INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

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

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

Bell & Howell Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600

UMI®

MEDICAL PLURALISM: DISEASE, HEALTH AND HEALING ON THE COAST OF KENYA, 1840-1940

MAUREEN MALOWANY

Department of History
McGill University
Montreal

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements of the degree of Doctor of Philosophy.

August, 1997

ABSTRACT

The Kenya Coast is populated by Africans, Arab-descendants, Indians and Europeans. As part of the Indian Ocean trading network, the predominantly Muslim Coast is an unusually rich site for investigating the historical interface of distinct medical systems--Islamic, ayurvedic and indigenous--which gave rise to an ever-evolving situation of 'medical plurality'.

This thesis addresses medical knowledge, practice and authority on the Coast from the mid-nineteenth to mid-twentieth centuries. The Coast is significant because of the variety of populations which inhabit the area, the early development of Muslim institutions for learning, and the Coast's isolation from white settler-dominated central Kenya, which allowed its populations a relative degree of political and social autonomy.

Particularly crucial for the Coast in this period is the intersection of African migration to the cities, the resulting pressures placed upon urban populations, and changes in disease patterns and intensity. This combined with contests over land appropriation among elites form a backdrop to the Colonial State's attempts to provide sanitation and public health to growing urban communities.

Local responses to disease and colonial public health initiatives point to the intersection of multiple medical understandings and practices on the Coast. This thesis

explores the continuities of indigenous medical systems, the resulting inability of Western medicine to gain uncontested orthodoxy, and questions the conceptualization of 'traditional medicine' as a static, homogenous system. Interactions within various 'traditional medicines' are explained to show how indigenous healing and therapeutics have drawn on both formal, text-based and informal, experiential medical knowledge; coexisting and, in some periods, converging with external medical authorities.

Nineteenth century Western scientific medicine remained one of a multiplicity of choices available to local populations. Not until the advent of institutionalized Western medicine did Western medical practice become more widely accepted. Africans' encounter with Western science occurred primarily through British colonial attempts to regulate housing and purify the water supply. The impetus to provide better health for East Africans peaked in the 1920s as the British sought to generate a "productive" labour force. It is the reconciliation of economic demands, increasing populations and inadequate medical support that provides the background for the investigation of changing patterns of health and disease.

RÉSUMÉ

La côte du Kenya est peuplée d'Africains, de descendants de peuples arabes, d'Indiens, ainsi que d'Européens. Parce qu'elle appartient au réseau commercial de l'Océan Indien, la côte du Kenya, majoritairement musulmane, est une région particulièrement riche pour l'étude de l'interface de différents systèmes médicaux – tel que islamique, *ayervedic* et indigène – qui a donné lieu à une situation de "pluralité médicale" en évolution constante.

La présente thèse a pour sujet le savoir médical, ainsi que la pratique de la médicine, dans la région de la côte du Kenya entre 1840 et 1940. Ses populations diverses, le développement d'institutions musulmanes d'enseignement vers la fin du dix-neuvième siècle, et l'isolement de la côte de l'intérieur du Kenya, dominé par les colons blancs, qui a contribué au développement d'une certaine autonomie politique et sociale des populations côtières, font de la région un important objet d'étude.

De plus, la migration des Africains aux villes a exercé des pressions sur les populations urbaines et a changé le profil démographique de la santé et des maladies. Cette coïncidence de facteurs, combinée aux rivalités entre les élites pour l'appropriation de la terre, constituent l'arrière-plan des tentatives du gouvernement colonial de créer un service de santé publique pour les communautés urbaines croissantes.

Les réponses locales aux projets d'amélioration de la santé publique et aux maladies témoignent de la coexistence de multiples pratiques médicales et de diverses perceptions de la médecine dans la

région de la côte du Kenya. Cette thèse examine la continuité des systèmes médicaux indigènes, ainsi que l'incapacité de la médecine occidentale d'atteindre une position d'orthodoxie incontestée, et remet en question la conceptualisation de la "médecine traditionnelle" comme un système statique et homogène. Des interactions entre diverses "médecines traditionnelles" sont expliquées pour démontrer comment la médecine et la thérapeutique indigènes ont intégré les connaissances des médecins savants et la médecine expérimentée, tout en coexistant et, dans certaines périodes, convergeant avec des guérisseurs et des textes revêtus de l'autorité.

La médecine scientifique occidentale du dix-neuvième siècle n'était qu'un choix parmi plusieurs offerts aux populations locales. Ce ne fut qu'avec l'introduction de la médecine occidentale institutionalisée que la pratique médicale occidentale s'est vue devenir de plus en plus acceptée. La rencontre entre Africains et la science occidentale a été en grande partie un résultat des tentatives des colons britanniques de réglementer le logement et d'assurer une alimentation en eau potable. Le désir d'assurer de meilleures conditions de santé aux populations de l'Afrique de l'est a atteint son apogée dans les années 1920 lorsque les Britanniques ont cherché à créer une main-d'oeuvre "productive." La conciliation d'exigences économiques, de populations croissantes et d'un système médical insuffisant (et inadéquat) constitue l'arrière-plan pour une étude des changements dans le profil démographique de la santé et des maladies.

ACKNOWLEDGEMENTS

Research that spans continents and cultures owes debts of gratitude to many. The financial support of McGill University and the Social Sciences Research Council of Canada enabled me to conduct fieldwork and archival research in Great Britain and Kenya. Mary McDaid, Department of History, remained a comforting and skilled Guide through the labyrinth of grant applications and a doctoral programme.

To the following archivists and staff I extend my thanks for their knowledge and support: Mr. Richard Ambani, Kenya National Archives, Nairobi, particularly, and to many others at the Fort Jesus Museum, Mombasa; Rhodes House, Oxford; University of Birmingham; Public Record Office, Kew; School of Oriental and African Studies; Centre for Contemporary Medical Archives, Wellcome Trust Library; British Medical Association and British Library, London. For permission to conduct my research I also thank the Office of the President, Nairobi, Kenya and the District Commissioners for Mombasa and Kilifi Districts.

Coastal people are known for their warmth and hospitality. I am indebted to Mama Hadija Nabahany and family and Amina Kassam for both. Mohamed K. Hemed provided invaluable assistance interviewing midwives in his village of Takaungu. Doreen Kathure and Carol Gatwiri struggled with transcriptions. Conversations with Dr. Shirin Walji, Lynn Thomas and Susan Beckerleg provided welcome criticism and laughter while in Kenya and London.

To Dr. David Anderson, whose knowledge of Kenya archival materials is encyclopaedic, I extend my appreciation for his intellectual generosity. To my

supervisor, Dr. Myron Echenberg, my gratitude for his unfailing assistance and guidance through two theses and many conundra as we shared our interest in disease!

To my communities of friends--Gwen Schulman, Tamara Myers, Catherine LeGrand, Megan Davies, Colin Coates, Jean Filipovich, Ismail Rashid--gratitude for 'head' support; my neighbours for 'body' support (particularly to those who fed my daughter when I seemed to forget about meals); my 'moon circle' women for 'soul' support. Health and healing were never far from my door!

Finally, to my daughter, Anastasia, for her affirmation and understanding of the complexities of living our many roles as women.

DEDICATION

To my daughter,

Anastasia Lescia Marie Malowany

TABLE OF CONTENTS

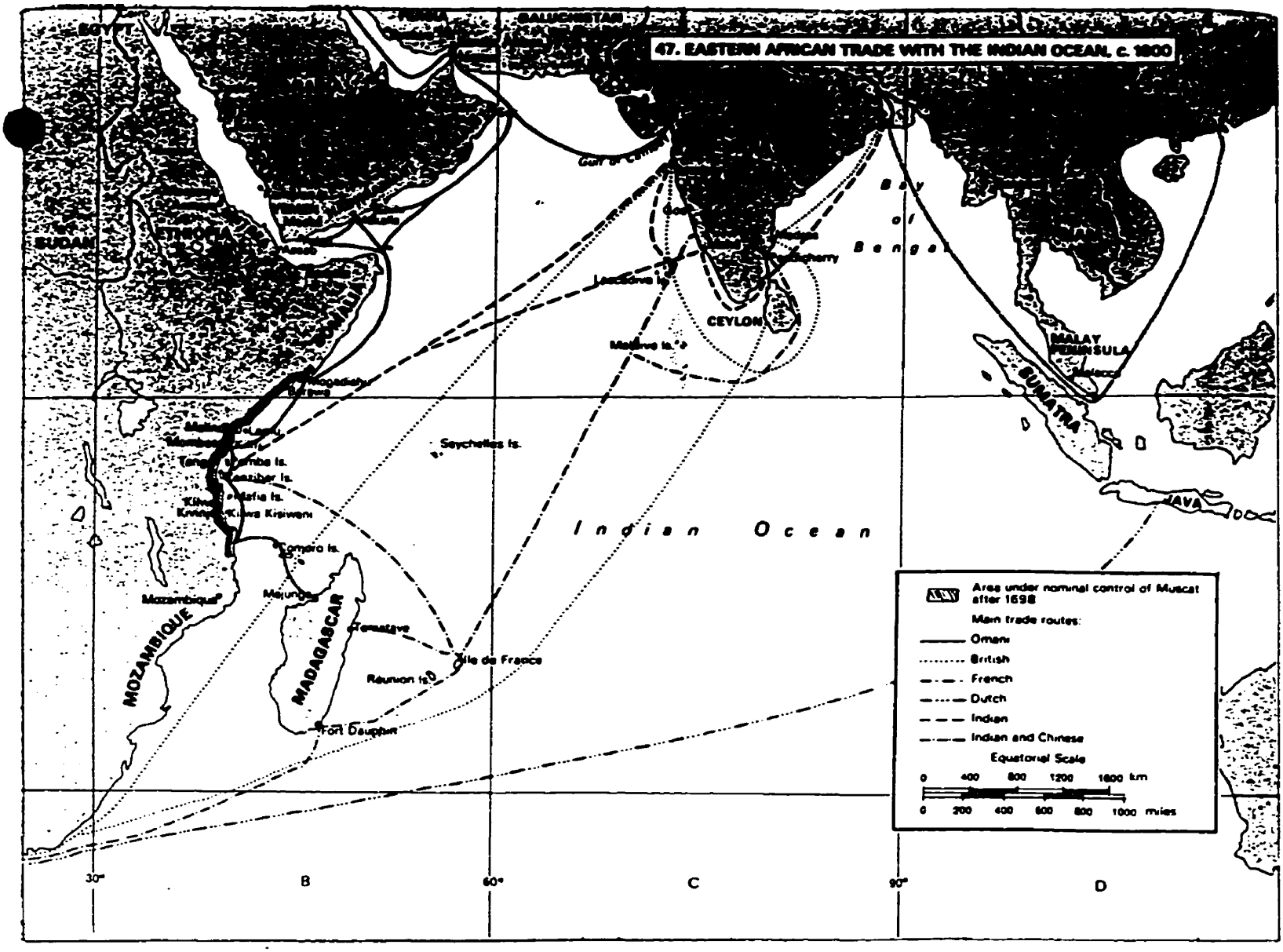
LIST OF MAPS

INTRODUCTION

This thesis addresses medical knowledge, authority and practice on the Coast of Kenya from the mid-nineteenth to mid-twentieth centuries. The research provides a much-needed general history of the Colonial State's introduction of Western medicine to this area, the logic of this contribution and local reactions to it. While representative of many regions of East Africa in the development of public health and Western medical institutions, the Coast is significant because of the variety of populations which inhabit the area, the early development of Muslim institutions for learning, and the Coast's isolation from white settler-dominated central Kenya, which allowed its populations a relative degree of political and social autonomy.

The Kenya Coast must be seen not as a fixed place or as a location of bounded cultures, onto which others have been grafted. Rather it is a place or space into which other cultures have been woven. Historians, particularly James de Vere Allen, have written of Swahili culture as a culture of entirely human synthesis--multi-layered, multi-purposed, exploring and desirous.[1] The Coast is a space in which over and through time local peoples of their own agency welcomed and fought against, integrated and resisted comings of power and trade, language and religion, learning

[1]James de Vere Allen, Swahili Origins (London: James Currey, 1993) [published posthumously].



MAP 1. Indian Ocean Trading Network

SOURCE: G.S.P. Freeman-Grenville, A Modern Atlas of African History (London: Rex Collings, 1976).

and authority. This is not to deny contention in social relations, power and authority, class and slavery, as well as severe demographic dislocation and relocation which intensified the already difficult climates of drought, famine and disease. But, it must be emphasized, no one matrix, either time- or place-defined, allows us access to the Coast's history.

To appreciate the complexity and breadth of medical knowledge on the Coast, it is necessary to adjust our vision of coastal peoples within the context in which they actually lived and traded from as early as the eighth century. The East African Coast has been a vibrant part of an extensive Indian Ocean trading system that at one time linked China, the Hadramaut--Yemen, Oman--India, the Benadir Coast of today's Somalia south to Zanzibar, the Comoro Islands and Madagascar. Immigrants and traders came from all of these areas to form Coast towns. Trade in knowledge was as vibrant as trade in goods. Particular to medical cultures of the Coast was the layering of knowledge that took place as a result of the intense immigration and migration of Indians, Arabs and Africans (Swahili and non-Swahili speakers) in the mid-nineteenth century.

The task for this thesis has been to understand how communities, always within their social contexts, make sense of disease, health and healing. The questions which constantly reinforced this framework were very basic: what was

the disease, who were the healers, what were the therapies.[2] The four medical systems present on the Coast were Islamic (Qur'anic), ayurvedic, Western allopathic and indigenous. Answers to who owned power and authority over medical knowledge were intrinsically tied to decisions about healers and therapies. No research has made this case as compellingly as that of Feierman and Janzen.[3] Their models have challenged that of Western medical science which would separate the disease from the person; the treatment from notions of spiritual health of the individual and community; the healer from the doctor. Contemporary medical scientists, advisers and policy-makers at national and international levels, while recognizing medical pluralism, remain committed to a hegemonic allopathic model, marginalizing healing and therapeutic systems of indigenous peoples. Western allopathic medicine has been reluctant to integrate spirit into mind, soul into body. And yet this research into Islamic, ayurvedic and indigenous African systems points to the power of integration, of the acceptance of a plurality of disease causations as well as disease treatments.

---

[2]See Gwyn Prins, "But What Was the Disease? The Present State of Health and Healing in African Studies", Past and Present (Vol. 124, 1989), pp. 159-79; and Social Science and Medicine (Vol. 28, 1989), Special Issue on the Political Economy of Health in African and Latin America.

[3]Steven Feierman and John M. Janzen, eds., The Social Basis of Health & Healing in Africa (Berkeley: University of California Press, 1992), "Introduction", "The Decline and Rise of African Population: the Social Context of Health and Disease", and "Therapeutic Traditions of Africa: A Historical Perspective".

This thesis has located medical changes and continuities within the social contexts in which they were constructed and reconstructed both individually and collectively. As part of the Indian Ocean trading network, the Coast is an unusually rich site for investigating the historical interface of distinct medical systems, which gave rise to an ever-evolving situation of medical plurality.

This research is concerned with the history of disease on the Kenya Coast and thus returns to those links with environment and ecology that formed part of indigenous understandings of health and disease. Feierman and Janzen have noted that it is Africans' knowledge and use of the environment that has allowed for the greatest therapeutic efficacy.[4] Desire to control epidemics (plague, influenza, smallpox and yellow fever) motivated the Colonial State to address health issues through preventive measures. Particularly crucial for the Coast in this period is the intersection of African labourers' rural-urban migration, the resulting pressures placed upon urban populations of Africans, Arabs and Indians, and changes in disease patterns. Labour migration intensified the incidence of diseases present at the Coast, making epidemic what had been endemic malaria and exacerbating incidences of yaws and rates of helminthic parasitic infections. In addition, contests over land appropriation among European, Indian and Arab elites form a backdrop to the colonial state's attempts to provide sanitation and public health to growing urban communities.

---

[4]Feierman and Janzen, eds., Social Basis of Health and Healing, "Introduction".

Examination of local responses to disease and colonial public health initiatives points to the intersection of multiple medical understandings and practices on the Coast. Thus my research explores how Coast populations received Western medicine into their indigenous medical practices. The inability of Western medicine to gain uncontested orthodoxy leads us to examine the continuities of indigenous systems and to question some investigators' tendency to conceptualize 'traditional medicine' as a static, homogenous system. This thesis explores the interactions within various 'traditional medicines' still vital on the Kenya Coast to show how indigenous healing and therapeutics have drawn on both formal, text-based and informal, experiential medical knowledge.

This work challenges the reductionist construction of 'traditional medicine' to show how various indigenous medical systems coexisted and, in some periods, converged with external medical authorities. Islamic medicine (both scholarly and itinerant) and ayurvedic medicine (brought with Indian immigrants) have come to be integrated into indigenous knowledge. Thus humoral systems found resonance with indigenous therapies. Today their diagnostic and therapeutic components are woven so tightly into the African framework that it is difficult to trace any practice to a single source. For coastal urban populations, particularly, the continued option of Islamic medical treatment has severely constrained Western scientific medicine's attempts to gain the orthodoxy it appears to hold in the rest of the country.

Nineteenth century Western scientific medicine, as practised by missionaries at the clinical level, remained one of a multiplicity of choices available to local populations. Not until the advent of institutionalized Western medicine in the early twentieth century, delivered primarily through hospitals, did Western medical practice become more widely accepted. As important as the provision of hospital care was for the European population, the Africans' encounter with Western science first occurred mainly through British colonial attempts to regulate housing and purify the water supply. Rooted in the nineteenth century British sanitation movement, the Colonial State's health policy from 1905 through 1940 moved only gradually into public health in response to directives from the newly-created British welfare state. The impetus to provide better health for East Africans peaked in the 1920s as the British sought to generate a "productive" labour force. It is the reconciliation of economic demands, increasing populations and inadequate medical support that provides the background for the investigation of changing patterns of health and disease.

Methodology

In investigating changing disease patterns on the Coast, the advent of Western medicine and its interactions with local medical traditions, this thesis draws on many sources. Some are archival: collections from missionary societies,[5] private papers, the British Medical Association and the Colonial State (Public Record Office, Kenya National Archives, Mombasa Municipal Archives). In addition, oral interviews with Qur'anic healers and scholars as well as African and Indian midwives, supplemented with published ethnographic accounts of coastal communities, provided the 'African voices' necessary to begin documenting local initiatives and responses to the Colonial State's medical project.

Although the records have marginalized women and their experiences with health and healing, in this thesis issues of gender have been incorporated into the general text rather than separated into a chapter on women's history. Without the pioneering work of Strobel, Mirza and Romero which provided documentation of Coast women's histories, the possibility of inclusion would have been severely constrained.[6] As women have not lived in isolation from males or from patriarchy,

---

[5]Records of the Medical Committees of the Church Missionary Society are not yet accessible to researchers. The handlist for this deposit (held at the University of Birmingham) suggests a rich corpus of evidence for empire-wide comparative study.

[6]Margaret Strobel, Muslim Women in Mombasa 1890-1975 (New Haven: Yale University Press, 1979); Sara Mirza and Margaret Strobel, ed. and trans., Three Swahili Women. Life Histories

so, too, must their record be integrated into what is predominantly a patriarchally-organized and constructed narrative. Women's encounters with and resistance to the colonial medical project are perhaps not as important as the networks which women have formed to maintain their cultural and social locations, the loci of their power. Uncovering these 'threads of solidarity', a process begun in this thesis, forms the basis for the author's future research.[7]

Review of the Literature

Although the history of Kenya has been well-served in the historiographical literature, particularly the recent two-volumed work of Berman and Lonsdale, Unhappy Valley and Kitching's publication on the political economy of Kenya, the

---

from Mombasa, Kenya (Bloomington: Indiana University Press, 1989); and Patricia W. Romero, "Mama Khadija: A Life History as example of Family History", in Patricia W. Romero, ed., Life Histories of African Women (London: Ashfield Press, 1988),pp. 140-58.

[7]Feminists of all persuasions have adopted the image of women as weavers or spinners of threads. This phrase is the title of a reflective and analytical work that wove issues of race, gender and class into the complex world of women's labour in South Africa. See Iris Berger, Threads of Solidarity. Women in South African Industry, 1900-1980 (Bloomington: Indiana University Press, 1992). For the historiography of writing on African women generally and an examination of the debate on inclusion vs. a separate women's history, see the author's M.A. thesis. Maureen Malowany, "Representations of African Women in the Historical Literature of Nigeria, 1890-1990", M.A. Thesis, McGill University, 1992.

Coast history has received less attention.[8] How to write about the Coast has troubled historians as writers struggled with the placement of the various Coast cultural communities with Swahili culture and Swahili-speakers. Questions of origin and lineage, addressed by Chittick and Rotberg, have dominated the early historiography.[9] Salim's history of the Coast in the colonial period has provided an authoritative base from which to extend research on all coastal populations.[10] Definitions of identity, addressed by Chittick and revised by de Vere Allen, have encouraged the writing of community-specific histories.[11] Spear's research on pre-colonial Mijikenda and Brantley's studies of Giriama have provided a basis for

---

[8]While the historical corpus on Kenya is immense, the historiography has been integrated, graciously and authoritatively, into Bruce Berman and John Lonsdale, Unhappy Valley. Conflict in Kenya & Africa. Book One: State & Class. Book Two: Violence & Ethnicity (London: James Currey, 1992). For an earlier study on the political economy of Kenya, see Gavin Kitching, Class and Economic Change in Kenya: The Making of an African Petite Bourgeoisie, 1905-1970 (New Haven: Yale University Press, 1980).

[9]For a discussion of definitions of Swahili, see Neville H. Chittick and Robert I. Rotberg, eds., East Africa and the Orient (New York: Africana, 1975); A.H.J. Prins, The Swahili Speaking Peoples of Zanzibar and the East African Coast: Arabs, Shirazi, and Swahili (London: International African Institute, 1967); and the more recent publication of de Vere Allen, Swahili Origins.

[10]A.I. Salim, Swahili-Speaking Peoples of Kenya's Coast 1895-1965 (Nairobi: East African Publishing House, 1973).

[11]Chittick has produced a number of articles on the archaeology of the Coast. See especially: N.H. Chittick, "The 'Shirazi' Colonization of East Africa", Journal of African History (Vol. 6, 1965), pp. 275-94. On Swahili, see: de Vere Allen, Swahili Origins.

histories of contact. The recent example of Willis' Mombasa, the Swahili and the Making of the Mijikenda has shown how contact and migration have established settled urban communities.[12]

Research conducted on the Coast included works specifically on Islamic communities. Pouwels' Horn and Crescent provided the pre-colonial evidence which stimulated questions on medical authority and gendered roles this thesis addresses about Qur'anic healers and healing in the colonial period.[13] Cooper's examinations of labour relations through both the pre-colonial and colonial periods of the Coast, important for analyses of migration, have been formative also in understanding those Imperial policy directives produced by the Colonial Office and applied to the Coast.[14]

---

[12]Thomas Spear, The Kaya Complex: A History of the Mijikenda Peoples of the Kenya Coast to 1900 (Nairobi: Kenya Literature Bureau, 1979); Cynthia Brantley, The Giriama and Colonial Resistance in Kenya 1800-1920 (Berkeley: University of California Press, 1981); and Justin Willis, Mombasa, the Swahili, and the Making of the Mijikenda (Oxford: Clarendon Press, 1993).

[13]Randall Pouwels, Horn and Crescent. Cultural Change and Traditional Islam on the East African Coast, 800-1900 (Cambridge: Cambridge University Press, 1987).

[14]Frederick Cooper, From Slaves to Squatters. Plantation Labour and Agriculture in Zanzibar and Coastal Kenya 1890-1925 (New Haven: Yale University Press, 1980); On the African Waterfront: Urban Disorder and the Transformation of Work in Colonial Mombasa (New Haven: Yale University Press, 1987); ed., Struggle for the City: Migrant Labor, Capital and the State in Urban Africa (London: Sage, 1983); Decolonization and African Society. The labor question in French and British

The medical history of the Coast of Kenya has yet to be written. The few distinctly medical works have incorporated the Coast into a narrative of the Colony of Kenya, dominated by the Central Province.[15] Beck's histories were the first to incorporate archival records held in East Africa, but the intent of her research was to document the development of Western medicine.[16] Published studies of the Swahili-speaking coastal region or adjacent islands have provided comparative works but none address the Kenyan Coast and medical practices directly. Evidence on medical practices has been drawn from broader narratives particularly Caplan's African

---

Africa (Cambridge: Cambridge University Press, 1996), "Introduction" and "Part I: The dangers of expansion and the dilemmas of reform".

[15]John A. Carman, A Personal History of the Colony and Protectorate of Kenya: A Personal Memoir (London: Rex Collings, 1976); Isaac Sindiga, Chacha Nyaigotti-Chacha and Mary Peter Kanunah, eds. Traditional Medicine in Africa (Nairobi: East African Educational Publishers, 1995) offer a number of articles on Kenya, none of which address the Coast; C. M. Good. Ethnomedical Systems in Africa: Patterns of Traditional Medicine in Rural and Urban Kenya (New York: Guilford Press, 1987); and Marc H. Dawson, "Socio-Economic and Epidemiological Change in Kenya, 1880-1925", Ph.D. dissertation, Northwestern University, 1974 (unpublished).

[16]See Ann Beck, A History of the British Medical Administration of East Africa, 1900-1950 (Cambridge: Harvard University Press, 1970); Ann Beck, Medicine, Tradition and Development in Kenya and Tanzania (Waltham: Crossroads Press, 1970); Harvey G. Soff, "A History of Sleeping Sickness in Uganda: Administrative Response, 1900-1970", Ph.D. dissertation, Syracuse University, 1971. Unpublished works which provide comparative research on medical issues or disease campaigns for sub-Sahel Africa are: Heather Bell, "Medical Research and Medical Practice in Anglo-Egyptian Sudan", University of Oxford, 1996; and Elizabeth Boudina van Heyningen, "Public Health and Society in Cape Town 1880-

Voices, African Lives and Sperling's article on "the nature of mantic activity" which included medical healing practices and therapeutics among Mijikenda people. Beckerleg's unpublished anthropology dissertation on Swahili medicine complemented the comparative ethnographic evidence. Lambek's study of the sociology of knowledge in Comoro Islands provided a useful theoretical model of syncretized knowledge within the context of Islam.[17]

There is a perceptible lineage, however, in the development of the medical history of sub-sahel Africa into which this thesis can be placed. The triumphalist accounts of the success of Western medicine in the development of a healthy Africa were challenged first from by historians of science and later by historians of Africa. McKeown challenged the perception that population increases in the past century were a direct result of the competence and efficacy of medical practice. His critique

---

1910", Ph.D. thesis, University of Cape Town, 1989.

[17]David Sperling, "The Frontiers of Prophecy", in David M. Anderson and Douglas H. Johnson, eds., Revealing Prophets. Prophecy in Eastern African History (London: James Currey, 1995), pp. 83-101; for comparative studies of the coastal region, including the islands, see: Pat Caplan, African Voices, African Lives. Personal Narratives from a Swahili Village (London: Routledge, 1997),; Michael Lambek, Knowledge and Practice in Mayotte: Local Discourses of Islam, Sorcery and Spirit Possession (Toronto: University of Toronto Press, 1993); and P. Lienhardt, "Introduction" to The Medicine Man: Swifa ya Nguvumali, by Hasani bin Ismail (Oxford: Clarendon Press, 1968). Also see: Susan Beckerleg, "Maintaining Order, Creating Chaos: Swahili Medicine in Kenya", Ph.D. dissertation, School of Oriental and African Studies, University of London, 1989 (unpublished).

raised issues about the value of medical interventions for the public health.[18] Since the late 1970s Africanist historians have used the framework of the political economy of health to incorporate macro- and micro-level studies of African populations into larger analyses of the effects of and resistance to colonialism. As Turshen has shown for Tanzania, community responses to disease, particularly epidemics, highlighted existing political, economic and social tensions. Janzen's research on the management of health introduced the importance of kin-based therapy, forcing historians to contextualize health-seeking practices within community relations.[19] Collections such as those of Arnold, Hartwig and Patterson,

---

[18]McKeown challenged the belief that the rise in population growth from the nineteenth through the twentieth centuries could be attributed to the contributions of modern medicine. McKeown assessed changes in food production and nutrition as significant factors in the health of populations and their consequent increase in numbers rather than any interventions of Western medical science. For what has come to be called the "McKeown Thesis", see his monumental critique: T. McKeown, The Role of Modern Medicine: Dream, Mirage or Nemesis? (Oxford: Oxford University press, 1979).

[19]Historians incorporated medical terminology and constructs into historical discourse. P. Curtin, "The Epidemiology of the Atlantic Slave Trade", Political Science Quarterly (Vol. 83), 1968, pp. 190-216 was one of the earliest. For research on East Africa, H. Kjekshus, Ecology Control and Economic Development in East Africa (Berkeley: University of California Press, 1977) provided the data on political economy that opened new paths for historians and demographers. See, for example, Meredith Turshen, The Political Ecology of Disease in Tanzania (New Brunswick: Rutgers University Press, 1984). Anthropologists joined historians in this discovery of a new 'lens' through which cultural meaning could be examined and explained. The most influential of these works for Africa has been John F. Janzen, The Quest for Therapy in Lower Zaire (Berkeley:

MacLeod and Lewis that crossed geographical and chronological boundaries provided Africanist historians with the comparative research needed to show both how experiences in Africa were unique and how they shared features of empire-wide colonial encounters.[20]

For Africanists, the authoritative body of research which sought to link disciplines, theoretical bases and methodologies was Feierman and Janzen's Social Basis of Health and Healing.[21] This collection of articles by anthropologists and

---

University of Califiornia Press, 1978). From the scientific medical perspective, the merging of social medicine with historical and anthropological research was significant. The journal, Social Science and Medicine, became a forum for the publication of these cross-disciplinary studies. See Social Science and Medicine (Vol. 15B, 1981) and the later issues, Special Issue on the Political Economy of Health in Africa and Latin America (Vol. 28, 1989).

[20]See R. M. MacLeod and M. Lewis, eds., Disease, Medicine, and Empire. Perspectives on Western Medicine and the Experience of European Expansion (London: Routledge, 1988); David Arnold, ed., Disease, Medicine and Empire (Manchester: Manchester University Press, 1988); and from anthropology, Murray Last and G.L. Chavunduka, eds., The Professionalisation of African Medicine (Manchester: Manchester University Press, 1986). The collections of Africanists began with G.W. Hartwig and K.D. Patterson, Disease in African History: an Introductory Survey and Case Studies (Durham: Duke University Press, 1978) and a later collection from the Africanist demographers and economists, D.D. Cordell and J.W. Gregory, eds., African Population and Capitalism: Historical Perspectives (Boulder: Westview Press, 1987).

[21]This collection spans the period from pre-colonial to post-independence Africa. Feierman and Janzen, eds., The Social Basis of Health & Healing in Africa.

historians has provided the model for both the questions and the empirical documentation of this thesis. Balancing evidence with meaning, both located within the social contexts of people's lives, has been the model this thesis attempts to follow.

Africanists have discovered how the "therapeutic map began to lose its clear lines" as the charting of medical systems did not follow ethnic let alone political boundaries.[22] Some anthropologists (Michael Lambek), and historians (Megan Vaughan) have responded by investigating the production of medical knowledge of local populations.[23] Reflecting on the work of anthropologists, Jean and John Comaroff, on South Africa and David Arnold for India, Vaughan and White have deconstructed this knowledge as a site of contention between colonizer and colonized and see the product as metaphor for the cognitive and social realities of African populations.[24] Without denying the power relations and concomitant

---

[22]Ibid., 'Introduction', pp. 2-3.

[23]Lambek, Knowledge and Practice in Mayotte and Megan Vaughan, Curing Their Ills. Colonial Power and African Illness (Stanford: Stanford University Press, 1991).

[24]See Vaughan, Curing their Ills and Luise White, "'They Could Make their Victims Dull': Genders and Genres, Fantasies and Cures in Colonial Southern Uganda", American Historical Review (September 1995), pp. 1379-1402; "Blood Brotherhood Revisited: Kinship, Relationship, and the Body in East and Central Africa", Africa (Vol. 64, No. 3) 1994, pp. 357-372; and "Tsetse visions: narratives of blood and bugs in colonial Northern Rhodesia, 1931-39", Journal of African History (Vol. 36, 1995), pp. 219-45. Two publications have been

authority represented in medical knowledge discourse which these relations establish, there is a need to return to a more empirical base.

Colonial medicine did not create the subject. It entered a world of established and ever-changing medical terrain: diseases, treatments, healers and clients. The historiography of medicine in the colonies has evolved from as many sites of knowledge and practice as the plurality of medical cultures it represents. From the hagiographic accounts of European medical practitioners, through the analysis of militaristic and jingoistic disease control campaigns to treatment of 'the body' as ultimate object of medicalizing imperialism, the literature represents paradigmatic shifts in twentieth century historiography, generally, and cross-disciplinary comparative studies of 'third world' areas more specifically. In the transition to the post-structuralist concern with metaphor, we may have lost sight of the need to construct a solid empirical base for our theoretical analyses of the social reproduction of disease, health and healing. This thesis has taken a step back from the metaphor to those people whose thinking and activities about disease, health and healing have served to both continue and evolve local medical cultures. Included

---

particularly influential in dissecting the ideology of colonizers and colonized: J. Comaroff, Body of Power, Spirit of Resistance (Chicago: University of Chicago, 1986) and Jean and John Comaroff, Of Revolution and Revolution (Chicago: University of Chicago, 1991). See also David Arnold, Colonizing the Body. State Medicine and Epidemic Disease in Nineteenth Century India (Berkeley: University of California Press, 1993).

in these populations are the government proponents and practitioners of Western health care delivery. Although not an homogenous medical culture, Western medicine was practised clinically in institutions and communally through public health campaigns. The influence of Western medicine gains momentum after 1940, and is thus outside the scope of this thesis, but the groundwork is laid in the early colonial era.

This thesis begins in the period prior to colonial medicine, from the point at which we have the most continuous written records. For the Coast of Kenya, there are records and chronicles, which pre-date the mid-nineteenth century but they have been sporadically produced. This thesis introduces its presentation with the records of the first missionary to East Africa, Johannes Ludwig Krapf.

Telling the story from the point of view of the Colonial State would require the following framework, now almost a trope in British colonial medical history. Prior to the First World War, the Colonial State was concerned with European health and thus funding and policies for local populations were minimalist in nature and practice. Although Joseph Chamberlain spoke of a 'constructive imperialism', the targeted beneficiaries were European settlers and landowners not local populations. With the demographic devastation of the First World War and the development of the Colonial Medical Service, the metropole became interested in health and development at home and, by extension, in the colonies. During the interwar period,

disease control was effected, but not effective, primarily through colony-wide anti-disease campaigns. The passage of the Colonial Development Act of 1929, made redundant at its inception by the Depression before the development plan was fully funded or implemented, signified the metropole's interest in an economically sound colonial system but, again, one which served European and settler capital. Domestic colonial development did not begin until 1940 with the passage of the Colonial Development and Welfare Acts which guaranteed sums of money to the colonies tied to local, community-based development projects. The 'native' had been reconstructed to the 'African' as the colonial state hesitantly rethought how Africans really could take their place as both labourers and town-dwellers.

This sequence of Colonial Office policy shifts, directed from the metropole evidenced within the context of medical and health policies of the Colonial State, has not been documented for the colony or protectorate of Kenya. More specifically for this thesis, even a description of government health policies as they affected the Coast has not been published. This thesis seeks to bring forward the particular narrative of the Colonial State's commitment to provision of medical services and promotion of public health from the policy level centred in Nairobi to the practical application of policy at the Coast.

This is a disembodied narrative into which must be included the experiences of local populations, their networks of social organization, the sites of contention

between the state and the Coast's communities as well as among local populations themselves. This thesis constantly grounds colonial policies and programmes, metropolitan and domestic, in the social relations of the communities the state purported to both serve and control.

Chapter Summary

In Chapter One the thesis presents patterns of coexistence of Islamic and animist African and Christian mission medical systems. In the absence of a central organizing state, local populations generated and shared their own medical knowledge. Convergence of medical systems depended on contact. For this first period of mission presence, from mid-nineteenth to the early twentieth century, mission doctors and indigenous healers shared an understanding of disease causation that included both spiritual and physical causes. Although Christian missionaries remained unwilling to accept with equanimity the role of spirits with the hand of God, they did share with African healers an acceptance of multiple layers of disease causation that included environmental and social factors.

Chapter Two charts the early years of the colonial medical project as the Colonial State introduced Western scientific medicine to the Colony and Protectorate. While committed to health care delivery through institutions such as hospitals or dispensaries, the state became embroiled in "crisis medicine" developing policies and programs in direct response to disease epidemics. International

pressures for disease control drew the Colony into a pattern of legislated health care that would continue until the Second World War. The period ends with the introduction of a racially constructed public health policy based on the report of the ubiquitous Mr. W. Simpson, Colonial Office expert on plague control and, by extension, public health.

The colonial state, bolstered by economic interests of white settlers, became an aggressive actor in colonial policy-making through the 1920s. In Chapter Three the focus of the thesis shifts from the Coast to central Kenya and the capital, Nairobi. As the state attempted to consolidate its hold on the affairs of the Colony through the building of bureaucratic frameworks, competing interests of white settlers, Indian residents and African communities over land and labour formed an underlying tension which surfaced initially around the policy of racial segregation, placed within a medical framework of public health. Thus medical concerns became intrinsically tied to commercial and capital interests and these interests were framed at the central government level.

Mirroring metropolitan notions of gendered roles for males as waged workers and females as domestic supports, both missions and the state initiated training programs for Africans, appropriating male labour first. Women remained marginalized as health care personnel but included as targets of campaigns, particularly with the institutionalization of Maternal and Child Welfare in the early 1920s.

As Chapter Four explains, initiatives from the central government could not meet local needs. In response, the government devolved its mandate to local governments for both policy direction and funding. Control of the timing and process rested with the colonial government.[25]

This period was also one of building networks. From 1913 to 1940, urban initiatives in Mombasa married devolution of power with the rise of voluntary societies, community based, which sought to take upon themselves the responsibility for social reconstruction. State policy focussed on maternal and child welfare but women's participation in this program depended on class, education and the need for community linkages. Coast women of longer settlement, particularly women midwives, resisted inclusion and appropriation. The largest city and former capital, Mombasa, as the site of urban conflicts, cooperation and resistance, forms the basic geographical focus of this chapter.

As Mombasa was distinct from Nairobi, so was the bordering hinterland distinct from the Coast. The central state continued to hold to a stereotype of Africans as "rural natives" in spite of evidence to the contrary, particularly in the Swahili settlements of the Coast. The Coast populations were seen to be particularly resistant to labour recruitment and their distance from European settler

---

[25]Cooper, Decolonization and African Society, p. 213.

plantations provided a wide margin of negotiable space. Nevertheless, as the state sought to devolve power to the local level, Local Native Councils were established to both advise and implement state policies. Chapter Five addresses rural initiatives and responses to health and disease through the period 1913 to 1940. Evidence for both urban and rural populations supported Feierman and Janzen's astute point that Africans and other local populations used Western medical institutions in ways they knew best but were unable to shape them to meet community needs.[26]

[26]Feierman and Janzen, eds., Social Basis of Health and Healing, p. 217.

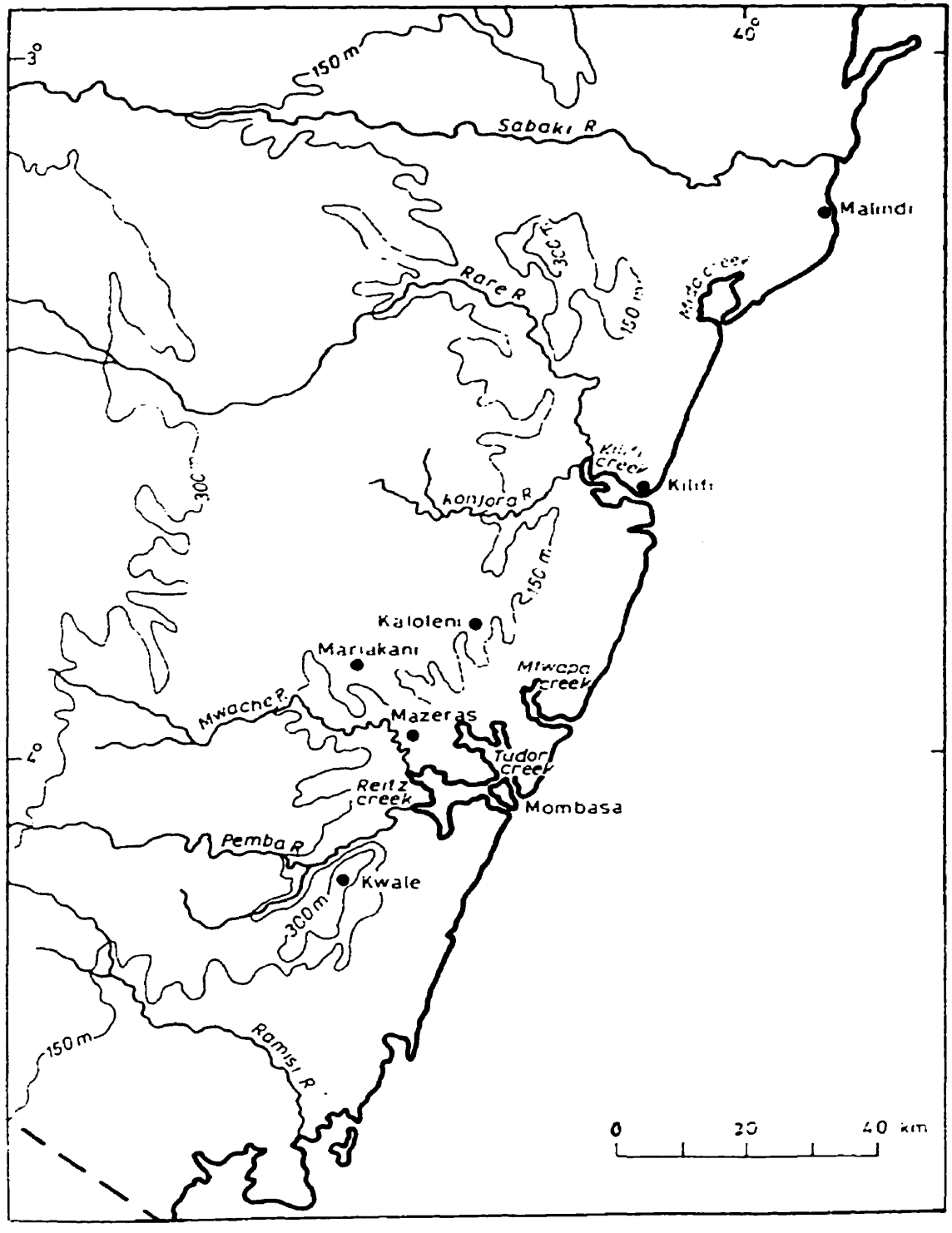
CHAPTER ONE

MEDICAL SYSTEMS ON THE COAST, 1840-1910: CONTEXTS FOR COEXISTENCE AND CONVERGENCE

Multiple medical systems have for long dominated the Kenyan Coastal landscape. Muslim traders and scholars introduced Islamic medicine; Indian traders brought ayurvedic remedies; Christian missionaries layered evangelism with nineteenth century Western science. All systems have coexisted on the Coast since the mid-nineteenth century, some within a context of contact, others in isolation, in a pluralistic medical culture.[1] This chapter explores the possibilities for choice in the areas of medical knowledge and practice that existed for and were exercised by Coast populations in the late nineteenth century. With coexistence came opportunities for convergence, a process always located within the social community and mediated by that community's political economy of health. Within indigenous medical systems, the most successful interloper was Islamic medical knowledge. The weakest crossovers

---

[1]Medical historians of Africa have not agreed on the connotations, definitions and uses of the terms "medical pluralism" or "pluralistic systems". For the purposes of this thesis, pluralistic systems are those in which hegemony has not been established. For a discussion of the issues involved in attempting to form a discourse on comparative health and healing systems that functions across disciplines, cultures and periods, see: n.a. "Issues and Findings", Social Science & Medicine (Vol. 15B) 1981, pp. 429-37.



MAP 2. Mombasa on the Kenya Coast

SOURCE: Justin Willis, Mombasa, The Swahili, and the Making of the Mijikenda (Oxford: Clarendon Press, 1993).

were between indigenous systems and ayurveda. Mission medicine lay between the two.

Although previous historical writing (in Whiggish fashion) has posited a deterministic evolution from the beginnings of Western medicine, as presented by missionaries, to the inevitable establishment of Western biomedicine as a hegemonic medical system, evidence does not support that claim. Nineteenth century mission practitioners were guided by an environmentalist, miasmatist understanding of disease causation. In addition, for Christian evangelists, treatment of the body was not divorced from that of the soul. On this point, Christian, Muslim and African healers shared epistemological ground. Those ideological systems which addressed mind, body and soul as integrated units facilitated convergence in areas of healing and therapeutics. During this initial fifty-year period of missionary contact with indigenous healers, prior to the adoption of a laboratory-based, twentieth century science, opportunities presented themselves for complementary rather than competing models of health care and disease control.

In the pre-colonial period, no single medical system had attained orthodoxy at the Coast. The roots of this pluralistic medical culture lie in an attitude towards medical knowledge held by coastal populations that placed all medical knowledge, including the allopathic, Western scientific model on an equal footing rather than ordering them hierarchically. On what basis then did

local populations make choices for healers and treatments? As clients rather than patients, Africans, Arabs and Indians exercised their right of choice based on a number of factors. The cause of the disease, environmental, human or spiritual, determined the choice of healer and therapy. Treatment could be individually or communally administered. As long as mission practitioners aligned with these categories, their medicines were as welcome as any others.

From the 1840s, the point at which we have written evidence, through to 1910, when colonial legislation begins, medical territory was a flexible, negotiated space within which a rich storehouse of therapeutic options existed for Coast populations. What coastal peoples were able to maintain through this early period of colonization was their position of client not patient vis-a-vis medical healers. Agency--the choice of healer--was mediated by religion, geographical location and class. All healers were not available to all clients but all clients had options and exercised their right to choose.

What is significant about this period is that at no other time on the Coast was the possibility of medical convergence so rich. Intense immigration and migration in mid-nineteenth century brought together African, Arab and Indian commmunities. This was a dynamic period marked at one end by intense contact and plurality and at the other by constraint with the intervention of the colonial state in medical practice.

The period 1840-1910 began with a dominant motif of coexistence of medical systems and ended with one of control. Periodization for this chapter corresponds to the model established by Berman and Lonsdale for political and economic developments in Kenya.[2] The narrative of medical practice on the Coast has been dominated by mission evidence, particularly the archives of the Church Missionary Society (CMS) whose presence through this period was the most stable and continuous of mission groups.

Reading the mission archives as context as well as text was crucial to this study. Mission evidence delineated the sites of medical knowledge and practice as they coexisted with Coast African systems, particularly Swahili, Giriama and Digo. Underlying medical knowledge was the shared perception that diseases were predominantly environmentally-determined. In consequence, therapies employed by African populations involved a complex system of use of locally available materia medica. It is in the area of pharmacology or herbal treatments that the greatest degrees of assimilation and adaptation of medical systems has occurred. African systems of medicine which pre-dated Islamic influences easily appropriated Islamic notions of herbal treatment through contact and conversion. Ayurvedic remedies, dispensed by Indian populations, did not enter the African pharmacopoeia until the mid-twentieth century.

---

[2]John Lonsdale, "The Politics of Conquest in Western Kenya 1894-1908", in Berman and Lonsdale, eds., Unhappy Valley. Book One. State & Class, Chapter 3, pp. 45-74.

This chapter situates the mission evidence within a context of medical knowledge and practice. Identification of diseases and their treatments formed a significant empirical base for documentation of convergence. Previous works have focussed on missions within the context of the debates on the abolition of slavery, specifically, and more generally on the political effects of missionaries on state labour policies and practices.[3] The attempts to control and define medical practice within the Western, scientific framework appeared at the end of the period with the coincident formation of the colonial state, its medical bureaucracies and the commitment to hospital-based medical practice. As stated above, mission records provided the first documentation of indigenous medical practices. The interplay of these with mission medicine, as far as the record permits, will be outlined below.

Issues of gender persist through all periods of this thesis. For the European mission populations, women arrived as wives of medical missionaries, often performing the work of assistants or dispensary 'nurses' though most lacked any formal medical training. In this early period, their voices are silent.

---

[3]The most authoritative work has been Roland Oliver, The Missionary Factor in East Africa, 2nd ed. (London: Longman, 1965). Significant publications on the history of medicine are those by Ann Beck. These focus on the establishment of the Western, scientific model of medical practice. See Beck, A History of the British Medical Administration and Medicine, Tradition and Development. Marc Dawson's research on medicine in Kenya, which includes a critique of the missionary presence, focussed on Central Kenya not the Coast. Dawson, "Socio-

For local populations, medical knowledge first underpinned existing and later established new roles of power and authority. Factors such as literacy, education and access to colonial power become significant indicators of the development and entrenchment of medical elites which become increasingly male through the colonial period.

From research on the kaya periods, particularly for the matrilineal Digo people, we know of particular spiritual roles assigned to community women. How these changed as Africans moved from their kayas to the Coast or how these roles may have been appropriated by others in times of political transformation remains part of unrecorded memory. Thompson's research on Giriama medical practices affirmed that medical knowledge was differentially associated with practitioners according to gender.

> Men generally perceive that their task is to control the greatest threat to life and well-being today in their work against sorcery. They cleanse the victims of sorcery and offer protection against further attacks. Women are mainly concerned with threats to future life, - they deal with reproductive problems, illness of babies....

Her sensitive analysis of the of role transformations of akuzi, female healers in Giriama society, will be described below.[4]

Economic and Epidemiological Change in Kenya".

[4]Sally Gaye Thompson, "Speaking 'Truth' to Power: Divination as a Paradigm for Facilitating Change among Giriama in the Kenyan Hinterland", D. Phil. thesis in Anthropology,

Contexts: The Geographical Landscape

The coastal area of what became the Protectorate and Colony of Kenya presented itself as a lively, heterogenous landscape to its inhabitants and visiting traders and explorers. Coastal Africans since the tenth century AD had participated in trade relations with Muslims from various parts of the neighbouring Arab world. The Portuguese also had enjoyed a short-lived period of colonizing presence in the urban centre of Mombasa but their influence in areas of health and healing was non-existent.

In contrast, numerous Arabic-speaking traders settled on the Coast and their continual reengagement with peoples from Zanzibar to the northern Benadir area of contemporary Somalia has made substantial contributions to language, religious belief, cultural practices and medical knowledge and practice. An examination of contemporary healing practices shows a fusion of "Arabic/Islamic/Qur'anic" medicine and African systems and written evidence does not distinguish between indigenous and post-contact knowledge.[5]

SOAS, University of London, 1990, pp. 55-61.

[5]The term "Unani medicine" may also be applied to Greek medical knowledge transmitted through Arabic and Persian sources. The main text of this Unani medicine is the Canon of Ibn Sina. The authoritative work on the lines of transmission of the medical knowledge of Greece through the Persian Empire to the Arabs remains that of Manfred Ullman, Islamic Medicine, Islamic Surveys II, (Edinburgh: Edinburgh University Press, 1978). See especially Chapter Two, "The Age of the Translations" and Chapter Three, "History of Arabic Medicine", pp. 7-54. Arab medical knowledge also worked back into the

Missionaries recorded what they saw: a humorally-based healing practice and therapeutics informed and augmented by "the Book", not the Christian Bible, but the Qur'an.

