental hospital in Nassau. “Carey,” a native of Savannah Sound, had been court martialed at Taranto for refusing to clean toilets. Going to the hilltop hospital, colloquially known as “Crazy Hill,” Dupuch

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400 Haddon-Smith to Colonial Secretary, March 1, 1920, CO 318/353/12341.
visited his padded cell and peered at him “through a peep hole in the door.” Carey “was crawling around the room on all fours like a caged tiger,” Dupuch narrated. “As soon as he became aware of my presence at the door, he raised up on his legs and charged violently at the peep hole.” Dupuch mourned his debased state, announcing, “This was a man who had volunteered to give his life to king and country in defence of a noble cause!” West Indian ex-servicemen’s associations, too, continually mobilized the trope of the mentally-ill veteran as evidence of the general lack of care paid to Afro-Caribbean servicemen. For them and Dupuch, the generally poor state of mental healthcare facilities throughout the British Caribbean was further evidence of Mother England’s abandonment of the non-white veterans who had loyally served her. For Carey, colonial official’s habit of putting funds towards promoting incompetent white officers – rather than in modernizing facilities, care, and staff – left him and other suffering ex-servicemen in a void of outdated and ill-suited care.

VI. Silent Treatment: Forgetting Indian War Trauma, 1919-36

Why was there no widespread medical or social discourse surrounding the phenomenon of mental illness in the Indian Army comparable to that which developed in Britain? Was the inconvenient truth of non-white war trauma so easily forgotten? Unlike the extensive attention paid to British victims of war neuroses, experts who treated Indian

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402 Ibid, 79.
sufferers chose not to write about the patients they encountered. There was no formal post-war inquiry into Indian soldiers’ trauma, for combat soldiers or Labour Corps members.404

Historians of military psychiatry in Britain generally agree that despite the early fervor of inquiry into “traumatic neuroses,” much knowledge and experience was lost in the 1920s, as disillusioned physicians left medicine, moved into academic psychology, or shifted into civilian medicine.405 As Peter Barham and Deborah Cohen have argued, it took British veterans’ charities to fill the gap when the military retreated, spreading public consciousness and treating war trauma before interest in military psychiatry surged again in the late 1930s.406 Perhaps these same factors explain why RAMC and IMS physicians who treated Indians during the war neither researched nor published studies of Indian traumatic neuroses in the 1920s. But moreover, as illustrated in the first months of the war, officials did not want to expend effort on an inquiry into problems with subject populations distanced from the epicentre of state and empire.

Lack of medical studies of the trauma suffered by colonial troops mirrored the diminished institutional concern and funding from the Government of India. Nevertheless, the lack of attention is surprising given the expanding appeal and disciplinary development of psychiatry and psychoanalysis in Great Britain and India in the 1910s and 1920s. What’s more, the IMS and the Indian Army had an ongoing, long-

404 Gajendra Singh claims that there was no formal post-war inquiry into Indian soldiers’ trauma, “because there was a greater openness to the possibility that sipahis could suffer from war neuroses.” However, this does not hold with psychologists’ postwar denial of Indian trauma, nor does it account for the differences in treatment and perception of Sepoys and Labour Corps members. Singh, Testimonies of Indian Soldiers and the Two World Wars, 50.
405 Jones and Wessely, Shell Shock to PTSD, 43; Reid, Broken Men, 83; Leese, Shell Shock, 123.
lasting interest in monitoring the morale and mental state of their troops, a legacy of the Indian Mutiny of 1857.

We find some clues towards explaining this peculiar silence in the recorded meetings of Britain’s Royal Medico-Psychological Association, where the question of non-white, wartime mental illness was occasionally brought up in discussions of research in the colonies. At the February 1930 meeting of the Royal Medico-Psychological Association when Dr. Donald Ross claimed to have observed almost no “shell shock” among the “finest units of the Indian Army,” he also claimed to have witnessed among Indians “several very interesting cases of genuine mental derangement.” By designating Indian cases as genuine, yet not shell shock, Ross, like Yellowlees, verified mental illness in the Indian Army, yet refused to align it with the shell shock suffered by white soldiers.

It is telling that after the war, the only cases of non-white war trauma which psychologists discussed openly were those suffered by laborers, often low-caste Hindus – and not the afflictions of active Sikh and Muslim fighters. Ross added that the only case of “‘Cold feet’ and definite malingering” he had encountered was, ironically, in a man called Gunga Din. Ross did not clarify whether this individual was a bhisti of the same name and ilk as Kipling’s loyal water carrier, but his title suggests that he was a low-caste laborer. Despite sharing a name, Ross claimed that his “Gunga Din” displayed cowardice by counterfeiting mental illness. Two years later, at a February meeting of the Royal Medico-Psychological Society in 1932, Ross again claimed that he had “met some very interesting mental and neurological cases” while serving with Indian troops during the war, but only specified cases from the Native Labour contingent, which came from
what Ross specified as “the primitive hill tribes.” Ross’s failure to mention any cases among martial race sepoys may have been due to his belief that they did not suffer shell shock, or alternately, his desire not to pollute the myth of the stoic martial race soldier.

Amnesia towards non-white traumatic psychiatry was not limited to medical personnel. Popular accounts of the war in Britain perpetuated pre-war ideas of martial race Indians’ imperviousness to pain and fear. In his 1919 war account, The Sepoy, journalist and writer Edmund Candler titled sixteen of its eighteen chapters after individual ethnic groups that constituted “martial races,” attributing special characteristics to each. In his “Gurkha” chapter, moments after losing an arm to a shell blast, the sepoy Tegh Bahadur attends to his officer, mourning only his inability to keep fighting. “It would be a great injustice to the Pathan if it were thought that any failed us through fear,” Candler urged, citing the case of Mir Dast, one of the few Indians to win the prestigious Victoria Cross. Likewise, “the Jat,” an agricultural caste group from the Punjab, “is not troubled with nerves or imagination, and he is seemingly unacquainted with fear. Alarms, bombardments, and excursions having become his normal walk of life, he will continue on his path, probably with fewer inward questionings than most folk.” “Drabi” sepoys, a group of Punjabi Muslims recently admitted as combatants, had “no more nerves than mules.” Candler pounds home the idea that martial races were immune to the terrors of mechanized warfare. Similar popular accounts abounded in the 1920s, speaking to a deep-seated desire to forget the horrors of the Great War through a

409 Ibid., 73.
410 Ibid., 121.
411 Ibid., 213.
return to earlier ideals of social order. In the British Raj and the Indian Army, this meant returning to a social order predicated on constructed ideas of martial prowess and ethic difference.

It is unsurprising, then, that sepoys’ psychological terrors and illnesses were recovered not by colonial officials or British psychiatrists, but by an Indian novelist. In his 1939 novel of Jat soldier Lalu’s wartime experiences, *Across the Black Waters*, Mulk Raj Anand described several instances of mental illness among Lalu’s fellow soldiers. Anand portrays the soldier Daddy Dhannoo’s increasing melancholy in the weeks before his death, “involved very much in his own world of misery… living and moving in a dark furtive underground life of his own, in a state of somnambulistic confabulation, which was perhaps his only defence against the strangely complex behaviour of men in civilization and the avalanche of horrors that the sahibs hurled on each others’ head.”

After Dhannoo’s dies, Lalu hallucinates his corpse chasing him as he runs in retreat from a trench offensive.412 As the weeks progress, Lalu notices the increasingly strange behavior of his father-figure, Uncle Kirpu, who becomes restless, sleepless, and hallucinatory as war rages around them. Lalu is later shocked when Kirpu “bumped his head against the wall, beat his forehead with his hands and burst out crying.” He is stunned as Kirpu sobs:

Lalu contemplated the face of his comrade, a brave, lively, mischievous face at the worst of times, now old with wrinkles of grief. The boy had never imagined that the wise, cynical Uncle Kirpu would break down in the face of anything. He stared at him embarrassed and full of tenderness. He could not bear to see the old man crying like a child when he himself felt curiously detached.413

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413 Ibid, 173.
Kirpu’s mental condition continues to deteriorate, ending with his suicide. That Anand does not use the terminology and trope of traumatic neuroses and “shell shock” popularized in British war literature of the 1920s and 30s is emblematic of the way in which Indian veterans were denied the scientific enquiry and cultural recognition afforded to British ex-servicemen. Nonetheless, Anand plays off of this narrative in the wealth of metropolitan novels to acknowledge the analogous experiences of Indian soldiers.

Conversely, Dhunjibhoy’s claim that Indian Army servicemen suffered “very little insanity” during the war may have been prompted not so much by the imperatives of colonial hegemony, as by his ignorance of the wartime crisis and his interest in maintaining the prestige of the Army and the IMS. Educated at the Bombay Medical College during the war, Dhunjibhoy was appointed to the IMS in 1917, and did not see military service until 1940.\textsuperscript{414} His first experiences with “military insanes” came in Indian asylums, rather than abroad in hospitals in Europe and Mesopotamia. Though we know little about his political disposition, Dhunjibhoy’s professional rise was enabled by progressive Indianization of the medical and civil services. Such policies were meant to culminate with India’s increased self-sovereignty and potential independence.\textsuperscript{415} As evident in Candler’s postwar affirmation, the Indian Army was a respected cornerstone of Indian power and loyalty. Dhunjibhoy may have felt that publicizing cases of trauma in the military would weaken arguments for Indian self-sufficiency and continued advancement in professional ranks.

\textsuperscript{414} Ernst, \textit{Colonialism and Transnational Psychiatry}, 210, no. 14.

\textsuperscript{415} Waltraud Ernst’s exceptional close study of Dhunjibhoy suggests that he was a non-political, grateful recipient of the boons of Indianization. He reportedly “felt that he owed everything he had achieved to the Army.” Ernst, \textit{Colonialism and Transnational Psychiatry}, 19.
Lack of medical interest in the trauma suffered by colonial troops mirrored diminished institutional interest and funding from the Government of India. Despite their wartime policy of taking fiscal responsibility for the “military insanes” institutionalized in the Raj’s asylums, the Army Department of India grew increasingly apathetic towards sufferers who were army laborers and non-combatants. Their negligence caused friction between the regional mental hospitals seeking to continue care for veterans, and Army administrators and paymasters who sought to limit the costs they were liable for with respect to these patients.

The Ahmedabad Mental Hospital was the subject of one such debate. In January of 1918, a series of Government Orders established that maintenance charges for military insanees coming from overseas would be paid for by the Central War Controller, and later through the Indian Military Department. In 1932, they ceased doing so. Exasperated, administrators at the Ahmedabad Hospital wrote to the Controller of Military Accounts in Poona in June 1934, to ask for unpaid maintenance charges for four military insanees still resident in the hospital. Admissions papers proved that all of the men had been admitted to the hospital between 1917 and 1918, and while payment records prior to 1929 were destroyed, the Accountant General confirmed that the military authorities had paid yearly dues – 6 annas per day – for Sweeper Maksar and Mura Ragha of the 6th Poona Division, Ganoo of the A. B. Corps Secunderabad, and Piadkhan of the Combined Labour Corps from 1925-1932. Upon receiving the bill, the Controller of Military Accounts not only refused to pay the debited amount. He claimed that all prior payments from the Military

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416 Maharashtra State Archives, General Department Order No. 428-W-21 (January 21, 1918), and Government Order, General Department No. 6503 (June 15, 1920). Secretary to Gvt. Bombay, March 15, 1918, Bombay General Department 1918 file 996-1; Sec. to Gov. of United Provinces to GOI, 19 March 1920, Bombay General Department 1920 file 10:2.
Department for the four men were made under a misapprehension and department error. These men were not “military insane,” and therefore the Army would pay for none of them.

Lyons, the Surgeon General of Bombay, sided with the Ahmedabad staff and demanded that the Army Department support the care of its mentally ill. A General Department memo on 5th November, 1936, confirmed that it “seems somewhat unfair for the military authorities to argue at the lapse of so many years that the claims for maintenance charges of the insane in question were accepted by them under a misapprehension.” Yet Lyons was unwilling to drag out unpleasantries with the Military Department. He suggested dropping the charges against the Army and treating the four as paupers, whose maintenance charges would be paid for by local government. The bureaucratic dispute was resolved by shifting the burden to local government. The same conflicts of responsibility did not occur for the management of British patients. Earlier in the same year, the Defence Department acknowledged and agreed to pay rising maintenance charges for “insane British soldiers” housed at the Central Mental Hospital in Yeravda.417

As in India, conflicts over the funding and condition of ex-military mental patients in the Caribbean broke out in the early 1930s. Due to the small number of patients, these issues arose infrequently. Where the Military Department in India sought to limit its responsibility for mentally ill laborers, government administration in Jamaica sought to bring West Indian servicemen’s untouched pensions to use in the colony. Decrying that “insane ex-soldier[s]” with unpaid pensions were required to wear the same

417 Ibid., 41.
clothing as pauper patients, R. E. Stubbs, Governor of Jamaica, advised that money should be withdrawn from their untouched pension funds to pay for “extra medical and personal comforts.” Stubbs compared black military inmates with white British inmates, noting that in England, insane ex-soldier pensioners got 2/6d pocket money per week, as well as special clothing to set them apart. Stubbs arranged for R. J. Hewson, the Medical Superintendent of the Kingston Asylum, to visit the Ministry of Pensions to discuss the matter in March of 1931: one year later, the Ministry agreed to give a weekly pension allocation to “certain mental War pensioners of the British West Indies,” payable to the asylums. The remainder would be held by the asylum until the patients’ release or death, in which case the unpaid balance would be transferred to their wives, children, or dependents; however, the Ministry noted that these grants “should be limited and only made in exceptional circumstances.” As in Britain, veteran’s families were especially concerned that mental hospitals recognized the special status of military inmates, particularly in the case of the Kingston Asylum, an outdated institution with high levels of overcrowding offering little in the way of actual therapy. Stubbs, in the midst of a fraught debate with the Ex-British West Indies Regiment Association over unpaid soldier pensions and veteran benefits, seemed to welcome the opportunity to crusade for asylum-bound inmate’s pensions. His campaign provided positive publicity for his political profile on veteran’s affairs, while providing stable supplementary funding which went through government coffers, rather than directly to soldier’s families.

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418 R. E. Stubbs to Philip Cunliffe-Lister, January 6, 1932, CO 318/404/3.
419 Accountant General, Ministry of Pensions, to Under Secretary of State for Colonies, March 1, 1932, CO 318/404/3.
Only as the world careened toward the Second World War did colonial administrators – in the metropole and India – direct themselves toward understanding the enduring legacy of shell shock. During WWII, physicians monitored and widely acknowledged the reality of psychological disorders among both white and Indian troops. Lt. Col. Bidyapati Bhattacharjya, Senior Specialist in Psychiatry, forthrightly concluded that there was “a tremendous increase in the admission rate for mental diseases” from 1941-45.\(^{421}\) Serving as a psychiatric consultant in field hospitals throughout Persia and Iraq, Bhattacharjya’s commission in the Indian Medical Service was the result of the interwar Indianization of the Indian Army and IMS.\(^{422}\) This prominent position likely contributed to his outsize role in forwardly identifying the rise of psychological casualties in the Indian Army.

According to Bhattacharjya’s figures, Indian troops were admitted for “mental diseases” during WWII at a rate of 4.05 per 1000, almost four times as frequently as in peacetime.\(^{423}\) When cases peaked in 1945, they displaced malaria as the central cause of invaliding. Yet while mental illnesses were now more commonly diagnosed as psychiatric disorders rather than malingering, established medical opinion still did not consider the possibility that the same trauma could give rise to different symptoms depending on the sociological character of the patient. In fact, they conflated symptom and cause, treating the two as one. In doing so they perpetuated the belief that racially

and culturally diverse troops not only expressed trauma in different, culturally shaped ways, but that these soldiers were mentally different on a fundamental level.

Bhattacharjya claimed that both “educational and racial background produced interesting divergence in the type of disease.” He alleged that Southern Indians made up “proportionately more cases of psychoneuromes than the so-called martial races of Northern India.” In his own words, “the breaking point of people of different provinces of India possibly varies.” South Indian cases were marked with “hysterical symptoms,” while the Northern Indians showed many more cases of “anxiety neuroses.” Comparisons between WWI and WWII figures, he allowed, were somewhat distorted in the sense that new psychiatric classifications were introduced in 1944; as a result, more disorders were categorized as legitimate mental diseases. Furthermore, psychiatric services were far better organized and expanded in the Second World War.

Bhattacharjya and his study illuminate the transformations and continuities in British colonialism and racial ideology since 1915. Indianization and the rise of military psychiatry meant not only that South Asian soldiers were treated for psychological neuroses during WWII, but that they were treated by a South Asian psychiatrist. The IMS validated and attended to the psychological wounds of both British and Indian troops. Yet Bhattacharjya’s research also reveals the long shadow of martial race theory and his own internalization of it. Even as he abandoned its fine-grained ethnocentric premises, he reproduced its overarching imagined geography by suggesting a North/South division in

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424 In this, the 1949 study followed the War Office’s 1922 Report of the Committee of Enquiry into Shell Shock. Physicians testifying in 1922 affirmed that “anxiety neurosis” was more pervasively identified as a war-attributable illness, caused by the war and not the quality of the soldier in question, than hysteria. War Office Committee of Enquiry into ‘Shell-Shock,’ *Committee of Enquiry in to ‘Shell Shock’* (London: H.M.S.O., 1922), 68.
mental fortitude. Racial differentiation lived on in broader categories: physically and psychologically strong Northern Indians and weak Southern Indians.

Conclusions

Studies of military psychology from 1914 to 1945 expose three different albeit sometimes overlapping ways of thinking about race and trauma. Some officials ethnicized mental illness in order to deny its existence. Some officials ethnicized mental illness while affirming non-white soldiers’ suffering; others still came to believe that wartime trauma was caused by experiences as a soldier, rather than as a Pathan, Sikh, or Jamaican. These viewpoints produced a range of effects. In the case of the Indian Army, heightened monitoring of sepoys led to an acknowledgement of a mental health crisis – and the allocation of some resources to deal with it. Yet in the long run, deficiencies in frontline care and treatment may not have been as damaging to non-white servicemen as the lack of public awareness of their plight. Silencing the subject in the colonies left much of the native population unaware and uninformed of the mental health crisis. For white soldiers in Britain, community pressure and well-funded voluntary organizations such as the Star and Garter stepped in where the War Office and Ministry of Pensions failed. The absence of such public consciousness in India and the Caribbean left afflicted sepoy and non-combatant soldier-subjects bereft of extra-state support. No matter how broad the scale of racial differentiation, soldiers’ race shaped the distribution of health resources. At the same time, without deeper research into care at home in the interwar decades, we cannot know to what extent non-white veterans made use of alternative therapies and sought treatment outside of the colonial system.
The convergence of the first truly “global” mobilization of the British Empire with the mass incidence and recognition of psychological disturbance in the military generated this mixed medical response to a multiethnic crisis. These early – if conflicted – foundations gave rise to a multicultural psychiatry attentive to race and ethnicity. This is evident later in the structured care of the Second World War, and in the expanding fields of multicultural psychology and medicine in the second half of the twentieth century. The Great War provoked awareness of an underlying shared humanity that undermined the racial ideologies upon which colonial power was based. Nonetheless, trauma remained a privileged category that many non-white servicemen were unable to fully claim. British clinicians and officials continued to debate the extent of non-white subjects’ interiority. The willful amnesia about colonial soldiers’ mental illness denied Indian and West Indian servicemen the same postwar recognition as their white counterparts. The conflicting ideas produced and challenged in this wartime laboratory rippled out across realms of colonial science, culture, and politics, and established the terms of still unresolved debates about the entangled histories of race and trauma.
Chapter 4: Bones
Rehabilitation, Re-education, and Re-Membering Colonial Veterans

On the evening of the 8th of September, 1918, only two months before the signing of the Armistice, a minor battle broke out on British soil: a dispute between patients at the Belmont Road Auxiliary Hospital in Liverpool, many of whom were single or double amputees, escalated into a full-scale brawl. Belmont was a rare site, which treated black and white troops in the same facility. In the fight’s confusing aftermath, reports identified the factions as a group of West Indian soldiers against a variety of white troops. About the cause of the conflict, there was no agreement. Black interest newspapers, activists, and the West Indian Contingent Committee, set up in London to help advocate for troops of the British West Indies Regiment (BWIR), blamed racial taunts from white South African soldiers and misunderstandings about room access and equal treatment between the troops. The Times and other Liverpool-area local publications attacked the West Indians and emphasized their supposed aggression and uncontrollable violent tendencies. The Times never referenced the grievous injuries of the West Indian servicemen. Instead, the paper characterized soldier John Demerette as a fierce and deranged instigator who, without provocation, “drew a razor and slashed wildly with it,” inciting the “other coloured men” to become “very abusive.” The report notably failed to mention the fact that he walked on two stubs instead of feet. Demerette, like the others healing at the hospital, had yet to be fitted with prosthetics, and could only crawl or walk with crutches.

425 “Disturbance by Black Troops, Army Nurses Death,” The Times, September 26, 1918, 3.
426 Ibid.
This omission forms part of a larger pattern of silence about black disability in the mainstream British press. The *Times*, the Liverpool *Echo*, and the Derby *Daily Telegraph* all described the encounter between West Indian troops and “some 400 wounded British soldiers.” In contrast to the British, none of the BWIR troops are described as injured. To the contrary, the *Times* noted that “the coloured men had been over-staying their time allowed them out of the hospital,” suggesting that the soldiers were well-enough to leave and traverse on their own.427 What was at stake in the British media’s refusal to acknowledge that black colonial servicemen, too, had been critically injured by the war and – perhaps more shockingly - were treated alongside white soldiers? The *Times*’ conceptualization of the black disabled body as a potential weapon reflected official anxieties. Non-white disabled veteran bodies posed a serious and significant threat to the racial hierarchies and gender matrix of colonial order: their bodies were evidence that their physical sacrifice for the mother country could be as great or greater than that of the British, validating their post-war demands for pensions, care, and potentially, expanded rights. Disabled subject-soldiers like Demerette were, by and large, far more concerned with obtaining functional prosthetics and sustainable work than with fomenting revolution. The colonial government and War Office were eager to show that they healed white Tommy and Indian Sepoy alike, but debated how similar the opportunities and aid presented to them should be. Would disabled white Britons, Indian servicemen, and West Indian laborers receive the same provisions, or did the colonial nature of imperial veterans, under a distinct military and government, require different prescriptions? This practical question masked an unstated concern amongst prosthetic

427 Ibid.
mechanics, medical experts, government officials, and military officers: how similar or
different were white and non-white bodies wounded in war?

This chapter takes up this issue by examining the development and distribution of
prosthetics and the structuring of rehabilitation therapies for disabled non-white troops
from the colonies. Compared with their British counterparts in the metropole, South
Asian and Afro-Caribbean veterans received less technologically-advanced artificial
limbs. And while racial and ethnic stereotypes often informed administrators’ choices,
postwar care for the colonial disabled was shaped more deeply by a combination of
complex political and commercial debates. Even where care was accessible and open,
orthopedic devices and techniques were based on Western standards which failed to
recognize the different needs – both mental and physical – of imperial soldiers. This
colonial narrative of wartime disability care offers new insight into how therapeutic
devices both ruptured and remade bodies in unexpected ways. In this context, networks
and technologies of care were simultaneously mechanisms of healing, inequality, and
hybridity. They had a deep impact on the lives of the colonial veterans in question, and
sometimes, surprising effects on their bodies.

**Imperial Responsibility & Benevolence: Establishing Orthopedic Care**

The colonies occupied a unique space in international discussions of care for
disabled veterans. Canada, South Africa, Australia and New Zealand were well-
represented in the “Inter-Allied” conferences held in 1917 and 1918. The 1917
conference, organized in Paris, was a Euro-centric affair. Staged in London
(Westminster) from the 20th-25th of May, 1918, the second “Inter-Allied Conference for
the Study of Professional Re-education and other questions of interest to soldier and sailors disabled by the war,” broadened its scope to recognize the global dimensions of the disabled soldier. It included delegates from the US, Siam, South Africa, and New Zealand, among other European nations and British Dominions.\textsuperscript{428} In his forward to the published proceedings of the 1918 Conference, the novelist and eminent advocate for the disabled, John Galsworthy, spoke of the disabled veteran question as an Empire-wide problem with imperial answers:

> And all our own far sister lands, having each her special flower of promise; having, all, the clear eyes and adventuring hearts of the young. To their pride of new race it will seem intolerable that their best and bravest should go starved of help and opportunity. Sooner would an Arab’s hospitality fail than the freemasonry of the new worlds neglect their maimed heroes! And India, the wonder-land. She, too, will care for her children. And this Britain of ours! Shall the work of restoration fail with us! Unthinkable!\textsuperscript{429}

If war had brought the Empire together, Galsworthy believed that rehabilitating its wounded would also be a mobilizing project. In his optimistic imagining of colonial rehabilitation, each dominion would take up care for her own disabled, despite the vast differences in governmental responsibility for the maimed.\textsuperscript{430} Likewise, the servicemen in question are distinct. The settler dominions, concerned with their “pride of new race,” heal “maimed heroes.” Galsworthy’s vision runs in line with contemporary configurations of Australia and New Zealand as racially pure, young, and vigorous, in contrast with the decrepit old Britain. Their “freemasonry” alludes to their modern

\textsuperscript{428} Inter-Allied Conference on the After-Care of Disabled Men: Reports Presented to the Conference (London: H. M. Stationery Office, 1918).

\textsuperscript{429} John Galsworthy, “Foreword,” in Inter-Allied Conference on the After-Care of Disabled Men, 14.

\textsuperscript{430} Galsworthy’s dedication to and organizing on behalf of disabled veterans in Britain has been well-documented. See, among others, Seth Koven, “Remembering and Dismemberment: Crippled Children, Wounded Soldiers, and the Great War in Great Britain,” American Historical Review 99, no. 4 (October 1994): 1167-1202; and Jeffrey S. Reznick, John Galsworthy and Disabled Soldiers of the Great War (Manchester: Manchester University Press, 2015).
industriousness and progressive development. In these “new worlds” granting rehabilitated men “opportunity” – occupation by another name – was paramount to healing the dominion itself. Galsworthy’s India, conversely, tends not to her “best and bravest” but to her “children.” This brief reference alludes to the fundamental tensions of imperial rehabilitation. The rhetoric of advocates of the disabled, and the policies of metropolitan and colonial officials, envisaged rehabilitation as both a unifying imperial project and a program differentiated from colony to colony. They alternated between visions of the non-white colonial disabled as unfortunate heroes and crippled children. Furthermore, this discourse left out large populations of incapacitated servicemen. In the Allied Conference proceedings, delegates from the settler dominions never referenced initiatives for indigenous and non-white veterans. African, West Indian, and black British disabled soldiers seemingly had no place in the public rhetoric of imperial rehabilitation.

Though Galsworthy figured non-settler colonies as part of the Empire’s therapeutic project, they were rarely an active part of Allied conversations about care for disabled veterans. Apart from the Dominions, only India contributed to the British colonial presence at the second Inter-Allied Conference. Even this was the subject of debate. In January 1918, the Ministry of Pensions inquired whether representatives from the Government of India should attend the Conference. The India Office replied that an Indian Government representative would attend only as spectators. What’s more, they would only do so “if Indian troops aren’t to be discussed directly.”\footnote{India Office to Ministry of Pensions, c. January 22, 1918, British Library (BL): India Office Records (IOR) L/MIL/7/18481.} Col. Stanton at the Ministry of Pensions noted that the primary focus would be European soldiers, but felt it was important that the Gov. of India have a representative. The India Office agreed, yet
instead of ten representatives as the Ministry had originally asked, only Mr. F. S. Stewart from the India Office attended the conference. Indian government officials’ reluctant participation in an event intended to broadcast the Empire’s active compassion is illustrative of the friction in colonial approaches towards assuming responsibility for disabled denizens. The humane desire to aid subjects disabled in service of the Empire stood in tension with overlapping, fiscally challenged interwar bureaucracies and contentious colonial politics.

As colonial troops circulated through British hospitals, physical rehabilitation and treatment in hospitals was adjusted to the different troops that doctors encountered. Yet just as black disability was often ignored in the British press, the majority of historical scholarship has failed to acknowledge the presence of colonial troops in these hospitals, nor examine how their presence shaped the medical practice at the sites they were convalescing in.432 Notably, the Roehampton Hospital that treated non-white labor corps workers and Indian soldiers in the first few months of the war was converted into a convalescent hospital for disabled British men, which in turn supplied materials and corresponded with various representatives from the Government of India on the subject of healing servicemen back in the colonies.433 Likewise, once the War Office removed

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432 Among the extensive narratives of British rehabilitation and caregiving for the disabled, see Julie Anderson, War, Disability and Rehabilitation in Britain: ‘Soul of a Nation’ (Manchester: Manchester University Press, 2011); Ana Carden-Coyne, Reconstructing the Body: Classicism, Modernism, and the First World War (Oxford: Oxford University Press, 2009); Jeffrey S. Reznick, Healing the Nation: Soldiers and the Culture of Caregiving in Britain during the Great War (Manchester: Manchester University Press, 2004); and Julie Anderson and Heather Perry, “Rehabilitation and Restoration: Orthopaedics and Disabled Soldiers in Germany and Britain in the First World War,” Medicine, Conflict and Survival 30, no. 4 (2014): 227-51.

433 Occupational therapy for the white wounded had the potential to effect colonial subjects in far more negative ways. In addition to the traditional and established industries of boot manufacturing, brush making, and tailoring, among others, the Ministry of Pensions eagerly endorsed a training program at the Brighton Technical School to teach disabled British soldiers the work of diamond polishing. Proposed by the famed British diamond importer Bernard Oppenheimer, the Ministry of Pensions advocated for the course on the grounds that it would provide (relatively) high paid employment to the disabled while
most Indian troops from the Western Front and from their hospitals in Brighton, the Royal Pavilion Hospital was transformed into a rehabilitation facility for British soldiers. Disabled colonial servicemen experienced sharp disparities in the levels of care they received the farther they moved from the battlefield. The War and Colonial Offices eagerly promoted their provision of healthcare as evidence of their dedication to the Empire’s “crippled natives” in an effort to stem a rising tide of anti-colonial demonstrations. Administrators emphasized that the level of care which Indians received was fundamentally equal in all ways to that of British soldiers, even if it was somewhat slower in reaching the patients in question. At the Kitchener Hospital in Brighton, Col. Bruce Seton acknowledged that the Orthopaedic Department was well behind other institutions in providing artificial limbs. Showing a somewhat astonishing lapse in judgment, he claimed “it was not possible at an earlier stage to foresee how the demand for an Orthopaedic Department would materialise,” despite the quick and heavy involvement of Indian troops in the first months of the war. Nonetheless, he quickly authorized the development of an Orthopaedic Department in Brighton, in addition to an electrical and galvanic treatment room and Dowsing radiant heat treatment center.  

boosting British industry. As the Ministry put it, diamond polishing had “almost entirely been confined to Amsterdam and Antwerp, and it is hoped, inasmuch as almost all diamonds come from British Colonies, that this will soon be an essentially British Trade, and one that will be a permanent benefit to hundreds of those who have suffered in the Field.” The Government’s investment in disabled men and the polishing industry, conducted in a “bright and healthful environment,” privileged the white disabled: its ever-expanding diamond mining operations in South and West Africa crippled innumerable black laborers who toiled in its dark and incapacitating mines. See “The ‘After-Care’ of the Disabled Sailor and Soldier,” 1918, IOR L/MIL/7/18582. On the long history of mine labor and its ensuing disabilities and impact on health, see Julie Livingston, Debility and the Moral Imagination in Botswana (Bloomington: Indiana University Press, 2005); and Randall Packard, White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa (Berkeley: University of California Press, 1989); among others. Nonetheless, the Orthopaedic Department at the Kitchener opened only three months before the entire Indian hospital system in the UK was demobilized, as Indian Battalions were removed from the Western Front to campaigns in Africa and Mesopotamia. Col. Bruce Seton, Reports on the Kitchener Indian Hospital, 1915, IOR L/MIL/17/5.
Physicians lauded the latter two therapies as top of the line developments in orthopedic science. At their hospital beds, officials promised that they would receive the best limbs available.

Recent histories of veteran policy and protest in the metropole affirm that developments in new medical technologies and health systems did not necessarily improve the life of the disabled ex-soldier: neglected by the Ministry of Pensions, British ex-servicemen often struggled economically, socially, physically, and psychologically, aided instead predominantly by philanthropic associations. Furthermore, artificial limb provision for white veterans was not without its own controversies. The Great War spurred fast-moving advances in prosthetic development, from mechanical ankle and knee joints to new durable, lightweight materials. Though innovators had suggested the use of aluminum in artificial limbs since the 1860s, the first lightweight duralumin prosthesis was not developed until 1913, when aviator Marcel Desoutter and his brother Charles developed a prototype after a flying accident. The “Desoutter limb,” along with other duralumin limbs of the time, were widely regarded as the height of modern technology, desired by soldiers and lauded by the public. These devices were widely greeted as an improvement upon past specimens, from the standard wooden peg leg to its early nineteenth century update, the bucket-and-pin or shaped wooden leg. The latter prosthetic allowed for greater flexibility in the knee and ankle joints. For above the knee amputees, the bucket-and-pin also added a well-shaped divot for increased comfort, while the shaped leg resembled its human counterpart more closely than a straight peg. When the duralumin limb began distribution shortly before the First World War, it was both

435 M. P. Leahy, “Artificial Limbs,” *British Medical Journal* 1, no. 3297 (March 8, 1924): 446.
lighter and more durable than its predecessors. Their convenience and innovation came at a high price: the limbs cost between £15 and £30 depending on the size of the limb and the extent of a patient’s amputation. Not extortionate, but out of reach of the average British pensioner, the cost put a significant strain on the Ministry of Pensions. Yet the training of skilled mechanicians did not match the level of wartime innovation. As American manufacturers sought to fill gaps in British limb supply, the Ministry of Pensions found that disabled British veterans often had to wait months for fitted duralumin limbs, though most were accommodated in a growing list of institutions and hospitals dedicated to their rehabilitation. These problems were magnified a hundredfold in the colonies, where a far less developed medical infrastructure and bureaucratic crossed wires further confounded the problem of limb distribution and fitting.

