HEALTH, STATE AND SOCIETY IN KENYA
Faces of Contact and Change

George Ndege

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PREFACE AND ACKNOWLEDGMENTS

In recent years, historians of colonial medicine have provided the analytical framework for understanding the role, authority, and influence of colonial policies on biomedicine and the changing relationship with the people these policies were meant to serve. In addition, historians have brought into the orbit of analysis the tension between the "medical occupier" and the "colonized." The theme of tension has formed a primary motif in the new social history of the interaction and change that accompanied the way Western biomedicine was received in the colonial context. Indeed, a host of scholars have correctly pointed to the limitations of imperial authorities, as well as biomedicine, as a factor in acculturating the masses to the Western biomedical order. Building on this theoretical foundation, this study discusses how Africans perceived and critiqued Western biomedicine and yet continued to embrace and institutionalize its presence in Kenya.

I initially intended this monograph to focus on the political economy of health care in colonial Kenya. However, that intention was left behind as I delved into a wide array of archival materials, field interviews, and secondary sources. I became aware that a full understanding of the health care system, both in the colonial and postcolonial periods, went far beyond the boundaries of political economy and encroached upon areas of social and cultural history. I was intrigued by the controversies that surrounded the introduction and development of Western biomedicine, particularly the meanings and interpretations given to its shortcomings and successes by Africans in Kenya. I have striven to explore the controversies from many perspectives ranging from political economy and racial attitudes to indigenous culture and production of knowledge, while paying attention to the specific intervening factors that have shaped the developmental course of health care in twentieth-century Kenya. A major objective has been to create a narrative based on the role of Africans as proactive participants in the health care debates. I have attempted to avoid the shortcomings of the top-down approach, which views the issues of health care and medicine only through the eyes of the colonial rulers. But in the same vein, I have also

shied away from the "view from the bottom" that takes account only of the perspectives of the conquered. Thus in the chapters that follow, I argue that beneath the strands of tension and conflict there also existed a world of compromise, accommodation, and coexistence between African and Western biomedical practices. By privileging local perceptions, knowledge, and apprehensions and the accommodative power of indigenous cultures, I show that the Africans were far from powerless in shaping colonial medical policy and that the colonial rulers were far from all-powerful in shaping Kenya's health care system. Thus by avoiding a simple hierarchical top-down diffusion model in which Africans are projected as the powerless victims of colonial economics, colonial politics, and epidemic diseases, this study illuminates the proactive activities of Africans as the prime movers of health care development in Kenya in many and varied ways, for example, in the provision of funds for health care in the rural areas and in the production of knowledge and personnel that helped to promote coexistence between traditional and Western biomedicine.

Through the voices, experiences, and records of those who lived in the worlds of both traditional and Western biomedicine, I show how from the 1920s, the issue for most Africans was not whether to accept or reject Western biomedicine as a whole, but rather what to embrace in colonial health care that was in resonance with their age-old tradition as well as with emergent colonial experiences. I also show that the colonial experience exhibited enduring strands that persisted into the postcolonial period. The study shows the ambiguities and challenges that the postcolonial state has faced in its attempts to recast the image of its predecessor, particularly in relation to the provision of health care services. Humbled by internal economic constraints and external forces, the state has been forced to shed the pragmatic and compassionate attitude that it had assumed at the time of independence. This disengagement has undermined the availability of basic health care services. Yet the state's passive disengagement has coincided with the major pandemic of our times, AIDS. While only 10 percent of the world's population lives in sub-Saharan Africa, the area accounts for two-thirds of all HIV cases and just over 80 percent of all AIDS-related deaths. Kenya is a country that has been hard hit by the pandemic. In analyzing the impact of the pandemic, I have focused on the reasons for its spread, its diagnosis, and the available therapeutic options, in order to examine the interface between economy and culture on the one hand and disease on the other, in the last decade of the twentieth century in Kenya.

While I alone am responsible for any errors, distortions, and intellectual weaknesses this book demonstrates, my debts to others who

made this project possible are enormous. The research that produced this book was funded by the following: the Institute for Research and Postgraduate Studies, Maseno University College; the Rebecca Donally and Henry Everett Thornburg and the Robert and Wynona Wilkins Awards, Department of History, West Virginia University; a Graduate School Research Grant and a College of Arts and Sciences Mellon Grant at Saint Louis University.

I have also been exceptionally fortunate in having received over the years encouragement and support from many people. The footnotes in the text reveal some of my debts to others. It is difficult to express the depth of my gratitude to Robert M. Maxon, who has always been a fertile source of ideas. He read and reread the manuscript with great care and nudged me along when I needed nudging. He gave excellent advice, all of which I appreciated and most of which I accepted. Amos Beyan, Robert Blobaum, Rodger Yeager, and Daniel Weiner read the draft and offered the insights and encouragement one expects from distinguished scholars. I benefited from my numerous discussions with Priscilla Shilaro, Agnes Odinga, Nameeta Mathur, and Oluoch Otieno, budding scholars in their own right. William Ochieng', Bethwell Ogot, and Peter Odhiambo Ndege deserve special thanks for their constructive criticism and comments on the draft proposal for this work. E. S. Atieno Odhiambo has been supportive for well over a decade, introducing me to the nuances of African historiography. Toyin Falola read the manuscript and insisted that it become a book. I also wish to thank my various informants who willingly gave their time for the interviews. The data gathered from informants has been vital in the writing of this book. Their voices, words, and memories have humanized this study. My field research would not have been possible without the extraordinary and unbounded help I received from Frederick Aloo and Kennedy Okeyo in the field. My debt to them will last for ever. In producing this book, Tim Madigan proved to be both a cooperative and a congenial editorial director. He was extremely helpful in expediting the publication of this book. I gratefully acknowledge his assistance and that of the entire University of Rochester editorial staff.

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Finally, and beyond the walls of professional concerns, I wish to thank my wife, Pauline, whose boundless affection, cheerfulness, patience, and unshakable support made this book possible and our marriage a partnership of joy. I dedicate this book to three people whose lives shaped mine in many ways. My parents, Lawrence Ndege Alar (1925–1992) and Mary Aluoch Ndege (1936–2001), and my brother, Captain John Ouma Ndege (1963–1991), always took a keen interest in my academic progress. Their untimely deaths prevented them from seeing the completion of a project they would have wished to identify with, although I believe they would have disagreed with some of my interpretations. I dedicate this book to their memory as a small installment on a debt of love and appreciation that accumulates daily and can never be fully repaid.

ABBREVIATIONS

CK	Central Kavirondo
CKAR	Central Kavirondo Annual Report
CNC	Chief Native Commissioner
CNPRB	Central Nyanza Political Record Book
CO	Colonial Office
DC	District Commissioner
EALB	East African Literature Bureau
EAP	East Africa Protectorate (name given to Kenya 1895–1920)
EAPH	East African Publishing House
HMG	His/Her Majesty's Government
IMF	International Monetary Fund
IO	India Office
KANU	Kenya African National Union
KEPI	Kenya Expanded Program on Immunization
KNA	Kenya National Archives
KPU	Kenya Peoples Union
LEGCO	Legislative Council
LNC	Local Native Council
MO	Medical Officer
MP	Member of Parliament
NADAR	Native Affairs Department Annual Report
NK	North Kavirondo
NKDAR	North Kavirondo District Annual Report
NN	North Nyanza
NNAR	North Nyanza Annual Report
NNPRB	North Nyanza Political Record Book
NPAR	Nyanza Provincial Annual Report
NZA	Nyanza
PC	Provincial Commissioner
PH	Public Health
PMO	Principal Medical Officer

PRO	Public Record Office
SK	South Kavirondo
SKAR	South Kavirondo Annual Report
SKPRB	South Kavirondo Political Record Book
S of S	Secretary of State
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

1

INTRODUCTION

Historical interpretations of the nature and dynamics of health care give racial and cultural conflicts pride of place as critical factors in the introduction, management, and development of Western biomedicine in colonial Africa. Such conflicts and dichotomies present the African as overwhelmed by the colonial state, mesmerized by Western biomedicine, and humbled by European colonization. Indeed, the preexisting African traditional political, economic, and social environment faced many and varied changes brought by colonization. The previously existing political structures were restructured to accommodate the reality of the new colonial order in which the colonial state began to reign supreme.[1] At the same time, new economic frontiers symbolized by the emergence of migrant wage labor, the growth of the European settler economy, and the development of colonial trade began to affect household economic production patterns. The economic and political developments necessitated the development of social infrastructure: schools and hospitals. These projects of the new colonial order generated debates among local communities in Kenya on how to go about incorporating some of the newly introduced changes. Specifically, the issue for most Africans was how to incorporate some of the newly introduced schemes that were relevant to their needs. The stakes were quite high, particularly in the area of Western biomedicine because of the way in which it was introduced. The proponents of Western biomedicine adopted an uncompromising attitude toward African healing strategies. They sought to supplant traditional values, knowledge, and beliefs that were critical to African therapeutic practices. Yet the traditional values and beliefs expressed

and reinforced fundamental ideas about health and healing. The flagrant denial of those values amounted to cultural disinheritance. Consequently, Africans critiqued certain aspects of Western biomedicine and some of its proponents. Suffice it to remark, however, that Africans and Europeans were not locked in perpetual conflict. The truth of the matter is that beneath the strands of conflicts that attended the introduction and institutionalization of Western biomedicine there existed an array of accommodations and compromises.

This book examines the conflicts brought on by the introduction, management, and institutionalization of Western biomedicine through the prism of African proactive involvement in conceptualization, interpretation, and acceptance of biomedical practices against the backdrop of colonial policies in Kenya. It is about contact, conflict, and compromise in the making of health care in twentieth-century Kenya. From the very dawn of the colonial state and the arrival of Western biomedicine, particularly its physical manifestations, hospitals and laboratories, Africans actively engaged in intellectual and empirical conversations among themselves as well as with the state over issues and meanings about sickness, health, and therapy in the emergent colonial order. How could sickness be determined and explained? Were the traditional explanations about causes of diseases irreconcilable with the laboratory-based system of examining microbes? What was the role of the state and the colonial officials in the simmering differences between Africans and Western biomedical practitioners? These were some of the weighty issues, which were by and large answered differently by those on either side of the debate on Western biomedical and African health and healing practices. In determining the nature and context of the conflicts, accommodations, and compromises, such factors as time, education, changing epidemic contexts, and colonial governance are important in understanding the developmental course of Western biomedicine in twentieth-century Kenya.