The first European missionary to visit this part of East Africa, Johannes Ludwig Krapf, noted in 1844 that when he presented an Arab Atlas to the Sultan of Zanzibar, the Sultan showed Krapf that he had already received a Christian Bible written in Arabic from an American donor.[6] The Qur'an had arrived with the earliest traders around 950 AD, although informants insisted that Qur'anic teaching has been conducted on the islands of Lamu and Zanzibar from 'time immemorial'.[7] When a young student, male or female, completed

---

west. According to Ullman it is the translations of the eleventh and twelfth centuries of Arabic works into Latin that laid the foundations of the 'Arabism' in the medicine of the West. "For long the rule held that he who would be a good doctor must be a good Avicennist.", p. 54. For comparative discussions of how scholars should select terms of "Arab", "Islamic" medicine within Africa, see Ismail H. Abdalla, "Diffusion of Islamic Medicine in Hausaland", in Feierman and Janzen, eds., The Social Basis of Health and Healing, pp. 177-194. Abdalla used "Islamic medicine" with the qualifier that this term includes the medical experience of all peoples of the Islamic world, of Dar al-Islam, so that all writings on medicine and allied sciences in all languages of Dar al-Islam be included.

[6]Church Missionary Society (CMS) Archives, CMS Mission Books, C A5 M1, Krapf's hand-written journal, entry dated March 17, 1844.

[7]Interviews with numerous Qur'anic healers and teachers in Lamu and Mombasa, March 1996, provided consistent testimony to what we know to be historically inaccurate. Informants appeared to be unwilling to speak of a pre-Islamic past.

madhrasa schooling, further Qur'anic study was possible, including specialties in law and medicine.[8]

Although most Muslims at the Coast could not read Arabic in the nineteenth century, texts were available to them to be used as the basis for consultation of medicine 'by the Book' or taratibu in Kiswahili. Beckerleg's research on Swahili medicine provides evidence for the use of these texts up to

---

[8]There appears to be no agreement among historians or Islamicists on distinctions between the term "Islamic medicine" or "Qur'anic medicine". Africanists have used the term "Islamic medicine" to describe all medicine practiced by Muslims. See Abdalla, "Diffusion of Islamic Medicine into Hausaland", 177-94. Abdalla traces a debate within Islam regarding the rights of practice and medical authority, as elite control of medical knowledge began to break down. He cites Ibn Khaldun, the renowned fourteenth century sociologist-historian, and the intellectual transformation of Dar al-Islam [186], a period of a freeze on intellectual freedom to "safeguard the law against unorthodox innovations"[187]. Abdalla states: "By the time Islam made its first inroads into Hausaland, this intellectual traditionalism and conservatism was already three to four centuries old in the lands further north."[188] "From the twelfth century onward, those traditions that dealt with medicine and similar subjects were extracted from the larger body of the hadith, compiled in separate 'medical' books under the title Al-Tibb Al-Nabawi (Medicine of the Prophet) and were hence given wider circulation in Dar al-Islam."[189] The issue of inherited power (baraka inherited through the Sharif line of descendancy from the Prophet) versus acquired power (through education) is also a feature of competition over medical authority on the coast. For a discussion of the transmission and continuity of humoural medicine across Arab, Greek and Indian sources, see Lawrence I. Conrad, "The Arab-Islamic medical tradition", in Lawrence I. Conrad, Michael Neve, Vivian Nutton, Roy Porter and Andrew Wear, The Western Medical Tradition. 800 BC to AD 1800(Cambridge: Cambridge University Press, 1994), Chapter 4, pp. 93-138.

the present.[9] But they form only one part of the range of medical knowledge available at the Coast. Islamicized as well as non-Muslim African peoples had their own environmentally-specific system of disease classification and therapeutics. Unani or Islamic medicine was flexible in its incorporation of domestic flora and fauna to treat local diseases.[10]

The riverine areas of the northern Coast presented very different herbal possibilities from those of the south Coast or of Mombasa Island. Migration of peoples to the Coast from drier areas inland added further knowledge and adaptations, so that what missionaries recorded as in existence in the 1880s on the coast was already a many-layered hybrid of practices and therapeutics determined by two basic factors: conversion to the teachings of Islam, and the environment.

The influence of Islamic knowledge can be seen among the Swahili, who had become Muslim centuries before the arrival of the missionaries, and the

---

[9]Beckerleg, "Maintaining Order, Creating Chaos", Introduction, Chapters 1 and 12.

[10]According to Abdalla, Hausa medicine reflects this same process of assimilation and adaptation. He states that Hausa medicine "...retained many of the characteristics of pre-Islamic therapy, as exemplified by its emphasis on indigenous materia medica, on bori rituals for healing, and the association of pre-Islamic spirits with certain ailments." He sees Hausa medicine as a "...continuum of medical practice and theory, at one pole of which is the Maguzawa traditional pre-Islamic therapy, and at the other, Islamic or Greek medicine." Ismail M. Abdalla, "Islamic Medicine in Hausaland", p. 179.

Wadigo who had converted late by coastal time, at the end of the nineteenth and beginning of the twentieth centuries. The Swahili systems exhibited a much stronger humorally-based, Galenic form of medical knowledge in the north than did the Wadigo south of Mombasa. Islamic teaching reinforced a learned elite among Swahili-speakers, dominated by the Sharif families. In their actual medical practice, using the Qur'an and other medical texts for clinical consultation, members of this elite institutionalized specialization in specific diseases, both spiritually and physiologically determined. The itinerant Swahili healers treated the common problems, practicing what was considered to be a less complex level of herbally-based therapeutics. This distinction is much like the difference between medical practitioners and pharmacists of other medical systems, and, in fact, closely resembles the hierarchy of medical knowledge and specialization in Britain prior to the Medical Registration Act of 1858. There are further parallels in the characteristics of the 'gentleman doctor'. In Britain the elite practitioners were also classically-trained scholars, learned gentlemen. At the Coast, for these elite families, being a good doctor was co-requisite to being a 'good Arab'. Piety and religious knowledge were closely linked to this definition of a 'good Arab'. Theirs was a tradition based on texts, taught at only the best mosques to those whose social standing reflected their acceptance in the eyes of God and their right to practice as Islamic healers. It was a complicated world of medical knowledge linked to and dependent upon social

status reinforced with a specialized training.

As in other parts of the Islamic world, where formal unani, text-based medical knowledge has been found, there co-exists a form of itinerant, lay healing as well. The flexible and inclusive nature of Islamic medicine has been a significant factor in its adoption as a medical system by African communities. In an examination of the labelling or naming of disease and therapeutics one is able to see the extent to which humoural knowledge was combined with Swahili to produce an amalgam which represents both.[11] In contrast, within newly converted communities, such as the Wadigo, medical knowledge continued to be more strongly orally based, herbally directed, and linked with the spiritual and social aspects of healing. Gerlach's extensive study of Digo conceptions of health and disease demonstrates the resilience of medical ideas and practice. Even after the Digo had removed themselves from their kaya

[11]This syncretization is a common experience throughout the Arab-speaking and Islamicized world although the social contexts have determined a variety of medical expressions. For similar comparative studies see: Byron J. Good, Medicine, rationality, and experience (Cambridge: Cambridge University Press, 1994), Chapter 4, "Semiotics and the study of medical reality", pp. 88-115. Andras Zempleni's comments on Senegal offer a competing view: "...in Islamic black Afica, for example Senegal, where I once worked among Moslem populations, pre-Islamic traditional therapies were sharply distinguishable from Islamic therapies by an opposition. It appears that the pre-Islamic therapies are always based on a process that consists in moving from the 'unnamed' to the 'named', whereas the Islamic therapies, by contrast, are based on the idea of passage from the 'polluted' to the 'pure'." n.a. "Issues and Findings", Social Science and Medicine (Vol. 15B), p. 429.

centres, and after their conversion to Islam, categories of disease causation continued to include land/kaya-based spirits or shaytani, and treatments included waganga who specialize in shaytani diseases; waganga who specialize in Qur'anic healing through the use of amulets; or those whose treatments demand a curing of the social group or extended family as well as the 'patient' bearing the disease.[12]

David Parkin has identified three ecological zones as constituting the coastal area of Kenya: the coastal strip, the central agricultural zone, and the western cattle and livestock zone.[13] The coastal strip came under the suzerainty of the Sultan of Zanzibar in the 1830s and was populated by Swahili, Arabs and Mijikenda. This is mainly a fishing and agricultural area, with wooded grassland and relatively high rainfall. The second zone, less populated, is composed of mixed forest and wooded grassland with large areas of coconut

---

[12]Mganga (n), (pl. waganga):" a native doctor, medicine man". The root 'ganga'(v.) means" to bind up, fasten together, splice, mend (what is injured or broken); save, get out of a difficulty, set free from a charm". Uganga (n.), Uganguzi, is defined as "(1) art (profession, fee) of a native doctor, doctoring, healing, surgical and medical aid--including use of charms." A Standard Swahili-English Dictionary(founded on Madan's Swahili-English Dictionary) (Nairobi: Oxford University Press, 1995), first edition 1939. L.P. Gerlach, "Some Basic Digo Conceptions of Health and Disease", Conference Paper presented to the "One-Day Symposium on Attitudes to Health and Disease among Some East African Tribes", East African Institute of Social Research, Makerere College, Kampala , Uganda, December 1959, pp. 9-34. Mimeograph.

[13]David Parkin, Sacred Void (Cambridge: Cambridge

palm production. In the mid-nineteenth century the southern part was called Weruni, the two northern areas were Godoma and Gallana and the western one was called Biryaa. The hinterland cattle zone with a much lower population density falls outside the scope of this study.[14] It is within the coastal strip that most contact historically took place and indeed continues so today. Successive migrations to the area through the nineteenth century were particularly due to recurring famine.

The disease-famine-epidemic cycles of eastern Africa are now well documented and understood as is the importance of the links between populations, environment and disease.[15] The chronology of epidemiological challenges for the Coast is tied intrinsically through trade and migration to that of the eastern Africa region. Famines recorded as early as 1837, both preceded and followed periods of drought. The narrative is unrelenting. The most

---

University Press, 1991), Appendix I, pp. 232-35.

[14] Parkin gives the following population density figures based on the 1962 census of 17.5 for cattle area, 85 for the central coastal areas. For 1979 the figures the relationship between the cattle zone and the coastal strip was 29 to one. Parkin, Sacred Void, pp. 234-35.

[15]This demographic lineage began with James Christie's nineteenth century research on cholera. Christie mapped the incidence of cholera throughout the region demonstrating significantly that cholera sites followed trade and migration routes into East Africa. James Christie, Cholera Epidemics in East Africa; an account of the several diffusions of the disease in that country from 1821 till 1872, with an outline of the geography, ethnology, and trade connections of the regions

significant drought years from 1844-1907 were Nzala ya Mwakisenge, 1883-85, followed by a smallpox epidemic; Mkufu, 1889-90, followed by a rinderpest epidemic; Bom-Bom, 1894-95, followed by locusts and, for this period directly, Magunia (its name derives from the word for gunny sacks [gunia/magunia] which held the grain, imported from India, as famine relief by the state and mission societies), 1898-1900, considered to be the worst famine in the coastal region, affecting more than two million people throughout East Africa. It was accompanied by a smallpox epidemic, dysentery and a jiggers plague, together killing more than 40,000 people.

Local strategies to survive periods of drought and famine included planting new crops and migration, particularly for the Mijikenda peoples. The poor diet of the famine years certainly exacerbated local suffering caused by the endemic presence of bilharzia, hookworm and malaria.[16]

Written records are most abundant for the middle of the coastal strip and the the areas bordering Mombasa Island, for it is here that the most successful

---

through which the epidemics passed (London: Macmillan, 1876).

[16]Major works which establish links between populations, environment and disease include: James L. Giblin, The Politics of Environmental Control in Northeastern Tanzania, 1840-1940 (Philadelphia: Univ. of Pennsylvania Press, 1992); Kjekshus, Ecology Control and Economic Development; Turshen, The Political Ecology of Disease; and Thomas J. Herlehy, "Historical Dimensions of the Food Crisis in Africa: Surviving Famines Along the Kenya Coast, 1880-1980", Working Paper No. 87, African Studies Centre, Boston University, 1984.

mission stations were placed. Working back in time from contemporary anthropological writings, it is possible to reconstruct some of the more northern peoples' medical systems. For Giriama, this period is called the kaya time, when Giriama lived among themselves, in their own villages, according to customary laws under the direction of the elders of the kaya, their sacred spaces. According to Thompson, the efficacy of medicines strongly depended on a process of animating the materia medica

> Publicly uttered words have witnesses guaranteeing their acceptability....The knowledge of Giriama medicine can be traded, exchanged or given freely among people, and between spirits and people. It is regarded as property. The commoditisation of this knowledge has facilitated key transformations in the use of medicines since the days of kaya occupation. Most medicines which are today claimed to be 'from kaya' were used there in public and communal ways.[17]

For Digo people south of Mombasa, there is very little early ethnographic evidence. According to Gerlach, in kaya times each matrilineage had it own kifudu hut, a place to house sacred objects, including powerful medicines which would ensure fertility and continuity of the lineage. A second type of hut was the mamba, used to store other types of root and herb medicines. During the period of Gerlach's study (1950s), kifudu and mamba huts continued to be built to house medicines, although the links to a specific matrilineage were no longer

---

[17]Thompson, "Speaking 'Truth' to Power", p. 50.

as important. Digo believe that certain illnesses, especially sterility, and ailments of vital organs were caused by being in disharmony with kifudu and mamba forces. This disharmony could also increase the difficulty of illnesses, including impairing effective treatment. Specific rituals would restore harmony. Preventive acts involved observing Islamic injunctions such as prayer, fasting, and alms-giving. In this way walimu, or Qur'anic teachers, became the specialists in these rituals.[18]

Possibilities of Convergence: Mission Medicine, Disease Narratives and Treatments

Historians have used mission records to discover how particular European communities interacted with African peoples or how the presence of missionaries affected the relationship between African peoples and the colonial state. Both the questions and the contexts explored in these accounts distanced narratives of missionary communities from those indigenous narratives recorded by ethnographers.[19] More recent studies of the colonial period have taken a second look at missionary records to investigate how missionaries saw

[18]Gerlach, "Some Basic Digo Conceptions of Health and Disease", pp. 21-23.

[19]Roland Oliver's pioneering study on East Africa reflects this separation. See: Oliver, The Missionary Factor in East Africa.

themselves in their social environment, making the missionaries both subject and object of the texts. They have challenged the previous works, which explained a knowledge and power relationship that was missionary-controlled, to present a more nuanced, dialectical relationship, in which the forms of the exchange were mediated by both sides.[20] This study agrees with the position that both parties of the African missionary relationship consciously worked within self-generated agendas and mutually-defined roles, although the question of power in that relationship became, over time, more solidly tied to those allied with the colonial state. The contribution of this study is an examination of another layer of knowledge and power, of indigenous medical systems seen through the lens of missionary medicine. What constitutes mission medicine changes in this period in ways which reflect the larger shifts in European medical knowledge and practice. Although this chapter shows the medical missionary at his most adaptive, there were limits to his flexibility. The mission doctor, as physician of the 'double cure', of body and soul, never relinquished his position of medical and spritual authority. And yet missionaries included extensive descriptions of African medical practice as medical and called some African medicine-men "doctors". These momentary glimpses of recognition of

---

[20]Jean Comaroff, Body of Power and Terence O. Ranger, "Godly Medicine: The Ambiguities of Medical Mission in Southeastern Tanzania, 1900-1945", in Feierman and Janzen, eds., Social Basis of Health and Healing, pp. 256-82.

possessed by African medicine-men in this period would be severely mediated by the colonial state's commitment to a scientific model of health care and its embodiment within the hospital institutions after 1908. Non-scientific medical practice came to be characterized increasingly as superstition and quackery.

As already stated, diseases and their treatment were first recorded by Krapf in the 1840s.[22] Without medical training, Krapf noted what he saw (as opposed to what practitioners would have diagnosed from presenting symptoms): dermatological diseases, fevers, particularly malaria, and 'incontinence' (diarrhoea). Although the intent of his journals was to describe the political and economic relationships of Mombasa and the hinterland, his medical information provides an initial description of prevalent diseases. The year of his arrival was not a famine or drought period (the previous major famine for eastern Africa was 1837-38), thus what Krapf observed would have been the 'normal' rather than crisis diseases for the populations of that region.

When Krapf arrived in Mombasa in March 1844, he was approached by Rashid, a friend of the governor "...who came in quest of physic for one of his

---

[22]Krapf's hand-written journal entries and letters home to the Church Missionary Society's various committees serve as the principal evidence for this section. Krapf's journals and correpondence can be found in the CMS Mission Books, C AF M1-M6. M1 covers the years 1842-46. See also: J.L. Krapf, Travels and Missionary Labours during an Eighteen Years' Residence in Eastern Africa (London: 1968, first published, 1860) and A Dictionary of the Suahili Language, Compiled by the Reverend Dr. J.L. Krapf (London: 1882).

[the governor's] sons. I declared that I was no physician & had picked up the little medical knowledge I possessed, merely from books & some practice in Abyssinia..." Krapf noted at the entrance to the fort two young boys, about six years of age, who were

> ...as white as that of any European child of that age...owing to some kind of disease. The poor creatures were covered with sores & dirt in such a manner that they could hardly open their eyes....their parents, who are Wonicas, had run away & left them to their own selves....After I had seen the patient whose case was beyond my medical knowledge....[23]

It is significant that Krapf was approached for medical assistance. This was a period of shared knowledge and therapies. Coastal peoples were used to traders arriving with many types of goods, including medicines, for sale. Whereas this early contact with the missionaries and the requests for 'physic' was lauded by mission administrators from the metropole as indigenous recognition of the superiority of the Bible and European knowledge, the evidence suggests something quite different. Missionaries were viewed as immigrants and traders. As coastal peoples approached a variety of waganga for therapeutic advice they extended this search to include the missionaries.

---

[23]CMS Mission Book, C A5 M1, March 14, 1844. Later diagnoses would have considered these symptoms of severe malnutrition, perhaps of pellagra. The 'sores and dirt' were reported frequently throughout the nineteenth and twentieth century medical records as ulcers or ulcerated sores, some of which erupted into gangrenous conditions.

The Coast of Kenya in this period was not unlike parts of the United States in the nineteenth century before the establishment of hospitals. Therapeutics and advice were dispensed by the 'quacks' in the United States in much the same manner as by African itinerant local healers. It was not laboratory medical science which underwrote these systems of medical knowledge but the agreement that disease and therapies were often environmentally caused and treated. Diseases were seen to be specific to particular locations and remedies existed within that same environment to treat the diseases. In addition, client relationships which involved an exchange of goods or money formed the framework of these treatment systems.[24]

Krapf wrote to the CMS Home Committee on August 13, 1844 to request "a stock of good, fresh and various medicines" for the East Africa Mission. "The variety of medicines (applicable to various diseases which may occure[sic]) is the principal thing; the quantity of each is of less importance, except in medicine which are frequently required as antidotes against fever in its various ramifications...The freshness of physic is also another very weighty

[24]For a history of unorthodox practitioners in the United States see: James Harvey Young, Medical Messiahs: A Social History of Health Quackery in Twentieth-Century America (Princeton: Yale University Press, 1967); and for a comparative history of the related topic of specialization in the United States and Great Britain, see: Jeffrey Berlant, Profession and Monopoly (Berkeley: University of Califronia Press, 1975.

requisite." His request was more of an order for consumer goods than one which rested on medical knowledge. Like other missionaries, Krapf was a nineteenth century religious trader with new goods to display. The medicines may have been commodities but the diseases had touched him personally. The gravestones of his wife and child, both of whom died of 'coastal fever', are the oldest European gravestones at the Coast.

Krapf made Mombasa his headquarters with frequent visits to Rabai K'nu and Rabai Mp'ya, both Wanyika areas. He was joined by Rev. John Rebmann, also a native of Wurtenberg and a student from the Basel Seminary, who had completed his theological training and received ordination in England. Krapf in the 1850s began work in earnest on the mainland and settled at Rabai Mp'ya. Both Krapf and Rebmann made long journeys into the mainland as far west as Kilima-Njaro and south along the coast to Cape Delgado. Krapf and Rebmann spent much time on language, compiling manuals and vocabularies as well as translating portions of Scripture.[25] It is from Krapf that we learn that a mganga (pl. waganga) is a medicine man who uses magic. The definition is significant. Krapf was able to recognize both aspects of African medical practice: the diagnosis and treatment of environmentally-caused diseases and the equally potent treatment of spiritually-caused illness.

---

[25] n.a., The East Africa Mission (London: Church Missionary Society), 1905, pp. 16-21.

Reverend John James Erhardt's papers have provided evidence of both medical difficulties on the Coast and hints of elite collaboration.[26] Erhardt arrived in June 1849 with another missionary who died of fever soon after arrival. There appears to have been a form of elite collaboration during this first period of missionary-waganga contact. Erhardt informed the Home Committee, in a report on the "Distribution of Medicine" that medical knowledge was important to his work. He wrote,

> Among our people here medicine is sought for with as much activity as among the Mahomedans....Every illness, even the slightest indisposition is attributed to the agency of some evil spirit. For this belief the poor people are daily stengthened by the wicked Suahele [Swahili] and their own Waganga. The first is cunning enough to deceive with his amulets and repetitions of arab sentences, as long as he is well paid for it...the Waganga are men, who have generally aspired a little above their countrymen.[27]

What is most interesting about Erhardt's report is not only that the waganga engaged in both healing with plants as well as with power over the spirits, but that the waganga had a very clear understanding of their medical role and their society's expectations. "[T]hey admit when talking with us that they were deceiving the people with all their amulets, form of prayers, mysterious signs, etc. and that they adapted them merely for the sake of gain...." The waganga were very conscious of their clients' connections between spirits and disease

---

[26] C A5/09/1-17 Erhardt, Rev. John James. Original Papers. Letter to Rev. Venn, writing from Rabbai, Sept. 24, 1850.

[27] Ibid.

and thus treated both accordingly. Erhardt stated that people went to their neighbourhood waganga and then came to the Msungu to try the European's art.[28] He was frustrated with attempts to explain to people that sickness was a result of natural causes, not spirits, or from their 'bad way of living'. He was disheartened because people "don't pay attention to directions with the physic given" and concluded "...that medical Knowledge has not turned out so important for the natives, for our missionary influence among the people as we might have wished." To enter into the social and thus spiritual presentation of African medical healing was anathema to Erhardt.

> **If we would indeed feel inclined imitating the Suaheli and native Waganga; to make strange mysterious signs over the patients; pretending to drive out devils etc. we could ring a great stir among our Wanika, but how can we do such works of darkness?[29]**

This ultimate inability of mission medicine to align itself with local systems that included a spiritual dimension was only highlighted by the opposite position presented by Islam. Erhardt, as stated above, was willing to draw from African medical practice that which he recognized as 'doctoring'. But to have extended this acknowledgement to the realm of the 'double cure' was not possible. The

---

[28]Mzungu: a European; pl. wazungu, perhaps from uzungu: strangeness, novelty. A Standard Swahili-Engligh Dictionary, under the direction of Frederick Johnson (founded on Madan's Swahili-English Dictionary) (Nairobi: Oxford University Press, 1995), first edition, 1939.

[29]C A5/09/1-17 Erhardt, ibid.

Christian domain had to remain separate and superior. Not so with Islam. With its rich heritage of book medicine, its inclusion of bush healing and learning, and its intense commitment to the spiritual aspects of disease causation and treatment, Islamic medicine was able to maintain a medical primacy over popular descriptions and reproduction of health. It would be illogical and self-defeating for Christian missionaries to do the same. Their theological framework did not permit inclusion of animist beliefs.

Erhardt concluded his report with an assessment of the health of the station. He stated that from the beginning of his practice in August 1849 to September 1850 he had treated 115 people for physic, most from the Rabbai community. The numbers were not significant given the population base but were enough to satisfy the home committees. Erhardt, in the manner of many medical officers through the colonial period, recognized the need to tread a difficult line of both trying to portray the health problems that were presented to missionaries as serious and in need of medicines while at the same time not undermining the continuance of the mission stations themselves by demanding too much financial support. He stated, "The people at this place are a sickly race, owing to their way of living, being Mahomedans, and to the prevalence of fever." The phrase "being Mahomedans" would have underscored the importance of the mission's presence as a site of conversion. He added the 'most general complaints' were "derangement of the digestive organs and by

the males a bloody discharge from the urethra generally unaccompanied with pain." His conclusion voiced the contradictions of providing relief from suffering and the need to treat the soul,. "...[W]hen hearts are melted down with bodily sufferings, gospel can be brought."[30]

The underlying tensions of this association of medical treatments of the body with the mission project of converting the soul and the inability of medical missionaries to separate these sites of treatment were outlined in a letter to Rev. H. Wright, Frere Town, on October 10, 1878. The writer, George David, reported on his work among the Giriama people up the coast.

> ...[T]he fame of the skilfulness of the doctors ...is dearly loved by the Africans, and forms a great pitch of attraction in the minds of those who are tormented by various kinds of sicknesses. Thus, whenever a doctor is heard of having being settled in the Mission field, to do good to the sick both of soul and body, the latter word body is so sweet to them, that it forms a note of sweet music to them, and thrills their hearts for joy, and causes them to cripple from village to village to go to the skilful doctor; whereas the former word soul, for which the Physician of Physicians came to cure, to them is nothing but gloomy.[31]

---

[30] Ibid., Letter sent to Rev. H. Venn, Honourable Secretary of the Church Missionary Society.

[31] CMS Mission Book 5, 1877-78, East Africa Mission. in C A5/06. Printed letter.

Urban Contexts: The Opening of Frere Town

Thus far, the evidence has focussed on rural experiences and contacts of medical missionaries. With the opening in 1873 of Frere Town as the CMS Mission for runaway slaves, one mile by creek from Mombasa, possibilities for medical contacts between Islamic healers and missionaries, and between migrants living in Mombasa and missionaries were greatly expanded. [32] The mission site was extraordinarily important to the establishment of a CMS presence on the Coast. Situated so close to the largest urban port north of Zanzibar, Frere Town had access to large numbers of coast populations.

The mission was first headed by Rev. W.S. Price, an experienced missionary, formerly in charge of the Nasik Asylum in India. He was sent out with some 200 African Christians, freed slaves formally entrusted to his care

---

[32] Frere Town was named after Sir Bartle Frere, who was sent in 1872 on a special mission to Zanzibar to negotiate a treaty to end slavery on the coast of East Africa, following a Parliamentary Commission appointed in 1871 charged with collecting and presenting evidence on the East African slave trade. He urged the C.M.S. administration in England to establish a settlement at Mombasa for the reception of liberated slaves. A large fund was raised to enable the Society to plan this development. The land was bought in 1874 and named Frere Town. The first inhabitants under Rev. W.S. Price were the 'Nasik boys' brought by Rev. Price from Livingstone's mission station at Nasik and joined by some 150 other Africans brought from Bombay, Rev. Price's 'African proteges'. C.M.S. Missions in Africa (London: Church Missionary Society, 1913), p. 12.

[referred to as "Bombay Africans" in later literature[33]]. These people formed the nucleus of the colony with the addition of some 450 rescued slaves from British cruisers. Other freed slave stations were established inland at Rabai (Kisulutini), and further north at Mwaiba (Giriama country) and Sagalla in Taita country. These latter stations were established for Africans from the immediate area, whereas Frere Town was designated for slaves from all over eastern Africa.[34]

This mission might never have achieved the popularity it did had it not been for the famine of 1884, during which many people came to Frere Town for food.

> Husbands had lost their wives from starvation, and wives their husbands; others had fled their country to escape capture from the Swahilis...Our greatest difficulty was to support them, and at the same time to make them understand that the relief would not be permanent...I judged it better not to employ them and then pay them in food, otherwise it would have been more difficult to send them back to their country when the rains came; Wa-Digo and Wa-Nyika, who were unable to return, I have been able to settle on uncultivated ground and provide them for a time with food and seed.....[35]

---

[33]See Joseph E. Harris, The African Presence in Asia (Evanston: University of Illinois Press, 1971) on the African diaspora in Asia.

[34]n.a., The Mombasa Mission, East Africa, with an Account of the Church Missionary Society's Work among the Freed Slaves at Frere Town (London: Church Missionary House), 1885. pp. 5-7.

[35]The Mombasa Mission, pp. 12-13.

They were joined by approximately 240 Wa-Zaramo, chiefly "poor natives [who] sold themselves for food", rescued by H.M.S. Osprey and brought to Frere Town. According to Rev. J.W. Handford in his December report, the famine was the worst known for thirty years.

Perhaps more because of their ability to provide famine relief than medical efficacy, medical missionaries had, by the twentieth century, taken their place as one of the local systems of therapy. Africans and Arabs had allocated these doctors specialty areas, as noted below. Although missions would have wanted Africans to be exclusively dependent on their medical services, this was not the reality. Most missionaries possessed only limited medical knowledge.

> You will be glad to hear that my little knowledge of medicine has already proved to be very useful. On an average about twenty people come daily for medicine, their complaints are mostly very bad ulcers also other diseases which I will not mention. I treat all, warning certain cases if they do the like again...the other day thirty six came for treatment, when I had finished I was thoroughly tired...I commence speaking to the people about the disease common to us all and the ...great Physician....[36]

The "unmentionable" was most likely a form of sexually transmitted disease. Other missionaries complained of being "used" by Arabs who simply came back again and again for similar treatment. The mission doctors were correct. They were being used by Arabs who recognized that mission doctors could treat

---

[36]C A5/01-051-8, 1873-74, Letter from Mombasa, Feb. 7,

particular diseases efficaciously. What the records show is a certain stability in the medical relationship between local populations and mission doctors. The missions had come to be recognized as an alternative place for treatment and the site of choice for particular diseases.

Institutionalized training was not organized until the 1930s, and will be discussed in the following chapters. But the attempt to appropriate Africans into a Western model of medicine began in the settled Christian missions in the 1870s. The decision to train male Africans to be medical assistants was not a result of policy direction from the metropole but a response to local needs, particularly the missionaries' desire to extend their services outside the stations, and insufficient European staff to carry out this task.

Medical work included itinerant health care. In theory, a local person had the language skills to communicate with patients and the cultural understanding to compete with local healers. Dr. Forster's first African medical assistant was James Ainsworth, referred to as "native doctor". Ainsworth was trained by Dr. Forster and acted as dispenser for the area. Dr. Forster applauded Ainsworth's attitude and abilities: "He takes the deepest interest in his work, and dispenses, not only for our own people, but also for Rabai, Taita, Mwaeba, and numerous strangers from Mombasa and surrounding districts."[37]

1874, from Rev. William Bartlett to Mr. Wright.

[37]The Mombasa Mission, p. 11.

Dr. Forster did not comment on the range of languages spoken by the Frere Town community nor the cultural differences that must have been evidenced at the mission station. We can perhaps assume that James Ainsworth surmounted both of these difficulties. Training extended to only one other African resident, James Asswara, "a faithful friend, a conscientious Christian, and an intelligent learner...Two or three years of sound medical education in India or England would make him a very useful man." Asswara, a freed slave probably from the southern Coast, spoke 'imperfect' Kiswahili and English; thus Forster recommended he receive language training.

When asked about female staff, Forster advised against sending out a nurse 'trained to the rigid discipline of an English hospital, lest being sickened and discouraged she should quickly tire of the work."[38] African male assistants were designated to fill these positions.

It is in this significant area of medical training that the experiences of African populations in different colonies need to be compared. Both Uganda and Kenya had similar medical mission beginnings as colonies with European missionary doctors who sought to work with their African counterparts and in time hoped to supplant them both religiously and scientifically. The story of the Coast is strongly affected, however, by the immigration of indentured Indian

---

[38] Ibid.

medical labour. Initially brought for service to Railway labourers between 1900 and 1902, many Indians remained after their term(s) of service for the Railway were over; by the time the state was ready to establish a supervised medical service, the assistants to medical officials were Indians not Africans. In Uganda there was an incremental growth in the development and orthodoxy of the Western model of medicine and of medical training. As in Kenya, medical missionaries realized they did not have the staff to meet the needs of Africans. But in Uganda, they trained Africans as medical assistants and then, as medical doctors. As will be noted in later chapters, it was the Ugandan Africans, by virtue of their education and medical training, who dominated medical practice in East Africa.[39]

In Kenya, these first twenty-five years of training of Africans by medical missionaries, however minimal, gradually gave way as missionaries and the Colonial State, in its early years, abdicated their responsibility for training Africans. Relations between Indian and British-trained practitioners, as well as the training of African men and women, form a major theme of the following chapter.

---

[39]Evidence from the record has been substantiated by the research of John Iliffe, who will submit his manuscript on medical doctors of East Africa for publication shortly. Conversations with John Iliffe, Nairobi, 1995 and 1996.

The Medical Landscape: Mission and Indigenous Medical Practices

Dr. Forster's quarterly reports for 1875-76, following the famine year, provided clear evidence for the existence of a very popular Swahili system of medicine.[40] His reports will be discussed in chronological order as they mirror the increasing complexity of populations and disease that marks this period for Mombasa and the vicinity.

Forster worked not only in Frere Town itself but in the city of Mombasa. He established his free dispensary on July 10, 1875, open daily from 9 o'clock to noon, and soon began to make home visits. It was in this urban locale that he came into competition with resident healers and his reports documented a lively medical trade on the island of Mombasa. He stated,

> There exists...a decided feeling (not so much a popular, as a class one) on behalf of the Swahili Medicine-Man: this is shown by the fact that medicines received have not been taken by the recipient owing to the persuasion of the patients' friends who have substituted Swahili remedies; again persons do frequently visit us for ailments which are very true ones, but these visits are more visits of curiousity and inquisitiveness...these cases seldom turn up a second time..the Swahili waganga still identified with the peoples' woes: the higher class Arabs, too seem shy of patronising our new ways.[41]

The range of diseases he documented was also greatly expanded from

---

[40]C A5/0 10/6-8 Handwritten quarterly reports of Edward Wood Forster, medical missionary, Mombasa 1875-76, addressed to the Committee of the CMS.

[41]Ibid.

that of earlier rurally-based practitioners. Mombasa was a multi-faceted city in the 1870s through to 1900. The intense migration of Mijikenda and Digo labourers added to the Arab clans and Swahili who were long-time Mombasans. The networks described by Willis as of fundamental importance to survival in Mombasa--clan, family, allegiance to a patron--attested to the complex social differentiation of Mombasa's populations and those of the surrounding area.[42] New social networks became layered with medical choices, increasing therapeutic options. Dr. Forster faced a situation of increased and adamant competition.[43]

He attended aproximately 563 cases from July to September 1876 with a range of diseases of the ear,"... digestive system entozoa, eye, fevers, general diseases [abscesses, hernia, anaemia, oedema, ulcers] and Genito-Urinary system difficulties [acute prostatisis, gonorrhea, constitutional syphilis] respiratory and skin scabies." Forster firmly declared that his scientific treatment was superior to local methods as "...many diseases which under the empirical treatment of native Medicine men would have become chronic...if not

---

[42]See Willis, Mombasa, the Swahili, Chapter 2, "Clients and Slaves in the Nineteenth Century" and Chapter 4, "Casual Labour and the Swahili in Mombasa" for a highly-textured account of Mombasa populations through this period.

[43]For the importance of networks, the works of Cooper provide a complementary picture to that of Willis in the area of labour relations. See Cooper, Plantation Slavery and From Slaves to Squatters.

before long fatal to the patient."[44] And yet it was not clear that the medical clients of Mombasa and vicinity fully shared his convictions of scientific superiority.

The most interesting sections of his report were those in which he provided descriptions of modes of treatment employed by Swahili medicine-men. On this point Dr. Forster made clear distinctions between what the medicine men actually did and the perceptions held by their patients (Forster's term) and clients (waganga term) about what a mganga should do. He pointed out that in the popular mind waganga knowledge was "generally connected...with some power to be dreaded rather than with some benign personal divinity." He continued, "The waganga are a class of men separate and distinct: a candidate for admission to their corporation must pay a sum of money: having done so he is initiated into the secrets of the company, is taught the use of various herbs, roots, external applications, and finally the charms which are used as the last resources."[45] He pointed out that unsuccessful advice was not compensated! The irony of his observations was not self-evident: African clients paid only for successful treatments. They employed a variety of practitioners sometimes successively for their ailments. Efficacy was important; appearing to be efficacious was the challenge.

---

[44]C A5/O 10/6-8. Forster, ibid.

[45]Ibid.

Dr. Forster narrated a rich record of specific remedies used by Swahili medicine men: cauterization, especialy for chest complaints; wood ashes for cases of heartburn and sourness or acidity; sulphur mixed with water or oil applied externally in skin diseases; wood from Madagascar called 'lirva' applied externally for prickly heat; bluestone applied for some forms of ulcers. The patient was also prohibited from eating meat or fish in the case of ulcers. Blood-letting, free cutaneous incisions, was a frequent practice especially as treatment for headaches and opthalmics. Purgative medicines were rarely administered. "Patients suffering from fever, in whom the physical conditions have abated, are directed by the waganga to bathe in hot water; an advisable plan, which, even in England, might be more frequently carried out." He then described bone setting, the use of splints and employment of roots of various plants and trees applied externally or infused and given internally. A most interesting conclusion to the first report was: "When all other remedies fail, or when the patient's temper fails, or the powers of nature fail, and nature's final hour seems imminent, then charms and magic are resorted to."[46] In other words, after all that is medically possible has been tried, the "psychiatrists" and "priests" were called in.

There were many waganga spoken of in other reports whose only

---

[46]Ibid.

medical therapy was based on charms and amulets but what Dr. Forster portrayed was a series of therapies much more textured. When nothing more could be done, the patient was given over to the spirits, and the spiritual, and often then for African societies to the larger group or community. This social aspect of healing remained invisible to the medical missionaries. Whether they were unable to recognize healing in the community arena or whether they were never exposed to this level of therapeutic treatment remains an unanswered question.

Dr. Forster's responsibilities extended over time to include maintaining the mission station at Frere Town, the dispensaries of Mombasa and the mission stations approximately 50 kilometeres inland. In his second quarterly report, Dr. Forster reported on the influx of liberated slaves and their poor health. For the first time in the record, psychological ailments were introduced: "...melancholy, mental dejection...." Women were mentioned as suffering from "melancholia".

A major concern was paediatric disease due to malnutrition. Mesenteric diseases of children were probably due to "inappropriate, unwholesome and insufficient food". "We are at present examining into the dietaries, wherein there seems room for great improvement....The staple foods of the people are rice, muhayo and vihazi, or sweet-potatoes, also dried shark, the fruits are few and very inferior by reason of no proper cultivation owing to the slave customs,

very little flesh meat is used...."[47] There were no references to treatment or specific dietary recommendations.

Adult African and Arab male populations appeared to increase their use of mission medical personnel. They placed mission doctors in the position of supplier of treatment almost 'on demand'.

> I still have to deplore the number of cases of gonorrhea, syphilitic diseases, and impotency; aphrodisiacs are often inquired for.
>
> On one occasion having gently chided an elderly Arab for his sensual desires he answered that it 'was well for youth to speak virtuously of such things, but virile power and desire was the privilege of age.'

Another client impatiently stated, "Finish, finish quickly, I have come for medicine, not to talk."[48]

An area in which mission doctors might have won popular support was minor surgery. Willing but constrained by lack of facilities, this specialization was not established until the end of the period. Dr. Forster reluctantly refrained from many surgical cases "because I know that the cases would probably not be successful owing to the fact that the native dwellings are a mass of filth and discomfort, and I have no special house or hospital to place the patients in after

---

[47] C A5/0, 10-6-8. Quarterly Report of Medical Mission Work in Mombasa and Frere Town. Edward Wood Forster, MRCS, England, Mombasa December 1875.

[48] Ibid.

an operation....."[49]

Dr. Forster's third report, dated 30 April 1876, recorded visits by patients from Pangani and Pemba, approximately 200 kilometres to the south of Mombasa, as well as Wanika and Wakamba from nearby. The bulk of his patients came from Mombasa (652) and the freed slaves' colony in Frere Town. The tone of his report was wearied: the hospital in Mzizima was being built without his consultation, and he deplored a lack of independence and power to select or dismiss servants and assistants.

Conditions of freed coastal slaves dominated the mission reports into the 1900s.The medical men who replaced Dr. Forster no longer reported in his commanding and descriptive manner. It is unclear why the following documents were written so tersely, with no information on the urban populations.[50] The records' concentration on Frere Town perhaps reflects mission doctors reluctance to travel to Mombasa or the bush. In contrast, evidence did discuss

---

[49]Ibid.

[50]It is possible that the more descriptive reports were actually sent directly to the CMS Medical Committee from this period through to the 1940s. Unfortunately, the extensive records of the CMS Medical Committee are presently unavailable for consultation. CMS archives have very recently been transferred from Partnership House, London to the University of Birmingham Library. The University will make these records available following the construction of a library addition. The hand-list for these records has been made available to this researcher. The records will provide an intensely rich resource for comparative medical studies within the British Empire.

the increased layering of medical staff within Frere Town. Those Bombay Africans, freed slaves who were schooled in India and then brought into the Coast missions, became assistant teachers and medical attendants.[51] Medical mission work among the Swahili peoples, outside the station, was much less intense. Dr. Baxter complained, in 1881, that "the people are too much attached to their charms" to transfer allegiance to mission medical men.

There is another possibility for the decrease in medical contact, perhaps directed by the local populations. The reputation of medical missionaries was severely challenged by the smallpox epidemic of February 1882. Significant numbers of deaths of African servants were reported and milder forms of smallpox among missionaries. This scare prompted a "list of urgent wants for the East African Mission" of two young missionaries, a schoolmaster, a medical man and medicines. The request for a medical man continued, unresolved, in the record through January 1883. The problems could have been internal as conflicting needs were presented by Mr. H.K. Binns, writing from Frere Town in August 1882 when he referred to Dr. Praeger, "...a good doctor. Should he return, there will be little for him to do in his medical capacity only. The doctor

---

[51]"Three boys to be selected and instructed to be medical assistants." From Minutes of Finance Committee of Oct. 7, 1881, as part of a letter from Mr. Taylor requesting a microscope for medical purposes. G3 A5/P1. CMS Precis Books, Group III East Africa Mission, 1881, No. 2.

and lay superintendent, or doctor and schoolmaster, should be combined."[52] Mr. Binns was not a medical practitioner but had been assigned certain medical duties in the absence of a qualified doctor.

African mission populations remained stable in size through this period only to be reduced with the abolition of slavery in 1907. Numbers remained higher in the rural areas than in the city as Frere Town had 297 African Christians and Rabai, 700, in March 1883. (The numbers could be deceptive. In Frere Town itself the count was exact; in the rural stations, such as Rabai, the numbers were approximate.) In his monthly letters, Binns continued to request a man with knowledge of medicine. He "has come to the conclusion that a Medical Mission is the one best suited to win the people."[53] He reported that they were busy reading Dr. Christie's new book on East African illness![54]

Mission correspondence into the twentieth century was marked by a heated discussion between the London headquarters and the Coast missions regarding who was allowed to make medical decisions on the Coast. Certified medical men opposed the granting of certificated, semi-official status to local missionaries, and reports of abuse of Africans was seen to reflect the lower

---

[52] Ibid., p. 2.

[53] Ibid.

[54] Christie, Cholera Epidemics in East Africa.

class of these semi-officials.[55]

Further up the Coast another missionary group, the United Free Methodist Church, established their stations. Like the stations themselves, records produced were not as prolific as those of the CMS. What evidence was made public was edited, sanitized and published in the journal of the United Free Methodist Church. Two prominent missionaries were Thomas Wakefield and Charles New, who evangelized among the Nyika (Mijikenda) and Galla peoples. New, born in 1840, began his work in Africa in Sierra Leone in 1859 but, inspired by Krapf, set out for East Africa in 1862 with three other missionaries. The publication of Charles New's travel notes in 1873 provide early northern Coast mission evidence.[56] Thomas Wakefield remained on the Coast for over thirty years. He wrote a column in The Missionary Echo entitled 'East Africa' from 1894 until his death in 1905, with no successor to provide information on the northern Coast.

---

[55] Mr. W.E. Taylor, Frere Town, May 1887 encloses correspondence with Mr. Binns on the subject of alleged 'cruelty' to a boy named P. Wright. A handwritten note on another page of recommendations, handwritten, states: "To be dropped." Mr Taylor in a letter dated July 6 recommends James Ainsworth, employed at the Dispensary, for medical training in England. The request was not approved. Precis Books. Group III East Africa Mission, Precis Book 2.

[56] Charles New. Life, Wanderings, and Labours in Eastern Africa, Third Edition (London: Frank Cass & Co. Ltd., 1971).

New, like many of his contemporaries, was interested in slavery, the slave trade and the spread of Islam through the trade and caravan routes. He sought to establish a freed slave colony, modelled on the one in Sierra Leone, to combat the spread of Islam as well as slavery itself. New had little appreciation of the Indian population as he comments: "Banians and Hindoos...[are] anything but straight and clean..." He lauded the climate of Mombasa over Zanzibar but deplored the state of its public areas: "If the town were cleansed, and the soil brought under cultivation, it would be one of the healthiest of tropical towns."[57]

He gave contradictory evidence on Swahili doctors, "The Wasuahili have little knowledge of medicine and they resort instead to charms. Pieces of paper, containing passages from the Koran....Many diseases are attributed to Pepo (evil spirits)."[58] Although he continued to discuss the inefficacy of Swahili remedies, and offered the Swahili requests for dawa (medicines) from the missionaries as evidence of Swahili belief in the superior skill of Europeans, he also noted, "Medicinal herbs and roots there are in great numbers, some of which are watched over by the natives with great care and jealousy."[59] Like Dr. Forster, he was seemingly unaware of the contradictory nature of his evidence. On the one hand, Swahili treatments were seen to lack efficacy but Swahili

---

[57] Ibid., pp. 52-54.

[58] Ibid., p. 68.

[59] Ibid., p. 87.

healers continued to be the Africans' first choice of healer, in his words: "finding them of no avail come to us in the last extremity."[60]

New's ideas of health were firmly rooted in nineteenth century Calvinism and miasma theory. He was convinced that the non-coastal people of Kisigau, whom he described as "hale and hearty" enjoyed vigorous health because of their "hard work and mountain air".[61] Repeated throughout missionary writings of this period was the belief that tropical air by its very nature was unhealthy, breeding "lassitude, fevers, and internal gastric disturbances". When challenged by a mganga named Muachania, with whom New travelled, about the right of people to choose their own medical practice, New thought the exchange worthy of record but did not answer the question. The mganga asked New: "[Y]ou Wazungu have your book, the Wajomba have theirs (the Koran), and we have ours. Each prefers his own: why should you forbid me the use of mine?"[62] On this same journey, but in Chagga country, New is again challenged by a mganga. "The mganga next asked for 'medicines', by which he meant charms. I explained that I was not a mganga (sorceror), and denounced charms....The chief said that he knew all this, and only wanted a few drugs." New, afraid of being poisoned, gave him sulphur, quinine and others. When New expressed

---

[60]Ibid., p. 142.

[61]Ibid., p. 331.

[62]Ibid., p. 329.

some fear that the chief would forget their uses, the chief replied, "cooly,'Nay, I shall not do that, for I will write down their uses from your lips. Will you hand me a pen?" New did and the chief wrote. This same mganga gave New a lecture in defence of pombe, saying it was a good liquor not only exhilarating but also nutritious and strengthening![63]

From the above evidence we can conclude that local medical systems were hierarchical in both authority and knowledge. Waganga were not a homogenous medical group. They possessed varying degrees of training and knowledge; some waganga treated only with herbs, others used the Qur'an. They were sensitive to the needs of the clients and were able to adapt their medical practices accordingly. Two significant features of local medical systems were the link between individual and social healing evidenced in both diagnosis and treatment and specialization. With regard to the first, what Feierman has called 'the social basis of healing', that is the role and context of the community in therapeutics, had its roots in pre-colonial times.[64]

---

[63]Ibid., pp. 394-96.

[64]See Feierman and Janzen, eds., Social Basis of Health & Healing, "Introduction", pp. 1-23; John M. Janzen, The Quest for Therapy in Lower Zaire (Berkeley: University of California Press, 1978), and Susan Beckerleg, "Brown Sugar", paper presented to the African Studies Seminar, SOAS, University of London, November 1994 which outlined her work with Giriama elders and the community in Malindi concerning heroin addictions of Giriama youth. The elders addressed this medical problem as a social problem requiring consistent and consensual therapeutic treatment for the individual and the community.

According to Thompson, for Giriama people during the kaya period, healers used their knowledge of medicines in group enterprises. "The most important leadership activities in kaya times were carried out by elders in their roles as healers [aganga]." Medical knowledge was regarded as property. "The commoditisation of this knowledge has facilitated key transformations in the use of medicines since the days of kaya occupation. Most medicines which are today claimed to be 'from kaya' were used there in public and communal ways."[65]

Migration, with its disruption of community healing relations, appeared to generate increased specialization. For Giriama peoples who moved from the kaya to the coastal strip, and thus away from the sacred places of community healing, medical specialization in knowledge and practice increased.[66] Issues of gender and power became increasingly significant. Thompson's research on the

---

[65]Thompson, "Speaking 'Truth' to Power", pp. 50-96.

[66]Spear enlarges this discussion by placing the abandonment of the kayas within the larger political economy. He says that wealth gained in trade supplanted the wealth, power, and control over esoteric practices gained by old age. Trade often involved migration to the coast and with the added push factor of famine in the homesteads, possibilities for new elites were created. These challenges to the kaya elders thus coincided with the abandonment of kayas as central residences. The niche created was often filled by traditional doctors who practiced in the new coastal locations. Spear, The Kaya Complex., pp. 149-196. See also David Parkin, Palms, Wine and Witnesses (London, 1972).

appropriation of female-defined roles by males after migration to the Coast will be discussed in a later chapter.

An area of specialization that was not reported in the records was midwifery. Although absent from the record, midwives were ever-present in all communities of the Coast. Although this medical role remained gendered female throughout the period, changes in "who acts as midwives for whom" highlighted interesting shifts in caste and ethnicity. Perhaps because numbers permitted, African women continued to employ women from their own cultural community to deliver their children. For Indian women, there were shifts in medical personnel highlighting changes common to immigrant populations. For Hindu women, specifically, midwives or dais came from the lowest caste, for these were women who touched bodily fluids, menstrual fluids and were thus unclean. No 'purified' Hindu woman could perform this task.

Early immigrants to Zanzibar in the mid-nineteenth century perhaps brought with them women of their lowest caste to act as midwives. The records do not provide us with immigrant information based on caste. But lowest caste women did not and could not immigrate on their own and thus later generations of Hindu women were faced with decisions as to who could, would and should perform the duties of a midwife. Oral histories provided evidence of extended networks. A Sikh woman stated that all of her siblings were born at home (1940s-1950s). When asked about the midwife, she

responded: "Oh, we had an Ismaili woman." She went on to say this woman was single and of a lower economic class.[67] But the point is the Ismaili woman was not a Sikh. Neither caste (for Hindu women) nor religious affiliation (for Sikh women) appeared to have entered into deliberations as to appropriateness, as the maintenance of the boundaries of caste were almost impossible. It was possible that the issue was deliberated but eventually abandoned given the reconfiguration of social relations determined by circumstances of immigration.

Ismaili women, not bound by caste, could continue to use midwives from their own community. An informant, recalling the days of the Sultan in Zanzibar, and her family's social connections with the men and women of the court, stated that her family always used Ismaili women as midwives. When asked if they would consider an African woman, the response was a definite 'no'. House servants in the mid to late nineteenth century were males and the entry of an African woman into the domestic space of Ismaili women was virtually prohibited. Although she told me her mother was often asked to come to 'lay her hands' upon a child, "even a child of an Arab family", because her mother had 'the gift', the role of midwife remained within this Muslim community.[68]

---

[67]Interview with Sikh informant, Montreal, December, 1995.