Despite broad consensus that the Desoutter design was superior, the Indian Medical Service decided that the new grade aluminum limbs would not suit Indian veterans. As the War Office began to move Indian troops out of Europe and progressively closed Indian hospitals in Britain, the India Office shifted Walter Lawrence from his position as Indian Commissioner for the Sick and Wounded to a new post – the War Office’s liaison in connection with discharged and disabled Indian soldiers. In his 27 May 1915 Report to Kitchener, Lawrence recalled his conversations with I.M.S. Officers at convalescent depots scattered throughout Hampshire. These officers, he claimed, were


437 Furthermore, most wartime innovation benefitted disabled veterans whose amputations were at or below the knee. Ex-soldiers who had particularly short thigh stumps did not receive lightweight metal limbs that accommodated their condition until the 1920s.
“generally of the opinion that the artificial limb should be of the simplest description and that anything elaborate would be mere waste of money.” IMS officers debated what this ‘simple’ limb would be, and whether it could be used for all disabled Indian servicemen. In a 1923 report one official acknowledged that “the Indian Pensioner uses his artificial appliance far harder than the British Pensioner at Home, due to the conditions under which he lives,” and therefore deserved “the best articles procurable.” However, IMS officers continued to intimate that disabled Sepoys would do best with the simplest variety of prosthetics, since they insisted on returning to their home villages, where they had farmed prior to the War – and where they inevitably went on to treat their devices roughly and ruin them. H. Austen-Smith, Lt. Col. of the IMS, for example claimed that teaching amputees trades was often a well-meaning yet pointless act, as “it must be remembered that many of them wish to go back to their homes as soon as possible, and to do what they can in carrying out their agricultural pursuits.” In this regard, Austen-Smith argued, the pin and bucket stump was actually “more handy” as more developed, shaped legs would not be appreciated by the Sepoy farmer, who would inevitably wear down the limb. Other officials believed that the complex societal matrix in the Raj should be taken into account when prescribing artificial devices; a telegram from the Viceroy Chelmsford to the India Office agreed that simple pin limbs were preferable to shaped limbs in most cases, however, the final decision should be left to local medical authorities, who could consider “caste, occupation and status of the invalid and his personal inclination,” when determining what type of limb to provide. Given

439 Collender to Director of Medical Services Simla, July 15, 1923, IOR L/MIL/7/18266.
440 Telegram from Viceroy Chelmsford to Secretary of State for India, June 8, 1918, IOR L/MIL/7/18263.
the large number of disabled (at one point estimated to be over 24,000) the India Office and Army Department decided that Indian troops should be offered a middle ground between a simple version of the artificial leg (the bucket and pin) and contemporary innovations like the duralumin limbs supplied to British soldiers.

The War Office clearly intended aftercare for veterans who moved back to India to be the domain of the Indian Government, yet a general lack of arrangements and provisions meant that rehabilitation efforts were chaotic and short-reaching. All officials agreed that permanently disabled British soldiers routed to India must be invalided to England, and receive further treatment in the metropole before returning to the colonies. In contrast, various “high personages” visiting Brighton’s Indian Hospitals assured wounded Sepoys that “maimed men… would be given first-class artificial limbs of a suitable and practical nature when they reached India.” Yet “first-class” and “suitable and practical” did not necessarily mean the same thing for disabled Indians. All Indian amputees first treated in Brighton were routed to the Marine Lines War Hospital in Bombay, where they were supposed to be fitted with limbs by Mr. Eyres, the Surgical Appliances Specialist attached to the Bombay Medical Store Depot.

The Military Department of India meanwhile openly acknowledged that British veterans received higher grade, duralumin artificial limbs. Disabled British officers based in India faced many of the same difficulties in accessing orthopedic facilities as Indians; however, their mobility and status made it far easier for them to travel to Britain,

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442 Walter Lawrence to Sir Alfred Keogh, September 17, 1915, Mss Eur F143/65: 1914-1916.
443 Alexander Tottenham to Military Department, India Office, November 15, 1928, IOR L/MIL/7/18266
where many received superior limbs and expert repairs.\textsuperscript{444} This privilege extended to white soldiers from the settler colonies and Dominions. Medical administrators were deeply concerned with ensuring that disabled white Australian and South African ex-soldiers received prosthetics suited to their home climates. As early as 1916, W. Holford, the Secretary of Queen Mary’s Convalescent Auxiliary Hospitals, wrote to the Royal Hospital in Chelsea to argue that soldiers returning to hot climates needed special limbs, as an “ordinary wooden leg” would be “practically useless... because of the insects.”\textsuperscript{445} In contrast, no administrators or limb technicians in the Raj suggested such specialization for Indian servicemen.

\footnotesize{\textsuperscript{444} In general, administrators were willing to go to far greater lengths to accommodate British soldiers. J. R. F. Barber, a former Deputy Assistant Director of the Military Works Service, managed to have his medical care and artificial limbs provided for and constantly replaced at the cost of the India Office, despite losing a limb after being released from service. Furthermore, while Barber was paid at the rate of a Captain and working in a post typically filled by a military officer, he was a civilian and had never been in active service. Barber had his left leg amputated “a few weeks” after being released in Waziristan in 1921, due to blood poisoning, and initially paid for his medical expenses himself, before requesting and being granted coverage by the Ministry of Pensions. A few months later, Barber complained the artificial leg he had purchased in India was faulty and “too heavy,” and was supplied at Roehampton with a second set of Desoutter limbs, the most technologically advanced specimen produced at the time. In addition, he was issued a pension effective immediately, calculated according to the degree of permanent disability appropriate for “his race.” By 1927, Barber, whose Medical Report noted had “become fatter in 1922,” needed a new limb: the waist band was broken, knee joint rubbers worn thin, and his weight gain produced the ungainly effect of making his artificial limb sit higher than his right leg. This was problematic: the British Military Hospital at Colaba, Bombay, never had the equipment and expertise to make changes to duralumin limbs, and none were manufactured by Indian firms. After months of debate, Barber was directed to report to the Assistant Director of Medical Services at Bombay so that a cast of the stump could be prepared. From there on, a limb would be manufactured to measure in England, and sent to India. Whether Barber ever received this is unknown: he failed to report himself to his depot. But the lengths to which various governmental offices were willing to go for him far exceeded that of most disabled Indian veterans, whose distance and laboring bodies were considerably more difficult to reach and heal. Government willingness to supply further limbs varied on a case by case basis. In 1920, Captain D.A.G. Dallas asked the Ministry of Pensions to accept liability for a third limb: he had rejected his first Hanger limb on the grounds that it was too uncomfortable, and had it replaced with a Kenney limb. Satisfied, he asked for a second Kenney limb to fit the new muscular growth on his expanding stump. Swain refused, stating that it was Army policy only to pay for two limbs. Likewise, when Captain Gough of the 2\textsuperscript{nd} Gurkhas requested a new set of artificial eyes, the Dept. of State for India declared that they would not fund a new pair until he retired. Grant of Disability Pension and provision of artificial limbs to temporary civilian engineer, case of Mr. J. R. Barber, IOR L/MIL/7/294-8: 1922-1928; Case of Captain D. A. D. Dallas, 1920, IOR L/MIL/7/15052. \textsuperscript{445} W. Holford to Major General Charles Crutchley, December 15, 1916, The National Archives (TNA) PIN 48/326.}
Waiting to be fitted for limbs, Indian soldiers convalescing in war hospitals were deeply concerned with how their bodily disabilities would be received back in India. Their letters convey that far from worrying over their physical appearance, they were most anxious over how their physical limitations would impact their economic contributions to their families: for decades, the bulk of retired Indian Army soldiers had returned to agriculture in their home villages after completing their service. For some, death was preferable to returning to India unable to provide for oneself and one’s family. Convalescing in the New Milton Home, Dafadar Ragunath Prasad wrote to a Driver friend attached to the 38th C.I. Horse, bemoaning how he was left disabled rather than killed: “My legs are absolutely useless. I am always praying to God and saying ‘Oh God it would have been much better, if I had died, for what can I do in India in such a crippled condition?’” In a similar position, Lance Naik Phina Ram wrote to a friend in Kangra in December of 1915, parsing through alternatives to living at home with the shame of disability: “I am absolutely crippled in the legs, and wherever I go I shall be avoided. They will even turn me out at home. Since I joined the regiment I have always been having shocks… If they do not welcome me at home, I am thinking of going on a pilgrimage and living by myself on what government may give me.”

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446 Perpetuating this trend, Ravi Ahuja argues that Sepoys’ extended time abroad during WWI, amid six boom years of army recruitment, made soldiers all the more eager to return to their villages as soon as possible, both to retain their hold on property and their identity – and respectability – as peasant-soldiers. See Ravi Ahuja, “The Corrosiveness of Comparison: Reverberations of Indian Wartime Experiences in German Prison Camps (1915-1919),” in *The World in World Wars: Experiences, Perceptions and Perspectives from Africa and Asia*, in Ravi Ahuja, Katrin Bromber, Katharina Lange, Dyalaa Hamzak, and Heike Liebau eds. (Boston: Brill, 2010), 136-7; David Omissi, *The Sepoy and the Raj: The Indian Army, 1860-1940* (Basingstoke: Macmillan, 1994).

447 Dafadar Ragunath Prasad to Bidesi Ram, December 30, 1915, IOR L/MIL/5/826/2.

incapacitated and psychologically fragile, Ram recognized that his changed body and inability to labor would make him an anathema to both family and the public.

Fears like these were not entirely unfounded. Relatives sometimes claimed that they would reject the physically disabled, particularly when they did not come with sufficient compensation from the Army. Mamu Khan of the 40th Pathans was undergoing treatment at the Pavilion Hospital when he wrote to his regiment-mate Abdulla Jan, who had been sent back to India, “You wrote that you were offered a pension of eight rupees, but had refused it. Do as you please. Are eight rupees not enough for an ox (like you)? For you have one hand and one foot missing, and are of no use at home.”

Though disabled veterans in Britain struggled with unemployment, they nonetheless benefitted from a wider variety of jobs open to them which did not involve hard physical labor, from clerical to factory work. Indian soldier amputees had far less opportunities – largely illiterate, most employment required them to be mobile and physically able.

While some Sepoys had positive first impressions of their limbs, they did not necessarily anticipate the wear and tear which would result in future difficulties. Malik Rajwali Khan, a Punjabi Musalman sepoy, wrote from the hospital in Bombay to a friend serving as a ward orderly at the Kitchener Hospital in Brighton in December 1915, noting that “The men who have had their legs cut off all get artificial legs from Bombay. I too have got one. They are very good.” Khan added that he had not yet had news from or reached his home in the Punjab. There, he and many other veterans met new difficulties and stymied attempts to receiving upgrades and care for their orthopedic devices.

Building Bodies in British India

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449 Mamu Khan to Abdulla Jan, December 21, 1915, IOR L/MIL/5/826/2.
450 Malik Rajwali Khan to Kazandar Khan, December 8, 1915, IOR L/MIL/825/9.
As the disabled returned home, their broken bodies were met with a deeply fractured network of colonial veteran healthcare. Radically, WWI was the first time in which physician-approved, specialist limbs were made available to Indian men. Yet availability of revolutionary medical technology did not necessarily lead to a revolution in accessible care: bureaucratic conflict and local politics presented different obstacles to comprehensive treatment and rehabilitation.

The advent of war drastically changed Indian attitudes towards military disability and prosthetics. Indian novelist and nationalist Mulk Raj Anand illustrated these shifting perspectives over the course of his “Great War trilogy,” published between 1939 and 1942. In *Across the Black Waters*, he attributes the pre-WWI rise in Indian Army recruits to the rare return of war heroes awarded with a medal or a Government pension. Anand suggests that physical disability conferred a special distinction and admiration upon the veteran:

…And once now in a while in a district [there was] a hero, a man who had earned both a medal and a pension attached to it. And he soon became a legend and people came to see him, the wonder, especially if he had left an arm, a leg, or an eye behind, and used a miraculous wooden substitute.451

Prior to the Great War, the limited nature of veteran disability among Indian soldiers rendered it something of a distinguished spectacle. This sense of technological wonder is present, too, in many early histories of medicine which promulgated a narrative of wartime medical innovation, in which the exigencies of conflict prompted drastic improvements in medical fields like prosthetic technology. In this telling, the advent of mass disability produced not only modernized artificial limbs, but modernized men.

But Anand’s later meditations on the flood of disabled soldiers returning to India after World War I offer a very different perspective. Depicting a period of increased nationalist agitation and periodic colonial violence, the injuries and deaths of Great War soldiers and the general populace figure as casualties, not of German aggression, but of British rule. In *The Sword and the Sickle*, the final installation of the trilogy, Anand asserts that after the Great War, Indian soldiers’ disabilities lost much of their pre-war glamour, even conflating his main character’s wartime wounds with the deaths and disfigurements suffered by victims of the Amritsar Massacre. The return of many of the 1.4 million South Asian servicemen begs questions of how the issue of mass disability affected the relationship between colonizer and colonized, and how prosthetic technology and rehabilitative therapies mediated this relationship.

Recognizing the gravity of the impending crisis of debility, army administrators in India set about establishing a scattered series of orthopedic facilities at hospitals throughout the center and north of the colony. Government provisions for limb supply were sporadic enough during the war that ICS Secretary N. E. Majoribanks had to write to the Government of Bombay in May 1918, to question whether they had any poor funds which could be counted on to supply funding for artificial limbs, crutches, and trusses. The Indian Medical Service equipped a number of centers with electro-therapeutic treatment, where soldiers’ lame muscles were treated at the Lady Chelmsford Special Red Cross hospital at Dehra Dun, Mussoorie, and eventually at hospitals in Colaba and Deolali. Likewise, orthopedic centers were developed at the King Edward Memorial Hospital in Cawnpore, where soldiers were treated in a special 125-bed ward “given by

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452 N. E. Marjoribanks to Secretary of the Government of Bombay, May 4, 1918, Maharashtra State Archives, Mumbai, General Department Order No. 758.
the people of Cawnpore,” as well as at the Indian Troops War Hospital in Ambala and at one war hospital in Karachi. Yet exactly who and how many received care in these facilities is unknown, as is whether they were open to Indian army followers and laborers as well as Sepoys. At the same time, the Government of India rejected some treatments received by white soldiers as unnecessary and costly. In 1918, the Military Department inquired whether disabled personnel in India could receive the same distinctive white armlets issued to disabled soldiers in Britain. C. H. Kenderdine, the Director of Artificial Limb Supplies at the Ministry of Pensions, noted that the armbands would mark deserving men out, and potentially help “preserve the man from accident in a crowd” by making his disability more visible.453 Yet after a month of correspondence back and forth, the Government of India rejected the proposal without explanation.

In the interwar years, the supply of artificial limbs was hampered by a catalogue of errors from mismanagement and neglect to absenteeism. As Ministry of Pensions official G. J. Gilbert later reported to the India Office in 1925, the history of the supply and repair of artificial limbs and surgical appliances was “a very chequered one.”454 In 1918, under pressure from the Government of India and the India Office, the Army Department in India decided to hire an orthopedic “expert.” Realizing that there were no such experts available, the Indian Medical Service sent Captain Sidney Hepworth, presently serving with the Indian Field Ambulance in Palestine, on a tour of medical centers throughout the metropole, in the hopes that he would return with a knowledge of all of the “latest orthopaedic development[s].”455 Hepworth toured the preeminent

453 C. H. Kenderdine to Under Secretary of State for India, August 28, 1918, IOR L/MIL/7/18610.
454 Administration of Imperial Pensions in India: Report by G. J. Gilbert, 1925, TNA PIN/15/737.
455 Report of Captain S. M. Hepworth on Deputation to England to Study Latest Orthopaedic Developments, February 25, 1919, IOR L/MIL/7/16093.
healing institutions of the war, from the extensive facilities and rehabilitation workshops at Roehampton to the war hospitals of Liverpool – including the notable Maghull Hospital for the treatment of “psychoneuroses.”

Yet one “expert” would not be enough. Orthopedic devices required intense supervision and extensive practice. Mechanicians and orthopedic technicians recalled cases of spine curvature resulting from too-short limbs, or shoddy workmanship. While Hepworth trained, the India Office decided that it was essential that India have its own expert in the making of artificial limbs. As one October minute noted, the “best quality” was necessary for the Sepoys who had sacrificed their bodies for Mother England.456 In 1919, the Army Department recruited Hugh Ernst, the son of Frederick Gustav Ernst, orthopedic mechanician to the National Orthopaedic Hospital during the war. Ernst the younger was appointed an “expert” in artificial limbs to oversee production in India. Hugh Ernst’s tenure as Artificial Limb Expert to the Government of India was a short one. In 1921, he was convicted of embezzlement and fired. His replacement died within a year, and was followed by Captain K. G. F. Collender in 1923. In the same year, the lease for the Bombay factory expired, the Government of India closed the factory, and all work was given over to the local Indian Station Hospital. In review, the Gov. of India decided that “the comparatively small number of limbs etc. supplied and repaired did not justify the retention of a separate establishment.”457 At this point, it transferred all work to Messrs. Powell & Co., a firm making surgical instruments in Bombay run by Anandsar Laxman Nair. Gov. of India officials concluded that the post of “Expert” in artificial limb production was unnecessary given the allegedly “small number” of men needing

456 India Office Minute, October 6, 1919, IOR L/MIL/7/18264.
457 Administration of Imperial Pensions in India: Report by G. J. Gilbert, 1925, TNA PIN/15/737.
care, and Collender moved to a civilian hospital, where he consulted part-time on military issues.

Prosthetic care drove conflict within local government as well. A number of Indian politicians’ nationalist sentiments prompted them to reject the growth of new networks for the supply of orthopedic appliances in India. They did not object to the provision of prosthetics. Rather, these legislators identified the growth of this medical administration as yet another example of cumbersome British bureaucracy and its propensity to create positions for white civil servants. Collender, in particular, came under fire from members of the Bombay Presidency’s Legislative Committee in his capacity as a part-time military and civil limb mechanician and adviser. Several Indian representatives protested against Collender’s continued employment at the cost of the Government. Instead, they argued that private firms like Messrs. N. Powell & Co. could provide mechanical appliances to the disabled – military and civilian – without the supervision of an “expert.” M. B. Velkar, representative for Bombay City South, went as far as to claim that the establishment of Government positions for artificial limb supervisors was an imperial scam for European job creation. He claimed of Collender, “He is a retired military officer and this post was made for him. We know how experts are created in this country. Whenever a man of the ruling race requires a certain post he at once becomes an expert.”

To Velkar, whose district had absorbed a mass of demobilized veterans before their return home, an orthopedics supervisor constituted yet another imposition of the majority-white Army administration on the local government.

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458 Debate on Technical Adviser for Orthopaedics, Bombay Legislative Council, March 5, 1926, 763, IOR L/MIL/7/18266.
The debate that followed pitted a majority of Indian members of the Council against its white representatives; Representatives Khurshed F. Nariman, the Parsi future mayor of Mumbai and nationalist politician, and Rao Saheb D. P. Desai were outraged that no Indian applicants were considered for the post. Yet none applied – the Indianization of the IMS, with its increase in numbers of native officers, did not fully take effect until after the War. On the other side, B. V. Jadhav tried to explain that further supervision was necessary for the production of decent quality limbs, arguing that “The ready-made splints that are sold in the bazaar are not so useful in complicated cases as splints and limbs specially made to measurements supplied by competent surgeons.” Jadhav believed that these would not be readily available – or properly made – by workmen in local markets. The complex corporeal damage of modern war required customized devices.

In the end, the motion to remove Collender from the Government’s roster entirely was rejected 33 to 42, yet 33 out of 56 Indian representatives (the entire ‘Aye’ count) had voted to oust him. Thus pro-nationalist Indian representatives in state government made healthcare provision – particularly military welfare and medical aid – into an issue of self-sovereignty versus British rule: would the members of the Legislative Council sanction continued European dominance over “expert fields” and force regional governments to pay for white positions?

This protracted disorder, alongside a litany of complaints received by the Ministry of Pensions and India Office back in Britain, prompted the metropolitan bureaucracy to critically reexamine administration in India. The India Office had little faith in the

459 Ibid, 769.
Government of India’s commitment to disabled veterans or to prosthetics technology. Military Department official J. Smith raised the alarm in April of 1926. “In the end it will amount to this that Indian soldiers who have lost limbs in the War will be denied the alleviation of their similar disabilities which properly constructed and properly fitted artificial limbs afford. In the long run it may cost Government less to maintain a supervisor than not to.”\textsuperscript{460} Smith’s concerns were both fiscal and compassionate. They were compounded by his sense that veterans in the Raj were not taking advantage of the aid available to them. “Indian soldiers may not avail themselves of their rights as much as they ought,” he declared.\textsuperscript{461} Visual confirmation of veteran neglect soon arrived to bear out his disquiet.

The Ministry gathered a mass of evidence of the poor construction and lack of oversight of Powell & Co.’s prosthetics, from a range of photographs to a sample leather band which had snapped (still in the Ministry’s files).\textsuperscript{462} One image of a below-the-knee shaped leg showed how the bucket had broken away, while the wooden peg was fitted by a patient and received no upkeep. Another below-knee pin leg’s joint was entirely gone, rawhide peeled off, with a broken bucket and steel heel entirely worn through. One below-knee shaped leg had broken at the joint and had been mended by the patient with U-shaped pieces of iron. Photographs of prosthetic boots showed soles and extensions completely worn out. For the Ministry of Pensions, the broken and hard-used prosthesis acted as a proxy for the broken veteran, who, innumerable miles from a medical center and specialized care, was neglected by the Government of India.

\textsuperscript{460} Government of India Military Department Minute 2382, April 12, 1926, IOR L/MIL/7/18266.
\textsuperscript{461} Ibid.
\textsuperscript{462} Photographer unknown, in K. G. F. Collender to Under Secretary of State for India, May 11, 1925, IOR L/MIL/7/18266.
The Ministry charged the Government of India with abandoning its disabled native veterans, and insisted that it make greater efforts to accommodate them. Ousted to work in a civilian hospital, Collender sided with the metropolitan authorities. He wrote to the India Office claiming that military hospitals in India were completely out of date in regard to splits and appliances.\textsuperscript{463} When the Ministry of Pensions questioned the suitability of Powells & Co., and the quality of the limbs they manufactured, the Government of India accused them of interfering in their internal administration.\textsuperscript{464} Writing to the Director of Medical Services in Simla, Collender suggested that a permanent artificial limb factory be established in Dehra Dun, far closer to the majority of disabled pensioners than Bombay – advice which the DMS failed to act on. Collender and Smith’s warnings to their fellow colonial administrators reveal the fractures within official positions on prosthetic provisioning within the Raj. Humane and fiscal concerns came up against resistance from both local Indian politicians and senior British administrators.

Even in British investigations of the orthopedic provisions in India, intended to aid veterans to the greatest extent possible, racial stereotypes mixed with cultural ignorance. In the subsequent decades, several metropolitan authorities cited Indians’ supposed carelessness as evidence that the Government of India was not adequately providing for its veterans. As J. Smith observed in April 1927, “Indians of the uneducated classes are very destructive of mechanical contrivances of all kinds, never providing ‘the stitch in time.’ If then India spends on the average less than the Ministry of Pensions it is obvious that the artificial limbs are not being kept in proper order” [emphasis in

\textsuperscript{463} K. G. F. Collender to the Under Secretary of State for India, May 11, 1925, IOR L/MIL/7/18266.\textsuperscript{464} Administration of Imperial Pensions in India: Report by Mr. G. J. Gilbert, 1925, PIN 15/737.
According to Smith, low artificial limb repair figures were proof that the Government of India was neglecting disabled Sepoys – not because the Government necessarily lacked facilities and outreach, but because it was common knowledge that any Sepoy would quickly ruin his prosthetic device. While various Ministry of Pensions officials privately made similar complaints about white disabled Briton’s ability to adequately care for their prostheses, the greater sensitivity accorded to the veteran issue in interwar Britain, and the much lower frequency at which the duralumin limbs were repaired, meant that such complaints never gained much traction in the metropole.

S. K. Brown at the India Office argued that Indians’ negligence towards their artificial limbs might later be used insidiously for subversive means. In June of the same year, he claimed, “The danger may be that, in the absence of steady guidance and periodical supervision, the disabled pensioner may too often be content to allow his artificial limb to become inefficient or useless, and may then be used as an object lesson by the disaffected to show that the Government is indifferent to the fate of the ex-soldier.” Brown claimed that an I.M.S. officer from the Punjab had related an example of this to him, but provided no specifics. In 1928, the Indian Soldiers’ Board conducted a survey about artificial limb supply in the North West Frontier Province, the Punjab, the United Provinces, and the Bombay Presidency. Of the 191 responses from pensioners

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465 Minute 2171, April 13, 1927, IOR L/MIL/7/18266.
466 S. K. Brown to Secretary of Gov. of India, June 28, 1927, IOR L/MIL/7/18266.
467 The Indian Soldiers’ Board and its provincial counterparts were established after the war to mirror the function of England’s Ministry of Reconstruction. Intended to distribute and monitor awards made to ex-soldiers and their relatives and to safeguard their interests, the Board combined civil and military authorities so that it stood outside the bounds of the Military Department. Provincial counterparts of the Indian Soldiers’ Boards performed the bulk of administrative legwork; however, Tan Tai Yong asserts that by the mid to late 1920s, these District Soldiers’ Boards were effectively bureaucratic instruments for military surveillance, particularly in the Punjab. See Tan Tai Yong, *The Garrison State: The Military, Government and Society in Colonial Punjab, 1849-1947* (New Delhi: Sage Publications, 2005), 145-146, 164.
with artificial limbs, 46% responded that their limbs were “wholly or partially” unsatisfactory. 40% answered that inspection facilities were inadequate. Yet administrator Alexander Tottenham proclaimed that there was no reason to suppose that these were serious complaints. Rather, the unsatisfied 46% answered so “in the hope that a complaint might obtain for them an increase in their disability pensions.”468 Yet other British officials rejected fatalism as an explanation. G. M. Young, a chairman of a District Soldiers Board (DSB) in India, wrote privately to S. K. Brown, claiming that he did not believe “the pensioned Sepoy is quite such a fatalist as [Brown’s] I.M.S. informant supposes... When a wooden leg is uncomfortable someone in authority is always told about it, and often when it isn’t.”469 As a member of a DSB, Young had more access and contact with veterans than Tottenham, isolated in his Military Department Office.

The wealth of authorities’ claims about Indian’s destructiveness towards orthopedic devices, in addition to the Soldiers’ Board survey, suggests there was a huge demand for quality orthopedic devices which went largely unmet. Hundreds of disabled veterans were complaining and in need of repairs, but far from being flooded with veterans in need, the medical and orthopedic facilities provided to them were notably empty – the Government of India cited the lack of patients as reason for abolishing the position of “Expert” and closing their Bombay factory. When the Ministry of Pensions and India Office questioned this, the Military Department assured them that there was “no justification” for employing a medical official to supervise work done in artificial

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468 Alexander Robert Tottenham to Secretary of Military Department, India Office, November 15, 1928, IOR L/MIL/7/18266.
469 G. M. Young to S. K. Brown, January 6, 1926, IOR L/MIL/7/18266.
limb workshops. Furthermore, they claimed, despite their estimate that around 1,800 Indian pensioners would need artificial limbs, as of July 1928, only 595 had applied for orthopedics.\textsuperscript{470} Officials back in Westminster were strongly dissatisfied with this explanation. One India Office worker noted that the Military Department’s response deliberately sidestepped their inquiries and their argument, “which was that the higher Indian figures [of disabled men, compared to those who applied with artificial limbs] showed a proportionate neglect of repair.”\textsuperscript{471} Comparing the shockingly low pension figures reported by the Government of India compared to India Office estimates, Medical Advisor J. A. Simpson concluded that the Govt. of India had a severe lack of facilities for repair, and that their position was “thoroughly unsatisfactory.”\textsuperscript{472}

Despite claims otherwise, earlier records indicate that disabled ex-servicemen using artificial legs applied for renewals and maintenance at a high rate: though the Army Department declared 24,000 cases eligible for prosthetic legs from the military from 1926-27, nearly double that number, 42,135, made applications for renewals and maintenance.\textsuperscript{473} However, only 30% of eligible veterans with artificial arms applied for renewals or repairs for the same years. This sharp disparity suggests that either the arms provided were proving more satisfactory, were deemed less critical by potential recipients, or both. One Colonel Harvey disparagingly expressed the opinion that when the government did supply arm prosthetics, Indians used them “for firewood.”\textsuperscript{474}

\textsuperscript{470} Alexander Robert Tottenham to Secretary of Military Department, India Office, November 15, 1928, IOR L/MIL/7/18266.
\textsuperscript{471} Comments on Alexander Robert Tottenham to Secretary of Military Department, India Office, November 15, 1928, IOR L/MIL/7/18266.
\textsuperscript{472} Ibid; J. A. Simpson, Minute, May 28, 1927, IOR L/MIL/7/18266.
\textsuperscript{473} Ministry of Pensions to Military Department, India Office, May 13, 1927, IOR L/MIL/7/18266.
Veterans’ failure to request artificial arms points to another series of pitfalls in Indian administration’s medical networks. When fewer than anticipated disabled soldiers sought further care as the decade wore on, Government officials in India and in Britain consistently failed to question why they failed to do so, tending instead to blame Indians’ lifestyle and occupation. According to “expert” opinion, ex-Sepoys returned to their agricultural occupations after the war, and as a result of the nature of this work, quickly ruined or discarded their artificial appliances. They lived in rural districts or villages far from official headquarters and thus did not travel to receive aid. British authorities failed to extend the military and medical infrastructure in order to meet veterans’ needs. Alexander Tottenham asserted that most recipients of prosthetics belonged to the “peasant class,” in which they “have found the limbs a hindrance rather than a help to their work, and therefore may have not troubled to apply for replacements when the original limbs became unserviceable.”475 No medical officer sought to adjust limbs for non-British veterans’ lifestyles. British administrator’s one-type-fits-all policy towards artificial limb design was based on Western standards that all too often blamed Indian veterans for their devices’ inadequacies.

In planning and implementing the physical rehabilitation of Indian troops, the Army Department and Indian Medical Service failed to develop limbs which considered the physical culture and practices of Indian troops. Standard British artificial limbs may have suited the bodily technologies and performances of European veterans, but they did not necessarily accommodate those of Indian veterans, particularly those whose military career was over and who returned to their villages. Very few first person accounts from

475 Alexander Tottenham to Secretary of Military Department, India Office, November 15, 1928, IOR L/MIL/7/18266.
disabled Indian veterans exist, but a few accounts verify that Sepoys found their prosthetic devices ill-suited. In August 1915, Rajwali Khan wrote to a Lance Naik friend in the 59th Rifles in France. Convalescing at the Kitchener Indian Hospital in Brighton, Khan rejected the prosthetics offered by British physicians, noting that “They gave me an (artificial) leg, but I did not take it, because it was useless to me. So I am going without.” Khan does not specify why he felt the limb to be useless, yet still elected to return to India without the prototype prescribed by European orthopedists.

Government officials and physicians recognized the incongruities of fitting Western-developed limbs to Indian amputees, yet failed to consider the development of alternatives. G. J. Gilbert, the Ministry of Pensions official in charge of critiquing the Indian Government’s provisions for veterans, observed that Indians were only supplied with boots for one of their two leg appliances, which seemed “justifiable as the Indian does not, as a rule, wear boots.”

Similarly, colonial bureaucracy rarely considered the effects of distance and travel on disabled Indians seeking medical aid. On the surface, British provisions for veteran care appeared to be liberal and accommodating – new limbs would be provided free of charge to replace older, run-down or unserviceable models to any pensioner who sought one. Yet up until 1925, disabled veterans could only be refitted for limbs at the government workshop in Bombay. Though the Army Department pledged to provide railway warrants free of cost, there was no specified repayment for road travel, and little

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476 Rajwali Khan to Chaudri Khan, August 24, 1915, IOR L/MIL/5/825/5.
to no compensation for loss of remunerative time. Ex-servicemen in need of prosthetic repairs had to sacrifice valuable time, and commit to a long and arduous journey in order to have their appliances serviced. Furthermore, as the Military Department pointed out in their own memos, a large portion of soldiers disabled in the first years of war were Gurkhas, who, after reaching their homes in Nepal, “would be reluctant to return to India” to receive replacement limbs. The same difficulties applied to the large percentage of veterans who lived in the rural outreaches of the Northwest Frontier far from British administrative centers or railways.

Army officials in India ascribed the gaps and shortfalls in their provision of care to their respect for soldiers’ rights to privacy and self-determination. When urged by the India Office to rethink their accommodations for disabled veterans, Military Department representative Alexander Tottenham explained the government’s position as an issue of privacy rather than medical necessity. After all, the commissioned medical officers who performed limb inspections could be stationed at least two or three days’ journey from pensioners’ villages. As the men were “no longer under official control,” Tottenham explained, “any attempt to enforce such an order [to attend an inspection] would be resented as an interference with their liberties.” Tottenham figured British attempts to fit men with limbs as a form of bodily/individual invasion, rather than medical aid.

Debates over the extent of the Indian Army’s responsibility towards disabled soldiers in the 1930s also led to a rise in tensions between government and corporate interests. Hoping to train more Indians in orthopedic appliance making and fitting, the

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478 Ibid.
479 Alexander Tottenham, Secretary to Govt. of India, to Secretary of Military Department, India Office, November 15, 1928, IOR L/MIL/7/18266.
480 Ibid.
Government of India ran into problems with commercial protectionism and territorial patenting. When an Indian major requested that three Indian trainees study limb assembly and repair at the Roehampton factory workshop of the Ministry’s current provider, Ideal Limbs Ltd., Ideal Limbs asked the Ministry of Pensions to refuse on their behalf. Despite slagging production rates and overwhelming demand, the company was reluctant to train men who presented a “threat to their export trade.” Ideal Limbs did however agree to teach limb manufacturing to the Russians, who “compensated them for the loss of their trade secrets.”

Two other limb manufacturers and fitters, Steepers and Hangers, also declined to allow Indian trainees unless adequately compensated. When Steeper learned that a factory in India was already producing a wrist piece originally made at the Roehampton workshop, he grew upset, referencing again that even the Russians paid them for their trade secrets. Ministry of Pensions-sponsored limb manufacturers did not feel that imperial duty and ties required them to accommodate the medical needs of colonial subjects over and above their commercial interests – if the colonies wanted to establish a self-sustaining prosthetic industry, they should pay for it like anyone else.