The aggressive nature of the public health campaigns during the formative years of colonial governance undermined any attempts to understand the intention of the state officials and their firm determination to pursue the Western biomedical agenda. African apprehensions and protests were not given sufficient attention by most state officials. It is hardly surprising, therefore, that conversations aimed at bridging the gap between the various groups on the issue of health and healing often broke down, particularly during the first two decades of the twentieth century, because of the strong, natural desire of the local populations, the state, and the biomedical practitioners to protect their respective hallowed traditions, approaches, and identities in the emergent colonial order.

However, as epidemics of sleeping sickness, bubonic plague, smallpox, and pneumonia began to be a permanent feature of the country's disease regime, positions began to soften. The spiraling mortality rates and the interdependent nature of the colonial economy, which is exemplified by the links between rural and urban areas, European-settled and predominantly African areas, and household and migrant wage labor, combined to draw attention to the incessant danger of a disease outbreak in one part of the country spreading to engulf the entire colony, and sometimes spreading to neighboring territories. The colonial state sought to find solutions to the problems by establishing various commissions of inquiry. Most colonial commissions of inquiry were commentaries on race and conflict, inequality and injustice, and the power of the governing class over the governed. Little attention has been paid to the role of such commissions on the subject of health care.

In the South African context, where commissions of inquiry have been the subject of scholarly studies, it has been argued that such commissions elaborated the "idea of state."[2] In a sense, the commissions are instituted by the state with a view to legitimizing in the minds of the citizenry what the state wants, but would not have been able to accomplish through formal policy pronouncements. In this regard, it can be argued that commissions of inquiry are mere window-dressing, resorted to by the state as means to introduce and legitimize its agenda. The present work builds on this basic foundation by examining the significance of some colonial commissions in the development of colonial health care. It focuses on the intense debates that followed the submission of commissions' reports and on how clauses and aspects of such reports that touched on health care were adopted, adapted, or rejected. By showing how tensions of race and conflict were turned into dialogues about accommodation and compromise on matters pertaining to health and healing in twentieth-century Kenya, I demonstrate that the fundamental question and commentary on colonial commissions should not focus only on the composition and the recommendations of these commissions, but even more closely on the process and the post-hoc apprehensions, comments, and dissent with regard to the final determination of what ought to be done, how, and with what consequences for the stakeholders. This is not to deny the fact that the appointing authority had a disproportionate influence on the outcome of the final report, no matter the professed absence of bias. While residues of race persisted throughout the colonial period, and were turned into distinctions based on economic means in the postcolonial era, I show how the shape, form, and structure of health care in its long and torturous twentieth cen-

tury has been the subject not only of conflicts but primarily, and more significantly, of accommodations and compromises.

Conflicts were manifested in formal protests, avoidance of public health institutions and drug prescriptions, and indifference to the colonial state's public health campaigns. Meanwhile, accommodations and compromises were negotiated in schools, mission stations, and commissions of inquiry on the subject of health and healing and were manifested in the many Africans who lived "double lives," not willing to commit themselves fully to either traditional or Western biomedicine, as well as in those who served as dressers, nurses, medical assistants, and physicians and pioneered the expansion of colonial health care in the countryside.[3] These varied responses and initiatives highlight the fact that Africans were not a monolithic group, particularly in the way they tried to come to grips with the new Western biomedical order. Thus, while all the stakeholders, Africans, Asians, Europeans, and the state, cautiously pursued the path of compromise in defense of their core interests and values, the way they went about defending and making sense of the emerging system of colonial health care differed among and within the various groups. In essence, the persistent conflicts among and within the groups were not an end unto themselves. Rather, they were a means to an end. The conflicts necessitated a healthy dialogue, whose focus was on the continuous search for an essential common good, rather than on holding onto a mirage of partisan satisfaction that only stifled dialogue and precipitated suffering and mortality among Africans, Asians, and Europeans in Kenya. The politics, economics, and culture of health and healing are thus emblematic of the state of society in twentieth-century Kenya.

The triad of conflict, accommodation, and compromise went through various developmental stages in the shaping of health care in Kenya. Beginning in the shadow-boxing era from 1895 to the mid-1920s, when the colonial state lacked precise knowledge, resources, and popular support to combat the spread of epidemics, the state naturally and expectedly embraced the Western biomedical order. The intent, role, authority, and influence of imperial policies on biomedicine and its changing relationship with the people it was meant to serve have received considerable and necessary attention over the last decade.[4] However, emphasis has been placed on biomedicine as a necessary part of the conquest, occupation, and settlement of the empire. This line of scholarship has articulated the fact that Western biomedicine was instituted as a symbol and carrier of Western progress, technology, and culture. This, of course, explains the natural affinity between the state and Western biomedicine. But the direct result of biomedicine's inability to immediately come to grips with the devastating

epidemics, as well as the failure of its pioneers and proponents to acknowledge its weaknesses, is only just beginning to be a major theme in historical scholarship.[5] The present study contributes to this genre of scholarship by showing how the limitations of Western biomedicine were caused by many factors, of which the problems of coordinating efforts from top to bottom and of insensitivity to the traditional cultural strands of African health and healing reign supreme. Thus, this study is more than an examination of how Western biomedicine emerged as the mainstream health care system. Rather, and perhaps more interestingly, it focuses on how the development of health care policy and the delivery of services were vulnerable to the voices of local dissenters.[6]

The European imperialism of the late nineteenth century was unique, not just in its political, economic, and nationalistic aspects but also in its medical aspects. It coincided with the revolution in medicine, particularly the laboratory revolution. Medicine began to demonstrate clear causal links between specific microbes and particular diseases. Blood, tissues, and infected glands were manipulated with a view to providing effective therapies. Rather than being viewed as unique constellations of environment and physical predisposition, epidemics could now be viewed as caused by microbes: microbes which could invariably be located in the body of the sick individual and be made to present themselves to microscopic inspection. Simple in principle, if not in actual practice, this new model of disease causation soon dominated Western medicine.

As biomedicine absorbed, routinized, and extended the medical manipulation of blood and other tissues, the colonial state embraced this brand of medicine, tying it, perhaps not directly but irrevocably, to the administration of the colonies. African medicine was not accorded a similar place by the state. The irony, however, is that although the microbial culprits were known, effective therapies did not necessarily follow automatically upon this Western biomedical knowledge. The lack of effective therapies not only opened new avenues for medical research and hopes for new treatments but also raised doubts among the colonized about the intent, efficacy, and supremacy of Western biomedicine. Western biomedicine had its traditions, its hallowed approaches, and its self-image, all of which influenced its positioning in the conflicts, accommodations, and compromises in the colonial context. The immediate conflict stemmed from the denial of indigenous therapeutic knowledge, personhood, and agency. The denials provoked a local cultural critique that questioned the very tenets that biomedicine espoused, particularly during the shadow-boxing period of medical experimentation.

The shadow-boxing period lacked a systematic and precise knowledge-driven policy on how to control and contain epidemics. For nearly two decades, the colonial state lacked a firm grasp of the magnitude of the epidemic challenges. Consequently, it kept on lurching from one method to another in a sincere determination to contain the epidemics. But its methods, rooted in aggressive public health campaigns, were, by and large, based on British experience; since these methods were not based on knowledge of conditions in Kenya, they failed to yield immediate results. The aggressive "medical" methods of the colonial state evoked African critiques of the state as well as biomedicine's interpretations of the cause and effect of epidemics. In fact, the study shows that it is a mistake to speak of any clear policy, preventative or curative, that came to grips with the epidemics in the face of inadequate facilities, personnel, and knowledge. I contend that the inadequacies reduced the containment methods to "military exercises," particularly when the colonial state engaged the services of colonial retainers, *askaris,* to help in forceful evacuations.

The concurrence of these methods with the interventionist phase of colonial conquest led to mistrust and suspicion of any measures instituted by the colonial state. Biomedical institutions, such as hospitals and laboratories, were not warmly embraced. Mists of doubt clouded people's perception of these institutions, leading to widespread apprehensions, which persistently hovered over biomedical practices. Stories of bodies disappearing never to be seen again, narratives of blood sucking for mysterious reasons, and high mortality rates in hospitals abound in oral histories of the colonial period. Luise White has argued in a brilliant study of rumor and history that what is important in such stories is how they "describe meanings and powers and ideas that informed how people thought and behaved."[7] Indeed, as White has correctly pointed out, such stories "showed the grim and mercenary motives of the colonial state."[8] However, there was another dimension to the latent motives of the colonial state that were suspected because of its inability to deliver the necessary services. The gap created by the difference between promise and achievement aroused local concerns and innovative interpretations. While on the part of the proponents of Western biomedicine there was optimism and faith in the methods pursued by the state, the Africans, in contrast, were pessimistic about the outcome of aggressive policies that were being implemented without their input. Faith and optimism on one side of the aisle evoked suspicion and mistrust on the other side. In this study, I provide qualitative and quantitative data that reveal the basis of apprehensions about colonial health care policies, methods, and facilities during the infancy of colonial governance.

There was hardly any distinction between the colonial officials who presided over the evacuation campaigns and those who treated patients at the hospitals. In addition, the laboratory revolution required that a patient's bodily fluids be collected to determine the precise cause of the disease. But collecting such fluids sometimes went against tradition. The hospitals were few and far between. Death in hospitals was understandably not uncommon. The Public Health Act provided for the disposal of a corpse by the state if the immediate relatives did not claim the body. But how could it be explained to people that specimens were collected too late, that the diagnosis was completed too late or was inaccurate, and that when a patient died in a makeshift hospital the state was forced to dispose of the body because the relatives did not arrive in time to claim it for a culturally correct burial ceremony?

I argue that these "rumors" were not without foundation. Having studied documents from the Colonial Office records and the Kenya National Archives, and oral testimonies collected in field interviews, I submit that such narratives are commentaries on the condition of the health care infrastructure in colonial Kenya. The narratives not only served to render a verdict on the inadequacies of the biomedical infrastructure in colonial Kenya, but they also constituted a form of protest in which signals were sent out to the citizenry about the "dangers" inherent in the Western biomedical hospitals and laboratories at a time when they only nominally existed and, therefore, were only fractionally effective.[9] The narratives also reflect the agony of cultural contact as well as the dilemmas about the tensions between and within the boundaries and spatial domains of the two health traditions: Western biomedicine and African traditional therapeutic practice.