[68]Interview weith Mrs. Mohamed Keshavjee, Nairobi, December, 1994.

It was not until hospitals were established by the missions in the early twentieth century and by the state in 1910 in Mombasa that an alternative to home delivery became possible. Yet birthing women stayed away from these institutions retaining local and perhaps domestic control over this aspect of their health. As will be discussed in the next chapter, even the often strident campaigns for well-babies in the era of state-sponsored Maternity and Child Welfare of the 1920s were unable to shift childbearing into the hospital sphere.

Conclusion

This chapter has outlined the medical landscape on the Kenya Coast in the last quarter of the nineteenth century. Where opportunities for contact existed, so did possibilities of convergence. The beginning of the twentieth century witnessed a shift away from a time of choice and plurality as the institutionalization of health care and hegemony of Western scientific medicine became the goal of the colonial state. Local medical systems continued as the Western model evolved from the 'country doctor' image of medical practice to the hospital-based showcase of scientific medicine.

CHAPTER TWO

COLONIAL STATE MEDICINE: EARLY INITIATIVES, 1905-1913

With the consolidation of the Colonial State through its phases of Company Rule to Protectorate to Colony, the foundations were laid which provided the framework for medical policy and health care delivery for the colonial period. It is in this early stage that the initial ordinances were proposed and passed that provided the legal scaffolding for medical administration. As with many other British colonies, model ordinances were transferred from one colony to another; for Kenya models came from India, Northern Nigeria, Nigeria, South Africa and Hong Kong. Although the Colonial Office, framing for an homogenous empire, attempted to keep this process a simple one through minimal changes in wording of ordinances, they were often unsuccessful. Both text and application of these ordinances were often mediated by local conditions or elites. Given its particular history as a white-settler colony, Kenya was no exception to this pattern.[1]

---

[1]Manderson's research on Colonial Malaya provides a comparative study for the effects of the influx of Indian and Chinese labour into Malaya which posed challenges to local populations similar to those of the Kenya Coast in this period. Her work offers similar historical patterns of the state's use of racial stereotyping and essentializing within the context of public health. Manderson contends that this strategy served to deflect attention and responsibility from a popular critique of capitalism to one of an undifferentiated general population. See, Lenore Manderson, Sickness and the State: Health and Illness in Colonial Malaya, 1870-1940 (Cambridge: Cambridge

Legislation only highlights those diseases of interest to the state. Thus this chapter continues to address relations between disease and health care delivery at the community and clinical level. One needs to ask the recurring questions: 'what was the disease?' and 'who were the healers?.[2] The disease-profile up to 1913 for the Coast, as recorded by medical missionaries and government officials, balanced the record. With increased bureaucratization, the demands for locally educated staff were also voiced by mission and government personnel. The inclusion of Christians and exclusion of Muslims in the colonial medical project, particularly as regards training of African medical personnel, began in this period.

The period is significant for three determining agents or situations which governed the production and initial application of state policy in this period and, indeed, which delineated policy for the next thirty years in Kenya. Although the capital moved from Mombasa to Nairobi in 1905, the balance of state interest remained at the Coast with an emphasis on Mombasa as urban centre, plague site and target of state control.

The primary determining conditions which affected policy were causally linked: the construction of the Railway and the importation of labour. These two

---

University Press, 1996).

[2]Prins,"But What Was the Disease?".

aspects of Kenya's internal history have been singularly important in the decisions as to how medical policy would be constructed and maintained. As the employer of the largest numbers of African labourers, the Railway administration established the first imperial model for the medical treatment of labour in the colony. The concern of this chapter is not to narrate labour history and the interaction of imposed labour relations on pre-existing customary conditions and regulations, although this aspect of Kenya's history has yet to be fully written. Rather, it is concerned with the medical aspects of the Railway presence: how Railway practice informed the construction of state policy; and how the importation of Railway medical labourers from India affected local labour relations within the medical field. The state chose to frame its concerns within the safety of a debate on public health rather than the deleterious effects of capitalist labour and economic policies. The problems established in this period extend in larger, more politicized contexts and debates after 1913 and will be discussed in the next chapter.

Another factor affecting policy formation, partially in response to local conditions but generated by the metropole, was the Colonial Office's determination to form an empire-wide colonial policy on plague control and public health. The shape of the public health ordinance for Kenya became a critical site for discussions of public health, racism, and land control. The agent

provocateur was William Simpson, plague expert and the Colonial Office's Tropical and Sanitary Advisory Committee's representative throughout the empire. Simpson carved the policy that was to become the Public Health Ordinance for Kenya. His interests mirrored empire-wide concern with public health and established this area as the principal cornerstone of medical policy for the years to come. The Medical Department would continue with its commitment to hospital-delivered medicine at the institutional level (and, in doing so, seriously challenged the solvency of mission health care) but, at the local and municipal levels, it was public health concerns and policy that framed how local populations experienced the formal medical presence. Attention paid to Simpson and his Report in this chapter directly reflects the power and authority of his decisions for Kenya medical policy through the colonial period.

The Railway: "...the beginning of all history in Kenya"[3]

The Uganda Railway Bill in its reading on December 11, 1902 was the subject of much debate. While Chamberlain and his wife were visiting the Protectorate, Mr. Herbert Samuel, Hon. Member for Cleveland, who himself had

[3]Sir Edward Grigg, Governor of Kenya, 1925-30 and first High Commissioner of Transport for Kenya and Uganda, speaking to the Africa Society in London, March 15, 1927. Quoted in M.H. Hill, Permanent Way. The Story of the Kenya and Uganda Railway (Nairobi: East African Railways and Harbours, n.d.), p. 243.

visited the Protectorate, vociferously objected to the expenditures the Railway would incur. He told the House:

> He would rather spend a million of the country's money on the construction of railways to help English farmers than see this country command the head-waters of the Nile....If they were going to carry out philanthropic humanitarianism where it was most needed, there were women in London and in the slums of other cities who might be rescued from a calling which they pursued for economic reasons.

The figures Mr. Samuel presented to the House should have provided evidence for caution: "...2,367 deaths of labourers up to 1901; 6,354 had been invalided and taken back to India in that year; and 12,644 of these poor labourers had been admitted to hospital." He went on to charge the administration with "...neglect of sanitary precautions which ought not to be tolerated for one moment longer...."[4] The Bill nevertheless passed all its readings and as Sir Edward Grigg was to state twenty-five years later, Kenya was "...not conquered by force of arms...it was conquered by a railway....[I]t was the railway which created Kenya as a Colony of the Crown."[5]

Perhaps Grigg had not overstated this relationship. The railway was the instrument through which the "hinterland doctrine" was implemented. In 1887 the goal of the Imperial British East African Company (IBEAC) was to open

---

[4]Hill, Permanent Way, p. 235.

[5]Ibid., p.243.

territory behind the coast, push into Uganda and the Lake regions both for reasons of trade and military security in anticipation of possible German advances. Line construction did not begin until 1896 from Mombasa Island under the supervision of officers of the Indian Public Works Department, which employed Indian 'coolie' and African 'native' labour. The numbers were significant and the railway's impact on migration, immigration and settlement cannot be overestimated for this early part of the century.

The European population of Mombasa Island in 1896 which included Protectorate officials and families, railway employees and families, missionaries and various business people was 107. Added to these were 269 Goans and Eurasians, 5,962 Indians; 494 Baluchis; 596 Arabs; 14,574 Swahilis; 2,667 slaves and 150 native prisoners bringing the total population to 24,719.[6] The 'coolie' employment figures from "the hardy tribes of the Punjab" had grown from approximately 2,000 in 1896 to just over 13,000 in 1898 two years later.[7] The pressures on Mombasa Island were enormous. Even though administratively the Railway was separate from the Protectorate, its presence significantly and severely affected local populations through its increased demand for land and water.

---

[6]Hardinge's report in Hill, Permanent Way, p.146.

[7]Hill, Permanent Way, p.189.

From a clinical medical perspective, the Railway administration provided a model for health care delivery for labourers that far surpassed what the Protectorate was supplying for its native populations. Medical expenses were included in labour cost budgeting and Indian medical staff was recruited by the railway to serve along the railway line. The Railway bought land on Mombasa Island for workshops, housing and hospital facilities. This, of course, led to widespread speculation by Europeans on what was considered 'unoccupied' land.[8] Revenues from this period of land acquisition were to underwrite the fortunes of those first European businessmen for generations to come.

The main problems which faced the Railway administration were lack of water, hospital facilities and staff housing. With no urban infrastructure to facilitate meeting these demands, health for all populations suffered. Over fifty per cent of the 'coolies' reported on-going contraction of malaria and all other Railway staff had been afflicted by malaria. Ulcers and jiggers were also causing difficulties. In reports of January 1897 half the labour 'coolies' were on the sicklist. Added to these problems were engineering strikes in England which delayed equipment deliveries. Outbreaks of plague in Bombay, which delayed

---

[8]Not without opposition were land grants made. The Indian Land Acquisition Act was applied to the Protectorate as a legal framework for settlement of disputes. As Hill remarked, "[e]ven so, there was a crop of lawsuits...." Hill, Permanent Way, p.149.

the railway advance further, caused labour to remain in place and thus further strained local conditions. As the port of Karachi opened and closed due to plague, 'coolies' were detained under medical supervision in Karachi, further restricting the numbers of supervisory and subordinate staff transshipped to Mombasa.[9]

The Railway was completely responsible for the policing and sanitation of the whole line. Sir Guildford Molesworth, a Labour Inspector, reported extensively in 1898 on medical conditions. He stated that a dispensary staffed by five medical officers had been established at Kilindini. This staff was soon increased to six European medical officers with twelve Indian assistant surgeons and eight hospital assistants. It would be many years before the Protectorate could provide a similar ratio of medical staff to population. The death rate of twenty per thousand per annum for young males, by contemporary standards was unacceptable and causes of death need to be noted: 30 per cent by fever,

---

[9]The continuity of immigration of Indian labour to the East African coast was affected by the growing international concerns with sanitary policy. In 1887 the new Native Passenger Ships Act called for adequate latrines, compartments for the sick and a resident medical officer on board to enforce quarantine restrictions. Although by the 1890s most European countries felt that quarantine was neither necessary nor desirable, the coast remained subject to decisions made for the ports of Bombay and Karachi. The outbreak of plague in Bombay in 1896 challenged this more flexible attitude. Mark Harrison, Public Health in British India: Anglo-Indian preventive medicine 1859-1914 (Cambridge: Cambridge University Press, 1994), Chapter 5.

25 per cent respiratory diseases, 30 per cent dysentery and diarrhoea and 15 per cent from other causes.[10] Although specific mortality figures have increased, the disease profile of migrants to the Coast did not change significantly from the late nineteenth through to the mid-twentieth centuries.

Perhaps searching for environmental and social causes of an underproductive labour force, Guildford further commented on the "inebriate or incompetent" subordinate staff, both imported Indian and local, and that inadequate care had been taken with the selection of European subordinate staff. He noted the camps were "...areas of squalor, crowded with prostitutes...small boys, etc. horrible vices and corruption...badly supervised and administered...".[11]

Although general histories of Kenya have noted the effects of Railway construction on conditions of labour, migration from up-country and gendered access or restriction to waged income, the medical aspects have not previously been addressed. They extend beyond the construction period itself. Dismantling the Railway staff after 1903 was akin to demobilizing troops and, as will be discussed in Chapter Three, the attempts of Indian medical staff to continue to practice within Kenya upon termination of employment with the railway formed

---

[10] Sir Guildford Molesworth in his Labour Report quoted in Hill, Permanent Way, pp. 183-87.

[11] Ibid., p.186.

a site of racially-defined elite competition.

Medical Regulation: from the Railway to the State

The beginnings of the Colonial State were both tentative and fragmented. When the IBEAC failed in 1895, the Foreign Office took over direction of the East African Protectorate, often leaving former Company administrators in charge. Under the Foreign Office Uganda was the prime focus of Imperial concern, and administration of the Coast was left primarily to the railway or local Arab leaders under the Sultan. The medical department was not transferred to the Foreign Office until 1903 when it was placed under the general control of the Principal Medical Officer of the Protectorate, Lt. Colonel J. Will.[12] In recognition of separate development strategies for the colonies, in 1908 the Medical Service of the East Africa and Uganda Protectorate was separated into two departments, reverting to the arrangements which preceded 1903.

As in land disposal, an area in which the Foreign Office would have wanted more financial control but remained ineffective, local directives and initiatives in areas of economics and politics became the principal motors of the state. With settler immigration into the highlands of Kenya and their

---

[12] Berman and Lonsdale, Unhappy Valley, Book One, Chapter Four, pp. 79-88 and CO 544/1, p. 3.

concomitant desire to dominate state policies, reflected in part in the transfer of the capital in 1905 from Mombasa to Nairobi, the Coast increasingly lost its significance to the interests of the Treasury, the Foreign Office and the Colonial Office. Nairobi, a fledgeling settlement, was named the capital of the Protectorate (Kenya was not named a colony until 1920), the railway had pushed into the lake region and the Coast was bequeathed its position as the "Cinderella" of the Protectorate.[13] Whereas Nairobi was seen as an Indian town into which a wedge of European settlement was to be driven, Mombasa was left to its continued development as an Arab and African town.

The earlier years had brought considerable excitement to Mombasa. With the advent of the Imperial Government in 1895 and the establishment of Mombasa as the Coast Terminus of the Uganda Railway, hopes were raised for improvements to the problems of the town, at least those experienced by its European population. According to Dr. J.A. Haran, Medical Officer of Health (MOH) for Mombasa, in his 1907 report, these expectations were not met. The opportunity to control or direct "Mombasa" was lost and the Native Town of

---

[13]The term was expressed to me by Dr. Karim Janmohammed in an interview in Nairobi, 1996. Janmohammed's unpublished PhD on colonial labour in Mombasa forms a significant contribution to labour history of the coast which merits far greater recognition than has so far been the case. Karim Janmohammed, "A History of Mombasa, c. 1895-1939: Some Aspects of Economic and Social Life in an East African Port Town during Colonial Rule," Ph.D. dissertation, Northwestern University, 1977. See

Mombasa continued to expand "...as it willed with little or no guidance." The population of approximately 24,500 people had one refuse cell destructor, inadequate streets, absence of tenure by house occupants, or, in the words of the MOH, little 'pride of ownership', water left in uncovered wells near cesspools, no public latrines, and water supply and drainage in need of attention.[14] These criteria reflected European measurements of a liveable urban centre primed for economic growth. They had little bearing on the day-to-day life of the city's African and Arab residents.

Mirroring European sanitation and public health concerns, Dr. Haran's principal targets for Mombasa were vaccination, sanitation (public and private), and mosquito control. Although the FrereTown mission station had been supplied with lymph and mission staff had guaranteed immunisation, the attitude of natives in the town was one of resistance. In the absence of an epidemic, Dr. Haran found it difficult to convince the local population of the need for vaccination. Some workers complained that they would lose pay while a sore arm left them unfit for manual work.[15]

Anti-mosquito measures to eradicate malarial fever and other mosquito-

---

also, Cooper, On the African Waterfront.

[14]CO 544\1, Report by Dr. J.A. Haran, MOH, Mombasa, pp. 3-5.

[15]Ibid.

borne diseases by separating the mosquito from its victim were organized in conjunction with local Arab administration, through the Liwali's office.[16] House-to-house visits were conducted by the Liwali's representative in Arab and Swahili houses. Haran noted that Mombasa was unusual as a port city with "singular immunity from plagues and epidemics".[17] He saw malaria, whose reported incidence was on the rise, as the chief curse. Malaria incidence was recorded as 183 per 1000 in 1908, up from 140 per 1000 in 1907.[18] Blame was squarely laid upon both the Railway and Public Works for the formation of borrow pits left during construction of roads and drains. Quinine was available as a prophylactic but a lack of supervisory staff to distribute the drug left medical staff to attack the mosquito directly. A Mosquito Ordinance was

---

[16]During this period the twelve-mile coastal strip was under the suzerainty of the Sultan of Zanzibar. Local administrators, subject to the Sultan, were appointed according to Muslim law and custom for the Islamic community until 1922 when the sultanate was abolished.

[17]The pattern of bubonic plague transmission in colonial Kenya was exceptional. Port cities were usually the point of entry for bubonic plague but the first outbreak of plague occurred in Nairobi, not Mombasa, in March 1902. Dr. Haran's experience with plague was first-hand. He was the MOH at Kisumu when plague claimed its first victim in 1904. For the patterns of plague in Kenya generally, see: Dawson, "Socio-Economic and Epidemiological Change" Chapter Two, "Changing Nature of Plague in Kenya"; and for Western Kenya specifically: George Oduor Ndege, "Disease and Socio-Economic Change: The Politics of Colonial Health Care in Western Kenya, 1895-1939", Ph.D. dissertation, West Virginia University, 1996, pp. 106-14.

[18]CO 544/1, MOH Report, p.26.

proposed but deferred pending the education of public opinion.

> In this town propagandist measures have been begun--and in no other town is it so much needed. An intelligent Arab was detailed to visit in the native quarter, and instruct the house- and hut-holders there on the necessity of frequently examining their water-barrels and earthen vessels; to empty out receptacles containing mosquito larvae; and to point out the danger of allowing collections of stagnant water to lie around the house.[19]

Although no epidemics were reported for this year, cases of smallpox had arrived by steamer from India and Aden and patients were placed in the isolation hospital (a building Dr. Haran called a "...travesty--iron sheds, neither wind nor water proof".[20]) Medical concerns focussed on syphilis for Indian labour admitted to hospital; parasitic diseases, particularly ankylostomiasis, for natives; malaria and tuberculosis for all other patients. The number of outpatients treated in the Native Hospital in 1907 was 9,736 and in 1908 was 13,218--while inpatients for 1907 were 1,368 and 2,042 for 1908. Malaria and blackwater fever presented themselves most frequently. We see in Mombasa the continuation of medical options available to local populations. Dr. Robertson, Medical Officer (MO) for the Native Hospital, noted that natives often cured themselves in the initial stages of ankylostomiasis by drinking a remedy made by boiling iron chips in coconut milk. Dr. Haran also noted: "A

---

[19]CO 544/1, MOH Report, pp. 33-34.

[20]Ibid.

very large number of the inhabitants prefer to seek aid from the Native herbalist or cupper, rather than go to the Dispensary for medicine."[21]

The Mombasa Civil Hospital, which replaced the Railway building, opened in November 1908 to admit subordinate clerical staff--with a separate ward for Goanese staff. Institutional segregation on the basis of race was to become the model for all Protectorate hospitals. Further racial exclusions and interventions in the broader area of medical practice were to be enacted with the ordinances of the coming years.

For those areas outside the town of Mombasa, statistics were unevenly gathered and information from up the Coast tersely reported. Segregation of leper settlements isolated this disease and reports on the lazarettos described them to be clean and sanitary. For up-Coast populations generally, malaria, rheumatism, dysentery and parasitic diseases were the most frequently reported. Dr. Norman Leys showed a proportion of ankylostomiasis infection at 30 per cent. Where 3 out of 42 Indians were infected, 29 out of 58 Africans and Arabs harboured the parasite. Although he noted that the number of Arabs

---

[21] CO 544/1, MOH Report, p. 2. See also Emily Ruete, Memoirs of An Arabian Princess (New York: Doubleday, Page & Company, 1907), Chapter XV, Medical Treatment. She states: "The grand, universal remedy is cupping, for every ailment, from smallpox to cholera, this atrocious operation being also regarded as a preventive. Hence persons in robust condition submit themselves to cupping at least once a year, that their blood may be cleansed, and their bodies strengthened against

admitted was not large enough to allow for separate statistics, his experience with out-patients showed a higher incidence for Arabs than Africans, possibly a result of more intensely crowded living quarters.[22]

Attempts to Institutionalize: The Case of Hospitals

The entrenchment of the Colonial State had little effect on the work of medical missionaries in the early twentieth century. With the exception of Frere Town, just across from Mombasa Island, most mission stations were far enough from Mombasa Town to continue almost independently of local medical officials. They were the first to subscribe, however, to the need for hospitals and surgical theatres.

Costs of institutional care ran high and the records show that all mission stations had difficulty maintaining hospitals of only a few beds. Even with a 'progressive' attitude towards the training of African staff, hospital revenues were unable to meet costs. They opened and closed with crippling frequency through this period, signalling the demise of mission medical care. Funding for the missions continued to come from abroad until after the First World War,

---

possible future sickness.", p. 158.

[22] Dr. Norman L. Leys, "Note on the Proportion of Cases of Ankylostomiasis Occurring Among the Patients in Kilindi Hosptial (1906)", in CO 544/4/, pp. 93-94.

leaving mission stations outside the heated financial debates conducted between the Treasury and Colonial Office and the Colonial and the Protectorate's administration, but also underfunded. Sites of conflict with the state were first, over the fight for abolition of slavery and secondly, in discussions concerning education. Health was a tertiary concern. A letter to the Society from the Rabai Mission listed the "urgent wants for the East Africa Mission", as two young missionaries and a schoolmaster, with medical staff as a third requirement--and medicine supplies as eighth.[23] Although cases of smallpox and fevers challenged the health of missionaries and their staff, the record is much more concerned with recurring famine.

By 1888 the old hut which had been used as a hospital was closed and Dr. Ardagh wrote that "...no operation can now be performed; and, as far as surgical operation goes, his [the doctor's] work is at a standstill." Although the missionaries had trained African assistants, Dr. Ardagh went on to say: "A qualified assistant from India would be of the greatest use. Would like some Urdu books to help him...."[24]

The CMS debated whether to construct a hospital in Mombasa. They felt the IBEAC would buy their mission house and establish their own hospital. They

---

[23]CMS Archives, G3 A5/P2.

[24]Ibid.

could then concentrate efforts in Frere Town and further along the coast. Dr. C.S. Edwards of Frere Town presented the annual expenditures for a proposed hospital for Mombasa which included wages of a cook, native doctor, two 'boys' as dressers and two boat 'boys' for a sum of Rs. 780. The Sultan of Zanzibar donated a twenty-five acre site for medical work and treatment for lepers. Mzizima Hospital, planned by Dr. C.S. Edwards, was completed in November, 1892, to accommodate 100 patients. Much of the land was planted with coconut palms, and crops of banana, cassava, beans and Indian corn to raise funds for Mission expenses and provide food for the patients. Hospital buildings included three main wards and a dispensary. The Mission was able to maintain itself until 1904 when Dr. Edwards' departure for a stay in Uganda forced its closure for three years.[25]

It is difficult to assess precisely the significance of medical care provided by this hospital. Given that the island of Mombasa had a population of over 20,000, a hospital bed size of 100 would seem to have been inadequate. Medical mission work had begun in the Mombasa area in 1875 but it was not until 1892 that work was consolidated on the island of Mombasa at Mzizima. In the early days, two-thirds of the daily average of forty patients were treated for

---

[25]G3 A5/P4 and G3 A5/P6 and n.a. "C.M.S. Medical Missions. A Comparative Survey. 4. Mzizima (Mombasa), East Africa", Mercy and Truth, Vol. 17, No. 194, February 1913, pp. 54-55.

ulcers, a condition that did not warrant surgical respite. Dr. Edwards reported in 1897 an increase in patients from town and fewer from the country. "Many...are now better cared for at their homes and at Miss Ackerman's dispensary, and one is not sorry to lose the poor folks who used to drag themselves here only to die." Much of East Africa was suffering the effects of a rinderpest epidemic, drought and widespread famine.[26] By July 1900, Dr. Edwards reported over 300 in-patients for that year presenting predominantly ulcers but also dysentery, famine, diarrhoea and some smallpox. One patient came from as far as Malindi for treatment for blindness. The case must have been successful as two years later Mrs. Edwards reported a man who came "all the way for eye treatment, having heard of my husband from other Washahiri who had received help at Mzizima...."

C.M.S. Archbishop W.G. Peel of Mombasa's public statement that: "Medical science can be used...as miracles were once used, to prove to those to whom we are sent that we have in our hands a gift of God which may be made a blessing to men" seemed somewhat presumptuous but reflected a certain confidence felt by the medical missions of this period. As long as medical efficacy was assessed through a combination of treatment of body and soul, conversions to Christianity were sufficient to maintain confidence. Beck

---

[26]C.S. Edwards, "East African Patients", Mercy and Truth, Volume 1, 1897, p. 131.

contends that this construction of a "ministry of healing" rather than delivery of medical care protected the missions from providing treatment according to the standards prescribed by the London College of Physicians and Surgeons.[27] Issues of standards of medical care were never the focus of state concern over mission medicine. Social control over African populations was the site of primary conflict. It was the controversy over circumcision which focussed mission critique of the state and sharpened the state's responses to competing power bases. The timing of the politicization of the circumcision debate, just after the First World War, parallelled the Medical Department's ability to increase government medical staff. As the state supplanted the medical control of missionaries, it also aggressively countered mission critique of state policy on medical grounds. It is at this point that state criticisms of mission work became voiced openly.

Medical Training of Africans

As stated in Chapter One, medical missionaries were training Africans to

---

[27]C.S. Edwards, "Medical Work in Mombasa", Mercy and Truth, Vol. 5, No. 49, July 1901, 18-19; Mrs. Edwards, "Letter from Mzizima", Mercy and Truth, Vol. 7, No. 83, November 1903, 2; and
Beck, A History of the British Medical Administration, p. 54.

be medical assistants as early as 1881.[28] The first condition for acceptance was undeniably conversion to Christianity. We know how access to education for select African communities in the later colonial period disrupted social relations and challenged existing authority. Medical training allowed for similar shifts, opening opportunities for previously disadvantaged people--by class or social group-- particularly those of former slave families. We know little about those first converts to Christianity in the early mission days. Some of the African staff were drawn from Frere Town, and therefore from 'freed slaves' or 'Bombay Africans', outsiders to the area with no kin or kin-based social location.

That one had to be Christian and speak English in order to be trained by the medical missions provided the basis for the construction of new elites and the exclusion of old at the coast. Education and training were and continue to be the guarantees for employment, with English as the language of instruction. Excluded then were Muslims who did not send their children to English schools or Christian schools for fear of conversion. Training requiring conversion to Christianity and a knowledge of English, ultimately brought an end to the era of the possibility of medical convergence between Western medicine and local systems. Medical coexistence continued through to the present day, played out as local populations exercised their right of therapeutic choice. Isolation of

---

[28]CMS Archives, G3 A5/P2.

mission stations and their retreat from urban centres decreased possibilities of contact. The opportunity for medical convergence at the level of practitioner, of Qur'anic medical knowledge being shared with Western 'scientific' medicine, was lost from this point. Resistance to convergence remains with the state's commitment to Western biomedicine as the medical model for the twentieth century.[29]

Medical pluralism continued, however, for local populations, particularly in urban locales where mission doctors and African healers continued to practice. Although committed to Western science, medical missionaries acknowledged the skills and knowledge of some of their African counterparts. Dr. Shepherd provided interesting observations on what he termed "native doctors", a group he divided into two classes: those who cured using native medicines, such as herbs, who "...in surgical cases have often some truth at the bottom of their treatment", and those who used witchcraft. He was quick to assert, however, that doctors and herbalists both "trade on the native idea of demon propitiation".[30]

He described a Christian "native doctor of great reputation" at Frere

---

[29] Author's interview with members of the Faculty of Medicine, University of Nairobi, March, 1996.

[30] Dr. R.K. Shepherd, "About Native Doctors", Mercy and Truth, Vol. 14, No. 157, January 1910 and "C.M.S. Medical Missions", Vol. 17, No. 194, February 1913.

Town who specialized in cure of 'safura', the Swahili word for anaemia, a very common condition caused by ankylostomiasis and heart disease (according to Shepherd). The African doctor's treatment was an infusion of iron (using iron filings) accompanied by a special diet. "He certainly does cure some cases, and has a great reputation not only in his own district, but far up the country. Then, again, he is a great snake doctor, as he alone can cure persons bitten by poisonous snakes...", and added that "with his medicines there are associated non-medical things [told a woman not to cut her hair]."[31] Shepherd's comments typify the conceptual difficulty mission doctors and other colonial settlers had reconciling the 'native' and the 'civilized'; the 'natural' and 'rational'. Even when African healers were seen as doctors, one had to be reminded of their link to the non-rational world.

Shepherd travelled from Mombasa up-country to the Taita areas where he noted communities with native surgeons and midwifery specialists. "[O]ne man I hear of actually pared his nails and washed his hands before operating, and knew a certain amount about his subject." He also found a doctor who cured through incantation, burning herbs and beating of drums.

Mission compounds provided the space in which African converts were

---

[31] Ibid.

seen to be able to leave behind their 'nativeness'. Within the CMS stations were three English-trained African assistants: James Ainsworth, Frederick Mumba, house surgeon of Mzizima hospital and dispensary and Shadrach Karissa, in charge of Rabai dispensary. As senior staff, they were responsible for supervision of other African apprentices. Ainsworth, who worked at the Mission for thirty-seven years, was a freed slave who taught at Nasik (India) and acted also as anaesthetist for the hospital.[32] Shepherd wrote that Ainsworth "...knows English and Hindustani which is of great use in the town dispensary, where a large proportion of our patients are Indians from Bombay and Kurachi."[33] Significantly, these assistants also visited the sick in their homes. It is this particular inter-racial treatment, African medic and Indian patient, that would be forbidden under the Medical Practitioners and Dentists Ordinance of 1910.

The government was slow to follow the mission lead. Government support for training of native assistants was initially limited to work with lepers,

---

[32]As noted in Chapter One, James Ainsworth first appeared in the papers of Dr. Forster, medical director of Frere Town in the 1870s, who had trained Ainsworth as dispenser for the CMS mission stations in and around Mombasa.

[33]In what is an ironic twist, there are today communities in northern India which remain Swahili-speaking. Conversations with Dave Anderson.

although by 1911 the state was willing to grant 5 pounds per 'lad' and 2 pounds for expenses per person for those training as hospital assistants. By 1913 the state had come to rely on mission training for assistants employed in Government hospitals. Hospitals themselves charged fees "at the discretion of the doctor" and recovered about one-third of costs in this manner. Unlike the situation in Uganda, where the CMS mission doctor, Dr. Albert Cook, had forged a unique relationship with the state as resident expert and advisor, mission doctors at the Coast became suppliers of trained labour but were never entrenched within a state education system.[34] Nairobi, not Mombasa, was the

[34]Uganda was designated an African colony whereas Kenya was white-settler dominated. This agenda, taken together with the dynamic presence and foresight of Dr. Albert Cook, continued to make Uganda the exception to the patterns of East Africa. The definitive work on Sir Albert Ruskin Cook's (CMG, OBE, Bsc. BA, 1870-1951) life and medical work has yet to be written. Born in Hampstead, graduated from Trinity College, Cambridge and St. Bartholomew's Hospital in 1895, Cook went to Uganda with the CMS in 1896. He received his knighthood in 1932 just two years before his official retirement (although Cook was President of the Uganda Branch of the British Medical Association from 1936-38; he was also the first President from 1914-18). He died in Kampala, aged 81. Cook was responsible for the establishment of Mengo Hospital in 1897, with his wife, Katharine Timpson, a missionary nurse, the Lady Coryndon Maternity Training School in 1921 (following the first School of Lady Cook's in 1919); the school for African medical assistants in 1917. Together with his brother, J.H. Cook, they were the first to diagnose sleeping sickness in East Africa. The library at Makerere University, Kampala, bears his name and the extensive materials which he deposited with the University, including his case notes, are presently being microfilmed under a grant from the Wellcome Trust. Wellcome Contemporary Archives Centre, PP/COO; 12 boxes and 1 folder.

capital and the designated centre for medical training. The costs of living in Nairobi were prohibitive for almost all Coast peoples and they were quickly left behind in the formation of an African elite begun before the First World War.

From the Institutions to Local Clinical Records: The Patients

As court records have provided opportunities for local voices to be heard in the reconstruction of colonial social histories, clinical evidence serves a similar function.[35] Patient records attest to the increasingly cosmopolitan nature of Mombasa's populations and the varied responses of these populations to the presence of Western medical practice. The lower attendance rate of Muslims pointed to their resistance to the links between medical service and Christianity. Agency was not the only factor, however, affecting how and when Muslims chose mission medical treatment. As stated above, Arab populations were excluded from state education on the basis of language and of apprenticeship training on the basis of religion. Therapeutic choices were connected instrinsically with the character of early state formation. Statements that: "When we first re-opened people came slowly, as the Swahili prefers to try his

[35]Clinical evidence used in this chapter has been drawn from both anecdotal and statistical records. What is needed are practitioners' case notes. Some Qur'anic scholarly healers have kept these patient/client records and an examination of their case notes forms the basis of my further research. Author's interviews with healers, Mombasa and Lamu, March, 1996.

own medicine first, and only when that has failed will he come to you." may be read as an exercise of client rights, but within the context of political and social policies also reflects an ongoing exclusion of Muslim peoples from the colonial project.[36]

Within a year, hospital attendance had increased from between 50 and 60 daily to approximately 80. It is the composition of patients that is most interesting. In 1907, one-half were Indians and one-half Swahilis and Arabs, with approximately 40 per cent of all being Muslims (Indian, Swahili, Arab). By 1909 the numbers of "heathens" and Christians increased, and the percentage of Muslims decreased to 27 per cent. The medical staff commented that work among Muslims was far more difficult than among the 'heathens': "They (Muslims) were more intelligent as a class, but they seem to turn an absolutely deaf ear to the teaching given...."[37]

If there was resistance to the evangelical side of mission medicine, what aspects of their treatment drew local populations? Surgical to medical cases, probably simple cases of ulcers, were seen in an average ratio of seven to four. (This was a significant increase from reported figures, noted in Chapter One, of

---

[36]Dr. R.K. Shepherd, "Medical Work in Mombasa", Mercy and Truth, Vol. 11 No. 126, June 1907, 174.

[37]Report on East Africa Mission, Mercy and Truth, Vol. 12, No. 142, October 1908 and Vol. 13, No. 151, July 1909.

the late nineteenth century.) As in earlier years the common diseases recorded were consumption, malaria, yaws and anaemia (ankylostomiasis). Given disease recurrence, the clinics offered health management rather than disease control. Most patients came from the "poorer classes, the richer patients being treated by private practitioners or in connexion with the Government hospital."[38] In addition, by group, up-country Wakikuyu, Wakavirondo and Coast Wadigo labourers from nearby plantations formed the bulk of the patients. The numbers of lepers treated at the hospital gradually decreased as this medical area increasingly became a target for Government management and lepers were removed from their communities. While missions and the state presented increases in patient attendance as indicators of compliance with medicalization, their conclusions were faulty. Local populations, which were primarily Muslim, remained significantly outside the medical project while migrant populations, in the process of building new communities at the Coast, turned to mission and state clinics.

Competition between mission and government institutions was inevitable. The years 1913-14 were crucial for the CMS Mzizima hospital and its fate seemed to be sealed. Figures from the 1913 survey of Mzizima Hospital show further decreases in Muslim patients to 15 per cent of the total ("Heathen", 69

---

[38] Ibid.

per cent and Christian, 16 per cent). The hospital was in need of better operating equipment, a suitable operating room and a nurse. Anticipated revenue from fee-paying patients, European and Asian, was lost due to the competition of the subsidized Government hospital and staff.

Convincing local populations to use hospitals was a difficult task and the mission hospitals suffered most. Patient numbers actually diminished as fears over plague contagion and the 'msumori', or nail (serum syringe) became a strong mitigating force against African use of mission hospitals and dispensaries. Decreases in local staff affected the quality of hospital care. Junior hospital assistants faced with the choice between higher-paying Government employment or lower remunerated employment with CMS, chose Government service. By 1914, the Government proposed to purchase Mzizima Hospital, now an 86 bed institution, for use as a quarantine station.[39] CMS kept their hospital at Kaloleni, but even this hospital became too expensive for the mission to operate and came under government control in the 1920s.

Successful State Expansion: Control Through Legislation

The colonial medical project involved more than institution-building. Hospitals were the physical manifestations of westernized health care, but

---

[39]"East Africa Missions", Mercy and Truth, Vol. 18, No. 211, July 1914, 196-97.

commitment to this model could not rest on the efficacy of the institution itself. While local medical personnel realized the value of education to achieve social control, they had neither the staff nor the institutional support to implement educational initiatives. Community education required institutional support and it was not until the 1920s that the state would have this infrastructure in place.

The policies had to be set first, so the state proceeded with a period of intense legislation. Attempts to control disease transmission through legislation derived both from British international concerns and direct local pressure. The Foreign and Colonial Offices were intent on establishing their place in the international sphere of Sanitary Conventions and control of trade, with particular attention paid to all traffic (people and goods) through the Suez Canal.

One of the first pieces of legislation for the Protectorate was "The Infectious Diseases Ordinance of 1903", to prevent the introduction of infectious or epidemic disease. Pilgrims to Mecca were the specific targets of international legislation. To this law was added the more directly applicable "Plague and Cholera Ordinance of 1907" which governed overseas introduction of these diseases. In 1912, two specific ordinances were added to the Statute List: "The Vaccination Ordinance, 1912" which made smallpox vaccination compulsory and "The Quarantine Ordinance, 1912". Interestingly both of these were preceded by the Sultan of Zanzibar's 1910 proclamation that all persons

resident in his Dominion were to be vaccinated against smallpox.[40] The Vaccination Ordinance was taken from Zanzibar with additions from the Ordinance of Northern Nigeria whose Section 8 safeguarded rights of Muslim women, and therefore was particularly applicable to the Coast. Under this Ordinance a person could be prosecuted for not presenting him/herself for vaccination upon entry to a local area to which the Ordinance had been applied. The Colonial Office and Resident Governor of the Protectorate were anxious to legalize the appointment of the Zanzibar Quarantine station as the Sanitary Station for the Protectorate, in part to distance Mombasa from "difficult individuals" and also to control more effectively inoculations of livestock against east coast fever. Passengers from Bombay often arrived without proper medical certification as the agreements between port authorities, under international supervision, were under constant negotiation. Indian women protested against medical examinations by males, forcing the authorities to second female staff,

---

[40]See CO 544/4, p. 12 for the text of the Sultan of Zanzibar's decree. For comparative legislation and its effects on Indian populations, see Harrison, Public Health in British India, especially Chapter 6, "Political visions and political realities, 1896-1914", pp. 139-165; David Arnold, "Cholera and colonialism in British India", Past and Present, 113 (1986), pp. 118-51 and "Smallpox and colonial medicine in nineteenth-century India", in David Arnold (ed.), Imperial Medicine and Indigenous Societies (Manchester: University of Manchester Press, 1988), pp. 45-65.

who were in very short supply, to the port.[41] Although local medical personnel wanted malaria to be a notifiable disease, their requests were ignored.

African Labourers: Shared Control but Poorly Managed Health

Having constructed the necessary legal framework, the state then needed to address particular population sectors for health management and disease control. Given the concern with African labour recruitment, it would have been logical to begin with labourers, but the demands were too great for the state to actually manage. Medical care for employed agricultural labourers was left in the hands of the estate owners. They were subject to the Masters and Servants Ordinance of 1910, under which companies could be prosecuted if found to be in violation of those sections which called for provision of: proper housing (Section 24); medical attendance (Section 29); notification of deaths (Section 30). As C.W. Hobley, Provincial Commissioner for the Coast, pointed out: "Proper housing is however a difficult matter to define and there is no clause dealing with systematic neglect of sick men."[42]

---

[41] CO 533/104 and letter from Bowring to Harcourt, 9 September 1912, CO 533/106.

[42] Confidential despatch, Hobley to Belfield, 24 February 1913, a report on labour conditions on East African Estates Limited at Gazi. CO 533/121. This report was forwarded to Harcourt on 18 August 1913 as the Company was prohibited from engaging any more natives from up-country until their housing

By 1912 the unhealthy situation for labourers on coast plantations was a matter of local and metropole concern. Recruitment of Kikuyu labour stopped in July, 1912, on account of high mortality.[43] Local labourers proved recalcitrant on plantations: "...natives of the hinterland are in a very backward condition...[they] show no desire for plantation or any other kind of work...". That local Africans were farming is certain but they were not interested in living and working on rubber and sisal estates far from their own shambas. Coastal estate owners blamed the consumption and traffic in palm-wine as deleterious to a proper work ethic.[44] In December, 1912, planters tried another route for labour recruitment. They requested Arab labour from Aden or Somalis for rubber, sisal, cotton and other tropical produce. They were to regret their request for Somali labour. These labourers refused to accept the miserable working conditions on the estate, and actively resisted armed attempts to control them.

Blame for poor health was laid on highland labourers themselves, who

---

and medical arrangements were brought to standard.

[43]CO 533/108.

[44]Brantley's work on Giriama resistance to colonial labour and migration impositions outlines how Giriama organized to re-frame labour patterns according to their own needs and wants. See Brantley, The Giriama and Colonial Resistance.

"...do not always thrive in the tropical regions near the coast."[45] Although accurate in their understanding of the health difficulties encountered moving from one environmental zone to another, employers carefully ignored their own responsibilities to provide adequate housing and medical care to their recruited staff. As stated by Mr. E. Powys Cobb, Managing Director, Powysland Plantations BEA Limited and member of a deputation to the Secretary of State, with regard to housing and health:

> I think the housing question has been altogether exaggerated. My own experience is that the native prefers to live in his own grass hut...I think far more could be done towards their health by a strict system of sanitation. ...First of all there must be the provision of water and then efficient steps must be taken to prevent pollution of that water....

Labourers had not been permitted to bring families which, according to Cobb, was a major factor in their lack of health: "The whole of the Medical Officers I think agree that one of the great reasons why natives when moved from one district to another are sometimes unhealthy is because they have to feed on badly cooked food." His somewhat circular argument stated that "...health on the coast where conditions have been resonably favourable has been quite satisfactory." He employed a daily average of 250 men and in five years had "...lost 7 men which is not a bad percentage." According to Cobb and other plantation owners, up-country chiefs ordered men down to the Coast. While

---

[45]CO 533/111.

healthy Africans bargained for their freedom from the chief's orders, it was the weakest who were forced to respond. While in transit, "Railway Indians" and "semi-civilized natives" robbed the workers. Cobb believed that with a proper system of recruiting and transport there would be no difficulty getting healthy labour for the Coast.[46]

State Commitment to Public Health

The Colonial State was very concerned with labour recruitment but left its medical aspects to non-medical departments. The Medical Department, freed from the need to respond to questions of unhealthy labourers, pursued its own concerns for public health and sanitation. Outbreaks of bubonic plague wedded the Medical Department and Colonial Office agendas to that of preventive legislation.

By 1912 there was clear call to combine all regulations into one comprehensive Public Health Ordinance. It was the incidence of an epidemic of bubonic plague on the Coast, particularly in Mombasa, and the fears aroused on this account, that charged the Colonial Office with sending their personal emissary, and expert on plague and sanitation, Mr. W.J. Simpson. Simpson, a former health officer in Calcutta and the co-editor of the newly-constituted Journal of Tropical Medicine and Lecturer at the London School of Tropical

---

[46]Minutes of Proceedings at a Deputation to Secretary of State at House of Commons, 16 December 1912, CO 533/113.

Medicine, would report on the situations in Nairobi and Mombasa. Simpson's comprehensive report became the basis for the Public Health Ordinance of 1913. Prior to his arrival, the Sanitation Division as a branch of the Medical Department came into being on 1 April 1913. It was Simpson's job to organize the department and report on the sanitation of the country.

The intense debates over sanitation policy, causes of disease, role of bacteriology, use of vaccines (particularly Haffkine's Vaccine) and the role of the state were not initially played out in the Protectorate. Use of this vaccine, developed in 1896, had led to riots in Bombay following the initial inoculations. Even among medical professionals in India and England disputes arose over its preventive value. The contest in India demonstrated the weight and influence of sanitary reformers who would win out over the principles of bacteriology.[47] By

---

[47]Haffkine's anti-plague innoculations in India following outbreaks of bubonic plague in 1896 were met with agitated resistance. When Europeans presented no adverse effects from the inoculations, Indians accused them of being given rosewater while Indians themselves were being poisoned. Riots brought on an intensified "colonial assault" in the form of British administrators and soldiers. See David Arnold, "Touching the Body: Perspectives on the Indian Plague, 1896-1900", in Ranajit Guha, ed., Subaltern Studies V: Writings on South Asian History and Society (Delhi: Oxford University Press, 1987), pp. 55-90. For a discussion of the debate between bacteriologists and sanitary reformers over how to control plague in India, see Mark Harrison, "Towards a Sanitary Utopia? Professional Visions and Public Helath in India, 1880-1914", South Asia Research (Vol. 10, No. 1), May 1990, pp. 1940. On the cause, spread and form of bubonic plague, consult the modern expert, L.F. Hirst, The Conquest of Plague: A Study of the Evolution of Epidemiology (Oxford: Oxford University Press, 1953). On the

the time plague had reached East Africa, the colonial positions and policy had already been defined. Once again the links across the Indian Ocean system were highlighted as Kenya colonial policies, particularly regarding malaria and bubonic plague, were modelled upon public health in India. The doctrinal wars which were fought over policy in India in the late nineteenth century referred back to the metropole and transferred to other British colonies for the twentieth. Luminaries such as Patrick Manson, Ronald Ross and W.J. Simpson became advisors to the Colonial Office as members of the Tropical Advisory Committee on Medical Services (TAMS) following the plague epidemics of 1896 and later in Bombay and other centres of India.[48] Once again the Indian Ocean system firmly linked the East African Coast with India: through immigration and knowledge as well as political and economic policies. The Protectorate was directly under the aegis of the Bombay Presidency until 1905 when administrative and fiscal responsibility was shifted from the Foreign to the

---

shift to a laboratory-based definition of infectious disease with the construction of modern medical science, see Andrew Cunningham, "Transforming Plague. The laboratory and the identity of infectious disease", in Andrew Cunningham and Perry Williams, ed. , The Laboratory Revolution in Medicine (Cambridge: Cambridge University Press, 1992), Chapter 7,pp. 209-44.

[48]For a discussion of plague policy within the British Empire, see Rajnaranay Chandavarkar, "Plague panic and epidemic politics in India, 1896-1914", in Paul Slack and Terence Ranger, eds., Epidemics and Ideas (Cambridge: Cambridge University Press, 1992),pp. 203-40.

Colonial Office. Decisions regarding the distribution of quinine, treatments for blackwater fever and policies of segregation or quarantine were all informed by the medical experiences of India. The direct link for the Protectorate was Professor W.J. Simpson, sent on a mission "...for the purpose of examining the sanitary condition of the Dependency, advising the local Government and reporting on the form which the sanitary policy of the Administration should take. Later, I received further instructions with reference to combating plague in Mombasa and to extending my mission to Uganda and Zanzibar."[49] Simpson brought to this challenge his experience in Hong Kong, India, South and West Africa.

Plague Years: Urban Directives and Consolidation of Public Health

The earliest written account of what was thought to be plague in East

---

[49]Simpson's full report is titled: Professor W.J. Simpson, "Report on Sanitary Matters in the East African Protectorate, Uganda, and Zanzibar", African No. 1015. Colonial Office, August 1914 in CO 533/168. For an analysis of Simpson's scientific attitudes which informed his policy directives, see: Mary P. Sutphen, "Not What But Where: Bubonic Plague and the Reception of Germ Theories in Hong Kong and Calcutta, 1894-1897", to appear in 1997, special volume of Journal of the History of Medicine and Applied Sciences, edited by Nancy Tomes and John Harley Warner; and Mary P. Sutphen, "Rumoured Power: Hong Kong, 1894 and Cape Town, 1901", in Andrew Cunningham and Bridie Andrews, eds., Contested Knowledge (Manchester: Manchester University Press, 1997). Simpson's recommendations for segregation in Kenya were based on his earlier experiences in Cape Town. See: Maynard Swanson, "The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909", Journal of African History (Vol. 18), 1977, pp. 387-410.

Africa was of a disease that struck the port of Mombasa in 1697. The first bacteriologically confirmed cases of plague East Africa were recorded in Dar Es Salaam, Tanganyika, by the eminent Robert Koch who had been sent by the German government to investigate malaria. Discovery of plague in Nairobi led to the burning of the Indian Bazaar in 1902 after moving the residents of the Bazaar to a segregation camp.[50] By December 1904, plague had reached Kisumu in western Kenya but, exceptional for a port city, Mombasa remained plague-free.

The Colonial State's primary concern for Mombasa was to reorganize the medical and sanitary departments to ensure that Mombasa did not become the distribution centre for plague or any other epidemic diseases. At the meeting of the TAMS Committee on 7 January 1913, during which the Annual Medical and Sanitary Report for the East Africa Protectorate for 1911 was considered, Sir Ronald Ross stated that sanitary legislation was in need of revision and that an expert should be sent out. Simpson agreed and warned that Mombasa could become like Hong Kong, a distribution centre for plague. He continued that more supervision was required in areas of labour recruitment as well as sanitary standards. This particular 1911 report noted that, in addition to a heavy percentage of disorders of the digestive system, the "...percentage of

---

[50]Dawson,"Socio-Economic and Epidemiological Change", pp. 73-90.

sick to the average number resident, the percentage of invaliding to total residents, the percentage of deaths to total residents and the percentage of deaths to the average number of residents were all very much higher in the Coast Zone than anywhere else in the Colony."[51]

Problems of sanitary administration were the focus of an extensive letter from Dr. Norman Leys, Acting MOH, Mombasa, to the PMO, Nairobi,in April 1913. Leys was a thorn in the sides of both the Colonial Office and the Colonists' Association of Central Kenya throughout his term of employment in Eastern Africa. His criticisms are particularly sharp regarding treatment of native labourers (Leys called it slavery) and use of native land in the controversial Masai and Nandi moves.[52] Leys, while acknowledging the contributions of the recently-retired head of Town Conservancy for Mombasa, requested a clearer and more coordinated system that allowed for delegated and shared responsibilities. "I need not remind you how absurd is the present distribution of duties, how neglected are some of the prime necessities of administration. Malaria and Ankylostomiasis might be made rare diseases on the island.

---

[51]Memorandum of minutes from the meeting of the TAMS Committee on Medical Report 1911, CO 533/107.

[52]Leys published three major critiques of colonial administration in Kenya. See: Norman Leys, Kenya (London: Cass, 1973. Originally published 1924); A Last Chance in Kenya (London: L. and V. Woolf at Hogarth Press, 1931); and Land Law and Policy in Tropical Africa (London: League of Nations Union,

Tubercle might at least receive discouragement instead of encouragement."[53] He reminded the PMO of the incident in Nakuru which involved a shed infested with plague rats, under the charge of the Railway Department. Two deaths from plague resulted during the eight day delay before the shed was burned.

His statements with regard to the particular differences between Nairobi and Mombasa were insightful but went unheeded. He stressed "...how inapposite to Mombasa are many provisions proper to Nairobi....The drafting of satisfactory byelaws for Mombasa will have to be done clause by clause, by all with local knowledge working together." His letter concludes with an appeal that the medical requests of the MOH be addressed seriously and locally. The timing of such requests is ever-important. For Dr. Leys, the outbreaks of smallpox and then plague forced control and direction back to Nairobi and London--and the expert, Professor Simpson.[54]

The Impact of the Simpson Report

One cannot overestimate the importance of the plague epidemic as catalyst for the reorganization of sanitation for Mombasa and Coast Province as

---

Pelican Press, 1922).

[53]KNA. PC/Coast/1/15/31, Dr. Norman Leys to PMO, Nairobi, 12 April 1912, p. 4.

[54]For a discussion of the relationship of Leys and the Anti-Slavery Society, missionaries and the Colonial Office and appropriate references, see Cooper, From Slaves to Squatters,

well as the need for state control--with clear delineations of power between conservancy or municipal officials and medical personnel. The outbreaks of plague in 1912 and the declaration of the epidemic in 1913 in Mombasa followed immediately upon very severe outbreaks of two infectious diseases: cerebro-spinal meningitis and smallpox. The population of Mombasa must have felt akin to the Ancient Egyptians during the plague visitations.