The Ministry of Pensions felt the pressure and cost of medical care for the Indian Army even more keenly in the Second World War. Near the end of the war in May 1945, the Ministry of Pensions suggested that the Government of India cover one third of the cost of the limb factory expansion at Roehampton. The Indian Army’s British officers and Indian officers and soldiers constituted such a high portion of requests for artificial limbs, Minister Walter Womersley reasoned, India should meet some share of

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481 E. G. White to Seymour, February 8, 1947, PIN 38/439.
responsibility. After a year of debate, the proposal was scrapped – the Ministry of Pensions decided that “the needs of India” and India’s soldiers would be satisfied by wooden legs, cheaper and more easily produced locally in India than contemporary, light metal limbs provided to British soldiers in Europe.\textsuperscript{482} This decision represented the continuance of pre-WWII artificial limb policy, while also distancing the Ministry of Pensions from a responsibility to universally provide prosthetics – especially modern, top of the line devices – to soldiers in India.

In fact, it was not until the 1970s that specialized prosthetics appeared in India. After years spent watching his patients, most of whom were victims of industrial accidents, reject hospital-supplied prosthetics and elect to go without, Dr. Pramod Karan Sethi resolved to provide a useful alternative. There were numerous problems with Western prosthetic design that made them unsuitable when applied to the lifestyles of Indian veterans and workers. European-style artificial legs and boots did not allow for their wearers to sit cross-legged. Nor were they suited to going barefoot, as many of Dr. Sethi’s patients did. This problem in post-Independence India was a legacy of the Great War, when British army prosthetics began to be developed en masse. The limbs which Dr. Sethi fitted civilian patients with in the 1960s were standard army-issue devices whose weight and heavy boots rendered them impractical for many of his barefoot and impoverished patients. In 1968, after years of development with artisans, philanthropists, students, and amputees, Sethi released his invention, the “Jaipur Foot,” a rugged, waterproof prosthetic whose inexpensive design and materials makes it ideal for wearers in tropical and sub-tropical countries. As Raman Srinivasan has established, it is also

\textsuperscript{482} Meeting Minutes, May 15, 1945, PIN 38/439; R. A. Ledgard to Captain R. H. Webb, May 20, 1946, PIN 38/439.
“culturally appropriate, by virtue of its design,” which enables its users to sit cross-legged, squat, and go barefoot.\textsuperscript{483} Since its inception, it has revolutionized prosthetic and orthotics care and become commonplace throughout South and Southeast Asia, Kenya, Nicaragua, and abroad.

**Physical Rehabilitation and Reeducation in the Raj**

Even those disabled soldiers who did receive adequate artificial limbs struggled with employment. The overwhelming number of studies conducted on veteran experience in Britain have established that despite ex-servicemen’s prominent position in the public consciousness, their access to adequate postwar care was by no means guaranteed. In dire economic straits, the British state offered very modest compensation to the wounded and there were few government-backed rehabilitation programs. Instead, Deborah Cohen has established that voluntarists and private charities assumed the greater part of care-taking and reeducation.\textsuperscript{484} Care for disabled Indian veterans was remarkably similar in many respects to that of many British servicemen – the best and most enduring care came from private institutions and charitable individuals, each with their own agendas.

Numerous scholars have established that the precedents for limb provision and soldier re-training in Britain had been established long before the war. Seth Koven identifies how patterns of treatment and public reception of disabled soldiers were

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\textsuperscript{483} The Japiur foot’s rubber body and toes also allows users to customize and decorate it as they would a normal foot. Srinivasan recalled seeing women whose Jaipur feet were adorned with henna and toe-rings. In the 1970s, the makers of the Jaipur feet also made efforts to customize them to patients’ skin color. Raman Srinivasan, “Technology Sits Cross-Legged: Developing the Jaipur Foot Prosthesis,” in *Artificial Parts, Practical Lives: Modern Histories of Prosthetics*, Katherine Ott, David Serlin, and Stephen Mihm eds. (New York: New York University Press, 2002), 328.

\textsuperscript{484} Cohen, *The War Come Home*. 
strongly linked to the analogous treatment of children crippled in industrial accidents in
the late nineteenth century – down to the institutions in which they were treated and the
presence of disabled children during soldier’s treatment.\textsuperscript{485} In contrast, very few
institutions for the disabled existed in India and the Caribbean prior to the war. The few
that did were funded and run by non-profits and philanthropists, of which there were far
more in the British Raj than in the Caribbean. Like many analogous institutions in
Britain, they were founded and run upon Victorian principles of charity and welfare. Yet
while this produced some continuities for the disabled in Britain, trade training in a
rehabilitative institute was an entirely new experience for Indians, especially rural
Sepoys.

Government officials in India seemed happy with this arrangement, and used the
existence of private care to justify not providing additional government funding for
treatment. In 1919, the Army Department of India assured the Secretary of State for
India, the Right Hon. Edwin Montagu, that they had adequate facilities for the
rehabilitation of disabled veterans, though most of the programs they referenced were
private ventures. Philanthropic institutions and private charities unquestionably
dominated care for the blind, which the army and the IMS had little to do with. When
asked about facilities for the blind, Charles Lukis IMS noted that unseeing veterans could
attend the Victoria Memorial School for the Blind in Bombay, and vaguely, at a “similar
school in Lahore.”\textsuperscript{486} However, IMS and Army officials were in agreement about one
thing: very few blind soldiers sought care, and in their opinion, few would go on to. Yet

\textsuperscript{485} Seth Koven, “Remembering and Dismemberment: Crippled Children, Wounded Soldiers, and the Great
\textsuperscript{486} Army Department Dispatch 4, 10 January 1919, IOR L/MIL/7/18481.
again, British officials envisioned “Oriental fatalism” as preventing disabled Indians from receiving aid. C. P. Lukis assured Montagu that while the number of blinded soldiers who presented themselves for training was small, this was “not due to any lack of advertisement of institutions.” Various officials claimed that they placed adverts in Indian papers and the *Fauji Akbar*, the popular Indian Army newspaper, directing blind soldiers to St. Dunstan’s or the Victoria Memorial School for care. H. Cox echoed this sentiment in March 1919 when he observed that he was not in the least surprised by the failure of blind Indian veterans to apply for technical instruction, for “the Oriental fatalist habit would be all against it.” By all accounts, very few veterans sought care in these institutions – most likely because of their great distance from the rural villages where most soldiers were from. To take advantage of these schemes disabled soldiers would have to have literate family members or acquaintances alert to such opportunities, and willing to forgo their work in order to undertake a long, arduous, and uncertain journey to the few centers that existed in India.

British authorities envisioned retraining disabled Indian men in disability-friendly professions as more difficult than enacting similar programs for white veterans: as one official noted in a meeting minute on the presence of Indian Gov. representatives at the 1918 Inter-Allied Conference, “the problem of the Indian soldiers is so distinct that it might hardly be worth while for the India Office to be represented.” Likewise, an Army Dispatch to Montagu, Secretary of State for India, mused that “the question of what trades could be taught… presented some difficulties arising mainly out of the

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487 Ibid.
488 Cox, 25 March 1919, IOR L/MIL/7/18481.
489 India Office Minute, IOR L/MIL/7/18481.
problem of caste.” As mentioned above, as administrators dealing with artificial limb provision found that most Sepoy veterans came from rural agricultural backgrounds which they wished to return to after the war. Few men were eager to stay in urban areas after their long absence from home, and even fewer were eager to navigate the admissions process to a reeducation institute in industry and trade-focused programs.

Nonetheless, philanthropists eager to support the retraining of Sepoys disabled in the service of Mother England found a worthy outlet for their charity in the form of the Queen Mary Technical School, founded in Bombay in 1917. Like many contemporaneous rehabilitation schemes in Britain, the QMTS ran on Victorian principles of social aid while running on private funding with government authorization. However, its politically sensitive position in the British Raj treating Sepoy subjects rendered it a hybrid institution, whose board members and contributors combined this model with paternalist (imperial) rhetoric. Alongside healing and rehabilitation, the training regimes of the QMTS sought to reforge the worthy and loyal Indian Sepoy into a model of Western industrial productivity, while reinforcing their colonial subjecthood.

From its inception, Queen Mary’s Technical School (the QMTS) combined Victorian humanitarianism and welfare initiatives with a “civilizing” program. It began in much the same way as other like-minded institutions in Britain. Lady Willingdon, wife of the Governor of Bombay, founded the school in 1917, adding it to her repertoire of philanthropic activities. As befitted any dutiful wife of a high-profile politician in

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490 Army Department Dispatch 4, January 10, 1919, IOR L/MIL/7/18481.
491 In 1914, she contributed the Bombay Sanitary Association in setting up the “Lady Willingdon Scheme,” intended to improve women’s and infant’s healthcare by training midwives and establishing maternity homes to provide antenatal and postnatal care. The Willingdon’s philanthropic ventures are still in plentiful evidence in India today: Bombay’s YWCA still utilizes the UNESCO Heritage-Awarded Lady Willingdon Hostel to house over 60 working women, and only in 1998 did the Lady Willingdon Nursing Home become known as the Chennai Willingdon Corporate Foundation. Willingdon was a formidable
the colonies, she was dedicated to and active in many public health initiatives and charities in Bombay. By 1917, she had already established the Lady Willingdon’s Women’s Branch of the War Relief Fund. This effort was quite successful in soliciting donations from various Indian princes and royal households, setting the stage for the same donors to contribute to the QMTS. In a feat which only a high society lady experienced in charitable maneuverings could achieve, Willingdon secured premises in the palatial Braganza Hall in Byculla, rent free, from the estate of the late, prominent merchant Sir Jacob Sassoon.492 At its founding, the site had enough bedrooms to accommodate two hundred students, and was fitted out with many of the trappings of modern Western medicine, including electricity and fans. A fashionable neighborhood in Bombay, Byculla had been an exclusive, predominantly European enclave and was the site of numerous social and residential clubs for governing members of the Raj.

Addressing the chosen location, one handbook noted that the Hall was “healthily situated and admirably suited for the purpose.” The school organizers deemed Indian soldiers worthy and, indeed, needful of the climate and environment preferred by Europeans in order to best heal.

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492 An Indian Tribute to the Indian Disabled: A Brief Account of the Queen Mary’s Technical School, Bombay, and its Work (Bombay: The Times Press, 1919), in IOR L/MIL/17/5/2316. The Sassoon family had been renowned merchants in Bombay since the 1830s. Sir Jacob Sassoon was, incidentally, the cousin of renowned war poet and writer Siegfried Sassoon.
The conversion of Braganza Hall into a site for rehabilitation has much in common with the War Office’s use of the lavish Royal Pavilion in Brighton as a hospital for wounded Indian soldiers in the first two years of the War, both in impulse and public representation. In Brighton, British officials and organizers had hoped that healing and retraining the veterans in sites of Western prestige and rich ornamentation would convey the benevolent Empire’s dedication to her imperial children; here, Lady Willingdon and her army of white and Indian philanthropists carried out the same mission. In recognition, Queen sent a photograph of herself to hang in the school, assuring the soldiers of her “sympathy with them in their afflictions, the loss of arms and legs.” Upon the completion of their course, the soldier veterans were given a diploma depicting the King and Queen, reminding them where their second chance at a sustainable life had come from.

For all its humanitarian mission and rhetoric, the school’s administrators reinforced the superiority and segregation of the martial races by admitting only disabled men discharged from army ranks – passing over the hundreds of disabled men who served as army followers in labor corps and kitchens with the fighting Sepoys of the Indian Army. At first, it drew the bulk of its students from those waiting for artificial limbs at the Marine Lines Hospital. Only later were applications distributed and opened up to those back at home, in hospital, or in regimental depots in the provinces. Veterans arriving at the former army camp would read the following motto, chosen by Lady Willingdon: translated from Sanskrit, it reads “Although hurt, I grow, become young again, and thus offer shade, flowers, and fruit in the service of humanity.”

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493 June 14, 1918, Meeting Minutes Vol. I., Queen Mary Technical Institute [hereafter QMTI], Pune, India.
institution’s clear intent was to restore the most respected imperial fighters in the Empire to their former glory, as much as possible.

Despite claims to the contrary, the issue of class and ethnic caste at the QMTS was keenly felt. Amar Singh, a Rajput officer assigned to patrol the buildings, recalled a fight between an army laborer working at the school and a resident Havildar.\textsuperscript{494} When the laborer was transferred to another position, fellow laborers at the school believed that he had been court martialed for his protest against the Havildar. In response to their unrest, the army assigned two additional officers to monitor the school. This tension between school workers and trainees speaks to the gulf in experience and aid received between low-caste laborers and wounded yet still-superior soldiers.

Despite the message that their reeducation came at the behest of their colonizers in the metropole, the QMTS in fact combined the philanthropy of local British and Indian society. Like the voluntary societies and organizers of British institutions, private philanthropists were far more influential than the government, donating their money and time to the school. Making Sepoys productive was a mission not only for British high society in India, eager to support the sacrifices of the Indian Army, but also for wealthy Indians themselves.\textsuperscript{495} Though organized by Lady Willingdon, contributors came mainly


\textsuperscript{495} Within India, raising money for rehabilitation programs was as much a spectacle as the Raj’s earlier pageants of empire. A number of scholars have drawn attention to the massive response of native rulers to the war effort in general, but the manner in which these gifts were given is crucial. The act of charitable giving was wrapped up in the perpetuation of local princes’ prestige and distinguished by spectacles intended to verify their leadership both to their people and the British. One of the QMTS’s most celebrated donors was the Maharana Rajsahib of Wankaner, who, after being made a Knight Commander at the Delhi Durbar of 1911, was granted a temporary, then permanent Captainship in return for his generous donations to the Indian war effort. Sir Amarsinhji engaged in a vigorous campaign of wartime bequests, travelling to France in November 1915 on a troopship, where he had an audience with their Imperial Majesties. Upon his return to India, the Maharana’s string of donations continued: a grant of Rs. 5,000 was given to Lady
from three groups: British administrators of the Raj and wealthy Indian Army Officials, small government grants and existing war funds, and local Maharajas, Nawabs, and assorted Indian ‘royalty.’ Throughout the tenure of its operation, central actors in the colonial administration visited the school. Meanwhile, local British civilians were able to insert themselves into the very framework of the school by volunteering to train the disabled, thus asserting both their charity and their expertise. Every class was taught by an Englishman, who was “assisted” by a fellow Indian instructor. In some cases, the School’s mission brought the war-changed British together with their Indian counterparts. The QMTS’s first superintendent, Leonard Hirsch, had himself been traumatized by the conflict: Unable to sleep, continually depressed, and subdued, he was granted a 50% permanent disability pension “in respect of neurasthenia aggravated by the Great War.”

Mirroring the conflicts between philanthropic institutions and the government back in the metropole, the QMTS frequently clashed with the Government of India over how to run the school, and who was deemed eligible to enroll. The Government of India repeatedly legislated in favor of re-educating only the most serious of disabled cases. In

Willingdon’s Women’s Branch of the War Relief Fund to mark the occasion of his daughter’s marriage in January 1917. These gifts affirmed the status and prestige of the Prince while aligning him with the British show of ruling benevolence, and they were notable for their dramatic trappings. When Lady Willingdon’s War Relief Fund had held a “fancy fete and war sale” at Ahmedabad in 1917, the Maharana sent lion and leopard cubs to be auctioned, whose proceeds would be donated to the Fund. By the end of the war, he had donated over Rs. 101,500 to various war funds and loans, Rs. 5,300 of which went to Queen Mary’s Technical School for disabled Indian soldiers (in addition to the cubs, he also donated a 60 h.p. Berliet motor-car, three Indian cavalry horses and two mounted infantry ponies throughout the course of the conflict). This pattern was followed by many of the other native rulers. Donations flowed into the QMTS from princely states across India, from Ratlam in Malwa, Central India, to the Punjab in the north and Savanur state in the Bombay Presidency. The Indian Review reported that the Maharajah Scindia of Gwalior provided Rs. 5000 as an initial donation for the school, praising its arrangements and operations. A few months later, the visiting Gaekwar and Maharani of Baroda was so delighted by the “evident care taken for the comfort and assistance” of the wounded that he asked whether the School’s program could be extended to civilians, and “decided on the spot” to send one of his men from Baroda to enroll at the QMTS. The Madras-based Review, where the visits of numerous Gaekwars, Nawabs, and Maharajas were reported, was a respected and notably pro-nationalist paper. Its interest in publishing these spectacles of charity indicates the deep impression they made on the paper’s middling readers.

1918, the Army released a Circular claiming that admission had been restricted to men
drawing first and second degree injury pensions – despite the fact that no such rule was in
place. This provision would have limited the admissions pool to veterans who had lost
entire limbs. Dissenting, the QMTS board noted that the school already had 80 students
whose disabilities were deemed 3rd degree, and that it would continue to accept invalided
soldiers with any disabilities. Four months later, the Army notified the school that the
Rs. 6 they provided per month per student would now be limited to students of the 1st and
2nd degree – only 40 men of the 143 currently enrolled.497 The fact that governmental
contributions were small compared to private donations did not stop tensions from
breaking out between offices over the funding of the School. In 1923, the India Office
conducted a review to consider whether to keep funding the QMTS. Acknowledging that
State support was quite low, about Rs. 18,859, in contrast to the QMTS’s approximately
Rs. 80,000 from other endowments, the Deputy Secretary to the Governor of India
confirmed that since the School was doing “undoubtedly good work,” they should
continue their contribution.498 Nine months later, however, the War Office concurred
that the QMTS was a worthy venture, but refused to pay for soldiers being transported to
the School from the North West Frontier, rather than from Overseas.499 Once invalided
soldiers returned to reside in India, they claimed, their funding was the domain of the
Government of India.

Its funding and instructional programs paint a picture of the QMTS as a model
institution: while it rendered the disabled productive, the school’s organizers also

497 21st Nov. 1918, Meeting Minutes Vol. I., Queen Mary Technical Institute, Pune, India.
498 Dept. Secy. To Gov. of India to Military Secretary India Office, June 7, 1923, IOR L/MIL/7/12521.
499 March 20, 1924, IOR/L/MIL/7/12521.
intended it to educate (and in many ways, ‘civilize’) the Sepoy. A “lady teacher” established a voluntary class in colloquial English and Elementary reading and writing in March 1918, and the School socialized its pupils during harmonium concerts, indoor and outdoor games, and various outings, where men were taken to local Bombay theaters and the Zoological Gardens. The School board sanctioned smaller, informal classes in knitting, poultry farming (the only agricultural activity supported at the School), and the making of artificial flowers. As in Britain, the QMTS sent its students and their wares to be shown at exhibitions across India, displaying the work of the disabled. In 1919, the School sent a representative to an exhibition of handwork at the Senate House in Madras to show work done at the school, and in 1922, the Superintendent and two students travelled to Bombay to attend the Red Cross Fete, where they sold socks and stockings at a stall.

The school’s organizers also attempted to enforce social mores among their students. When a rash of venereal disease cases appeared at the School, the Committee ruled that any disabled trainee found to have contracted a sexually transmitted disease after they began their course would be immediately discharged. Students who had contracted VD before their tenure at the QMTS would be treated at the local hospital – but would have one anna per day deducted from their Relief Pay while there. It would not do for honourable Sepoys receiving British philanthropists’ benevolence to act “immorally” – the School was intended to re-educate them not only in terms of work, but

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500 “Queen Mary’s Technical School at Kirkee for the Training of Disabled Indian Soldiers,” c. 1917, IOR L/MIL/7/12521.
501 September 10, 1919, Meeting Minutes Vol I, QMTI; November 18, 1922, Meeting Minutes Vol. I, QMTI.
502 March 23, 1923, Meeting Minutes Vol. I, QMTI.
also in social values and behavior. In their attempts to support “traditional” lifestyles, the School’s board established and repeatedly expanded when possible family housing for students, so that soldiers might have their families close by. In QMTS housing, students’ dependents received daily rations to support them while their breadwinner was in training.

The school’s course offerings were typical of analogous institutions in Britain; however, trade-focused education represented a departure from veteran employment norms in the subcontinent. Trades were chosen with an individual’s disability in mind – the driving class, for example, required students to have the use of all four limbs, though one could be shorter than another - but apart from physical requirements, participants were apparently allowed to choose which trade they wanted to learn. For British veterans, such training was not particularly revolutionary, as most of the trades had been heavily practiced in the United Kingdom for over a century. But for incapacitated Sepoys, nearly all of whom were primarily agricultural laborers, being retrained as a cinema operator, engine mechanic, or chauffeur represented a radical change in occupation designed to equip them for work in a rapidly shifting economy, driven by expanding colonial and commercial interests. Some students willingly embraced the opportunity to train in modern, non-agricultural careers – though the British public found this surprising.

Many of these courses introduced industrial trades and mechanics, feeding into the further mechanization of India (and destruction of cottage industries). The School often sold knitting machines to graduating students to take home with them as a means of continuing their work. Engineering classes instructed students in various classes and
types of mechanics. Pupils learned how to operate everything from oil engines, ice-making machines, and flour mills to rice hullers and saw benches. The men were taught by R. C. Porter of Messrs. Greaves Cotton & Co., one of the very few British-owned mills in Bombay. 503 More elementary engineering, including turning, fitting, and molding, were available from the retired Engineer Foreman of the Great Indian Peninsular Railway Workshops. Other courses included tailoring, under the instruction of Mr. Sydney Smith of Messrs. Leach and Weborny, practicing philanthropists and subscribing members of the Anglo-Indian Evangelisation Society. Hosiery making classes were taken on by the manager of the Bombay Woolen Mills, who advocated the work as a type of employment widely spread throughout the Punjab, the home province of many returning soldiers.

By far the most popular class was Motor Car Driving, which officials noted was quite suitable for men with foot and leg disabilities fitted with orthopedic boots. Patrick Archibald Stewart, General Manager of the Bombay Motor Car Co., instructed men in driving as well as vehicle mechanics and repair. This workshop had on average sixty to seventy men in training at any given time. While the department had opened for instruction with a single car, by 1918, it had proved so desirable they were operating with twelve cars of differing makes. The QMTS handbook explained that the course’s popularity was due to its short length (only four to six months) and the ready availability of decently paying chauffeuring jobs across India. As such, certified students could reasonably expect to return to their home province, unlike engineers and cinema operators, who were generally restricted to work in or near larger urban centers.

Outside observers were deeply interested in the popularity of the driving course: Western journalists and travelers latched onto the scene of Indian men driving cars as a fundamentally paradoxical sight, the unmodern East meeting the modern West (ignorant of the fact that many Indian men had driven before and during the War). A 1919 issue of the *American Journal of Care for Cripples*, gave examples of technical workshops for disabled servicemen across the globe – though the Queen Mary was the only example of care offered to non-white individuals. Douglas McMurtrie, a well-known authority on rehabilitation and the Director of the US-based Red Cross Institute for Crippled and Disabled Men, described the various classes offered by the School, singling out its chauffeuring workshop. Here, automobile mechanics could be studied by “the crippled natives, whose imagination has been roused by this method of equalizing their physical handicap.”

In a more extensive report on “Re-education in Bombay” a few months later, the journal again singled out the chauffeur classes, noting with surprise that “The tastes of these bearded mystical soldiers in regard to a future occupation are curiously like those of the automobile-minded youths of Western armies.” McMurtrie plays on the incongruities between wounded white Western soldiers, and wounded Indian troops, the unbearded, Christian youths sharing the same interest in motorized vehicles as the unshaven, un-Christian subjects. McMurtrie, who wrote about the QMTS in various forums, encouraged a fantasy of the exotic disabled Sepoy, in another volume, he refers to them as “olive-skinned curly bearded trainees.” Despite their participation in all theatres of the Great War, and their experience of all its technologies, the Indian soldiers were still

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designated as fundamentally unmodern. In referring to these “crippled natives,” McMurtrie implicitly, though no doubt unconsciously, gave voice to the double-bind these veterans found themselves in: even if they managed to overcome their physical disabilities, they would still be forever “handicapped” by their race.

As the first and one of the only rehabilitation centers to do the work of healing and retraining in a non-settler colony, those interested in demonstrating Britain’s commitment to her colonial veterans put Queen Mary’s Institute at the center of a publicity stunt that stretched from India to Europe, Britain, and all the way to America. Amid the uneasy political atmosphere in the subcontinent, dozens of colonial newspapers reported the Duke of Connaught’s February 1921 visit to the school, next to reports discussing the unrest in Tonk and Nagpur, religious conflict in Makana, and meetings held in Lucknow by “Gandhi the extremist.” The Times Press in Bombay distributed a handbook about the School in 1919. Photographs described the men’s training, and a short section depicted full body images of disabled soldiers, including their name, regiment, pay, the training course they were enrolled in, and their disability.

Just as wartime propaganda and publicity about the Brighton Pavilion had sought to define the colonial wounded in the public consciousness as Indian, stoic, and grateful, so the rehabilitated Indian began to assume a role as the token disabled colonial veteran, and the QMTS as the token colonial reeducating institution. Images of the School from its handbook were featured in a photographic exhibit “on Rehabilitation of the Crippled and the Blinded,” depicting the School’s workshops in carpentry and chauffeuring, under

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505 “India,” *Western Mail* (Perth), March 3, 1921, 13.
the heading “India Restores her War Cripples to Self-Support.”

This poster was the sole image and example of rehabilitation for non-white soldiers in the entire 18 panel, forty-five foot long exhibit, which included scenes from America, Britain, France, Italy, and Germany. The Red Cross Institute for Crippled and Disabled Men and the Red Cross Institute for the Blind, funders who hoped to educate the public about newly disabled citizens, had the exhibit printed into over a thousand sets and put into national distribution throughout the United States. However, the exhibit couches India as the principal agent of this relief, rather than Britain, the Empire, or the School’s benefactors. This phrasing reassured viewers not only that the Empire’s prized fighters would be “seen right” in the end, but that the bulk of this effort would come from “India” herself, rather than draining precious resources devoted to healing British soldiers at home in the metropole. The final panel in the exhibit announced, “The Disabled Man Who Is Profitably Employed Is No Longer Handicapped.”

By all accounts, the institute was a great success. At the end of its first year, the QMTS had admitted 233 men to study, with 59 already passing examinations and presented with school diplomas. Typically, courses lasted about six months, and were supposedly open to all ranks and classes of men invalided out of the Indian Army, the Imperial Service Troops, and the Royal Indian Marine. The school reported that they were receiving, on average, twenty applications a month; however, what records exist suggest that the bulk of the students were relatively high-ranking men of martial races,

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506 The exhibit was made available in book form the same year. See Douglas C. McMurtrie, A Graphic Exhibit on Rehabilitation of the Crippled and Blinded: Issued jointly by the Red Cross Institute for Crippled and Disabled Men and the Red Cross Institute for the Blind (New York: Red Cross Institute for Crippled and Disabled Men, 1919).

507 American Journal of Care for Cripples 6 (1919), 507.
not laborers or lower-class sailors (although the administrator’s claimed to accept all veteran servicemen, regardless of rank or role). In reality, of course, the QMTS served only a tiny fraction of the actual percentage of wounded and disabled servicemen. Official statistics held that the total number of Indian wounded was 65,126, but acknowledged that this did not always account for the cumulative injuries of the over 474,000 “followers” not listed as active combatants. If the average course took six months – a very optimistic estimate – than the School could only instruct 400 per year. Even if it went on treating men from the Great War for a decade, it could still only impact 0.06% of the wounded and disabled.

What’s more, the high visibility yet limited reach of the QMTS obscures the realities of the interwar care-giving, the bulk of which was done by women and children whose invisible labor as care-givers would have occupied a significant portion of their everyday lives. While the War Office may have intended the Government of India to assume fiscal responsibility for its disabled veterans, all parties presumed that the Indian family or community would be the main providers engaged in the physical labor of care-giving.

While rendering good and important work, the QMTS was a plaster on the gaping wound of war trauma and disability in India. The visibility of the QMTS and the extent to which it captured the public and private imagination, then, can be ascribed not so much to its success at dealing with the disability crisis, but rather its symbolic role as an institute through which fraught imperial relationships and obligations could be mediated. For the British authorities the QMTS proved valuable as a propaganda and PR tool which validated their claims to be addressing the needs of wounded troops while not
contributing much, if any, additional financial or material resources. In India it served as an outlet for Indian men of status and colonial administrators to demonstrate their personal generosity and dedication to the empire. Meanwhile the photographs and news reports the QMTS generated fed back into the British public’s paternalistic vision of a benevolent and caring empire that tended to its loyal and devoted colonial troops. At the same time, officials in India and the metropole relied on the rhetoric of native simplicity to insist that the vast majority of disabled Indians were freely choosing to forego further rehabilitation or treatment, and that such efforts would in any case be wasted on a people who were neglectful and simplistic. Finally, it also diverted public attention away from the fates of disabled African and Caribbean servicemen, who typically received even less care than the already meager resources offered to Indian troops.

“Treated Like Parasites”: West Indian Rehabilitation & Re-education

Recognizing the physical toll of service on non-combatant servicemen meant acknowledging Britain’s debt to groups far less esteemed than the martial race Sepoys. Rehabilitation and reeducation in the Caribbean was a world apart from the philanthropic establishments of India. Though the British West Indies’ contribution of men to the war effort was small when compared to that of Britain or India, it represented a significant percentage of the population of able-bodied men in the islands. William Henry Manning, the Governor of Jamaica from 1913 to 1918, expressed the seriousness of the situation when he mused that if only 5% of the ten thousand men sent to War were incapacitated,
500 men would return to Jamaica potentially unable to work and in need of public assistance. This called for action and preparation for the returning disabled.

In response, the Ministry of Pensions reiterated the same promises it had made to disabled Indian and British veterans: “Volunteers for service with the Imperial forces are on the same footing in respect of the provision of artificial limbs and appliances as are our own men enlisted in this country; the cost of such supplies being a charge against the funds of this Ministry,” the Secretary of the Ministry pledged in February 1918. A man disabled while on Active Service “who suffers the loss of a limb, an eye, or a Tooth is entitled to be provided at the public expense with the artificial appliance best suited to the needs of his case.” Yet as in the case of the Raj, how easily disabled West Indians could avail themselves of these provisions, and what limbs and appliances the Ministry deemed “best suited” to their needs, was highly variable.

Though West Indian colonial governments were clearly aware of the impending wave of debility before armistice, they failed to establish networks before soldiers returned. Colonial administrators instead intended to push most cases of disabled servicemen off to private philanthropy or pre-established and longstanding organizations for paupers. In December 1917, Barbados Governor Leslie Probyn wrote to Sir Walter Long, Secretary of State to the Colonies, assuring him that the local government had confronted the question of granting medical assistance to “discharged invalids” Their

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508 William Henry Manning to Colonial Secretary, January 25, 1918, CO 137/728/37.
509 Secretary of Ministry of Pensions to Under Secretary of Colonial Office, February 28, 1918, CO 318/347/63
510 Ibid.
solution was to trade responsibility: they had referred the question to the Poor Law Guardians of the island’s parishes and Parochial Medical Officers.\textsuperscript{512}

In Jamaica, bureaucratic crossed wires and budget problems dominated a scarce and difficult to access medical system for veterans. Reeducation seemed to offer the white leadership of Jamaica a chance to once again make the Jamaican civilian into a useful, productive individual; however, public and private resources to do so rarely materialized. In January 1918, Governor Manning wrote in a plea to the Colonial Office and the Ministry of Pensions for the funding of a rehabilitation scheme based in Kingston, “It is moreover desirable on other grounds that such men should be given every opportunity of rehabilitating themselves, and becoming useful citizens.”\textsuperscript{513} Presided over by the newly inaugurated Jamaican Governor Leslie Probyn, the Jamaican Legislative Council approved a sum of £10,000 in December for the establishment of an institution for the temporary housing and training of disabled men from Jamaica’s war contingents.\textsuperscript{514} However, conflicts over the purchase of the Constant Spring Hotel for its grounds, and an inability to find £10,000 in the 1918 budget forced the Council to suspend the proposal. Further attempts to find funding were hindered by tight postwar finances and vague gestures towards fiscal responsibility. The Red Cross Society promised a one-time donation, alleging that they could not commit to an annual contribution. Still, the organization refused to specify an amount until they were informed of how much the Ministry of Pensions and the colonial government intended to

\textsuperscript{512} Ibid.
\textsuperscript{513} W. H. Manning to Walter Long, January 25, 1918, CO 137/728/37.
\textsuperscript{514} Governor Probyn to Walter Long, December 17, 1918, CO 137/728/37.
pledge.\textsuperscript{515} There was little co-operation between the Caribbean colonies, virtually all of whom had few resources and no visible system for orthopedic care apart from Jamaica.

Despite their desire to help ex-soldiers back to work, government officials’ opinions on how and whether to offer veterans in the Caribbean retraining and rehabilitative programs were rife with age-old stereotypes of West Indians as “lazy” and indolent. J. H. W. Park, the President of the Central Recruiting Committee in Kingston, claimed that invalided and disabled men were “unable, and to a considerable extent unwilling to provide themselves with proper medical attendance, or to take steps and learn new trades or occupations.” Without offering specific institutions or opportunities, Park asserted that the men should be encouraged to undergo training; however, the majority were “better employed in cultivating the soil.”\textsuperscript{516} How soldiers disabled to various extents were expected to become successful farmers, he did not say. Park blamed disabled West Indians for their own medical condition, in asserting that they were effectively too lazy or stubborn to take advantage of what little medical care and welfare the Government supplied.

Similar stereotypes ran through artificial limb provision. Though few were involved in fighting while serving as laborers, West Indian soldiers still found themselves in need of orthopaedics and prosthetics. Most cases of lower body amputations were due to frostbite and exposure, and nearly all lost both feet or legs below the knee.\textsuperscript{517} In September 1918, 40% of BWIR cases in the Liverpool General Hospital were double amputees. Colonial governments’ lack of preparation came to a head in the summer of

\textsuperscript{515} Robert A. Hudson, Chairman of the Finance Committee of the British Red Cross Society, to Gov. William Manning, March 4, 1918, CO 137/728/37.
\textsuperscript{516} J. H. W. Park to Sir Walter Long, December 22, 1917, CO 137/728/37.
\textsuperscript{517} List of West Indian Discharged Soldiers who Require Artificial Limbs, March 1, 1918, CO 318/347/63.
1918, when it emerged that a number of Afro-Caribbean amputees had been sent to the West Indies without having been given artificial limbs.\textsuperscript{518} No facilities existed to fit prostheses once the veterans returned to their home colonies.