African initiatives were summarily dismissed and denied recognition in the emergent biomedical order. Furthermore, the majority of Africans were repelled by the condemnation of almost everything African, from traditional religion to medicinal practices. If winning the soul for the Christian God was problematic, so too was winning over the body and mind to the Crown of the United Kingdom and the world of biomedicine. Thus the dismissal and subsequent marginalization of the African ways of diagnosis and therapy reduced the state to more or less the lone health crusader in an epidemic and cultural environment that it knew very little about. The state ignored what could have been its most potent ally, the indigenous population, in the fight against epidemics. Yet, the point of fact is that apart from possessing a near monopoly of instruments of violence and a coercive apparatus, the colonial state was ill-equipped to address the al-

ready existing challenges as well as the emergent challenges brought on by disease and the imposition of the colonial order. It was understaffed and underfunded, and its experts' knowledge about the ecology of disease and culture in Kenya was fairly sparse. My research extends the boundaries of the role of indigenous knowledge and initiatives in the making of colonial health care in Kenya.

The use of the term "indigenous knowledge" is subject to many interpretations. It evokes images, questions, and ambiguities that are subject to various interpretations. In this study, I use indigenous knowledge and initiatives as an illustration of the community-based practices and institutions that constitute the basis for local decision making. Indigenous knowledge is therefore unique to a particular culture and society. The fact is that indigenous knowledge was the capital of the local societies in their constant dialogue with the environment, epidemics, and healing. Indigenous knowledge, like all other knowledge, cannot claim victory over all epidemics. However, it was not humbled into submission by all epidemics. It won several victories against epidemics. On the other hand, it lost battles in the fight against some diseases. Nevertheless, it sustained the precolonial societies that are the subject of this study. It remained their most potent capital, being constantly enriched by experience of failure as well as success in the fight against pestilence.[10]

Yet by word and deed, the state made its position abundantly clear. In words, the state spoke to the fact that the only route to an epidemic-free society was via the newly instituted biomedical order, which was still very much in its infancy in Kenya. Similarly, the state's combative anti-epidemic campaigns, embarked upon without society's input, narrowed the level of tolerance for the state and the biomedical order among the indigenous population. The upshot of all this is that conversations on the subject of health and healing in Kenya in the pre-1920s period were reduced to a binary debate about "them" and "us," and "their" and "our" methods.

Beginning in the second decade of the twentieth century, the issue of African labor in the colonial economy became a major preoccupation of the colonial administration. The colonial state painted an artistically compelling portrait of the settler plantation economy as well as the infant townships as the critical targets for economic regeneration and growth. Health care was viewed not as a social necessity, but merely as part of an economic strategy. Thus, during the formative stages of colonial rule, health care was structured primarily to address the health concerns of Europeans and residents in the townships. It was designed to protect them from epidemics that were erroneously perceived to be "African" and "rural" in nature.

The outbreak of bubonic plague in the major townships of Mombasa, Nairobi, and Kisumu provided a rationalization for the colonial state to proceed with the planning of towns on the cardinal principle of the separation of various groups: Africans, Asians, and Europeans. Thus, the distribution of health facilities in the urban centers was, to one extent or another, geared toward unequal access based not on need but on race. Colonial health care became steeped in conflicts that were "extramedical" in nature. The colonial state reclaimed "extramedical" prejudices and programmed them as part of the colonial health care agenda. As a consequence, the plague created a compelling opportunity that was seized on to institutionalize colonial patronage and social control.[11]

However, as the colonial period wore on, the colonial economy complicated the situation. Economic interdependency blurred the dichotomy of African versus European, and rural areas versus urban areas. Africans worked on the settlers' farms, while they still maintained strong links with their homes of origin. Economic reality began to determine and define health care delivery as a social necessity, but nevertheless, a social necessity framed in reference to its economic advantages to the state. Indeed, episodes such as the labor migration and the outrage over venereal diseases in 1912–1913, the world wars of 1914–1918 and 1939–1945, and the increased incidence of malaria during the Kakamega gold rush at the height of the Great Depression of 1929–1935 forced the colonial state to reinvent itself with a view to actively addressing the emergent health problems. In this regard, the African constituency was critical in furthering the cause of colonial health care. Accommodation and compromise also assumed center stage from the middle of the 1920s onward, partly because of the emerging educational system.

The philosophical foundation for British colonial policy in Kenya, of creating "a small, semi-literate, indigenous population of good Christians," was producing a small number of Africans ready for careers in the colonial medical service from the 1920s onward.[12] What is important, however, is the correlation between the nature and type of education and the entry positions of Africans joining the colonial medical service. The curriculum was rich in Western biomedical texts, but deficient in the psychotherapeutic aspects of health and healing. In the 1930s and 1940s, Africans, mostly males, held the lower cadre positions of dressers, midwives, and clinical assistants in mission as well as government hospitals. The African employees in mainstream colonial health care constituted an underclass whose upward mobility to senior levels was frustrated by lack of educational opportunities, much to the chagrin of the nascent African elite. The conflict

in the 1930s shifted to the question of why only a few Africans were being enlisted in the colonial medical profession, and worse still, at the lower cadre level. Thus from the early 1930s the critique of Western biomedicine was no longer based on the issue of whether to accept or reject biomedicine, but rather on what to embrace, and how to institutionalize what was embraced.

This shift, however, was not driven by what Ann Beck has called the desire of being guided to "social betterment."[13] This study demonstrates that the route to social betterment lay not in Western biomedicine *per se,* but rather in embracing certain aspects of it and retaining certain core traditional therapeutic practices. Thus, while the state envisioned a situation in which biomedicine would supplant traditional medicinal practices, Africans saw the two systems as coexisting and supplementing each other. In essence, the route to "social betterment" lay not in a single tradition but rather in the coexistence of the two traditions. Pluralism made perfect sense because of the limitations associated with each tradition. And it is this duality, anchored on the foundation of experience and pragmatism, that prevailed, persisted throughout the colonial period, and outlived colonialism. It is still a potent reality at the dawn of the new millennium. Evidently, therefore, accommodation and compromise were manifest in relation to the dilemmas that faced Western biomedicine and African medicinal practice. Neither could meet the challenges of the moment alone. Neither could supplant the other. Each tradition had unique advantages not found in the other. The path of compromise was necessitated by prudence, which was reflected in accommodation and gradualism in the cultural dialogue within and between the two health traditions.

But health and healing were also about financing the supportive infrastructure, including the construction of hospitals and the purchase of ambulances and drugs. The establishment of Local Native Councils in the mid-1920s instituted cost-sharing in the colonial health care system. Local Native Councils were mandated to take responsibility for constructing dispensaries and maternity wings and, in some cases, even for purchasing drugs. The state took the responsibility for training medical personnel as well as paying their salaries. The cost-sharing scheme brought mixed blessings. In the Local Native Councils that were endowed with resources, the development of colonial health care proceeded at a much faster rate than in the areas of scarce resources. With its material foundation based on African financial contributions, the development and expansion of health care, particularly in the predominantly African areas, was largely the work of Africans. I demonstrate how African preeminence best explains the expan-

sion of health care during the Great Depression period, 1929–1935, when the state resorted to bureaucratic cuts as part of the fiscal measures introduced to trim its expenditure.

Africans exploited the inherent weakness of the colonial health care system and built on their strong position to influence changes from within it. This, of course, is not to deny the paternalistic nature of the colonial system. In fact, the significance of compromise under a paternalistic system lies in its pragmatic approach of coming to grips with and challenging the system from within. The issue of paternalism had a major impact on gender roles in the colonial health care system. For instance, fewer women than men had access to education, and therefore the colonial medical service, by and large, remained a male-dominated career. The problem of women's under-education was actually twofold: females not only had even less access than men to education, but once they did find their way into the schoolhouse, the curriculum they were taught reinforced, rather than challenged, the colonial government's traditional views about women.

While some members of the emergent African elite claimed that educated men preferred to marry women that were their intellectual equals (thus raising the bride-price), most Africans still feared that sending their daughters to school would encourage them to reject their traditional roles as wives and mothers. The gender assumptions of traditional African culture combined with the uniquely European brand of sexism to install a tollgate on the road to women's access to education—a tollgate that let only a few women into the higher echelons of education that would sustain their competitiveness in the colonial medical profession. Thus, I demonstrate how women found themselves confronted by two main forces: the patriarchal strands of the traditional society and the colonial capitalistic system that was constructed on the basis of preexisting patriarchal structures and gender practices. Despite the fact that women played critical roles in many health care services in the community, their efforts received hardly any official recognition in mainstream colonial health care until the late 1930s. Although women were victims of patriarchy and the state, however, they were not powerless. They engaged in many roles in the colonial medical service, herbal medicine, traditional education, and midwifery. They were victims who sought to alleviate their victimization and to provide for the basic health needs of their families.

In articulating the roles women played in colonial health care, therefore, I have brought within the orbit of analysis colonial medical service personnel, herbal medicinal practitioners, and traditional educational programs and institutions used in educating the youth about the dangers of

some of the newly emerging diseases. I demonstrate that concepts of African agency, patriarchy, and state paternalism require critical examination in the study of colonial health care.

The attainment of independence in 1963 did not mark a break with the essential characteristics of the colonial health care system. It is continuity, rather than discontinuity, that best describes both the transition and the relationship between the health care system under the patronage of the colonial and the postcolonial states. But, notwithstanding the shared and unifying institutional and ideological patterns that characterized both the colonial and the postcolonial periods, the state in the immediate decade after independence projected a compassionate image that was in contrast to the lean and mean characteristic that was the spirit and emblem of the colonial state. In 1965, the independent government of Kenya promulgated *Sessional Paper No. 10,* in which it defined health care as a basic social necessity. While the government expanded the training facilities for physicians as well as auxiliary staff, training as well as deployment remained elitist. Curative measures were emphasized over preventative ones. The deployment of physicians was highly unbalanced, with the majority employed in the major cities. Yet the majority of the population lived in the rural areas.

Notwithstanding the elitist approach to the training and deployment of medical personnel, by the late 1980s, considerable gains had been made in the public health sector. The manifestations of this included an increase in lifespan, a decline in infant mortality rates, an increase in the number of health care facilities, and an increase in services. Considering what the postcolonial state achieved in less than three decades of its existence, against a background of spiraling population growth, compared with the colonial state's achievements over a period of nearly seven decades, independence initiated a marked development in health care delivery, at least until the late 1980s. This, of course, is not to minimize the limitations that came with the growth, such as the uneven distribution of facilities and services, the insignificant gains in preventative measures, and the continuance of an elitist approach.