As stated in the Annual Medical Report for 1913: "Never within the history of the Protectorate, and certainly the knowledge of the present generation, has occasion arisen to draw attention to the existence of epidemics of plague, cerebro-spinal meningitis and smallpox running concurrently with the presence of malaria, chicken-pox, measles and dysentery to the extent that has occurred."[55] Plague cases alone numbered 208 with 184 deaths, or 88.46 per cent mortality. The Medical Department proceeded to have the Medical Officers give lectures to the Police; to publish precautions against all infectious diseases in the press and to print over 20,000 handbills in five languages regarding plague.[56] Captain D.S. Skelton's 25 page report on the plague epidemic surpassed all previous reports in its effort to provide a complete scientific

---

pp. 62-65 and footnotes. See also Leys to Haran, ibid.

[55]KNA, Annual Medical Report, 1913, p. 39.

[56]KNA, Annual Medical Report, 1913, p. 57.

picture of the outbreak and its treatment. Analysis and recommendations were left to Professor Simpson who had arrived in Kenya in the middle of the epidemic. Mombasa's reputation as being 'singularly immune' to plague had disappeared on 28 August 1912 when the first case of pneumonic plague was detected, a Kikuyu labourer, who subsequently died, at the Native Hospital. By October 1912 there had been a total of 16 cases, only one of whom survived.[57]

Inoculation of the entire population with Haffkine's vaccine became the major medical goal. For the Muslim and Indian female population a special nurse was appointed (with a 40 pound special plague allowance) to assist the MOH, Mombasa. Her duties were to: (1) inspect the bodies of the female dead; (2) vaccinate women; (3) visit households where suspicious cases of illness among women existed; and (4) inspect female passengers on ships. The plague allowance was recommended as her duties would not only be physically more trying than that of the Nursing Sisters in hospitals, but more importantly, that "...she will run the risk of infection and incur the chance of insults."[58]

Popular concealment of infections and deaths was the worst fear of the Medical Department. As Dawson's research shows,

> At the first report of human or rat plague, medical authorities usually banned rail-travel by Asians and Africans without a special

---

[57]CO 533/107.

[58]Bowering to Harcourt, CO 533/107.

> medical permit [sic] as many Asian merchants and their dependents frequently fled the city without reporting the disease. Medical authorities worried that that this might further spread plague.[59]

Experiences in Nairobi set the tone for those in Mombasa. Acting PMO Dr. J.A. Haran's report on plague in Nairobi and Kisumu blamed the 1911 epidemic on the Indian community. His unbridled and racist criticisms of the Indian bazaar are echoed in Simpson's later report and the crisis that ensued on the subject of racial segregation. On the conditions of the bazaar, Haran was quick to point out how "...the filthy condition in which they [Indians] maintained their houses and the consequent danger of invasion of the disease" prompted the Indian community to ask for state assistance to remove female prostitutes working there. Haran further stated: "The attitude of the Oriental towards matters concerned with the prevention of disease and his complete inability to rise to a sense of Public Duty on the occasion of epidemic prevalence render his neighbourhood both undesirable and dangerous." The statistics which Haran presented in this report actually show the Nubian community with highest incidence and mortality: second was the Wakavirondo and third was the Indian.[60]

---

[59]Dawson, "Socio-Economic and Epidemiological Change", p. 94.

[60]Haran to Bowring, CO 533/102.

The Medical Officer's experiences in Mombasa as he tried to contain a smallpox epidemic added to the racially constructed medical profiles. Smallpox was considered endemic in the Protectorate but in 1912 the disease once again reached epidemic proportions at the Coast. Dr. R. Small stated he encountered great difficulty "...owing to the apathetic and fatalistic manner in which the disease is regarded by many of the inhabitants." But it is no surprise that asking people to leave their homes without providing alternative accommodation should have met with resistance. Although he says those Arab and Native communitites who understood inoculation were helpful, the Asiatics concealed the disease "and have throughout...by passive resistance and stupid apathy done their worst to prolong the epidemic." He strongly suggested that all Asiatics should be inoculated at their port of departure and legally obliged to report contagious diseases. He also pointed to the problem of migrant labour from up-country and especially upon arrival their state of "reduced semi-starved condition, and are most liable to the attack of disease."[61]

Professor Simpson's report does not fail to expand on a racially-driven construction of the Indian population as repository of disease. His recommendations built on a long history of British policy which used

---

[61]Dr. R. Small's report was submitted as part of a full report from Dr. Milne, PMO to Belfield and presented to the 50th meeting of the TAMS Committee, 4 March 1913. CO 533/109.

quarantines extensively to fight plague. In the six specific and urgent conditions he identified in the Protectorate which foster disease and its spread, three of which address coexistence of other epidemic diseases, he cites as fourth: "Immigration from infected countries of Asiatics whose habits, customs and secretiveness are such as to require a watchful control over the disease they spread, and the intimate connection which the various races in the population maintain with their friends and relations in infected countries and localities." The sixth condition was "The insanitary conditions existing and constantly arising in towns and trade centres with a mixed population of Asiatics and primitive Africans." He also cites the "greater liability of the natives to epidemic disease" but this is not due to a natural propensity towards sickness or dirt but their "greater intercommunication with increasing commerce".[62]

It was in the context of a volatile political climate that Simpson voiced these opinions. In Nairobi the white settlers, many of whom had come from South Africa, were already confronting the Colonial Office with demands for representative government, local control of trade and economic development, and an agenda of separate development based on race. The native population was to continue to be a labour force on rural plantations; the Indians would be allowed to carry on middle-level trade; and the white settlers would control land

---

[62]Professor W.J. Simpson, "Report on Sanitary Matters in the East African Protectorate, Uganda, and Zanzibar".

allocation and plantation agribusiness. Nairobi was considered an Indian town which had to be reconstructed on more sanitary lines, that is along racially segregated lines, to enable the colony of Kenya to take its proper shape.[63]

But Mombasa was not Nairobi. Here there was a settled, urban core of Arab and Swahili landowners, up-country and coast hinterland labourers resident in and near the town, an Indian population marked by differences in class, religion, and length of residency and finally, a small core of white business people, civil servants and mission personnel. The issues of racial segregation were fought out over Nairobi, with resonance in Mombasa.

Certainly, land ownership and settlement were also issues in Mombasa. By 1912, the Sultan still retained extensive treaty rights over the coastal strip (inland treaties had been concluded in the 1880s between the British East Africa Association [later the IBEAC] and various hinterland peoples). The Land Titles Ordinance would not apply to the Witu sultanate until 1915.[64] The targets

---

[63]For an examination of the relationship between land use patterns and colonial and independent government polciy, see George K. Kingoriah, "The Causes of Nairobi's City Structure", Ekistics (Vol. 50, No. 301), pp. 246-54; and R.A. Obudho, ed., African Urban Quarterly, Special Issue 1993.

[64]By 1887, twenty-one treaties had been concluded and the "hinterland doctrine", mentioned above, guided the push into Uganda. M.H. Hill, Permanent Way, 15-22. See also Salim, The Swahili-speaking Peoples, pp. 89-135 for an analysis of the economic conditions of the coast with particular reference to land rights.

for development on the island were the construction of a second, deep-water port at Kilindini and a system of roads for the town. Both of these projects provided extensive labour possibilities for residents and hinterland peoples allowing Mombasa's development to remain somewhat distinct from the arguments taking place in Nairobi.[65] Whereas up-country debates concerned the native reserves and land acquisition, settlers versus the paternalistic Colonial State's position of what came to be called by the 1920s "African paramountcy", Mombasa was left on its own. "The development of Kilindini Harbour and the increase of Indian wholesale trade in Mombasa attracted a

---

[65]The development of the coast has been framed within a coast/hinterland debate. Two positions have been taken. The first was presented by Memon and Martin who sought to explain the emergence of the coast as periphery in relation to the development of Kenya. They argued that the hinterland of the coast was the peasant enclave in the lake basis of Uganda-Tanganyika and in the settled White Highlands of Kenya. They ignored what both Cooper and Willis have documented: the extensive trade/labour relations between the immediate hinterland and the coastal strip. I would agree with Memon and Martin that the coast suffered from many of the decisions of the metropole and the colonial state: forced abolition of slavery in 1907 without attention to the consequences; an unfair collection of taxes from local people, forced recruitment during the First World War, and proportionately less money spent on government services. The evidence provided by Willis especially on the economic roles of Mijikenda labour and secondarily, by Cooper on up-country labour, support the view which sees the coast as intrinsically tied to its immediate hinterland. See P.A. Memon and Esmond B. Martin, "The Kenya Coast: An Anomaly in the Development of an 'Ideal Type' Colonial Spatial System", Kenya Historical Review (Vol. 4), 1976, pp. 187-206; Cooper, From Slaves to Squatters, Chapter 6 and Willis, The Making of the Mijikenda.

significant number of Hadrhamis...[who] also took to trading in cattle and opened petty businesses in the towns like the Indian dukawalla." The communities may have lacked capital, but their commitment to small-scale capitalism belied the image of Arab apathy and decline on the coast.[66]

Simpson delicately framed the costs to the government which would be incurred by his recommendations. He was quick to acknowledge that rapid development had brought financial embarrassment to the state, whereby the "calls on Government purse [were] greater than income." And that "...claims of sanitation and public health and medicine, which possess the disadvantage of being usually considered unproductive and which could only add to the monetary embarrassment, have not received the attention they deserve."[67] Simpson was very much aware of the importance of the ports to Mombasa and played on the financial costs of uncontrolled disease when he stated that the Mombasa plague had resulted in dislocation of trade, disorganization of labour, restrictions on shipping, ships reduced in communication with Mombasa because of the risk of being quarantined in foreign ports and losses later passed on to the general population in rising prices.

Simpson then introduced the necessity of a Public Health Ordinance

---

[66]Salim, The Swahili-speaking Peoples, p. 135.

[67]Simpson, "Report on Sanitary Matters...", 4.

which included giving the state "...powers of inspection and enforcement of sanitary measures, control of overcrowding, removal of nuisances, suppression and prevention of infectious diseases, demolition of insanitary areas, closure and demolition of houses unfit for human habitation, control of town planning...". He further emphasized the need for Town Planning schemes which would embody separate quarters for Europeans, Asiatics and Africans. In Europe, he reported, where

race is practically homogenous, town planning merely arranges space and rental and class act as controls. But in the Protectorate,

> ...the standard and mode of the life of the Asiatic do not ordinarily consort with the European, whilst the customs of Europeans are at times not acceptable to the Asiatics, and that those of the African unfamiliar with and not adapted to the new condition of town life will not blend with either. Also that the diseases to which these <u>different races are respectively liable</u> [emphasis added] are readily transferable to the European...a result specially liable to occur when their dwellings are near each other.

His report then articulated how to establish separate wards based on race with a "...neutral belt of open unoccupied country at least 300 yards in width between the European residences and those of the Asians and Africans." This protective zone, he ventured, could be used for recreation purposes. "Open zones round towns are in accord with ancient Hindu laws", wrote Simpson. He did not demand restricted ownership, simply restricted residency. Housing should be modelled on that in India and Singapore where European houses were

spacious, comfortable and cool. He commended the housing in neigbouring German territory (Tanganyika) as erected on "fairly good sanitary lines, superior to British East Africa and Uganda."[68]

Underlying the entire report was Simpson's belief that native Africans had to be taught how to live in towns. Even when he acknowledged the western portion of the town as in a "comparatively clean condition" he pointed out that these were Swahilis or Africans who had adopted Swahili modes of life and the houses were actually makuti huts with thatched roofs and no windows. He advised that each hut must have its own compound, thereby completely ignoring the social realities of African community living.

Divisions according to class were acknowledged by Simpson but when these differences were found in Indian peoples, his racial criticisms were paramount. The old stone quarter of Mombasa, inhabited by Indians and Arabs, he described as a "huge insanitary area...[the] quarter [in which] the incidence of plague has been greatest. The quarter is a reproduction on a small scale of some of the worst parts of Bombay in its poorest quarters, only that in the latter the streets are wider. It is in general an Indian town of the worst kind, and in many respects squalid and unhealthy dwellings." The houses present the "...same defective building arrangements with absence of light and ventilation,

---

[68]Simpson, "Report on Sanitary matters", pp. 8-12.

presence of vermin and uncleanliness and nauseous smells."[69]

The use of Bombay as a referent was not without a very layered contextual connotation. Simpson submitted his report to the Colonial Office and to the Advisory Medical and Sanitary Committee for Tropical Africa, to the Secretary of State for the Colonies and the highest-ranked medical advisors, Patrick Manson and Ronald Ross. Whereas the Colonial Office was trying to maintain its status and separation from the India Office, it was forced on many occasions not only to consult that institution but to defer to the India Office's decisions in areas that concerned Indian populations in other colonies. The TAMS would have been able to heighten their presence and influence if their experience dealing with Bombay and infectious diseases generally and their desire that all medical personnel in the tropics be trained in public health and tropical medicine had been seen to be particularly useful in East Africa.

It could be argued that Simpson was simply drawing a referent from his own experience. He had served in Calcutta and studied conditions of plague in Bombay and Hong Kong.[70] But to mention Bombay and Mombasa as interchangeable except with regard to scale could only have affirmed the worst fears of the Colonial Office and their advisors. In Nairobi, Mr. A. Jeevanjee and

---

[69]Simpson, "Report on Sanitary Matters", p. 40.

[70]See: Sutphen, "Not What But Where" and "Rumoured Power".

a few other wealthy, prominent Indian businessmen were at this same time challenging the Governor and the Colonial Office to grant them equal representation with the white settler lobby. The Colonial Office was not pleased to find itself in the middle of competing colonial power interests, nor was it prepared to grant equal rights to Indian populations. Simpson's report provided the metropole with the evidence it needed to maintain directional control over the development of the Protectorate.[71] The Nairobi government knew that any funds allocated by the Colonial Office for local use would be insufficient to meet Professor Simpson's demands.

Governor Belfield in a long confidential despatch to the Secretary of State complained that Simpson had disregarded both questions of expense and the difficulties of private ownership on the island. He supported Simpson's recommendations that the population (particularly African labourers from up-country) should be encouraged to locate in an alternative area such as Makupa. He pointed out that the area Simpson had designated as a European business quarter was presently owned by wealthy Arab and Indian communities. Of the 50,000 pounds sterling approved by the Colonial Office for costs, the neutral zone Simpson recommended would cost double the amount remaining in

---

[71]Swanson has pointed to the appropriation of medical arguments by Colonial States as support for public policy for Cape Colony. See: Swanson, "The Sanitation Syndrome".

Colonial Office coffers after certain properties had been bought out. The plan was not economically feasible.

Belfield also opposed the recommendation that medical officers should have a Diploma in Public Health. He opposed sending the Chief Sanitary Officer, Dr. W.J. Radford, to England for this diploma as the costs were too great.

Simpson, in a personal letter which accompanied his report, must have anticipated this opposition. He wrote: "Tropical Sanitation is evidently appealing to the American as something that will pay for itself." He had heard that an American (most likely Rockefeller) had given 20 millions sterling a year for combatting tropical diseases. "An information Commission is to be formed. I should like to be on that Commission."[72]

Conclusion

This chapter has outlined the effects of two agents on the construction of state policy. The Uganda Railway provided the transportation link to move both labourers and disease. Its construction highlighted the need for an on-site medical staff to ensure a healthy labour force. The introduction of Indian indentured labourers and medical officers would prove problematic for the Colonial State.

---

[72]Belfield to Harcourt, CO 533/118 and Simpson to Read, CO 533/120.

The second agent constrained rather than expanded the movement of populations. By July 1913, Simpson's responsibilities in the Protectorate had been fulfilled. His report became the draft copy for the Public Health Ordinance passed that year. The Medical Department could only have been grateful to Professor Simpson for drawing attention to their understaffed department and undertrained sanitary officers. Never feeling supported by Belfield, the Department had a voice, a representative that spoke to their medical and personnel concerns, in Simpson.

Town planning had been a concern of Belfield's government. Intentions to construct a municipal government had preceded Simpson's visit. His report simply confirmed the need for town planning. Where his report had the most effect, however, was not of Simpson's design. The issues of racial segregation, equality of rights, and representation for the multi-layered communities of Indians, white settlers and Africans in Nairobi and of Indians, Arabs and Africans in Mombasa were to fuel a politicized debate within Kenya that was a small mirror of the larger and much more difficult fight within India. These issues, which both point to the Coast's dependence on the central state in Nairobi for policy direction and to the ability of the Coast to reframe policy according to its own needs, are explained in the following chapter.

CHAPTER THREE

STATE MEDICAL CONCERNS: THE VIEW FROM NAIROBI, 1913-1935

The Colonial State, bolstered by economic interests of white settlers, became an aggressive actor in colonial policy-making through this period. Consequently, the focus of the thesis shifts from the Coast to central Kenya and the capital, Nairobi. Colonial elites and competing interests of white settlers, Indian residents and African communities reconfigured the character and concerns of medical institutions from the end of the First World War through the 1930s. During the war all plans for development for the colony, including medical, were put on hold. The Coast, unlike Kavirondo and Nyanza in western Kenya, was not a major site of military recruitment.[1] The southern Coast, near the border of Germany's colony, Tanganyika, saw direct military action but, for the most part, the area was much less affected by the First

[1]For an analysis of the effects of recruitment of Africans into the Carrier Corps and the necessity of food provision for troops by African labourers, see George Oduor Ndege, "Disease and Socio-Economic Change: The Politics of Colonial Health Care in Western Kenya, 1895-1939", Ph.D. dissertation, West Virginia University, 1996, Chapter Five, "The Politics of Health Care During the First World War, 1914-18", pp. 168-215. Ndege's research on western Kenya notes the scarcity of colonial health provisions during this period. His scathing analysis of the EAP Economic Commission Report as a "viciously racist document" supports this author's contention that medical concerns of this period were strongly directed by white settler interests in the Kenya Highlands whose acknowledgement of the "intricate economic interdependency between the Africans and the settlers in the colonial economy" cannnot be denied. pp. 198-99.

World War than central and western Kenya. Even the Compulsory Service Ordinance which came into effect in March 1917 made few incursions into daily life. "[M]en who are in the bona fide employ of any commercial concern or on any plantation" could not be called upon to serve in the military.[2] Giriama opposition to forced plantation work and the state's attempts to remove them from their agricultural holdings erupted into a major rebellion in 1914.[3] But within the context of medical and health issues, the war itself took second place to issues of segregation and settler political control. With the onset of a period of reconstruction in 1919, shored up by the metropole's commitment to the creation and/or maintenance of a healthy population, a rearticulation of medical concerns was announced. Given the importance of the central state as architect of medical frameworks, this chapter will consider policies for the Colony as a whole and leave the specific applications to the Coast for the following chapters. This period is marked by state concerns which highlighted issues of health and hygiene: segregation, increased labour demands on Africans and the development of local government. Medical issues became

---

[2]CO 533/157, CO 2097 of 13 January 1916, Belfield to Andrew Bonar Law, SoS for the Colonies.

[3]For a discussion of the confrontation between Coast administrators and Giriama over forced labour recruitment and removal from their land, see: Cynthia Brantley, The Giriama and Colonial Resistance in Kenya 1800-1920 (Berkeley: University of California Presss, 1981).

intrinsically tied to commercial and capital interests and these interests were framed in Nairobi.

At the level of the individual practitioner, the East African Medical Service began its fight for increased salaries equal to those of medical personnel in other parts of the Empire. Medical practitioners were concerned that demobilized Indians would subvert their cause and control. British practitioners' challenge to the Colonial Office was supported by the British Medical Association, and their concerns found voice in the newly-established Kenya Medical Journal. At the collective level, pre-war commitments to increased public health found new impetus in the state's intensified involvement in settling issues of land ownership and labour control. Especially in the early period, from 1919 through to the mid-1920s, the primary interest of the Colonial State was the recovery of control over African labour. To this end the colony was divided into labour zones, and the state introduced the "kipande" or pass system to 'encourage' labour to stay on native reserves.[4] In keeping with

[4]For a detailed analysis of labour for the colony as a whole, see, Bruce Berman and John Lonsdale, "Crises of Accumulation, Coercion & the Colonial State, The development of the Labour Control System 1919-1929", in Berman and Lonsdale, eds., Unhappy Valley, Volume 1 (London: James Currey Ltd, 1992), pp. 101-26; Gavin Kitching, Class and Economic Change in Kenya: the Making of an African Petit Bourgeoisie (New Haven, Conn.: Yale University Press, 1980) for inter-regional comparative analysis and Frederick Cooper, From Slave to Squatters: Plantation Labour and Agriculture in Zanzibar and Coastal Kenya, 1890-1925 (New Haven, Conn.: Yale University Press, 1980) for labour relations specific to the coast.

the Empire-wide efficiency movements for an "A1" population, the "unfit" African came under scrutiny.[5] The demobilization of malnourished African soldiers and the ravages of the influenza pandemic of 1918-1920 reinforced the need to address population health issues for both the metropole and colony. The need for African labour was great and intentions were to increase demand. The necessity of ensuring that the labour reserve was healthy and fit for work drove the state to reconsider the allocation of all medical/health tasks. To provide a united front to address sanitation, hygiene and health, the medical department was reorganized as "Medical and Sanitary Services". Both sections were administered by medical practitioners, with the Chief Sanitation Officer responsible to the Principal Medical Officer. Organizationally the Chief Sanitation Officer sought assistance from the Department of Education to establish a colony-wide system of hygiene education.

The Jeanes School played a significant role in this venture and formed one of the links to a second major concern of the period. The Colonial Medical Service had been chronically understaffed, with much of the demand met by Indian medical officers. By 1919 the need for medical personnel and the

---

[5]The roots of British social policy culminating in the Beveridge Report of 1942, which effectively established the 'welfare state', find voice in this post-Edwardian period. For an analysis of the social concerns of the British state for healthy populations and the development of policies for local and central government, see: John Stevenson, British Society 1914-45 (London: Penguin Books, 1988), Chapters 1, 2 and 7.

Colonial Office's policy of 'native paramountcy" met in the plan to educate natives through government-sponsored training programmes. The most radical introduction to medical services was the creation of a departmental sub-section for Maternal and Child Welfare. As described in Chapter Four, the targeting of women and mothers was an empire-wide project which grew from the concerns and policies outlined for the metropole and transferred to the colonies. Until 1924 community-level care came under the central government's direction and funding, but with the passage of the Local Government Ordinance, responsibility for community-level health devolved to the town or municipality.

Medical Administration

Administration of medical departments from 1920 to 1935 was led by Drs. Gilks (1920-1932) and A.R. Paterson (1932-40). Their tasks and concerns could not have been more divergent. Gilks was appointed to begin the process of post-war construction of a fully-credited, centrally-administered medical services department. Paterson, who had been Chief Sanitation Officer, challenged the separation of roles and stressed the importance of integration of medical services with other departments, particularly Labour and Native Affairs.

Earlier writing on colonial medical officers has not proved helpful in understanding on what bases these men made policy. Beck's treatment of East

Africa as a unit has left lacunae for colony-by-colony study.[6] In this chapter the terms of Drs. Gilks and Paterson as Principal Medical Officers (PMO) will be presented in the contexts of the medical issues of their period. For Gilks, this was the initial building of the administration, staffing the department, attempting to capture medical control from the missions, and pursuing his own academic interest in nutritional studies. Paterson inherited a consolidated department which remained understaffed. He directed his concerns toward training.

According to Paterson's first Annual Report submitted in 1932, in which he reviewed the history of the medical departments, medical services for Kenyan local populations were negligible until 1920, "the end of a decade during which the development of social services had been for all practical

---

[6]Beck was the first historian to chronicle the development of medical services for East Africa. Although commendable for its use of archival materials, particularly those held within East Africa archives, Beck's hagiographic narrative was wedded to an uncritical notion of progress and development and the role of medical care in changing "native attidues toward nature, their environment, and their society...by proving that medicine did not depend on magic." In response to her own question as to the success of medical departments in East Africa, she believed "...they performed very well." Ann Beck, A History of the British Medical Administration of East Africa, 1900-1950 (Cambridge: Harvard University Press, 1970), pp. 145-48. For less contextualized works, see: Brian O'Brien, That Good Physician (London: Hodder and Stoughton, 1962); John A. Carman, A Medical History of the Colony and Protectorate of Kenya: A Personal Memoir (London: Rex Collings, 1976); W.D. Foster, Early History of Scientific Medicine in Uganda (Nairobi: East African Literature Bureau, 1970).

purposes impossible, ...the activities of the public health service were confined almost entirely to the towns...." Paterson added that before 1920, "there were no Government institutions in the native reserves which could properly be termed hospitals, while only one European medical officer was posted to these areas, and there was no African staff which had been systematically trained in any fashion."[7] The year 1920 coincided with the appointment of one of the least-liked but perhaps most efficient colonial officials, Dr. J.L. Gilks, as Principal Medical Officer for Kenya.[8] In addition, 1920 marked major shifts from war-time concerns to the beginnings of new policies, what Paterson called 'a revolution' in health care delivery for Kenya.[9]

---

[7]The African Native Medical Corps had been formed in the summer of 1917 under the direction of Captain Keane of the Royal Army Military Corps (RAMC), but had provided no training for Kenyan African medical personnel. "The cream of the boys of the Uganda schools (Kings School, Budo) volunteered almost en masse and the school had to close down temporarily." PRO, CO 533/227, Captain Keane to Parkinson, 21 October 1919. A later mention of the African Native Medical Corps in the file stated that "...some 1700 natives passed through" as subordinate medical staff to the Uganda Medical Service. CO 533/252. For a detailed explanation of the dominant roles performed by Ugandan medical personnel in East Africa, see, Diane Leinwand Zeller, "The Establishment of Western Medicine in Buganda", Ph.D. Dissertation, Columbia University, 1971, unpublished, Chapter V, "The Spread of Western Medicine: The Growth of Government Medical Institutions", pp. 189-262.

[8]Dr. Gilks was Acting PMO in 1919 and was appointed PMO in 1920. CO 544/11. Material for this introduction is taken largely from Dr. Paterson's Annual Report located in PRO, CO 544/37, titled "Medical Department Annual Report 1932".

[9]PMO, Annual Report 1932, Paterson, p. 6.

This revolution would have been difficult for Dr. Gilks to envision when he took up his post at the end of the First World War. To him fell the problem of administering a Medical Department with a severely depleted medical staff. General terms of service were not seen to be equivalent to those of the Indian and Army services, and thus the colony was unable to attract well-qualified professionals. Dr. Gilks engaged in continued negotiations with the Colonial Office, with little success, to provide medical officers with improved salaries, facilities and study leave. What came to be called the war over registration and hiring of medical officers did not erupt between Dr. Gilks and the Colonial Office, however, but between the Colonial Office and the British Medical Association (BMA). The quarrel was over medical 'turf' and harkened back to the registration ordinance of 1910 which protected British-trained medical officers. The racial card was used in this war to boost the BMA's claim. On one side Gilks and the Colonial Office agreed that registration of medical practitioners could be amended to include those Indian officers who chose to stay in Kenya following the end of the war. Opposed were the European medical officers themselves, the Kenya Branch of the British Medical Association (founded in 1920), the London Central Office of the British Medical Association and the Dominions Committee. The Europeans wanted protection from Indian competition and sought BMA support to uphold racially-defined professional standards.

The story is most clearly understood in the context of the recommendations for racial segregation made by Simpson in his report on public health which commenced with land issues and then extended into control over medical professionalization. The report was clearly used to shore up and expand upon the control exercised by European landowners in Mombasa and Nairobi. Race and class were never so clearly aligned in the history of the coast as within this debate which took place in the 1920s. Business empires came to be consolidated in this boom-time. And those speculators who controlled urban land were guaranteed financial rewards in this period of anticipated capital expansion. How the boom affected the development of health policies and social welfare in both Mombasa and rural areas of the coast will be developed in the following chapters. It is at the level of the Colonial State, including politicians in the colony and the Colonial Office, that the framework of the debates was set. An examination of this framework and of the arguments generated within are outlined below, beginning with the intensely politicized issue of segregation.

Segregation, Separation or "Social Convenience": "Savouring of race distinction"[10]

[10]Mr. Jeevanji's objection to segregation as 'savouring of race distinction' was presented in a memorandum to the Municipal Committee, Town Planning, Nairobi whose full report

Professor Simpson's report of 1913 recommended separate quarters or wards in every town or grade centre for Europeans, Indians and Africans. A neutral belt of open, unoccupied land at least 300 yards in width was to be established between the European residences and those of Indians and Africans. For both Mombasa and Nairobi, Simpson clearly demarcated the areas of proposed settlement, expansion or restriction. Governor Bowring's application of these recommendations took them one step further. In Nairobi, Bowring had refused to approve the transfer of certain plots in the European business area of Nairobi from Europeans to Indians. Thus Indians were excluded from both residence and ownership of land in designated European areas. As Bowring stated in writing to the Colonial Secretary, "The fact that Indians do already hold some plots in this area is not regarded as an argument for allowing them to acquire more."[11]

The Indian communities of Mombasa and Nairobi, led by a prominent, wealthy businessman, Mr. A.M. Jivanji (Jeevanjee) took their case directly to the Colonial and Indian Offices in London.[12] The Indian Overseas Association

---

can be found in CO 533/164, CO 51184, 5 November 1915, "Nairobi Sanitation".

[11]PRO, CO 533/219, Bowring to Lord Milner, August 15, 1919.

[12]Mr. Jeevanjee, a Nairobi businessman, was the Indian representative on the Legislative Council of Nairobi. Although not without his critics, both personal and business, Jeevanjee was the first President of the British Indian National Congress

hand-delivered a pamphlet entitled "Sanitation in Nairobi" to Viscount Milner. In this pamphlet Jeevanjee wrote:

> ...the sanitary condition in Indian locations on which the policy of Municipal Segregation is chiefly based, has been due to the culpable negligence of sanitary improvements by both the Administration and the Municipality. If these authorities, on which the Indians have not been properly represented, had performed their duty to the Indian community, the main ground for the policy of Segregation would not exist.[13]

The arguments around the issue of segregation were directly linked to the racist, anti-Indian practices of the settler population and the colony's administrators. The arena of medical registration was very quickly introduced by the Indian memorialists (as they came to be called) as one over which they were prepared to challenge the clearly racist colonial policies. A proposed Amendment to the 1910 Ordinance would give the PMO the authority to register those medical officers who served the Colony, particularly through the war years, who were not previously eligible for registration. Gilks sought to increase his medical staff with the addition of those Indian Assistant and Sub-Assistant Surgeons who chose to stay in Kenya rather than return to India after the war. The European medical doctors, both government and private practitioners, opposed this relaxation of the Ordinance and the proposed

---

and an indefatigable spokesperson for equal rights.

[13]A.M. Jeevanjee, "Sanitation in Nairobi", printed pamphlet found in CO 533/249.

Amendment. On their own, their numbers would have been insufficient to mount a campaign against the Colonial Office. But neither the Indian leaders nor the Colonial Office anticipated the vehemence of the interventions of the British Medical Association on the side of European doctors who opposed any amendment to the Medical & Practitioners Ordinance of 1910.

Many British medical officers resigned following the end of the war with some Indian Assistant and Sub-Assistant Surgeons rejoining the Indian Army.[14] For those left in the East African Medical Service the issues which needed to be addressed were government salaries and rates of pay. The British Medical Association (BMA) had heard similar complaints from many areas of the Empire, including the West Indies, Malaya and Fiji and East African possessions. On 20 November 1919 meetings were held in the BMA's London Office to discuss the East African Medical Services and the proposed revisions to the salary scales. In the previous year, representations had been made from medical officers in the East African Protectorate, but decisions were not taken at that time.

> In 1918 the Association had before it urgent representations from a large number of the members of the Association who were medical officers in the EAP as to the conditions of service of medical officers in that the terms and conditions of medical service in the Protectorates in East Africa were greatly inferior to those in West Africa.[15]

---

[14]PRO, CO 544/11, Annual Medical Report 1919, John L. Gilks, Acting PMO.

[15]British Medical Association Archives, London. Dominions Committee. Minutes, Agenda and Documents. B/162/1; 1919-20.

By 1920 the official version of the "Report of the Departmental Committee Appointed by the Secretary of State for the Colonies to Enquire into the Colonial Medical Services" was presented to a London meeting of the BMA. The Kenya reports reiterated that salaries were too low and not equitable with other colonial medical services. To show their dissatisfaction with the recommendations of the Committee, the BMA placed an embargo on the publication of advertisements for the Colonial Medical Service Committee.[16] The Association, in agreement with the protests received from their members in East Africa, stated that the new salaries would mean an actual loss of pay to the medical officers in the intermediate grades who formed the main body of the services. The Association went on to recommend that the salaries of Colonial Medical Officers be revised and brought into line with those in the Army, Navy and Indian Medical Services, which would have resulted in at least a 50 per cent increase on pre-war salaries, including emoluments. As discussed below, female medical practitioners were not considered part of these negotiations. They were segregated from their male counterparts and grouped with all other female medical employees for discussions on salaries and working

---

Cyclostyled reports.

[16]Reported in CO 533/249. British Medical Association's letter of 18 August 1920, Deputy Medical Secretary, G.C. Anderson, MD to Under Secretaty of State, Colonial Offfice.

conditions.

In response, a Colonial Office official stated: "I do not think it possible to defend, and I am not concerned to defend, the action of the British Medical Association. The only reason that I think it desirable not to accept this declaration of war is that in the long run there is quite a risk that they will be too strong for us, as they have been in the past for the Army, for instance." The Minute to file continued with recommendations for a passive counter-attack:

> ...I should hint, very delicately, the necessity for our throwing open the medical practice in all the Colonies to people not on the British Register, if the Association takes steps to prevent our getting medical assistance from those who are so registered. I should, however, keep that as the very last recourse of all, as, personally I believe it is a doubtful point whether we should not be worse off with American and some Canadian, and foreign doctors generally, than with no doctors at all.[17]

The Colonial Office was not willing to take on the racially-driven conflicts of the Colony directly nor was it willing to address the specifically economic complaints of the medical officers.[18] For its part, the BMA was intent on

---

[17]Signed "AF", Minute on file to Mr. Grindle, CO 533.249, August 1920.

[18]During the 1920s, the Colonial Office was staffed by a "new breed of Oxbridge administrators, so distrusted by the settlers". This conjuncture of adamant settler representation within Kenya, a weak local administration, overtly racist attacks on the development or integration of the Indian populations by white settlers and a public school Colonial Office firmly entrenched in administrative paternalism all brought together under questions of the use of African labour

supporting its members in their demand for fair salary and employment conditions. Although the twentieth century records do not state this directly, nineteenth century records reveal that the BMA had suffered challenges to its control in India from Indian medical practitioners and politicians particularly. Following the passing of the Medical Registration Act of 1858, the British medical profession closed its doors to unlicensed practitioners. Attempts to pass similar legislation in India were resisted by the Government of India and many Indian practitioners. The debate clearly rested on British concern over the Indianization of the medical service. Although registration legislation was passed in 1912, the voices of opposition to British control over education and recruitment of medical practitioners continued.[19]

Such directives against Indian practitioners devolved from racist attitudes held by Europeans toward Indians generally. Settlers in Kenya intended that the Colony would be theirs to govern. Yet Indians outnumbered Europeans by an approximate ratio of four or five to one in 1919.[20] A Colonial Office clerk added:

---

seriously affected the context within which other seemingly less-politicized debates occurred, for example, the debate over medical registration. See Lonsdale and Berman, "Crises of Accumulation, Coercion & the Colonial State".

[19]The literature on this subject is vast. For a recent discussion of the historiography, see Mark Harrison, Public health in British India: Anglo-Indian preventive medicine 1859-1914 (Cambridge: Cambridge University Press, 1994), Chapter One, "The Indian Medical Service", pp. 6-35.

[20]The 1911 census which breaks down the population by

...we have often been told that the type of Indian in East Africa is mainly low caste: superficial observation confirms this. Heaven forbid that one should suggest that all the Europeans in East Africa are models of what a European should be, but speaking generally, it is certainly true that the European element, official and unofficial, with its Western culture, religion and ideals is in spite of many obvious defects and quite irrespective of numbers more potent for good than the Oriental community.[21]

White settlers and European elites had the Christian churches on their side, albeit with a different rationale, for the intent of the churches was to protect the native African from the "pernicious and deleterious influences" of Indians. In response to the public statements made by Mr. Jeevanjee in the Daily Chronicle, leaders of three missionary groups--Dr. H.E. Scott of the Church of Scotland Mission, Bishop Allgeyer of the Roman Catholic Church (Bishop of Zanzibar) and the Anglican Bishop of Mombasa--were united in their condemnation of what they perceived to be the Indian claim in British East Africa. The "Bishops' Memorandum", as it was later to be called, intended to

---

occupation lumped Asiatics under "Miscellaneous"--included in this category were workers in government, traders, commerce, shopkeepers, shoemakers, tailors, etc.

[21]CO 533/219, file marked "Practice in Medicine", note initialled "ACCP".

address problems of recruitment of native labour and was a significant critique of Colonial Office policy. Sir Percy Girouard, a former Governor of the Protectorate, in 1919 acting as advisor, summarized the Bishops' position to the Colonial Office in these words:

> Their thesis briefly is that the native of Africa is their primary care, and that the presence of the Indians in British East Africa, mostly a low class, is positively harmful to the native both as regards development in industrial and agricultural pursuits, morality and general advancement.

Appended to this note was the comment that:

> For the present, equality in all respects between Indians and Europeans in East Africa cannot be admitted....No concession will be made to Indians which would involve anything contrary to the best interests of the country as a whole, as determined by the conceptions of justice, morality and hygiene held by the Western nations....[22]

It is not the purpose of this chapter to analyze the intense debates that took place in the Protectorate (Kenya Colony in 1920) between settlers and the state. The central issues have been delineated in the literature: policy over native land and labour recruitment, metropole support for capital expansion, representative and empowered government in the Colony. These debates spanned the first decades of the Protectorate/Colony to the immediate post-First World War period. The significant and singularly East African component

---

[22]CO 533/219, Sir Percy Girouard to the Colonial Office and Minute to File signed "ACCP", referred to later as "Major Parkinson", 1919.

to the intensity of the arguments and the breadth of their effects was the presence of large and expanding Indian communities, of all classes and religions. These communities were both inspired by and grounded their appeals within the framework of the nationalist Gandhian movement taking place in India in these same decades. The Indian communities in East Africa were distinct in their proximity to India and the ongoing direct exchanges of peoples and ideas across the Indian Ocean.

Although Indians won some of their East African battles on the basis of metropole defence of liberal democratic rights, success was partial on the medical front. Simpson's recommendations for segregation were quickly seen by local European populations to further their own initiatives for political and economic segregation. Opposition by the Indian communities addressed the immorality of segregation. But the opinion and weight of medical science and its promoters continued to be stronger than moral argument. An extensive memorandum, titled "The Indian in Kenya", written by Lord Delamere and Mr. Archer, two appointed representatives of the white settler community, proposed to "give the British Public an idea of the true position of the Europeans and indigenous inhabitants of this Colony, and of the menace to their national and economic existence, if equal status with British-born subjects be granted to the Indian residents in the Colony...." They pointed to the 1921 June census population statistics: "9,651 Europeans and 22,822 Indians. The

natives number some two and a half to three millions." The minority position of Europeans was clearly demonstrated. Delamere and Archer then refuted the two grounds on which Indians claimed equal rights: first, legally, Indians were British subjects and thus demanded equal treatment, and second, morally, reinforcing the Indian's commitment to the empire as British subjects, their contributions of war services had to be considered. Delamere and Archer stated that equality was "...an ideal suited to some future Utopia...not...a practical policy to-day...." They appealed to local elites, the Church leaders and members of the professions, to validate settlers' demands that the civilizing enterprise remain in the control of Europeans. They quoted Dr. Burkitt, a senior private medical practitioner in the Colony whose link with science and experience as a medical officer in India provided the required expertise:

> 'I say as a medical man who has been up against all this, that no sanitation or hygiene can be carried out in the face of the abominable religious customs of Indians and judging by what I myself have seen of them, I say unhesitatingly that they are much more degrading and debasing than anything I have seen or heard of amongst the Natives of this country. Venereal disease, in peoples following such debasing religious customs, I need hardly say, is rampant, more rampant probably than anywhere else. The statistics, as far as they can be taken in Bombay City this year, and as given in last month's British Medical Journal, exceed anything yet known. The same may be said of bestial sexual offences, also generated by these religions and which are almost unknown among primitive peoples. With regard to plague, our greatest disease danger in this country, I have not the remotest hesitation in saying that its incidence in this country is due to the

insanitary customs of our Indian compatriots.'[23]

Lord Milner's policy directives which supported racial segregation in residential and commercial areas of the Colony as required to establish principles of sanitation and "social convenience" survived the challenges put forward by Indian representatives for two years more. Milner commented on his policy, "There is no question here discrimination against the Indians." [sic][24] While on a tour of the Colony, Mr. Winston Churchill, Secretary of State for the Colonies, spoke to residents at a dinner on 27 January 1922 on the subject of relations within the Empire. His speech must have soothed the fears of local agitants for the rights of British settlers. "The democratic principles of Europe are by no means suited to the development of Asiatic and African people." Churchill went on to affirm the reservation of the highlands for European settlers and the Colonial Office's commitment to the development of a "characteristically and distinctively British colony", with the interests of British settlers and the native population paramount. Indian immigration would be strictly regulated.[25]

---

[23]"Memorandum by Lord Delamere and Mr. Archer, September 1921. THE INDIAN IN KENYA.", reprinted in G.H. Mungeam, Kenya. Select Historical Documents, 1884-1923 (Nairobi: East African Publishing House, 1978), pp. 565-71.

[24]Milner to O.A.G., May 21, 1920, Govt. Note 281, Official Gazette, E.A.P., August 18, 1920, reprinted in Mungeam, Kenya Historical Documents, 558-60.

[25]Speech by W.S. Churchill (Colonial Secretary) at East

Strong resistance was played out in the press by representatives of the East African Indian National Congress whose particular goal was to ensure the commercial place of Indians in the Colony. Their opposition was mobilized against the motto of the newly formed European and African Traders' Organization "Every European and Every African is an Asset to Africa, Everyone Else is a Liability". The economic realities were that white settlers were unemployed and African leaders, particularly Kikuyu, voiced concern over threatened settler encroachment on their land. They were also aware of the numbers and chose to support the side which presented the lesser problem. Kikuyu elders aligned with the settlers to "oppose recognition of equal rights of Indians if additional alienation of highlands at the expense of natives [is] involved."[26]

African Dinner, January 27, 1922, from The Times, January 28, 1922, reprinted in Mungeam, Kenya: Select Historical Documents, p. 576. Correspondence between Churchill and Rt. Hon. Edwin A. Montagu (a British MP) on the position of Indians tensely discussed the possible effects of the situation in Kenya as making disorder in India more intense. There had been considerable pressure from Members of Parliament on the Colonial Office to consult the India Office. The Colonial Office continued to show reluctance, fearing that consultation was actually submission. In addition, the Colonial Office had enacted legislation changing East African currency (not Tanganyika) from the rupee to the shilling without consulting the India Office. CO 533/288/19600, marked "Secret" and CO 533/267.

[26] The Secretary of State for the Colonies, the Duke of Devonshire, espoused an ideology which had declared "imperial trusteeship for African interests". As will be seen below, this policy challenged both settler and Indian interests. Harry

Issues were resolved at the metropole level with the "Devonshire Declaration".[27] This policy statement was arrived at following meetings with European and Indian delegations and the Governor at the Colonial Office headquarters. In addition a delegation of three Indian political leaders came from India. The points at issue were: representation on the Legislative, Executive and Municipal Councils; segregation; reservation of the highlands for Europeans; and immigration. Determined not to have elections fought on racial lines, the Government was "prepared to grant Indians a wide franchise". While quotas remained for Indian representation at all levels of government, unofficial membership on the Executive Council increased from two to four, with five elected Indian unoffical members on the Legislative Council. In keeping with identity representation, for the Arabs there would be one elected member in addition to the nominated Arab official member for which provision already existed. Europeans held their eleven elected representatives.

The most interesting development outlined in the document was an

---

Thuku had been arrested on 17 March 1922 after challenging both the state and Kikuyu elders. Kikuyu elders knew they had the support of the Colonial Office and appeared to align with them on this issue. See Berman and Lonsdale, "Wealth, Poverty & Civic Virtue in Kikuyu Political Thought", pp. 405-407; and CO 533/295, O.A.G. to Colonial Secretary, Telegraph, June 11, 1923.

[27]The "Devonshire Declaration" and the Parliamentary Paper "Indians in Kenya", July 1923 are published in Command 1922 (1923). CO 533/289.

agenda for the dismantling of segregation. The memorandum stated that commercial segregation had been discontinued by common agreement. Residential segregation between European and Asiatics in the townships, a dispute whose non-resolution had stopped all sales of township plots, was abondoned on the advice of "competent medical authorities" who argued that, "as a sanitation measure, segregation of Europeans and Asiatics is not absolutely essential for the preservation of the health of the community; the rigid enforcement of sanitary, police and building regulations, without any racial discrimination, by the Colonial and municipal authorities will suffice." For native populations, however, while acknowledging that "strict segregation would be unworkable" for servants, areas should be set aside for native residence and "no encroachment thereon by non-African races should be permitted."[28]

With regard to the highlands, they were reserved for Europeans with the recommendation that an area of the lowlands be set aside for possible agricultural development by Indians. Immigration would be managed so that places were left open for Africans in "mechanical and subordinate clerical work and in small trade".[29]

Thus the framework for further development was outlined. Clearly, part of the long-term plans for the Colony was the training of Africans to take

---

[28]"Devonshire Declaration", Item 7, p. 607.

[29]Ibid., Item 9, Immigration. p.609.

gradually the place of all positions held by Indians. It is this political policy that would underwrite Paterson's African medical training policies in 1932. As well, a framework for local native government, managed by the central state, was fundamental to effect the colony-wide economic and political agendas. As we return to the Coast, the practical applications of policies of African training and local government--both municipal and rural--offered their own challenges. The first was to settle the land question and incorporate the "Kenya Protectorate" land, still under the protection of the Sultan of Zanzibar, into the Kenya Colony. The effects of the devolution of certain powers to local government were significant in the area of public health and are explored in Chapters Four and Five.

Medical Knowledge: Views and Concerns of the Medical Department

Health needs of local populations determined the medical department's concerns between 1920 and 1932. The decade began with severe epidemics of plague and smallpox. In this matter, the Protectorate/Colony followed the disease patterns of other sub-Sahel African countries which experienced the mobilization of large numbers of people for First World War military engagements, demobilization of malnourished troops and the coterminous arrival of the flu pandemic in 1918-19. Added to these social dislocations and epidemics were periodic outbreaks of enteric fever, mostly among Railway

employees and their neighbours in the townships.

Both state and private practitioners grouped medical issues into two categories: those whose origin could be traced to problems of sanitation and thus of concern to the general public, and the remainder which fell under disease categories particular to individuals. This division between sanitation and clinical medicine was reflected in the administrative structure of the Medical and Sanitary Service Department: Dr. J.L. Gilks was named Principal Medical Officer and Dr. A.R. Paterson became the Chief Sanitation Officer.[30] Thus both areas were under the jurisdiction of medically-trained officials yet were to effect policies through different arms of government at the local and reserve level. On the ground the delineation often proved problematic as advice given by local Medical Officers was often ignored by local sanitation officials who lacked medical or public health training.

Dr. Gilks' initial concerns were with government control over health care delivery, especially in the area of hospital care. He failed in his attempts to withhold subsidies to mission stations and was forced during his time as PMO

---

[30]This model follows the recommendations put forward in Dr. Andrew Balfour's publication, Health Problems of the Empire (London: W. Collins and Sons Co., 1924), in which he recommended "furthering preventive medicine, not make the sanitation side of medicine subordinate to the curative - but have them hand in hand." Quoted in "Clinical Notes", Kenya Medical Journal (Vol. 1, No. 8), 1924, pp. 248-49. Dr. Balfour was the first Director of the Rockefeller Foundation-funded London School of Hygiene and Tropical Medicine.

to work with mission doctors and their specific aims. Some of these, above all the debate over female circumcision, placed pressure on government officials to take unpopular stands against particular segments of native populations. Although 'native paramountcy' was the guiding state policy, Gilks preferred to leave these debates in the hands of Native Affairs. He faced a depleted and disgruntled medical staff combined with increased demands on medical care. Settling salary demands was a first priority.

On a personal level, Gilks was sincerely interested in the area of nutrition. As Worboys has noted, colonial interest in nutrition developed in the 1930s, although Gilks and his colleagues had been writing on this area through the 1920s.[31] In his position as Acting Principal Medical Officer, Gilks sent out a circular letter in 1917 to Administrative Officers, Medical Officers and

---

[31]Worboys' pioneering research contextualized science and tropical medicine in the British colonial period. His research points to the development in the 1930s of the notion of 'welfare' in the colonies which, he noted, culminated in the Colonial Development and Welfare Act, 1940. According to Worboys, 'welfare' embodied both biological and physical criteria, particularly those related to nutrition. He saw this policy as a "complete redirection of colonial science away from the health problems of expatriats [sic], and the problems of plantation and cash crop agricultural production. Also, nutritional problems were by definition interdisciplinary and their investigation required the cooperation of both the main colonial sciences, tropical medicine and tropical agriculture." See: Michael Worboys, "Science and British Colonial Imperialism, 1895-1940", D. Phil. thesis, University of Sussex, 1979 (unpublished), pp. 348-49; Michael Warboys, "The Discovery of Colonial Malnutrition between the Wars", in David Arnold, ed., Imperial Medicine and Indigenous Societies (New York: Manchester University Press, 1988), pp. 208-25.

Missionaries asking for information on a great number of points in connection with native customs, including food.

His awareness of the links between endemic helminthiasis and diet as well as the contemporary concern with the 'healthy native' as labourer made him an early advocate of nutritional studies. During his term as PMO, the Rowett Institute sent researchers to investigate and report on the links between agriculture, diet and nutrition. Gilks spoke and published extensively on this issue.[32] With his colleague from the Rowett Institute, Dr. J.B. Orr, Gilks concluded that Kenya natives were unduly susceptible to disease. Their study noted a high rate of sickness and mortality. "A native is thus by no means the 'noble savage' that he is frequently supposed to be. Infantile mortality, in purely native areas, is somewhere between 400 and 500 per 1,000."[33] They identified

---

[32]See particularly J.B. Orr and J.L. Gilks, "Studies in Nutrition: The Physique and Health of two African Tribes - the Kikuyu and Masai", Medical Research Council, Special Reports Series, No. 155, (London: 1931). Worboys provides the following inormation on J.B. Orr. Dr. John Boyd Orr (1880-1971) was Director of the Rowett Research Institute for Animal Nutrition, Aberdeen, Scotland in 1918. His book, Food, Health and Income (1936) was suppressed by government because of its findings on poverty. In the 1930s, Dr. Orr began work with the League of Nations and in 1944 was appointed first director of the Food and Agriculture Organization of the U.N. See: Biographical Memoirs of Fellows of the Royal Society, 18 (1972), 43-81. Drs. Gilks and Orr originally published their research as "The Nutritional Condition of the East African Native", Kenya Medical Journal (Vol. IV, No. 3) June 1927 reprinted from The Lancet, i (1927), p. 561.