Despite the general consensus that the debility crisis required swift actions, colonial administrators in the British West Indies found themselves facing the same questions that preoccupied officials in the British Raj: what prosthetic devices suited West Indian veterans? Writing to the Colonial Office in February 1918, Secretary of the Ministry of Pensions Matthew Nathan reiterated the need for the distant Ministry to work with local authorities to give discharged and disabled men “the necessary relief.” But this was not a simple matter of limb provision and fitting. Rather, Nathan suggested, “whether or not, it is to the men’s advantage to provide them with complicated mechanical limbs, in place of the more simple peg-leg is a matter in which local knowledge of the man’s condition and development would be of greatest assistance.”\textsuperscript{519}

Just as Viceroy Chelmsford had proposed considering Indian veterans’ “caste, occupation and status of the invalid and his personal inclination” when choosing prosthetics, Nathan too hinted towards the desirability of limb choice. But his invocation of “the man’s condition and development” recalls analogous discussions in India, in which officials deemed modern mechanical limbs incompatible with non-European lifestyles. Nathan added to a growing British colonial lexicon of disability and development, that, all too often, served as a flimsy veil for concerns about how uncivilized, Oriental, or non-white populations could handle modern limbs.

\textsuperscript{518} Under Colonial Secretary to Ministry of Pensions, July 26, 1918, CO 318/347/83.

\textsuperscript{519} Matthew Nathan to under Secretary for the Colonies, February 28, 1918, CO 318/347/63.
Coming from the Ministry of Pensions, Nathan’s opinion gives off a veneer of practicality – West Indians would not have the resources to maintain a duralumin limb of the type given to British veterans. While orthopaedics and prosthetic workshops rapidly expanded at the same time in the UK, no similar medical infrastructure grew in the Caribbean. In the same letter, Nathan suggested that while those local authorities should have the final say in such matters, “the cheapest way to have the work done… would be for the men concerned to go to New York.”\(^{520}\) His recommendation failed entirely to consider the difficulty of transporting disabled BWIR veterans on a long and arduous journey to acquire the very limbs that would make that journey possible. An alternative method had already been tested during the war. The local Brigadier General to Jamaica and Grenada recounted how he had sent to New York for an expert who, upon arriving, took measurements from the men and returned to New York.\(^{521}\) There, he completed the limbs, and returned with the finished articles – a four-part trip which cost the Government £70.17.8, not including the limbs in question. At this point, the flow of disabled servicemen back to the Caribbean was small enough to justify outsourcing their orthopaedic care. After Armistice, however, the greater numbers of the disabled rendered this impractical and costly.

As in the case of ex-soldiers in India, officials believed that West Indians were prone to misusing their prosthetics to the point of destruction. Belief in Afro-Caribbeans’ technological incompetency led administrators to assign them “simpler,” cheaper, and less modern limbs. In September 1918, Ministry of Pensions official Charles Kenderdine instructed the R.A.M.C. orthopaedist T. P. McMurray to prescribe West Indians

\(^{520}\) Ibid.
\(^{521}\) Brigadier General to Governor Haddon-Smith, November 27, 1917, CO 318/347/63.
“unbreakable” artificial limbs. As the Director of Artificial Limb Supplies, Kenderdine had a thorough knowledge of the most modern prosthetics. Yet these would not do for Afro-Caribbean veterans. McMurray advised that while no limbs were unbreakable, the bucket-and-pin or peg leg were both strong and “in no way complicated.” He advised that all men be fitted with a bucket-and-pin, as well as a peg leg to use as a reserve. Kenderdine sanctioned the policy, but only in the case that Sir Robert Jones, the eminent Director of Military Orthopaedics, thought it “essential that West Indian Soldiers” receive a substitute peg leg. Ministry of Pensions authorities continued to bemoan the cost of supplying further artificial limbs to men who had “ruined” them.

Other officials linked Jamaican pensioners’ supposed carelessness with the environmental rigors of the Caribbean. Their opinions were communicated through G. J. Gilbert, a Staff Clerk at the Ministry of Pensions. In 1925, Gilbert was sent across the Empire to ensure that colonial governments were dispensing due care to veterans of all races and creeds. Gilbert frequently reproduced colonial racial stereotypes while simultaneously calling attention to the inadequacies of their care. Though his report alleged that Jamaicans were “natives full of guile and deceit,” his analysis of artificial limb deterioration confuses pensioner responsibility and climate. It was impossible to compare the cost of repairs in Jamaica to those in the British Isles, he claimed, because:

Pensioners in Jamaica frequently mis-use their limbs. They will walk on them without any boots, and in several cases I was told it was clear that they had waded into salt water with their limbs on. The excessive perspiration induced by the tropical climate rapidly deteriorates rubber and leather, and causes frequent renewals necessary. It must also be borne in mind that the head of the Technical

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522 T. P. McMurray to Charles Kenderdine, September 14, 1918, CO 318/347/92.
523 Charles Kenderdine to Colonial Office, September 17, 1918, CO 318/347/92.
524 Matthew Nathan to under Secretary for the Colonies, February 28, 1918, CO 318/347/63.
Department frequently repairs limbs which would be absolutely cast aside as worthless by limb-makers at Home.\textsuperscript{525}

Just as India Office officials accused self-treating Sepoys of abusing their prosthetics, Gilbert’s complaints ignored how disabled Jamaican pensioners also sought to self-medicate. These veterans likely waded into salt water to ease the soreness and bleeding often caused by the simple bucket-and-pin or peg leg construction. For Gilbert and the Ministry of Pensions, however, self-treatment was mis-treatment if not prescribed by an authorized doctor or orthopedic mechanician.

The disjointed nature of colonial governance and institutions in the Caribbean made the creation of a comprehensive orthopaedic care system difficult, and government authorities did little to improve the situation. The resources they provided were far from adequate. Jamaican officials outfitted the Technical School in Kingston to repair limbs – though whether they hired any specialist or professional to do so is unknown – but it lacked the skilled personnel or materials to measure and produce surgical appliances. Hoping to instruct returning veterans on the options available to them, the members of the West Indian Contingent Committee (WICC) continued to track provisions made for disabled BWIR troops after the armistice. In January 1919, the WICC’s secretary wrote the War Office to question what arrangements had been made for the repair and replacement of artificial limbs after BWIR servicemen’s repatriation.\textsuperscript{526} The War Office declared that artificial limbs and legs were not standardized, and spare parts could not, 

\textsuperscript{525} J. G. Gilbert, Report on the Payment of Pensioners and Other Matters Incidental Thereto by the Command Paymaster, Jamaica, 1925, PIN 15/1781.

\textsuperscript{526} Meeting Minutes, January 14, 1919, School of Advanced Studies, Institute for Commonwealth Studies [hereafter ICS], London, United Kingdom, 97 1/6/1.
therefore, be sent to the West Indies.\(^{527}\) Distance and a lack of funded philanthropy in the Caribbean made other aid devices difficult to access and replace.

In the mid-1920s, after years of navigating the chaotic medical infrastructure for veterans, native Jamaicans filled in gaps in prosthetics provision themselves. The colonial administration found this to be a satisfactory arrangement, notably because Jamaican labor was far cheaper than importing expertise from the metropole or America. One such mechanician, I. G. Adams, reported that he had been trained at the technical school under the last British manufacturer, Mr. H. Cocking, for seventeen years before striking out on his own. His prices were “probably 15-20% cheaper” than American or British manufacturers. In 1926 the Jamaican Command Paymaster paid Adams and his contracted workmen a combined £600 for their yearly labor, less than half what the government had paid Cocking’s operation in 1927.\(^{528}\) Other forms of aid could not be replicated at home. West Indians veterans’ distance from the metropole rendered some of these provisions ineffective in the long term. The Ministry of Pensions claimed that they supplied hand-propelled mobility tricycles to all disabled members of the Jamaica Contingent who were missing both legs – a policy also practiced for disabled soldiers in the metropole.\(^{529}\) However, when the British Red Cross distributed new motorized tricycles to many disabled British veterans a few years later, incapacitated Jamaicans were left with their outdated technology.

Care provisions for the disabled grew significantly worse throughout the 1920s and 30s. In 1934, the mounting costs of caring for disabled pensioners set off infighting

\(^{527}\) Meeting Minutes, February 21, 1919 ICS 97 1/6/1.  
\(^{528}\) H. O. Browning to Langhorne, April 6, 1934, PIN 15/1781.  
\(^{529}\) C. C. Cobbe to Office of Works, January 2, 1937, CO 137/823/16.
in the Government of Jamaica. Frustrated with continuing care, medical administrators identified a number of amputee ex-servicemen who were too costly. They recorded data on the 51 “most expensive” pensioners, all of whom had needed multiple prosthetic replacements. D. T. Richardson, a RAMC Major working for the Senior Medical Officer of Jamaica, singled out one ex-Private E. Dyce, a double amputee, as being “particularly careless in the use of both his artificial legs and stumps.” In reply, SMO A. L. Stevenson bitterly complained, “These limbless pensioners – who are being kept supplied with artificial legs at King George’s expense – are costing a fortune.” Stevenson tracked these transgressions carefully, noting that he “kept a book” with details of each pensioners disablement and every charge incurred for limb repairs. The Medical Office administrators believed that they had good reason for stringent documentation – one Brigadier urged the Office to force veterans receiving new limbs to hand in the old ones. Otherwise, he alleged, “they will be utilized for fraudulent claims.” Were disabled veterans using such schemes to profit from a black market on prosthetic limbs? The practice is unlikely. Yet the Medical Office repeatedly called for further analysis and study. One 1934 report on artificial limbs and surgical appliances noted that individuals’ employment – such as working on a “swampy banana plantation” – sometimes justified the high frequency of repair and replacement. Nonetheless, when the Senior Medical Officer judged that pensioners neglected or misused their limbs, he was granted the power to assess this extra cost and take it out of the ex-serviceman’s pension.

530 A. L. Stephenson to Brigadier J. Langhorne, March 13, 1934, PIN 15/1781.
531 J.A.D. Langorne to Senior Medical Officer, March 28, 1934, PIN 15/1781.
532 Ministry of Pensions Report on Artificial Limbs and Surgical Appliances Supply, October 5, 1934, PIN 15/1781.
Some metropolitan officials objected to these practices. J. E. Bury at the Ministry of Pensions, condemned Gilbert’s plan to pay a lump sum of “£15 to £20” to Jamaican pensioners using government-provided mobility tricycles rather than continue to repair and replace them – particularly as the cost of the tricycles in 1925 was £35. “I believe it is against the policy of the Ministry to commute its liability,” Bury proclaimed. He added, “In these circumstances it would be difficult to justify to these black gentlemen or to anyone how £20 could possibly discharge the Ministry’s liability.” Faced with criticism from the Ministry, the Medical Officer of Jamaica rejected accusations that the colonial administration was fiscally irresponsible in its handling of disabled pensioners.

Military authorities in Jamaica provided the supply and upkeep of artificial limbs for veterans until 1935, when Governor Denham deemed the arrangement “too expensive” – around £1,000 per year. When the Medical Department took over the same work, soldiers were forced to seek repairs to their artificial limbs at the General Penitentiary, though they took pains to note that new limbs were imported from “one of the best manufacturers in England,” and all soldiers received treatment free of charge. The C.S.A.C. asserted that while the arrangement may not have matched the technological development and therapeutic range in Britain, it was “adequate” and had “effected a considerable economy.”

Despite these claims, members of the Ex-BWIR Association asserted that the new arrangements made terrible impositions upon the disabled. Some disabled men had not received any pension, they claimed, and had been living off of Pauper Funds. One of the

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534 Director of Medical Services Kingston to Secretary of Royal Commission, December 1, 1938, CO 950/93.
Association’s representatives, Mr. Gouldbourne, claimed that men were now asked to pay for repairs to their own artificial limbs. Furthermore, despite the Island Medical Office’s statement that they repaired veterans’ tricycles, Ex-BWIR Association President Burkley asserted that veterans now had to repair their own tricycles or give them over to poorer mechanics, leaving the vehicles in worse condition and making it harder to get about.

When the chair and steering committee of the Ex-BWIR Association was finally invited to give oral testimony in late November, the Royal Commission doubted their claims that artificial limb provision was so poor. Nonetheless, the C.S.A.S. admitted that the Committee funds were barely sufficient to provide to actively sick men, never mind helping ex-soldiers with employment. The Island Medical Office confirmed that while ex-soldiers using prosthetics used to be given a grant of £1 for the purchase of boots suited to artificial limbs, the C.S.A.C. could not lately afford this. Disabled men who received 10 shillings 6 pence per week received 10 shillings annually to provide boots – those getting 21 shillings per week were expected to provide for shoes on their own.535

The lack of government-provided opportunities for re-training and re-education elicited protest and pleas from local veterans’ organizations. As a petition from the Ex-BWIR Association questioned, “Is it conceivable that British Justice and Gratitude would permit of a man becoming disabled while serving his King and Country, and after victory notwithstanding his inability to perform his usual vocation his pension is stopped and he is told nothing can be done for him?… One crippled man living in St. Catherine Parish lived on one shilling weekly from the Pauper Fund, supplemented only by a twenty-six week grant from Jamaica’s Central Supplementary Allowances Committee (C.S.A.C.) of

535 B. M. Clark, Central Supplementary Allowances Committee, to the West India Royal Commission, December 1, 1938, CO 950/93.
one shilling.” Disabled veterans deeply resented this seeming lack of concern for their basic welfare. As time passed, complaints increased, and the Ex-BWIR Association’s claims were supported by letters from individual pensioners. In November 1938, Francis L. Hanchard wrote to the West India Royal Committee to state his plight living as a disabled ex-soldier in Jamaica. Serving with the 9th BWIR Battalion, he was injured in service and had come back from the war “a disabled man or I may say a cripple for life.”

Hanchard was entitled to a Victory medal and the British War Medal, yet his pension of 14 shillings per week was not enough to support his family, living in a room on Love Lane in Kingston which cost 15 shillings a month. Hanchard asked to come into Kingston to give oral testimony to the Committee, making his case:

My suffering is not the only case it is the common fate of all disabled soldiers in Jamaica. Like the English man we went to the war to uphold the prestige of our beloved Empire, but unlike the Ex Soldier in England we men in Jamaica are treated like parasites. We find ourselves going swiftly to our grave due to war casualty [sp], and yet the medical authorities here would never recommend you despite of your further ruined condition for any further pension. They would rather see you struck off the roll.537

The West India Royal Commission dismissed Hanchard’s pleas, noting only that they regretted that they were “unable to entertain them.”538 Hanchard shared his “common fate” with hundreds of other permanently disabled Jamaicans, reduced to “parasites” by a colonial government that refused to equip them with modern prosthetic technologies, while simultaneously deriding those whose prosthetics failed them.

The West India Commission’s general inaction towards disabled veterans in the British Caribbean was matched by archival neglect. At some point in the interwar years,

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536 BWIR Association, Memorandum of Evidence, c. 1938, CO 950/93.
537 Francis Hanchard to West India Royal Committee, November 7, 1938, CO 950/93.
538 Secretary of West India Royal Committee to Francis Hanchard, November 13, 1938, CO 950/93.
the War Office literally erased much of the history of war-service attributed black disability from the historical archive. Though the exact date and rationale remain unknown, the Colonial Office’s records confirm that records relating to the British West India Regiment were destroyed some years prior to 1935 under the authority of the War Office. Only records of grants of medals, several post-war pension disputes, and material from the Ex-BWIR Association give insight into individual cases. As such, it is virtually impossible to track individual cases of disabled BWR veterans. They were cut off from documentary evidence of their disablement in war. This archival death also precluded disabled Afro-Caribbean efforts to receive reparations decades after the war.

Conclusions

In the interwar years, these prosthetic subjects confronted not only their own physically and affectively broken bodies, but a dysfunctional system of care. Imperial responsibility was largely limited to the work of literally making the disabled subject body whole through prosthetics. British and Indian soldiers alike found that the work of rehabilitation and re-education was taken up not by the government, but by private philanthropies and individuals. For Indian soldiers, this system was deeply classed, privileging a select few martial race Sepoys over laboring non-combatants. Likewise, Afro-Caribbean ex-servicemen found few prospects of deeper efforts towards recovery

539 Despite popular conceptions, the BWIR-related records destroyed prior to 1935 are different from the body of destroyed pension and Great War records ruined in the Arnside Street fire during the Blitz in September of 1940. The 1940 fire destroyed just over 80% of army service records, leaving only 1.25 million available. Many forums for veteran history, including the website of the National Archives, explain the lack of surviving BWIR-related materials as due to the fire; however, records make clear that the bulk were purposely destroyed long before. See C. Blackwell to Colonial Secretary of British Guiana, December 16, 1935, CO 111/731/3. For material pertaining to destroyed WWI records, see http://www.nationalarchives.gov.uk/pathways/firstworldwar/service_records/ sr_soldiers.htm.
and restoration – through re-training and re-education – that the government institutions and philanthropists provided to their colonial counterparts.

The care that British colonial governments and philanthropists provided to them was not only difficult to access, it was standardized towards white, Western bodies and their physical and cultural practices. Colonial veterans met these challenges with varying responses. In India, South Asian ex-servicemen alternately rejected, modified, or repaired their prosthetics themselves. This prompted metropolitan investigations into the inadequacies of care provided by the Government of India. Yet even when imperial actors galvanized resources to improve access to care, none considered how poorly British-designed devices suited the men who had to wear them. In the West Indies, where environmental, structural, and laboring rigors caused limbs to break down quickly, disabled veterans with access to medical facilities attempted to make use of the care available to them, repeatedly applying for prosthetics to replace those which had failed. Far from being met with introspection and compassion, local medical and military officials looked on their requests with suspicion, and charged them with negligence.

With the advent of mass disability, Anand’s disabled veteran “wonder” and his “miraculous wooden substitute” were now commonplace in the British Raj. Where John Demerette’s disability had been silenced and hidden in the Belmont Hospital riot, he and his fellow amputees were plainly visible in the Caribbean. The effects and inadequacies of imperial prosthetics were laid bare, provoking a vivid and enduring debate between patients, officials, local and imperial governments over the shape and place of the disabled non-white body. Wounded veterans across the Empire found their bodies permanently changed, both by their disablement and their prescribed prosthetics. Many
would spend the next decades declining, modifying, or hybridizing orthopedic devices in an attempt to make British medicine work for them. British colonial authorities found themselves engaged in a continual renegotiation of prosthetic provision. In the process, these conversations produced a new lexicon of disability and development and reworked British understandings of race and imperial responsibility.
Chapter 5: Genitals
Sexual Health, Racial Hygiene, and the Leaky Bureaucracy of Repatriation

If military healthcare sought to remake men, and in turn, manpower, it was also deeply preoccupied with maintaining their sexual health. This meant protecting soldiers’ genitals from the insidious threat of the pox and the clap – in short, from venereal disease. As historians have repeatedly shown, this required an intricate dance that balanced official and medical policy with the rhetoric of purity. By making it illegal for any woman with communicable venereal disease to solicit or engage in sexual relations with a member of the British armed forces, the infamous Defence of the Realm Regulation 40D placed the burden of regulation and punishment on women. Given the way in which sexual health was tied up with national health, it is unsurprising that wartime concerns over sexual hygiene were inextricably tied up with anxieties about racial hygiene. The British Empire had long cultivated a practice of gendered and raced intervention around VD in the military, notably through the Contagious Disease Acts from the 1860s to 1880s.

During the Great War, as Philippa Levine has noted, venereal disease control was seen as

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a “war within a war,” and the conflict itself “as much a site of moral struggle as it was a global war.”

Throughout the war and its aftermath, the politics of racial hygiene were most visible in scenarios which involved enemy combatants – the German criminalization of the French-African presence in the occupied Rhineland in the 1920s (the so called Schwarze Schmach, or black shame). Anti-miscegenation attitudes were arguably less sensationalistic and visible in scenarios where the parties involved were allies, or part of the same Empire. Yet they were pervasive and far-reaching. Furthermore, they stemmed from the wartime presence of non-white colonial subjects in British ports, battlefields, and hospitals. It is perhaps unsurprising, then, that some of the first and only historical insights into race and health at war have revolved around the control of venereal disease.

To date, historians have explored the sexual health of non-white colonial servicemen more than any other type of ailment or medicine. It is worth reflecting on

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542 Levine, Prostitution, Race & Politics, 146.


why. The bulk of this literature was produced at the height of gender history and its interventions into wartime and interwar British culture. As working-class women and non-white colonial subjects experienced new freedoms, civil and military authorities grew concerned over the extent of these liberties. They responded with socially-prescriptive regulations. Much of their rhetoric and policies reflexively tied military health (and the might of Britain) to the dangers of women’s mobility. Colonial and war officials were invested in healing and remaking non-white servicemen into functioning soldiers and laborers, but the black body could also be dangerous, insofar as it came into contact with white women. Historians’ overt focus on venereal disease and colonial soldiery mirrors the vocal preoccupations of wartime officials. At the same time, it also reflects the ease with which colonial soldiers could be reduced to their bodies’ most basic and socially-threatening function: reproduction.

Scholarly focus on the complicated politics of race and sex at war has been followed by interest in the same issues during the interwar decades. An increasing array of studies over the past two decades have made arguments for the strong and growing presence of non-white migrants, particularly men, in metropolitan cities during the interwar period. They settled primarily in British ports, but also in inland cities, where some made lives with British women. Much existing scholarship tracks the difficulties and conflict – both social and political – that these interracial couples faced.545 The

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governmental response to this “white wife problem” could be both draconian and flexible, depending on the origin, gendered identities, and class of the men and families in question. Yet much of this work also traces the enduring dedication of these unions, and to a lesser extent, the social acceptance, cultural multiplicity, and enduring migration pathways that these migrants found and forged in the foreign metropole.

The majority of this scholarship identifies labor mobilizations during the First World War as the foundations of this moment. At the same time, few explain this link beyond general references to the burgeoning number of colonial subjects present in Europe and the metropole during the war, occasionally referencing interracial relationships or migrants’ invocation of their war service.

If Lucy Bland has explored “the ways in which miscegenation in Britain was conceptualised and problematised in this period of the war’s aftermath,” this chapter argues that understanding the same issue during the war is crucial to understanding its interwar condition.\(^{546}\) To do so, it thickly ties the multi-layered policies and reactions to wartime VD regulation to the porous regulation of wartime and interwar interracial sex. By highlighting the similarities in these policies, this chapter makes two claims. First, it argues for a deeper and more direct historical connection between wartime colonial mobilization and interwar migration. It does so through the second contention: that British political responses to both direct (wartime) and indirect (interwar) sexual regulation were variable and fluid, predicated on a complex equation of race, class, gender, and able-bodiedness.

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\(^{546}\) Bland, 33.
Interwar migration, settlement, and repatriation were pre-empted by wartime mobilization of non-white colonial labor. Interwar debates over the presence of non-white workers in the metropole, the race riots of 1919 and beyond, and contentious reactions to interracial unions, were all indelibly linked to the shifts of the war. Colonial and metropolitan administrators and ex-servicemen themselves cited war service when discussing the state of blacks in interwar Britain. The persistence of interracial relationships in the interwar years both validated the administration’s anxieties and highlighted the way in which colonial mobilization made these relationships possible.

**Sex and Medicine at War: Race, the Military, and Venereal Disease**

The British military had a long and storied history of concern over the relationship between venereal disease, sex, and race. In the late nineteenth century, a wide variety of medical scholars and purity campaigners expressed fears that syphilis, gonorrhea, herpes, and the like would lead to the racial degeneration of the Anglo-Saxon nation. Mark Harrison and Mario Ruiz both describe wartime military authorities’ fears that the British Tommie would find himself in particular danger in Egypt and Mesopotamia, where he had access to sexual relations with non-white or “Asiatic” individuals. As Commander of the Army in India in 1905, War Secretary Kitchener had warned soldiers against such contact: “Similarly, syphilis contracted by Europeans from Asiatic women is much more severe than that contracted in England. It assumes a horrible, loathsome, and often fatal form through which in time… the sufferer finds his hair falling off, his skin and flesh of his body rot, and eaten away by slow kankerous [sic]

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547 Harrison, “The British Army and Venereal Disease”; and Ruiz, “Manly Spectacles.”
Kitchener followed a long tradition of Orientalizing disease by arguing that Egyptian prostitutes constituted a graver threat to British soldiers than white sex workers. Their race was diseased, and their disease raced. These warnings attempted to caution white British troops away from disease as much as they tried to discourage them from transgressive interracial sex. With the Great War’s multiracial mobilization across fronts, then, the War Office had to regulate venereal disease for a diverse array of troops. Non-white colonial servicemen had to remain free of VD to serve as adequate manpower. Furthermore, their racialized sexuality was also configured as a threat to white women.

Fears over the sexual health of colonial soldiery began before embarkation. With the war already raging and problems with venereal disease rampant, the Colonial Office grew particularly concerned with the prospect of STDs among fresh recruits in the Caribbean. In 1917, one year after the first B.W.I.R. battalions arrived in Europe, the Barbados Recruiting Committee conducted a study into the prevalence and prevention of sexually transmitted disease. Their report found that VD was a serious problem long before men were shipped out. 20% of the Leeward Islands Contingent were unable to proceed to Europe, and the report claimed that at least 25% of all men put into training had developed VD since being recruited. The Recruiting Committee observed that the

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548 As Harrison has elaborated, in the years leading up to the War, the higher rates of VD in troops stationed in Egypt seemed to confirm Kitchener’s belief in the virulence of VD carried by “ Asiatic” women. Kitchener, Memo to the British Army in India of 1905, quoted in Harrison, op. cit., 149.

549 To meet this supposed threat during the war, the War Office sanctioned the creation of the “Cairo Purification Committee” to address the problem of VD control and local prostitution. Harrison and Ruiz illustrate how, far from punishing British soldiers for their indiscretions and rowdy behavior, the military authorities cracked down on local venues associated with vice and immorality. Harrison, Ruiz, op. cit. note 8 above.

construction of better, more isolated barracks may help to minimize the danger of rising VD rates among recruits – namely by separating them from the local populace. This, however, would entail a “considerable expenditure” that the Recruiting Committee refused to spend. Furthermore, such measures could seriously set recruitment efforts back – the Report argued that recruits would be significantly less enthusiastic about registering if they had to train in isolation.

Recruiting officers in other Caribbean colonies encountered similar problems and offered no more concrete solutions. Of the 51 recruits out of 121 found unfit by the Medical Board at St. Georges in Grenada, venereal disease was the top reason to pull men from the regiment.551 In Jamaica, L. S. Blackden, the Brigadier General in charge of recruitment, suggested that his officials had explored all possible ways to prevent infected men from embarking onwards. The only option was a “radical cure” – “to absolutely confine every Non-Commissioned Officer and man to the Contingent Compound… [to] forbid them to see their friends and relatives, in fact to treat them as prisoners.”552 This was not a viable option. Blackden confirmed that such measures “would rouse more than resentment, and would… stop us getting another contingent.”553

Eager to make some inroads, the British Army Council encouraged B.W.I.R. recruitment officers to practice early treatment in the colonies. The Army Council sent on copies of the three standard leaflets distributed among British soldiers, encouraging the Colonial Office to distribute them to the West Indies Regiment and citing the apparent “prevalence of Venereal disease” in the B.W.I.R.554 The leaflets detailed

552 Minute by L. S. Blackden, September 2, 1917, CO 137/720/27.
553 Ibid.
methods of early treatment of urethritis and syphilis. They instructed potentially infected servicemen how to clean their penises with antiseptic lotion, irrigate the anterior urethra with a cold diluted solution of Potassium Permanganate, and to rub the Glans Penis thoroughly with Calomel Ointment. After some discussion, the Colonial Office agreed to distribute copies of the pamphlets.

As the war progressed and servicemen were deployed across France, Italy, and Palestine, the War Office faced the same reality confronting European and American soldiers. In a global war, venereal disease was a global problem. Some officials believed that early treatment was misguided. Not only might West Indian servicemen regard segregation for treatment as “an insult,” one C. R. D. at the Colonial Office intimated, but what was the use of treating soldiers who would go on to contract venereal disease again while on duty? “Moreover,” he commented, “the returns of cases of V.D. from Egypt show that [War Office] cannot or do not stop infection there.”

C. R. D.’s musings hint towards some resentment of the Army’s incompetency at VD prevention, but they also point to his implicit assumption that West Indian servicemen would be engaging in sexual relations while on service. Despite agreeing to distribute the leaflets, there is no evidence that B.W.I.R. servicemen were given the tools of prevention themselves – such as the prophylactic kits of calomel cream made available to British soldiers. Some colonial recruitment centers, notably St. Vincent, referenced that they fitted barracks with the Early Treatment irrigation apparatus used in the VD Depots established for British and Anzac troops; however, it is unclear the extent to which such facilities were procured.

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or made known to BWIR recruits. For the majority, their treatment – and sexual activity – was to be mediated by medical professionals.

As in other British dominions, some colonial officials took umbrage at accusations that the entire West Indies was rife with venereal disease and medical neglect. Sir William Lamond Allardyce, Governor of the Bahamas, sent on a 1917 report to Colonial Secretary Walter Long that affirmed both the Bahamas’ strict procedures for weeding out cases of VD, and the overall lack of sexually transmitted diseases on the colony. The report included testimonies from resident surgeons, the Chief Medical Officer, the Commandant of Police, and members of the Bahamian Recruiting Committee. All verified that men were carefully examined, the vast majority both physically and morally clean. S. A. Dillet, a member of the Recruiting Committee, affirmed that “the doctors were extremely rigid and it appears to me that the Bahamas must be the least among the sinners.” The comparison of colonial sexual health and morality continued with L. W. Young, who asserted that the investigation was a matter of procedure: “I take it that this was only sent to the Bahamas for our information… but not that it really applied to the men of the Bahamas. I must say that the greatest of all mistakes was to have our men mixed up with the Jamaicans who seem to be everything but fit for anything.”

Despite initial attempts to prevent any West Indian recruits with venereal disease from embarking, demands for manpower encouraged growing exceptions. By the time recruitment officers attempted to raise a 9th Contingent, enlistment rates had drastically

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dropped off, prompting officials to accept venereal cases. The desire to swell the ranks of the BWIR pitted colonial officials and recruiting offers against biomedical authorities. In one 1917 case, at least one hundred and twenty-seven infected enlistees were sent to Jamaican hospitals for brief treatment and then put on ships by BWIR officers without their Medical Officers’ approval. One round of treatment was not sufficient to improve the men’s condition. The General Officer Commanding in Kingston approved these manoeuvres on the understanding that the men would most likely be cured in a “reasonable time.” Yet the ships that ferried them to war were not provided with the means to continue treating the infected en route. The imperative for West Indian manpower outweighed the need to heal them fully before embarking. Unsurprisingly, rates remained high upon arrival. Venereal disease constituted the tenth highest cause of admissions to the Lady Hardinge Hospital for Indian Soldiers in 1916. By the end of the war, Sir William Macpherson estimated that twenty per cent of the entire battalion was afflicted with venereal diseases.

The War Office’s approach towards venereal disease treatment varied by ethnicity, class, and colonial background. Officials interested in maintaining the parameters of colonial hierarchies and difference had a heightened interest in sexually transmitted diseases, not only because of their potential threat to military efficiency. Venereal disease was irrevocably linked to sexuality. Philippa Levine has illustrated how the War Office adopted venereal disease prevention as a major justification for restricting

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559 N. N. White, War Office to Colonial Office, November 17, 1917, CO 318/344/27.
certain groups’ mobility, namely working-class women and non-white colonial servicemen. Levine details how mobility and sexuality were closely linked and controlled. The social and medical evil of sexually transmitted diseases, she argues, were the public face of much older anxieties about the mixing of ‘loose’ women and soldiers of color. Wartime imperatives granted these groups increased mobility and freedoms, to varying extents. Levine links British anxieties over working-class women’s “war nymphomania” and black male desire to the growth of official restrictions on their movement – in the case of the former, through various Defense of the Realm Acts provisions, for the latter, through segregated hospitals and closely monitored trips outside British barracks and medical facilities. Where miscegenation threatened to destabilize abstract colonial and racial hierarchies, VD amongst servicemen of color posed two immediate hazards. It jeopardized military efficiency, and if contracted after embarkation, acted as medical evidence of colonial soldiers’ probable sexual relations with white women. Levine details how modes of treatment varied according to colonial politics of race and culture.

The British Army approached venereal disease through preventive medicine. This represented a new shift in Army policy. Until the Great War, Army rhetoric generally followed by crusading appeals of Lord Kitchener to stamp out impure talk and temptation through restraint, muscular Christianity, and mental and physical exercise. By 1911, several physicians and bacteriologists in Britain and France had pioneered new, successful treatments, from the anti-syphilis drug Salvarsan to preventive disinfectant

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562 Philippa Levine, “Battle Colors.”
563 Philippa Levine, Prostitution, Race and Politics, 145-177.
ointments of calomel and potassium permanganate.\textsuperscript{565} When war broke out, the British High Command continued to emphasize its prior endorsement of abstinence. Military administration backed up their threats with punishment. Initially, British soldiers diagnosed with VD in hospital had their pay and leave withheld. They were also subjected to an extended stay at the unpopular VD hospitals established in 1915. A hospital visit offered rest and time away from the front, yet the new treatments could be disagreeable and even painful. Salvarsan and mercury treatments could induce convulsions and jaundice; the irrigation method used for gonorrhea was uncomfortable and exposing; \textsuperscript{566} Yet as VD rates continued to rise, and the manpower crisis grew, treatment after infection only went so far. Harrison has detailed how abstinence encouragement and regulated prostitution gradually made way for disinfection and early treatment therapies.\textsuperscript{567}

Prophylaxis was deeply controversial. A variety of moralizing civilian associations across the Empire believed that prevention kits effectively sanctioned evil.\textsuperscript{568} At the same time, Levine makes clear, the British felt that white British and Dominion soldiers could not be blamed for these morally and medically damaging diseases. Instead, they were led into temptation by irresponsible women, predominantly envisaged as working-class and ethically poor. Preventive medicine that sanctioned sex could, nonetheless, be justified if it was in the service of “fundamentally decent and loyal” soldiers.\textsuperscript{569} In the case of activists from the settler dominions of Australia and New

\textsuperscript{565} Ibid, 138.  
\textsuperscript{566} Ibid, 140.  
\textsuperscript{567} Ibid, 147.  
\textsuperscript{568} Levine, \textit{Prostitution, Race and Politics}, 147-8.  
\textsuperscript{569} Levine, \textit{Prostitution, Race and Politics}, 151.
Zealand, notably Ettie Rout, the sanctioning of prophylactic medicine was entwined with language about the preservation of racial purity.\textsuperscript{570}

Nonetheless, preventive medicine was increasingly practiced through prophylactic kits and early prevention depots. Despite pressure from purity organizations and politicians, prophylaxis was haphazardly yet progressively available as the war continued, primarily through the ANZAC forces (which nonetheless maintained the highest rates of VD admission throughout the war). Facing still rising rates at the beginning of 1918, the Director General of the British Army Medical Service agreed to distribute prophylactics among British troops.\textsuperscript{571} Such measures allowed soldiers a modicum of discretion and self-treatment, though skilled attendants were typically present at the latter to aid the irrigation procedure.