Sadly, since the late 1980s the health care system has been in disarray due to a host of factors, both internal and external. The imposition of Structural Adjustment Programs and the onset of the AIDS pandemic have significantly contributed to the reversal of earlier gains in health care. The generosity and liberality of the postcolonial state in health matters has been critiqued and dismissed by external forces as uneconomic and out of line with the shift toward a leaner and more efficient government. As a result,

the state has been forced to retreat from its health policies of the first two decades of independence on the grounds that health care cannot be immune from market forces in the emerging world, where domestic policies are not the monopoly of a "sovereign" state, but are strongly influenced by international financial institutions and global market forces that are far removed from the reality on the ground. In a sense, the development and delivery of health care services is now reminiscent of the colonial period when the colonial state operated under the umbrella of the British metropolitan government. In the closing decades of the twentieth century, the donor community and the international financial institutions, such as the World Bank and the International Monetary Fund, have had a more important say than the elected government of the people.

Thus globalization, which reached a high level of development during the last decade of the twentieth century, and domestic economic constraints have forced a return to the lean and mean nature of the state in health matters, a familiar theme from the colonial era. I show in this study how individuals and communities cope with the problems caused by pandemics in the face of a weak economy and a retreating state. In this regard, I highlight the voices of patients and healers and emphasize the significance of home treatment, as well as traditional therapeutic remedies, in the postcolonial period. I submit that the intersection of health and economy constitute a feedback loop, in which the state of the health care system affects the state of the economy and the health of the economy affects health choices.

I have woven together information from official archives, secondary sources, and oral testimonies in producing this history of health, state, and society in Kenya. Besides using annual medical reports and provincial and district annual reports, I have also consulted Colonial Office records to show the complex nature of policy formulation that cannot be captured by the summaries contained in annual reports. While it is true that some of these records exhibited a condescending attitude and included commentaries biased against Africans, it would be a fatal mistake to dismiss the records as if they did not exist. It would be falling into the trap of the pre-1960 African historiography, in which African oral texts were dismissed as myths and African activities relegated to footnotes. After all, the history of health in colonial society should be reflective of the combined memories of all participants in the process of its construction. History should neither romanticize nor disparage, based on non-consulted sources.

Close readings of the documents show quite clearly that the colonial state was not a monolithic institution. Indeed, the debates among colonial

officials demonstrate that it was a house very much divided from within on matters of health care policy formulation as well as methods of implementation. Yet any discussion of health care delivery without reference to policy formulation and the attendant discussions between the Colonial Office, the colonial state, and the Africans can only tell half the story of what actually occurred and why it occurred at the time it did. For however unpalatable the colonial era was, African initiatives occurred within that specific political and economic context. Just as the forces imposed by the colonial order were impacting African developments, African initiatives were also influencing colonial policies. Thus in the writing of this history of health, state, and society, I have not prejudged or ignored any text, European or African, that I was able to find. Instead, I have confronted the documents and I have not only delved into what the stakeholders in the health care system said, and why they said it, but I have also investigated how they acted and what motivated their actions.

I have utilized information from oral interviews that I conducted at various times in 1997, 1998, and 1999 as well as during an earlier related research study undertaken in 1987–1988. Most of my examples are drawn from the western part of Kenya where I conducted the oral interviews. Nevertheless, the study is national in setting and scope. I have utilized a wide range of archival information and incorporated many sources that, in sum, provide a fairly detailed picture of the development of health, state, and society in twentieth-century Kenya. I have also consulted the memoirs of medical officers who were in the colonial service in Kenya during the period of study. In essence, this is a history of colonial health care replete with memories that reflect the positions of the stakeholders in the health care system. I challenge the discourse of colonial documents by a close reading of the colonial texts, as well as by a critical analysis of oral narratives from Africans. It is in both the singularity and the plurality of the memories of the actions and responses of the stakeholders in the health care delivery system that one can situate the triad of conflict, accommodation, and compromise on matters of health and healing in twentieth-century Kenya in the proper historical context. In sum, what emerges from this study is that systems of health and healing in Kenya paralleled the larger systems through which both the colonizer and the colonized operated.

This book, therefore, is not a new chapter in the familiar anti-state discourse. Its agenda is threefold. First, it is concerned with how health and healing interacted with and were caused by societal systems in colonial Kenya. Second, it is concerned with how conflict and dialogue reshaped

and reorganized the conceptual and institutional conditions of biomedicine in Kenya. Third, it is about Africans as the prime movers of colonial health care in the areas where they lived, worked, and reproduced. And it is this agenda that is dealt with in the subsequent chapters, which are structured to reflect both chronological and theoretical changes in the history of health care in Kenya.

In the next chapter, I examine how the simultaneous construction of the colonial state and introduction of Western biomedicine began on a note of doubt among the local population because biomedicine was not simply a health and healing strategy; it was enfolded in a climate of opinion linked to militarism and cultural superiority, which by and large dictated the state's measures against the emergent epidemics. Through the prism of the state and the African responses to sleeping sickness and bubonic plague, the two most devastating epidemics, at the dawn of colonialism and biomedicine, I examine the triad of tradition, colonial state, and biomedicine in Kenya during the initial decades of very unsettling contact. The theme of the chapter is how indigenous knowledge and initiatives were pitted against Western meanings about epidemic causation and control. Public disagreements over the use of spaces in rural as well as urban areas are examined against the backdrop of the emergent epidemics.

Although conflict was the dominant theme in the relationship among African tradition, the state's epidemic campaigns, and Western biomedical practices, conversations were held among the three constituencies on how best to address the new challenges that bedeviled public health. In the third chapter, I examine the intervening factors, particularly the developing labor-intensive colonial economy, World War I, and the Great Influenza Epidemic of 1918–1919, as critical factors that precipitated and defined the parameters of the conversations. I privilege individual voices, African, Asian, and European, as well as institutions and organizations, in the debates on their perceptions of the infant colonial health care system. These voices demonstrate the necessity of accommodation and the making of compromises essential for the common good.

Chapter 4 discusses the development of careers in the mainstream health care system, as well as in the African health and healing tradition. The correlation between Western education and the personnel produced in the medical profession is examined against the backdrop of patriarchy, the patronage of the colonial state, and the content of the curriculum in the medical training centers. The prevalence of medical pluralism is also examined. I argue that traditional healing strategies were not nullified by the Western biomedicine-based colonial health care system because the tra-

ditional therapeutic skills continued to be valued by a society that appreciated and valued the shortcomings as well as the strengths of both medical systems.

In chapter 5, I address three main issues of development strategy: cost sharing, the transfer of public health to local budgets, and the dilemma of inequities in health delivery. In this regard, consideration is given to the role of Colonial Development Loans, as well as the Local Native Councils' expenditure on the triad of education, health, and economic development. The dominant theme in this chapter is the African factor in the expansion of health care. The institutionalization and expansion of colonial health care could never have occurred in Kenya without the overt support of Africans. But their support went through various developmental stages. Thus in the period after World War II, the critique of the colonial state's public health care policies was quickly turned into an assessment of the legitimacy of colonial governance.

Chapter 6 delves into the issue of how the post-World War II colonial reinvention impacted the development of health care at the time of decolonization. The chapter also examines the themes of mainstream health care delivery, the postcolonial state's development policies, and African health and healing traditions against the backdrop of three decades of independence, the AIDS pandemic, and Structural Adjustment Programs. The chapter shows how the breakdown in the mainstream health care system delivery has created a major void that traditional herbalists are struggling to fill. The conclusions of the study are outlined in chapter 7.

2

THE UNSETTLING CONTACT: EPIDEMICS, BIOMEDICINE, AND THE IDEOLOGY OF ORDER

The last three decades of the nineteenth century marked the period when biomedicine reached adulthood in the development of public sanitation, pathological discoveries, and general awareness that many tropical diseases are carried by insects and other arthropods. As biomedical science embraced, absorbed, routinized, and extended advances in biomedicine, it endeared itself to the colonial state in Kenya. Biomedicine became a critical ingredient of imperial expansion and remained integral to the colonial state's project of institutionalizing a new political, economic, cultural, and biomedical order.[1]

The search for meanings, solutions, and compromises in addressing the critical issues of sickness, therapies, survival, and death against the backdrop of emergent epidemics, which spiraled during the establishment and institutionalization of colonial rule, continued to be a major preoccupation of the colonial state. Unfortunately, the search was tainted by preconceived biases. African initiatives were considered antiquated residues of cultural systems of the past that had no place in the emergent world of biomedical science as framed and relayed to the local populations by the colonial state. The colonial authorities summarily dismissed African experiences and approaches as belonging to the domain of ritual and witchcraft, rather than the realm of thought and action.[2] By relegating African initia-

tives on epidemic prevention and control to the domain of illegal, unscientific, and repugnant practices, the state denied local voices a place in the official discourse of prevention and cure of various pestilences.

This chapter examines the striking limitations in the dialogue between traditional society and the proponents of biomedical science during the formative period of colonial governance. It delves into how the traditions, hallowed approaches, and self-image of Western biomedicine triggered off intercultural conversations in Kenya by projecting an image of unrivaled power over the prevention and control of epidemics. The establishment of institutions such as hospitals and laboratories as manifestations of the progress of biomedical science is examined against the backdrop of the apprehensions, mistrust, and subaltern conversations that gained wide currency among indigenous societies in early colonial Kenya. The critical connection between biomedicine and the intended result of extending short lives and preventing sudden deaths during epidemics was compromised by two main factors: first, the perverted notion that biomedical science was the absolute science, with a universal definition not subject to local interpretation; and second, the force-driven nature of the public health campaigns.