[33]Gilks and Orr, "The Nutritional Condition of the East African Native", p. 89.

respiratory diseases as the cause of nearly 50 per cent of deaths with a large portion caused by pneumonias. Pulmonary tuberculosis was also common and Mombasa, in 1922, 1923 and 1924 showed tuberculosis as the second highest cause of adult mortality, equal to the high incidence found in Nairobi. Ulcers continued to be very common. The incidence of dysentery, rarely amoebic, was paralleled by the incidence of pneumonia among South African miners. Orr and Gilks made the comparison with the Katanga mines where African men had a carefully adjusted diet and were relatively immune. "[I]t is the custom to draft newly recruited labour to a special camp where the men are fed properly to put them into good condition before they are allowed to work."[34]

Dr. Gilks encouraged further research into the links between health and nutrition, and with support from the Empire Marketing Board, obtained the cooperation of Great Britain's nutritional experts. A committee was struck, consisting chiefly of members of the Nutrition Committee of the Medical Research Council and medical representatives of the Colonial Office, to outline a scheme of investigation on problems of nutrition. Two members of the Rowett Institute were also sent to determine the correlation between diet and disease.

---

[34] Ibid., p. 87.

Debating the 'Native Condition'

The question of the period was how to improve the 'native condition'. The publication of Dr. Norman Leys' highly critical book on the inadequate attention paid to native peoples in development policies represented one pole of the debate.[35] Leys, a medical officer in the Colony, was a Labour supporter and presented a forceful challenge to the Colonial Office. The lauded response to Leys' critique, A New Dominion: a Crucial Experiment in Tropical Development, and its Significance to the British Empire, was written by much more moderate (and anti-Labour) public servants. This book argued for improvements in native diet, education and most strongly, native housing. While it linked health problems to the structural requirements of sanitation, Africans ultimately remained the cause of their own plight.[36] In contrast, Leys' work linked

---

[35]Dr. Leys wrote two books on Kenya both of which were highly critical of British colonial policies with regard to recruitment of African labour and administration of African land. See Norman Maclean Leys, Kenya (London, L. and V. Woolf, 1924) and A Last Chance in Kenya (London, L. and Virginia Woolf at Hogarth Press, 1931). Much to the chagrin of the Colonial Office, he made his critique known to an international audience through his published pamphlet, Land Law & Policy in Tropical Africa (London: League of Nations Union, Pelican Press, 1922), particularly the chapter "The Kenya Policy". For background to Leys' thinking, see By Kenya Possessed: the correspondence of Norman Leys and J.H. Oldham, 1918-26 (Chicago: University of Chicago Press, 1976). CO 533/289.

[36]CO 533/273. Leys' most vocal opponent was John Ainsworth, a former IBEAC administrator who became the highly-esteemed government official appointed as commissioner for various districts in the interior of the country. Ainsworth was the state's primary witness to give evidence to the Kenya Land

increased population and worsening health conditions to declining land availability and the encroachment of capitalist plantations on agricultural land that had been used for small-business and subsistence agriculture.

The connections that Leys made between forced labour and disease were singularly perceptive and scathing. Leys was adamant that the employment practices of Kenya be seen as "forced labour". He challenged the underlying ideologies of state policy that included a construction of the African as unwilling labourer. He reminded officials in London and in Kenya of the effects of industrial conscription for Eastern Africa.

> The 30 per cent-40 per cent...of able bodied natives always absent at one time from home in the average village rose to 70 per cent-80 per cent and 95 per cent. The whole machinery of industry in the village ran down. Houses, normally rebuilt about every 6 or 8 years had to last somehow, though alive with vermin - these the great carriers of infective diseases. Food was so short that seed corn was eaten. Large areas were literally devastated by war....[T]here are no figures but the Kenya Government admitted 23,000 deaths among its unarmed porters.[37]

Immediately following the war, the government granted homesteads to several thousand European soldiers whose farming work was to be done by African labourers. Using comparative figures from other colonies, Leys extended his attack to the issue of wages. Wages for African labourers were set by

---

Commission in 1926-27 (Feetham Commission).

[37]Letter from Dr. Norman Leys to Borden Turner, 3 May 1921, with enclosure. CO 533/274, pp. 44-72.

"[g]overnment in concert with planters....[N]one can doubt that men at fourpence a day are wastefully used. The rate in fact makes it cheaper than slave labour since costs of replacement are saved."[38]

Again, he linked the below subsistence-level wages to the prevalence of disease, particularly malaria and ankylostomiasis. African labourers required mosquito netting to protect themselves from the mosquito and shoes to protect their feet from infected ground. "If everybody slept under nets, malaria in most places would die out, and if everybody was well shod, ankylostomiasis would die out completely everywhere. How can labourers buy nets and boots for themselves and their families on four pence a day?"[39] It was industry's responsibility, according to Leys, to ensure a healthy and efficient labour force.

Leys challenged the "fundamental wrong and folly of imagining that Africans can be turned into passive instruments for the production of wealth for aliens" as neither politically wise nor economically viable. He called for liberty for Africans: "...why not leave Africans not only land that is their own but leave them also free to use it, free to refuse to be helots for the profit of conquerors."[40]

His letter concluded with a summary of conditions and recommendations.

---

[38]Ibid., p. 50.

[39]Ibid.

[40]Ibid., p. 52.

Compulsion and fourpence a day would not make Africans industrious. "Their industry and docility have made them the slaves of the rest of the world."[41] In addition, he estimated that less than one tenth of the wage earners in East Africa were provided with even the minimum conditions necessary for a healthy existence.

While the Colonial Office would not act as advocate for settler capital, it could not be seen to accept criticism from Labour. The CO's response through this decade was to send commission after commission repeatedly to investigate, report and advise on policy. They chose as their area of interest the development of local government in concert with the CO's policy of making the Colony self-administering and self-financed.[42]

Not all medical concerns found themselves framed within local debates; some were also generated by the international scientific community. European practitioners were keen to underscore their membership in the wider, international community of medical scientists. The issue of eugenics appeared

---

[41]Ibid., p. 6 of enclosure; file p. 67.

[42]See particularly The Report of the Local Government Commission, 1927, referred to as the Feetham Commission, after its Chair, Mr. Justice Feetham. This report was the "most important and comprehensive document which has yet been issued with regard to public health administration in Kenya." It included an analysis of existing methods of organization and administration in both townships and settled areas and advised on how to effect administration of same. Kenya Medical Journal (Vol. IV, No. 5), August 1927, p. 157. The full report is found in KNA K.352.06762 KEN.

throughout this period in the medical journals and correspondence but never managed to affect policy. What is interesting is that this ideology of biological racism, which attracted a considerable following among European practitioners in Kenya, never seriously entered the debate on race and residential segregation of Indians.

Contemporary concern with comparative physiology and the links between physiological and cognitive development found their representatives in Kenya. The first indications of the debates in the printed record appeared in 1927. The local medical community was fascinated with Leakey's findings and the possibility that Kenya might have been the early home of a race "...more nearly related to the Britons than to the Bantu."[43] By 1932, the discussion was framed within the context of "the physical basic of mind". Dr. F.W. Vint, Assistant Bacteriologist, Nairobi, concluded that the cerebral development of the average African adult is that of the average European boy of between seven and eight years of age.[44] Some of the arguments were framed within discussions of native education. Non-eugenicists linked poor performance to diet and climate which spawned a number of articles through the early 1930s

---

[43]n.a., Kenya Medical Journal (Vol. IV, No. 4), July 1927, p. 102.

[44]F.W. Vint, "A preliminary note on the cell content of the prefrontal cortex of the East African native," Kenya Medical Journal (Vol. IX, No. 2), May 1932, p. 48.

on the effects of climate on Europeans and Africans. On 5 July 1933 the founding meeting of the "Kenya Society for the Study of Race Improvement" was held and chaired by Mr. R.F. Mayer. Membership was open to all Europeans over the age of eighteen. Discussions at the meetings broached "World Population Problems" and "Climate in Relation to White Settlement".[45] Investigations by Drs. Vint and Gordon were published in London newspapers. In Kenya, doctors focused on the nutrition aspect of Gordon and Vint's work. In London, a letter from The Eugenics Society to the Editor of The Times commented favourably on Vint and Gordon's investigations and expressed the need for further expert scientific research to develop a successful native policy.[46]

Editorial comments in the Journal although giving full discussion to Gordon and Vint's work did not appear to favour one view of "backwardness" over another. Although much space in the journal over these years was given to articles on physiology, institutional concerns focussed on daily health care delivery.

---

[45]In "Notes", Kenya Medical Journal (Vol. X, No. 12), March 1934, p. 370.

[46]Reprinted from The Times, 25 November 1933 in "Correspondence", Kenya Medical Journal (Vol. X, No. 9), December 1933, p. 282.

A Return to Health Care Delivery: Recruitment of Female Medical Staff

The early 1920s mark a concerted effort to recruit women firstly, as nurses and secondly, as health visitors to the colony. Following Uganda's example, Kenya sought to capture the African female population through provision of extra nursing sisters and a lying-ward for women near the hospitals. In Nairobi, provision was also made to house women training as midwives.[47]

Female medical staff were marginalized in every respect within the medical system in this period. As late as 1933, female Medical Officers were not members of the East African Medical Service. Nurses were recruited through the Overseas Nursing Association (formerly the Colonial Nursing Association), which was established in 1896 to recruit trained nurses in Britain to work for the British communities in the colonies.[48] The Association was

---

[47] n.a., "Estimates of Medical Expenditure, 1925", in Kenya Medical Journal (Vol. 1, No. 7), October 1924, pp. 168-70.

[48] Registration of midwives was established under the Midwives Act of 1902 but conflict among different sections of nursing work impaired attempts to introduce legislation for nurses. It was the use of partially-trained and untrained women as nurses in the First World War that provided the impetus for agreements on the issue of state registration. Three years after the formation of the College of Nursing, the General Nursing Council was established. Registration and regulation of training of nurses in England, although established in 1919, was not really implemented until 1939. A special committee, the Athlone Committee, was set up in 1937 to investigate the General Nursing Council which had been established by the 1919 Nurses Act. The Committee's 1939 interim report proposed

funded through voluntary subscriptions and bequests, and as their official history states, the support of Joseph Chamberlain, Secretary of State for the Colonies, was crucial. (Mrs. Chamberlain, later Mrs. Carnegie, was one of the founding members of the organization.) The Association recruited, for both private nursing and Colonial Government Hospitals, from Australia, New Zealand, South Africa and Great Britain. Responsibility for pensions and superannuation schemes fell to the employer or Colonial Government. Association members performed a variety of medical roles: nursing sisters, sister tutors, health visitors, male nurses for mental hospitals, physiotherapists, radiographers and occupational therapists. The years 1927 to 1931 saw the highest number of government appointments which directly coincided with the implementation of Maternal and Child Welfare appointments.[49] As discussed

---

specific recommendations to address problems of low salaries and poor working conditions. Public Record Office, "Civilian Nurses and Nursing Services: Record Sources in the Public Record Office", Kew, 1990.

[49]The Overseas Nursing Association, Sixty-Seventh Annual Report For the Year ended 31st March, 1963 (Oxford: Church Army Press, 1963), Rhodes House, Mss. Brit. Emp. s.400, Overseas Nursing Association, Item 49. See pp. 4-7 for the "Historical Survey, 1896-1963". Governor Grigg had actually proposed to the Colonial Office that nurses for the European hospitals be hired from the Lady Grigg Welfare League as they would be employed at a lower rate of pay than those who worked in the native hospitals and would not be government servants. The government would pay a subsidy to the League. Minutes to file discuss this unfavourably and anticipated criticism from the ONA should this recruitment policy be initiated. The CO recommended that no action be taken and the issue was filed. CO 533/388.

below, fears on the part of female medical staff regarding recruitment crystallized over the issue of local versus colonial control.

Female medical staff were concerned about questions of appropriate salaries and working conditions as were the male practitioners. As stated above, married women were not pensionable. The female Medical Officer employed by the Government at Mombasa worked from 1931 to 1933 on a "monthly agreement". Under this category, she had no increments in salary and could be dismissed at a month's notice. The government was required to pay neither her passage nor leave salary. This lack of security, according to Dr. Shaw, would not have existed for a male Medical Officer.[50]

Regarding policies toward nursing sisters, Dr. Shaw had been informed that government practice was to engage a nursing sister for two tours (5 years) and then discontinue her employment to avoid pension payments. Technical officers were eligible for pension after two and a half years, while nursing sisters required a five-year term. Health visitors fared no better. They were trained nurses who also held a certificate from the Central Midwives' Board and a Public Health Certificate. The extra two years of training, and the costs thus incurred, were not reflected in their salaries. A health visitor's salary was equal to that of a nursing sister with the additional expense of being required to buy a

---

[50]"The Position of Some Women in the Colonial Service", (Dr.) Mrs. M. Shaw, 1933, in ONA, 136/1/86-95 (mimeo).

car. Dr. Shaw provides comparative salary figures:

> Salaries for Health Visitors in England recommended by the College of Nursing are L250 - L350.
> Salaries here are L240 - L340.
> Travelling expenses (i.e. bus or tram) are allowed at home. Here they are made to buy a car and although their running allowance may cover petrol and oil it does not, in most cases, cover wear and tear and repairs.[51]

Housing was also totally inadequate. While women were usually at least thirty years of age, privacy and comfort were not government considerations. Health visitors and nursing sisters were required to share residence with one or two other European health visitors or nursing sisters. "If the Health Visitor, after going in and out of stuffy, smelly native houses in the hot sun, or, often, the pouring rain, gets back to an atmosphere unpleasing and uncongenial, her lot is indeed rather pitiable." The information provided by the Overseas Nursing Association, according to Dr. Shaw, was of no value. Women coming to the colony were advised by the ONA in London to buy, among other things, caps, white aprons, white dresses, and white shoes and stockings for their tour of duty. "Can you imagine anything more fatuous than a Health Visitor trailing 'round in the mud of Pangani on a wet day in such a uniform? A pair of high boots and a stout macintosh would be infinitely more to the point." Dr. Shaw's extensive letter to the Medical Director quoted two important tables from the colony's "Code of Regulations". While the first compared salaries of the Medical

Department with those of Government House gardeners, the second showed salaries from the Education Department. The state clearly ascribed greater monetary value to its gardeners than its educators. These tables were followed with her parting shot: "Comment is superfluous."[52]

Issues of salaries for medical officers and funding of health care were subsumed under legislation which placed public health under the financial control and responsibility of local governments. Public health promotion was devolved to local government authorities under the Public Health (Amendment) Ordinance of 1928. The Local Government (Municipalities) Ordinance of 1928, in concert with that of Public Health, arranged for "...the engagement of public health staff and the promotion of the public health within the area under their jurisdiction." The two chief types of local public health authorities in the Colony were the Municipal Councils or Boards and the District Commissioners. Councils and Boards were entitled to impose rates locally for public health purposes and under certain circumstances to receive a reimbursement of fifty per cent from the central Government for those expenditures on public health.[53] How urban and rural governments and populations responded to the central state's

---

[51]Ibid.

[52]Ibid., pp. 4-5.

[53]Annual Medical Report, 1936, submitted by Dr. A.R. Paterson, CO 544/48, pp. 2-5.

directives will be discussed in Chapters Four and Five below.

Medical Administration: The Transition to Training

Training of African personnel remained the responsibility of the Central State. Although Colonial Office advisors had advocated the establishment of medical training schools for Africans as early as 1920, the 1920s were also a period of financial retrenchment.[54] The Medical Department was perhaps encouraged by a change of director from Dr. Gilks to Dr. Paterson in 1933. Dr. Paterson had attended a number of empire-wide conferences through his tenure as Chief Sanitation Officer and wanted to produce an "A1" population. He stated that from 10 to 40 per cent of infants died in their first year.[55] While Paterson argued thatwhat was required was the cultural improvement of the African people and his aim was to "treat the patient as well as the disease". He was also somewhat enamored of the investigations of Gordon and Vint. He called for further research into the African mentality, the physical basis of the

[54]The Colonial Office wished to take control of medical training away from the missions but was unwilling to provide the necessary funds. They continued to subsidize mission stations through the 1920s in spite of the opposition expressed by Dr. Gilks. CO 533/276, Minutes from the PMO Conference of December 1920, brought forward for discussion in 1922.

[55]Although acknowledging that the statistics of health, mortality rates, and invalidity rate attempted to be scientific, they were, in fact, mainly inferential.

African mind and the process of African physiology under African conditions.[56]

Training of Africans became the central focus of Paterson's term as PMO. In his 1933 report, he stated:

> ...the needs of the African population for medical, maternity and nursing service are so great that these needs can never be met in any reasonable measure except by Africans, by African doctors, African midwives, and African nurses: but if Africans are to render this service efficiently they must be trained in a service where the very highest standards of efficiency and honesty of purpose prevail...more funds should be devoted to the training of African staff and especially of an African female staff.[57]

Dr. Shaw addressed the need for training female staff as outlined in Paterson's report:

---

[56]Paterson relied specifically on H.L. Gordon, "Amentia in the East African", The Eugenics Review, January 1934 and F. W. Vint, "The Brain of the Kenya Native", Journal of Anatomy, January 1934. Annual Medical Report 1933, CO 544/39.

[57] Dr. Paterson referred to the League of Nations "Conference on Rural Hygiene, Medical Assistance, the Publich Health Services and Sanitation in Rural Districts" as provider of guidelines that would be useless to follow in Kenya. The Conference recommended that beds should be close to 6,000 for the population of Kenya whereas the reality was that approximately 1,700 beds were actually available. Annual Medical Report, 1932, p. 40. Although Gilks is still officially PMO, Paterson signed this report as Director of Medical and Sanitary Services. CO 544/37.

> A propos of this topic of nurses it may interest you to know that I have been fighting hard for over a year to get a training centre for female native nurses at the Native Hospital, Narobi[sic] -. This, as I told you, being a Colony run by men for men possess a school for training male nurses and ward masters but nothing for women. I can safely state that the majority of female dressers are the native counterpart of 'Sarah Gamps' - the only exceptions being a few trained at Mission Hospitals and those trained in Midwifery at the Lady Grigg African Maternity Hospital. The consequence is that it is extremely difficult to persuade the better type of native woman living in the locations here to go into the Native Hospital.[58]

European nurses brought into the Colony were normally required to be qualified in general nursing and midwifery and to have been trained in surgical technique and theatre work. Preference was given to those nurses trained at one of the larger training hospitals.[59] Replicating this extensive training for African women was extremely difficult. Pat Holden made this point clearly:

> ...in most East African colonies serious nurse training for women

---

[58]Sarah Gamp was the notorious character in Charles Dickens' novel, Martin Chuzzlewit (1844). Mrs. Gamp attended women in childbirth, watched over the sick, and lay out the dead. Dr. Shaw refers to the portrayal of Sarah Gamp as reckless, often inebriated and generally un-Christian in manner. Ironically, according to Anne Marie Rafferty, Sarah Gamp became also a powerful symbol for reform. As her activities threatened the practices of male doctors, religious sisterhoods and educated nurses, female reformers invoked her frequently. Dr. Shaw, unlike many of her generation, was not fearful of all African women who acted as medical assistants, only those who were not 'properly trained'. CO 544/37. "Extract from a Letter from (Dr.) Mrs. M. Shaw." For a discussion of class tensions within the professionalization of nursing, see Anne Marie Rafferty, The Politics of Nursing Knowledge (London: Routledge, 1996).

[59]Sir Charles Jeffries, The Colonial Empire and its Civil Service (Cambridge: Cambridge University Press, 1938).

> had as yet been almost impossible due to lack of adequate pre-vocational education. The training had been done almost entirely by mission hospitals where European nurses and women workers had been more numerous than in government hospitals for Africans. These women had therefore been in much closer contact with the community and were thus able to attract a 'better type of girl' for training. After instruction, she says, the trainees in East Africa were variably called hospital nurse, midwife, nurse-midwife, nurse aid, infant welfare worker, nurse dispense, health visitor, etc. All trainees had varied educational standards and the word nurse might be something of a misnomer. Furthermore, medical training for men in East Africa had a well defined programme, while there was nothing similar for women.[60]

According to Dr. Welch, amateur historian for the Overseas Nursing Association, the primary need in Africa was for a non-institutional rural community nursing service and 'an army of public health or community nurses who can reach the hospital-shy population'. Nurses would have to be educated to address the major medical problem of nutritional deficiency. Welch felt it was possible both to separate the African nurse and her patients from their native world ("of magic") and yet also incorporate modern science. Modern nurses were to be trained to embrace the

> concept of nursing as preventive and as involving mental, social and environmental factors. The old nursing system of apprenticeship had produced skilled and devoted workers but

---

[60]Pat Holden, "Nursing Sisters in Nigeria, Uganda, Tanganyika, 1929-1978", Rhodes House: The University of Oxford Development Records Project Report 18, 1984, mimeo, pp. 6-10. Holden's section on "The Training of Nurses" is based on a monograph written by Dr. Janet Welch, "Nursing Education Related to the Cultural Background in East and Southeast African Colonies", ONA Papers.

'didn't provide the underlying education for intelligent understanding and scientific knowledge of the principles behind those procedures' -- more emphasis should be placed on education rather than the services provided by the nurses in training.[61]

One of the most influential training centres for African men and women was the Carnegie-funded Jeanes School, established in Kabete, outside of Nairobi, in 1925.[62] This school, although staffed by missionaries, closely followed Dr. Paterson's slogan for the 1930s: "Better farming, better living, better business."

The Jeanes School would link education in agriculture with resocialization in proper family life. The School was to offer a two year course whose objectives would be: "The improvement of Education and Social conditions in the Native Reserves...". Male teachers would take courses in "simple hygiene and sanitation, first aid; wives of teachers would take simple hygiene and sanitation, maternity work - general principles; care of children feeding; childrens' ailments, etc." Africans trained in the Jeanes School went forth to be both teachers and community health workers throughout the country, including the coast.

---

[61]Holden, "Nursing Sisters In Nigeria", pp. 7-8.

[62]Mr. F.P. Keppel, Carnegie Corporation, presented $37,500.00 to Dr.Thomas Jesse Jones, Education Director of the Phelps-Stokes Fund, New York, as trustees for this grant to the Kenya Colony for education. Letter from M.F.P. Keppelto Dr. Thomas Jesse Jones of 7 April 1925. The Jeanes School was ready for occupation in January, 1926. Letter from Department of

Although coast populations were not among the trainees, they were nevertheless affected by the state's utter fascination with this school and its emissaries. The school was fully endorsed by the Departments of Education and Medical & Sanitary Services. They believed that an African family, properly trained in hygiene and nutrition, could reproduce this model throughout the Colony. Roles were gender-specific: men were brought in to be teachers, women as teachers' wives.

Following South African models of village schools, boys were taught personal and social hygiene through "clearing grass, looking for mosquitoes, compulsory use of latrines, drains, rat prevention..." and first aid encompassed treating "fractures, cuts, burns, scalds, dysentery, pneumonia, plague, ophthalmia, malaria". Moral training found its catechism in the programme of Baden-Powell's Boy Scouts programme: "A thorough training in Boy Scout ideals and methods. Posting of Boy Scout laws and promises in every school. Boy Scout badges."[63]

Governor Edward Grigg, who had previously written to the Colonial Office to recommend monies for the Lady Grigg Welfare League, stated in a lengthy despatch to the CO concerning the responsibilities of the Jeanes School

---

Education to Major Vischer, 7 January 1926. CO 533/344.

[63]Letter from Department of Education to Major Vischer, CO 533/344.

to African women:

> The importance of instruction being given to native women in Housewifery, Infant Welfare, etc....has not been overlooked at the Jeanes School, where the wives of the teachers who are being trained by a qualified European Nursing Sister (who is in residence) in general knowledge of maternity and child welfare....I believe that in the instruction of native women by European women will be found the only certain means of raising the moral and physical standards of the native races in the Colony. Nothing, therefore, is of greater importance in Native policy than this.[64]

Training schemes for Africans as laboratory assistants, dressers and dispensers had been under consideration as early as 1926. Dr. Gilks rather unrealistically had expected that Kenyan Africans could be trained in Uganda where such training was already established under the direction of Dr. Cook and Dr. Owen for laboratory work. Education in English for Africans living in or near Kampala was firmly entrenched up to English "O" and "A" levels. The educational opportunities for Africans in Kenya lagged far behind. Thus, when the CO was asked to provide funds to support this scheme, the reply was that this was an impossible arrangement "...owing to their ignorance of England and their low standard of general education." For the Coast specifically, the colonial government's attitude predetermined their exclusion. The Waswahili's "[l]ack of ambition, lack of concentration, improvidence and shiftlessness keep them in a more subordinate capacity than they need occupy if they would only develop

their unquestioned mental capacity. Technical training, except in agriculture, they seem largely to regard as beneath them, and their future constitutes a very difficult problem." The same analysis was applied to the Pokomo. Arabs were "apathetic" and only the Shirazi of Malindi District were "hard and industrious workers". Yet even they could not be counted on as "trainable".[65]

The Report of the East Africa Commission of 1925 commented adversely on how Africans were being trained and made particular reference to inadequate medical training. In response the Native Medical Service appointed a local Department Committee to investigate and propose specific recommendations for an improved programme. Their first suggestion was to form an enlisted African Medical Corps, on a basis similar to the Police. Conceivably "enlisted" Africans could be more systematically screened for educational background and ability. It was hoped that the 'military' style of the programme would attract the 'better African'. Given the residential requirements, the scheme was financially unviable in terms of building space alone. What the Department really wanted was a complete reorganization of existing African staff training under the auspices of the Department, not a separate body. Agreement was reached in 1929 to introduce a modified scheme which would provide to selected

---

[64]Grigg to Amery, 21 January 1926, CO 533/345.

[65]Medical and Bacteriological Reports, 1924 and Native Affairs Report, 1924. CO 533/346.

individuals a systematized technical course of instruction in hospital duties over a period of three to four years. These men would be "medical apprentices". The programme commenced in November, 1929, and by June, 1931, thirty pupils were under instruction. Preference was given to applicants who had received an Elementary "C" Certificate. Upon graduation, their official title was "Hospital Assistant". A similar course of instruction was available for laboratory and sanitary assistants.

Advances beyond the assistant level were curtailed by a Department unwilling to place Africans in direct competition with Indian employees. "Advancement by natives to posts commensurate with those now held by Indian Sub-Assistant Surgeons is not contemplated."[66] In this context, the apparent support for the Indians' position was more likely covert resistance to the full medical training of Africans in Kenya.

The residential training programme presented somewhat contradictory messages. While the curriculum provided very basic medical knowledge, a sub-text continued the nineteenth century association of medical learning with the 'gentleman scholar'. Courses included anatomy, physiology, medicine, nursing, surgery and pharmacology. The upper-level class was employed at the Nairobi Hospital for 90 per cent of the time while junior classes who were taught

---

[66]CO 533/423. East Africa Commission Report, Command 2387, quoted and commented on in Minute to File, unsigned.

elementary anatomy, physiology, hygiene, first-aid and drill, were introduced to hospital work after their first year. There is no mention of pay for this hospital work, even at the apprentice level. Thus these assistants-in-training served much the same functions as nurses-in-training in hospitals--subservient, free labour. Extra-curricular activities reminded students of their role as "gentlemen". They were required to meet as a debating society once a week. The debates were held, of course, in English. In overt contradiction, a reminder of the lower status of the diploma was in the certificate itself. Deeds of apprenticeship were given under the 1910 Master and Servants Ordinance, as opposed to any part of a registration ordinance. Salaries were set to begin at 20 shillings a month with increases to 60 shillings a month plus clothing, bedding, utensils and quarters. While the wages were certainly above other clerical positions of the time, the emoluments were a fixed reminder of a paternalistic medical department and the refusal of the colonial government to provide a living wage. African medical staff were excluded from elite competition and forced to remain in subservient labour positions.[67]

---

[67] Ibid.

Conclusion

This period was one of building frameworks. In the early 1920s the colony and metropole were convinced that increases in production and trade would result in a self-sustaining, invigorated and prosperous colony. The economic crisis of the 1930s brought increased restrictions on funding, particularly on the "frills" of training and community-level health care. Throughout the period, the Colonial Office and the Kenyan medical departments continued to underfund and understaff health care delivery. The institutions established in the 1920s had one short decade in which to build the medical systems envisioned by local governments and the Colonial Office as early as 1914. The health aspects of medical care were so closely linked to larger concerns of labour recruitment and land ownership that as these problems were addressed, health matters were subsumed or passed down to the local government level.

Medical knowledge as applied to diseases of the tropics remained fairly constant through this period. There were no major discoveries that would eliminate the diseases of the time such as malaria, enteric fever, measles, tuberculosis and ankylostomiasis. And yet the concern with healthy labour did spin off into extensive studies of diet and nutrition. These would have specific applicability at the south Coast as the 'anti-hookworm' campaigns became established.

Other issues which became medicalized in this period were returned to the origins of the debate to be settled. Problems which arose from Simpson's report and its application to residential segregation were settled on the basis of civil rights, not medical knowledge. Hygiene education was best delivered by Jeanes School teachers, mission-educated and funded, not the state. Maternal and Child Welfare programs can only be evaluated at the community level and thus will be left for the next chapter. As well, the Local Native Councils would demonstrate which medical policies proved popular and affordable at the rural level. It is to the Coast that we now return to examine how colony-wide policies and recommendations were actually implemented at the level of the Coast's city, Mombasa, and its rural areas.

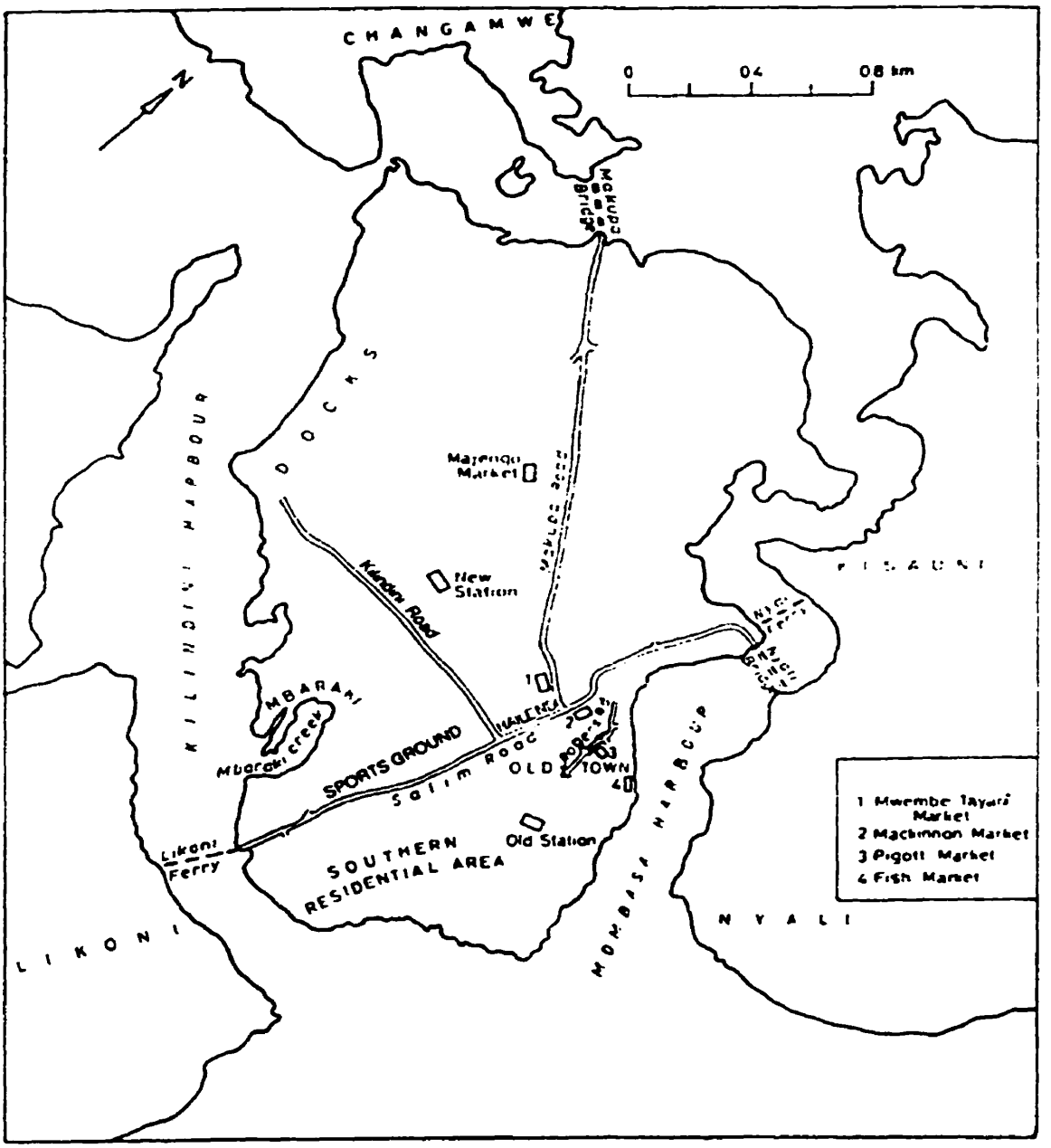
CHAPTER FOUR

MOMBASA, URBAN INITIATIVES IN HEALTH AND HYGIENE, 1913-1940

Historical writing on nineteenth century Mombasa has been dominated by political concerns and that of the twentieth century by issues of labour and labour relations. For the early twentieth century, this literature has reflected the principal interest of the colonial state and the metropole during a period of bureaucratization, intensified agribusiness and recruitment of African labour.[1] With the focus on the worker, scholars have uncovered the frameworks through which African labourers organized their work and time. As Willis has so carefully teased out of the labour documents, local populations, forced to integrate migrant labourers, reconfigured identity, while Cooper has shown how Swahili men organized labour/client networks (serangs) as strategies to counter an

---

[1]For early labour history of the Coast, see Cooper, From Slaves to Squatters, Chapters 5-7. Karim K. Janmohammed, "A History of Mombasa, c.1895-1939: Some Aspects of Economic and Social Life in an East African Port Town during Colonial Rule", Ph.D. dissertation, Northwestern University, 1977 provides the primary documentation to understand the problems faced by African labourers in Mombasa, leading up to the port strikes; and for a critique and contextualization of the 'floating labour population', see Willis, Mombasa, the Swahili Through an examination of Mijikenda labourers both in Mombasa and the immediate hinterland, Willis' work challenges the theory that Mombasa was an isolated labour pool whose boundaries were set by the island itself.



MAP 3. Mombasa Island

SOURCE: Justin Willis, Mombasa, The Swahili, and the Making of the Mijikenda (Oxford: Clarendon Press, 1993).

TABLE I: POPULATION OF MOMBASA, 1911-1946

YEAR	EURO-PEAN	INDIAN	GOAN	ARAB	OTHERS	AFRICAN	TOTAL
1911	241	3,957	-	-	-	-	4,198
1921	653	7,302	696	5,700	-	17,983	32,254
1928	885	7,556	942	7,523	365	26,906	44,177
1931	1,132	11,841	1,077	6,679	446	22,077	43,252
1934	981	10,609	1,045	6,849	497	21,771	41,752
1937	1,316	12,932	1,421	7,715	559	28,388	52,331
1940	1,455	11,803	1,459	9,350	662	33,389	58,118
1943	1,269	13,887	1,311	12,334	1,086	49,950	84,837
1946	1,755	23,956	1,522	15,272	573	56,449	99,527

Source: KNA. PC/Coast/I/74. Municipal Board of Mombasa. Mombasa Old Town Replanning Scheme, 1947. Appendix I. Table IV.

increasingly directive and coercive state.[2] Alignments for economic and social support were crucial for those men who arrived without their families into a city of non-kin.

Evidence shows that just as serangs were African adaptations of control over male labour relationships; voluntary associations, both political and social, became vehicles through which Indian male merchants and elites organized their power base. Local government boards were constituted to control and limit access to power by non-Europeans but, in spite of restrictions, politicized Indian communities were vocal in their demands for equal representative rights.

The narrative of this period of Mombasa's history has been one which has sought to explain a reconfigured social cohesion; to expose and unravel how local communities maintained their boundaries or integrated migrants during what Willis has termed the period of "planning Mombasa". Given that medical practices can only take place within the context of social relations, one would expect that issues of population growth, identity, new labour opportunities and the institutionalization of the local state, all of which interplay through this period, would be as dynamic within

---

[2]Willis, ibid. Discussion of the role of serangs, their links to other African associations (Beni dancing societies), see Cooper, On the African Waterfront, Chapter 4; and Frederick Cooper, "Colonizing Time: Work Rhythms and Labor Conflict in Colonial Mombasa", in Nicholas B. Dirks, ed., Colonialism and Culture (Ann Arbor: University of Michigan Press, 1992), pp. 209-245.

the context of health as they were within the context of "planning" and "settling" Mombasa. Within the medical context that includes health, disease and healing, the appropriation of local government institutions by Mombasa's elites and the development of voluntary associations, both political and social, by the marginalized Indian male elites can be elucidated. However, the exclusions are stark; large numbers of women and other non-waged workers of the city of Mombasa.

The point is not so much their absence from the framework, or the inability of the framework to encapsulate these populations. The site of contest is the extension of late nineteenth century "new imperialism" into the post-First World War period as it became embodied in the local state. Consider Cooper and Stoler's assessment of this attempt to transform indigenous culture, work, government or medical practice.

> ...[T]his form of colonization attempted to reorganize not only the polity, but social relations, economic structures, and values. It was not just the violence of pillage, but the violence of self-conscious and self-righteous transformation of social life. And its destructiveness was not just a question of conquest but of law: an attempt to redefine norms as well as practices. Colonial law never embodied a purely class-or market-based vision of social order...but legislated what kinds of activities each category [Africans, Asians and Europeans] could engage in; the law defined permissible activities by gender as well.
>
> Projects were not necessarily successful--the very intimacy of the domain they sought to penetrate made them frequently resistant to the blunt instrument of colonial

> bureaucracies....[T]he modern state, with its projects as well as its organizational instruments [entered] more and more domains of social life [tending] to turn conflicts over a variety of social issues into conflict over the state itself.[3]

In telling the story of health, disease and healing for Mombasa in this period, those social relations that centred on the state will be presented. But what must also be included are those networks and relations of social production that co-existed with the political, state-centred narrative, sometimes in conflict but more often in complementary, invisible (to the state) networks of community life. What is crucial to this continuity of African social reproduction within the medical context is the African communities' intransigent commitment to multiple layers of disease causality. As long as Africans remained wedded to "beliefs in the tenets of indigenous philosophies of misfortune" and sought healing from diseases caused by misfortune, no examination of medical practice can be complete without consideration of how these aspects of disease and health were treated.[4]

Access to power for all women was severely constrained by male elites. However, Indian women, perhaps recognizing

---

[3]Frederick Cooper and Ann L. Stoler, "Introduction. Tensions of Empire: Colonial Control and Visions of Rule", American Ethnologist (Vol. XVI), 1989, p. 614.

[4]Terence O. Ranger, "Godly Medicine: The Ambiguities of Medical Mission in Southeast Tanzania, 1900-1945", Social Science of Medicine (Vol. 15B), 1981, p. 262.

the possibilities of representation, were the first to become involved in the state's reorganization of maternal and child welfare. Swahili women, many of whom were in seclusion during this period, remained outside of formal organizations but continued to develop and reorganize their internal associations.

An examination of the institution-building of local communities, at the state, municipal and voluntary level highlights the racial and economic tensions that existed in Mombasa during the colonial period. Race and class continued to underpin the bureaucratization of the city as competing elites learned how to wield power through a municipal structure. As Strobel has stated, "[t]he colonial government promoted racial categorization, which exacerbated local antipathies between people of different religious and ethnic backgrounds."[5]

Links between race and disease, established through colonial reportings on urban experiences of plague and instituted in the Simpson report, continued through this period. Willis is correct to signal the use of the 'contagion metaphor' as a tool of state policies of constraint. Issues of disease control subsumed issues of race, segregation and landholding, thus disguising economically-driven policies under the linguistic cover of medical science. While pertinent at the level of policy and

---

[5]Strobel, Muslim Women in Mombasa, p. 37.

local government, it is not clear from the evidence that this metaphor permeated those activities that could be called health-providing or health-seeking on the island of Mombasa from 1913 through to 1940. The state had not fully penetrated social relations at the Coast.

Both Cooper and Willis focussed their inquiries on a particularly male-dominated area of conflict and coercion, waged labour, raising class to the forefront of the critique. What complements this understanding is the untangling of the resident populations on the island as communities and the inclusion of women as essential components of social populations. Not only gender but the residual stigmas of slavery must be factored into these configurations. In spite of the abolition of slavery in 1907, Swahili women's associations continued to mirror divisions between descendants of free-born and slave women.

This chapter addresses the multiple levels of health care policy, delivery and the formal and informal institutionalization of health practice in Mombasa. From 1913 to 1928, health initiatives remained framed by the concerns of the central state of which disease control was the dominant issue. One of the most significant institutional additions in this period was the establishment of maternal and child welfare as both a state concern and a funded state policy. From 1921, the major state interest for the health of Africans was targeting women and children for

preventive health care. Interest was shared by other communities, particularly Indian, and resulted in voluntary initiatives for community-based welfare associations.

Discussion of the effects of devolution of responsibility for public health to local government in 1928 grounds this narrative. It is discussed within the contexts of town planning, disease control, and maternal and child welfare. The layers of health care networks that were constructed and reconstructed from 1920-1940 by members of various Mombasan communities forms another thread. It is the local level of community organization and the identity politics played out at the municipal council level that provide a more visible class-based appreciation of the ways in which Mombasa communities articulated and met their health needs. The chapter draws on the primary records of the Municipal Council and its Health Committee, the published pamphlets of the Mombasa Service League, archival records of other Indian associations and interviews with informants in Mombasa involved in the provision of community health care from 1913 through to 1940. We turn to ethnographic research and oral testimony for evidence of the continuities of multiple levels of disease causality and treatment.

Health, disease and healing in this period remain very discrete as categories and as practice. Health, which had been subsumed under Simpson's rubric of public health,

remained firmly under the supervision of sanitation officials, often in conflict with town planners. Disease was directly identified with epidemics--plague, smallpox, yellow fever--and their consequent eradication campaigns. Discussion of the relationship between town planning and the anti-disease campaign model follows. Curative practice remained the domain of hospitals while preventative medicine became the health focus of city clinics.

Healing, at the corporate and individual level, continued to be provided by local African and Arab practitioners. Although evidence from this period for these urban community healers is extremely scarce, ethnographic research conducted in the 1970s and contemporary interviews with healers, midwives, vendors of therapies clients provide links back to the colonial period.[6] While Indian, African and Arab communities maintained separate institutional relations through this period, particularly in the use of hospitals and the work of welfare associations, pharmacology and treatment continued to be an area of shared therapeutic

---

[6]For Swahili women of Mombasa, see Strobel, Muslim Women in Mombasa and Mirza and Strobel, eds. and transl., Three Swahili Women. Comparative ethnographic research from the coast of Tanzania is found in Caplan, African Voices, African Lives. For Swahili customs generally, see Mtoro bin Mwinyi Bakari, The Customs of the Swahili People: The Desturi za Waswahili of Mtoro bin Mwinyi Bakari and Other Swahili Persons, ed. and trans. J.W.T. Allen (Berkeley: University of California Press, 1981).

expertise.[7]

State Initiatives: Targeting Urban Populations, Disease Campaigns, 1913-1928

This period is marked by a singular insensitivity to the long-term health needs of Mombasa's populations. While concerns for plague and plague control measures dominated state interest, Mombasa populations continued to face a topography of diseases. Parisitic diseases, particularly ankylostomiasis, malaria and tuberculosis, increasingly evident among Indian communities, continued to frame the disease parameters of the island yet remained ignored by disease prevention campaigns.[8] For the most part, Coast

---

[7]Interviews with Qur'anic healers and wholesalers of ayurvedic treatments, Mombasa, March, 1996.

[8]Parasitic diseases were seen to be more of a rural than urban problem. The anti-hookworm campaign of 1928, discussed in the following chapter, was a significant state response to the presence of this disease. However, reasons for state interest had much more to do with the maintenance of healthy labourers for plantation agriculture than with healthy urban populations. As late as 1928, malaria was more strongly linked to water levels than parasites. P.C.C. Garnham's research findings which linked a pre-erythrocytic parasite in the liver of monkeys with malaria (in conjunction with Dr. H.E. Shortt) and the early epidemiological research in East Africa of D. Bagster Wilson were not published until the late 1940s. Packard's studies on malaria in Colonial Swaziland report also that the first major malaria survey did not occur in Swaziland unitl 1946, despite the presence of malaria since the beginning of the historical record. P.C.C. Garnham, "The Placenta in Malaria and Immunity", Transactions of the Royal Society of Tropical Medicine and Hygiene (June 1938) was the earliest of his pubished work; see Elliott Fitzgibbon, "Malaria et hoc genus omne" East African Standard, September 10, 1928 for links between malaria and miasma theory; D. Bagster Wilson, "On the Present and Future Malaria Outlook in

populations, both indigenous and European, considered those endemic parasitic and viral diseases to be a normal part of the local environment. On one hand, there was little that Western medical science could do to control or prevent endemic disease. And yet, the failure to address these diseases was due, perhaps, in part to the particular European construction of the 'tropical' environment.

> Despite sanitary and medical advances in the nineteenth century, disease remained in the European mind one of the defining characteristics of the tropical world. The emergence of 'tropical medicine' as a medical specialty by the 1890s and 1900s served both to celebrate Europe's growing sense of mastery over the tropics and the abiding idea of tropical difference. The very idea of 'tropical diseases' and 'tropical medicine', always difficult to justify in purely epidemiological terms, since few diseases are in fact unique to the tropics, epitomized the way in which medical science in the imperial age gave its own endorsement to the idea of tropical otherness.[9]

On the ground, local government had to convince the public of both their commitment to and success with disease

---

East Africa" The East African Medical Journal (Vol. 26, No. 12), December 1949, pp. 378-85; J.P. de Mello, "Fifty Years of War Against Malaria", The East African Medical Journal (Vol. 26, No. 6), June 1949, pp. 155-57; and Randall M. Packard, "Maize, Cattle and Mosquitoes: The Political Economy of Malaria Epidemics in Colonial Swaziland", Journal of African History (Vol. 25, 1984), pp. 189-212. The first major study of tuberculosis in Kenya was based on research conducted in 1947-48. See W.S. Haynes, "Tuberculosis in Kenya", in KNA.K.616.995.Hay; reproduced in file without citation references.

[9]For a full discussion of the "invention of tropicality", see David Arnold, The Problem of Nature. Environment, Culture and European Expansion (Oxford: Blackwell Publishers, 1996), p. 153.

control. Experiences with Health and Public Works Departments' campaigns had not produced confidence in the government's medical system. Although state reports recorded large numbers of vaccinations and of rats caught to counter plague transmission as evidence of compliance and confidence, anecdotal remarks undermined this picture. The MOH, in charge of anti-plague measures in 1913, stated, "The Native, and especially the Indian, population has to be taught the rudiments of municipal cleanliness, and no matter how unpopular such a measure should prove it had to be carried out, opposition or no opposition."[10]

Opposition was covert. Inhabitants offered no resistance to the "Clayton machine gang" who came with their portable gas machine to fumigate the house but compliance with other measures was more nuanced. Rat trapping posed a major problem for home owners as the immediate consequence of reporting was quarantine of the house and residents. "Inhabitants practically refused to cooperate with the department in rat catching." [11] Given that much trade continued to be conducted out of homes, the deleterious

---

[10] The initial plague report, "Scientific Report on the Epidemic of Plague in Mombasa" was written by Dr. D.S. Skelton, brought from Zanzibar to investigate and write the scientific report. There was tension at the local level in terms of administrative direction and control of health policies. Skelton's report, although thorough and well-received, was rendered insignificant with the arrival of the plague expert, Professor Simpson. CO 544/5. Annual Medical Report, 1914, p. 71.

[11] Ibid., p. 73.

economic effects of quarantine were significant. In addition, domiciled restriction of movement of householders would have made market trade impossible.

Plague control measures were interventionist and no doubt offensive. In houses where plague was suspected, all clothing was burnt on the spot. If the house had a makuti (straw) roof, it was removed and destroyed "to allow the sunlight in".[12] Compensation for destroyed property although promised was neither immediate nor adequate to meet the owners' losses. The medical report gave contradictory evidence. While it called the local populations apathetic, the implication was that most complied. However, Simpson was forced to meet with heads of communities to enlist their aid in gaining cooperation from local populations.[13] Individual resistance was noted from Muslim women who initially refused to be inoculated by male workers. Compliance was generally obtained when a special room for women was maintained at the health centre. With the provision of a female health worker 24,000 of an estimated 30,000 women were inoculated.[14] Collective resistance by railway employees to quarantine resulted in a strike by locomotive drivers. According to the Chief Sanitation Officer: "Case incidence among Railway employees living in the Railway area [was] approximately 10

---

[12] Ibid.

[13] Ibid.

[14] Ibid.

per thousand compared with the general inoculated population which in August 1913 was 0.3 per thousand." Their militant objections to forced removal to the city's quarantine camp resulted in the railway administration establishing a special camp at Kilindini Pier.[15]

Vaccinations against smallpox and plague, distribution of quinine for malaria, and education formed the basis of health prevention strategies. Quinine was made available through the health dispensaries and post office for all island communities although how popular this method of distribution became is not recorded. Inoculation with Haffkine's anti-plague vaccine continued until 1914 when a conscientious objector to war conscription threatened to bring legal proceedings against this compulsory measure. These challenges led to an immediate declaration that Mombasa was plague-free and all precautionary measures stopped.[16] Mombasa would not again be declared an infected area for plague until 1917.

The convergence of two epidemics, smallpox and plague in 1914, spurred intensive education campaigns. Police, medical officers and school teachers both heard and delivered lectures on sanitation and health prevention. Handbills printed in five languages were widely distributed

---

[15]CO 533/138. "Scientific Report on the Epidemic of Plague in Mombasa", by Capt. D.S. Skelton, R.A.M.C.

[16]CO 544/7. Annual Medical Report, 1914.

on the island informing the public of precautions to be observed against plague, cerebro-spinal meningitis (although incidence was low in Mombasa), enteric fever and malaria. As large numbers of the population were not in school, and not literate, the efficacy of any education campaign was suspect in this period.

Communicable diseases actually showed a decrease from 1915-1918, although reporting was unreliable. Influenza, drought and famine all contributed to a stimulation of communicable diseases at the end of the war. MOH Milne reported a rapid spread of tuberculosis and an estimated 75 per cent of the African labour force infected with helminthic diseases. The closure of military hospitals was directly linked to the increase in sickness. Milne estimated that roughly 73 per cent of cases brought to the military hospitals were due to preventable causes. The reports show a noticeable change in tone when reporting on local populations. The derisive attitudes evidenced through the plague years became more sympathetic: "The natives of the coast suffered as severely as their brothers elsewhere, due to the same causes."[17] Therapeutic segregation remained racially constructed. In the influenza circular, very specific therapeutic directions were given for Europeans regarding dosages, remedies and food requirements. Africans were told to take one teaspoon of paraffin oil (not

---

[17]CO 544/7. Annual Medical Report, 1918, p. 24.

recommended for Europeans) and food at frequent intervals.[18]

While 1920 marked a major transitional year for central state policy, with the provision of government medical centres in "Native Reserves" and a commitment to the provision of free treatment for all Africans to "obtain the confidence of [the] native and impress him with the advantages of European methods of treatment and sanitation", these policies had little effect on Mombasa.[19]

Although the early 1920s were noted for substantial immigration of Shiriri Arabs from the Hadramaut, placing increased burdens on housing and food provision for the island, there was actually a decrease in numbers of patients applying to the health dispensaries and hospitals for treatment. As the Coast lacked facilities for pathological investigation, even those reported diagnoses were unrealiable to provide a clear disease profile for the communities. Gilks' statements that there was a debt owed to Africans "not only in consideration of taxation but also because of services rendered in the war..." had no bearing on Mombasa.[20] The city's populations continued to suffer under the rule of exceptionality. According to Nairobi, "a native of Africa is by habit and necessity essentially an

---

[18] Ibid.

[19] CO 544/12, Annual Medical Report, 1920, p. 18..