Medical policy for non-white troops was drastically different. British Medical Officers and their superiors worried that giving soldiers of color preventive kits was akin to sanctioning their sexual activity with a variety of European and Middle Eastern women. Lest they facilitate such relationships, Army authorities chose to restrict non-white servicemen’s mobility rather than arm them with prophylactic tools. Likewise, Indian Army officials never raised the possibility of the early treatment depots offered to British and Anzac forces.\textsuperscript{572} Instead, Army Medical Officers denied them any agency of their sexual health. Afro-Caribbean soldiers who ventured outside battalion boundaries, or whom officers suspected of fraternizing with women, were subjected to forced

\textsuperscript{570} As in the case of the British crisis over male fitness, concerns over racial purity and white degeneration were exacerbated by losses in the Boer Wars and, increasingly, the First World War. See Chapter 1; Levine, \textit{Prostitution, Race and Politics}, 152; Zweiniger-Bargielowska, \textit{Managing the Body}, 62-71.
\textsuperscript{571} Harrison, 147-148.
\textsuperscript{572} Levine, \textit{Prostitution, Race and Politics}, 151.
treatment. Reviewing the differing provisions for the imperial army in 1923, Macpherson commented that “disinfection on return to camp was made practically compulsory” for the British West Indian Regiment.\(^{573}\) Exactly how and where these forceful disinfections were applied is unclear. But according to Captain C. Doble, the RAMC officer attached to several BWIR battalions, this castigatory policy reduced infections from 80 per week to 4 per month.\(^{574}\)

Soldiers contracted VD under a multitude of conditions. Some sought to infect themselves. One Sikh recovering in an English hospital wrote to a friend in France complaining about the “pain of heat… in my groin.”\(^{575}\) Despite his discomfort, he suggested the disease as a viable way to get out of the Army and back home – “If you & [redacted] Singh are in trouble certainly say that you are ill and have the pain in your groin. So you will come (here). Those who are ill in this way are certainly sent back to the Punjab.” For some, venereal disease – or the faking of it – offered a way out of army service, even if it came with mandatory hospital stays, quarantines, and invasive treatments.

But more commonly, STDs resulted incidentally from sexual contact with local partners. Rather than bringing over sexually transmitted diseases from South Asia, William Macpherson pointed out that many Indian troops contracted venereal diseases during their stay in Marseilles, (as well as, to a lesser extent, Bombay and Egypt).\(^{576}\) Knowledge about the prevalence of STDs at war filtered back to the colonies. Bhagat Ram, a clerk with the Commissariat Department in Jullundur, warned Khan Shirin Khan


\(^{574}\) Ibid.

\(^{575}\) Anon. Sikh to Friend, January 30, 1915, India Office Records (IOR) L/MIL/5/825/1.

in Rouen in metaphors to be cautious of intercourse with French women, for “within
there rages a fiery furnace.” Should Khan be “scorched in that flame,” Ram warned,
“do not be like that wretched sowar who used to sit near your tent and bewail his
condition.” Where Ram gave his advice allegorically, the British censor erased his
ambiguity in the surviving copy of his letter: “Stand in the open, sword in hand, and call
everyone to witness what the enemy (venereal disease) has done. Do this, and then there
will be no delay in your getting the Victoria Cross (a cure).” Acknowledgement of
venereal disease and French-Indian relations was widespread enough for both a clerk in
India to comment on it, and an Army Censor to transcribe his advice.

Wartime vigilance continued after armistice. In 1920, the National Council for
Combating Venereal Disease established a West Indies Commission to produce a Report
on the state of VD in the British Caribbean. The Report cast doubt on the effectiveness of
previous treatments across the island colonies. In Jamaica, treatment was “nominally free,
but facilities extremely bad and inadequate,” in Grenada, “free and compulsory but out of
date.” The Commission deemed programs in Trinidad and Barbados satisfactory, but
asserted that awareness-speaking propaganda and effective treatment were hampered by
the “financial straits” of the islands. The Commission recommended further measures to
increase treatment and to spread its educational campaign to several local committees on
Jamaica, Trinidad, Grenada, and Barbados. Yet the fervor over Afro-Caribbean sexual
health decreased in urgency after the war. BWIR recruits were no longer in the service of
the British military. Keeping them free from venereal disease was no longer a question

577 Bhagat Ram to Khan Shirin Khan, April 19, 1917, IOR L/MIL/827/3.
578 “Results of Tour,” Western Commission’s General Report, 1920, CO 323/880/34.
579 Ibid.
of maintaining essential manpower. Rather than concerning themselves with sexual hygiene in the West Indies, the Colonial Office turned its attention to racial hygiene, focusing on the BWIR servicemen who remained in Europe. Before we turn to interwar policy and rhetoric on the threat of miscegenation, how did these moments of interracial intimacy occur during the war itself?

**Beyond VD: Interracial Mixing & Miscegenation Anxiety**

Military and Colonial officials did not deny the possibility of interracial contact and relationships. As discussed in Chapter 1, their acknowledgement structured the strict regulations around colonial soldiers’ mobility, particularly in the metropole. If venereal disease regulations attempted to curtail interracial contact between the sexes in the name of soldiers’ health, colonial and military officials used medicine as a legitimate rationale – and disease as scientific evidence – of the (literal) ills of miscegenation. As the following cases make clear, however, sex repeatedly foiled both martial and medical regulation.

Soldiers of all backgrounds found that the War Office regulated their mobility, at no time more than when they were granted leave. Governor Manning of Jamaica pressed the issue of B.W.I.R. leave to the Colonial Office. He noted that the West Indian Regiments clearly recognized that British units obtained leave, and were “most anxious to visit the Mother country.” He recognized “the dangers and temptations” that might occur, and thus suggested that the men should come to England in small detachments under a responsible officer, who would “prevent their being brought into contact with
loose women and other undesirable characters.”

Manning justified his request by citing the case of other colonial subjects. He recalled that such provisions had been made for members of the King’s African Rifles who attended the King’s Coronation in 1902. Interestingly, his parallels between West Indians and British subjects in Africa only went so far. Manning then commented on complaints made that BWIR men in hospital were treated “in the same manner as... the South African Labour Corps.” Noting that he understood “that Medical Officers and A.H. Corps orderlies find difficulty in distinguishing between the South African and the West Indian,” Manning nonetheless suggested issuing instructions that West Indians should be accorded treatment “in hospital as is given to the fighting ranks of other Corps.” Implicitly judging the morality of his soldier-subjects, he nonetheless sought to differentiate their worth from that of other black servicemen.

Colonial attitudes towards soldier accommodation and regulation differed not only by race but by ethnic background and class. In his reports on the Kitchener Hospital in Brighton, commanding Colonel Bruce Seton emphasized that most “crimes” and untoward behavior came from army followers (non-combatants), not orderlies or soldiers. This was likely due, he intimated, to the undesirable background of the largely urban and lower-class followers. These men were “the sweepings of Bombay city,” prone to drunkenness – marked opposites of the esteemed, rural, martial race sepoy, or the more educated ward orderly. When followers took advantage of the opportunity to associate with locals of the opposite sex, it was “bound to result in the gravest scandals.”

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580 Governor Manning to Colonial Office, November 7, 1917, CO 318/345 56310.  
581 Ibid.  
582 Col. Bruce Seton, Reports on Kitchener Indian Hospitals, IOR L/MIL/17/5/2016.
acknowledged that this contact was two-sided, commenting on the “ill-advised conduct of the women of the town… partly innocent in intention.” Nevertheless, the prospect of interracial mixing was grave enough to warrant passing prohibitions on all Indian personnel of any background leaving the Hospital grounds.\textsuperscript{583}

Other officials made no distinctions between the moral management of the Indian Army’s constituent parts. Reporting on an unsuitable letter, one censor working under Howell at the Boulogne Censor Office claimed that the missive revealed “the crude ideas of orientals about European women.” The censor put their behavior down to social differences, remarking, “they cannot understand the freedom with which the sexes mingle.” This culture shock was reason to restrict Indian servicemen’s free movement, for if allowed “unlimited freedom…. They are liable to gain many wrong ideas and impressions which might be difficult afterwards to eliminate.”\textsuperscript{584} The censor in question articulated the fears at the core of general anxiety over black mobilization – namely, that exposure to white women outside the restrictive confines of colonialism (\textit{British} colonialism in particular) would erode the social order and structuring mode of Empire.

In \textit{Across the Black Waters}, nationalist and novelist Mulk Raj Anand described the stilted nature of Indian sepoys’ response to the presence of white women:

Outwardly they began to regard the women in this country as part of the landscape of Vilayat, mem sahibs who were superior to them in status and beyond their reach and whom they were forbidden to be familiar with, though the French Government seemed to feel differently about the negroes, Senegalese and Moorish troops, who were allowed to talk to the local women in the cafes. Inwardly they aspired to them with all the suppressed urges of manhood which the sense of their loneliness exaggerated into the sheerest hunger. But, inured at home to rigid orthodoxy and custom, they did not exhibit eroticism so much as

\textsuperscript{583} Ibid.
\textsuperscript{584} Indian Mail Censor’s Office, June 26, 1915, IOR L/MIL/5/825/4.
they showed extremes of asceticism, obscenity and a mawkish sentimentality which found expression in snatches of maudlin songs or abuse.\textsuperscript{585}

Anand’s characterization of sepoy’s reaction to cultural difference echoes that of the censor official. Yet where the censor ascribed sepoys’ behavior to their lack of cultural understanding, Anand chalks this up to the awkward encounter of alternate imperialisms. For Anand’s soldiers, years of colonial hierarchy prevents interracial relationships, though not their imaginations. Their social conditioning against consorting with British women is too strong. Nonetheless, they are jealous of the French African troops and the French social norms which, to Anand, seemed to condone freer contact between colonizer and colonized. Sepoys’ exposure to alternate modes of imperial intimacy is at the crux of their wartime transformation. Anand does not show them acting on their desires, but points to how the social conditions of war – loneliness, dislocation – combined with new cultural consciousness to produce sepoys’ multi-layered reaction to European women.

Interracial contact and relationships occurred more regularly among the mobilized chaos and social regulations in France. Censors found evidence of these relationships, and sepoys’ thoughts about them, in soldiers’ letters. V. S. Panjre, an Indian Subordinate at the Lahore Indian General Hospital in France, recounted how sepoys could access sex for money while on duty. “The state of affairs here is this. Ten annas are equal to one franc. So by paying 6, 7, or 8 francs the women get men to have carnal intercourse with them. So that for a little money sexual pleasure is sold”\textsuperscript{586} Panjre went on to note that Sikhs and Drabis in particular took advantage of this sexual economy. Spelling out the

\textsuperscript{585} Mulk Raj Anand, \textit{Across the Black Waters} (Orient Paperbacks, org. 1939, edition 2008), 238.
\textsuperscript{586} V. S. Panjre to Pirdan Singh, April 1915, IOR L/MIL/5/825/4.
currency exchange of paid sex, his letter confirmed to authorities that the war afforded sepoys certain forms of transgressive mobility.

The boundaries between prostitution and looser social norms were not always clear. Writing to a friend in Sholapur, M. M. Pandit asserted, “The women here have no hesitation in walking with us. They do so hand in hand. The men so far from objecting, encourage them. The fact is that this is the custom here.”

Relationships between Indian soldiers and French women went beyond that of prostitute and client. Censors withheld one letter from a French woman reaching out to an Indian Veterinary Assistant of prior acquaintance. The woman complained, “I miss my chattar very much and hope to see you after the war. Why do you not remain in France? There are very many English still here, both infantry and artillery. No one likes the English. They are not kind like the Indians.” Others pursued marriage. One Zaman Khan wrote home to Nowshera, acknowledging that rumors of his French “sweetheart” were true. “I dare say I shall not return to India… I am preparing to get married here. France is an excellent country and so are the people,” he asserted. Similarly, from one of the few Indian Army cavalry units remaining in France after 1916, Abdul Ali described to a friend the forthcoming marriage of his regiment’s lance dafadar, Mahomed Khan, to a Frenchwoman. The ceremony, due to take place in the next two to three days, was dependent on Khan’s conversion to Christianity. Ali was disdainful of the union. He blamed it on the progressive erosion of traditional values over time, commenting, “You can judge the state of affairs when it has got to the length of our marrying

587 M. M. Pandit to friend, February 23, 1915, IOR L/MIL/5/825/2.
589 Zaman Khan to Mahomed Alla Khan, April 20, 1917, IOR L/MIL/827/2.
Frenchwomen.” As David Omissi has observed, Khan’s eventual marriage was the source of great tension between him and his family in India. Letters in the censor archive indicate that Khan remained in France with his wife, who soon gave birth to a child (likely conceived before their marriage).

While marriage may have been exceptionally rare, these lasting relationships appear in both official files and popular literature over the interwar decades. Novelist Anand suggested that such unions could cross enemy lines. In the final installment of his trilogy, *Sword and the Sickle*, Lalu returns from his years as a German prisoner of war and tells others of ‘Mitha Singh,’ a fellow prisoner, who “married a German Mem and has opened a shop there.” Anand may have drawn the fictional Singh’s story from news and rumors of interracial couples who settled in Europe. In April 1920, well after the armistice, a Military Despatch commented on the case of an unnamed disabled Indian soldier, who, after marrying a local woman, settled in France. The sepoy’s presence in Europe raised questions about responsibility for his future healthcare. What was the Ministry of Pensions to do about continuing treatment for pensioners resident abroad? Would they have to return home to Britain or their colonies of origin to receive care, or could the British Government arrange reciprocal treatment with an assortment of colonies, dominions, and nations?

The Military Department drafted a letter nine months later that set up a telling dual standard. Assistant Secretary W. H. Swain declined to approach the French Government...

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593 Military Despatch No. 23, April 15, 1920, IOR L/MIL/7/15056.
about the possibility of reciprocal care, as “the number of such Indians likely to be residing in France will be few if any, and any questions which may arise in connection with them could be dealt with specially.” Nonetheless, Swain asked if the Earl Curzon, the current Foreign Secretary, would “arrange that any treatment to be provided for British officers suffering from War disabilities should be made applicable to British officers of the Indian Army and Indian Medical Service,” who were “entitled to the same privileges under the War Warrants.” Thus, while the Military Department made efforts to ensure that reciprocal care policies applied to British officials in the Indian Army and IMS, granting them access to care and pensions if living abroad, they did not extend these privileges to non-white soldiers of the imperial armies. The anonymous disabled Indian veteran residing in France – one of few, Swain hoped – would have to go through extra measures and interface with the Indian Military Department when he needed treatment. This double-sided policy divided standards of care between colonizer and colonized.

III. Intermarriage & Repatriation: British Anxieties of Black Masculinity

After armistice, the public conversation about venereal disease and the health of the imperial military transmuted into other anxieties – namely, over the mobility of colonial soldier bodies that remained in the British Isles. Concerns about medicine and sex converted into debates about migration and sex. As scholars of interwar mobility have observed, immigration was not only a question of citizenship and subjecthood, but one of sex. Recent scholarship has challenged the narrative that interwar racial conflict in the metropole was sparked by anger over interracial relationships. It instead identifies

594 W. H. Swain to Secretary of Foreign Office, January 27, 1921, IOR L/MIL/7/15056.
595 Ibid.
economic discontent and unemployment, fueled by war, as the major instigator of violent conflict that rocked British port cities in the early 1920s. Yet Laura Tabili, Carina Ray, and Lucy Bland, among others, assert that miscegenation retained a powerful sway over the public imagination. Economic troubles were the root of interwar racial conflict and migration policy in Britain. At the same time, interracial relationships – or the specter of them – were constant fuel for racial rhetoric and periodic violence.

Though still comparatively rare, wartime service and migration clearly created opportunities for interracial relationships to a greater extent than before 1914. Men of nearly every colonial force, of all races, forged relationships with European women during their time in France or their sojourn in Britain. As wartime policy on VD and colonial troops’ mobility evinces, official anxieties over these affairs continued into the interwar decades.

Longer term relationships occurred unevenly across the imperial forces. Most Indian troops were removed from the Western Front by the end of 1916. As such, the vast majority did not pass through Britain before returning to India. The majority, stationed in Africa and Mesopotamia, were routed via Egypt back to Bombay. With Indian hospitals in Britain closed since 1916, the few divisions remaining in Europe were by and large transported without stopping in the metropole. Accordingly, relatively few South Asian servicemen appear to have continued interracial relationships or marriages after armistice. The situation was different among black colonial servicemen. Many labor regiments, particularly the BWIR, remained in Europe until 1919 or even 1920 to serve as laborers during the process of demobilization. Their gradual repatriation,
continued service, and proximity to British hospitals and towns gave them more access to the metropole before their return to the West Indies.

Opposition to interracial relationships was clearly not as universal as segregationist policies and venereal disease regulations suggested. In August 1918, Private James McDonald of the 6th BWIR Battalion applied for special leave from hospital to marry a local woman. Macdonald had lost both his feet in the war and was fitted with artificial limbs at the Belmont Road Hospital in Liverpool. He hoped to learn a trade, presumably to become fiscally independent in his disabled state, and to support his new wife. Seeking information on retraining and permission for the leave, McDonald consulted H. Galloway, a Captain with the Royal Army Medical Core serving at his hospital. Galloway himself wrote to the Infantry Records Office in London. His missive is the only surviving evidence of McDonald’s case. Without referencing McDonald’s ethnic background, Galloway politely asked his questions. Could his Commanding Officer grant Galloway approval for the discharge? Did the Records Office need the name of Macdonald’s prospective wife? And were there any retraining opportunities that a double amputee of the BWIR could access? The War Office turned over the case to the Colonial Office. They would leave the question of McDonald’s discharge to the latter, they suggested, yet advised that any such men should be required to sign a statement signifying “that he understands he will not afterwards have any claim to a passage to the West Indies at the expense of Imperial Funds.” After the Colonial Secretary stated no objection, McDonald and his unnamed fiancé disappear from the archive. As Ray

597 War Office to Colonial Office, August 2, 1918, CO 318/347/33.
suggests, there was perhaps greater toleration for Afro-Caribbean servicemen’s interracial unions than for African men. Even where authorities in the Colonial Office grew more set in their opposition to West Indians’ marriage to British nationals in the interwar years, policy was clearly more flexible on the ground.

Was this slippage due to McDonald’s physical condition? Did the maimed state of his body engender empathy, or lessen British concern over the potency of his ‘primitive’ masculinity? Alternately, were government officials reviewing his case not concerned with granting marriage and leave to remain to a double amputee with no retraining, and a West Indian one at that? The Colonial and War Office’s deliberation over McDonald’s future offers no clues. Yet the case highlights how, in some instances, West Indian servicemen trusted physicians with both their bodies and their futures. In his position as a member of the RAMC, Galloway oversaw McDonald’s convalescence and limb-fitting. In turn, he acted as an envoy for McDonald, sourcing a legal path for his marriage and future. Government responses to interracial relationships would become more stringent and defined over the 1920s, as the “white wife problem” came to a head. Nonetheless, McDonald’s case illustrates how the War offered opportunities for interpersonal connections on multiple fronts. It provided the conditions for interracial relationships to occur on a far greater basis than before.

When time came to repatriate West Indian servicemen, bureaucratic frictions complicated a chaotic process. The Home and Colonial Offices debated where black soldiers and seamen would be sent, whether or not they came with a socially transgressive family. Colonial governments had accepted repatriation expenses, but

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wished only to pay for their own subjects. Yet BWIR battalions had mixed servicemen from different colonies. “G.G.” at the Colonial Office complained that most colonies were “unwilling to repatriate,” instead, “very properly insist[ing] on proof of origin which it later writes to acquire.” This made for a drawn-out and intricate bureaucratic process.  

The slow pace of repatriation produced conflict within servicemen’s families as well. In December 1919, the Colonial Office found itself hurrying to find a ship to bear a load of BWIR servicemen and their relations. These men had likely travelled to Britain to enlist before the official sanctioning of a West Indies regiment, bringing their families with them; alternately, their wives may have travelled after the armistice while their husbands waited for demobilization at the Knotty Ash BWIR Camp in Merseyside. The group had been awaiting repatriation for at least two months. Algernon Aspinall, the Secretary of the West Indian Contingent Committee, brought the matter to the Colonial Office’s attention. He visited the Maddox Hotel in Liverpool on the 28th November, and found eighteen wives and twenty children, “crammed into two or three small rooms.”

Noting their poor conditions, Aspinall warned the Colonial office that “if epidemic of illness broke out it might be a very serious matter,” citing the case of a woman “indulging in an attack of vomiting” during his visit. He gathered warm clothes for the group, but advised that the Colonial Office act quickly to secure the men and their families passage on a Jamaica-bound vessel, lest they “have a fresh scandal.” The Colonial Office acted quickly, sending an Embarkation Officer to make a surprise visit to the Hotel, where they chided the Hotel’s Proprietor and ordered him to grant the women and children extra milk

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600 Algernon Aspinall to H. T. Allen, December 1, 1919, CO 318/351/16.
and sugar. But they could not move the families, for no other hotel in Liverpool would “accept coloured people.” The particular conditions of BWIR servicemen’s gradual repatriation, it seemed, produced an extended crisis. Families were caught up in colonial bureaucracy as they crossed borders and oceans to remain or reunite with loved ones.

Interracial relationships in metropolitan Britain elicited more pushback. West Indian men often engaged in relationships with European women in their course of work as seamen, servicemen, or local workers in the metropole in war factories. As the economy struggled to return to prosperity, tensions grew in the metropole, particularly in port cities where concentrations of non-white migrants and seamen were greatest. These tensions frequently spilled over into racial violence. W. C. Harrison, a black veteran in Liverpool, grew increasingly frustrated with the fractious atmosphere. He appealed to the Colonial Secretary, writing in July 1919 to enquire whether something could “be done to protect coloured people in this country from mobs?” After all, the population of non-white subjects in the city “cannot suffer for what two or three men did.” He went on to accuse the British press of inciting violence by running articles encouraging mobs. He was frustrated with the double standards toward white and non-white migrants. Harrison called attention to the “hundreds of thousands of English people” who resided freely and peacefully in the colonies, comparing them with the situation of travelers from the Colonies in the metropole:

It is time the English people realize the different classes of coloured people in this country... We Coloured people gave our assistance to Britain... Now you see what is being given us for our loyalty. Any foreigner, so long he is white, is welcome and protected, and can remain in England. I do not really understand

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601 Assistant Embarkation Commandant to Director of Movements, War Office, December 5, 1919, CO 318/349/74.
602 Ibid.
603 W. C. Harrison to Colonial Secretary, 10 June 1919, CO 323/818/71.
You don’t expect a Foreign Government to accept, and protect us when we are disowned and driven adrift by our own Government. We cannot help for our colour; perhaps God has regretted for making such a mistake. I must say mistake because the way in which we are treated, as though the whites are perfect, and are the only human being which appeal to God. I really can’t grasp the meaning of the word Civilization [sic]!  

Harrison ended his missive by emphasizing his voluntary sacrifice for the imperial motherland: “I was not [drafted] here as some paper stated. Some of us came here honourably, not for the white girls either.” Harrison thus established his moral worth both through his war service and his lack of romantic or sexual intentions towards white women. He rejected the lascivious intentions so often ascribed to black colonial servicemen. Yet back in the post-Armistice metropole, he came up against rigid policies, social hostility, and white violence directed towards black masculinity and sexuality. His treatment after demobilization outraged him far more than that during the war. For Harrison, the racial violence in Liverpool triggered a radical rethinking of the “Civilization” he had defended in the name of the British Empire.

Rather than responding to Harrison’s plea with empathy or understanding, the Colonial office refused to answer it, “in view of its threatening tone.” Instead, the officials reading his letter advocated an even less friendly program of action towards West Indians in the metropole. The Colonial Office suggested that the Government ought to expand their policy of repatriating B.W.I.R. servicemen and non-white seamen, to go “further and expatriate all coloured men who can be induced to go.” The current process, by which the colonies insisted on proof of origin before paying for their subject’s repatriation, was “too long and too uncertain.” Rather, they advocated a risky

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604 Ibid.
605 Minute by G. G., June 14, 1919, CO 323/818/71.
606 Ibid.
policy of indiscriminately removing non-white subjects from the troublesome port cities—regardless of whether they were sent back to their actual homes: “If the men are repatriated at our expense we can in view of the servicemen… send them to the Colonies they belong to according to their own account and chance it.”\textsuperscript{607} This radical suggestion refused both Harrison’s claims of wartime sacrifice and loyalty, and his assertion that few West Indian servicemen pursued interracial relationships. Indeed, the proposed policy placed all non-white civilians under blanket suspicion of miscegenation.

With the end of the war, economic downturn, and increasing tensions in the metropole, numerous colonial subjects sought to return home with their new families. Yet colonial governments were not so accommodating. Instead, Carina Ray and Laura Tabili have illustrated how the desire to retain colonial social conventions and racial barriers resulted in family separation.\textsuperscript{608} Interracial marriage was subject to legislation and bans intermittently throughout the Empire. At ports in British West Africa and the Somaliland Protectorate, women were denied entry to the colonies with their husbands. Interracial families were forced to choose between separation or enduring racial prejudice as a couple in the metropole. Unlike other British territories, no legislation explicitly forbid miscegenation in the West Indies. The Colonial Office, Ray argues, felt that the longer history of racial mixing in the West Indies provided grounds for allowing interracial migration.\textsuperscript{609} Local officials in the colonies felt differently. Discussing several cases of intermarriage and migration in Jamaica, Herbert Bryan, the Acting Governor of Jamaica, asserted via telegram that “while there is no objection, on principle,

\textsuperscript{607} Ibid.
\textsuperscript{608} Carina Ray, “The White Wife Problem”; Laura Tabili, “Edith Noor’s Progress.”
to white wives of coloured seamen being admitted to Jamaica, such a course in most undesirable in the interests of the wives."

Unable to expressly forbid it, Bryan nevertheless strongly discouraged interracial migration. In doing so, he expressed many of the same concerns for white womanhood echoed in the restrictive policies in British African colonies.

The intersection of Colonial Office policy (tacitly allowing interracial migration, particularly where it removed such couples from the metropole) and local colonial discouragement of this meant that interracial couples’ experiences varied widely in the interwar decades. White wives and West Indian husbands still faced explicit bias and an array of difficulties making a life in the Caribbean. In November 1919, Cyprian Robinson, a “coloured seaman,” asked to be repatriated to St. Vincent with his Irish wife. Robinson had left the island as a sailor in 1900, but after nearly two decades at sea and years at war, wished to return and bring his family with him. Reginald Popham Lobb, the Colonial Administrator of St. Vincent, brought the case to the attention of the Governor George Haddon-Smith. Popham Lobb was not disposed toward their repatriation. He noted that Robinson had no home on the island, and that his aging mother Jane Barrimore was a pauper receiving poor relief. In this situation, he argued, Robinson could not possibly provide for both himself and his wife without private means. Far from being racially motivated, Popham Lobb claimed, he objected to the couple’s migration in order to save them from others’ prejudice: “While there is but little racial feeling in St. Vincent, it is very likely that a European woman married to a man of Robinson’s class would become the object of petty annoyances and persecution on the

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610 Herbert Bryan to Viscount Milner, Secretary of State for Colonies, November 15, 1919, CO 318/349/74.
611 Reginald Popham Lobb to George Haddon-Smith, November 5, 1919, CO 318/349/72.
part of ill-disposed persons which might ultimately lead to trouble and it is most undesirable that such a contingency should be allowed to arise, if it can possible be prevented.” Yet Popham Lobb went on to undermine his claims to objectivity, concluding, “In my opinion no facilities should be given for the repatriation of any coloured native of St Vincent married to a European. Mixed marriages, particularly where the woman is white, are bound to have bad results and there are not a dozen coloured men in the Colony who are in a position to maintain a European wife in decent comfort.” Popham Lobb’s “bad results” euphemistically conveyed a myriad of white anxieties and preoccupations over the presence of black colonial subjects in the metropole, visible interracial couplings, and the specter of “racial suicide.” Governor of the Windward Islands George Haddon-Smith, agreed with his refusal to repatriate the couple. Their resolution forced Robinson to choose between a life of continued discrimination in England with his wife, and returning home to his indigent mother.

Faced with these stark choices, the Robinsons chose a third option - defiance. Three months later in February 1920, Governor Haddon-Smith complained to Colonial Secretary Milner that Robinson and his wife had flouted the Colonial Office’s advice and returned to St. Vincent via a ship repatriating ex-servicemen. Haddon-Smith claimed that he was personally approached by the “useless” Robinson and his “pitiable” wife, seeking “pecuniary assistance.” The Governor made his disdain for the veteran clear. Robinson’s 12/- per week pension, he reasoned, encouraged him not to pursue regular employment on St. Vincent. Rather, Haddon-Smith argued, his previous warning against

612 Ibid.
613 Ibid.
614 Haddon-Smith to Viscount Milner, February 16, 1920, CO 813/353 File 13748.
allowing the couple to return to the island had proven correct. Mrs. Robinson was
“publicly jeered at and annoyed in the public streets,” he asserted, compelling “the
Police… to give her protection.” Stymied in his attempt to keep the couple out of St.
Vincent, Haddon-Smith took matters into his own hands. He testified in his letter that he
advanced “passage money” to Mr. Robinson and “sent him by sloop to Trinidad,” and
arranged for Mrs. Robinson to travel imminently on a ship to Halifax, where she would
be given £2 on arrival before proceeding to Belfast. The Governor alleged that this
money was “for board and lodging” in between her travels. Was Mrs. Robinson returning
of her own volition? The only voice in their chronicle is that of Haddon-Smith. Whether
the Robinsons separated through their own choice, out of economic necessity, or by
forceful persuasion is unknown – as is whether Mrs. Robinson actually boarded the
steamer to Belfast.

Their case points to the complexity, conflict, and slippages that occurred
throughout the highly bureaucratic yet deeply disorganized process of demobilization.
After effectively paying off the Robinsons to separate and arranging for their transport to
do so, Haddon-Smith demanded that the Board of Trade (the body which organized the
repatriation of foreign seamen) cover the cost of Mrs. Robinson’s journey back to
Belfast. The Governor stressed the disparities between colonial and metropolitan
approaches to repatriation. In forcing the Board of Trade to pay for Robinson’s journey,
he asserted, “This action may have the effect in the future of causing [them] to realize
that those on the spot have a better knowledge of local condition than their officials who
reside in Great Britain.” Haddon-Smith’s complaint highlighted the tensions between

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615 Ibid.
616 Ibid.
officials based in the colony and metropolitan authorities intent on moving non-white servicemen out of Britain – with or without their transgressive families.

Nonetheless, the Colonial Office declined to pursue the Governor’s request. The Robinson’s had been accommodated on H.M. transports in light of Robinson’s wartime service, and the Office had never broached the “question of the white wives” with Naval repatriation authorities. “If we had attempted to do so,” Colonial Officer R.A.H. mused, “there would probably have been a fine outcry.” R.A.H.’s comments suggest that enacting or even suggesting policies to deal with “white wives” of colonial servicemen would open the Colonial Office to criticism and indignation. In the early years after armistice, then, formal opposition to interracial marriage and repatriation was not uniform among government authorities. This patchwork of colonial and military bureaucracy was rife with seams, across which families like the Robinsons were able to move despite the supposedly regulated borders – even when they had been explicitly prohibited from doing so by the Governor of a home colony. At the same time, these families were still subject to the vagaries of local officials once they arrived home. On this occasion, colonial authorities persisted in organizing and effecting their separation.

These cases illustrate how men attempted to navigate the red tape of repatriation policy, but what of the voices of the women marrying them? Though often silent in official correspondence, the women in question occasionally made themselves heard. The Robinson’s case is paralleled by that of Lottie Bryan, originally of Sheffield. In October 1919, Bryan wrote to the Colonial Secretary, asking to be repatriated to England. She relayed that she met Charles Bryan, “a coloured Jamaican,” when he worked in a

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munitions factory during the war, and married him in June 1918. A month later, she gave birth to a child. The following September they moved to Jamaica, where, Bryan testified, “my husband is neglecting me, and not supporting me.” Lottie’s discontent with her situation may have derived both from practical and personal circumstance: Charles’ work for the Jamaica Government Railway kept him away from home for long stretches of time and earned him only 30/- per week. In his absence, Lottie testified that she had “found out that he has several children already,” and claimed that, “on account of the parents of these children he is deserting me.” It took the Inspector General of Kingston another two weeks to interview Charles, upon his return from the Port Antonio Line. While making no claim to abandon her, Charles acknowledged that he was afraid “the wage he is getting here is not enough to keep his family as they should be kept.” He stated that he was “quite willing” for his wife and the child to return to England, but that he had no means to send them. The Inspector General affirmed that they appeared “destitute of means.” The Colonial Office observed that Bryan must have slipped through legislation “before the ‘white wife’ question came to a head.”

In the same paternalistic tradition that Ray and Tabili have exposed in British West Africa and Somaliland, colonial officials erased Bryan’s agency and scrutinized her character. Ignoring Lottie Bryan’s own claims about her husband’s extramarital relationships and responsibilities, the Colonial Office made their own judgments about her reasons for returning to England. They noted only that “no doubt the stoppage of ‘maintenance money’ and of ‘repatriation bonus’ [the small temporary grants received by

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618 Lottie Bryan to Colonial Secretary, October 27, 1919, CO 318/349/74.
619 W. E. C. to Acting Col. Secretary of Jamaica, November 15, 1919, CO 318/349/74.
620 On the “white wife” question and colonial politics around interracial marriage and citizenship, see Carina Ray, “The White Wife Problem,” 628-646.
most returning West Indian servicemen] has had a dampening effect on the desire of married seamen to take a trip to the W. Indies with their families.” These comments made in reference to Bryan’s case suggest that Lottie’s desire to repatriate was derived from her dissatisfaction with her material life and comforts, rather than her husband’s affairs as she herself alleged. If she had been transgressive enough to marry a black man and move to Jamaica, the Colonial Office asserted, Lottie could not have been distressed over marital fidelity. The officials reviewing the case implicitly denied her the moral and emotional subjectivity duly assigned to other ‘proper’ white women.