Epidemics and the Sanctity of Space: Schemes of Control and Containment

I: The Tsetse Menace and Contest over Sacred Spaces and Customs

At the turn of the century, Kenya was devastated by a virulent epidemic of human trypanosomiasis.[3] The disease acquired a disruptive power unprecedented in the history of the communities around Lake Victoria. People on the islands of Lake Victoria and the adjacent mainland of Nyanza died in the thousands as a direct consequence of sleeping sickness. In 1904, Commissioner Sir Donald Stewart reported, "The country through the northern part of Lake Victoria Nyanza has already been devastated by the ravages of the terrible disease known as Sleeping Sickness." [4] One year later, the Sub-Commissioner for Nyanza reported that "sleeping sickness continues to claim its victims along the shores of the lake, and many of the islands which were formerly thickly populated are reported to be almost denuded of people."[5] During the same period the South Kavirondo District Commissioner, G.A.S. Northcote, reported that Kanam was "becoming rapidly depopulated."[6] The geographical extent of the disaster was reported in the following words:

> This terrible disease is prevalent in those parts . . . along the lake shore from Rusinga to the Anglo-German boundary. Up to date, a considerable decrease in the population has taken place and some parts are now sparsely populated.[7]

The most heavily affected areas in Central Nyanza included Kadimu, Sakwa, Uyoma, Asembo, and Seme.[8] In South Kavirondo, the worst affected areas included Kanyamkago and Kanam.[9] Sigulu Island off Berkley Bay in North Nyanza was also adversely affected by the epidemic.[10] Due to lack of quantitative data, the cost in human lives could only be estimated. A report issued in 1907 states that "It is impossible to estimate the number of deaths which have occurred from sleeping sickness in the province. They must amount, however, to many thousands."[11]

Writing to the Secretary of State for the Colonies, Governor Hayes Sadler noted that "the comparative rapidity of its movements and the percentage of people reported to be infected show that the mortality will assume large proportions and measures must be taken to check it as far as possible."[12] The suddenness of the onset of the epidemic, the rapidity of its spread, and its high mortality rates astounded the Colonial Office, the colonial state, and the local population. While the geographical expanse of the epidemic was discernible without much debate, the attempt to circumscribe the pestilence led to several competing strategies.

One of the strategies was to segregate the already sick from the uninfected. This approach, heartily endorsed by the colonial state, focused on the population rather than the epidemic itself. The threat of the epidemic was viewed in terms of space. According to this conceptualization, it was assumed that by isolating the already infected from the uninfected, the epidemic would be contained. This program of separating the healthy from the infected vector was premised on the prevailing climate of entomological opinion, abandoned by 1914, that sleeping sickness was "transferred mechanically on the proboscis of the fly from one person to another."[13] Since tsetse flies could remain infectious for a long time unless their habitat was destroyed, the segregation of the population under the state-sponsored program did not yield tangible positive results.

The state's isolation policy and interventionist stance required a health care infrastructure that would identify precisely those who were already infected and those who were not. Hospitals, laboratories, and a thorough knowledge of the terrain where the uninfected were to be resettled were all prerequisites for any success in the strategy adopted by the colonial state. Hospitals were only nominally in existence, and they lacked the personnel

and facilities that would have enabled the early diagnosis of patients. The posting of F. L. Henderson to Kisumu in the capacity of medical officer following the outbreak of the epidemic was an inconsequential move viewed against the area that he was to cover and the transport facilities that were inadequate to reach the areas impacted by the epidemic.[14] Besides the Kisumu "native" hospital, where the infected were quarantined, one other medical station in Central Nyanza was established at Muhoroni by Dr. E. B. Adams.[15] In South Nyanza, similar medical stations were established at Marindi and Kisii.[16] Both the Commissioner's Office in Nairobi and the Colonial Office in London rejected District Commissioner Northcote's suggestion that local dispensaries be established at strategic places such as ports and in all the trading centers in the province.[17] The two offices cited the unbearable financial and personnel implications of undertaking such projects.[18]

The colonial state was left with the only affordable though not the most prudent method, that of establishing camps in the lake region where those who were presumed to be healthy were resettled. The establishment of the Kanyamkago camp was primarily intended for the people being evacuated from Kadem location, situated around Lake Victoria. This population, according to the South Kavirondo District Commissioner, G.A.S. Northcote, "was the clan worst affected by the epidemic."[19] The local communities had their own misgivings about the usefulness of such camps in combating the spread of disease among the uninfected. Their reluctance to relocate to the camps, which had been established without their input, forced the colonial provincial administration to consider compulsion, although there had been no serious efforts to determine the cause of local fears, reluctance, and pessimism about the camps. On this score the Provincial Commissioner wrote:

> I am convinced that if the government intends doing anything in the way of moving the people as has already been recommended that, at the start, certainly, we shall require to be prepared to compel them to move. A certain amount of land between Muhoroni and Kibigori, and again between Kibigori and Kibos is available for the purpose.[20]

The coercion coincided with the high point of imperial conquest and this blurred the distinction between genuine concerns about health and the state's militaristic enthusiasm for humbling the local communities into submission.

The military expedition against the Gusii community is reflective of the general confusion brought about by the colonial administration during the first decade of the twentieth century.[21] The violence and destruction of

life and property that accompanied such expeditions were excessive, sometimes leading to protests from officials in London. In one such instance, during the Gusii campaign, Winston Churchill, the Under Secretary of State for the Colonies, recorded:

> I do not like the tone of these reports. No doubt the clans should have been punished, but 160 have now been killed outright without any further casualties on our side. . . . It looks like butchery. If the House of Commons gets hold of it, all our plans in E.A.P. [the name given to Kenya, 1895–1920] will be under a cloud. Surely it can not be necessary to go on killing these defenceless people on such an enormous scale.[22]

The nature of the "punishment" referred to was not precisely defined, and its extent was not explained to the colonial officials in the Protectorate. The ambiguity that clouded the nature, type, and extent of punishment resulted in the colonial officials on the spot assuming too much power, which they wielded arbitrarily.[23] Houses were burned, crops destroyed, and livestock confiscated. In the wake of such encounters, the administration had an uphill task to present a medical rationalization for the forced relocation of the local communities into camps as planned by the state.

Brutality during colonial conquest and its coincidence with evacuation campaigns led to mistrust and suspicion. Tolerance was lowered and a feeling of antagonism became commonplace, with clear boundaries drawn between state and communities. The colonial state was seen in terms of "them" and "us," as well as "their" and "our" methods. Of significance was the fact that the professionals in the various departments accompanied colonial administration officials in their familiarization tours in the countryside. Similarly, the colonial retainers, *askaris,* whose function was to help maintain law and order, were the very officials involved in the forced evacuations. It is not surprising, therefore, that the local populations hardly drew a distinction between the doctors on duty at camps and in villages and those officials who carried out errands on behalf of the state by counting children or capturing livestock, in the name of collecting poll and hut tax.[24]

Recent scholarship has proceeded to assess colonial curative and preventative medicine by examining "germ theory" as a subtext underpinning the colonial state's strategies as well as its responses to the outbreak of infectious diseases. However, it needs to be pointed out that "germ theory" *per se* hardly influenced many of the measures undertaken by the colonial state, particularly during the formative decades of colonial rule. The preconceived notions of the colonial officials and the exigencies of the moment were what primarily determined the course and the content of the state's ap-

proaches. In the case of sleeping sickness, one is nudged toward an agreement with Anderson's perceptive assertion that the public health programs of the formative stages of colonial governance were "more structured along the lines of new practices of colonial warfare than following the contours of the latest European theory."[25] In fact, the coercive measures were not undertaken by medical personnel, who were still numerically quite few, but by local colonial retainers, *askaris,* who worked under the supervision of local chiefs and local administrative personnel. But the use of *askaris* who also doubled as "health policemen" undermined the confidence of local communities in the colonial state's methods. The local communities saw no distinction between "health policemen" and colonial administrative officials. The critical fact in this context was that the colonial state was preoccupied with orders and directives rather than consultation and dialogue.

The dilemma facing both the local communities and the colonial state points to a serious discourse about the requirements of public health versus the sacred liberties of the person and of property, which had become a major controversy in Britain during the middle of the nineteenth century. The adverse effects of industrialization necessitated in England a new model of administrative machinery that was focused on centralized decision making on substantive issues of health. The Public Health Law (1835) and the Contagious Diseases Act (1867) in England, for example, were responses to individualists "who would rather take a chance with death than be bullied into health."[26] The law rejected such laissez-faire views on the grounds that diseases such as smallpox, cholera, plague, and venereal diseases were menacing to the nation and required the direct intervention of the state. Operating in the shadow of the primacy given to public health laws in England, the colonial state officials who supported forced relocation believed that the law was on their side. Yet, the Public Health Law and the Contagious Diseases Act were, even in Britain itself, strongly resented by those who were opposed to invasion of their privacy on grounds of science, gender, religious faith, and liberty.[27]

In the Kenyan context, the government argued within itself and then sought to direct other constituencies, particularly Africans, without paying attention to their cultural norms. The state's contention was that its course was not only noble but also justifiable because it was in the best interest of the local population. In this regard, the government maintained that public health interests overrode sacred liberties. Local populations were indirectly being invited to sacrifice their freedoms and to adopt the sanitary measures outlined by the state. Since the liberties could not be separated from the societal culture, the suspicion and apprehension point to a clash

of cultures. Unlike England, where plagues visited society at only a few brief points in time, disease in Kenya described a continuing and shifting relationship between two different cultures.[28] Yet the colonial state's medical policy in the rural areas in the first two decades of colonialism was both disjointed and haphazardly executed. The state never stopped to consider the concerns registered by the local populations. In essence, therefore, the local populations were expected to sacrifice their traditions on the altar of arbitrary preventative measures arranged by the state without the local populations' input.

One of the areas that bred conflict was the role of family and community support systems in the face of the policy of isolation pursued by the state. The isolationist approach was in direct conflict with the traditional family system of providing support, nurture, and care during times of crisis such as epidemics. The sleeping sickness epidemic threatened the entire population; it was not an individual disease. Thus, contrary to the colonial state's well-intentioned action of dividing the infected from others, the community believed in familial and communal support during times of crisis. The colonial state's scheme undermined this traditional value system. J. Brunet-Jailly could not have put it much better when he asserted that "All over the world, for each human group in its own way, individual and collective attitudes to health are strongly influenced by concepts and representations which are deeply rooted in culture that has been inherited from past, and often much earlier generations."[29]

The available accounts of selected patients show that the incubation period, as well as the post-incubation period before death, was related to the economic viability of the household. During the initial stages, the victims experienced increased appetites, which resulted in livestock being killed to feed them. Thus, those who unfortunately could not meet the dietary demands of the disease during its initial stages often succumbed to death earlier than those who, other factors being the same, received sufficient dietary attention.[30]

All this not only depicts the significance of familial and communal support, seen by the local communities as a vital step in helping the already infected, but also articulates the dilemma faced by the proponents of the camps: how to reconcile the perceived, real, or imagined advantages of the camps with the internalized bonds of support inherent in the culture. In the traditional society, it was not the individual that was the locus of identity, action, and care, but rather the family. Epidemics in the precolonial period played pivotal roles in the reconfiguration of identities, leading to the disappearance of some groups and the strengthening of others through

migration and settlement. However, any such decisions in times of crises were given very careful and thorough consideration by the families concerned; coercive measures were not only rare, but also considered extreme.