[20] CO 544/13. Annual Medical Report, 1921, p.20.

agriculturalist and a pastoralist."[21] Mombasa was a cosmopolitan African city. It was not until 1928 that the necessity to both plan and govern Mombasa was fully realized.

State Initiatives: Planning for Local Government

Although Mombasa had been declared a township in 1903, the first town plan was not drawn up until Simpson's Report in 1913. With the move of the capital to Nairobi in 1907 the necessity of planning Mombasa became a secondary concern. A Town Planning Scheme was adopted in 1920 with the creation of the Kenya Colony and Protectorate recognizing the importance of Mombasa as a port whose development would be crucial to the economic growth of the Protectorate. The Medical Officer of Health was given wide authority and responsibility: control of conservancy work on Mombasa Island (including supervision of the Municipal Engineer's Department and a staff of sanitary inspectors), public health for Mombasa District and the Township of Mombasa and port health authority.[22] Until 1925 and the publication of F. Walton Jamieson's "Town Plan of Mombasa Island" (excluding the Old Town), interest in Mombasa centred on

---

[21]"Report of the Native Affairs Department for 1 April 1920 to 31 March 1921", filed in CO 544/12, Annual Medical Report, 1920.

[22]Report of the Local Government Commission, 1927, Vol. I (Feetham Commission), "Report on Mombasa and its Environs", p. 307. KNA: K.352.06762 KEN.

land acquisition and speculation by European business interests.[23] Under pressure to direct and control the construction of Kilindini Harbour, a deep water harbour on the south side of the island, the central government addressed more specifically the need for local government. The ordinance was passed in 1928 and the island of Mombasa began to direct its own municipal affairs. The all-European interim Mombasa Municipal Board met in December 1928 and immediately appointed a Medical Officer of Health for Mombasa, followed closely in January, 1929, with the appointment of a Health Committee. This Committee of five members was in charge of the Public Health Department, care and supervision of public health and sanitary conditions, and the prevention of 'abatement of nuisances'. Representation in May 1929 included Mr. Bomanji, the first Indian appointee to the Health Committee.[24] Financial control held by Mombasa's Municipal Board remained in European hands through this early period but representation, an issue which was contested, included Arab and Indian

---

[23]"Land values in Mombasa are undoubtedly high, probably abnormally high owing to a large amount of land having been withheld from the market pending the carrying out of the Town Planning Scheme, and the imposition of rates upon vacant land....there are a number of small plots held by Arab and Swahili owners of limited resources." Feetham Commission Report, pp. 285-86.

[24]Evidence on the Mombasa Municipal Board, the Health Committee and the General Purposes Committee has been taken from the Minutes of Committee meetings. KNA: ARC/MIL, Box VII, microfilm.

members.[25]

As the Liwali acted as the official representative of the Arab Muslim population, Indian members on the Board and the Health Committee also appeared to have represented their respective communities. At the March 12, 1931 meeting of the Board, Mr. Ghalan Ali petitioned that statistics of Goan and Indian populations be separated, with no reason given in the record.[26] Yet on issues of finance, particularly expeditures, Indians voted as a bloc to lower expenditures.[27] On the recurring item of hospital

---

[25]The Minority Report of the Feetham Commission, presented by J.B. Pandya, a prominent Mombasa businessman and member of the Board, strongly disagreed with the institutionalization of European dominance on Mombasa's Municipal Board. The proposed Council would have 19 members: 13 Europeans including officials, 4 Indians, 1 Arab and 1 Goan. Pandya argued that coast conditions differed materially from the rest of the colony. "I do not agree that commercial interests as such should be entitled to special consideration...the European population is a floating one, and has relatively little permanent interests in the affairs of the town. It would, therefore, be contrary to all canons of elective representation that a small minority of such a nature should have the largest voice in municipal administration....There are certainly sufficient number of capable and efficient persons amongst the non-Europeans of Mombasa who are fully qualified and willing to take the burden of municipal work." He went on to quote from the Commission's report, that "'the constitution of the municipal authority must be so framed as to secure representation of all interests which are fairly entitled to a voice in the management of Mombasa affairs.' I must at once say that as far as the Indian community is concerned the proposed representation is inadequate to safeguard their interests. "Mombasa and its Environs", pp. 312-317.

[26]KNA. Municipal Board of Mombasa. Minutes of the General Purposes Committee. Meeting of 12 March 1931.

[27]Ibid., Meeting of 30 April 1931.

facilities, Indian members repeatedly lobbied for the 'group' hospital rather than separation by race.[28]

Policy directives for a public health programme balanced between disease control and sanitation from 1923. Paterson, Acting PMO, submitted an extensive report on public health to a London meeting of the Colonial Medical and Sanitary Advisory Committee (CAMS), stating the need for organization of data, provision of adequate housing and nutrition. Paterson considered the gathering of vital statistics essential to planning. In addition,

> [t]here has undoubtedly been a tendency in the practice of preventive medicine in the tropics to give great attention to measures specifically designed to secure the prevention of particular diseases and to underrate, or overlook the importance of providing remedies for the fundamental insanitary conditions which are as common to the tropics as in England, the removal of which will secure in many instances the prevention of disease in the tropics equally as it does in England.[29]

The centralization of control and responsibility came three years after the Medical Department had specifically requested it. In 1925, the Department had written to the Colonial Medical and Sanitary Advisory Committee asking that

---

[28]Ibid., Meetings of 30 April 1931, 28 May 1931 and 11 June 1931. The hospital issue was not settled until 1945, under a motion proposed by Mr. Mbarak Ali, and supported strongly by the Indian members of the Committee (Doshi, Rana, Quran and Karve) that the principle of a group hospital be accepted. Meeting of 11 December 1945.

[29]Paterson to 193rd Meeting of the CAMS, Extract from the Minutes, CO 533/296/46531, 20 November 1923.

the colony be organized on the British model. Their concern, which reflected that of the state, was with up-country African reserves and African labourers, but policy suggestions were applied to the colony as a whole.[30]

State Initiatives: Devolution of Local Government in Mombasa, 1928-40

Devolution of responsibility and control over health and disease was formally instituted in 1928 under the Local Government Ordinance. Preventive and curative care, including institutional hospital care, were placed under the mandate of the municipal board. Although representatives elected and appointed to the board argued strongly out of corporate or community self-interest, the health and sanitation policies evolved from local needs rather than Nairobi's plan for the colony. The resurgence of central state direction occurred at the end of this period in 1941 with the anti-yellow fever campaigns. It is perhaps more out of lack of interest that the central state allowed Mombasa to chart its own direction through the intervening years from 1928 to 1940. Nairobi was concerned intensely with recruitment of African labour and economic development of the colony. Mombasa and the coastal strip did not gain attention until the combinations of labour strikes and

---

[30]Memo from PMO Gilks to the Colonial Office, regarding proposed extension of medical and sanitary work. CO 533/332/35677 of August 1925.

disease control peaked Nairobi's interest.

The Health Committee of the Municipal Board of Mombasa outlined its concerns at its first meeting in 1928: Anti-Malarial and Mosquito Campaign, Anti-Plague and Rat Campaign, Public Conveniences, an infectious diseases hospital and an ambulance.[31] By 1930 the budget for house inspections for mosquito control was overspent and control of drainage was an additional expensive concern. The Committee and the Board focussed their attention on taxation, the valuation of houses and property in order to meet the health and sanitation expenses. While conservancy staff was increased, no demands were placed on the European business sector to clean their own borrow pits or swamps. It was not until 1929 that a Malaria Prevention Ordinance was passed which required owners of plots with swamps to drain them.

The heaviest criticisms were directed towards Arab and Indian residential areas, and the African area of Changamwe, housing areas for railway workers. Refuse, drainage and sewage were growing problems through this latter period. Added to the natural increase in population of the Old Town, was the immigration of Shiriri Arabs, mentioned above and the up-country labourers who were not a 'floating population' but becoming a settled population in the African

---

[31]KNA. Municipal Board of Mombasa, Health Committee, Minutes, 30 November 1928 to 22 December 1930.

parts of the island. Initial town planning recommendations and funding had ignored the Old Town. British planners did not want to address the reorganization of this predominantly eighteenth century residential area. As the Old Town was part of the coast strip under the Suzerainty of Zanzibar, taxing property owners was impossible. Through the early 1930s, the Health Committee, chaired by Dr. Seth, repeatedly raised the issue that only with proper housing in the Old Town would the rest of Mombasa be healthy. It was only when, in August, 1933, the MOH declared the state of the Old Town to be "deplorable", and emphasized the terrible conditions under which people were living, that the Board began to discuss a policy of "slum clearance". The Town Clerk recommended Statutory Notices but the Board was worried that temporary improvements would be made, thus disallowing the Board's request for a demolition order. Where would residents go while their homes were demolished? Increased incidence of tuberculosis was raised as well as the need to educate the residents with regard to better conditions.

The Landowners' Association of the Old Town refused to cooperate with the Board to build latrines or any form of sewage removal. The absence of latrines was also a problem at the new "native locations". Although the Railway Administration was asked to share costs, the Board appeared to have little political power of enforcement. The Mbaraki Banda Town had one latrine and the Village Housing Estates,

although somewhat better, reported that 15 per cent of their population had no latrines.[32]

Devolving authority to the municipal level appeared to be an empowering strategy. In reality, monied elites combined to resist responsibility for sanitation and disease prevention both outside and within the Mombasa Municipal Board. In August 1934 the first proposal for funding was submitted to the newly-established Colonial Development Fund.[33] Business capital was once more released from its obligations by a paternalistic colonial government.

A severe outbreak of malaria in 1938 occasioned a new survey. This Old Town survey confirmed what all had known: malaria continued to be a problem, breeding mosquitoes were not controlled. Money was promised to Mombasa for 1939 for a malaria overseer trained by the government entomologist in Nairobi.

But malaria was to be overtaken by an international concern with yellow fever. On 15 September 1939, the MOH received a cable informing him of a suspected yellow fever outbreak in Egypt. In addition, with the British declaration of war against Germany, the Malaria Overseer was recruited to the Kenya Defence Forces. The dreaded mosquito was no longer the Anopheles but the Aedes aegypti. An outbreak of

---

[32]KNA. Municipal Board of Mombasa. Minutes of the Health Committee. Meetings of 22 May 1933, 1 August 1933, 12 September 1933, 17 October 1933 and 13 February 1934.

[33]Ibid., Meeting of 14 August 1934.

yellow fever could completely dislocate shipping and air traffic. By 12 December 1939, the Suppression of Mosquito Bye-Laws had been passed and the war against yellow fever had begun. The push came from the metropole and the Government of India which asked Mombasa what the city was doing to prevent the possibility of an outbreak. On an ironic note, the Government of India was worried about the transference of yellow fever to India by ship. All air traffic from Sudan and Uganda was rerouted from Mombasa to Nairobi.

Prosecutions for violation of the mosquito bye-laws were numerous and complaints against their harsh application equally so. Within three months over 80 people had been charged, almost all of them Indians. Mr. Rana informed the Board that only 8 out of 62 prosecuted under the Refuse Receptacle Bye-Laws had received prior written warning. Discussions at the Board level were heated. The MOH resented any interference with his 'medical' decisions. The Board members accused him and his staff of indiscriminate prosecution and asked that these prosecutions be brought before the Health Committee rather than being decided by the MOH himself. Rana and Shankerdass lost this motion.[34]

In spite of the fact that no cases of yellow fever were reported, the push for increased control continued.

---

[34]KNA. Muncipal Board of Mombasa. Minutes of the Health Committee meeting of 12 December 1939.

Outbreaks in Sudan and the Belgian Congo in 1941 fuelled an intense inoculation campaign for Mombasa and the coastal belt. The intensity of public works and medical department efforts to address the perceived threat of a yellow fever epidemic, and the monies allocated by the state for its prevention and control, outline one of the most important disjunctures of the relationship between colonial and local needs. A comprehensive report was published in 1941 on yellow fever in Kenya.[35] No single case had yet been reported in Kenya, one fatal case in the Belgian Congo and an epidemic in the Nuba Mountains of Abyssinia. The human targets for control were once again the Indian population.

> At present 400 Indians leave Mombasa every fortnight for India, the port of disembarkation being either Bombay or Karachi. Half of these 400 Indians come from Uganda, and the journey from Mombasa to India takes from 8 to 12 days. Although the port of Mombasa is remarkably free from Aedes aegypti other ports on the East African coast are not. The possibility that A. aegypti may thus gain entrance to a ship, be carried to Mombasa and there feed on an Indian in the infective period of yellow fever at an early stage on the voyage to India cannot therefore be excluded. Such a mosquito would be capable of transmitting the yellow fever virus by bite to other persons, on or shortly after, arrival in India.[36]

Suggested measures were quarantine, mosquito eradication,

---

[35]Colony and Protectorate of Kenya. YELLOW FEVER. Report by the Director of Medical Services. (Including a Summary of the Conclusions and Recommendations of the Nairobi Yellow Fever convergence of 1940 and a Memorandum by Dr. G.M. Findlay, C.B.E. of the Wellcome Research Institution, London (Nairobi: 1941).

[36]"Report on Yellow Fever", p. 3.

immunization and early diagnosis using laboratory tests. The infrastructre necessary to comply with these requests would be costly. Because of the perceived threat of this epidemic, Mombasa finally received an entomologist and field assistants; increased medical and health officers and funds for all necessary equipment and contingencies. The Colonial Development Fund addressed the shortfall.

At the same time, malaria mosquito control measures remained underfunded and understaffed. Yellow fever never appeared on the Coast of Kenya while malaria persists to the present day. By 1942 the free distribution of quinine was no longer considered affordable by either the state or the employers of African labour. Drawing on the medical literature derived from experiences with malaria and mosquito control in other parts of the world, particularly India and Panama, the medical department shifted its policy to provision of quinine in exceptional cases only. Kenya's malaria expert was Dr. Garnham, government physician at the Native Hospital in Kisumu.[37] In response to Dr. Paterson's Departmental directive that, "quinine is only to be given to

---

[37]Dr. Percy C.C. Garnham, CMG, FRS, MD, was a protozoologist (received a Diplome de medicine malariologie, Paris, 1931) who served in the Colonial Medical Services from 1925-1947. His scientific achievements included the discovery of the liver stages of the malaria parasite and the elucidation of the full life cycle of many species of malaria parasites. Other research areas included onchocerciasis, parasitic infections and virus diseases. He was a professor in the Department of Parasitology, London School of Hygiene and Tropical Medicine from 1947-1968. Wellcome, CMAC, Acc. No. 19, 161.

children and even then only when the child is obviously seriously ill," Dr. Garnham agreed that quinine should not be used indiscriminately as a prophylactic.[38] He pointed to the problem that many labourers were often given quinine based on a wrong diagnosis of malaria. Dr. Garnham's research on malaria in infants demonstrated "the almost complete tolerance rapidly obtained against the parasite in practically all areas and the comparative rarity of Malaria as a cause of death." He believed that there were "highly susceptible tribes" (Kikuyu, Nandi, Wakamba and others - significantly those groups which produced the highest number of migrant labourers). He suggested that prophylactic quinine be given to Africans who lived in areas where there was an epidemic season of malaria. For Coast populations, then, quinine was not recommended as a prophylactic.[39]

Community Initiatives: Urban Voluntary Associations

Constrained by lack of funds and dominated by business interests, the Mombasa Municipal Board focussed on sanitation and conservancy with some attention to disease eradication campaigns and maternal and child welfare. But

---

[38]Wellcome Trust Institute, Contemporary Medical Archives Centre, PP/PCG/A2 and A3, correspondence of Dr. P.C.Garnham, 1936-44. Included in this file is the "Circular to Employers of African Labour on the Use and Conservation of Quinine" and the Medical Department Circular No. 610, "Use and Conservation of Quinine" for all senior medical staff.

[39]Ibid.

in the growing city of Mombasa, the public's health faced severe challenges. The depression which followed the First World War brought hardships to many communities and the end to what K.R. Paroo has called the "Golden Era". Speaking for the Ismaili community in particular, Paroo reported that the years 1922 to 1937 were the economic 'ebb' for his community and all in East Africa.[40]

Mombasa's Indian communities were vibrant and confident in the early years of this century. Informants insisted that Mombasa be seen as a city distinctly different from the European-dominated Nairobi. Indian immigrants took up residence in this African and Arab city and built in the Old Port next to indigenous urban dwellers. Racism was a feature of Indian life. Indians were restricted not only to specific

---

[40]Kassamili R. Paroo was born at Bagamoyo, Tanganyika in 1906 of a well-known family. His grandfather, Sewa Haji (1851-1897) and Allidina Visram were economic pioneers in East Africa. Sewa Haji was also known for his support of education, including mission schools, for Indian and African children. He provided a philanthropic model which Kassamali Paroo has followed: donated money for funeral ceremonies, provided food to lepers, supported the Bagamoyo Hospital and the Sewa Haji Hospital in Dar es Salaam."Extracts from the Paper Prepared by Mr. W.T. Brown of Boston University", held by Mohamed Keshavjee, Nairobi, typed notes. (Walter Brown conducted doctoral research on Bagamoyo in the 1940s.) The family came to Mombasa in 1913. Paroo's father donated the statue of Allidina Visram which stands in front of the Municipal Buildings in Mombasa today. Interviews with Count Paroo (his official Ismaili title) form a significant background for the discussion of Indian voluntary agencies. Documentation provided by Paroo includes two unpublished monographs: "Pioneering Ismaili Settlement in East Africa" (1984) prepared for H.H. the Aga Khan and "Life Sketch" (1990) prepared for his grandchildren. Details of his involvement in associations will be discussed in the body of the text.

housing areas but also denied access to cinemas and to the Mombasa Club.

Institutional health care was also segregated. Until 1930 there were two hospitals in Mombasa: the Mombasa Hospital for Europeans and the Native Civil Hospital. Those Indian doctors who performed surgery were restricted to the Native Civil Hospital. But the use of the hospital has changed since the 1920s to the present. As Paroo commented, "Asians mostly used it for surgical work...Now if you get fever or something you go to the hospital. In old times you don't go to the hospital. It's all done at home."[41]

Paroo's grandmother gave him quinine weekly as a precaution against malaria. Mosquito nets were also used everywhere. Although he remembered a significant malaria presence, Paroo believed that the populations became immune to some extent. Other informants also reported using home remedies for fevers and stomach ailments.[42]

When Indian communities sought professional medical help, they were treated by Indian doctors. Although the record indicated that ayurvedic practitioners existed in Mombasa, informants acknowledged only those general practitioners qualified in allopathic medicine from India. Their presence, as noted in earlier chapters, was not

---

[41]Interview, Kassamali R. Paroo, Mombasa, March, 1996.

[42]Interview, Mrs. Mohamed Ali Rashid, Nairobi, December, 1994.

welcomed by Europeans. Gregory's research, quoted from the East African Standard, was hardly welcoming to a group of Indian doctors who had arrived from Bombay in 1908:

> 'They work on the principle of no cure, no reward. They carry around with them badly printed books in Babu Language which set forth the various diseases man is heir to and add the amount of reward expected if a patient is cured of any or all....This is is possibly the beginning of a Policy of annexation by India.'[43]

According to Gregory, most of the doctors who were first-generation immigrants possessed a medical degree from the Grant College of Medicine in Bombay and those of second or later generations had attended British institutions, usually Edinburgh.

The first Western-style practitioners were also closely linked to the establishment of private institutions. Dr. Mary de Souza, whose husband was also a physician, was the firt woman physician in East Africa. She was instrumental in founding the Lady Grigg Indian Maternity Home in Nairobi. Her husband, A.C.L. de Souza, had served at the coast as a government medical officer from 1916 to 1918 and, like many of his fellow elites, became a journalist, politician and public benefactor. One of the most popular and warmly-remembered practitioners of Mombasa in this period was Dr. Shanker Dhondo Karve, who came to Kenya in 1922 after

---

[43] East African Standard, 15 Feb. 1908, p. 9 and 25 Jan. 1908, p. 9 quoted in Robert G. Gregory, South Asians in East Africa. An Economic and Social History, 1880-1980 (Boulder: Westview Press, 1993), p. 225.

medical training and military service in India. Dr. Karve served on the Mombasa Municipal Board, the Kenya Legislative and Executive Councils, initiated the Indian Girls' School of Mombasa, and was a leader in both the Rotary Club and East Africa Indian National Congress. Based on an interview with Dr. Karve conducted in 1973, Gregory provided the following biographical information:

> [Karve was the] son of India's most honoured medical doctor, D.D. Karve, the pioneer in women's education who maintained his practice in Poona until his death at age 104. The younger Karve practised initially in Nairobi, then went to Edinburgh for further training, and on his return settled in Mombasa. There, he was a principal founder and chief surgeon of the Pandya Memorial Clinic, which became the most important hospital in Mombasa and, unlike the government institutions, had a non-racial policy in admitting and accommodating its patients.[44]

Dr. Karve opened the first maternity home in Mombasa in 1930. He stated, "I desired to improve the conditions under which midwifery was done by local Dayas. With this object in view, I engaged two qualified nurses from India who had had previous experience in midwifery with me in my nursing home in Nairobi. Indian women are very much averse to having their confinements in nursing homes..."[45] He worked in conjunction with an Ismaili charitable dispensary, discussed below, providing the nurses for this dispensary's midwifery

---

[44]Gregory, "South Asians in East Africa", pp. 218-29.

[45]S.D. Karve, "An Experiment in Midwifery", The East African Medical Journal (Vol. X, No. 12), March 1934, p. 358.

service.

> Under the scheme, I did from 1930 to the beginning of 1933...100 cases representing (roughly) two-thirds of the total births in that community. One can, therefore, be sure that these results were obtained in cases done under one scheme under very similar circumstances, and it was tried by the institution of a maternity box which was given free of charge to the poorer section of the [Ismaili] community and with the aid of financial help from the community to the poorer patients, equalisation in the matter of the conduct of these cases was aimed at.[46]

Paroo spoke of Karve as "expert in all", like the small-town English doctor. He "would even look into the spiritual side of you, give you advice...He was that type of person."[47] Dr. Karve's admission of the presence of dayas is significant as they do not exist in the official records. Oral evidence has confirmed that most deliveries were in homes through to the 1930s.[48] What is interesting about Karve's testimony is his appropriation of this non-institutionalized service into his own nursing home. According to Paroo, whose second daughter was born there in 1934, the maternity home had six to seven beds. Ismaili informants were quick to state how their community was the most 'progressive' through the colonial period.[49] Dr. Karve's initiatives certainly provided a Western-style

---

[46] Ibid.

[47] Interview with Paroo, Mombasa, March, 1996.

[48] Interviews with informants in Mombasa, March, 1996.

[49] Interviews conducted in Nairobi, December, 1995 and Mombasa, March, 1996.

alternative to home births to those Indian women who could afford the fees. The alignment of elites through the window of medical practice and health care became very visible from the 1920s. Clearly, Indian doctors relied on more than private practice for their maintenance. Restricted from access to European patients, Indian doctors like Dr. Karve created niches for themselves, in the light of modern medical science, to enable them to become the public benefactors of the period.

Attempts at Integration: the Mombasa Social Service League

The most influential health care association, established in 1921 and continuing to this day, was the Mombasa Social Service League. It is unclear if their dispensary is the one to which Dr. Karve refers. If it is, then Karve was mistaken about the League's provision of health care exclusively for the Ismaili community. At the time of its founding, the League was the only Indian welfare association that brought together on its Board and in its service, all Indian communities. This association was and continues to be a model of multi-racial, accessible health care. The League's motto was "Service to Humanity is true service to God", and since 3 May 1921 the League had continued to provide a dispensary, medicines, medical consultation and financial support for hospital stays. They have also provided maternity services, aid for school fees

and food for the poor. Donor members also represent every Mombasa Indian community, regardless of religion. Medical personnel, both generalists and specialists, again from all Indian communities, donated their services free of charge to the League. The continued existence of the League points to the state's inability in 1921 and in 1996 to provide adequate, affordable health care for its populations. Whereas users/clients were Indians in 1921, they are Africans today.

Delivering Women: State and Community Initiatives Combined

One of the most significant innovations in policy in the early twentieth century was the institutionalized focus on women and children. The impetus to initiate state policy and practice focussed on Maternal and Child Welfare was generated by the metropole and applied throughout the British Empire. Since the South African War of 1899, the British government was made aware of the lack of physical fitness of males recruited for the war. This knowledge was further underscored by the poor fitness levels of voluntary and conscript men in the First World War. The response of the metropole was to target women as breeders of the nation's infants to instill in them, through state-directed education, knowledge and practice of hygiene and nutrition. Bolstering the imperial race was extended to those native

peoples under the imperial gaze.[50]

Essentialist ideology placed the job of delivering Maternal and Child Welfare on the shoulders of female medical personnel. European nursing sisters were first appointed to native hospitals in 1920 in Mombasa and in 1921 in Nairobi.[51] The colony's health care for women was delivered by nursing sisters, recruited through the Overseas Nursing Association, and attached to the local Health Office as health visitors.[52] Terms of employment were highly discriminatory. Women who married while on permanent appointments were forced to resign and could only be re-hired on a "temporary footing or on agreement". No married woman, therefore, was pensionable.[53] Conditions did not encourage British women to shift their careers from the

---

[50]For British social contexts and policies see Anna Davin, "Imperialism and Motherhood", History Workshop Journal (Vol. 5, 1978), pp. 9-66 and Jane Lewis, The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939 (London: Croom Helm, 1980).

[51]Medical Department Annual Report, 1932. CO 544/37, p.4.

[52]Dr. A.L. Paterson, "Venereal Disease Work in Kenya", East Africa Medical Journal (Vol. 1, No. 12), March 1925, p. 370.

[53]"Code of Regulations for Officers of the Government Service, Colony and Protectorate of Kenya, 3rd Edition", Regulation 47, quoted in: "The Position of Some Women in the Colonial Service (with a special regard to Kenya Colony)", enclosure, letter from (Dr.) Mrs. Michael Shaw to Deputy Director of Medical & Sanitary Services, Nairobi, 2 October 1931, in Mss.Brit.Emp. s.400, Overseas Nursing Association, Box 136/1, 86-95 (mimeo). The only positions which were pensionable in 1923 were the Matron and two nursing positions out of a total of 22 appointments. CO 533/294.

metropole to the colonies. The task of organizing, fund-raising and staffing the required nursing and maternity homes was taken up by elite British women whose duty to the Empire was to ensure healthy populations. Women's commitment in the area of women's health and medical education was not new in the Empire. The Dufferin Fund, established in India in 1885, had been "proudly acclaimed for bringing the benefits of Western civilization to Indian women and, as Lord Curzon put it in 1899, lifting the veil of purdah 'without irreverence.'[54] One of the major dilemmas faced by the Fund's Central Committee concerned medical training. Was it better to recruit for India women educated in Britain or provide the funds to educate Indian women as medical practitoners? British women at home advocated for a women's medical service equal to the India Medical Service. The model chosen for Kenya certainly built on the Dufferin Fund's experiences in India. The government did not have sufficient staff to carry out the mandate of the Maternal and Child Welfare policies. In Kenya, they welcomed the Dufferin Fund model, in the form of the Lady Grigg Welfare League.[55]

---

[54]David Arnold, Colonizing the Body. State Medicine and Epidemic Disease in Nineteenth-Century India (London: University of California Press, 1993), p. 263.

[55]The first such philanthropic association was the Dufferin Fund, formerly known as the National Association for Supplying Female Medical Aid to the Women of India, established by Lady Dufferin at the urging of Queen Victoria in 1885. The Fund was to provide both training, medical relief

The numbers of nurses recruited by the state were never sufficient to meet the hospital and clinic needs of the Colony and Protectorate. As in other British colonies, notably India and Uganda, the call for increased female medical help was answered by the missions and voluntary associations. In Uganda, Dr. and Mrs. Cook, under the Church Missionary Society, were the first in East Africa to organize and institutionalize female recruitment (first European, then African) and local training. In Kenya, it was the private, voluntary sector that responded to the empire's call for healthy mothers and babies. The Lady Grigg Welfare League (with government financial support) opened its centre in Mombasa in 1926.[56] Although the model for the League was the Lady Dufferin Fund, the responsibility for child welfare

---

and institutions to deliver medical care. Medical instruction was provided for women as doctors, hospital assistants, nurses and midwives. Hospital, dispensaries and ward were established under female administration.

[56]Lady Grigg was the wife of Governor Sir Edward Grigg of Kenya Colony. In a letter from Grigg to Sir Henry Lambert of the Colonial Office, 7 July 1925, Grigg mentions: "...my wife has been going into that subject [infant mortality] this very morning with several ladies from Kenya who are anxious to see something in the nature of trained nurses provided for the natives. I promised to look into the question most sympathetically...." Lambert's minute to file states that 3000 pounds would be a sufficient beginning. But the CO replied that the Governor would have to wait for next year's financial estimates. CO 533/21. Investment in Nairobi was considerably larger. Lady Grigg told her husband she required 10,000 pounds to start the Institute. Rotschild Institute donated 3,500 pounds; 2,500 pounds was raised locally; steamship lines gave free passage. The 3,000 pound shortfall was met with private donations of a further 2,000 and a promised 1,000 pound government grant. CO 533/391.

work extended to other organizations as well. Medical missions (at least in Central Kenya) continued to carry out child welfare work, in a manner that Dr. Paterson called "not highly organized [but] very considerable." The Lady Grigg Maternity Centre showed a steady increase in resident deliveries from 36 in 1933 to 169 in 1936. In that same year Health Office sisters showed a total attendance of 33,203 women and 7,317 home visits. The Centre alone undertook to train African women as midwives.[57] Paterson had reported to the CAMS in 1923, "that it had not yet been possible to take any steps towards the training of native women as mid-wives there being no suitable class from which pupils could be recruited. A beginning had however been made with the training of African male nurses."[58]

The Colonial State was not willing to give full responsibility to voluntary associations. The long-term goal was state control of policy and practice, and to that end, the state began to ensure its directional control through legislation. Public health promotion was devolved to local government authorities under the Public Health (Amendment) Ordinance of 1928. The Local Government (Municipalities) Ordinance of 1928, in concert with that of Public Health, arranged for "...the engagement of public health staff and

---

[57]Annual Medical Report, 1935, A.R. Paterson, CO 544/45.

[58]Extract from Minutes of 193rd Meeting of the CAMS, CO 533/296/46531.

the promotion of the public health within the area under their jurisdiction." The two chief types of local public health authorities in the Colony were the Municipal Councils or Boards and the District Commissioners. Councils and Boards were entitled to impose rates locally for public health purposes and under certain circumstances to receive a reimbursement of fifty per cent from the central Government for those expenditures on public health.[59]

Opposition to this transfer of responsibilities to Local and Municipal Governments came from women in the medical service. (Dr.) Mrs. M. Shaw argued convincingly against this shift.

> If these new terms of service came into force nursing sisters will come under what has been termed the Local Civil Service. i.e. they will be recruited locally (<u>if</u> possible) and the terms of service very much altered chiefly in the direction of longer hours - less leave and fewer privileges.....What can one hope to recruit in this Colony in the way of first class trained nurses or health visitors? - and this is emphatically the only type we want....The work here is more difficult than at home and nothing but the best is good enough.[60]

In the following year, 1929, the local administration of Mombasa, in conjunction with the Departments of Veterinary Science and Public Health (a reflection of the

---

[59]Annual Medical Report, 1936, submitted by Dr. A.R. Paterson, CO 544/48, pp. 2-5.

[60]"Extract from a letter from (Dr.) Mrs. M. Shaw", in Rhodes House, Overseas Nursing Association, 136/1/86-95, mimeo.

links between agriculture, food production, business and health), created what would become an annual event: the Mombasa Baby Show. Booths were erected to educate women on all aspects of hygiene and nutrition. Women were encouraged to register their babies for the show in order to select the "Blue Ribbon Baby" of the year. According to informants, significantly more Asian women participated in these shows than did African as two women recounted their mother's stories of winning first prize with these babies! A government pamphlet on hygiene, written in Kiswahili, Bora Afia, was promoted as a reader during the late 1920s and early 1930s in schools.[61]

Sites of Authority and Contention: Midwives Within and Without the State

The Colonial State which so actively and insistently placed "women and children first" in the Empire-wide drive to raise the health status of native colonial populations achieved little success in medicalizing and professionalizing midwifery. The state began its programs by targeting mothers of young children, enticing women through

---

[61]On the "Blue Ribbon Baby" and popularity of the Health Exhibits, interviews with informants (December 1994 and March 1996), residents of Mombasa during this period, provided the personal stories. James H. Sequeira, "The Educational Aspect of Public Health Work in the Tropics (with special reference to Kenya)", the Chadwick Public Lecture delivered at the British Medical Association Hall, London, 28 April 1932 and reprinted in The East Africa Medical Journal (Vol. IX, No. 3), June 1932, pp. 59-78.

intensive propaganda campaigns and annual health exhibitions to come to hospitals for childbirth and to health centres for antenatal medical care. Kenya was following international trends. Natalist politics through the inter-war period formed the basis of both Empire and world-wide health concerns to reduce infant mortality.[62]

For the colonial state, internal and external agents undermined its success. State-generated structures for implementation of natalist policies, begun in 1922, were quickly abandoned by the central state and devolved in 1928 to the local level. While engaged in the rhetoric of maternal and child welfare, which included control and training of midwives, local interest and funds focussed on the antenatal care of children. Midwives did not make themselves visible to the state. Their culturally-embedded birthing practices, in addition, subverted the project of medicalization and professionalization.

Previous studies on this topic have focussed on East Africa as a unit.[63] On closer examination it is clear that

---

[62]Sonya Michel, Mothers of a New World: maternalist politics and the origins of welfare states (New York: Routledge, 1993); Jane Lewis, The Politics of Motherhood; and Valerie Fildes, Lara Marks, and Hilary Marlands, eds., Women and Children First: International Maternal and Infant Welfare, 1870-1945 (London: Routledge Press, 1992).

[63]Beck writes: "By 1914, however, western madicine had established itself in Kenya and Uganda. Statistics bear out this contention." and goes on to cite statistics on hospitals in Uganda. Beck, A History of the British Medical Administration, p. 56 and "Colonial Policy and Education in East Africa, 1900-1950", Journal of British Studies, 5 (1966),

while there were successes--and early ones--in Uganda, these were not mirrored at the Coast. As early as 1917, Dr. Albert and Mrs. Katharine Cook founded a school for African medical assistants and in 1921 established the Lady Coryndon Maternity Training School in Kampala.[64] Data collected by Dr. Cook provide evidence of early twentieth century surgical intervention by medical practitioners in obstetrics. For the capital region, Cook's statistics reported relatively high numbers of women's attendance at the maternity centres. Although the Kenyan Medical Department welcomed educational schemes such as the British Guiana's Baby Saving League in 1918-19, (lectures and demonstrations to mothers on pregnancy and infant health and hygiene instruction to all school children), these efforts remained divorced from practice of medicalized delivery in Kenya, generally, and the Coast, in particular.

The Colonial State in 1919, willing but unable to fund health/hygiene education, encouraged Indian and Goan Associations to propagandize their own and left the missions to carry on with their "excellent medical work" for Africans.[65] There are no statistics for Kenya that

---

128-45. For a comparison with Mombasa, see: R.R. Scott, "Public Health Services in Dar Es Salaam in the Twenties", East African Medical Journal, Vol. VII (1963), 343-7.

[64]Wellcome Contemporary Archives Centre, Cook Papers, PP/COO, 184.

[65]KNA, PC Coast/1/3/160.

paralleled the confidence of Dr. Cook in Uganda who suggested that where maternity and child welfare centres were most numerous, infantile mortality was lowest.[66]

Municipal and District Councils did not take the opportunity offered by the central government to fund the certification and training of midwives. Maternal and child welfare was consistently placed within the wider public health project and then ranked after sanitation/hygiene concerns for funding. While Nairobi had a government hospital training centre graduating women in the 1930s, the Coast's maternity training hospital remained mission-controlled. Managed care was also provided by voluntary agencies, including Indian Associations through respective community nursing homes. The exception to single community institutions was the Mombasa Social Service League, founded in 1921, which stood alone in providing medical care to all Indian groups. Residence in these homes was a mark of status. Ismaili women were among the first to link residence at a private nursing home, Western-style medical care and rising status and affluence. Although costs were subsidized by local communities, fees were considered to be expensive. Indian midwives, trained in India, were employed in Indian nursing homes. Allopathic practitioners report the use of ayurvedic medicine within these institutions but the records

---

[66]Sir Albert Cook, "Obstetrics in Uganda", The Practitioner, Vol. 134, No. 804, June 1935, pp. 748-761.

are unclear as to the midwives' medical training: as certified dais or nurse-midwives, within ayurvedic or allopathic systems.

Opinions expressed by the Medical Officers of Health and medical practitioners generally towards local midwives - both Indian and African - were predictably derogatory. At the 1929 Mombasa Health Week and Baby Show, the modern labour room with mother and infant, staged by the Lady Grigg Maternity Hospital, was a popular exhibit placed next door to a reproduction of the conditions "usually obtaining at the Coast, the mother carefully excluded from light and air attended by a doubtless well-intentioned old lady, with the usual quota of chickens and goats, in an atmosphere of charcoal fumes". Articles in the regional medical journal reinforced medical assessments of the unhygienic conditions of native deliveries and the danger of the unclean, uneducated dais or Indian midwife.[67]

Medical concerns did not translate into state appropriation of infant delivery. Although there was no state acceptance of local midwives, there were also no state attempts at the Coast in this period either to certify already-practicing midwives or actively train Africans as

---

[67]n.a., East African Medical Journal, Vol. VII, No. 6, September 1930, pp. 158-60.

nurse-midwives.[68] African, Arab and Indian women were expected to come to facilities available in Mombasa and be delivered by available staff. Indian nursing homes provided care but not training. The African women available in the Lady Grigg and the Mombasa Native Hospital were usually not from the Coast. Most Coast graduates left to find employment in Nairobi or Western Province and very few worked in rural centres.

Women did make choices about health care for their children that included using state-funded centres. Mombasa women's attendance at Health Centres steadily increased from 9,185 in 1927 to 40,240 in 1937.[69] Maternity figures are very low in contrast. Given the numbers of recorded births at the Lady Grigg, 36 in 1933 and 169 in 1936, as compared to the Medical Department's projected 250 births daily for the colony of 3 million Africans, the percentage of institutionally-delivered births was insignificant.[70] The Mombasa Municipal Board did not commit funds for maternity care and training until 1948 with the transfer of the Lady Grigg centre to city jurisdiction. Provision of nursing homes for Indian women, as stated above, was left to groups

---

[68]The Central Board of Health drafted rules for control of unqualified midwives which were sent to the Nairobi Municipal Council and accepted. There is no record of these rules in the Mombasa Council's minutes. KNA, Annual Medical Report, 1930, CO 544.

[69]KNA, CO 544, Annual Medical Reports, 1929-40.

[70]KNA, CO 544, Annual Medical Reports, 1927-1939.

such as the Mombasa Social Service League.

In Mombasa there continued to be uncertified and unregistered midwives--Asian, Arab, African--and very few registered, certified midwives. Of the eight registered, trained midwives for 1948, the end of this period, one worked at the Mombasa Native Hospital and seven at the Lady Grigg (three Arab; one Swahili; one Ugandan; and two up-country women).[71] Although certification could have been received from the Lady Grigg Home as early as 1930, in 1948 the majority of urban midwives worked outside the system and never became the targets of either state control or regulation.

The devolution of responsibility and funding in 1928 to Local Governments also delayed establishment of training schools for African nurse-midwives. Nursing training for African women did not commence in Mombasa until 1948, almost 25 years after the training of African women was declared by both the Colonial Office and the colonial government to be urgent. The records show African nurses as heads of wards in the Mombasa Native Hospital as early as 1929. These women were not from the Coast but rather from up-country and trained in either Uganda or Nairobi. Until 1948 the Lady Grigg was the only training centre at the coast and was funded through private donations, mission funds and minimal

---

[71]KNA, Health 3/166, Minutes of the Municipal Board of Mombasa,1 November 1948.

state support. Coincidentally, in 1948, the Mombasa Municipal Board finally agreed to accept financial responsibility for the Lady Grigg Maternity Home (both a lying-in hospital and training centre for midwives).

There were significant cultural dimensions to the Colonial State's failure to bring midwives under their legal and medical authority.[72] The state's project was to homogenize conditions of infant delivery. All women would deliver in sterile labour rooms, maternity centres or wards of hospitals and be delivered by medically-trained, certified midwives. In time, birth attendants would be replaced by fully trained nurse-midwives. Following racial segregation as legally outlined in the Medical Practitioners Ordinance and reinforced in the Public Health Ordinance, Indian midwives were to deliver Indian women, African

---

[72]In Mombasa, the colonial government attempted also to control ceremonies, particularly ngoma (literally a drum but the meaning also includes a dance. Ngoma ya kupunga (pepo) is a dance for the exorcizing of a spirit.) through regulation and permits. These social acts of reproduction included medical practices often linking divinatory procedures with types of therapy. While the government believed these activities to be a waste of "energy, time and resources that could be better spent on farming, herding or other employment", what they failed to realize in this early period was that these rituals provided the ground for the maintenance of culture and identity. A Standard Swahili-English Dictionary (Nairobi: Oxford University Press, 1995, first edition 1939). Control through permits began as early as 1908. Twenty-five permits were issued for ngoma ya pepo (colonial translation was 'spirit dances') between 10 March and 10 April 1908 in Mombasa. KNA. CP/84/105. District Commissioner, Mombasa to Asst. Supt. of Police. For a study of the wider inter-cultural dimension of spirit dances, see R. Skene, "Arab and Swahili Dances and Ceremonies", Journal of the Royal Anthropological Institute (Vol. XLVII, 1917), pp. 413-34.

midwives deliver African women, all under the supervision of British practitioners or nurses who, themselves, could deliver women of all races. The organization of medical wards within hospitals by race facilitated this segregation. As Mamdani has noted, institutional segregation was a characteristic feature of colonial rule throughout Africa. Mamdani has used this term within the context of indirect rule and policies of 'native control', particularly through African political institutions. For the Coast, institutional segregation was not restricted to African-European relations but included within its parameters control of Indian communities as well.[73]

Uncertified midwives obeyed none of the rules. They crossed lines of segregation in the cities and crossed local communities in the rural areas. How midwives remained invisible to state authority was certainly the effect of their non-compliance with personal or birth/death registration. More importantly, midwives retained the birth process within their cultural contexts. Women's culture, women's healing practices were not the state's domain.

What could the state offer midwives? Regulation would not have guaranteed better wages. Medical complications could be taken to clinics or hospitals should the midwives decide the birth warranted surgical intervention. These

---

[73]Mahmood Mamdani, Citizen and Subject. Contemporary Africa and the Legacy of Late Colonialism (Princeton: Princeton University Press, 1996), pp. 5-8 and 219.

women had no commitment to medical science, for its own sake, and their clients were very willing to be delivered at home. What the midwife was able to offer was precisely what the state had sought to eradicate: cultural adaptability to the birthing process.

Midwives understood women's culture; this was part of their training. They acknowledged the importance of both the birth process for the mother and the delivery of a healthy baby. For the state the goal of midwifery training was exclusively the latter. The mother would be addressed only after birth through education in hygiene and nutrition for the infant.

> On the night on which a woman is taken with the pains of labor, if she is young and it is her first child, so that she has no experience of childbirth, she is taken to her parents' house to be with her elder relations, her mothers and grandmothers, as well as the kungwi to assist at the birth. This kungwi has with her another woman, called the receiver or recipient, to receive the child when it is born.[74]

According to Bakari, the birth assistant, the kungwi, was an older woman who had assisted the younger's ritual change from a "kigori" [girl] to "mwari" [woman]. His work on Swahili customs has proved valuable for its ethnographic descriptions, but problematic in its tendency to define culture as static and traditional.

In contrast, Mirza and Strobel's informants have

---

[74]Bakari, The Customs of the Swahili People, p.4.

provided a much more complex and changing depiction of the social contexts of women's social production and reproduction. By the 1930s midwives [Kiswahili: mkunga or mzalishi] were engaged who had not necessarily played any other role in the birthing mother's life. For freeborn women and their daughters, the use of a kungwi was debasing, linking them to slave women, the 'others', the 'nyika' who performed dangerous and silly rituals. Bi Kaje, a Changamwe women, freeborn, member of the Three Tribes, described the following relationship.

> Among us in the past there were no makungwi. Back then a kungwi was a person--if a young woman has reached puberty, then she gets an older woman who shows her the proper ways. That's it, she has no kungwi. Nowadays they buy makungwi. That is, makungwi want a lot of money. When a person's child has married, the kungwi wants more money...They are greedy now. They aren't respectable people. Initially here, a daughter like us who is the child of a respectable family, who is known to be freeborn, she didn't wish to go to the makungwi. Those Nyasa, Ngindo, Yao whoever wished it herself,just did it among themselves.[75]

When Bi Kaje was asked about childbirth, she reported the use of midwives, but did not call them kungwi. Births took place at home and midwives were engaged for money (20 shillings or 10 rupees in the 1920s). For freeborn women a certain flexibility opened up for the engagement of midwives in this period. It was understood that the midwife had to perform the proper functions, which included placing heat

---

[75]Mirza and Strobel, Three Swahili Women, testimony of Bi Kaje, p. 59.

under the bed at the time of birth, receive the child (as women gave birth in the sitting position) and visiting for either seven or forty days after birth.[76] This was particularly important for the first birth. But not all Swahili women employed Swahili midwives. Bi Kaje also reported that Mrs. Anthony (a missionary or perhaps a nurse at a clinic, there is no information provided on her) delivered all of a friend's daughter's children.

Acknowledging both parts of this relationship between mother and midwife is crucial to understanding the possibility of state intervention in this period. Even had the state desired to appropriate control of midwifery, it is not clear that it would have been successful. The midwife was hired to help the birthing mother and the child. The process of giving birth was recognized by both mother and midwife to be crucial to the delivery of a healthy child. What characterized this process changed from culture to culture, from community to community. It was the midwife's responsibility to know the culture of the delivering woman and to replicate for her all that was necessary to ensure the delivery of a child, to the mother and the community. For some Swahili mothers, as stated above, the newborn was presented after seven days to the community (or after forty days in pre-colonial times), to hear the call to prayer, and thus acknowledged the infant as a member of the Swahili

---

[76] Ibid., pp. 54-55.

people and the world of Islam.[77]

Mishi wa Abdala, born between 1900 and 1905, was a leader of one of the groups of makungwi. She was a grandaughter of slaves brought from Mozambique to the freed slaves' mission at Frere Town. Mirza and Strobel point to the contrast to Bi Kaje of Ma Mishi's views of ethnicity.

> Ukungwi represents for her a world view, coexistent with Islam as much as does Bi Kaje's orientation as a Twelve Tribes woman....To Ma Mishi, the rituals represent a source of pride, the instilling of proper values, not the meaningless cruelty assumed by outsiders....These rites have changed, however, in being transported from the horticultural, often matrilineal societies in which they were practiced by slaves who were brought to Mombasa. The present rites include an element of Islamic ritual. Moreover, recently the magical aspects of their assumed efficacy--the transformation of the young girl into a woman--have receded, and the function of display seems to have taken precedence.[78]

In this society, women are the practitioners and their roles provide them access to authority and power in a patriarchal society. According to Mirza and Strobel, it is significant to understand the difference between mila (custom) and sharia (Muslim law). "To the extent that sharia prevails, women are excluded; in the realm of mila one finds more

---

[77]Swahili midwives in Takaungu confirmed the importance of the seven days. In their descriptions of assisting the mother, they talked of special teas, foods and massage. One midwife reported that she massaged women to sleep and woke them when it was time to deliver. Interviews with midwives in Takaungu, March, 1996.

[78]Mirza and Strobel, Three Swahili Women, pp. 70-71.

women active and in positions of real power."[79] As medical practice incorporated more of tabibu (book) learning, women's roles were increasingly marginalized. It is because knowledge of midwifery was seen to be experiential or hereditary as opposed to 'learned from the book' that further distinctions or specializations come to be made among women healers.[80]

It is not the purpose of this thesis to investigate sites of women's authority within these complex urbanized societies of colonial Mombasa. But it is impossible to understand both the resistance to and appropriation of women's cultural practices, such as midwifery, as medicalized activities, without acknowledging the shifting bases of cultural authority and renewal. This period was one of transition for women of Mombasa but as the reworkings took place almost invisibly to the formal, male political establishment, the records only show the end results, that is, the acquiescence of Islamic communities to women's education in the 1940s, and the early women's political associations of the 1950s, specifically the Muslim Women's Institute which was founded in 1957.

---

[79] Ibid., p. 72.

[80] Female informants in Lamu who were tabibu, advised women clients on 'female' diseases but did not practice midwifery. Interviews, March, 1996. Parkin also stated that bone-setting became a woman's specialty in Mombasa again because the knowledge was experiental not 'learned from the book.' Parkin, Sacred Void, p. 151.

The multiple local cultures of Mombasa's women provided openings for cross-cultural networks. For Shirin Virjee, an Ismaili midwife with over forty years' private practice in Mombasa, hospital-trained in Nairobi, the most important qualification for midwifery was "patience". Added to Shirin's words are those qualifications which she took to be understood: sensitivity, respect, availability, caring, wisdom and knowledge. Shirin delivered Indian, African and Arab women of all communities. She knew which women would want to deliver while sitting in a chair and who preferred to sit on the end of a bed. She knew what foods each group of women preferred to take before and during labour. Shirin could say that Jaluo women rose the next day for work while Swahili women expected her to come daily for seven days while they remained in. She gave all of this information without judgement. Women had the right to choose how to deliver their babies. Shirin was perhaps unusual in her wide-ranging cultural experiences, but she was typical of all midwives who knew that the birth process was signally important. Other female midwives of the coast affirmed the importance of these personal qualities and birthing skills. Mama Hanima demonstrated how she massaged women when they were in labour. She boiled special roots for a tea, and then blew into the liquid, "to give women the strength to

push".[81]

The state never truly understood the culturally sensitive role of the birthing process and, indeed, under the guidance of medical science, sought to eradicate any customs that would have reinforced the cultural specificity of birthing. Midwives, in contrast, carried on their medically subversive, culturally-resonant practices.

Conclusion

This period was one of building networks. Consolidation of state government at the local level provided a vehicle through which medical concerns, particularly those of sanitation and public health, could be discussed. Health care delivery remained outside the formal bureaucratic organizations. European interests continued to be served as individuals through clinical private practice and collectively through control of representation and funding on the local government boards or administrative posts. Indian business and professional elites fought for and achieved increased representation on local government bodies but, for the most part, were denied access to real power, as evidenced through the ongoing discussion of their request for a group hospital. Their most effective health delivery was instituted through voluntary welfare associations, most

---

[81]Author's interviews in Mombasa, Takaungu and Lamu, March, 1996. Mama Hanima was interviewed in Takaungu.

of which were established by an individual community to serve its own. The one exception was the Mombasa Social Service League, which aimed at representing and serving the needy of all Indian communities.

Africans and Arabs, populations challenged by intense immigration of up-country and hinterland labourers, continued to provide their own healing treatments, appropriating through contact therapies or practices of the new urban residents. Digo labourers were particularly effective as transmitters of Islamicized African medical practices into the communities of Mombasa. By the mid-1920s, Indian wholesalers had become vendors of ayurvedic and unani therapies for all communities, regardless of race or religion.

Women of Mombasa, particularly Swahili women of long residence in the city, retained identification with their respective communities, resisting inclusion in maternal and child welfare programs while maintaining their internal networks. Midwives were exceptions in this period. Their professional skills could serve those women whose own communities were in states of transition--from slave to freeborn status--or women from 'other' African groups whose attachment to waged labour or labourers forced them to reside in the city of Mombasa, without kin or community linkages. Women's health-seeking activities represented contradictions as they evidenced both the tightest

boundaries for their own groups and professional flexibility for cross-cultural health delivery.