Ultimately, they agreed to repatriate her at the Jamaican Government’s cost, but suggested that the Chief Constable of Sheffield first enquire whether her parents were “willing to receive” her and her fifteen month old child. Lottie Bryan’s attempt to repatriate herself and leave her husband is emblematic of the difficult decisions women involved in interracial relationships with colonial subjects often had to make. As Laura Tabili and Carina Ray have illustrated, they were faced alternately with an unaccommodating Colonial Office, and with an often difficult life in their husband’s home colony. Likewise, Charles Bryan appears to have found his postwar salary and benefits severely lacking. Faced with other relations and children to support, and perhaps marital strife fomented by fiscal difficulties, he supported Lottie’s petition to return to her parents back in Sheffield. Thus, even when British wives of black men were allowed to emigrate with their husbands, the local hardships faced by Afro-Caribbean veterans often made life difficult for their interracial families. The Bryans’ case suggests that even after

621 Colonial Office Memo on Lottie Bryan, November 15, 1919, CO 318/349/74.
marriage and migration, economic and social constraints rendered interracial relationships more unstable.

**Conclusions**

The existence of these cases confirms that metropolitan efforts to control interracial relationship and migration often failed. These marriages in the margins of the historical record are evidence of the persistence of interracial relationships, occurring at the porous boundaries where army regulations, metropolitan and colonial policy, and everyday intimacies met. They were both enabled, and disabled, by colonial mobilization, the very conditions that brought about interracial relationships also the mechanism by which they were regulated and dismantled. The patchwork of colonial bureaucracies allowed individuals to exercise a certain amount of agency, traversing loopholes and regulations due to their ambiguous positions. Yet even in the supposedly more permissive West Indies, local officials had discretionary power over interracial couples. As the cases of individual veteran petitioners make clear in the following chapter, non-white colonial servicemen used these gaps and intersections of colonial authorities to effectively leverage their position as people who did not fit neatly into the bureaucratic categories of Empire.
Chapter 6: Bodies in the Aftermath
Protest and Pensions in the Interwar Era

In 1926, at the behest of the metropolitan Ministry of Pensions, pensioning authorities in British East Africa put out a call soliciting claims to welfare from ex-servicemen. The Nairobi *Official Gazette* published a General Notice asking for pension claims for Great War “disablement” in 1926. Some ex-servicemen interpreted this liberally. One N. S. Patel, a railway assistant, wrote to ask for monetary compensation for his lack of promotion at work. When Patel was granted overdue leave time in 1917, he returned to India to find his promised bride already married. He claimed that he was forced to “wait for another chance” and remain in India to seek a wife, during which time he effectively abandoned his army post. After marrying and finding work in 1920, his desertion came back to haunt him. His superiors considered him junior and routinely kept him back from promotion due to his “broken service.” Patel alleged that his lack of leave in 1916 caused him a loss of salary, and appealed for compensation to remedy it.

Perhaps unsurprisingly, the pensioning authorities rejected Patel’s request. Yet his case offers striking parallels to many other non-white ex-soldiers across the Empire. Here was a South Asian veteran working in British East Africa, appealing to a colonial bureau for imperial welfare. Not all ex-servicemen were as mobile as Patel. Many had more recorded service and concrete claims for their welfare. But these men and their families had to cover great distances to appeal or receive government aid and compensation. They did so frequently and fervently. Pension petitions constituted the most vital form of colonial veterans’ engagement with the British government. Ex-

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622 “Case of N. S. Patel,” c. September 26, 1926, in Mr. G. J. Gilbert’s Report on Kenya Colony, The National Archives (TNA), Ministry of Pensions (PIN) 15/1142.
servicemen used the pension petition to vocalize their belief that their physical and psychological contributions in war entitled them to care. Furthermore, by engaging with imperial and metropolitan officials through letters, petitions, and protests, colonial veterans deepened their bureaucratic entanglement with the Empire they had served.

This chapter examines moments when the British imperial bureaucracy came face to face with the problem of colonial veterans and their wellbeing. It explores how the seemingly mundane world of imperial pensions administration reveals surprising moments of renegotiation and intervention. Applications and petitions relay vital questions of self, citizenship, and bodily parity between the colonized and their colonizers. Did veteran’s rights – a potent subject of debate in interwar metropolitan Britain – differ between citizen and subject? How did the Colonial Office and India Office, charged with maintaining stable rule in the colonies, negotiate the difference between the deserving and undeserving poor? In what ways did these ex-servicemen mobilize their experiences and contributions to petition an imperial government? What do these petitions and the British administration’s reaction to them say about the role of race in understandings of responsibility, dependency, and belonging in the British imperial world?

If the war globalized British welfare, it also further globalized its colonial servicemen. Their travels and experiences rendered them constant if often unsuccessful agitators in the interwar colonial state. Narratives of interwar veteran policy in Britain are silent on the fate of colonial servicemen, and narratives of interwar colonial politics often devalue the political engagement of ex-servicemen. Conversely, I will argue that
veteran policy was a touchstone of fraught political and social debate in many interwar colonies, for administrators and ex-servicemen alike.

These debates throughout the 1920s and 1930s illustrate the divisions that existed within the administrative arms of the Empire. Surprisingly, rather than supporting colonial governments, the Ministry of Pensions often negated its own fiscal responsibility for colonial veterans while sharply monitoring colonial governments to ensure that they provided basic care. Its commitment to ensuring such standards for ex-servicemen varied from colony to colony, and wartime labour role to labour role. In the interwar period, veterans’ needs and rights were the subject of frequent, fractured debate between metropolitan bureaucracies like the Ministry of Pensions, the Colonial Office, and the India Office, colonial governments, and the ex-servicemen themselves.

This chapter builds on existing scholarship on the British welfare state in the interwar era and shifts focus to the Empire, in order to show how veteran welfare was alternately expanded and limited in the colonies. By focusing on veteran pensions, it examines how Governments allotted rewards for service differently from space to space – sometimes based on pre-existing bureaucracies, on the amount of trouble anticipated from different indigent veterans, or on the perceived weight of their wartime contributions. Far from a top-down operation, colonial veteran welfare depended on a patchwork of regulations, mediated by different motives of political expediency, social custom, and human need. Occasionally, it spurred surprising developments in racial equality and social change.
Soldiery in Welfare Historiography

Why did pensions matter? After all, for all the legacy of World War One’s “lost generation” and contemporaneous cultural debates about the war and its meaning, few histories continue their studies past the immediate aftermath of the war. Fewer still are interested in the everyday lives and experiences of veterans over the next two decades – even as they returned to imperial crises and ensuing economic depression. Scholarship that builds on these stories, however, reveals the integral role of ex-servicemen in determining the political climate of the interwar decades.

Welfare in the colonies provides an interesting counter narrative to the tale of British veterans’ treatment at home. Comparative European studies have established the central role of the pension in establishing and facilitating the growth of the welfare state. Susan Pedersen’s analysis of the rise of the welfare state in Britain and France establishes the centrality of gendered family relations in structuring state social policy. Pedersen identifies how British policy in particular emphasized the ideal of the “male breadwinner.” This norm fed into the interwar configuration of pension schemes, which linked government aid to the primacy of the male provider.

Yet in the still developing welfare state, social insurance’s ties to masculinity did not necessarily mean adequate care for the destitute ex-soldier. Deborah Cohen has documented the generally appalling lack of on-the-ground assistance and government-provided care for wounded veterans. Cohen’s comparative work establishes that the majority of post-war care for British veterans came from private organizations and

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individuals, dedicated to communally providing welfare. The British government, she claims, provided little more than the bare minimum after Armistice. The Ministry of Pensions set compensation rates at or just above minimum wage, and disability was adjudicated on a strictly numerical basis (see Chapter 4). This arrangement, however, ensured that British veterans felt connected to those they had served and suffered for. Their supportive relationship with philanthropists and society at large discouraged them from engaging in widespread protest and rebellion, as occurred in Germany. The aid and welfare which the British colonial government provided to non-white colonial veterans may not have exceeded these low standards, but its role as a supervisor, administering policy and ensuring that colonies did not renege on their duty of care, tied them to colonial ex-servicemen in other ways.

Did the British government have more to give? Cohen illuminates how the Ministry of Pensions justified their lack of support, on the basis of a national budget crisis and necessary post-war austerity measures. Others point to the fact that the Coalition government faced new crises that took its attention elsewhere – specifically, towards its own Empire. It was preoccupied by lingering unease from the Easter Rising in Ireland and burgeoning civil unrest in India – both colonies which contributed heavily to the war effort. The notion that demobilized colonial subjects might turn against the Empire they had fought for seemed more and more likely. However haphazardly, the Colonial Office and India Office urged colonial administrations not to leave their veterans out in the cold, and thus create further avenues for protest and rebellion.

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Colonial veterans lacked anything close to the wealth of philanthropic institutions and organizations which took responsibility for British veterans at home. But in some ways, they had more government arenas and bureaucratic avenues to pursue. One colonial subject-soldier might bring his woes to his local ex-servicemen’s association or local soldiers’ board. From there, the individual or group could petition the colonial government, or skip that often unproductive venture altogether, pleading their case directly to the Colonial Office, the India Office, or the Ministry of Pensions itself. Yet even where the metropolitan government bore responsibility for colonial pension payments, there was no guarantee that the colonial administration was providing adequate facilities and outlets for basic care, or that intervention from abroad could prompt it to do so.

My interest is in elucidating welfare for disabled veterans. Nonetheless, this chapter examines pensions and assorted forms of compensation for veterans as a whole. It does so for two reasons. First, a comprehensive approach to colonial pensions requires consideration of veteran’s organizations and pensioning officials who dealt with ex-servicemen of all ilks, disabled or not. Disability could, alternately, be a defining determinant or entirely ignored in the different forms of military welfare. It played a crucial role in determining the value of ex-servicemen’s pensions. However, government officials and committees distributing and adjudicating land grants often failed to consider how provisions for disabled veterans might differ. The vast majority of ex-servicemen’s associations in South Asia and the Caribbean represented both whole-bodied and disabled veterans together. Second, the racialized terms of wartime disability means that distinctions between disabled and non-disabled colonial veterans were not as clearly
drawn in the case of non-white troops. As this chapter will illustrate, what constituted
disability varied widely. Blindness, amputation, advanced chronic disease, “lunacy” –
the Ministry of Pensions and its colonial auxiliaries configured all of these as forms of
“permanent” debility deserving of compensation. Historians of modern Britain have
carefully detailed the difficulties and contingencies of demarcating debility both as
“permanent” and as “attributable to war service” – both requirements to receive the
updated rates of pension established in the Royal Warrant of 1919.626 As the previous
chapters of this thesis have argued, however, the very diagnosis and treatment of wartime
wounds and disease was often predicated on clinicians’ and officials’ interpretation of the
relationship between race and medicine. Thus, the pensioning authorities may not have
recognized all disabled ex-servicemen as suffering from permanent debility.

In the colonies, the pension was both an integral part of racializing colonial
bureaucracy, as well as part of the aftermath of debilitating injuries or diseases. In both
the British Isles and the wider Empire, it required the state to assign monetary value to
body parts, capacities, and mental health (see Table 1). The official “Scale of Wounds” –
which designated what various parts of the body, and their loss, were worth – remained
the same throughout the metropole and Empire. However, the pensions derived from
those rates differed dramatically. Rates for disabled non-white servicemen from the West
Indies, Africa, and India were uniformly lower than those granted to disabled white

626 Deborah Cohen, “Will to Work: Disabled Veterans in Britain and Germany after the First World War,”
in Disabled Veterans in History, ed. David A. Gerber (Ann Arbor: MI: University of Michigan Press,
2012), 298; Seth Koven, “Remembering and Dismemberment: Crippled Children, Wounded Soldiers, and
the Great War in Great Britain,” The American Historical Review 99, no. 4 (October 1994): 1167-1202;
Julie Anderson, War, Disability and Rehabilitation in Britain: ‘Soul of a Nation’ (Manchester: Manchester
soldiers in Britain. Official discourse assigned these disparities to “the cost of living.”

Ostensibly, “cost of living” attempted to scale regional economics in the same way that the Wound Pension rates scaled the value of fingers, eyes, and mental stability. Yet the segregation of armed forces – through the assignment of white individuals to officer rank over non-white subjects, and in many colonies, the division between (white) combatants and (non-white) laborers – allowed the Ministry of Pensions to grant white citizens residing or receiving their pensions in the colonies higher rates than their subject counterparts.

Table 3: Scale of Wounds Pensions for Specific Injuries - Officers

<table>
<thead>
<tr>
<th>Specific Injury</th>
<th>Degree of Disablement %</th>
<th>Rate of Wounds Pensions (Pounds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Loss of two of more limbs. Loss of an arm and eye. Loss of a leg and an eye.</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Loss of both hands or of all fingers and thumbs Loss of both feet Loss of a hand and a foot Total loss of sight, Total paralysis Lunacy Wounds, injuries, or disease resulting in disabled man being permanently bedridden. Wounds of or injuries to internal thoracic or abdominal organs, involving total permanent disabling effects. Wounds of or injuries to head or brain involving total permanent disabling effects, of Jacksonian epilepsy. Very severe facial disfigurement. Advanced cases of incurable disease.</td>
<td>90 80</td>
<td>90 80</td>
</tr>
<tr>
<td>2. Amputation of right arm at shoulder joint.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Amputation of leg at hip or left arm at shoulder joint.</td>
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<td></td>
</tr>
</tbody>
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628 Royal Warrant of the Ministry of Pensions dated April 17, 1918, British Library (BL), India Office Records (JOR) L/MIL/7/2959.
This commodification of the body shared its genealogy with the practices of soldiery and slavery. At the same time, by valuing the sacrifices made by individuals for the state – both willingly and unwillingly – the veteran pension represented some of the first official recourse for colonial subjects to claim their corporeal value from an Empire that had long taken their bodies for granted. The mass mobilization of colonial servicemen in the First World War officially valued their labor and loss. The welfare system constructed for this empire of veterans, then, was as an extension of the racialized colonial bureaucracy and its biased assignment of labor value. At the same time, it offered them a unique voice and opportunity to call on the imperial state for aid.

Disparities in postwar pensions had their roots in differentiated wartime salaries. Indian sepoys and followers’ pay was already regulated at the start of the war under the separate domain of the Indian Army. As Richard Smith has detailed, BWIR pay was notably equal to that of British Army rates. At the same time, the War and

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Colonial Office set separation allowances for BWIR servicemen’s dependents significantly lower, citing the lower standard of living in the West Indies. When the War Office elevated British regiments’ pay in the Army Order 1 of 1918 – an increase of some 50% for privates – they did not extend the raise to BWIR servicemen. Instead, the order designated the BWIR as a “native” unit, ineligible for new rates. BWIR Officers, the West Indian Contingent Committee, and various Colonial Office administrators protested the sudden differentiation. In April 1919, after prolonged appeals and unrest, the War Office finally conceded the pay increases and bonuses withheld from BWIR troops.

When it came time to adjudicate regular and disability pensions for non-white colonial troops, the War Office and Ministry of Pensions found itself debating parity once again. In November 1918, the Ministry of Pensions set up a temporary body to deal with these questions: a “Committee appointed to consider pension schemes for coloured troops.” This irregular committee itself quickly threw out the suggestion that all “coloured troops” could be pensioned under the same rates across the Empire. As one administrator wrote, “it was manifest that a ‘Black Warrant’… was impossible.” If the separate forces had all retained separate rules and rates throughout the war, the Committee claimed, they found no reason to consider a “general scheme.” Still, they eagerly compared and debated the parameters of non-white pensions. The Committee produced a table comparing the pension charges, arrangements, and proposals for a variety of “coloured” troops, including the British West Indies Regiment, Maltese “Men of Colour,” Kroomen Seedies, Goanese, Cape Corps, Cape Coloured Battalion, Cape

630 Letter to Wynne, November 28, 1918, PIN 15/2656.
631 Letter to Mr. Tombleson, December 30, 1918, PIN 15/2656.
Indian Bearers, Mauritius Labour Battalion, The British South African Rhodesian Native Police, the Fiji Labour Battalion, the North Zion Mule Corps, the West African Frontier Force, the King’s African Rifles, and Lascars, among others.\textsuperscript{632} The fact that the Ministry considered a general scheme for “coloured troops” – and their continued comparison of “native” rates of pension in isolation – speaks to the endurance of practices of differentiation, from military authorities to welfare distributors.

\textbf{The Imperial Motherland Checks In: J. G. Gilbert’s Trip Around the World}

By 1925, the Ministry of Pensions was sufficiently concerned about the state of imperial welfare to commission a representative to travel across the Empire to visit, confer, and negotiate with colonial pensioners and the local pensioning authorities. In January of 1925, G. J. Gilbert, a Staff Clerk typically confined to his desk, was sent across the globe, visiting India, New Zealand, Australia, the Fiji Islands, South Africa, North and South Rhodesia, the Seychelles, and Kenya Colony, later proceeding to the Caribbean, where he stayed in Trinidad, Jamaica, Barbados, and British Guiana.\textsuperscript{633} On his journeys, he encountered helpful colonial officers and truculent government accountants, efficient and duplicitous prosthetics technicians, satisfied and disgruntled veterans. Ostensibly, Gilbert was supposed to ensure that colonial governments were dispensing due care and pensions to veterans of all races and creeds. His larger agenda, however, was to audit the local pension administration and, where possible, shift the liability for ex-servicemen to the colonial governments. The process of auditing, however, often

\textsuperscript{632} Present Pension Arrangements, PIN 15/2656.
\textsuperscript{633} Mr. G. J. Gilbert’s World Tour Itinerary, PIN 15/1673.
revealed the poor conditions of many local pensioners and prompted the Ministry of Pensions to reprimand the government bodies administering welfare and medical aid.

Shifting liabilities meant renegotiations between the metropole and colonial governments on a central question: who bore fiscal and moral responsibility for the colonial subjects who volunteered their lives and labor for the imperial state? Though individual colonial administrations organized recruitment and enlistment on their home territories, it was the War Office who, by and large, paid the soldiers’ salaries. The exception was the pre-standing Indian Army. As part of its sizable financial contribution to the war, the Government of India paid its Army’s soldiers, and post-war pension payment was business as usual for its Military Department.634 In contrast, most newly established colonial forces, like the British West Indies Regiment and the South African Native Labour Corps, had no administrative apparatus back home to manage the force. Most local governments made few plans to take over the care – both medical and fiscal – of their veterans after armistice. Thus, when Gilbert arrived on the shores and in the cities of imperial outposts, he was greeted with fledgling systems built on little precedence and an abundance of haphazard bureaucracy.

Gilbert himself was the embodiment of the liberal administrator. His agenda was focused, to a great extent, around metropolitan questions of soldier welfare. Almost no colonies he visited had special institutions for military “neurasthenics,” and few had their own facilities for artificial limb repair and manufacture, though such sites were relatively new and quickly multiplying in Britain. Nonetheless, he continually questioned colonial

governments on their provisions for veteran’s mental health and orthopaedic care, encouraging India and Kenya to become independent of the metropolitan imports. His recommendations often sought to economize care by making it more accessible and practical for veterans. Gilbert advocated locating medical facilities and pension distribution centers closer to the veterans in question, discouraging clustering services in one or two cities far from men in need. Gilbert succeeded in effecting changes over pension responsibility. Kenya was the only colony to decline administering pensions for the Home Government. Though the majority of dominions and colonies agreed to administer and foot the bill for their own veteran welfare, this shift did not end the Ministry’s involvement in colonial pension affairs. Instead, Colonial Office and India Office officials, including Gilbert himself, found themselves debating pension politics with colonial governments well into the 1930s and 40s.

Just as administrators in the metropole sought to limit their own financial liabilities for veterans, colonial pensions administrators across the Empire were deeply invested in cutting corners and costs for colony-paid charges. This resulted in a widely varying patchwork of systems which often imposed arbitrary conditions for pension collection. These restrictions often shifted fiscal responsibility away from the local government while targeting soldiers’ dependents (particularly illegitimates) and penalizing seemingly irresponsible veterans.

Who counted as a dependent for the purposes of welfare varied widely from colony to colony, reflecting both the Ministry’s attention to cultural norms and its fiscal parsimony. In South Africa, white veterans were entitled to dependent allowances for children born within nine months of their discharge, as well as wife allowances for
soldiers marrying up to two years after soldiers’ discharge. Yet local regulations excluded all ‘unmarried wi[ves]’ and ‘illegitimate children’ from receiving dependent allowances from soldiers who were alive – though it sanctioned allowances if the soldier died. Gilbert himself made note of this moralizing judgment, noting that “I understand that the Legislative Assembly were adamant upon penalizing the pensioner in this way.” Yet as Rebecca Probert has described, the term “unmarried wife” first appeared in official parlance as a result of wartime welfare initiatives. First used in trade union demands in the metropole in November 1914, the phrase both clarified the intended beneficiary (“unmarried”) and drew comparisons to normative nuptial relationships to elicit sympathy from officials (“wife”).

Probert traces how pensioning officials in Britain adopted the term and granted limited rights to unmarried women living with men from the start of the war until 1927. These included wartime allowances of twelve shillings and sixpence per week for “unmarried wives” of British soldiers who had “no other means of subsistence.” Rather than indicating a sudden change in official attitudes toward cohabitating couples, the military establishment hoped to thus bolster men’s morale and encourage further enlistment. After some debate, Parliament temporarily extended these benefits after the war to assuage the crisis of high unemployment. The 1921 Unemployed Workers’

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636 Ibid.
638 Ibid., 110-111.
639 Ibid., 122.
Dependents (Temporary Provision) Act allowed dependent “unmarried wives” to claim 5 shillings per week.\textsuperscript{640}

In the British West Indies, cohabitating partners also received a 5 shillings allowance. Yet they were subject to more restrictions than in Britain. “Unmarried wives” were entitled to allowances “only if and while maintaining” a home for the soldiers’ children. If the woman in question had no children, she was discounted from receiving the allowance. Ministry correspondence also illustrates differentiated terminology for West Indian dependents. Cohabiting partners were described alternately as “unmarried wives” or “concubines.” The latter term was never used in the same contentious discussions around white servicemen’s unmarried partners. All BWIR servicemen’s children – legitimate and illegitimate – received the same pay of 2 shillings and 6 pence.\textsuperscript{641} One ministry administrator justified this allowance on the grounds that “65\% of births” were thought to be illegitimate in the West Indies. The rates might “seem a trifle high,” he noted, but these should be considered alongside the Ministry’s allowances for rural British farmers: “it has to be remembered that the British rates are also high for the agricultural labourer’s family.” Thus, Ministry authorities’ debates and discussions of pensions drew on their understanding of regional and cultural differences in family structure. Yet they also incorporated their racial understandings of the groups they adjudicated.

\textsuperscript{640} Parliament extended these provisions again in 1922 and 1923. As time passed after Armistice and problems with unemployment continued, the Army and Parliament removed the category of ‘unmarried wife’ from eligibility for dependent allowances. Probert, 128-133.

\textsuperscript{641} With reduced rates for further child dependents – 2 shillings for the second, 1 shilling 6 pence for the third, and 1 pence for each child beyond the third. Rates were payable for children up to 14 years of age. \textit{Proposed Provision for the Widows and Dependants[sp.] of Men of the BWIR Regt.}, 1918, PIN 15/2656.
Certain colonies put up a strong resistance to paying non-white servicemen any pensions or gratuities whatsoever. The “Union Government from the first set its face against awarding pensions to Natives,” Gilbert recalled, shifting responsibility to the metropole.\textsuperscript{642} If the British government wanted any “Native personnel” of the South African Native Labour Contingents to receive a gratuity, they would have to pay it themselves – and pay it they did, for a few years. In 1923, the Ministry once again pressed the South African government to grant pensions to “Coloured and Native” veterans. They did so – but only for ten servicemen, out of over 20,000 SANLC members who served in France. When Gilbert visited four years later, Union officials informed him “that it was not intended to extend this list of Native pensioners.”\textsuperscript{643}

At points, colonial officials laughed off Gilbert’s cost-saving initiatives as bureaucratic conceits, unworkable in the colonies. While Gilbert successfully persuaded Ugandan officials to adopt extra measures against impersonation by welfare claimants, Kenyan authorities refused his suggestion that District Commissioners should offer their own secondary certification of pensioners collecting pension vouchers, in addition to the usual thumbprint verification.\textsuperscript{644} They alleged that the colony could not waste the manpower.

Too often, pension affairs in the colonies were plagued by deeply ignorant officials and crossed-wired policies. In Trinidad, where Gilbert found himself “rather hampered… by the rather inordinate interest taken in the inter-Colonial cricket matches,”

\textsuperscript{642} Mr. Gilbert’s Report on Administration of Imperial Pensions in South Africa, PIN 15/2611
\textsuperscript{643} Ibid.
\textsuperscript{644} Gilbert’s Report on the Colony and Protectorate of Kenya: Report on the Transfer of the Payment of Pensioners and Matters Incidental Thereto from the Late East African Representative of the British Ministry of Pensions…” PIN 15/1142.
colonial administration was thoroughly uneducated and ignorant on the subject of veteran aftercare. The Colonial Treasurer, Gilbert noted, “knew nothing” about treatment of Ministry pensioners, citing that they could attend the Public Hospital or District Medical Officer if they had need of treatment or complaints. In South Africa, “very few officials had read” or referred to the Ministry’s Memorandum of Instructions, while the Auditor had never even seen a copy. “Moreover,” claimed Gilbert, “the Instructions were frequently ignored, the Accountant expressing a view that he was only bound to follow them when he thought fit.” After reading Gilbert’s report of affairs in South Africa, citing “considerable ignorance,” Ministry officials concluded they would likely have to visit the Union for a follow-up in a few years. General obliviousness to Ministry policy – leading to extensive auditing – forced Gilbert to extend his visit, overstaying his scheduled time in nearly every colony.

Furthermore, no matter how many interventions Gilbert made, the imperial pensions system was simply not designed to accommodate mobile veterans. Administrators frequently worked to adjust the pensions of white ex-servicemen, most often those working and living between India and Britain. These men, predominantly officers, were paid higher rates of pension in India than in the metropole, and Pay Controllers monitored their changes in residence to adjust to cost of living. This careful attention did not carry over to non-white veterans. Pensions officials were especially confounded by the cases of West Indian veterans, who were far more mobile than their Indian and African counterparts – in large part due to the colonies’ own policy initiatives.

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645 Gilbert’s Report on Visit to Trinidad, British West Indies, February 1925, PIN 15/1775.
646 PIN 15/2611.
647 Comments on Mr. Gilbert’s Report on Visit to South Africa, PIN 15/2611.
Unable to secure employment in the depressed economies of the West Indies, and many with their pensions still processing, large numbers of Caribbean ex-servicemen travelled and migrated abroad in search of work. In some cases, local governments encouraged this. Over 4,000 demobilized Jamaicans migrated to labor in the Cuban cane fields under a government initiative that waived the £3 work permit.648

Yet travel came with its own problems. Dissatisfied with the welfare offered to veterans in Barbados, one veteran, George Blackman, went abroad for work, earning a living as a mechanic in Columbia and Venezuela. However, Barbadian civilians living abroad could not collect pensions: when Blackman finally returned decades later, he applied again, only to have his application go unanswered.649 At age 105, his application was still processing. For an Empire built on the movement of civilians and subjects, colonial bureaucracies patently failed at aiding non-white veterans who traversed their borders. As Gilbert sailed, railed, and drove across the Empire, his picture of colonial veteran administration, and its development since the Armistice, grew significantly more complex and tangled.

Pensioning India: Long Roads and Cultural Change

In India, where a looming bureaucracy and army apparatus had been distributing military welfare for over half a century, pensions were established and expected – though not necessarily satisfactory. Indian servicemen anticipated government aid in the form of

648 At least 3,593 men were given these “free Passports” to encourage them to migrate abroad to find work. Governor Edward Denham to Ormsby Gore, January 25, 1938, CO 137/828/5.
649 Blackman was featured as part of a series on colonial veterans in The Guardian, alongside a Sikh WWII pilot, a Colonel with the Indian Engineers, and a Jamaican member of the Royal Air Force. Simon Rogers, “Soldiers of the Empire: The Heroes Britain Forgot,” The Guardian (6 Nov. 2002).
pensions and medical care – it was the basis of over six decades of continued sepoy recruitment. In some cases, the precedent for this was long standing. In addition, the British Indian Army sporadically allotted extra pay, or *batta*, for overseas service.\(^{650}\)

Earlier iterations of pensions came with harsh terms – from the 1860s to 1870s, they required soldiers to remain in service for 40 years before granting them a reasonable payout.\(^{651}\) The Army’s welfare apparatus was gradually liberalized over the next century, a trend Kaushik Roy attributes to British attempts to retain the loyalty of their soldiers after the 1857 Mutiny.\(^{652}\) This process accelerated greatly during the recruitment crisis of WWI. During the war, sepoys saw their rate of wound and injury pensions improve along with that of Army followers, transport corps and labor corps members.\(^{653}\) Troops on service in Europe and the Middle East received a 25% pay raise and free uniforms, while new recruits and old hands alike received a series of bounties and bonuses.\(^{654}\) Indian sepoys repeatedly referenced their desire and expectation of pensions while in service, most often to assuage their families’ fears of destitution after the war. One wounded Sikh, convalescing in an English hospital in January 1915, comforted his wife that “If I


\(^{654}\) Omissi, *The Sepoy and the Raj*, 58.
die, you will profit greatly. For Government will give you a pension. Why should you worry? If I live, then Government will give us still more.”

When Gilbert arrived in Delhi in January 1925, he reported over 250,000 military pensioners in India. His attempts to succinctly envision the structure of India’s pension administration belied the enormous complexity of the system. Fourteen different Controllers organized pensions for both white and Anglo-Indian personnel, as well as the huge body of Indian personnel. Each group had different conditions for pension claims and rates, though even these grew confused and mixed. European claims had to be made within seven years after discharge, while Native claims were restricted to three years after discharge; however, Gilbert observed that the latter was “never enforced.” These various bureaucratic arms and requirements, he observed understatedly, “[did] not tend to uniformity in the matter of awards.”

Adding to general confusion, this period of pension and welfare negotiation coincided with the most noted period of Indianization of the armed services in India. Both the Indian Army and the Indian Medical Service made a concerted effort to recruit and hire Anglo-Indian or Indian staff. Diversifying the ranks of officials forced the government to reconsider how British and Indian staff were compensated. Thus, in the 1920s, pensioning authorities were faced with the question of whether or not to differentiate Indian and British pensions, when increasing numbers of Indians were serving as officers at the same level as Britons. Concerned about exacerbating ill-feeling, the Military Department shied away from overtly unequal compensation. In 1926, the

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655 X. Y. to wife, January 1915, IOR L/MIL/825/1.
656 G. J. Gilbert, Report on Administration of Imperial Pensions in India, PIN 15/737.
657 Ibid.
Secretary of State for India, (Frederick Edwin Smith)/the First Earl of Birkenhead, agreed with the Viceroy, the Earl of Reading, that “it would be inadvisable at this stage” to differentiate the invalid pensions of European and Indian officers in the IMS.659 Sepoys, past and future, benefitted from Indianization and the Army’s concurrent attempt to improve soldier welfare to retain loyalty – particularly in the midst of nationalist agitation.660

Yet promises of pensions were more common and assured than pensions themselves – particularly for NCOs, low ranking soldiers, and army followers. Rewards for service did not always take the form of cash payments. The Indian Army had regularly distributed grants of land in the Punjab, typically 500 acres, as rewards to those serving in the military campaigns and Afghan wars since 1857.661 The largely agriculturalist ex-servicemen valued land grants as much if not more than a relatively low-paying pension. Coming from a society where property was strongly synonymous with political power, the heavily Punjabi veterans saw the grants as crucial to establishing social status. As British agricultural developments rendered even more land arable in the northern province, the Indian Army increased its land grants to military servicemen in these “Canal Colonies” from their opening in 1890. Some half million acres were given to veterans.662 Laissez faire practices and agrarian unrest spread, and choice land grew increasingly limited in the 1900s and 1910s.

659 Earl of Birkenhead to Governor General of India, February 18, 1926, IOR L/MIL/7/2959.
660 Though retrenchment efforts in the late 1920s halted the progress of the immediate after-war period. Roy, “Logistics and the Construction of Loyalty,” 212-213.
661 Tan Tai Yong notes that this practice was carried on from similar practices under Mughal and Sikh leadership. During the First World War, the government also extended promises of canal colony land grants to prominent families involved in recruiting and contributions to the war effort. Yong, The Garrison State: The Military, Government and Society in Colonial Punjab, 1849-1947 (New Delhi: Sage Publications, 2005), 90-91, 132-133.
By the time of the Armistice, Army administrators recognized that there were not enough suitable land grants to reward sepoys’ war service. The Government concluded that land would only be distributed to servicemen who “rendered distinguished service” during the war.\footnote{Indian Soldiers’ Board Press Communique, Delhi, December 4, 1919, IOR L/MIL/7/18492.} Even these were conditional, with specific tenancy conditions. Still, there were too many nominated men and too little arable land. Their alternative was a unique pension – the \textit{jangi inam} – granting recipients Rs. 5 per month for \textit{two} lives – their own, and that of a nominated second, often children. The Army’s pension administration pledged a total of 20,000 rewards, estimating 9,000 land grants and 11,000 “special” \textit{jangi inam} pensions.\footnote{Ibid.} Gurkhas, most living outside of the official border of the Raj and its territories, found themselves excluded from land grants.

What for British soldiers in the metropole was a relatively simple process of applying and receiving was enormously difficult for soldiers in rural South Asia, where finances, illiteracy, and geography presented mammoth obstacles. For many veterans, it was more difficult to collect pensions than to apply and receive one. Nonetheless, many ex-soldiers and their families met these obstacles, incorporating imperial bureaucratic travails into their annual schedules and customs. In his report to the Ministry of Pensions on Pension administration in the British Raj, Gilbert described Gurkhas’ journey to receive their pensions as “more or less like a fairy tale.” In the independent States, payment was typically made to soldiers through the Resident or Political Agent, though veterans often had to travel great distances to get to him. In Nepal, however, sanctions against white residents and travelers made distribution considerably more difficult. The

\footnote{Indian Soldiers’ Board Press Communique, Delhi, December 4, 1919, IOR L/MIL/7/18492.} \footnote{Ibid.}
lack of railways and a functioning postal service made remote distribution impossible.