As more medical personnel became involved in the sleeping sickness campaign, particularly from 1910 onward, the role of the "health policemen" and the coercive measures increasingly came under attack from the medical professionals. The state's previous preoccupation with forced relocation into camps at the expense of checking the spread of the tsetse fly was criticized because it compromised familial and communal security without achieving the desired result of saving lives.[31] Dr. B. W. Cherrett, the coordinator of the sleeping sickness campaign in Nyanza from 1910, emphasized the necessity of tackling the cause of the disease by destruction of the fly through "clearing of such cover as harbours the *Glossina Palpalis.*"[32] He called for the clearing of all fishing areas and waterways frequented by people. Dr. Cherrett further advised that the cleared areas be brought under cultivation. In all of these recommendations, Dr. Cherrett won the support of the Principal Medical Officer, Dr. A. D. Milne, who concurred that the camps were an ineffective use of resources. Had it not been for the Anglo-German agreement, Dr. Milne would have recommended the abolition of the camps: "Were it not for the stipulation contained in the Anglo-German Sleeping Sickness Agreement requiring the maintenance of isolation camps, I would have recommended their abolition as a useless expenditure."[33] Nearly a decade of dialogue within the state bureaucracy revealed that many administrative and medical officials directly involved in the sleeping sickness campaign were very frustrated with the continuance of methods that were producing resentment and tensions instead of the support and confidence of the local population.

The state eventually admitted that the forcible removal of people from the tsetse areas was not yielding the desired results. Provincial Commissioner John Ainsworth reported that "The practical results obtained so far from the establishment of the camp appear to be of no great value. In the absence of a cure for the disease, the natives exhibit no particular interest in our efforts."[34] Similar sentiments were expressed by Dr. J. Pugh, a medical officer attached to the Kanyamkago Sleeping Sickness Camp, who wrote: "Owing to the fact that the majority of the cases which were treated at the camp have since died, the natives have no faith in the treatment, and say that since they cannot be cured, they would rather die in their own village than come to the camp to die."[35]

In the attempt to recast its hostile and brutal ways of enforcing relocation, persuasion began to thrive in the vocabulary of colonial administra-

tion officials. Governor Sadler began to emphasize systematic persuasion and gradual movement. In a letter to the Secretary of State he wrote: "I consider that a great deal may be done by systematic persuasion at first in South Nyanza, watching the effect, and afterwards, if necessary, moving village by village to fly-free country and gradually depopulating the fly-infected areas."[36] John Ainsworth, the Nyanza Provincial Commissioner, emphasized the risk and the potential danger to the whole scheme of resettlement unless it was popularized among the population.[37]

To preempt hostility in the course of movement, Ainsworth instructed all the district commissioners in the province to wage a massive campaign to win the confidence of the local community and its leadership.[38] He further advised them to "enlist the missionaries to assist in this work, and we should also require winning over to our ideas, the leading chiefs in the locations concerned."[39] The irony, however, was that the mission stations were still few and the majority of affected people satisfied their spiritual and material needs outside the orbit of the mission centers. Besides, there was a lot of discomfort with the condemnation of almost everything African, from traditional religion to medicinal practices. In essence, therefore, it was an insurmountable task for the colonial state to present a positive and persuasive image of its project. If winning the soul was problematic for the missionaries, so too was converting the body and mind to the colony's health program.

The voices of colonial officials speak to the fact that the "shadow-boxing" era of the first two decades of the twentieth century was an era in which the state resorted to methods that were at best experimental in the sincere desire to control and to contain epidemics whose etiology and therapy were still under investigation by the scientific community. Indeed, the debate on the etiology and methods of containing sleeping sickness were not just issues confined to the East Africa Protectorate (EAP). Neither the British Parliament nor British society was spared the differences that plagued the Protectorate and alienated the local population from the colonial administration. In the House of Commons, MP J. C. Wason asked Winston Churchill, then Under Secretary of State for the Colonies, what measures were being taken to combat the spread of sleeping sickness in the EAP. In his response, Churchill asserted that the only means of arresting the spread of the disease which would be practicable would be by the discovery of some treatment, curative or preventive, capable of being applied to man.[40] He rejected Wason's three suggestions, isolating the infected districts, destroying breeding places, and discouraging lake settlement, as options to limit the spread of the disease.[41]

In the long run, however, the suggestions put forward by Wason were pursued in one way or another. Moreover, the suggestions were put into practice without due regard to the precise causes and nature of the spread of the disease. They could thus hardly attain the desired objective. Progress was slow and casualties continued to increase. At the time Churchill was responding to Wason's question, the Sleeping Sickness Commission had yet to fully discharge its responsibility of determining the cause and nature of the spread of this virulent epidemic in the region. Churchill was a politician and could only rely on information he received from his medical experts and from amateurs in the colonial administration. The irony is that the experts in the Sleeping Sickness Commission, as well as the amateurs in the colonial administration, were by 1906 hardly in agreement as to the precise preventive and curative measures that were needed.[42]

A Royal Society Commission was sent to East Africa in 1902 to investigate the etiology of the disaster.[43] Members of the commission included G. C. Low, a parasitologist, Cuthbert Christy, a medical doctor and volunteer, and Aldo Castellani, a student at the London School of Tropical Medicine.[44] This group was beset by many problems such as leadership squabbles, personal acrimony, and, with the exception of Castellani, a lack of commitment and the pursuit of personal interests.[45] None of the members of this commission was a scientist of distinction with experience in tropical diseases because, in the words of John MacKenzie, "neither pay nor the conditions were congenial."[46] This necessitated the appointment of a second Royal Commission under the leadership of Colonel David Bruce of the Royal Army Medical Corps.[47]

Under Bruce, the commission proceeded to resolve the etiology of sleeping sickness. British entomologists and physicians recorded their own experience with the disease.[48] They also solicited the views not only of their colleagues in Europe but also of medical experts in the Protectorate.[49] In March 1905, the Commissioner for the EAP, Sir Donald Stewart, was asked to submit two copies of the 1904 Medical Report to the Commission.[50] The 1904 Medical Report was quite important because of its specific details pertaining to various diseases in the Protectorate among which sleeping sickness featured prominently.[51] One of the most vital investigations reported was the attempt by Dr. F. Haran, Medical Officer of Health in Kisumu, to experiment with serum injections on goats, rats, and dogs.[52] Since there was a urgent need to find a cure, the research on the epidemic constituted a race against time. Consequently, untested methods and schemes of control were executed without due consideration of their alienating effect.

Indeed, it is significant that some colonial governors had as early as 1900 sought to impress on the Colonial Office, as well as the British medical community, that the infrastructure in the colonies was such that the conventional approaches, which worked in the metropolitan country, sometimes proved counterproductive in the colonial setting. Sir William MacGregor, Governor of Nigeria in 1900, underscored the limitation of the British coercive and isolationist approach to the containment of infections and contagious diseases, during the infancy of colonial rule when physical and human infrastructure was still inadequate, when he wrote:

> In all international conferences on quarantine matters British delegates take their stand against the imposition of quarantine. Their system is the isolation of affected or suspected individuals, the disinfection of vessels, and sometimes of cargo. This procedure can be carried out successfully only in a country where there are highly developed police, health, and sanitary services. It requires ample hospital staff of favoured and intelligent officers to exercise surveillance over people who may have been exposed to possible contagion, and it requires the means of dealing with any of these wherever they may be found.[53]

Governor MacGregor's statement addresses a major error in the definition of methods of disease prevention, which was based on the distinctive theory behind Western biomedical practices. The erroneous assumption was made that what worked in metropolitan countries could work just as well in the colonial situation.

The problem with the formulation of the state's preventative measures lay in the inaccurate assumptions that public health campaigns were universally applicable and not subject to dialogue and accommodation with local cultures. Insensitivity to local knowledge was evident in the disengagement of the state from any investigations into the existence and meanings of traditions in local cultures, particularly their use in addressing the challenges caused by epidemics. Tradition, whether invented or not, has an important role in society. Tradition is a significant prism through which history, identity, and local culture can be evaluated, understood, and harnessed for dealing with catastrophes without eroding the commitment and participation of the communities held hostage by the disaster. Tradition is a creative cultural force that bonds a society, providing its members with a vision as a people. Therefore, the spiraling mortality rates, the forced displacement, and the disregard for societal ways of addressing disasters not surprisingly produced negative attitudes toward the colonial state's cherished measures.

The foremost challenge to the state was its experts' sparse knowledge of tropical diseases. In fact, the reluctance of local communities to accept the colonial state's relocation alternative was not simply based on traditional whims, nor was it without scientific foundation. People died whether they moved to the camps or not.[54] A number of pertinent questions were raised. Why should people continue to die in the camps despite assurances from the colonial administration that the camps were "safe spaces"? Why should those who had been "healthy" succumb to the epidemic after their involuntary relocation? Were the deaths caused by the epidemic or by other factors? While some colonial administrators, such as H. H. Johnston, simply dismissed people's apprehensions by arguing that it "was very difficult to induce families to take any precautions,"[55] both archival and oral sources indicate that the concerns went to the very foundation of biomedicine's techniques and practices of diagnosis and the attendant modes of preventing the emergent epidemics.

The issue, however, was not that of taking precautions *per se,* as contended by Johnston, but rather the context of such precautions and their impact on human lives. The diagnosis of sleeping sickness, as indeed of other diseases such as bubonic plague and smallpox, was often made late in the course of the disease, due to the undeveloped infrastructure and lack of personnel.[56] Perhaps even more significant is the fact that biomedicine as projected by its primary cosponsors, the state and the scientific community, failed to appreciate its limitations in early colonial Kenya. By denying local views any validity, and by claiming a monopoly over the diagnosis and prevention of disease, biomedicine created seeds of pessimism about its approaches to epidemics whose adverse effects it failed to remove.