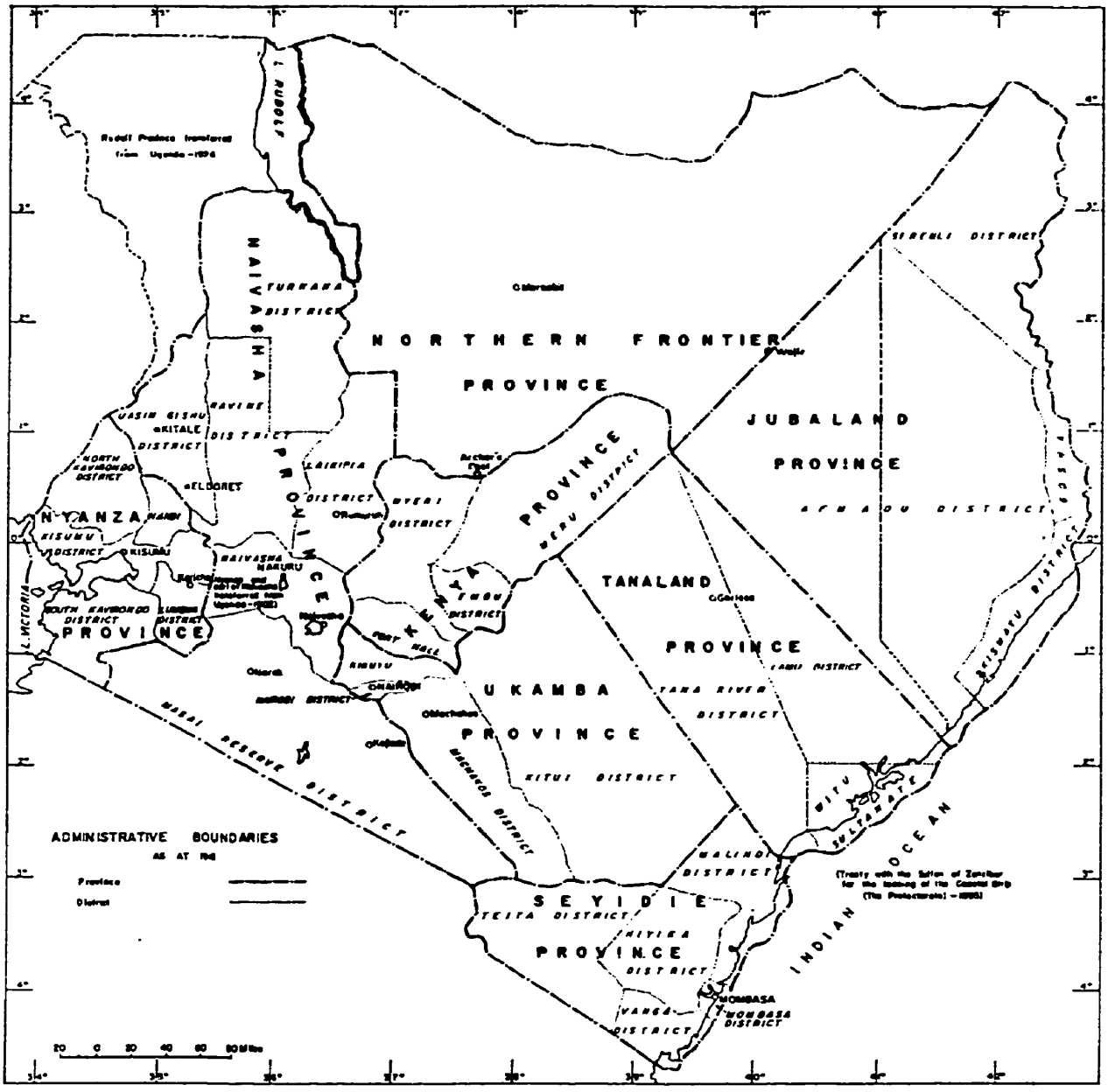
CHAPTER FIVE

RURAL INITIATIVES AND RESPONSES TO HEALTH AND DISEASE, 1913-1940

Rural studies provide the contexts which enable us to appreciate the strategies of African populations to address the disruptions and changes to their lives as they increased their contact with the Colonial State and its economic agents. And yet rural voices have been the most underrepresented in the historical record. Their silence in the colonial record is due partly to the dispersed and migratory nature of the populations making the gathering of evidence difficult, as well as colonial disinterest in the heterogeneity of rural populations. Historians rely on the ethnographic research of anthropologists to assist in understanding the changes and continuities of African rural populations through the colonial period. Given the nature of the construction of ethnographies, the localized, micro-level of social research, two areas, Digo and Giriama, have been selected for examination in this chapter. They could not be entirely representative of rural populations but as they are compared below, the similarities and differences between the districts provide a base from which a discussion of non-urban populations can begin.[1]

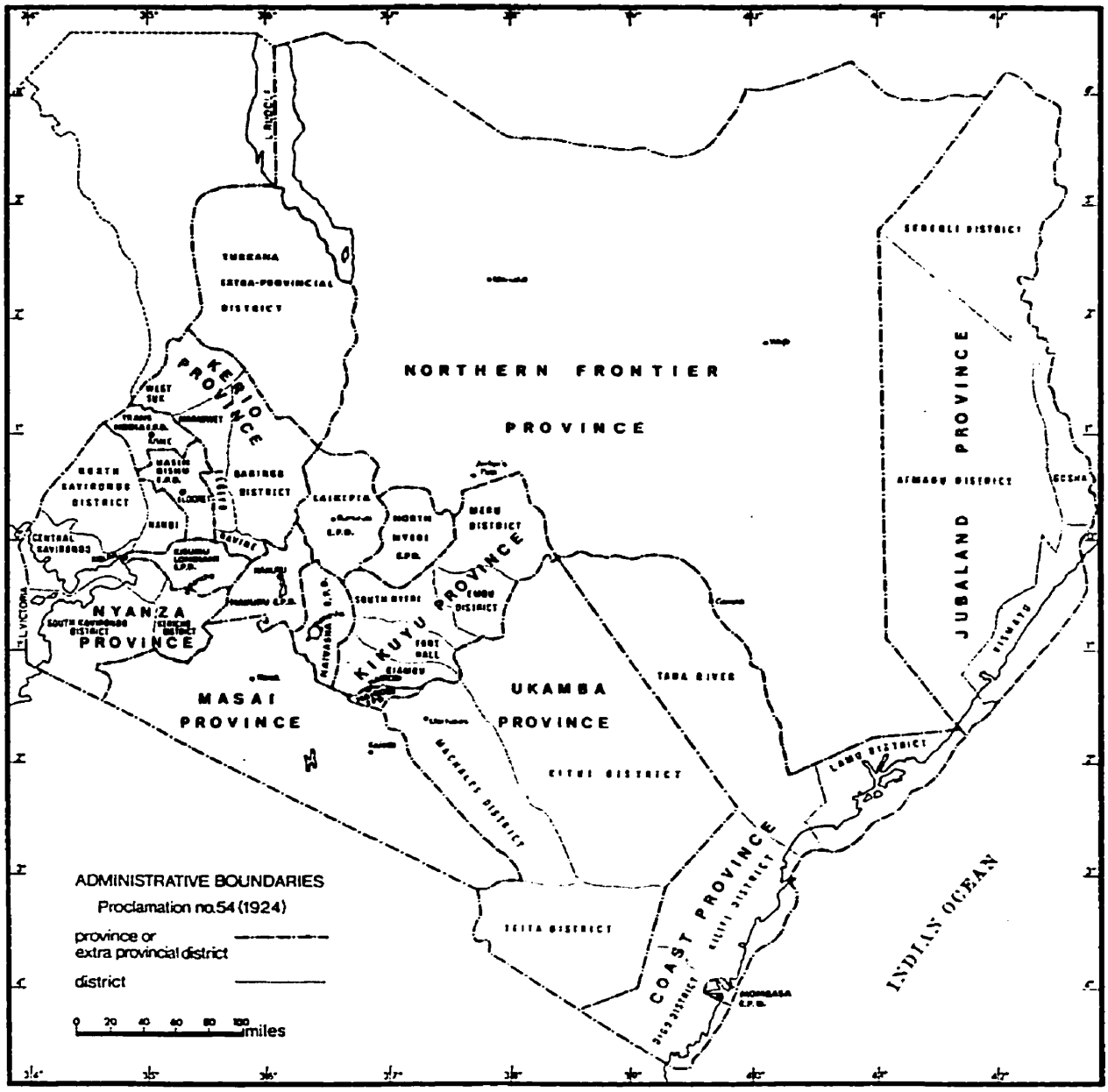
---

[1]The two areas under consideration, Digo and Giriama, are not synonymous with the geographically defined, administrative term "district". Official districts changed names and boundaries frequently throughout the early colonial period. From 1913 to 1919 Giriama Sub-District, which had been part of



MAP 4. Administrative Boundaries as at 1918

SOURCE: S.H. Ominde, Land and Population Movements in Kenya (Evanston: Northwestern University Press, 1975).



MAP 5. Administrative Boundaries as at 1924

SOURCE: S.H. Ominde, Land and Population Movements in Kenya (Evanston: Northwestern University Press, 1975).

An examination of medical practices and concerns for Digo and Giriama districts of the Coast has involved three levels of inquiry. Although labour migration expanded both the experiences and cultural possibilities of rurally-based populations, in the area of medical knowledge the rural areas continued to privilege local healers and practice. In these districts, Qur'anic scholarly healers, for example, have made little impact on the construction of medical knowledge. As urban-based practitioners, their direct influence has not been felt. However, in the area of medical practice, Islamic disease categorizations, therapies and the use of Qur'anic verses in amulets have gained in popularity and visibility through this period. Their influence has been manifested primarily in the areas of spiritual healing. Evidence below will show how disease classifications and etiology which were named in the Digo language in the late nineteenth century became "Swahilized" and Islamic by the end of this period. Convergence and appropriation were unevenly distributed on the Coast, although even non-Muslim Giriama, by the 1940s, had incorporated Islamic medical therapeutics into their own systems.

The Digo area lies just south of Mombasa and was the

Malindi District, was constituted as a separate part of Seyidie (Coast) Province. Kwale District was renamed Digo District in 1924 and reverted to Kwale again in 1946. For the purposes of this chapter, Digo and Giriama districts are those areas in which Digo- and Giriama-speakers lived from 1913 to 1940.

last Coast district to become Islamicized. Evidence for this level of inquiry has been based primarily on the field research and published and unpublished research of Sperling and Gerlach and secondarily on mission records.[2]

Comparison with the Digo district has been provided by an examination of evidence from a northern area. The Giriama district, north of Mombasa, was the site of late nineteenth and early twentieth century migrations from rural kaya centres to the coastal strip. Substantial ethnographic evidence on Giriama-speakers has been provided by the research of David Parkin and his students.[3] WaGiriama, like

---

[2]See particularly David Colton Sperling, "The Growth of Islam among the Mijikenda of the Kenya Coast, 1826-1933", Ph.D. Dissertation, School of Oriental and African Studies, University of London, 1988; Sperling, "The Frontiers of Prophecy", p. 83-101; L. P. Gerlach, "Some Basic Digo Conceptions of Health and Disease", and L.P. Gerlach, "The Social Organization of the Digo of Kenya", Ph.D. Dissertation, University of London, 1960.

[3] Research on Giriama peoples has been the life's work of anthropologist David Parkin. Through an extensive ethnographic relationship with Giriama-speaking communities that began in the 1960s and continues to the present, Parkin and the students he has sent into the field have amassed comprehensive evidence on Giriama communities throughout this period. Major works which have been consulted for this section include two monographs: Parkin, Palms, Wine and Witnesses, Sacred Void; and two seminal articles: David J. Parkin, "Politics of Ritual Syncretism: Islam Among the Non-Muslim Giriama of Kenya", Africa (Vol. XL, July 1970), pp. 117-33; "Medicines and Men of Influence", Man (Vol. 3, 1968), pp. 424-39. See also:

the Wadigo, form part of the Mijikenda peoples. While many have remained outside the Swahili communities, others have been intensely influenced by Swahili and Islam through their close residence and intermarriage. Early twentieth century Wadigo and Wagiriama medical knowledge and practice has shown the resilience of locally-derived, orally transmitted disease categorizations. Both populations have syncretized Islamic textual authorities and spiritual knowledge into their own, with the Wagiriama opting for complementary medical knowledge and the Wadigo, who have become Muslim, subsuming more of their practices to the rubrics of Islam.

The second focus of this chapter is institutionally-based. In 1925, health and sanitation activities of the rural coast populations were placed under the authority of the Local Native Councils (LNCs), which continued to 1940 in this legally constituted form. Minutes of Local Native Council meetings as well as supplementary district archival reports of Digo and Giriama districts have been examined in order to present the articulated concerns of local populations. Problems of representation, discussed below, culminated in 1945 in an institutional challenge to the Local Native Councils (from 1940 termed African District

---

Thompson, "Speaking 'Truth' to Power", and Monica Udwardy, "Gender Metaphors in Maladies and Medicines. The Symbolism of Protective Charms among the Giriama of Kenya", in Anita Jacobson-Widding and David Westerlund, eds., Culture, Experience and Pluralism (Uppsala: Uppsala Studies in Cultural Anthropology, Acta Universitatis Upsaliensis, 1989).

Councils) by constituents who did not feel their concerns were either being heard or met by the LNC membership.[4] The drive for district-based welfare associations dates from 1945. In 1947, the state reorganized health care delivery for urban and rural areas through the establishment of health centres, linked to district hospitals and dispensaries.

Anti-disease campaigns remained through this period as markers of state interest and intervention. Two such campaigns will be discussed in this chapter. The first was the anti-hookworm campaign led by Dr. Phillips from 1927 to 1929, seen to be highly successful and locally relevant. The second, the yellow fever campaigns of the latter part of the period, were also touted by the state as successful although they were of no local relevance, given that yellow fever did not ever present itself on the Coast. Although throughout this period malaria continued to be a difficult and sometimes manageable disease, it was ignored in rural areas. State-funded anti-malaria campaigns were urban based.

A third focus of this chapter is on medical concerns and healing space allocated to and appropriated by rural women. As in Mombasa, evidence has shown that rural women

---

[4]The 1940s mark a period of intense metropole interest in colonial development evidenced by the Colonial Development Welfare Acts initiated to encourage economic growth by both settler and indigenous populations. The discourse shift from use of the term 'native' to 'African' reflects the more inclusive policies of the Colonial Office.

maintained networks of health care delivery for themselves and their children that lay outside the formalized systems of health care. They were absent from the recruiting and training programs for dressers and dispensary assistants for reasons of gender and, concomitantly, insufficient education. In the area of midwifery, women continued to service their local populations outside the formal clinics and dispensaries. For the later part of the period, women were reported to have become increasingly involved as spiritual healers, or healers of diseases with a spirit-based etiology. Female populations became an item of short-term interest at the Local Native Council Meetings of the late 1920s as a result of state interest in female circumcision.

Mission and Islamic Medicine: Conversion and Convergence, 1913-1925

The Church Missionary Society faced increasingly diminishing numbers of applicants for field service by 1914. The First World War was primarily responsible for post-1914 reduction but the CMS College was "forced to adopt a policy of retrenchment on the mission field some years before 1914."[5] While missionaries in the field reported a mass

---

[5]Alison Hodge, "The Training of Missionaries for Africa: The Church Missionary Society's Training College at Islington, 1900-1915", Journal of Religion in Africa (Vol. IV, 1972), p. 96.

movement toward Christianity and a need for schools, the Society was unable to meet their demands. In the rural districts, missionaries performed teaching functions primarily. Dispensaries, even hospitals such as Kaloleni (Edwards Memorial Hospital), were not able to staff their institutions through the early 1920s. In the Digo area, where CMS missionaries had first established a site in 1882, they were unable to maintain mission continuity. In a missionary report of 1903 the CMS Secretary at Mombasa stated: "We must make great efforts to put teachers among the Wanyika (sic Digo) soon, or we shall find increasing numbers becoming Mohamedans. The transition from Heathenism to Mohammedanism is so easy...".[6] And they were right. WaDigo converted in large numbers to Islam throughout this period. In medical matters as well as other cultural aspects, Islam did not conflict with local knowledge and customs, but became either a source of new knowledge based on "the book", integrated completely or offered as alternative therapy.

Giriama peoples also resisted conversion to Christianity from time of early contact. As the state attempted increased land control and appropriation, the Giriama Rebellions of 1913-1914 solidified their policy of non-cooperation with colonial administrators as well as

---

[6]James D. Holway, "C.M.S. Contact with Islam in East Africa before 1914", Journal of Religion in Africa (Vol. IV, 1972), p. 208.

Christian missionaries.[7] Even Islam had little success among Giriama until the middle of this century and in this late period only among Giriama who migrated to the large towns of Malindi and Kilifi. According to Parkin, it is the strength and cohesion of the Giriama community's social organization through periods of change that has allowed them to maintain control of the production and reproduction of medical knowledge.[8]

Many Giriama have syncretized their knowledge with facets of Islam; borrowing both Islamic medicines and appropriating Islamic spirits into their own. Parkin's research concluded that in the latter part of the nineteenth century, the period of dispersal from the kaya, some Giriama came to consider Islamic medicine more powerful than their own.[9]

---

[7]Spear, The Kaya Complex, pp. 140-43; and Brantley, The Giriama and Colonial Resistance, Chapter 7.

[8]Parkin, "Medicines and Men of Influence", pp. 424-39.

[9]The dispersal of Giriama peoples from the kaya was discussed in Chapter III. The kaya are physical locations in the forests of Giriama-land (cleared land on a hilltop surrounded by dense forest), sacred sites of ritual as well as the defining characteristic of Mijikenda identity. The Giriama are one of the nine groups that make up the Mijikenda. Kayas represent a space and time continuum, that is, there was a kaya-time (before nineteenth migrations to the coast) when communities lived as clans and maintained their cohesion through direct kaya links. See Spear, The Kaya Complex for discussion of kaya origins. Contemporary Giriama waganga continue to travel into the forests for medicinal plants and spiritually-blessed objects used in healing practices. Interviews with healers on the Coast corroborated Parkin's research. The most prominent are those of the Kabwere family, highly esteemed waganga, whose compound houses over one hundred people, all of whom participate in some way with the

He linked this influence to contact with Arabs and Swahili at the coast but also interestingly to Giriama shifts in the base of medical knowledge. Parkin investigated internally-held Giriama characterizations of eastern tree farming peoples as "plagued by witchcraft and spirit possession" while western cattle-keepers "have greater respect for their ancestors and for the work and sanctions of the Vaya and other Kaya elders...." Giriama migrants in the 1920s came from these western cattle keeping areas and became planters of coconut palms and other trees. They were involved in the palm wine business and copra trade, selling their produce to Swahili and Arabs in Mombasa and along the Coast. "Swahili traders and Muslim holy men themselves came to settle in Kaloleni, setting up a Friday mosque there. In this way, Kaloleni, which had itself once been a cattle-raiding area, became inextricably a part of the coastal economy and, to a lesser extent, coastal culture."[10] In contrast, cattle-keeping homesteads, with minimal contact with Muslim Swahili and Arab traders, exhibited no evidence of Islamic 'active possessory spirits" in their spiritual

---

family business, one that has been in active existence since the 1920s, although they offically left the village in 1938. Kabwere Wanje, who died in 1995, father of the men interviewed, was himself the son of a kaya and vaya elder, and headed the Malindi Branch of the Mijikenda Union in the 1960s. Interview with Silvester Felix Mlanda, Manager and other members of the Kabwere family who continue to operate "Kabwere Wanje & Sons. Famous Herberlist [sic] & Spiritual Healers" Msabaha, near Malindi, March 1996.

[10]Parkin, Palms, Wine and Witnesses, pp. 18-19.

medical compendium.[11]

Thompson's ethnographic research on Giriama divination documented healing strategies, specialization and gendered roles in contemporary Giriama society. But it is her comparisons with the kaya times that are of relevance to this period. According to Thompson, practices that were corporatist in kaya times have become individualist in the contemporary period. Medical knowledge owned by males consisted of protection against present threats to life. Their domains include environmentally-caused diseases as well as those considered spirit-caused. Female roles were confined to threats to future life, that is, reproductive problems, illness of children, or midwifery. Midwives (ahokere, "the receivers") treat problems associated with pregancy, childbirth and women's diseases because the source of these illnesses is thought to be the "Divine Creator". As Giriama migrated to the urbanized coast, the female roles were those most threatened by encroachments of Western medicine. The state, in its attempts to institutionalize

---

[11]Parkin, Sacred Void, pp. 50-51. The bolstering of power and authority through the acquisition of 'outside knowledge' has been the practice of kings and rulers in communities and civilizations around the world, over many centuries. A very sophisticated analysis of why and how "...the attempt to bolster or sanctify state authority through reference to the spiritual and political power of a geographically as well as ideologically wider world" is masterfully and eruditely discussed in Chapter 4, "The Authority of Distant Knowledge", in Mary W. Helms, Ulysses' Sail. An Ethnographic Odyssey of Power, Knowledge, and Geographical Distance.(Princeton: Princeton University Press, 1988), pp. 131-71.

Maternal and Child Welfare, also created the basis for the diminution of female power and the shoring of male elites. Male waganga, especially those who were literate, could advance their knowledge of diagnostics and therapeutics as they came into contact with Islamic 'book' medicine.

> Most important leadership activities in kaya times were carried out by elders in their roles as "healers" (aganga). Senior ruling elders of the kambi council were collectively known as akuzi, (sing. mukuzi) a title referring to their knowledge of the most powerful medicines. In the kaya the important task of ritual cleansing using medicines known as viza (pl) was carried out by akuzi. Akuzi were probably the most influential men and women in Giriama society.[12]

That Giriama patterns of authority diminished with the dispersals of the colonial period was evidenced by the ceasing of kaya-based ceremonies of age-grade initiation after 1925.[13] Men kept alive particular oath-taking ceremonies and societies (particularly the Fisi or Oath of the Hyena). Women's societies of Kifudu and Forudahe continued through this period in spite of the shifts of land base. The context for women's medicines inextricably linked the physical land with the idea of maintenance of Giriama identity. Women's medicine was called mwanza wa kiche, or Makushekushe medicines used to define domestic and public social order. Brantley documented the women's use of Makushekushe medicine as an oath to proscribe a number of

---

[12]Thompson, "Speaking 'Truth' to Power", pp. 81-82.

[13]Ibid., p. 85.

activities encouraging unity against the British at the time of the Giriama rebellions, 1913-14.[14] Although it was the women's medicine that formed the strongest resistance to the British, "...the colonial government officers...continued to focus on the Elders of the Hyena Oath [males] who they saw as the controlling force in Giriamaland."[15]

Official medical records of the Coast, upon initial examination, appeared to have ignored local medical knowledge but further investigation has shown that what was 'medical' was subsumed under other categories of colonial discourse: divination, witchcraft or sorcery. "Colonial officers might occasionally encourage Kaya elders to carry out traditional ceremonies, such as rain-making or greeting the Giriama new year, but only ever for the benefits they might bring in pacifying unrest in the country, and not for

---

[14]One of the most interesting female resistance leaders of this period was Mekatalili who fought against British appropriation of Giriama male labourers and, as a healer of the land, wanted to "restore the country to its old condition". Arthur Champion, the District Commissioner, reported: "[Mekatalili and Wanje] collected a following under the guise of making harmless enquiries into the question of the rains (always a draw). The curious soon came to see what was happening, and in no time the witch Katilili got their attention and told them that the Government headmen had received each 1,000 R to sell young men to the Europeans, that the Europeans would send them over the sea and they would be sold as slaves and never see their native land again. That now was the time to resist for the Europeans had no power." Arthur M. Champion, "October Report on the Present Condition of the WaGiriama," October 1913 (KNA: CP 5/336-I), in Brantley, The Giriama and Colonial Resistance, pp. 85 and 150.

[15]Thompson, "Speaking 'Truth' to Power", pp. 94-95.

their value as part of a wider animistic philosophy."[16]

As in urban Mombasa, government agents sought to control and periodically ban spirit possession dances, funerary and oathing ceremonies. There was no possibility of policing the rural areas. These social acts of reproduction included medical practices often linking divinatory procedures with types of therapy. While the government believed these activities to be a waste of "energy, time and resources that could be better spent on farming, herding or other employment", what they failed to realize in this early period was that these rituals provided the ground for the maintenance of Giriama culture and identity.[17]
Rituals restored the purity of the kaya, according to Parkin. "Preserving or restoring the inviolability and sanctity of place is also reflected in the idea that the Kaya is complete, whole and self-sufficient (-zima) as regards the customary and medical knowledge which it, its forest and its elders hold....I[Parkin] would privilege the idiom of 'cleansing' and 'expelling dirt/death/disease/evil' over and above that of 'awe' as the dominant attribute of the Kaya's characterisation and appeal."[18] This urbanizing community adapted their rituals to new economies and

---

[16]Parkin, Sacred Void, p. 194.

[17]KNA. CP/84/105. District Commissioner, Mombasa to Asst. Supt. of Police.

[18]Parkin, Sacred Void, pp. 213-22.

cultures (Swahili) to replace the kaya-based reproduction of social bonds and practices.

Colonial governments in the 1950s and 1960s, just prior to independence, became very aware of the potential political power and challenge to the idea of homogenous 'nation' that could be wielded by groups who constantly reinforced their separate identities. Historians have examined the anti-sorcery movements of sub-Sahel Africa as possible precursors of revolutionary action against the colonial state. Parkin has pointed to the role these movements played internally to "redefine new sources of authority and economic opportunity". His research on witch-finding cults on the coast has demonstrated that control of medicines, or the trading of medicines as physical commodities, was a site of struggle for the redefinition of roles of influence and authority. The 1966 movement of the Mijikenda Union which threatened to eradicate the use of all medicines in the country because: "[m]edicines, they said, involved sorcery and people should in future use the government and missionary dispensaries and hospitals" falls outside the time frame of this thesis.[19] However, both the notions of medicines as commodities and their roles within struggles of role redefinitions remains a research area to be explored. The roots of these colonial struggles lie in the precolonial past.

---

[19]Parkin, "Medicines and Men of Influence", p. 433.

Whereas Giriama contact with Muslims was minimal, Digo (a southern Mijikenda people) trading relations were intense. The expansion of Islam south of Mombasa into the Digo area occurred late for the Coast, between 1865 and the 1930s. Early missionary reports document the use of Mijikenda as caravan porters in the 1840s.[20] With trade and contact came conversion. According to Sperling's informants, a number of Digo (particularly in the Rabai area) converted to Islam because of sickness; some had even been told to do so by their waganga in order to be cured. From as early as the 1880s, links between conversion and convergence of medical knowledge were established. For the early part of this period, "[a]nother group of Mijikenda, the sick and possessed, was liable to conversion by Muslim healers, but the random influence of healers tended to be less enduring than influences stemming from regular contacts."[21] Trade and the beginnings of migrant labour populations of Wadigo moving in and out of Mombasa provided such contact.

Periods of crisis also called for new solutions. During times of great famines, conversions grew in number. "His [Kivoyero Mwapodzo] conversion took place at the time of the

---

[20]CMS Archives, CA5/M1/575, Krapf's journal entry for 26 March 1845. Another missionary, Erhardt, reported that: "The leader was usually a renowned Muslim mwalimu (diviner or healer) who carred "a banner containing a protective charm". See Erhardt's "Reports respecting Central Africa, as given by Caravan leaders".CMS, CA5/MS file, RGS.

[21]Sperling, "The Growth of Islam", pp. 171-73.

Mwakisenge famine (1884-85). During the famine, Mwapodzo and his father went to stay with Digo (Muslim) relatives at Takaungu. At that time both Mwapodzo and his father contracted smallpox. Whereas Mwakulenje Podzo died, Mwapodzo 'was cured and became Abdallah'. When he came back after the famine he was a Muslim, and 'was speaking Swahili'."[22] This pattern was repeated over the next forty years. Through the famine of 1916-17, the smallpox epidemic of 1919-20, food shortages of 1921 and floods in 1922, oral evidence has documented the links between difficult economic times, sickness and conversion to Islam and use of Islamic healers. The period of greatest consolidation of Islam in the Digo areas corresponded to the drought, floods, smallpox, influenza and smallpox epidemics of 1918-23.[23]

---

[22]Interview with informant Abdallah Makanzu, Diani, 5/12/67 in Sperling, ibid., p. 147.

[23]Sperling, ibid., Chapter V and quotes from Tour Diary, Vanga District, entry for 28 April 1921, KNA, Coast Province, MP/47/1156; DC/KWL/1/1-8; DC/KWL/2/1 for Vanga District, cited in Chapter V. There is a second issue, regarding land alienation that affected the numbers of conversions. While the government by 1915 required that Title Deeds be filed to document individual ownership of land as both a method of land appropriation and the construction of the 'native' versus 'non-native' categories (each would inhabit separate residential areas), Digo Muslim converts, in a strategy to continue land ownership, often filed applications for Title Deeds. Digo who had converted to Islam and filed applications for land were considered by the government to be Swahili, and, by definition for the Coast a detribalized 'non-native' (given the 'special status' appointed to Swahili on the coast in this period). The government encouraged claimants to withdraw their applications on the grounds that individual ownership of land was contrary to customary law. Exploration of this relationship is beyond the scope of this thesis and waits to be properly researched. Ibid., pp. 130-31.

According to one of Sperling's informants:

> "My grandmother was born in Kauma. Her parents weren't Muslim, but she became a Muslim because of her mother's sickness....When my grandfather came to Takaungu from Conui during the Magunia famine [1899], he was already a mature man. He was one of eleven children (ten brothers and one sister), the rest of whom all died of smallpox....My mother was a Duruma....When my grandmother reached Takaungu she was taken in by Abdallah bin Nasir. She became a Muslim."

Another informant spoke to the links between contact with Swahili, Islam and the continued use of local herbal medicine:

> "...He [talking about a slave] was so favoured by his master that he was even taken on the pilgrimage to Mecca....The doings of the Mazrui were amazing. For example, once Rashid bin Salim's sister was sick and needed special medicine from the forest. The town-crier went around blowing his horn and announcing that all the people of the town had to go out into the forest to look for the medicine, whoever ignored this call do so at his own risk."[24]

Some informants did not consider the conversions serious. Sperling reported that persons from Tsimba who were sick or possessed by spirits would go to Mtongwe, a village of many Muslim conversions, in search of treatment. His informant stated:

> "There they would be told, Are you feeling pain?....you had better become a Muslim...There were others who went to Tiwi to be cured of sickness or spirit possession, and were converted there. People who were converted in this way didn't behave like Muslims, they didn't pray or fast. At that time the Digo didn't want Islam; they didn't become Muslims because they wanted to,

---

[24]Sperling, "The Growth of Islam", Appendix VI. Ten Biographical Sketches, pp. 198-203.

but because they were sick or possessed."[25]

A most interesting feature of the syncretism of Islamic medicine and Digo healing practices was the addition of a new type of healer. As of the 1920s, the Mijikenda mganga was joined by the Swahili-speaking, Muslim tabibu or, if also a teacher, a mwalimu. Muslim Swahili had already incorporated utabibu wa kitabu or "the art of healing by the book". The reference is not necessarily to the Qur'an directly but to written medical texts, some of which had been handed down through families. These texts were produced on the East African coast as they contained Swahili words and references to local medicines. The mganga was an unlettered healer, one who had not studied from texts and did not have to be literate to be a healer.

Whereas a Swahili tabibu would prescribe potions and medicines parepared from roots and herbs (miti shamba) in the same manner as a Mijikenda mganga, the tabibu would also follow techniques described in the written texts. In addition, the Swahili tabibu used herbs imported from India, whereas a mganga used local roots and herbs. But the waganga would also use pieces of written text of the Qur'an to prepare amulets (hirizi; Arabic hirz).[26]

---

[25]Interview with Juma Zani, Kundutsi, 17/12/67 in Sperling, ibid., p. 126.

[26]Sperling suggests the texts were Sahih of al-Bukhari, or Sa-at ul Khabar, printed in Cairo. Information was provided to Sperling by informants and appears in the Appendix to his

According to Parkin, Swahili women tended to specialize in treating spirit possession and in exorcism. Other specialities, particular to Mombasa, were those of women who set broken bones (considered a Digo specialty) and midwifery. Midwives (mikunga) because their knowledge was 'experiential' or 'hereditary', could not be considered tabibu.[27]

A very rich study, conducted in the late 1950s, by a medical anthropologist, L.P. Gerlach, confirmed the research of Sperling. Although the report falls outside the chronology of this thesis, the informants and the medical knowledge they present show marked continuities and, indeed, the entrenchment of Islam from the beginnings documented in Sperling's research. Gerlach stated that the Kidigo terminology was exactly the same as the Kiswahili term (only the Swahili prefix ki- was the Digo prefix chi-). The linguistic documentation provides crucial evidence for the syncretization of medical knowledge. Diseases caused by a lack of nguvu (vitality) or disruptions in mshipa (veins and arteries that carry blood) demonstrate a strong humoral basis for medical knowledge. Beckerleg's research on Swahili medical knowledge has cited these same terms as Islamic

---

thesis. Sperling, ibid., Appendix, pp. 197-204.

[27]Female informants in Lamu who were tabibu advised women on 'female' diseases, but did not act as midwives. Interviews, March, 1996.

(Galenic) incursions into local knowledge.[28] Spiritual diseases were caused by shaytani, and more specifically by the Islamic terms pepo and jini.[29] In addition, Digo informants told of illnesses caused by spirits called mzuka, which lived in sacred places, such as trees, caves, or lakes. In this way, Digo have kept also their locally produced understandings of disease causation. Rituals that treated the disharmony of kifudu or mamba forces persisted into the 1950s. Kifudu was a Mijikenda, kaya-based ailment that could only be treated by Mijikenda waganga.

Gerlach wrote of the ailment of disharmony with mungu, God, as a primary or secondary cause of illness. He noted that although mungu existed in pre-Islamic days,

> ...it seems that due to the influence of Islam Mungu is now conceived of has having more power than before. Disharmony with Mungu nowadays occurs from non-observance of Islamic injunctions, such as prayer, fasting, alms-giving, food and drink restrictions, as well as from failure to wear koranic amulets, or failure to abide by the advice of koranic diviners.
>
> Harmony is often established by prayer and pseudo-Islamic ritual and magic. Walimu or koranic teachers are the specialists in such ritual and magic.[30]

Gerlach was wrong to call these rituals "pseudo-Islamic".

---

[28]Beckerleg, "Swahili Medicine", Chapters 4, 5.

[29]Shaytani or shetani can be defined as evil spirits or "that which suggests supernatural power, whether evil or simply incomprehensible, e.g. a clever dodge, great skill, conjuring epilepsy, fits, hysteria. (Ibilisi, jini, pepo, koma, Arabic). Madan, A Standard Swahili-English Dictionary.

[30]Gerlach, "Some Basic Digo Conceptions of Health and Disease", p. 23.

They are what Islamic rituals have become within Digo society. The use of walimu (Qur'anic-trained healers) to treat diseases seen to be caused by Islamic sources is significant. He further documented that walimu wrote Qur'anic verses on paper and wrapped them into amulets or wrote with ink on metal plates and washed off the ink with water. The 'sacred water' was often mixed with miti shamba medicines, the herbs of the waganga, and given to the patient as a remedy. Thus the walimu have appropriated waganga pharmacopeia, but to treat Islamic diseases.[31]

It is into this rich tapestry of healers and therapeutics that the colonial government hoped to establish their Western medical practices. The agents for the period 1925 to 1940 were the Local Native Councils but lack of funds, commitment to the colonial medical project and insufficient staff undermined this program. Oral evidence provided by Sperling and Parkin document the continuing presence of local systems of healing through to the contemporary period. Although ethnographic evidence is largely absent from the official record, a survey conducted in 1917-18 provides a useful summary of the findings of the District Commissioners on dwellings, disease, disposal of the dead, fertility and food.[32]

At the request of Dr. J.A. Haran, Acting Principal

---

[31]Ibid., p. 25.

[32]KNA. PC/Coast/1/1/379, 29 October 1917.

Medical Officer in Nairobi, each district officer was asked to provide information on the above categories for the populations in his district. The results of this survey, although never published as a single volume for the Coast or the Colony, informed both thought and policy in medical matters for the 1920s. For WaGiriama and Swahili of Malindi District, Omar Din, Compounder, submitted that of a total of 2249 cases seen, diseases of Swahili populations were "...due to the climate conditions [malaria], poorly living & their ram[sic] and irregular food eating." Chief causes of deaths were helminthic infections, malaria and tuberculosis. For Giriama patients, malaria, respiratory and skin diseases were presented the most frequently. The disease profile presented no surprises to the medical authorities.[33]

Although the ethnographic evidence suggests otherwise, the District Commissioner suggested there were few 'medicine-men' in the area. When asked if the waganga were controlled by Chiefs, the DC responded: "Difficult to answer, as chiefs are largely a Government innovation."[34]

In addition to the above diseases documented for Swahili, prevailing diseases for Wadigo were smallpox, cholera,
elephantiasis (mshipa), kifafwa (fits, convulsions, epilepsy),matene (skin disease) and safura (described as

---

[33]Ibid., pp. 1-2.

[34]Ibid., p. 2.

either general anaemia or ankylostomiasis). In addition, the prominence of venereal disease was noted, particularly gonorrhea (kibuga) and syphilis (tego or sekeneko). Of these diseases gonorrhea was said to have been common from "time immemorial" while syphilis was introduced from Uzigua, Usambara and Wanyamwezi, and carried strong connections with sorcery. Both smallpox and cholera were introduced "from other places on the coast. 99 [sic] people died in one village in the Pongwe location in 7 days about 50 years ago from this disease, which was attributed to introduction from outside."[35]

Mortality rates were impossible to estimate although survey respondents believed malaria, safura, and being bewitched were causes of most deaths. The survey, submitted by the DC, reported that Wadigo believed they were not as long-lived as formerly. He also stated "...it certainly is seldom that one sees a very old Mdigo." Life expectancy was possibly 60 for a man and slightly more for a woman. Infant mortality was believed to be fairly high as well as frequent deaths of birthing women. Numbers of female births were significantly higher than male births.

Neither Western medicine nor local healing practices changed the disease profile of the Coast districts of this period. There was no vaccine for malaria; no 'cure' other than clean water and good hygiene for dysentery and

---

[35]Ibid., p. 3.

parasitic diseases. With the exception of epidemic smallpox and cholera these have remained through the colonial and independence period for Wadigo, Wagiriama and Swahili. Only one of these chronic conditions was addressed by an intensive anti-disease campaign with some success at eradication and that was ankylostomiasis, more commonly known as 'hookworm'. This campaign will be discussed below.

The State Reasserted: Local Government through Local Native Councils, 1925-1940

State concerns with urbanization and economic development characterized the interwar period in East Africa. Rural areas posed particular problems within this context. Intrinsic to the concept of 'rural' was the 'tribalized' native, the African who would retain cultural specificities in communities within confined geographical spaces called reserves. The state faced a contradictory role: on the one hand, it was to support economic development through the use of African labourers; on the other, Africans were to remain 'African', that is, rurally tied agriculturalists who worked in cities or plantations but were not defined by this form of labour. As Vaughan has stated, "Social disintegration and loss of control were feared to be the consequences of the system of labour migration, and the changes which capitalism was bringing to

rural African societies."[36]

In 1925, the state instituted a framework for local government at the rural, agricultural district level called Local Native Councils. In addition to tax collection, these Councils had the task of organizing and implementing business promotion, educational and health programs. Council meetings were attended by the District Officer who acted as Chair and Recorder for the meetings and had the right of veto. Medical Officers of Health were often present but local African residents formed the other twenty to twenty-five voting members of each council. Most appointments were by nomination and thus shored up local government chiefs and headmen. At the Coast, Islamic vazirs were also considered members of the council. Mission educated and 'progressive' Africans dominated the up-country LNCs. These men successfully consolidated their new class positions through mission grants and student bursaries. The LNCs became a channel for the granting of state capital to African entrepreneurs both directly as business loans and indirectly in the provision of salaried employment or construction contracts. According to Kitching, such local employment mitigated the effects of the Depression on the reserves.[37]

---

[36]Vaughan, Curing Their Ills, p. 202.

[37]Kitching, Class and Economic Change in Kenya, Chapter VII, "The Role of the Local Native Councils 1925-1952", pp. 188-99.

Berman and Lonsdale have argued that LNCs acted as inhibitors of resistance to the Colonial State. Districts were established as subdivisions on the basis of "tribe" in an attempt to institutionalize precolonial ethnic identities. Through the appropriation or, indeed, reconstruction of local elites on this basis, the LNCs became a vehicle for managed political control of rural Africans, preventing what Berman and Lonsdale have termed the "mobilization of the peasantry within the context of a trans-ethnic anticolonial struggle."[38] Although these authors provide extensive evidence for this coopting of African political activity for Central Province, particularly the Kikuyu areas, the records for the coastal districts do not render such sharp contours. As stated throughout this thesis, the Coast after 1909, with the exception of the interest in the construction of a deep-water pier at Kilindini Harbour in Mombasa in the 1920s, remained outside the political concerns of the colonial state. Coast populations continued to be receptors of government directives for the colony as a whole, but the generation of administrative structures and their control were much less in evidence in the coastal districts than in and around Nairobi.

The Coast LNCs did not have the large numbers of

---

[38]Berman and Lonsdale, Unhappy Valley, Volume I, pp. 162-63.

'mission Africans' in comparison with up-country. Although government-appointed chiefs formed the elite of the councils, the Coast district LNCs were more representative of local populations than those of up-country. Whereas education was the single largest item of expenditures in Central Kenya's LNCs, coast expenditures were more balanced among categories of sanitation, health, education and business control. LNC's "...provided a limited but slowly expanding source of revenue which the African petite bourgeoisie could use to gain credit and contracts for their businesses, better-paid jobs for themselves and their relatives, and education for their sons, as well as a number of institutional and other supports to general agricultural and veterinary improvements, from which the petite bourgeoisie were in a strong position to benefit disproportionately."[39]

In addition, and not insignificantly, the particularly male-defined construction actively excluded African women from these Councils, business loans, agricultural credit and medical training until as late as 1956. The first female to appear in the records as a member of any of the Council Boards was Mrs. Lois Mwangombe, a Councillor from Malindi.[40]

---

[39]Kitching, Class and Economic Change, p. 198.

[40]KNA, Local Authority Records, Minutes of Trades & Health Sub-Committee, Giriama African District Council, Book 11/8/57. Microfilm Reel 84, CAMP Local Authority Records, 1925-61, MF-

The records show that Local Native Councils, community by community, set their own priorities, developed budgets and allocated resources accordingly. Revenues were generated from central state funds, local taxes and, after 1930, assistance from the Colonial Development Fund. But the financial situations were precarious. In times of famine, cyclical occurrences at the coast, received revenues did not meet expenditures. Minutes of Local Native Council meetings examined through this period expressed concern for land use, sanitation, education, and establishment of dispensaries, in that order. When Africans requested medical workers through their LNC members, the minutes show that priority was given to dressers/vaccinators as the most urgently required medical personnel.

It is from the Handing Over Report of the Senior Commissioner for the Coast, Mr. McClennan of April 7, 1924 that we learn of the health conditions of the Coast immediately prior to the establishment of the Local Native Councils. Although populations both north and south of Mombasa were stated to be "in a very bad way from disease", the report was concerned with overall deterioration on the Coast. Problems were seen to follow from the recent devaluation of the Indian rupee, abolition of slavery, decreased dhow trade from Arabia for boritis (mangrove poles used for dhow construction) and high taxation. Added to

---

4914.

these were the medical conditions: smallpox epidemics from 1920 to 1921 (reported mortality of 10 per cent of the Digo/Duruma population) and no medical assistance, influenza and rampant yaws. The Medical Department had a programme of assisting Africans in the reserves to treat yaws with injections of Salvarsan. For this treatment some Africans walked fifty kilometres a day. Vaccinations were given by Kikuyu Africans as no local African dresser/vaccinator had yet been trained. The northern coast was also understaffed. One sub-assistant surgeon was to service a population of 50,000 people who lived on roughly 300 square miles of inland territory and over 100 miles of coast.[41]

Issues of food production, disease and land appropriation were intensely interconnected in the social and economic relations of Wadigo peoples and the state. Wadigo complained about the East African Estates which had been given 100,000 acres of their land. The Commissioner noted an article in the Weekly Times of Mombasa, August 24, that land leased from the East African Estates made a profit of 2400 per cent. One manager was reported to have burnt the huts of the Manyamwezi labourers "...because they attempted to grow a few native vegetables round their houses after work hours...I have seen an unfortunate native and his wife with their 30 day tickets each filled...walk to and from

---

[41]KNA. PC/Coast/2/5/4, 1922-28; Handing Over Report, Senior Commissioner, Mr. McClellan, 7 April 1924.

Mombasa...to get their pay....Kavirondo labour at Gazi (a Giriama area) could not get pay or food." Land allocations there too were a site of contention. "Every spare inch was almost surveyed out for the Company."[42]

Thus a complete study of medical concerns requires the economic context. As stated in earlier chapters, plantation owners took litle or no responsibility for the health of their workers. Support for capital appropriation further intensified the cycle of undernourished populations-decreased resistance-disease-epidemics-deteriorating health and productivity.

Local Governments and Rural Women

Although District Councils were advised by the central government to fund the certification and training of midwives, there were no attempts in this period to medicalize rural midwifery. As stated above, funding concerns were firstly sanitation, primarily the building of latrines. With the exception of the circumcision issue, the discussion of which was initiated by the Nairobi government, women's health concerns were not raised at LNC meetings. Matters of property, particularly dowry, were the most significant 'women's issues' to appear in the minutes.

Thus local authorities in rural areas allowed midwives to retain control over what was understood to be female

---

[42] Ibid.

work, birthing and infant delivery. Although midwives were officially responsible to Local Native Councils, and could have become waged workers, midwives were paid not by the Councils but by delivering women directly. Technical medical care--laboratory work, administration of injections, control of drugs--was gendered male and male dressers or assistants were often on salary from the Local Native Council with direct support from the state. Rural midwives, while marginalized, also remained independent of local state control.

The 1917 survey asked questions relating to fertility, infant feeding, mortality and midwifery. The details given on Wadigo midwives stated:

> Midwifery is a regular profession confined to old women, both on the coast and amongst the Wadigo. Two or three are usually summoned for a birth - one stands behind the patient, (who is delivered in a sitting position) to hold her, whilst another squats in front to receive the child. The usual food given is mtama gruel or rice (the former is more in request) flavoured with pepper. The food is not cooked with a coconut, but with water only. If the patient fancies it, meat (either of a fowl or a goat) is given to her. A poor woman would be given cuttle fish (pweza) which is considered to have some medicinal value.
>
> Lying in
>
> Amongst the coast people - a woman retires to her house when she is taken with the pangs and stays in the house for 40 days after the birth. Even if the woman is poor and has no-one to help in such matters as getting wood and water, she stays at least 14 days before appearing in public.[43]

---

[43]KNA.PC/Coast/1/379, p. 4.

Information on Wagiriama women, in contrast to those of the Digo area, was scantily reported. In the following description, the officer clearly neither searched out midwives nor asked them about their work.

> No particulars of any system of midwifery have been discovered, beyond the facts that the woman walks about until the moment she produces the child. Women have been known to produce a child while on the way from one village to another. After giving birth women are said to remain 7 days in their house, lying down near a fire. Fomentations [sic] of hot water are said to be applied. The food taken is maize Uji.[44]

In contrast to the DC's submission, oral evidence for this thesis documents a rich practice of midwifery on the coast. One elderly Swahili midwife, trained by her grandmother, told of the Giriama preference of delivering a baby while sitting in a chair, with the midwife sitting underneath. Swahili women in Takaungu spoke of assisting Giriama midwives when they faced birthing difficulties.[45]

The issue of female circumcision, although related to midwives in that they were the ritual circumcisors, was never fully contextualized within women's health care. Concerns over this practice were generated by Christian missionaries in the Central Districts of Kenya. Their lobby was effective enough to force the Medical Department to request information from all provinces and districts on this

---

[44] Ibid., Reference letter no. 28/838/2 of Vol. 2 from the Principal Medical Officer, Nairobi, p. 3.

[45] Interviews with midwives in Takaungu, March, 1996.

issue, with the intention of enforcing abolition. The first request to abolish the practice of circumcision was distributed to DCs and PCs in 1918. The Coast PC, Hobley, was averse to government intervention on this issue. His position was that any recommendation for abolition should come from Africans themselves. Should the government attempt to legislate against the practice, Hobley stated, it only would be carried out in secret.

> The missionaries, who have very little communication with the elders of the tribes, probably fail to realize how conservative natives are about such matters, and that they hold on to their customs as tenaciously as the missionaries do to many medieval beliefs which are recognized as absurd by educated people.[46]

The most aggressive circular was distributed in 1926 and coastal responses were again tardy. For some of the administrators at the coast, their responses were not even submitted until 1927.[47] The Acting Senior Commissioner stated: "The question hardly arises on the Coast. Various tribes practice circumcision but, it is believed, in a mild form only and no cases of unnecessary cruelty have been reported." The matter was raised in the meetings of the Digo/Kwale Local Native Council. The first meeting at which the Chief Native Commissioner's Circular No. 28 concerining

---

[46]KNA. PC/Coast/1/3/159, Hobley's response to Circular No. 11/191, 22 October 1918.

[47]KNA. PC/Coast/1/3/159, Circular No. 28 (A.aa/12/1) of 23 August 1926 from G.V. Maxwell, Chief Native Commissioner, to all Provincial and District Commissioners.

female circumcision, was raised was October 3, 1926.

> It appeared that in this District the more drastic of the two operations in vogue was generally performed, and this partly at the wish of the women themselves. The meeting was informed of the medical view on the subject and it was decided that they should discuss the matter with the Local Operators and the women, to see if any agreement could not be come to by which only the milder form should take place.[48]

Whatever discussions took place with the women involved were not recorded nor was the women's testimony entered into the minutes of the following meeting at which the formal recommendation was adopted. Instead, advice was sought of the Liwali regarding this issue. The text of the presentation stated:

> At the request of the President, the Liwali of the Coast, addressed the meeting at some length on this subject. He explained that there was absolutely no intention to coerce the tribes into foregoing or altering their legitimate tribal custom of circumcision. That government on the advise[sic] of their Medical advisers wished merely to put a stop to the wanton maiming of women through the negligence or ignorance of operators. That in cases where the true Digo form of circumcision was carefully carried out no harm accrued to the woman but that in numerous cases operators cut away large portions of necessary membranes and tissues as well as the actual clitoris, which did not much harm to the woman but was contrary to the Sharia.

When Mzee Nassor Mwamgwaja brought up the question of the necessity for a second operation, as there was growth of 'the part in question', the Liwali "...made it clear that this was entirely contrary to Sharia and pointed out that

---

[48]KNA. Minutes of Digo Local Native Council, held at Kwale, October 3, 1926. CAMP Local Authority Records, Reel 81.

they themselves never operated a second time on men and desired to know why they should wish to do so in the case of women. The meeting had no answer to this question."

The meeting stated it disapproved of the "unnecessary maiming of women through ignorance or negligence on the part of operators, but resolution or recommendation was framed other than the following: -Recommendation: That the subject of controling the circumcision of women be put back for further discussion and inquiries."[49] Although the District Commissioner had the right of veto on any issue raised with the LNC, this right was not exercised on the subject of restricting or making illegal the practice of circumcision.[50]

Uncertified midwives in rural districts, as with their urban counterparts, crossed local communities when required. Distance rather than cultural boundaries affected the ability of midwives to provide birthing assistance to women of other communities. Medicalization was not a consideration until after 1945 with the creation of Health Centres. Even then, when given the opportunity to register with the

---

[49]KNA. Minutes of Digo Local Native Council held at Kwale, December 11, 1926. CAMP Local Authority Records, Reel 81, pp. 1-2 of minutes.