Gilbert elaborated:

The only way in which the 13,000 pensioners – mostly Gurkhas – could be paid was to bring them over the border to the nearest Treasury office. So once a year, at the time when the passes are open, a little army of men, women and children tramp over the mountains – at least a 15 days’ journey – and invades the local Treasury. Here they build huts and camp round until such a time as the harassed Treasury officials can pay them. The occasion is regarded more or less as an annual holiday, and I was told that the whole encampment thoroughly enjoys itself. The Treasury can only pay 300 pensions a day and the pensioners, as they arrive, are classified into old and disabled, women and children, officers, and other ranks; are given on a day on which they will be paid, and are sent away to await that day. And sometimes they do have to wait – as long as three weeks – but there is no grumbling. Day by day, as the payments are completed, little companies depart for their long return tramp over the Passes, until the succeeding year brings them down once again for their small pension. Should a new claim be made which cannot be settled on the spot, the claimant is politely asked to call again next year!665

What Gilbert describes as a “fairy tale” was more likely a taxing journey for Nepalese pensioners and their families, who had to take valuable time off their own work to wait for an unknown period for their “small pension.” Nonetheless, the pension journey became an annual practice for the ex-soldiers and their dependents. Whether there was indeed “no grumbling” is debatable. Gilbert’s report makes no mention of disabled Nepalese veterans, whose family caretakers likely made the journey in their stead. The Gurkha pensioners and their relatives integrated the demands of British bureaucracy into their yearly schedule.

In other cases, the specific demands of the Western bureaucratic system limited veterans’ ability to control their own pensions. In Calcutta in 1925, G. J. Gilbert witnessed a Sikh’s appeal to the Military Controller. The veteran wanted to nominate his

665 Ibid.
wife as his heir for his pension, should he die. An easy procedure was made difficult by British bureaucratic conventions, for as Gilbert observed, “here, one of the many little troubles, peculiar to pensions administration in India arose, for, in accordance with the custom of his race, he would not mention the name of his wife and wild horses could not drag it from him. He could not write, and so no heir was nominated on that day.”

British rigidity and failure to adapt their pension system to the particularities of Sikh kinship and inheritance barred his widow from receiving just compensation from the colonial state in the event of his death.

On the other hand, local British officials were quick to change pension policies to suit their own cultural sensibilities, if it thwarted practices perceived as culturally backward. If an Indian pension holder died, their widow and children received an ‘heir’ pension until they were provided for under other means. In the case of daughters, heir pensions traditionally continued until they were married or turned sixteen – whichever came earlier. However, numerous officials complained about this stipulation, noting that a daughter was “often a mere child” when she was married, and continued to live with her parents after the “first ceremony.” In response, the Military Accountant decided to pay out heir pensions to daughters until they turned sixteen or were married, whichever came later. This exception meant that girls would be provided for when living with their remaining family; however, it also subtly encouraged Indian military families to postpone their daughters’ marriages and keep them at home until an age more suitable to British

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666 G. J. Gilbert, Report on Administration of Imperial Pensions in India, 1925, 7, PIN 15/737.
667 G. J. Gilbert, Report on Administration of Imperial Pensions in India, 1925, PIN 15/737.
This built on a long legacy of policies meant to reform marriage practices in the Raj, rendering them more palatable to British sensibilities.

Most discharged Indian sepoys received pensions, but gratuities (extra payments for services rendered) and the land allotments which recruiters had hinted at were more elusive. These “broken promises” stuck in the minds of both soldier and civilian in India, and sometimes became grounds for political disorder – though this was vocalized more often in nationalist literature than by ex-sepoys themselves. In the final installment of Mulk Raj Anand’s war trilogy, *The Sword and the Sickle* (1942), Anand’s soldier character Lalu, after years as a POW under the Germans, excitedly returns to his old regiment’s depot in the Punjab, anticipating a plot of land in addition to a pension. Instead, his time as a German prisoner, in contact with Indian deserters and seditionists, puts him under suspicion. His superior Colonel Peacock informs Lalu that he must forget all of this sedition if he is going to receive a pension, go back to his village, and “make a good farmer”:

‘Without a farm!’ Lalu wanted to say, ‘without the reward of a square of land that had been promised to each soldier’… ‘I don’t want the dirty money of the Sarkar,’ he said to himself as if he were trying to decide a conflict…. It occurred to him that among the many thought he had thought ever since he left Vilayat, he had seldom thought that he would be discharged from the army like that. He had wanted to get to India, and the quick succession of events across ports and railway stations and the blind faith in the benevolence of the Sarkar had precluded such whys and wherefores… He had believed that just because he had been in the trenches in Flanders for some months and then labored in road-making gangs in Germany, the Sarkar would be individually sympathetic to him, that it would ask him how he was feeling, give him a chair to sit on, a bottle of wine to drink, some cigarettes to smoke, pin a medal on his chest and announce his rise to the rank of Havildar, considering he was one of the few educated sepoys in the regiment.668

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Published in the midst of the Second World War, Anand links Lalu’s disillusionment with British rule directly with their failure to adequately compensate him for his service in Europe. At the end of the grand trilogy, the disaffected Lalu turns to anti-colonialism, speaking against the British government at rallies and associating with other revolutionaries. But Anand’s vision of the disappointed soldier’s radicalization was not a trend for the majority of discharged sepoys. Their first-hand testimonies in the censor record archive and interwar political movements confirm that most Indian Army servicemen remained loyal to the British government. Their lack of overt engagement with radical politics, however, does not mean that they abstained from politics altogether.

The District Soldiers Board and Veteran Political Engagement

Scholarship on the interwar Raj tends to downplay ex-soldier involvement in the political tremors of the 1920s and 30s; however, its focus on participation in radical movements fails to consider other arenas for veterans’ political involvement. The Ghadar movement, while implicated or directly involved in several minor mutinies during the war, largely petered out by the time Indian Army battalions returned to the subcontinent. Kate Imy has detailed how Sikhs’ martial image – more than ex-soldiers themselves – played a significant role in akali activism in 1920s Punjab, focused on reclaiming control over Sikh shrines. Yet experience abroad in the war did spur a number of veterans to agitate for political rights – though not necessarily nationalistic ones. Many native officers sought to augment their rights and civic roles by virtue of

670 Kate Imy, “Spiritual Soldiers and the Politics of Difference in the British India Army” (PhD diss., Rutgers University, 2016), 216-238.
their loyal service in India and abroad. They found the main vehicle for their efforts in the form of government-established soldier welfare agencies.

By the late 1920s, ex-servicemen across Northern India flocked to a growing number of groups for current and former military men which promised to look after the needs of soldiers and their families, during and off duty. The Government of India set up the Indian Soldiers Board (ISB) in Delhi in 1919, to deal with the mass of soldiers returning to their home provinces. A handbook distributed to members of the Indian Legislative Council explicitly linked the ISB to the British Ministry of Reconstruction established in 1917, encouraging ex-soldiers to see the Board and its extensions as an organization tailored to their needs and interests. Its practical functions ranged from soliciting and organizing funding for deceased soldiers’ dependents, finding discharged servicemen employment, administering gratuities to the disabled, and establishing commemorative monuments. To carry out actual work, the ISB delegated groundwork to the smaller provincial District Soldiers’ Boards. Setting up the District Soldiers’ Boards was relatively easy, as most of their administrative apparatus and personnel came from the Central Recruiting Boards set up to enlist soldiers during the war. As a result, the District board’s liaison officers often knew the region and its martial population very well, speeding along the process of creating an entire bureaucracy of veteran’s affairs.

District Soldiers’ Boards had a major hand in organizing, performing, and reforming the diverse communities of veteran sepoys, yet they were predominantly unsuccessful at effecting major changes. While the ISB was governed by predominantly

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671 Yong, 145.
673 Tan Tai Yong, The Garrison State, 146.
white officials and a variety of Indian maharajas, the District Boards were made up of a
diverse assembly of ex-officers of all ranks, predominantly Indian. They rejected many
of the complexities of pension bureaucracy while retaining an active hand in
contemporary recruitment. The Ambala District Board, for instance, advocated
publishing rules for recruitment in English, Urdu, Gurmukhi, and Hindi, to ensure that
prospective soldiers understood the terms and requirements of enlistment. At the same
time, they also rejected rules from military Deputy Commissioners which required a
member of the District Soldiers Board in the Punjab and Wazirabad to be present daily at
the post office of every tehsil in order for soldiers to receive their pensions. Citing the
vast expanse of the districts and limited number of Soldiers Board members, the Ambala
board members ruled it impracticable. DSBs also worked to incorporate veterans back
into the community, simultaneously ensuring them that their contributions were valued.
For example, District Soldiers Boards nominated members and soldiers to proceed over
Armistice Day celebrations.

Studies of interwar Indian and Punjabi history argue that the District Soldiers’
Boards effectively prevented the civil disturbances of 1919 from growing: their attention
to veterans’ issues cultivated enough loyalty to keep martial Sikh and Punjabi Muslims
from joining the anti-colonial movements like the Akalis, local communist groups, and
Ghadar nationalism.

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674 Memorandum from Ambala District Soldiers’ Board, November 21, 1928, IOR Q/13/1/13, Item 32.
675 Ibid.
676 Yong, The Garrison State, 145-147; Rajit Mazumber, “From Loyalty to Dissent: Punjabis from the
Great War to World War II,” in The Indian Army in the Two World Wars, ed. Kaushik Roy (Leiden: Brill,
2012), 477.
These narratives focus on the local Boards’ quick disbursement of funds to help struggling soldiers; however, they also played an important role in politicizing soldiers— not as nationalist agitators, but as political representatives with a unique claim for an augmented role in regional government. For the Government of India and Indian Army, the Boards served as a necessary tool of interwar control: they offered the chance to monitor returning veterans and provide them with benefits to head off the threat of radical agitation and rebellion. Yet they also empowered the ex-servicemen who staffed them and turned them into instruments of care, welfare, and politics. Veteran jemadars, subedars, and risaldars, many of whom had served overseas during the Great War, filled the ranks of the DSBs and communicated with others to shore up their mutual interests.

The efforts of District Soldiers Boards extended beyond managing the daily lives of retired army men to actively advocating for an augmented role for them in politics. The District Soldiers Boards represent a concerted attempt by retired officers to increase the political standing of army men in the interwar years. In 1928, District Boards across the Punjab engaged in a year-long dialogue to petition the Indian Statutory Commission to increase their political representation. Issued by at least ten district boards, their memoranda argued for seats for martial men in Punjab legislature, using their military service as leverage. These petitions claimed that military men, who were “of proved loyalty,” were “neglected and eclipsed by the so-called ‘politically minded class.’” Their army service, they claimed, called “for more work and less respite,” giving them less time to participate in local politics. At the same time, they argued that it was their

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678 Memorandum from the District Soldiers Board, Ludhiana, IOR Q/13/1/13, Item 18.
global deployment which sparked interest and made them worthy of political representation. The Rohtak Board memorandum called attention to their unique situation, noting that “Despite the facts that retired officers (at least 6,000 in the Punjab) in the majority of cases own little property, they take an interest in public affairs owing to their service in India and abroad. They and their families as being the backbone of the Indian Army have a great stake in the future of this country.”

The Rohtak Board justified their petition by arguing for the importance of ex-servicemen’s martial sacrifice and ensuing global knowledge, despite the fact that most of its members lacked the social status that came with large grants of land. Though individual memoranda had minor differences, all Boards asked for 5 seats on the Central Legislature for retired Indian officers living in the Punjab. The Karnal Board went further, requesting 3 seats for retired officers on the Punjab Central Legislature, and 10 seats on the nation-wide Imperial Legislative Council for retired Indian Officers and men.

Thus, while most sepoys’ experiences abroad in wartime did not spur them into the arms of competing nationalist and anti-colonial campaigns, this does not mean that they shrank from politics. Instead, many – especially officers promoted in the postwar Indianization wave – sought an increased civic role through the path of less resistance, justifying their political motivations with their wartime service. In a October 1928 petition for increased representation in government, one group of Punjabi veterans highlighted their quiet yet significant position in society: “We soldiers are not a very agitating or vocal section of the population and we trust that our determination to share in the constitutional progress of the country, will not be measured by the Sturdy silence

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679 Memorandum from the District Soldiers Board, Rohtak, 1928, IOR Q/13/1/13, Item 9.
which our profession imposes on us.” As such, District Boards’ petitions indicated that they were uneducated yet worthy – in sharp contrast to the educated ranks of the “politically minded class.” These claims were consistently backed with reminders of the importance of their wartime service. The Ludhiana Boards’ 1928 petition argued, “it is their class which has saved the Empire during the Great War, and in the Government which followed the War they should have adequate representation commensurate with their share in its protection.” While vocalizing their hope for expanded representation and increased higher education in rural districts, the Lahore Board also asked that veteran Officers’ sons be given preferential treatment in Government appointments, in recognition of their families’ military contributions. Thus, while few privileged officers engaged overtly in anti-colonial activism and civil unrest in the interwar years, they utilized the newly instituted DSBs as an organ to advocate for an augmented role in local and national politics. As seen in Chapter 4, they used DSBs to monitor and organize action for neglected disabled veterans. Rather than merely a state instrument of control, the DSBs offered veterans a chance to work within the system to agitate for the “soldier class.” At the opposite end of the Empire, Afro-Caribbean veterans faced a very different military welfare system, and organized new and different modes of appeal to the colonial government.

**Patchwork Welfare and Local Agitation in the British West Indies**

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681 The District Soldiers Board, Ludhiana, c. 1928, IOR Q/13/1/13, File 18.
682 Memorandum of Lahore District Soldiers’ Board, June 13, 1928, IOR Q/13/1/13, File 47.
Lacking pre-existing administrative apparatuses of the Indian Army, West Indian soldiers received virtually no aid beyond their leaving gratuities. Official provision of land grants and medical care was shoddy and often non-existent. This elicited a constant, if not highly effective, protest from Caribbean ex-servicemen in the interwar period. The transcolonial linkages of the Great War also meant that West Indian veterans located themselves and their protests in a cross-colonial world of ex-soldiers. Likewise, the bureaucrats dealing with their dissent found themselves struggling to fashion policies which would address the situation of a mobile, transitory body of veterans, who came from a variety of backgrounds and classes. All too often, their answer to these complexities was to shunt responsibility to a different bureaucracy or colonial state, even as some wanted to aid ex-service – for political or benevolent reasons.

In the diverse array of West Indian colonies, colonial administrators relied on promises of government welfare to draw in recruits in 1915 and 1916. Yet the gaps in colonial bureaucracy accentuated the unevenness of pension provision, dissuading potential enlistees. As early as December 1916, Governor Manning of Jamaica wrote to Bonar Law to complain that the War Office and Ministry of Pensions’ lack of attention to invalided West Indians had a serious impact on local recruiting: seeing how returned servicemen grappled with unpaid disability pensions, new recruits were slow to sign on. Manning’s complaints were supported by the Brigadier General, L. S. Blackden, who described the War Office’s instructions for paying discharged invalids as “very invidious,” alleging that the Ministry of Pensions took long periods of time to process payments. Blackden offered the hypothetical case of “Private Jones,” who, upon arriving

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683 Governor William Manning to Andrew Bonar Law, December 1, 1916, CO 137/717/59.
back in Jamaica on the 1st of November, 1916, received his last pay before being discharged on the 15th, yet did not receive a decision on his pension (and further payment) until January. 684 Thus, as Blackden observed, discharged and often disabled soldiers would be “cast… adrift for perhaps 3 or 4 months without pay on already overcrowded labour market.” 685 As a stop gap, the Jamaican government was forced to pay men 1/- per day. 686

These early disputes over responsibility of payment and its promptness set the tone for West Indian pension politics for years to come. The War Office was responsible for paying BWIR servicemen’s salaries during the war, but aftercare and further gratuities were the duty of individual colonial governments. Multiple authorities’ layered responsibility created avenues for further confusion: not all government officials could answer for others. In 1916, Governor Probyn of Barbados established that no pensions – whether disability pensions, general gratuities, or aid for widows and children, would exceed £2,000 in any one year. 687 He discouraged “over-estima[ting] the magnitude of obligations which the Colony is asked to undertake during the future.” 688 Probyn’s early attempt to reduce Barbadian responsibility for soldiers was calculating, but ultimately confounded by the multitude of agents involved in promising and delivering aid.

Unscrupulous recruiters often offered exaggerated benefits, frustrating both veterans and governments upon soldiers’ return. In petitions to their respective colonial governments or the Colonial Office, ex-servicemen, as individuals or in associations,
frequently referenced the benefits that were offered to them at their recruitment, only to be told that the Government never made such promises. These unofficial promises, combined with variations between colonies for pension policies, produced much confusion and bad-feeling. One Ministry of Pensions official, reviewing the pension schemes for the British West Indies Regiment in 1918, admitted his defeat at the hands of the complexities of Caribbean pension policy: “I am an old hand at dealing with official documents. Nevertheless these papers about pensions for colonial forces make my head swirl. It seems impossible to take in the whole question.”689

Much of West Indian soldiers’ discontent stemmed from a dual transparency and obliqueness of their wartime pay: a simple skimming of the Royal Warrants and pay sheets reveals that West Indian soldiers’ pensions were plainly less than their white counterparts; however, it was often extremely difficult for Caribbean soldiers to get answers about exactly how much their pensions would amount to. BWIR regiments were well aware for much of 1918 that they had not been granted the same increased salary and benefits stipulated in the general Army Act No. 1 of 1918.690 The Government of Barbados, for one, offered to make up this pay difference, while the Colonial Office made a notably belated argument to the War Office to match BWIR pay to that of other regiments. Questions over pay equality repeatedly surfaced in House of Commons debates. In November 1918 Sir John Butcher, the anti-Home Rule backbencher, doggedly pursued the subject of pay equality, citing the BWIR’s “distinguished” service in Palestine, only to be vaguely assured that they were “not eligible for further

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689 Report of Committee to consider pension schemes for coloured troops, 1918, PIN 15/2656.
690 For a detailed discussion of the debates over BWIR pay and pension rates, see Richard Smith, Jamaican Volunteers in the First World War, 80, 125-6.
concessions.” Nonetheless, most ex-BWIR servicemen continued to receive pay at lower rates than their British non-combatant counterparts. Ironically, the metropolitan authorities who kept salaries unequal during the war went on to police colonial governments for the same practices – once local administrations had accepted fiscal responsibility for the veterans after Armistice.

Local West Indian presses consistently aired veteran’s grievances and expressed discontentment over government provisions for returned servicemen. They did not wait for the end of the war to do so: when the Third Contingent’s frostbite casualties from the S. S. Verdala incident returned from Halifax, the Daily Gleaner quickly reported and emphasized the need for a government enquiry on the catastrophe. Likewise, in February 1917, the Port of Spain Gazette reported that one Reginald Stamford returned to Trinidad with fractured knees, yet he waited months before his pension started and received no help with employment. Glenford Howe has observed that local papers reacted differently to veterans’ neglect: the Jamaican Gleaner often reported on the cases of destitute ex-servicemen as an organ to reach local government; the Trinidadian Port of Spain Gazette on the other hand focused more on diffusing veterans’ anxieties and anger and dismissing allegations of government mismanagement and mistreatment. Yet anger in the community and the presses over local lack of provisions only exploded in the months and years following the war.

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692 “Reginald Stanford’s case,’ The Port of Spain Gazette (Trinidad: February 13, 1917), 3.

693 Glenford Howe, Race, War and Nationalism: A Social History of West Indians in the First World War (Kingston: Ian Randle, 2002), 78-79.
As the B.W.I.R. gradually demobilized, the Colonial Office and colonial Governors grew concerned over ex-soldiers’ sudden reintroduction to local society – and not without reason. Aside from the mutiny of the 9th Battalion at Taranto in Italy in December 1918, demobilization itself spurred several riots. Its slow pace and haphazard shipments of soldiers frustrated those who were left behind, who frequently found themselves performing even more menial work to make up for departed troops. Two weeks after the British Hondouras continent returned to the capital of Belize, the disbanded soldiers joined with civilians in a large-scale riot, systematically looting and threatening white residents. Shortly afterwards in July, a group of disgruntled servicemen disembarked from the Santille in Barbados, marched directly to the Treasury, and demanded advances, which they were hurriedly and anxiously given. Determined to avoid such threats, Barbados officials refused to allow the Orca to dock in September, after a minor mutiny among its passengers, which included 75 B.W.I.R. prisoners and 200 ex-servicemen. Suddenly, provisions for ex-servicemen seemed desperately necessary. B.W.I.R. members returning to their home shores were greeted by speeches promising them land and work. As the newly appointed Jamaican Governor Probyn concluded to a group of demobilized servicemen on their return on May 2nd, 1919, “I want Jamaica to become prosperous, and I want all people, in future, to reckon that this prosperity begun to run from the day on which Jamaica’s brave sons came back home from the war.”

These promises – made by the Governor who had suggested a cap on his liability for disability pensions – did not come to pass. Across the Caribbean, several West Indian

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694 Governor Probyn’s Speech at Kingston, May 2, 1919, CO 950/93.
governments mandated bodies to deal with issues surrounding soldiers’ return, but these proved largely ineffectual or indifferent. As discussed in Chapter 4, Jamaica, which had sent the largest number of soldiers to join the BWIR, had a single flagging philanthropic institution dedicated to providing continuing care for the disabled. One administrative apparatus, the Central Supplementary Allowances Committee, established parish offices mandated to help find employment for the returned.

As in India, ex-servicemen were deeply interested in land grants. Yet conditions were deeply different from colony to colony. As Governor of Barbados in 1917, Probyn argued that there was no land to grant in his own colony, and ensured Colonial Secretary Walter Long that he had entered into negotiations with British Guiana to provide land for Barbadian veterans there – an arrangement which never came to pass. When Probyn was transferred to Jamaica, he slowly arranged an optional grant of 5 acres of Crown Land in Portland parish for returning soldiers. Finally implemented in 1924, it included an advance for the farmers-in-making to purchase tools, seeds, and materials for a house. After servicemen’s initial war gratuity and savings dried up, the land grant was the only option for welfare available, regardless of whether the veteran in question wanted to farm, or was disabled. Over the two decades after the war, the Jamaican government distributed a total of 3,495 allotments to ex-servicemen, giving each an advance loan for tools and subsistence of £5. Yet these grants were not the boon ex-servicemen expected.

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696 Lands designated for ex-servicemen were predominantly of poor quality and badly situated, a trend which continued into the second world war. In Trinidad in 1946, the Government purchased lands from the Cadbury Estates in Maracas Valley which they openly admitted “need[ed] much drainage,” infested with malarial mosquitos. Bede Clifford to George Hall, May 31, 1946, CO 295/637/1.
The lands allotted were virtually set up for failure. Completely undeveloped, the colonial government made no attempt to build up infrastructure. Ex-servicemen arrived to lands that were three miles from any roads in Portland parish, and eleven miles from roads in St. Thomas.\textsuperscript{697} The Portland grants were crisscrossed by two rivers that were impassable in the rainy seasons. Neither had any schools, hospitals, or post offices – or any infrastructure whatsoever.

Even white landowners expressed doubt that ex-servicemen would be able to turn their land grants into a profitable – or even subsistence – venture. In August 1919, E. R. Clarke, a local estate owner, addressed a public letter to the Chairman of Trinidad’s Land Settlement Committee in the \textit{Trinidad Guardian}. Clarke thought the original provisions of the government’s scheme were a folly. “It is a fallacy” that a farmer cultivating forested land would be able to repay an advance by the end of his first year, he claimed, nor by his second.\textsuperscript{698} Nor would it do for the lands selected to be infertile or inarable. Clarke thought that grantees “ought to be given the best chance of success by giving them fertile lands such as would be selected by any connoisseur who would seek to become an estate owner or conuquero.” He drew attention to the lack of infrastructure in designated lands, and the time it would take to provide anything more than mud roads. The government should give a larger grant of funds – $25 – for starting farmers, he advocated, but it should only be given to the man once he had felled the first three acres. Furthermore, Clarke encouraged prospective grantees to consider the radical change in lifestyle that accepting a grant would bring – it would be difficult and isolating, a far cry

\textsuperscript{697} BWIR Association Memorandum of Evidence, c. 1938-39, CO 950/93.
\textsuperscript{698} “The Land Settlement Scheme: Mr. E. R. Clarke’s Views,” \textit{Trinidad Guardian}, August 23, 1919, 12.
from the men’s lives in social town and village communities. Nonetheless, Clarke did not encourage the Committee or government to consider alternate ways of aiding ex-servicemen. While ignoring Clarke’s call for lands to be of suitable quality, the Jamaican government took up his advice to place restrictions on how money was distributed.

When they extended allotments to Crown Lands in the parishes of St. Ann, Trelawny, St. James, St. Elizabeth, and St. Catherine in the coming years, they wrote in further stipulations for cultivation deadlines and loan payments. In doing so, the government created its own standards for the “deserving” pensioner. To retain their land, veteran farmers would have to put in an inordinate – and for Clarke, impossible – amount of labor.

The tight restrictions and tenancy requirements are a testament to how age-old racial stereotypes persisted in local colonial societies, despite the fervent and hardworking contributions of West Indians in wartime. Many colonial officials, far removed from the war itself, expressed doubt in Afro-Caribbean men’s ability to labor efficiently. The Governor of the Windward Islands lay the blame for their impoverished conditions squarely on veterans’ shoulders: “it is frequently the men themselves to make things difficult, not to say impossible… To my personal knowledge men have declined work unless given the status of foreman from which their ignorance debars them; when given a plot of land they will denude it of timber which is sold as firewood and then either leave it to be eroded or to return to jungle.”

Grant administrators deployed these

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arguments against ex-servicemen who complained about the state of the land they received.\footnote{Lack of belief in West Indian veterans’ willingness to work was particularly ironic given local businesses’ tendency to use “native employment” as an advertising ploy. Jamaica Fruit Sauce placed one such advertisement in the \textit{Ex-Service Man} newsletter, urging veterans to purchase the “Delicious and Cheap” sauce to “Give Employment to Natives.” Their final call to ‘\textit{REMEMBER} Jamaica Fruit Sauce” strikes an uncanny resemblance with calls to “remember” the troops. Clipping from \textit{The Ex-Service Man}, CO 950/93.}

These doubts about black work ethic found their counterpart in a proposal by the West India Committee – the London-based organization intended to aid ex-BWIR soldiers - to bring white, British men to work in the Caribbean. Despite the impending flood of working-age servicemen back to the West Indies after the war, and the downturned economy and lack of viable employment, the West India Committee (WIC) voiced a strong hope that the war would drive white, British men – particularly those of the middle or upper classes – to the West Indian colonies. In January 1918, Algernon Aspinall, the head of the WIC, wrote to T. C. Macnaghten, a Colonial Office bureaucrat dealing with questions of migration. “New blood is so badly needed there,” Aspinall mused, noting in another letter that their “experience and discipline would prove of value to the commercial and planting life of the West Indies.”\footnote{Algernon Aspinall to T. C. Macnaghten, January 24, 1918, CO 318/348/42; Algernon Aspinall to Antigua Agricultural & Commercial Society, January 16, 1918, CO 318/348/42.} Aspinall was especially interested in inducing “young public school men” to resettle, and suggested placing white migrants as overseers, clerks, and estate managers. No such proposal came to pass, but the Aspinall’s interest in pursuing it speaks to his lack of dedication to the cause of unemployed native ex-servicemen. For the WIC, West Indian regeneration would come from “new blood,” not native blood.
Ex-servicemen were also at risk for ill-health exacerbated by disease or disability during the war. Local governments did not make provisions for this when distributing land. Felix Berry, a Jamaican private with the 2nd BWIR Battalion, submitted a petition in 1941 to recover land lost during a bout of illness. Berry was granted Lot 25 at the Edgar Rio Grande Patent in October of 1922, but he did not hold it for long. In 1926, he was laid low by recurrent rheumatism, which Berry blamed on his wartime service, citing fifty-five days spent in a Station Hospital in Africa. Berry claimed that before he was able to recover, the Surveyor General had sold his land parcel to another ex-soldier. Left destitute when he regained his health in 1932, he began petitioning the local departments and government for employment and land grants. Yet his applications were denied – Governor Richards cited that Berry had not fulfilled the conditions of his land contract, under which Berry had three years to clear the land and maintain its cultivation. Furthermore, he claimed, Berry was not eligible for new land grant schemes because he had failed at his first. In a severe turn, he also refused to grant Berry a pension, citing that he was not on the “list of BWIR pensions and there are no funds for him.” 703 Yet Berry did not surrender his claims. Instead, he sought the aid of metropolitan officials, arranging for a solicitor and pleading his case directly to the Colonial Secretary. After several months of back-and-forth correspondence with Gov. Richard, Secretary Moyne replied that there was nothing he could do to assist him.

Despite the manifest shortcomings of government programs and provisions for ex-B.W.I.R. members, they made few efforts to update them. Five years after the first

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703 Richards, Governor of Jamaica, to Lord Lloyd, Colonial Secretary, August 24, 1940, CO 137/840/15.
Grenada Contingent sailed for Europe, *The West Indian* asked, “Was it worth while?” While proud of “Our Boys” victories abroad, they had not translated into victories at home. “No people can do more… than what has been done by ‘Our Boys,’ the first of whom sailed from these shores… to lay down their lives in defence of British ideals,” it proclaimed. “But it appears that we were made to fight against ourselves in fighting for Great Britain, because the fruits of war to us are clearly, we hope temporarily, to our degradation.”

Among this simmering frustration, several veterans’ interest groups sprang up to organize discontent into action. These groups were partially rooted in wartime predecessors, such as the Caribbean League founded in Taranto, Italy, in the aftermath of the Taranto mutiny. Founded by West Indian sergeants, and controversially dominated by Jamaicans, it was intended to promote the interests and welfare of colonial subjects in the British West Indies and adjacent territories. Richard Smith has argued that the short-lived League is evidence of burgeoning racial consciousness among BWIR servicemen, spurred by the hardships and discrimination they faced during the war. While the founding non-commissioned officers supported non-violent means, they were largely interested in preserving their higher wartime status, and purposely did not recruit nor involve the rank and file. By the late 1920s, several different veterans’ interest organizations sprang up to collect petitions and pursue audiences with visiting dignitaries.

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705 Ibid.
and the local government. The most prominent among them was the Jamaican-based Ex-BWIR Association, which instigated a lengthy string of appeals into the 1930s and 40s.

**Case by Case Challenges to Racial Binary Welfare**

As the collective petitions and protests of large veterans’ interest groups proved ineffective, official reviews of the pension system and veteran aid generally came only when individuals were able to create enough of a fuss over their personal cases. In the form of self-written missives and pleas, requests by West Indian ex-servicemen forced administrators in the colony and the metropole to consider individual tribulations under a magnifying lens. Even when such ventures proved unsuccessful, the veterans’ initiative compelled bureaucrats, from clerks to the Colonial Secretary, to read through their account of their wartime contributions and their current daily struggles. When petitions were addressed or forwarded to metropolitan officials, as they often were, it also pushed senior administrators to investigate how their colonial counterparts governed. While these conditions did not necessarily prompt policy change en masse, the individual case files reveal that officials were more likely to approve extending aid to veterans in question on the basis of their “unique” situation.

Frequently, successful petitions involved situations where confused geography or identity rendered policy unclear to both veteran and official. In one such case in 1920, a “coloured,” man, A. Francis, whose arm had been amputated on active service with the BWIR in France, appealed to the Ministry of Pensions for a higher pension. A resident of Britain when he enlisted, he deserved British, not colonial, pay and benefits. Or so he insisted. What had happened? Francis was a Canadian émigré to Britain, who, since
moving in 1898, had earned good wages working at a shipyard in Liverpool. Upon trying to enlist in the Derby Scheme in 1915, Francis found himself directed to join the ranks of the British West Indies Regiment, despite there being no record of his ever living in the West Indies. For the purposes of mobilization, race had trumped citizenship and resident status.

Since the amputation of his arm, Francis had been receiving the disability pension of a BWIR veteran; he appealed instead for the disability pension of the British Line Regiments, which was notably higher. The War Office and the Ministry of Pensions debated his case back and forth, and both agreed that he should receive the higher compensation for his loss. But crucially, officials worried over the precedent this might set for other non-white veterans. As one official of the Ministry, J. H. Penson, noted, “My Lords see no reason why such men should now be paid European rates.” To avoid having to grant all men of the BWIR, and other non-white servicemen, a higher allowance, the Ministry of Pensions found a loophole in the Royal Warrant of 1919, which allowed Francis to be granted a special, one-time “Alternative Pension.”

Other petitioners made clear that their experiences abroad had widened their perspective, envisioning themselves as part of an extensive network, with crucial experience abroad. This translated directly into how they negotiated their bodily value and fiscal worth in the imperial state. In the same year that Francis made his appeal, Private J. W. Hooper of the Coloured Labour Company wrote to the Ministry of Pensions and the Jamaican Government to argue for a higher pension – not because it had not been

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707 Ministry of Pensions to The Treasury, February 9, 1920, T 1/12482.
708 J. H. Penson to Secretary, Ministry of Pensions, March 20, 1920, T 1/12482.
paid, but because it was not equal to that received by other members of the Labour Battalion to which his Company had been attached. Hooper’s labour battalion was attached to the Royal Engineers, and served alongside labour companies from the Chinese Labour Corps and the Indian Labour Corps. In his complaint to the Colonial Secretary of Jamaica, Hooper claimed that he was sorely underpaid, and plainly stated, “I am of the firm opinion that I am thus treated because I am coloured.”

In a later letter to the Governor of Jamaica, he referred to news reports that, “5 1/4 d. per day allowance is granted to forces who have served in India[.] I did a little over two years in Indian Exp. Force, I am therefore entitled to this remuneration.” For Hooper, the racial boundaries which separated different military forces did not justify economic segregation of pensions: if he had served under the same conditions and in the same locale as a higher paid force, he demanded the same pay.