The isolationist approach that was relentlessly pursued by the colonial state failed to attain the desired objectives despite assurances by the state that the people who were being relocated had not been infected, and therefore would be safe. However, some infected individuals, who had not yet developed symptoms, were mixed with uninfected people. Consequently, even the camps were not exempt from the high mortality rates. As one informant aptly put it, "In our homes the sick died. At the camps our people, even the healthy, died."[57] Either way, the results were disappointing. In disillusionment, the local communities saw no hope in a state-sponsored program that only ended in more casualties.[58] A number of informants, such as Duado Omiti, were convinced that by ignoring the established customs and traditions with regard to establishing settlements in virgin territory, the colonial state led the "healthy" to their graves. In essence, the colonial state's failure to acknowledge its limitations, its resort

to arbitrary and coercive methods, and its claim to a monopoly of methods of epidemic control combined to create clouds of doubt over its health measures.

Local communities sought to find their own solutions to the crisis by turning back to long-standing traditions. The value of the customs and rituals of their own planned migrations came to be appreciated. The argument was that the colonial sleeping sickness camps as "new homes" for safety were established without due regard to ecological factors. Establishing such "new homes" in the traditional society, under normal or exigent circumstances, was subject to a careful reading of the environment to ensure its viability in supporting a healthy family, continued procreation, and perpetuation of the line.

Paul Mboya provides insight into the making of a homestead:

> It is the elder who establishes the homestead. The first thing he does is to consult medicine men, who shall determine whether his health, that of his family will be good enough to ensure procreation and perpetuation of the lineage. If the medicine man advises that he should not proceed with the plan of establishing a new home, the elder shall remain in the old homestead as advised.[59]

Critical to the settlement of new terrain was the cultural understanding that such lands carried security and epidemic risks. Settlement patterns among the various communities in precolonial Kenya were often created with a recognition of the dangers inherent in unplanned settlements that would bring catastrophe in the form of epidemics as a result of venturing into unknown terrain whose ability to support a human population had not been established.

Initial, unplanned frontier settlements rarely survived because they were often undermined by disease and conflicts. As a result, human habitation was confined to epidemic-free areas. Swampy, mosquito-infested areas along the banks of rivers and shores of lakes were often avoided. In general, migration and settlement were rational economic, political, and health choices undertaken with the intention of finding epidemic-free and agriculturally secure areas. Thus, the settlement of new terrain was undertaken after very careful consideration and with the clear purpose of reducing the risks of disease and the dangers associated with wildlife, drought, and human conflict.

The existence of well-defined buffer areas between communities and clans created free lands which were reduced to cultivation and settlement

only gradually and after very careful consideration by the communities concerned.[60] These precautionary measures were not irrational but the product of years of screening and experience. This cautious process was ignored by the state because of the presumed supremacy of Western biomedical practices, which constituted both the basis and the yardstick of a viable precautionary scientific method. Any tested cultural experience was ignored or screened through the prism of "official methods" which denied traditional ecological precautionary measures any consideration in the colonial discourse on methods of disease prevention and control. Consequently, such traditional measures were sacrificed at the altar of state-sanctioned methods and hardly brought within the orbit of serious discussion.

The consequence of preoccupation with avoiding risks was the existence of well-defined buffer areas that were uninhabited and uncultivated, known as "no-man's land." Such "no-man's lands," known as *thim* and *eshitsimi* among Luo and Luyia respectively, would gradually be reduced to settlement and cultivation by common consent and necessity as the attendant risks were reduced and such lands were claimed by a community or clan on a first-occupier basis.[61] It was believed that such unoccupied frontier land signified danger in the form of a trap by enemies, or that the former occupants had died from some mysterious disease.[62]

The frontier was not considered a safety valve for discontent where the disgruntled could go and set up homesteads; it constituted an integral part of the ecosystem balance. Consequently, advance parties comprising warriors and medicine men explored such lands first, to find out why they were not being occupied.[63] Settlement proceeded on a gradual, cautious basis to avoid the risk of the spread of disease or danger from wildlife. Thus, the conquest and subsequent settlement of the frontier was ensured through the combined effort of warriors, medicine men, and clan elders.

War leaders and clan elders helped define the movement to and the settlement of the frontier.[64] Close consultation between the political leadership and warrior groups in relation to any expansion resulted in the conquest and settlement of new land. The Luyia of Kabras distinguished between *Omukhulundu We kukwa,* clan elder, and *Omuviti,* war leader,[65] and the Luo made a similar distinction between *Ruoth,* clan leader or "chief," and *Thuon,* warrior.[66] The Gusii similarly distinguished between *Omogambi,* political leader, and *Omotang'ani,* warrior.[67] Medicine men and prophets also played a significant role in expansion.[68] These two groups were believed to be in possession of powers that were not easily accessible to the ordinary population. They, therefore, provided advice on the nature of the frontier and the planning required for expansion into an area. The con-

quest of the frontier was, therefore, never the decision of an individual, but the decision of a group.[69]

Thus, expansion into the frontier was in essence an extension of a community's cultural identity into a terrain. The settlement of a terrain meant the implanting of a culture, the widening of political space, and the defining of new economic opportunities. Indeed, settlement patterns reflected this sense of cultural identity. *Olukoba* and *Gunda bur,* among the Luyia and Luo respectively, epitomize the centrality of walled villages among some communities of western Kenya. [70] Cohen and Odhiambo aptly assert:

> Older Luo often remark that before 1900 people did not go around building just anywhere on the terrain. The land was rationally organized, and people were rationally organized, and settled in concentrated residential units (*gundni bur*; sing., *gunda bur*). Defensive requirements were important, according to these expositions, while collective settlements and collective planning of the use of the land were critical.[71]

Settlement and organization in a terrain was thus a rational historical process that encompassed the totality of a society's cultural identity including its political and economic system. During complex health emergencies such as those brought about by epidemics, it was not panic and emotion that dictated the option necessary for survival. Rather, it was recourse to history, pragmatism, and rationality that dictated the course of action. In this regard taboos had a tremendous influence on health behavior and conduct, defining the public health codes. These customs prescribed certain obligations that were vital for societal health. For example, the consumption of dead animals was prohibited.[72] Dead persons had to be buried within a specified period.[73] In certain cases, the house in which a person had died had to be pulled down.[74] If there were numerous simultaneous deaths, the place had to be abandoned. The significance of such measures lies in their being viewed as safeguards against dangers that if unchecked would bring disaster. Thus, it may be argued that prevention and containment constituted a major aspect of traditional health and the healing agenda in precolonial society. Susan Whyte reminds us that people should be seen as "actors trying to alleviate suffering rather than as spectators applying cultural, ritual, or religious truths."[75]

During the sleeping sickness epidemic of 1901–1902, the affected clans defined their course of action by resorting to voluntary migration in an attempt to contain the disease. At the same time, the traditions governing movement into new terrain were adhered to. Mass movement and sub-

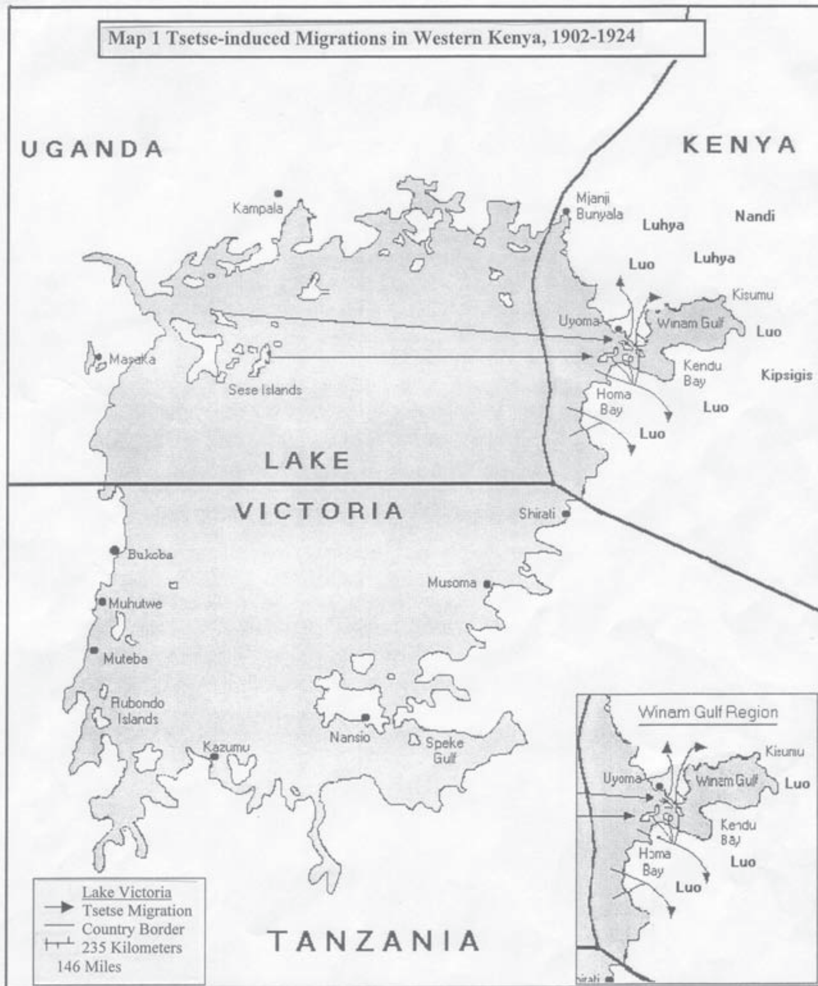
sequent settlement and involvement in agricultural activities, though resulting in some casualties, culminated in the destruction of the fly habitat and hence provided some relief to the uninfected.[76]

The pattern of the epidemic-induced migrations within the lakeshore belt was conditioned by the tempo and direction of the spread of the disease (see Map 1). The locality that was first hit by sleeping sickness in the Nyanza region was Mageta Island in 1901.[77] Mageta was the first to be affected because it was a major landing place for most of the communities that settled in the Nyanza region beginning in the seventeenth century.[78] Mageta's significance stems from the island's proximity to the mainland, which placed it in a strategic position for the purpose of surveillance of any advancing enemies by new groups of immigrants.[79] In the last decade of the nineteenth century, Mageta was reportedly a densely populated and agriculturally thriving island. In 1902 Engineer B. Whitehouse, of the Uganda Railway, noted that the island of Mageta had fertile soil, as well as fame as a fishing and hippo hunting point, and a thriving civilization with a cultural mix of such diverse professionals as blacksmiths and agriculturists.[80] A year after the epidemic, the once productive island had become deserted terrain.