[50]What became known as the "female circumcision controversy" remained localized in the Central Districts of Kenya, particulary Meru and Kikuyu. See Lynn M. Thomas, "'Ngaitana 'I will circumcise myself': The Gender and Generational Politics of the 1956 Ban on Clitoridectomy in Meru, Kenya", Gender & History (Vol. 8, No. 3, November 1996), pp. 338-363 for the historiography of this issue.

District Officers as local midwives, that is, bypassing African District Council authority, they declined to come forward.

Central State and Local Governments: Intervention through Anti-Disease Campaigns

Anti-malaria campaigns recurred throughout this period, with consistent strategies for success and consistent failures. Whereas in the early 1920s medical discussion centred around the use and dosage of quinine, it was the sanitation side of public health programmes (Public Works in Mombasa and Local Native Councils in the Districts) that attempted to address this endemic disease. There was no possibility of entirely eliminating the mosquito; the best that could be hoped for was to keep the mosquito separate from its victim. But malaria infection remained a problem through the colonial period. Intermittent campaigns were mounted against yaws or elephantiasis, but these were equally intermittently effective. Two major campaigns stand out for the intensity and the financial commitment of the state to this project: the anti-hookworm campaign of 1927-28 conducted in the Digo District and the Yellow Fever Campaign for the colony, with emphasis on the Coast, of 1940-41. The Colonial State hoped to redress the perceived lassitude of African Coast labourers through the control of helminthic infections and anaemia. Support for the Yellow Fever

Campaigns was tied to international pressure and military security.

The much-lauded inquiry of Dr. C.R. Philip produced a sixty-three page report which forms the basis of this discussion. The report followed the 1927-28 campaign. Dr. Philip continued to acquire data through to 1929. Both the breadth and depth of the inquiry were commended by the medical establishment.[51] The report provides statistics on a strikingly wide range of diseases. With the help of African sanitary teachers, who were provided with special training for this campaign, Dr. Philip commenced, in August 1927, a two-pronged attack on helminthic diseases, particularly ankylostomiasis (which was believed to be universal) and ascaris: sanitation and treatment.[52] A total of 52, 827 men, women and children were examined.[53] This

---

[51]"This document marks a new departure for it describes the first attempt made in the Colony to carry out a thorough investigation of the vital statistics of a native area of sufficient size to warrant the drawing of deductions as to morbidity and mortality." J.H.S. (editor), "Vital Statistics in the Digo District: A New Departure", The East African Medical Journal (Vol. X, No. 5, August 1933), pp. 144-49.

[52]Dr. Philip was Medical Officer for Digo District. His report was the most comprehensive study of health and disease of a particular area in all of the colonial period. For the full text, see: KNA. PC/Coast/2/5/11. Submitted to the Director of Medical & Sanitary Services (San. 722/15/ Vol. II), and forwarded to the Senior Commissioner, Coast in November 1928.

[53] This figure was approximately 4,000 above the official census of the reserve. Of those people seen, 3,152 were exempted from treatment leaving 49,675 actually treated. Ibid., Appendix, "Numbers Attending For Treatment".

represented roughly 98 per cent, of a total population of 54,251. No other rural campaign attempted this degree of contact.

The campaign was first met by significant resistance, described at first as "...launched by the witch doctor element, the success of which appeared almost imminent early in 1928."[54] It was more likely that local waganga were responding to legitimate concerns of the Wadigo population. Approximately 15,000 people in Kwale decided to oppose treatment in March 1928, according to Dr. Philip because of:

> exaggerated reports regarding the effects of the anthelmintic[sic], that it caused death, sterilised, and so on. It was realised that carbon tetrachloride might prove lethal if taken in association with alcohol, and people had always been warned to avoid tembo during and after treatment. Nevertheless one or two dawa-tembo casualties may have occurred without the knowledge of the Medical Officers at the time.[55]

Dr. Philip slowed the pace of the campaign, conducted discussions with community leaders, and attempted to slowly build confidence. Revealingly, LNC minutes make no reference to this resistance, only to their interest in supporting the campaign.

The first target was to instill in the Wadigo the "latrine habit". Helminthic infections, transmitted through contact with faeces, presented conditions of anaemia. Treatment would be ineffective over the long-term if the

---

[54] Ibid., p. 5.

[55] Ibid., pp. 17-19.

probability of re-infection remained. The state granted "...Headmen the power to compel natives in their jurisdiction to dig and use latrines of an approved pattern in their villages."[56] In addition, financial support from the LNCs was enlisted and received. Sanitation concerns were also directed towards refuse disposal and water supply. Trading centres (sale and storage of food) and villages became targets. Although Africans were said to cooperate, Indians were threatened with fines for non-compliance.

The labour estates, Ramisi Sugar, Gasi Sisal, Khalafan and Gogoni, were also visited by Dr. Philip and his sanitation squad, the latter under the supervision of a European Sanitary Inspector posted to the district in 1928. Estate owners complied grudgingly with anti-malarial operations and provision of clean water. It was unusual to have an inspector on a reserve and his work consisted mainly of assistance in house and latrine construction, and anti-malarial work. Native Sanitary Teachers, six ex-Waa School boys, took a course in technical training, masonry and elementary hygiene. In other areas, these students would have been brought from up-country, particularly from among the Jeanes School's graduates. Training local populations ensured a commitment to the project. A "Native Sanitary Bush Squad" was also formed to dig demonstration latrines and

---

[56]KNA. Local Authority Records, 1925-61, CAMP, Reel 81. Meeting of the Digo Local Native Council, 15 October 1927, Resolution No. 7.

assist in construction. In August 1927, at the beginning of the campaign, there were no latrines at all in the reserves.[57]

Dr. Philip's enthusiasm over latrine construction must have been dampened by the long-term results. According to Gerlach, the latrines were never built with cement and therefore kept falling in. In addition, as they were a new and expensive addition, those wealthier families were the first to build them. Gerlach reports that large numbers of extended family would come to use the latrines, only contributing to their early demise. Gerlach also argued that Digo had not truly appropriated Western medicine's beliefs on causation.

> There is some agreement among Digo that hookworm is caused by contact with infected fecal matter, although many feel this is nonsense. Digo sorcery beliefs do not cause them to wish to hide their fecal matter in running water or in bushes and forests as some peoples do, and they also have nothing against using a latrine for an other reason. Indeed, they enjoy the privacy and protection from the elements that a proper latrine affords, and having a latrine is somewhat associated in the minds of many with advanced civilization and proper Islamic behaviour. For some it is perhaps a source of heshima or pride.[58]

Regarding treatment, Dr. Philip drew on the success of other campaigns, particularly the Rockefeller campaigns in Ceylon. His initial investigations showed Africans as heavily

---

[57] Ibid., pp. 5-17.

[58] L.P. Gerlach, "Some Basic Digo Conceptions of Health and Disease", pp. 32-33.

infected (500 specimens, 498 positive to hookworm), many seriously ill and dying from the effects of the disease. The Digo and Swahili word for the advanced condition is safura and their treatment was the drinking of a tea/potion made with iron filings. Dr. Philip began with an education and propaganda campaign, with a baraza (meeting) in every location, and it is to this preparatory work that Dr. Philip ascribed the success of the campaign.. The teams travelled with a microscope to explain the presence of the disease.

Gerlach's research supports the possibility of Wadigo support for Western treatment in a very interesting way. According to his interviews, Wadigo based their inclusion of Western-style medicine into their own local practices on a singular factor. Western medical personnel, doctor, nurse and dispenser, used instruments to make a diagnosis. "The secret of European medicine is that it is dispensed after the patient has been properly examined and his ailments diagnosed." This distinguished Western techniques from those of local waganga or tabibu. "Digo recognize this defect [no tools for examination] of waganga and buruga to an ever-increasing extent, and claim that their practitioners only guess where Western medical personnel examine with precision." If a practitioner of Western medicine, European or African, only conducted clinical interviews, without the use of diagnostic tools, they were seen to be doing their job improperly. Wadigo refused to return to them. The

relationship between mganga and patient was expected to be understanding and friendly.[59]

Method of treatment was a mixture of Carbon Tetrochloride and Oil of Chenopodium, followed by concentrated magnesium sulphate. The treatment was unpleasant but Dr. Philip reported many travelled long distances to the treatment camps, with young children led or carried for miles. Medicine was taken to those infirm who were unable to come to the camps.

As stated above, diagnosis and treatment was administered for all diseases presented. In terms of the population's general health levels, Dr. Philip stated the level was below that of other African populations. He concluded:

> Apart from nutritional and food deficiencies which are appalling if compared with modern standards, these natives have to contend with a group of diseases which are definitely endemic, each of which causes ill health, chronic and progressive, leading to an infant mortality and adult death rate which must be astounding. These diseases given in the order in which they are responsible for the lower standard of health are

---

[59] Ibid., p. 28.

> helminthiasis (particularly ancylostomiasis), malaria, pulmonary tuberculosis, yaws, urinary schistosomiasis and pyorrhea. Of these malaria is the acute killing disease, as well as the chronic producer of ill health. The others are more or less chronic.....
>
> The above statements are not theories but facts and are corroborated by the figures available and attached to this report.
>
> As a result of such a variety of chronic toxin--producing and blood-destroying diseases, the whole population is suffering from toxaemia, anaemia and malnutrition, and these are the predominant features which strike the ordinary observer at first sight.[60]

Immediate positive results of treatment for hookworm were supplied by estate managers. A number wrote to the Medical Department applauding the treatment results. African labourers had become better disposed and more productive. Mr. Gehl, Manager of the Gasi Sisal Estate wrote:

> "I think perhaps the following facts will interest you. In December last year the highest task I could persuade my Wadigo labourers to do was to cut 1,000 leaves per day which of course was not sufficient. The same Wadigo labourers after having been treated by you for hookworm are now cutting 2,200 leaves per day and whereas last year Wadigo labourers for cutting sisal were very scarce, they are now plentiful.
>
> I also notice that the Wadigo appear to be more willing and cheerful since they have taken their anti-hookworm treatment."[61]

One could perhaps substitute 'soma' for 'anti-hookworm treatment' and appreciate the possible uses of medical knowledge for social engineering. However, this was not Dr. Philip's primary goal. His continued work in Digo areas

---

[60] Ibid., pp. 21-22.

[61] Ibid., pp. 2-3.

attested to his concern for the health of these populations. It is perhaps significant that in Gerlach's extensive report on Digo health, disease and healing based on his field work in 1959, he did not list safura as a major disease, although he did report the high incidence of malnutrition. The overall category, nguvu (strength, power, vital force) appeared frequently in informants' descriptions of their disase. A lack of nguvu (mwili tauna nguvu - body has no power) was a way of expressing general ill health. The cause of a lack of nguvu was often given as the breaking of social taboos, a supernatural cause termed chirwa. Treatments for chirwa were administered by waganga and were as varied as the symptoms presented. He considered malnutrition among children from the age of six months to three years of age to be general. When compared with Uganda, it would appear that the Wadigo's general health conditions had improved (although Dr. Philip cautioned in the article that the figures were calculated after a prosperous year, abundant rains and no locusts).[62] Digo statistics compared favourably with those from Uganda. The birth-rate was higher and the death-rate was lower. The ratio of still-to-live

---

[62]Dr. Philip's later findings reported the annual birth-rate was 49.36 per 1,000; annual death-rate was 20.19 per 1,000; infantile mortality rate per 1,000 births was 148.5 and the maternal mortality rate for 1,000 births was 11. In addition babies under one year had the highest death rate of 148.5 (compared with the elderly rate of 87.1). These statistics reported in, J.H.S., "Vital Statistics in the Digo District: A New Departure", The East African Medical Journal (Vol. X, No. 5), August 1933, pp. 145-46.

births among the Wadigo was given at 0.53 per cent while that of Uganda was 4.5 per cent.[63]

The Yellow Fever Campaign bore no resemblance to the Anti-Hookworm Campaign in structure, organization, involvement of the community or follow-up. The Yellow Fever Campaign format was much more typical of the types of campaigns that characterized the colonial period. The exceptions would be the epidemic-driven campaigns of smallpox, plague and influenza which did to a minimal degree follow the pattern of the Anti-Hookworm Campaign.

Yellow fever was never found on the Kenyan Coast although the mosquito which could transmit the virus, Aedes egypti, was located in water holes on the Coast.[64] As early as 1936, Health Propaganda Exhibits undertook to educate the Mombasa public on control of this mosquito, and an urban entomological survey had been completed by May, 1937.[65] Control measures were also to focus on the Coast strip as well. Termed a 'herculean task', an Aedes survey of the

---

[63]Ibid.

[64]The index rate was never of significanct value. PMO Paterson wrote in a personal/private letter to Dr. Garnham, MO, Native Hospital, Kisumu on 1 April 1941 that "...the house Aedes index at Mombasa is now only .1%." Wellcome Contemporary Medical Archives Centre. PP/PCG/A32. Correspondence. Box I. 1936-1944.

[65]KNA. ARC/Mic. Box VII, Reel 66. Mombasa Municipal Council, Minutes of the Meeting of the General Purpose Committee held 18 September 1936, 9 February 1937, 16 March 1937 and 11 May 1937. Microfilm.

strip was planned but never executed. The projected costs of this campaign were staggering. The campaign was to employ 13 Medical Officers, 9 Health Inspectors, 3 Entomological Field Assistants and 'African Staff' at a cost of over 20,000 pounds. Added to this were recruitment (including instruction) costs of 10,000 pounds, all for the first three months of the survey. Unfortunately, Dr. Philip did not publish the allocated funds and costs of his campaign, but the possibility that such a figure was spent on African labour and resident populations is extremely small. An outbreak or possible epidemic of Yellow Fever would have halted all international trade. A Yellow Fever Conference was held at Nairobi on 9 and 10 December 1940 and recommendations made to the colonial government were followed.

This was the first of a series of campaigns which characterized the later colonial period, outside the scope of this thesis. They were driven by international health concerns and often funded through support from the Rockefeller Foundation. The survey has been presented to document the momentary concern of the colonial state with African rural populations. The Anti-Hookworm Campaign was mounted because of the insistent pressure placed on the Medical Department by Dr. Philip. Following Dr. Philip's departure as MO for Digo District, no other campaign was ever mounted for these populations.

Conclusion

Layers of medical activities, knowledge and practice, continued with great vigour in the rural districts of the Coast through this period. The Colonial State's strategy to implement state health objectives through the Local Native Councils and the cooptation of local elites was of little effect in the area of health care. The large-scale campaigns, no matter how effective in the short term, did not alter the disease environment for rural populations. Malaria, parasitic infections and tuberculosis were as present in the 1940s as they were at the beginning of the century. Those changes in health and treatment that did occur were effected through Africans' adaptations to new living and work environments. Migration and contact introduced challenges to rural Africans' healing practices. To many peoples, Islamic medicine, both tabibu and hirizi (use of Qur'anic charms), provided additional therapies to those they had brought with them from other places and earlier times. As waganga appropriated Islamic practices, their use of dawa wa miti shamba (medicine of herbs and plants) and that of tabibu, although recognized as distinct, were not mutually exclusive. For Muslims what could have been a very clear separation between halali (lawful) and haramu (unlawful, that is not in the Islamic books, including dawa ya miti shamba) medical treatment under

Islamic law was not employed.[66] Cultural synergism embodied medical and therapeutic practices. Choosing the appropriate healer and therapy remained the most crucial aspect of health and disease management. As in the nineteenth century, those distinctions that were paramount to all rural populations in this period centred on disease causality. Once the cause was identified, the appropriate healer and treatment could be sought.

---

[66]One of the richest publications of ethnographic evidence is that of Caplan, African Voices, African Lives. Caplan has conducted fieldwork among populations of Mafia Island, Tanzania since the mid-1960s. This book is a compilation of interviews and responses, gathered over a thirty-year period.

CONCLUSION

The Coast of Kenya has been a dynamic and vital site for the examination of the coexistence and syncretization of medical systems. As part of the Indian Ocean trading network, Coast communities have participated in an unbounded exchange of Arab and Indian knowledge brought by traders and migrants since the eighth century A.D. This thesis has argued that an appreciation of the complexities of the Coast's layers of medical knowledge and practice demands a dual comparative framework; one that looks outward to the Indian Ocean and one that is grounded within the social space of contact on the Coast, ultimately organized at the policy level by the Colonial State.

The colonial medical project, with its dual emphasis on health care delivery through institutions and disease control through public health and sanitation, appeared through this period as a well-defined but underfunded structure. This thesis has challenged the model advanced by historians such as Beck of the seamless hegemonic development of Western scientific medicine from its earliest representations by mission missionaries to the formation of multiple sites and layers of health care in the 1940s. Western medicine has continued to be one of many medical systems used by local clients to manage their own health care.

The Colonial State's funding of government medical

institutions in the early twentieth century wrested controls from those of competing medical missions. In this institutional representation of health care delivery, Western scientific medicine achieved hegemony. In contrast, the medical model of individual patient care failed to supplant local populations' shared beliefs in communal healing and therapies. Whereas diseases in the allopathic model were caused by internal agents, localized in the patient's body, unani, ayurvedic, Qur'anic and indigenous systems attributed disease to ecological, social, spiritual and/or physiological agents. This thesis has demonstrated that a client's choice of therapies and healers was dependent primarily upon the perceived cause of the disease. Diseases which were seen to have multiple causes were treated by a number of healing specialists. Whereas a Western model invested authority in the practitioner, syncretized medical systems permitted a shared authority between healer and client.

The Colonial State may have built the frameworks for health care, but it was the networks established by all local populations, African, Arab and Indian, that served to accommodate, appropriate or resist the colonial medical project. In the 1920s with the devolution of health care responsibility to the local government, Indian communities in Mombasa established their own voluntary societies. As the Colonial State focussed on Maternal and Child Welfare,

hoping to garner the support of local women, most African and Indian women delivered their children outside the gaze and control of the state. Qur'anic healers treated their clients throughout this period invisible to the medical establishment. Although prohibited by law from medical practice outside their communities, their treatments reflected a model of inclusion as they dispensed remedies acquired from ayurvedic and unani dispensers to their African clients.

The medical landscape of the Kenyan Coast in the 1940s had changed little from that of the early twentieth century. The Colonial State remained committed to a public health model, attending to disease control and sanitation, and in this area there was some success. Medical interventions for epidemic disease control rested on policies of vaccination and sanitation so that diseases such as smallpox were controlled through vaccination; typhoid through quarantine and plague through rat control.[1] Residential segregation continued to inform town planning and urban development, as planners pointed to the success of these initiatives in

---

[1]Worries over possible plague epidemics were never far from the Colonial State's health concerns. "Rat gangs" were employed by local governments to trap rats which were then examined by bacteriologists. In 1941, the MOH complained the public was "not taking their responsibilities seriously enough...to destroy rats and mice." During the Second World War, the Colonial State assigned reponsibility for control to the military in spite of local opposition from Mbaruk Ali, the Liwali of Mombasa. KNA. Mombasa Municipal Board. Minutes of Meetings of the Health Committee, 10 February 1942, 9 June 1942 and 14 July 1942. Microfilm.

containing disease. But diseases of which populations? Endemic diseases such as helminthic infections and malaria, although targets of the Colonial State, remained daily health challenges for local populations. Interventions had been sporadic and, consequently, ineffective over the long term. Colonial health care strategies for the first twenty years of this century mirrored a primary concern for the health of Europeans.

Maintenance of satisfactory health conditions for rural and urban local populations depended more on clean water and food supply than clinics or dispensaries. Campaigns to construct latrines, organized and financed through Local Native Councils, were temporary interventions into health terrain. Thus, this thesis argues, the patterns which were established in the early twentieth century either remained in place or were intensified in mid-century.

Migration and labour, which featured centrally in this thesis as demographic agents affecting health and disease in the early twentieth century, became increasingly problematic in the 1940s and 1950s. Complaints of plantation owners that Coast populations were reluctant labourers echoed early twentieth century evidence. An officer in Kilifi, the growing town centre north of Mombasa, stated:

> The backwardness of Nyika can largely be attributed to drink, venereal disease, or malaria....The WaNyika suffer from five grave disabilities; drunkenness, apathy, lack of discipline, incompetent and apathetic headmen, and loose administration....Labour, with good

> employers, is at the moment one of the best medicines available for the WaNyika ills.[2]

African migration to the fertile coastal areas, historically a strategy to counter poor agricultural seasons in the hinterland, intensified into the 1950s. What had been a pattern of absorption from the 1900s through the 1940s became one of competition over land between European landlords and African cultivators. Significant contrasts appeared at the level of political organization. The paternalistic structure of Local Native Councils imposed by the Colonial State in 1928 evolved into the politicized, self-generated Coast African Association which, in its testimony given before the East African Royal Commission of 1953, called for the return of land to its original owners.[3]

It was the urban landscape that experienced the greatest stress throughout the colonial period. Local initiatives, the voluntary associations, particularly the Mombasa Social Service League, were impressive in their sensitivity and commitment to improving the health of the Island's populations. But they could not solve the fundamental

---

[2]KNA. DC/KFI/1/1. E.St. J. Tisdall, "Annual Report, 1936", quoted in Cynthia Brantley Smith, "The Giriama Rising, 1914: Focus for Political Development in the Kenya Hinterland, 1850-1963". Ph.D. dissertation, University of California, Los Angeles, 1973, pp.294-5.

[3]Richard E. Stren, Housing the Urban Poor in Africa. Policy, Politics, and Bureaucracy in Mombasa (Berkeley: University of California Press, 1978),p. 160.

problem of a growing population on a fixed water and land supply. Many of the migrant labourers of the early 1920s became squatters in the 1940s, and the urban poor of the 1950s. The 1931 census assessed Mombasa's populations at 43,252. By 1946 this population would have risen to 99,500. Family size was one indicator of increased pressure on housing. A survey conducted in 1948 of the Old Town found the average number of children per community as follows: Hindu Indian-4.8; Moslem India 4.6; Arab-2.75 and African 1.1. Placing these figures in their social context, acknowledging joint family occupancy, the average household was 6.2 members for non-Indian groups and 7.1 for Indian households.[4]

Colonial economic development of the 1930s was characterized by work stoppages and strikes on the labour front in Mombasa. Labour demands, met almost entirely with up-country, non-coastal labourers, that had begun with the Railway intensified into the 1940s. As a result inadequate supplies of water and affordable housing continued to mark Mombasa's urban landscape. By 1957, Mombasa reported the highest number of tuberculosis cases in its history, a direct reflection of overcrowding and substandard housing.[5]

The Colonial Office adjusted their program of

---

[4]Leo Silberman, "The Social Survey of the Old Town of Mombasa", Journal of African Administration (Vol. II, No. 1), January 1950, pp. 14-21.

[5]Stren, Housing the Urban Poor in Africa, pp. 137-38.

development in the 1940s to include welfare.[6] On the Coast this meant community projects that included recreation, government medical clinics which employed health care visitors, and, for Mombasa, a commission to collect data for the "Mombasa Social Survey". Social medicine, community health care delivery and social welfare became the new watchwords of colonial medicine.

This thesis has argued that, as for the early colonial period, colonial policy can only be understood within its social place, as it is received, experienced and reformed by local populations.

> Thinking of places in this way [as not only the product of social relations but that it is those relations which constitute the social phenomena themselves] implies that they are not so much bounded areas as open and porous networks of social relations. It implies that their 'identities' are constructed through the specificity of their interaction with other places rather than by counterposition to them. It reinforces the idea, moreover, that those identities will be multiple....[7]

Investigating the links between the multiplicity of medical systems and multiple identities constitutes an area of future research on the Kenyan Coast.

The Africanist community is at present calling both for macro-level narratives that link the histories of health, disease and healing in the sub-Sahel and for local studies

---

[6]Cooper, Decolonization and African Society, Chapter 3, "Reforming Imperialism 1935-40", pp. 57-109.

[7]Doreen Massey, Space, Place, and Gender (Minneapolis: University of Minneapolis Press, 1994), p. 121.

of perceptions of disease causation and therapeutic options. These must be placed on a continuum rather than seen as opposing approaches, one privileging "biological" and the other "cultural" definitions and patterns of therapy or treatment. The impact of Western medicine is significant in the promotion of health and control of disease. The application of Western medicine in East Africa had wide-ranging policy implications, particularly in the pre-independence period as African nations assumed control over health care delivery. But what also must be considered are those elements of the political economy which often appear as unexpected ramifications of government health policy. Although many of the reactions and interactions occur directly within the medical field, some do not. Effects on social life, politics and economic production have ethnic, gender and other cultural dimensions. The political, social and economic contexts into which the state applies medical interventions need to be fully considered if one is to understand the inter-relationships of health, disease and healing. For East Africa, we need to acknowledge the continued existence of a multiplicity of healing interpretations and practices as part of the dynamics of health and disease management.

BIBLIOGRAPHY

1) PRIMARY SOURCES

a) Archival Collections

British Medical Association, London, England
- Annual Reports of Branches.
  - Kenya. 1930-39
- Dominions Committee. Minutes, Agenda and Documents.
  - 1919-39

Contemporary Medical Archives Centre, Wellcome Institute for the History of Medicine, London
- Personal Papers:
  - Sir Albert Cook 1870-1951
  - Dr. Percy Garnham 1901-

Church Missionary Society Archives, University of Birmingham
- Africa (Group 3) Committee
  - CA 5 Series - Coast to 1880
  - G3A5 Series - Coast from 1880-1940
  - Letter Books
  - Incoming Papers
  - Precis Books
  - Mission Books

Kenya National Archives, Nairobi, Kenya

- Ministry of Health Deposits
  - Medical Arrangements 1912-45
  - Housing and Accommodation
  - International Organizations 1927-45
  - Medical Services 1912-1945
  - Hospitals and Dispensaries 1927-1945
  - Institutes 1917-1945
  - Diseases 1917-1945
  - Circulars 1905-1945
  - Local Authorities 1907-1945
  - Research 1926-1945
  - Food and Nutrition 1920-1945
  - Health Education 1938-1945
  - Shows and Exchanges 1930-1945
  - Sanitation 1922-1945
  - Social Services 1944-1950
  - Famine Relief 1929-1945
  - Child Welfare 1950-1955
  - Family Planning 1939-1945
  - Missions 1921-1945
  - Public Health Files 1906-1945

Coast Province Deposits 1905-1945
Annual Reports 1905-1945
Administration
Public Health
Trade and Commerce
Public Works
Publications

District Annual Reports 1905-1945
Mombasa District
Kwale District 1915-1945
Digo District
Malindi District

Local Government/Native Affairs Annual Reports 1924-1945

Minutes of Meetings of Local Native Councils 1924-1945
Kwale District
Digo District
Tana River District

Mombasa District Council Minutes

Mombasa Municipal Board Minutes
Health Committee Minutes
General Purposes Committee Minutes

East Africa Indian National Congress 1922-1955

Mackinnon Papers, SOAS, University of London

Mombasa Municipal Archives, Mombasa, Kenya

Mombasa Social Service League 1924-1947

Public Record Office, Kew, England
FO 2 Africa 1825-1905
CO 533 Original Correspondence 1905-1950
CO 544 Annual Medical Reports 1905-1950

Rhodes House, Oxford, England
Mss.Brit.Emp.s.400 Records of the Overseas Nursing Association 1895-1945
Personal Papers:
Mss.Afr.s.1653 T.F. Anderson 1915-57
Mss.Afr.s.1607 E.O. & R.N.Ashton 1902-27
Mss.Afr.s.1367 T.G. Benson 1925-65
Mss.Afr.s.143-48 K.W. Hobley 1890-97
Mss.Afr.s.1253 G.H. Osborne c.1920
Mss.Afr.s.1178 W. McGregor Ross, n.d.

Mss.Afr.s.702 R.A.W. Proctor 1921-1943
Mss.Afr.s.955 J.H. Taylor 1953
Colonial Records Project
Oxford Development Records Project

United Free Methodist Church Archives, SOAS, University of London
Correspondence Kenya 1933-1945
Women's Work, Africa 1934-1941

b) Printed Sources

i) Books

Christie, James. Cholera Epidemics in East Africa (London: Macmillan, 1876).

Handford, J.W. Mombasa Mission with Account of CMS Work Amongst the Freed Slaves at Frere Town (London: Church Missionary Society, 1885).

n.a. C.M.S. Missions in Africa (London: Church Missionary Society, 1913).

n.a. The East African Mission (London: Church Missionary Society, 1905).

n.a. The Mombasa Mission, East Africa, with an Account of the Church Missionary Society's Work among the Freed Slaves at Frere Town (London: Church Missionary House, 1885).

Krapf, J.L. Travels, Researches and Missionary Labours During an Eighteen Years' Residence in Eastern Africa (London, 1860). Edition 1968.

----------. A Dictionary of the Suahili Language, Compiled by the Reverend Dr. J.L. Krapf (London: 1882).

New, Charles. Life, Wanderings and Labours in Eastern Africa (London,: Frank Cass & Co. Ltd. 1873). Third Edition, 1971.

Ruete, Emily (Salamah bint Said). Memoirs of an Arabian Princess, trans. Lionel Strachey. (New York: Doubleday, Page & Company, 1907).

ii) Articles, Journals, Newspapers

Kenya Medical Journal;
East Africa and Kenya Medical Journal;
East Africa Medical Journal 1904-1945

Medical Mission Quarterly 1892-1896

Mercy and Truth 1897-1921

Mission Hospital 1922-1939

Missionary Echo of United Methodist Free Church 1894-1932

Way of Healing 1940

Barrett, Captain W.E.H. "Notes on the Customs and Beliefs of the Wa-Giriama, Etc., British East Africa", Journal of the Royal Anthropological Institute (Vol. XLI, 1911), pp. 20-28.

Johnstone, H.B. "Notes on the Customs of the Tribes Occupying Mombasa Sub-District, British East Africa", Journal of the Royal Anthropological Institute (Vol. XXXIII, 1902), pp. 263-72.

iii) Government Publications

East Africa Protectorate. Native Labour Commission. Report and Evidence. Nairobi: East African Protectorate Government Publications, 1913.

Colony and Protectorate of Kenya. Willan Commission Report. Report of the Commission of Enquiry appointed to examine Labour Conditions in Mombasa. Nairobi: 1939.

W.J. Simpson Report on Sanitary Matters in the East Africa Protectorate, Uganda, and Zanzibar. London: HMSO, 1915.

Report of the Kenya Land Commission. September 1933. Cmd. 4556. London: HMSO, 1934.

Report on the Departmental Committee on Colonial Medical Services. Cmd. 939. London: HMSO, 1920.

2) SECONDARY SOURCES

a) Books

Abdalla, Ismail H., "Diffusion of Islamic Medicine in Hausaland", in Steven Feierman and John M. Janzen, eds., The Social Basis of Health and Healing in Africa (Berkeley: University of California Press, 1992)

Allen, J.W.T., ed. and trans. The Customs of the Swahili People: The Desturi za Waswahili of Mtoro bin Mwinyi Bakari and Other Swahili Persons (Berkeley: University of California Press, 1981).

Anderson, David M. and Douglas H. Johnson, eds. Revealing Prophets (Athens: Ohio University Press, 1995).

Armstrong, David. Political Anatomy of the Body. Medical Knowledge in Britain in the Twentieth Century (Cambridge: Cambridge University Press, 1983).

Arnold, David. Colonizing the Body. State Medicine and Epidemic Disease in Nineteenth-Century India (London: University of California Press, 1993).

----------, ed. Disease, Medicine and Empire (Manchester: Manchester University Press, 1986).

----------. The Problem of Nature. Environment , Culture and European Expansion (Oxford: Blackwell Publishers, 1996).

Bakari, Mtoro bin Mwinyi. The Customs of the Swahili People (Berkeley: University of California Press, 1981).

Beck, Ann. A History of the British Medical Administration of East Africa, 1900-1950 (Cambridge, Mass.: Harvard University Press, 1970).

---------. Medicine, Tradition, and Development in Kenya and Tanzania, 1920-1970 (Waltham, Mass.: Crossroads Press, 1981).

Berger, Iris. Threads of Solidarity. Women in South African Industry, 1900-1980 (Bloomington: Indiana University Press, 1992).

Berman, Bruce and Lonsdale, John. Unhappy Valley. Conflict in Kenya and Africa (London: James Currey Ltd., 1992). Two Volumes.

Brantley, C. The Giriama and Colonial Resistance in Kenya 1800-1920 (Berkeley: University of California Press, 1981).

Caplan, Pat. African Voices, African Lives. Personal narratives from a Swahili village (London: Routledge Press, 1997).

Carman, John A. A Medical History of the Colony and Protectorate of Kenya: A Personal Memoir (London: Rex Collings, 1976).

Cell, John W., ed. By Kenya Possessed: The Correspondence of Norman Leys and J.H. Oldham 1918-1926. (Chicago: University of Chicago Press, 1976).

Chittick, Neville H. and Robert I. Rotberg, eds. East Africa and the Orient (New York: Africana, 1975).

Comaroff, Jean. Body of Power, Spirit of Resistance. (Chicago: University of Chicago Press, 1985).

---------- and John Comaroff. Of Revolution and Power (Chicago: University of Chicago Press, 1991).

Cooper, Frederick. Decolonization and African Society. The labor question in French and British Africa (Cambridge: Cambridge University Press, 1996).

----------. From Slaves to Squatters. Plantation Labour and Agriculture in Zanzibar and Coastal Kenya 1890-1925. (New Haven: Yale University Press, 1980).

----------. On the African Waterfront: Urban Disorder and the Transformation of Work in Colonial Mombasa (New Haven: Yale University Press, 1987).

----------. Plantation Slavery on the East Coast of Africa. (New Haven: Yale University Press, 1977).

Cordell, D.D. and J.W. Gregory, eds. African Population and Capitalism: Historical Perspectives (Boulder: Westview Press, 1987).

de Vere Allen, James. Swahili Origins (London: James Currey, 1993).

Dirks, Nicholas B., ed., Colonialism and Culture (Ann Arbor: University of Michigan Press, 1992).

Feierman, Steven and John M. Janzen, eds. The Social Basis of Health and Healing in Africa (Madison: University of Wisconsin Press, 1990).

Fildes, Valerie, Lara Marks and Hilary Marland, eds. Women and Children First: International Maternal and Infant Welfare, 1870-1945 (London: Routledge Press, 1992).

Ford, John. The Role of Trypanosomiasis in African Ecology: A Study of the Tsetse-fly Problem (Oxford: Clarendon Press, 1971).

Foster, W.D. The Early History of Scientific Medicine in Uganda (Nairobi: East Africa LIterature Bureau, 1970).

Giblin, James L. The Politics of Environmental Control in Northeastern Tanzania, 1840-1940 (Philadelphia: Univ. of Pennsylvania Press, 1992).

Good, C.M. Ethnomedical Systems in Africa (New York: Guilford Press, 1987).

Gregory, Robert G. South Asians in East Africa. An Economic and Social History, 1890-1980 (Boulder: Westview Press, 1993).

Harrison, Mark. Public Health in British India: Anglo-Indian preventive medicine 1859-1914 (Cambridge: Cambridge University Press, 1994).

Hartwig, G.W. and K.D. Patterson. Disease in African History: an Introductory Survey and Case Studies (Durham: Duke University Press, 1978).

Hasani bin Ismail. The Medicine Man. Swifa Ya Nguvumali. Edited and translated by Peter Lienhardt (Oxford: Clarendon Press, 1968).

Helms, Mary W. Ulysses' Sail, An Ethnographic Odyssey of Power, Knowledge and Geographical Distance. (Princeton: Princeton University Press, 1988).

Hill, M.H. Permanent Way. The Story of the Kenya and Uganda Railway (Nairobi: East African Railways and Harbours, 1961).

Hirst, L.F. The Conquest of Plague (Oxford: Oxford University Press, 1953).

Jacobson-Widding, Anita and David Westerlund, eds. Culture, Experience and Pluralism. Essays on African Ideas of Illness and Healing (Uppsala: Acta Universitatis Upsaliensis, Uppsala Studies in Cultural Anthropology 13), 1989.

Janzen, John M. The Quest for Therapy in Lower Zaire (Berkeley: University of California Press, 1978).

Jeffery, Roger. The Politics of Health in India (Berkeley: University of California Press, 1988).

Jeffries, Sir Charles. The Colonial Empire and its Civil Service (Cambridge: Cambridge University Press, 1938).

Johnson, Frederick, ed. A Standard Swahili-English Dictionary (Nairobi: Oxford University Press, 1995) first edition 1939.

Kjekshus, Helge. Ecology Control and Economic Development in East African History (Berkeley: University of California Press, 1977).

Kitching, Gavin. Class and Economic Change in Kenya: The Making of an African Petite Bourgeoisie, 1905-1970 (New Haven: Yale University Press, 1980).

Koven, Seth and Sonya Michel, eds. Mothers of a New World: Maternalist Politics and the Origins of Welfare States (London: Routledge, 1993).

Lambek, Michael. Knowledge and Practice in Mayotte: Local Discourses of Islam, Sorcery and Spirit Possession (Toronto: University of Toronto Press, 1981).

Last, M. and G. Chavunduka, eds. The Professionalization of African Medicine (Manchester: Manchester University Press, 1986).

Lewis, Jane. The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939 (London: Routledge, 1980).

Leys, Norman. Kenya (London: Cass, 1973. Originally published 1924).

----------. A Last Chance in Kenya (London: L. and V. Woolf at Hogarth Press, 1931).

----------. Land Law and Policy in Tropical Africa (London: League of Nations Union, Pelican Press, 1922).

Lonsdale, John, "The Politics of Conquest in Western Kenya 1984-1908", in Bruce Berman and John Lonsdale, eds. Unhappy Valley. Book One. State and Class (London: James Currey, 1992).

MacLeod, Roy and Milton Lewis, eds. Disease, Medicine and Empire: Perspectives on Western Medicine and Experience of European Expansion (New York: Routledge, 1988).

Mamdani, Mahmood. Citizen and Subject. Contemporary Africa and the Legacy of Late Colonialism (Princeton: Princeton University Press, 1996).

Manderson, Leonore. Sickness and the State: Health and Illness in Colonial Malaya, 1870-1940 (Cambridge: Cambridge University Press, 1996).

Maxon, Robert M. Struggle for Kenya. The Loss and Reassertion of Imperial Initiative, 1912-1923 (London: Associated University Press, 1966).

McKeown, T. The Role of Medicine: Dream, Mirage or Nemesis? (Oxford: Oxford University Press, 1979).

Mirza, Sarah and Strobel, Margaret, eds. and trans. Three Swahili Women. Life Histories from Mombasa, Kenya (Bloomington: Indiana University Press, 1989).

Mungeam, G.H. British Rule in Kenya, 1895-1912 (Oxford: Clarendon Press, 1966).

----------. Kenya, Select Historical Documents, 1884-1923 (Nairobi: East African Publishing House, 1978).

Oliver, Roland. The Missionary Factor in East Africa. (London: Longman, 1965) Second edition.

Parkin, David J. Palms, Wine, and Witnesses (London: Intertext, 1972).

----------. Sacred Void (Cambridge: Cambridge University Press, 1991).

Pouwels, Randall L. Horn and Crescent. Cultural change and traditional Islam on the East African Coast, 800-1900 (Cambridge: Cambridge University Press, 1987).

Prins, A.H.J. The Swahili Speaking Peoples of Zanzibar and the East African Coast: Arabs, Shirazi, and Swahili (London: International African Institute, 1967).

Ranger, Terence and Paul Slack, eds. Epidemics and Ideas: Essays on the Historical Perception of Pestilence (Cambridge: Cambridge University Press, 1992).

Sabben-Clare, E.E., D.J. Bradley and K. Kirkwood, eds. Health in Tropical Africa During the Colonial Period (Oxford: Clarendon Press, 1980).

Salim, A.I. Swahili-Speaking Peoples of Kenya's Coast 1895-1965 (Nairobi: East African Publishing House, 1973).

Spear, Thomas. The Kaya Complex: A History of the Mijikenda Peoples of the Kenya Coast to 1900 (Nairobi: Kenya Literature Bureau, 1979).

Stren, Richard. Housing the Urban Poor in Africa: Policy, Politics and Bureaucracy in Mombasa (Berkeley: University of California Press, 1978).

Strobel, Margaret. Muslim Women in Mombasa 1890-1975 (New Haven: Yale University Press, 1979).

Trimingham, J.S. Islam in East Africa (Oxford: Oxford University Press, 1964).

Turshen, Meredith. The Political Ecology of Disease in Tanzania (New Brunswick: Rutgers University Press, 1984).

Ulmann, Manfred. Islamic Medicine: Islamic Surveys II (Edinburgh: Edinburgh University Press, 1978).

Vaughan, Megan. Curing Their Ills. Colonial Power and African Illness (Stanford: Stanford University Press, 1991).

Willis, Justin. Mombasa, the Swahili, and the Making of the Mijikenda (Oxford: Clarendon Press, 1993).

Yoder, P. Stanley, ed. African Health and Healing Systems: Proceedigns of a Symposium (Los Angeles: Crossroads, 1982).

b) Articles

Arnold, David. "Cholera and Colonialism in British India", Past and Present, (Vol. 113), 1986.

----------. "Touching the Body: Perspectives on the Indian Plague, 1896-1900", in Ranajit Guha, ed. Subaltern Studies V: Writings on South Asian History and Society (Delhi: Oxford University Press, 1987), pp. 55-90.

----------. "Smallpox and colonial medicine in nineteenth-century India", in David Arnold, ed. Imperial Medicine and Indigenous Societies (New York: Manchester University Press, 1988), pp.45-65.

Beck, Ann. "Colonial Policy and Education in East Africa, 1900-1970", Journal of British Studies (Vol. 5), 1966.

Berg, T.J. "The Swahili Community of Mombasa 1500-1900", Journal of African History (Vol. IX, No. 1), 1968.

Chandavarkar, Rajnarayan. "Plague panic and epidemic politics in India, 1896-1914", in Paul Slack and Terence Ranger, eds. Epidemics and Ideas (Cambridge: Cambridge University Press, 1992), pp. 203-40.

Chesterman, Clement C. "Training and Employment of Auxiliary Personnel in Medical and Health Services in Tropical Africa", Journal of Tropical Medicine & Hygiene (Vol. 61, Jan.-Dec., 1953).

Chittick, N.H. "The 'Shirazi' Colonization of East Africa", Journal of African History (Vol. 6, 1965), pp. 275-94.

Conrad, Lawrence I. "The Arab-Islamic medical tradition", in Lawrence I. Conrad, Michael Neve, Vivian Nutton, Roy Porter and Andrew Wear, The Western Medical Tradition. 800 BC to AD 1800 (Cambridge: Cambridge University Press, 1994).

Cook, Sir Albert. "Obstetrics in Uganda", The Practitioner (Vol. 134, No. 804), June 1935, pp. 748-61.

Cooper, Frederick and Ann L. Stoler. "Introduction. Tensions of Empire: Colonial Control and Visions of Rule", American Ethnologist (Vol. XVI) 1989.

Cunningham, Andrew. "Transforming plague. The laboratory and the identity of infectious disease", in Andrew Cunningham and Perry Williams, eds. The Laboratory Revolution in Medicine (Cambridge: Cambridge University Press), pp. 209-44.

Curtin, P. "The Epidemiology of the Atlantic Slave Trade", Political Science Quarterly (Vol. 83), 1968, pp. 190-216.

Davin, Anna. "Imperialism and Motherhood", History Workshop (Vol.5, Spring 1978) pp. 9-65.

Feierman, Steven. "Popular Control over the Institutions of Health: a Historical Study", in Murray Last and G.L. Chavanduka, eds. The Professionalisation of African Medicine (Manchester: Manchester University Press, 1986), pp. 203-20.

Herlehy, Thomas J. "Historical Dimensions of the Food Crisis in Africa: Surviving Famines Along the Kenya Coast, 1880-1980", Working Paper No. 87, African Studies Centre, Boston University, 1984.

Hodge, Alison. "The Training of Missionaries for Africa: The Church Missionary Society's Training College at Islington, 1900-1915", Journal of Religion in Africa (Vol.IV), 1972.

Harrison, Mark. "Quarantine, pilgrimage, and colonial trade: India 1866-1900", The Indian Economic and Social History Review (Vol. 29, No. 2), 1992, pp. 117-44.

----------. "Towards a Sanitary Utopia? Professional Visions and Public Health in India, 1880-1914", South Asia Research (Vol. 10, No. 1), May 1990, pp. 19-40.

Hartwig, G.W. "Demographic Considerations in East Africa During the Nineteenth Century", International Journal of African Historical Studies (Vol. 12), 1979, pp. 653-72.

Holway, James. "C.M.S. Contact with Islam in East Africa before 1914", Journal of Religion in Africa (Vol.14, 1972)

Janmohamed, Karim. "African Labourers in Mombasa, c. 1895-1940", in B.A. Ogot, ed., Hadith 5 (Nairobi: East African Literature Bureau, 1975).

Karve, S.D. "An Experiment in Midwifery", The East African Medical Journal (Vol.X, No. 12), March 1934.

Kingoriah, George K. "The Causes of Nairobi's City Structure", Ekistics (Vol. 50, No. 301), 1983, pp. 246-54.

Memon, P.A. and Esmond B. Martin. "The Kenya Coast: An Anomaly in the Development of an 'Ideal Type' Colonial Spatial System", Kenya Historical Review (Vol. 4, 1976), pp. 187-206.

Packard, Randall M. "Maize, Cattle and Mosquitoes: The Political Economy of Malaria Epidemics in Colonial Swaziland", Journal of African History (Vol. 25, 1984), pp. 189-212.

Parkin, David J. "Politics of Ritual Syncretism: Islam among the Non-Muslim Giriama of Kenya", Africa XL (July 1970), pp.217-33.

----------. "Medicines and Men of Influence", Man, Vol. 3, 1968, pp. 424-439.

Prins, Gwyn. "But What Was the Disease? The Present State of Health and Healing in African Studies", Past and Present (Vol. 124), August 1989, pp. 158-79.

Ranger, Terence O. "Godly Medicine: The Ambiguities of Medical Mission in Southeast Tanzania, 1900-1945", Social Science and Medicine (Vol. 158) 1981, pp. 261-71.

Romero, Patricia W. "Mama Khadija: A Life History as example of Family History", in Patricia W. Romero, ed. Life Histories of African Women (London: Ashfield Press, 1988), pp. 140-58.

Skene, R. "Arab and Swahili Dances and Ceremonies", Journal of the Royal Anthropological Institute (Vol. XLVII), 1917, pp. 418-34.

Sperling, David. "The Frontiers of Prophecy", in David M. Anderson and Douglas H. Johnson, eds. Revealing Prophets (London: James Currey, 1995), pp. 83-101.

Sutphen, Mary P. "Not What But Where: Bubonic Plague and the Reception of Germ Theories in Hong Kong and Calcutta, 1894-1897", Journal of the History of Medicine and Allied Sciences, 1997 (Special volume, edited by Nany Tomes and John Harley Warner).

----------. "Rumoured Power: Hong Kong, 1894 and Cape Town, 1901", in Andrew Cunningham and Bridie Andrews, eds., Contested Knowledge (Manchester: Manchester University Press, 1997).

Swanson, Maynard W. "The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909", Journal of African History (Vol. XVII, No. 3), 1977, pp. 387-410.

Thomas, Lynn M. "'Ngaitana, I will circumcise myself': The Gender and Generational Politics of the 1956 Ban on Clitoridectomy in Meru, Kenya", Gender and History (Vol. 8, No. 3, November 1996)

Udwardy, Monica. "Gender Metaphors in Maladies and Medicines. The Symbolism of Protective Charms among the Giriama of Kenya", in Anita Jacobson-Widding and David Westerlund, eds. Culture, Experience and Pluralism (Uppsala: Acta Univeritatis Upsaliensis, Uppsala Studies in Cultural Anthropology 13, 1989).

Waite, Gloria. "Public Health in Precolonial East-Central Africa", Social Science and Medicine (Vol. 24, No. 3), 1987, pp. 197-208.

White, Luise. "Blood Brotherhood Revisited: Kinship, Relationship,and the Body in East and Central Africa", Africa (Vol. 64, No. 3), 1994, pp. 357-72.

----------. "'They Could Make their Victims Dull': Genders and Genres, fantasies and Cures in Colonial Southern Uganda", American Historical Review (September 1995), pp. 1379-1402.

----------. "Tsetse visions: narratives of blood and bugs in colonial Northern Rhodesia, 1931-1939", Journal of African History (Vol. 36, 1995), pp. 219-45.

Worboys, Michael. "The Discovery of Colonial Malnutrition between the Wars", in David Arnold, ed. Imperial Medicine and Indigenous Societies (New York: Manchester University Press, 1988), pp. 208-55.

----------. "The Emergence of Tropical Medicine: A Study in the Establishment of a Scientific Specialty", in G. Lemaine, R. Macleod, M. Mulkay and P. Weingart, eds. Perspectives on the Emergence of Scientific Disciplines (The Hague: Rodopi) 1976, pp. 75-98.

Wylie, Diana. "Confrontation Over Kenya: The Colonial Office and Its Critics, 1918-1940", Journal of African History (Vol. 18), 1977, pp. 427-47.

3) UNPUBLISHED THESES AND PAPERS

Beckerleg, Susan. "Maintaining Order, Creating Chaos: Swahili Medicine in Kenya". Ph.D. dissertation, School of Oriental and African Studies, University of London, 1989.

Bell, Heather. "Medical Research and Medical Practice in the Anglo-Egyptian Sudan, 1899-1940". D.Phil. thesis, University of Oxford, 1996.

Dawson, Marc Harry. "Socio-Economic and Epidemiological Change in Kenya: 1880-1925". Ph.D. dissertation, University of Wisconsin-Madison, 1983.

Gerlach, L.P. "The Social Organization of the Digo of Kenya". Ph.D. dissertation, University of London, 1960.

Gerlach, L.P. "Some Basic Digo Conceptions of Health and Disease", paper in the Proceedings of a Symposium on Attitudes to Health and Disease Among Some East African Tribes, Makerere College, December, 1959. Microstyled.

Janmohamed, Karim. "A History of Mombasa, c. 1895-1939: Some Aspects of Economic and Social Life in an East African Port Town during Colonial Rule". Ph.D. Dissertation, Northwestern University, 1977.

Malowany, Maureen. "Representations of African Women in the Historical Literature of Nigeria, 1890-1990". M.A. thesis, McGill University, 1992.

Ndege, George Oduor. "Disease and Socio-Economic Change: the Politics of Colonial Health Care in Western Kenya, 1895-1939". Ph.D. dissertation, West Virginia University, 1996.

Soff, Harvey G. "A History of Sleeping Sickness in Uganda: Administrataive Response, 1900-1970". Ph.D. dissertation, Syracuse University, 1971.

Sperling, David Colton. "The Growth of Islam among the Mijikenda of the Kenya Coast, 1826-1933". Ph.D. Dissertation, School of Oriental and African Studies, University of London, 1988.

Thompson, Sally Gaye. "Speaking 'Truth' to Power: Divination as a Paradigm for Facilitating Change Among Giriama in the Kenyan Hinterland". Ph.D. thesis. School of Oriental and African Studies, University of London, 1990.

Udwardy, M. "Gender and the Culture of Fertility among the Giriama of Kenya". Ph.D. dissertation, School of Oriental and African Studies, University of London, 1990.

van Heyningen, Elizabeth Boudina. "Public Health and Society in Cape Town 1880-1910". Ph.D. thesis, University of Cape Town, 1989.

Worboys, Michael. "Science and British Colonial Imperialism, 1895-1940". D.Phil. thesis, University of Sussex, 1979.

Zeller, Diane Leinwand. "The Establishment of Western Medicine in Buganda". Ph.D. dissertation, Columbia University, 1971.