The barrage of cases and appeals for benefits meant that British officials were constantly questioning and negotiating just how different or similar white and black minds and bodies were. What concessions and allowances were granted, in many cases show that judgments were based on factors other than race alone. Geography, heritage, and class fed into final decisions on individual cases, highlighting a diverse and international body of soldiers. In one such instance in March 1919, A. B. Rennie of Kingston, Jamaica, a black veteran lieutenant of the BWIR, applied for a scholarship from the Lord Kitchener National Memorial Fund to complete a law degree in the UK. The Fund was intended to benefit disabled officers and men: Rennie was clearly an

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710 J. W. Hooper to Probyn, Governor of Jamaica, July 21, 1920, CO 137/746/3.
711 J. W. Hooper to Colonial Secretary of Jamaica, November 27, 1920, CO 137/746/3.
educated, respectable young man: In his application, he included numerous affidavits of support from his former Brigadier General, as well as from his brother and a barrister, Mr. King, who had lent him law books to study when he went off to war. Even so, racial considerations could not be suppressed. The Colonial Office debated the case for about a month before concluding that the “colour question” would not be a bar to his candidature, as there was “an increasing no. of coloured men at Cambridge.”\footnote{Frontispiece to case of Scholarship for Lieut. A. B. Rennie, May 13, 1919, CO 137/731/25.} One official agreeing to this concession still found it necessary to note in the memo, “I hope this distress[ing] phenomenon will not spread to Oxford.” This was a profoundly unheroic moment in which the race bar was broken, albeit with absolutely no desire to champion black men’s access to higher education in the metropole. No records indicate whether Rennie received the scholarship, but he achieved his dream of studying law: by 1934, he had taken up a post as a Crown Solicitor in Jamaica.\footnote{Alfred Baillie Rennie later became a Magistrate and Justice of Jamaica. He continued to head efforts to investigate police brutality, as in the 1962 Rennie Commission of Enquiry into the 1962 Labour Day disturbances. “City Debaters Annual Dinner: Mr. A. B. Rennie, Honoured,” \textit{Jamaica Daily Gleaner}, December 17, 1934, 42; Annual Report on Jamaica (H. M. Stationery Office, 1951), 163; Terry Lacey, \textit{Violence and Politics in Jamaica, 1960-70: Internal Security in a Developing Country} (Manchester: Manchester University Press, 1977), 125.} Small exceptions for individual veterans had a way of turning into much larger forces of change: Rennie’s contributions to the 1951 Report of the Commission of Enquiry into the [Jamaican] Police Force prompted the first reforms in eighty five years, helping to erode race exclusion in the upper ranks of the Force.

The success of case-by-case challenges and individual petitions was not limited to the West Indies. Colonial officials seemed willing to argue for helping cases when the Ministry of Pensions would be footing the bill. In East Africa, the Deputy Governor of
Kenya pleaded one such case to the Colonial Office in 1921, on behalf of Mahomed Yusuf, a member of the Arab Rifles attached to the King’s African Rifles. Yusuf was blinded on active service. He received the maximum rate allowed for veterans of the King’s African Rifles – 8 florins and 33 cents per month – but, as the Deputy Governor relayed, his food alone cost over 10 florins a month. In a letter to the Colonial Office, the Kenyan administrator recommended a “special increase” to 15 florins “on the ground that an ex-soldier who has been maimed in fighting for the British cause should not be left to beg or starve.” After assuring the Colonial Office that they did not anticipate “many claims of a similar nature,” the he reminded them that the cost of KAR disability pensions was chargeable to Joint accounts between the local government and the Imperial Government. There is no record of Yusuf’s own correspondence or petition, but it appears his most basic needs were met. Though G. L. Barstow at the Ministry of Pensions expressed general unwillingness to authorize a large increase to all, he sanctioned a “special pension” to Yusuf of 15 florins per month, “on the understanding that the case is regarded as very exceptional.” In such instances, the East African colony’s unwillingness to assume total responsibility for its subjects’ pensions occasionally helped those who had the means and ability to pursue their own cases.

Over time, some colonial officials warmed to granting West Indians pensions on a more equal footing with Europeans. These changes, however, were often instigated by intrepid individuals pleading their own cases, and revealed the intensely muddled state of colonial pensions administration. One such case stretched over a decade in British

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714 R. J. Coles, Treasury, to Ministry of Pensions, November 17, 1921, PIN 15/1142
715 Ibid.
716 G. L. Barstow to Treasury Chambers, December 31, 1921, PIN 15/1142
Guiana. In April 1936, William Alfred Hinds, a member of the 9th BWIR battalion, addressed a petition to his Governor asking for an increased disability pension. Invalided from France with a bad case of trench feet in 1918, the Medical Board at the Charterhouse Military Hospital in London assessed his disability at 100%. Hinds claimed that he was being pensioned at the rate of a private, when in fact, his acting rank had recently been promoted to an Acting Warrant Officer Class II. He had been petitioning for a higher rate since 1924. In 1927, his case was taken up by the grassroots British Guiana Ex-Servicemen’s Association, who argued to the colonial government that the difference in “local” (BWIR) rates and “imperial” rates was unjust. “This differentiation in pension to his mind, is clearly a breach of faith with the British West Indian man,” concluded R. O. Sibley, Chairman of the Association. Urged by the Association and the local Soldiers’ Pension Board, the British Guyanan government adopted “Imperial Rates” of pay, bumping up ex-servicemen’s pensions by nearly a third. Yet Hinds was still not satisfied – having moved to Trinidad for a number of years, his rate was not updated with British Guiana’s new policies. Furthermore, he was still receiving the rate of a private, not a Class II Warrant Officer.

When Hinds wrote again to the government requesting a higher rate in 1936, Governor Northcote asked the Colonial Office for clarification on proper pension rates. What the Colonial Office discovered was a tangled mess of miscommunication: ex-BWIR British Guyanans should not have drawn “imperial rates,” rendering them overpaid due to a “series of misunderstandings” in 1927-28. Furthermore, the Ministry

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717 J. A. S. Northcote, Governor of British Guiana, to J. H. Thomas, Colonial Office, April 18, 1936, CO 111/731/3.
718 Copy of Minutes of a Soldiers Pensions Board Meeting held on April 19, 1927, CO 111/731/3.
719 Frontispiece to Petition of William Alfred Hinds, January 2, 1937, CO 111/731/3.
of Pensions had never recognized Acting rank as valid for pension rates, rending Hinds’ claims invalid. In an apologetic letter to Ormsby-Gore, Colonial Secretary, Governor Northcote expressed regret for keeping the Ministry of Pensions uninformed of colonial pension developments.\footnote{J. A. S. Northcote, Governor of British Guiana, to Ormsby-Gore, Colonial Secretary, November 16, 1936, CO 111/731/3.}

It would have been relatively easy for the British Guyanan government to reject Hinds’ claim – after all, they were not required to recognize Acting rank, and had been overpaying their ex-BWIR pensioners. Nonetheless, Northcote argued that “Hinds present application merits consideration.”\footnote{Ibid., 6.} The Colonial Office even approved these measures, reasoning that if others in British Guiana had been paid the higher rates, Hinds should be treated in the same way, “although the arrangement appears to be irregular.” “Strictly, one could hold that two wrongs do not make a right, and that the fact that others were treated more favourably than they should have been is no reason for making another mistake in favour of Mr. Hinds,” reasoned Mr. Roberts-Wray, “but I think this would be unwise in all the circumstances.”\footnote{Frontispiece to Petition of William Alfred Hinds, January 2, 1937, CO 111/731/3.} Thus, miscommunication and crossed lines between metropolitan and colonial branches of pension administration in some cases benefitted ex-servicemen.

**New War & Old Welfare**

Individual petitions could pass through the mire of pension bureaucracy with some success. Yet despite increasing activity in the 1920s, group protest and advocacy
organizations never gained their desired results. The arrival of the Great Depression and economic crisis, however, galvanized a new period of protests from the Jamaica-based Ex-BWIR Association. The board directed its efforts toward extra-colonial officials and visiting metropolitan dignitaries, in the hope that outside attention would force the Jamaican government to face its veteran problem. When Sir Ian Macpherson, a former Minister of Pensions, visited Jamaica in 1933, he entertained a deputation from the Ex-BWIR Association. They presented him with hefty evidence and forward petitions on two subjects: pensions – cases where gratuities had not been paid, where pensions stopped without notification; and land grants – the sore subject of poor land conditions and difficult tenancy requirements. The hearing was well publicized. The Gleaner, among others, recorded Macpherson’s promises to do everything possible to aid the men and their claims. Local officials did much to warn Macpherson against taking the Associations’ demands seriously. A. R. Slater, the contemporaneous Governor of Jamaica, affirmed that there were many “excellent men” in the organization, but that its management “has fallen into the hands of three or four ‘barrack room lawyers’ who are working very hard at present stirring up discontent with the result that we are now being

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723 Anne Spry Rush has detailed how, though intermittently concerned with standard of living in the Caribbean, British officials largely left middle-class West Indians to address social issues on their own in the 1920s and early 1930s. See Anne Spry Rush, The Bonds of Empire: West Indians and Britishness from Victoria to Decolonization (Oxford: Oxford University Press, 2011), 71-72.

724 Economic crisis and high unemployment were furthered by the flow of reverse migration from the Americas to the Caribbean from the mid-1920s through the 1930s, as would-be migrants faced restrictive immigration policies and economic depression in the United States. On the economic and social conditions of the British West Indies during the 1930s depression, see, among others, Rush, The Bonds of Empire, Chapters 3 & 4; and “Depression and Disillusion” in Colonialism and Development: Britain and its Tropical Colonies, 1850-1960, Michael Havinden and David Meredith, eds., (London: Routledge, 1993),160-186.

subject to one of the sporadic outbursts of complaints.”  There was no need to be seriously concerned, he claimed, after all, these “arise from time to time shortly to die down.”  This attitude meant that protests rarely elicited comprehensive reforms and improvements.  In 1935, the *Ex-Service Man* newsletter reprinted a 1924 column published in the *Argosy*, the extant newsletter of the Old Comrades Association, astounded that it shared an “identical contention” with the Ex-B.W.I.R. Association’s petition a decade later.  The Ex.-B.W.I.R. was *still* petitioning for radical changes in the administration of land grants.  There were “scores of letters” seeking application forms not yet answered, crown bailiffs and surveyors often failed to make appointments at the expense of the land-holder, and settlement lands still lacked adequate infrastructure.

The most intense swell of protest arrived in the late 1930s.  The Ex-BWIR’s timing was no accident, but came among severe economic downturn and social unrest throughout the Caribbean.  Association petitions attempted to relay their concerns through non-violent missives, yet they made no attempt to dissuade veterans from civil disobedience and public protest.  On the morning of August 14th, 1937, nearly one thousand ex-servicemen, augmented by men who had never served in the army, marked on Kingston Race Course.  One year later, mass strikes amongst dockworkers and plantation laborers, transit workers and those in public service rocked Jamaica in the

726 Alexander Ransford Slater had extensive previous experience in colonial administration.  He began his career in the Ceylon Civil Service at the turn of the century, before rising to leading posts as the Governor of Sierra Leone from 1922-27, and the Governor of the Gold Coast from 1927-32.  A. R. Slater to Ian Macpherson, 8 Feb. 1933, CO 137/799/10.
727 “A Decade At It,” in *The Ex-Service Man*, 1935, clipping from BWIR Association Memorandum of Evidence, 1938, CO 950/93.
728 Edward Denham, Gov. of Jamaica, to Ormsby Gore, Colonial Secretary, September 20, 1937, CO 137/820/13.
summer of 1938. In response to the growing unrest, the Colonial Office established a Royal Commission on the West Indies to investigate the economic and social conditions throughout the Caribbean colonies. Headed by Lord Moyne, the future Colonial Secretary, the “Moyne Commission” received petitions from numerous Ex-BWIR branches from Kingston to Spanish Town, and entertained an audience of Ex-BWIR Association board members. The hearing on 30 November, 1938, pitted A. G. Burkley, the President of the Association and Chief Witness for the day, against Reginald Edward Stubbs, the Chairman of the Local West India Royal Commission – and former governor of Jamaica in the 1920s. Burkley gave detailed and exhaustive evidence: citing documents, the exact stipulations veterans’ land grants, their geographic condition, and alternate plans the Association had put to the Jamaican government, even reciting figures on banana prices to suggest ways in which ex-servicemen could be granted opportunities for productive work. Stubbs discounted his testimony by emphasizing all the aid which Jamaican veterans had received – even as Burkley testified to the uselessness of these provisions. The other Committee questioners were occasionally more generous in their approach to the Association’s witnesses, but the lack of documents and pension files concerning BWIR servicemen was an insurmountable obstacle to the Association’s evidence. Despite Burkley’s extensive evidence – both archival and vocal – the burden of proof was on the petitioners. “I think everybody wants to help you, but we cannot help unless you are able to make sure of your facts and, as far as I can judge, on a number of essential points there is no evidence at all,” questioner Sir Walter Citrine alleged, asking “What do you suggest we can do to secure the carrying out of promises made to you when, in fact, the evidence of those promises has disappeared in those fifteen or eighteen
Yet minutes earlier, Citrine himself acknowledged that such evidence – the War Office’s records of BWIR men – had been destroyed by the government (see Chapter 4). When released in December 1939, the Moyne Commission’s Report called for drastic improvements to the dire state of education, health, and welfare throughout the Caribbean.\textsuperscript{730}

Where were the ex-BWIR veterans in its calls for reform? Nowhere to be found, at least in its final form. In April 1940, H. Beckett of the Colonial Office suggested, in a confidential missive to J. A. Hunter, that they should “give a little thought” to one passage “not repeated in the published Recommendations… on the grievance of ex-servicemen.” “The Commission obviously did not feel strongly about this,” Beckett related, but “we think that tiresome and greedy as many of these men, or the associations which claim to speak for them, may have been in the past, there is probably advantage in taking a little trouble to turn them from a disgruntled and occasionally a subversive element into a loyal and even useful one.”\textsuperscript{731} He suggested giving them more public ceremonies to acknowledge their contribution, granting them meeting places or clubs, and granting them occasional reviews and audiences at which their grievances could be heard.

Veteran protests from May of 1938 to October of 1939 were well-versed in the policies toward other soldiers who fought for Britain in WWI. The petitioners repeatedly cited provisions made for soldiers in other parts of the Empire, and, significantly, they compared their situation to that of soldiers in Britain who were put dole when they could

\textsuperscript{729} Transcript of Twenty-sixth Session of the West India Royal Commission, November 30, 1938, CO 950/93.
\textsuperscript{730} Anne Spry Rush, \textit{The Bonds of Empire}, 73.
\textsuperscript{731} H. Beckett to J. A. Hunter, April 19, 1940, CO 318/445/6.
not find employment. They objected sharply to being reduced to applying for pauper aid, rather than being aided as veterans: in a 1949 petition members declared, “We want to live as other citizens in other countries in the world, so that when we depart from this life, our families will have something to bury us… WE do not want to live and allow the Government to bury us as paupers.”

West Indian soldiers were vocalizing many of the same demands as British soldiers, but without any similar philanthropic effort to appease and provide for them. Yet equally, there was no one to silence them: their years at war, surrounded by other denizens of the Empire, led Caribbean veterans to draw undeniable links between themselves and other servicemen. Mobilizing comparison to enhance their status, they located their military labors within Britain’s global armed services to demand appropriate compensation.

By the late 1930s, however, the Jamaican administration was thoroughly finished with entertaining BWIR veteran’s petitions and demands, and had a significant number of Colonial Office officials in their corner. One C. G. Stevens summarized the Ex-BWIR Association’s January 1938 memo, relating the cases of numerous veterans with grievances. J. Shepherd complained that his allotment was of poor quality; E. Brown alleged that he had not been made aware of the conditions for receiving an allotment; H. H. Robertson claimed a gratuity for his wartime service, only to be told that his claim could not be entertained, the relevant files having long since been destroyed. Stevens noted that some “demands are childish,” but also acknowledged that many of the men may have been illiterate, increasing their confusion over claiming post-war benefits. Still,

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732 “Reclaims of Promises,” Letter from Jamaica Ex-Servicemen Trsdes & People’s Labour Union to Colonial Secretary Creech Jones, c. 1949, CO 137/885/2.
Stevens concluded to his fellow Colonial Office administrators, their claims should be dismissed. “There can be no doubt that these men have been thoroughly spoiled, and there is no need to treat their periodical grumblings as evidence of widespread in justice,” he claimed, for “They have failed to obtain their full advantages in some cases owing to laziness.”

Only towards the end of the Second World War, as West Indian governments prepared once more to demobilize and resettle a wave of ex-servicemen, did attitudes change. All parties involved seemed more aware of the shortcomings of the First World War’s resettlement schemes, due in no small part to the findings of several Committees and their reports. Veterans’ interest organizations and their metropolitan allies and advocates were particularly eager to avoid repeat performances of broken promises and useless grants. In Jamaica in 1946, Governor Huggins acknowledged to the Colonial Secretary that the land grants in the 1920s and 30s were unworkable from the start: “After the previous World War unsuitable land was acquired in several areas for ex-Servicemen with the most unsatisfactory results.” In the same memo, Lt. Col. Jarret-Kerr, a Jamaican-born officer, noted the prejudices conditioning veteran land grants. The Chairmen of Parish Absorption Committees were typically large land-owners, convinced that “as the returning men are unwilling to work for them... they are lazy and good for nothing.” Kerr accused these high-standing men of “effectively sabotag[ing], by Fabian tactics,” their own mission to resettle black ex-servicemen. Kerr noted that he had seen or heard of these situations everywhere, “both in high places in India, and in the

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733 C. G. Stevens, “Grievances of Ex-Soldiers of British West Indies Regiment,” December 12, 1938, CO 137/828/5.
734 Governor Huggins to George Henry Hall, September 20, 1946, CO 137/866/6.
villages, and also in England…. Frankly, the wrong people are chosen out there, merely because they are Custodes or prominent businessmen.” Biased white property owners, he asserted, would never give their “inferiors” a decent chance.

The Jamaican government mocked Jarret-Kerr’s continuing letters, claiming that he was “out of touch” with their provisions for veterans, but his concerns continued to resonate. In 1946, after repeated agitation from the League of Coloured Peoples and ex-servicemen’s groups, the Government was forced to establish a committee to enquire into the Land Settlement Scheme for Ex-Servicemen of the First World War. The Curphey Committee, named for its chairman, sent inspectors and studied all grant sites and reports gathered on the settlement attempts. Its report, finished in November 1947, concluded that while the land grants were virtually “the only means of rehabilitation offered” to ex-servicemen from the government, they were woefully underprepared and lacking.\(^\text{735}\) 86\% of still occupied lots were deemed unsuitable for agriculture – not including those which grant-holders had already given up on. Confirming numerous Ex-BWIR Association petitions and testimonies, most lots lacked any connection to roads, shelter, water supply, or “normal social amenities” such as schools, post offices, or medical facilities. It concluded with a damning judgment: “It is clear that the scheme was badly organized and that the Ex-servicemen were unfairly treated... The Committee is aghast at the number of Ex-servicemen whom they have found to be in various Poor Houses in the Island, or on the Pauper Rolls.”

The Committee suggested a number of measures to repair the decades of damage: ex-servicemen still occupying unsuitable lands should be transferred to any passable lots

left, so that their children and grandchildren might in some way benefit, and grants should be offered to those who were physically unable to carry on cultivation. However, as the Committee themselves pointed out, new benefits would have a limited reach. Many of the men in question were old or infirm, ranging from age fifty to seventy – some were already dead.

Despite – or perhaps because of – the Committee’s inflammatory findings, Governor Huggins refused to make the Report public knowledge. He reasoned, “It is not considered advisable to publish the report at this juncture since it will only tend to revive and encourage false hopes in the ex-servicemen concerned.” In an address to the Jamaican House of Representatives, he continued to blame the dispositions and motivations of veterans, claiming that “after being allotted lands, [they] have shown themselves either unable or unwilling to develop their holdings, and in many cases have made little or no attempt to do so.”

Exonerating the Government’s responsibility for the failures of the past two decades, he went on to propose that ex-Servicemen settlers be provided with a higher grant of £30 and a meager subsistence allowance of £1 for half a year. Yet these concessions were qualified by noting that settlers would be selected more carefully, and burdened with heavier supervision of their progress at their holdings. Ex-servicemen were prevented from transferring holdings within the first three years of ownership and required to “properly develop” at least one-fifth of their holding within six months of possession - virtually negating any benefits for settlers from the WWI veteran generation.

736 Governor Huggins to House of Representatives, Jamaica, May 2, 1949, CO 137/885/2.
Yet concern continued to ripple from the colony to the metropole, particularly in light of a new generation of Jamaican ex-servicemen. In July 1949, General and MP George Jeffreys discussed the Committee’s report in the House of Commons, urging his honorable members to force the Huggins to publish it and redeem the forgotten veterans. The matter was brought to his attention by a veteran’s organization for the small, pre-war contingent of the West Indian Regiment, the Jamaica Ex-Servicemen Trades and Peoples Labour Union. In their plea, they astutely assured him that they were not a “political body” but an organization dedicated to finding employment for the demobilized.737 Jeffreys took up their case with zeal. He castigated the Jamaican Government for “completely disregard[ing] both their sacrifices and claims,” and reminded his peers “that the British Government are not without responsibility in this matter.” Furthermore, he called attention to the ex-servicemen from the Second World War, noting that they were “not in a very much better plight,” and subject to the Government’s continuing “callous disregard.” The young men of Jamaica were not likely, he emphasized, to eagerly flock to the defense of Her Majesty’s Empire, should they once again be called to duty. Nonetheless, just as members of Parliament agreed on the necessity of change in Jamaican veteran policy, they encouraged ex-servicemen to “organise… but stay out of politics.”738

With its extensive responsibilities and oversight, the Colonial Office was far less active than the Ministry of Pensions and metropolitan India Office in following up on allegations of veterans’ mistreatment. Though it extended a listening ear and followed up

737 C. I. Mackenzie to Sir George Geffrey, May 2, 1949, CO 137/885/2.
on nearly all petitions, individual and group, the Colonial Office was consistently slow in its responses, granting license and exceptions for individuals while ignoring broader appeals. Colonial Secretaries in the interwar decades responded to group appeals with a shrug of the shoulders, relaying that the Jamaican, Barbadian, or Guyanan governments were relatively independent, and funds were limited. Thus, despite protracted engagement and agitation, retrospective Government-sponsored reports in their favor, and a sizeable range of contacts and allies in the metropole, most West Indian ex-servicemen were left unaided.

During the Second World War, veterans’ interest organizations were more overtly political and connected to anti-colonial groups. By the time the war ended, disappointed ex-servicemen in Jamaica allied themselves with the League of Coloured Peoples. The powerful civil rights organization petitioned the Colonial Office on behalf of the veterans, reminding them that “the question of rehabilitation for ex-servicemen is an imperial responsibility on the highest level.” Yet in the coming years, the local and metropolitan arms of colonial governance were distracted by burgeoning problems elsewhere in the fracturing Empire. Within the decade, there would be no more “imperial responsibilities” in the West Indies or India, as the British government washed its hands of its colonial servicemen once and for all.

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In the aftermath of the First World War, the veteran pension was both the lifeblood of ex-servicemen’s day-to-day survival, and a vital part of their continued engagement with the British government. Veterans increasingly cited their self-sacrifice

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739 T. E. Sealy to Colonial Secretary, May 30, 1946, CO 137/866/6.
as part of their continuing dedication to the Empire, and as a fundamental justification of their need for further aid. Their political engagement, self-advocacy, and individual fortunes varied widely, not least depending on the nature of their colonial aftercare. In the British Raj, the Indian Army’s pre-existing welfare infrastructure supplied land grants and various pensions. Yet the distribution and qualification of these benefits shifted from individual to individual and province to province. While few veterans engaged in outright political dissent, the military lobby was a powerful force in interwar governance.

Through the establishment of the District Soldiers Boards, Indian officers mobilized the Army’s wartime service to argue for expanded government representation. They advocated for soldiers’ rights and care while working closely with the military authorities and British government.

The British West Indies stood in contrast with this ordered yet contentious system. Caribbean colonies had little infrastructure or desire to devote the fiscal resources necessary to aid ex-servicemen. Afro-Caribbean veterans – particularly those who were disabled and unable to work – found that their pensions rarely covered the needs of their dependents. Government concessions given more freely – namely, land grants – came with restrictive policies in inaccessible territories. Their dire condition prompted many to engage with the local, colonial, and metropolitan government directly, either through individual missives or group petitions and protests. Across the globe, veterans found that the fractured nature of British pension bureaucracy rendered care difficult to access. At the same time, individuals and groups seeking further support occasionally found ways to use this system to their advantage.
It is difficult to track the involvement of any remaining WWI veterans in the anti-colonial movements of the 1950s and 60s; however, the postcolonial British government has not managed to escape more recent debates over its responsibilities to veterans from its bygone Empire. In the past two decades, several ex-colonial forces have established interest groups and charities in the UK to advocate for the forgotten soldiers, from the Royal Commonwealth Ex-Services League to the West Indian Ex-Servicemen and Servicewomen Association. The most prominent of these returns the focus to South Asian servicemen: the high-profile campaigns to recognize Gurkha’s continuing service in the postcolonial decades asked for equal pay as British soldiers – a request denied – as well as for the right to settle in the country they had given their lives to – a request controversially granted. Conversely, legacies of British welfare in the colonies have produced strange remnants in the colonies. Jangi Inams, the special two-life pensions granted by the British government in WWI and WWII, have caused continued frustration in post-colonial India, where several children of independence activists have petitioned the Government for Jangi Inams, arguing that “freedom fighters” deserve them as much as soldiers fighting under the British.

Yet belated advocacy and British responses have come too late for nearly all veterans of the Great War, whose unfortunate timing – too late to be of great consequence

740 Counter-arguments and criticisms of the UK-settlement campaign, led by actress Joanna Lumley, claim that the settlement concession is useless without also awarding pension increases. The British Gurkha Welfare Society argues that in current conditions, it would be more cost-effective and beneficial for veteran Gurkhas to receive higher pay in Nepal, rather than wasting money on immigration to Britain and languishing in council housing, permanently on benefits. See “Was Lumley Campaign Good for Gurkhas?,” last modified July 31, 2011, http://www.bbc.co.uk/news/world-south-asia-13372026; David Miller, Strangers in Our Midst: The Political Philosophy of Immigration (Cambridge, MA: Harvard University Press, 2016), 115.

to the imperial government, yet too early and downtrodden to participate and reclaim
dues during decolonization – largely condemned them to obscurity in the greater
historical narratives of World War One. Their frustration and aspirations, vocalized in
petitions, letters, group meetings, and witness testimonies, express their deep-seated
desire to have their voice heard, and their abiding ties to the Empire valued – fiscally and
emotionally.
Conclusions

“Civilization altered the situation, and it is worth noting that the British Empire as a civilizing and colonizing power has been a good ally to healthcare…. Let us turn to present-day conditions, and endeavor to get some idea as to what the term ‘Health and Empire’ now connotes. Presumably it has various meanings. It may mean, and does mean, that health is a factor in achieving and maintaining empire; it may signify, and does signify, that the Empire is responsible for the health of these peoples under its flag: it may indicate, and does indicate that the first wealth of the Empire is health.”

- Andrew Balfour, March 1930

The global mobilization of colonial soldiers in the First World War, and their integral role in securing Allied Victory, did indeed affirm that “the first wealth of Empire is health,” as renowned Tropical Medicine expert Andrew Balfour asserted in his Hastings lecture to the British Medical Association in March 1930. The Allied Armies would not have succeeded without the millions of colonial subjects who enlisted, were recruited, or were coerced into the Empire’s global war. Their health – as wartime soldiers and laborers, or as demobilized veterans reintegrating to work in the colonies – fired the engine of the British military effort.

If, as Balfour suggested, “the British Empire as a civilizing and colonizing power has been a good ally to healthcare,” this dissertation has illustrated how a war that refuted “civilization” challenged this supposition. Rather, as it did in the metropole, the project of healing soldiers just as often called into question how civilized, benevolent, and responsible imperial Britain was. Caring for non-white colonial servicemen was a contentious, haphazard project. The war substantiated Balfour’s contentions at the same

time that it exposed cracks in them. Health was certainly a factor in achieving and
maintaining the Empire – British and colonial clinicians’ healing and caretaking of
colonial soldiers ensured that they continued to fuel and fight in the War. But healthcare
also undermined the pinnacles of imperial management, by calling into question the
raced, gendered, and classed ideologies of labor and the body. The War also underscored
the Empire’s responsibility for the health of its peoples, perhaps more immediately than
any other epidemic or medical crisis in imperial history. But for every Indian sepoy
pensioned, and every Afro-Caribbean serviceman fitted with artificial limb, colonial
medical and welfare apparatuses failed others.

This dissertation has demonstrated how typologies of race informed military
medicine and policies that shaped constructions of self, subjecthood, and the body. The
conditions of wartime care transformed and transfigured these ideologies of difference.
Individuals – those performing and receiving medical care – claimed effective care as
their right; they articulated their traumatic experiences in ways that complicated
typologies of race while actively shaping the landscape of veteran healthcare. The
healthcare and welfare provided to non-white colonial servicemen represented the British
Empire’s acknowledgement that care was a duty, not merely a gift. Yet in performing
medicine and organizing care from the battlefield to the colonies, British physicians,
military officials, and pensioning authorities struggled to provide care free from bias or
prejudice. In doing so, they contributed to the long legacy of global health disparities in
the war’s aftermath.

This dissertation has sought to decolonize and provincialize white narratives of
masculinity in combat – and combat-induced crisis – to illustrate how ideas of physical
and psychological health are inflected by raced ideas of masculinity and empire. It illustrates how British Tommies’ whiteness invisibly subsidized their care. Care for non-white colonial servicemen was not a narrative of compassionate aid and public appreciation. But it was also not a Foucauldian paradigm of all-seeing state control, raced biopower, and the dehumanized medical gaze. Nor was it fully the ‘broken promises’ narrative of abandonment. Instead, the networks of healing represented a microcosm of greater colonial politics at work: some men were healed and pensioned to a far greater extent than others. These decisions were predicated on a complex and changing matrix of bodily worth and ideologies of labor.

Set during the war, Chapters 1 & 2 examined how mobilization, the infrastructure of healing, and practices of feeding were intimately tied up with ideologies about race, ethnicity, gender, and labor. The former traced how these ever-changing typologies both structured mobilization of non-white colonial servicemen and were changed by their wartime service. The British Empire saw its colonial people as laboring bodies, and attempted to control their muscle for use – from its history of slavery and colonial exploitation, through to military recruitment and wartime service. But practices of recruiting, the assignment of wartime work, and the healing of the wounded also revealed fault lines and contradictions inherent in British conceptions of the “martial races” and of Afro-Caribbean “primitive masculinity.” The subsequent chapters explored how medical attention to different parts of their corporeal selves subverted the vision of non-white colonial servicemen as nothing more than imperial muscle.

Chapter Two illustrated how these soldiers were also more than passive stomachs. Rather, food was a contentious subject of debate between military officials, medical
officers, and soldiers themselves. The War Office’s race and unit-specific rations met with resistance from colonial servicemen who protested for religiously or culturally-appropriate foodstuffs, requested their personal preferences, or articulated demands for more fuel. Likewise, clinicians and scientists pushed military personnel to alter and amend diets to suit nutritional needs. These groups’ demands prompted the rationing authorities to rethink how race, religion, and culture corresponded – or did not correspond – to food and practices of eating.

The final four chapters traced how care fluctuated from the warfront and war hospital to the colonies servicemen returned to. Chapter Three took up the treatment of war-induced psychiatric disorders and asked how race impacted the development of British military psychiatry. It argued that mental health treatment in the Great War served as an experimental site where officers and soldiers contested ideas about race, pain, and the body, revealing the simultaneous staying power and flexibility of racial ideologies. Likewise, Chapter Four illustrated how British ideas about raced labor roles shaped colonial policies on prostheses provision, disability pension allotment, and reeducation techniques. It argued that even when care was made readily accessible, British prescriptions failed to take account of the different environments, cultural practices, and bodily techniques of South Asian and Afro-Caribbean servicemen. Disabled colonial servicemen alternately protested for better care, and turned to their own therapies. Chapter Five shifted to examine how racial ideologies inflected medical treatment of venereal disease. Non-white soldiers were set apart and never offered the avenues for prophylaxis and self-treatment that were increasingly available to white troops. Instead, military authorities attempted to control their sexual health through close control and
monitoring of non-white servicemen’s movements, and alternately, forced disinfection practices where West Indian servicemen moved outside of their prescribed boundaries. The chapter traces how these efforts to control sexual hygiene were tied to British attempts to preserve “racial hygiene” – namely through preventing and impeding interracial relationships. However, the spread of VD and the interwar migration efforts of interracial couples underlined how colonial mobilization in the war facilitated these social and sexual transgressions. Finally, Chapter Six tracked how practices of military welfare differed across colonies. It illustrated how pensions acted as an enduring tie between colonial ex-servicemen and the British state. Individual veterans and group organizations made their case to colonial and metropolitan governments by articulating their self-worth and moral service alongside calls of imperial duty and responsibility.

The cross-colonial relationships and intimacies forged in the First World War, along with its fractures and dismemberment, traumas and neglect, would encircle the Empire once again when it entered the Second World War. By that point, anti-colonialism and nationalism had gained a firmer foothold in the Caribbean, Africa, and the Raj. The Empire would not survive the second global conflict, superseded by new ideologies, nations, and world orders. The effects of multi-racial service in the First World War would remain long after decolonization and the move to independence. While the war’s crisis of debility left many colonies with a basic medical infrastructure – like that for orthopedic care – many of these invisible inequalities remained well into the postcolonial period. Mentally wounded servicemen still sat in the Bahamas’ “Crazy Hill” mental hospital in Nassau, and in the Ahmedabad Hospital in Gujarat. Disabled veterans still meandered through the streets of Kingston, and Indian soldiers and civilians received
physically limiting and culturally unfitting prostheses from the British well into the
1970s. Imperial British pensioning apparatuses continue to stir up conflict in independent
India, Pakistan and Nepal to this day. The former metropole’s acknowledgement of
colonial subject’s service in the First World War – or the lack thereof – remain
contentious subjects throughout the former Empire.

These historical lessons underscore the need for medical regimes and global
health systems to attend to how cultural bias informs and inflects them. Multicultural
initiatives in medicine can – and in the case of the First World War, did reproduce
structural inequalities. They also drew attention and support to cultural difference. The
debates that grew out of the First World War’s encounter between colonial servicemen
and physical and psychological trauma structured healthcare and welfare systems of
colonial subjects for decades to come. They established the terms of still unresolved
debates about the entangled histories of trauma, race, and disability.
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