The survivors of Mageta fled to Majimbo and Misori to seek refuge.[81] Some Kasigunga families migrated to their present homes in Kamagambo, Kongo Division.[82] These movements influenced lineage and ethnic identity changes in the region during the disastrous epidemic. Those who fled as individuals or small families came to identify themselves with the new communities where they settled. In essence, the epidemic reconfigured the previous lineage identities. The reconfiguration was also manifested in the shifting economic patterns of the emigrant survivors.

The immigrants adapted to the prevailing occupational situations where they settled. The Kasigunga families who settled in Kamagambo adapted to a predominantly agricultural lifestyle which was in contrast to the pastoral and fishing lifestyles that had characterized their sojourn around the lake. The lake people, locally known as *jonam,* were becoming inland people, *joramba.* These terms did not merely describe proximity to and distance from the lake, they signified economic cultures that explained household reproduction. With these changes came a new lifestyle that revolved around an agricultural calendar with its requirements of planting, weeding, and harvesting during certain times of the year.

Sleeping sickness was primarily a rural disease; its impact on the as yet infant townships and administrative posts was fairly limited. By contrast, however, bubonic plague, which constituted a major health crisis in



Map 1 Tsetse-induced Migrations in Western Kenya, 1902-1924

early colonial Kenya, mainly impacted the townships of Mombasa, Nairobi, and Kisumu. The state's approaches to the containment of bubonic plague were in certain aspects similar to the measures it had adopted in combating sleeping sickness. These included the manipulation of space as a means of social control, as well as the way local populations were taken for granted in the methods of control directed by the state authorities. However, there were also marked differences. Bubonic plague threatened the colonial eco-

nomic system and necessitated an aggressive definition of space in the infant townships with a view to separating Africans, Asians, and Europeans. It was the first major epidemic that set the parameters of social control in colonial Kenya.

II: Bubonic Plague and the Spatial Context of Social Control

Bubonic plague is characterized by the "swollen, and sometimes suppurating, lymph glands (buboes) that give it its name."[83] The plague claimed its first victim in colonial Kisumu on 28 December 1904.[84] Within the next two days, more deaths were reported.[85] Although the deaths were reported to the Medical Officer of Health at Kisumu, Dr. F. Haran, no action was taken immediately since he was indisposed.[86] When he examined the "smear from a gland-puncture, taken from a swollen bubo," on New Year's Eve, Dr. Haran identified the deaths as having been caused by bubonic plague, and the Sub-Commissioner, S. Bagge, was immediately informed.[87]

The plague was reportedly not new to the inhabitants of the locality around Kisumu. According to oral information collected by medical authorities at the time, local African informants stated that the region had witnessed an outbreak of plague sometime in the middle of the nineteenth century.[88] According to Dr. Milne, "inquiries as to the previous existence of plague at Kisumu revealed the fact of a common knowledge amongst the natives of a fatal malady that had attacked the dwellers on the present Government site, long before the advent of the white man. The symptoms were reported to be 'pain and swelling in the groin and fever, the swelling sometimes very large.'"[89] It was also noted that there was "no cure for it," and the mortality was quite high, resulting in "many men, women and children dying rapidly from it including the chief and his son."[90] The only escape from death was to move from one spot to another.[91]

The origin of bubonic plague in colonial Kisumu raises a fundamental issue as to why it broke out at the time it did. No direct link between the precolonial plague and the outbreak that erupted in 1904 in Kisumu existed. The locality had not witnessed an outbreak for over a half a century. Some have argued that the first outbreak of plague in colonial Kenya occurred in an Indian bazaar in Nairobi in March 1902.[92] In Kisumu, the available evidence strongly indicates that the outbreak of the plague was caused by the movement of infected immigrants into the township.

The first casualties were a Swahili on 28 December, who had come from Baringo via Londiani, and two Basoga from Uganda on 30 Decem-

ber.[93] By 9 January 1905, Baganda and Indians had also succumbed to the disease.[94] In the month of January, out of the twenty-six people attacked by the plague, twenty-five died; only one was a local person.[95] The ethnicities and identities of the victims, as well as the type and location of their residences within the township of Kisumu, strongly suggest that political and economic factors contributed to the outbreak and spread of the epidemic among a certain section of the population. These factors also influenced the response the epidemic evoked from the colonial state.

The victims lived in grass-thatched huts in densely inhabited residential areas. The developing colonial township of Kisumu had been transformed from a mere market and fishing village into a major railroad center within the relatively short period of five years. As a result, Kisumu had become a colonial commercial and administrative center, attracting people of various ethnicities and nationalities and from various epidemiological environments. Despite these changes in the demographic and economic structure of the township, insufficient attention was paid to the types and conditions of housing needed to forestall the outbreak of disease. In addition, the town lacked basic public health facilities. The town was a setting conducive to the outbreak of diseases such as the plague. Furthermore, the introduction of the hut tax resulted in congestion in African residential areas; Indians in their bazaars fared no better.

Following the diagnosis of the disease as the plague, the reaction of the colonial administration was swift, as steps were taken to stem the tide of the disease and its devastating results. Dr. P. H. Ross, a bacteriologist, was immediately dispatched to Kisumu by the Principal Medical Officer. Dr. Ross arrived in Kisumu on 3 January 1905 and immediately began an investigation into the nature and type of the plague.[96] Doctors Ross, Haran, and Henderson identified the specific form of the plague and its attendant symptoms.[97] The plague was septicaemic, which is the “severe, rapid, systemic form.”[98] Regarding the symptoms, they wrote:

> Invasion was marked by a rise of temperature, severe headache, staggering, thickened speech, rapid pulse, hurried breathing, epistaxis. Tender or enlarged glands either simultaneously appeared or very quickly followed. . . . Death usually took place within 24 hours of the onset.[99]

A number of measures were carried out with a view to containing the disease. All the hut-tax quarters where the outbreak had occurred were burned down.[100] Strict quarantines were imposed. In addition, constant and rigor-

ous inspection of the Kisumu Indian Bazaar was maintained.[101] The Kisumu Bazaar was cleaned and lime washed.[102] Dr. A. Milne, the Deputy Principal Medical Officer, summed up the energetic measures taken as follows:

> (1) inquiry as to the presence of dead rats; (2) daily inspection of the Indian Bazaar, with instructions as to the cleaning of the houses and exposure of goods to the action of the sun. (3) Frequent inspection and cleansing of all Railway Quarters and Landies [workers' compounds], and all native dwellings within the immediate conceivable reach of the spot.[103]

The measures taken to isolate the sick, as well as the systematic cleansing and disinfection of goods and dwellings, show the commitment of the colonial state to preventing the disease from spreading to unaffected locations and people. However, the state's concern also speaks to the differential treatment extended to the townships, particularly those such as Kisumu that were considered important economic nodal points.

The swift reaction of the colonial state was facilitated by the significance of Kisumu in the colonial economy and the impact the epidemic would have not only on the residents of the township but also potentially on those in the reserves, the areas designated by the colonial state as African residential areas in the countryside. Kisumu was both at the head of the railroad and also the major inland port in East Africa. It constituted an important economic link between Uganda and the EAP. Furthermore, because of the steamer service on Lake Victoria, an epidemic in Kisumu would have a wider epidemiological implication, even for German East Africa (called Tanganyika after World War I, and since 1964, Tanzania). The bacteriologist, Dr. Ross, could not have put it much better when he wrote:

> This unhappy termination of the Uganda Railway renders all precautions at Railhead most necessary for while outbreaks at isolated stations may be regarded without fear the presence of many centers of a more or less insanitary character along the line makes an outbreak of plague the cause of greatest apprehension.[104]

Thus, the outbreak of the plague in Kisumu was viewed as a potentially explosive health and economic hazard, leading to the loss of more lives as the epidemic spread among the population in the small stations along the railroad as well as the other inland ports on Lake Victoria. The imposition of quarantine to control the spread of the disease and the resulting trade decline negatively impacted the economy. Within the township, the disease eventually spread to the European population. These factors forced

the government to resort to long-term measures designed to effectively stamp out plague in the township.

Provincial Commissioner Bagge suggested that the government buy the bazaar outright, undertake the construction and maintenance of a new one, and let out the houses at an annual rent. He further recommended that all subsequent construction be subject to building regulations.[105] In essence, Bagge was advocating strict state laws that would regulate urban growth. However, the Under Secretary of State for the Colonies best articulated the ideology of social control in colonial urban development in Kenya. Upon receipt of Bagge's enclosure on the outbreak of plague in Kisumu, he suggested that

> In view of the fact that this disease appears to be endemic about the Victoria Nyanza great care should be exercised in the selection of sites for settlements, in keeping the native and European locations well apart.[106]

The recommendations of these two administrators signified an emerging trend in colonial Kenya in which epidemics were associated with certain specific groups. The issue of keeping various groups apart in the attempt to control the plague epidemic was premised on the mistaken assumption that certain groups were intrinsically unhealthy or prone to epidemics. Thus, the call for institutionalized segregation in residential and commercial places began to generate controversy in the politics of urban development as well as in colonial health care. One of the major manifestations of the emerging trend was the enactment of the Plague and Cholera Ordinance of 1906.

The 1906 Ordinance, which replaced the East Africa Plague Ordinances of 1900 and 1905, added the port of Kisumu to those places which would be subjected to surveillance by the colonial medical authorities.[107] Certain clauses in the 1906 Ordinance were biased against Africans and Asians. For example, clause 3 (6) read:

> Any native of Africa, not being of European or American origin, and any Asiatic disembarking at any port of the Protectorate from a ship which is an infected, suspected or healthy ship within the meaning of this Ordinance, may be detained under observation by the Medical Officer of Health for a period not exceeding five days from their arrival of such ship at the port, and any thing in this Ordinance notwithstanding.[108]

This clause strongly indicates that "native" Africans and Asians were viewed by the colonial state as potential disease carriers and hence could be detained for observation at any time as deemed necessary by the Medical

Officer of Health, even though they might have traveled in the same ships as whites. This edict and subsequent ordinances were deeply colored by the political tensions which developed out of the health crisis caused by the plague. Such ordinances strengthened the partiality of the colonial state and undermined the objective assessment of the health needs of the local community.

Hardly three years had passed after the 1904–1905 epidemic when the township was hit by another wave of bubonic plague that lasted from June to October 1908.[109] Starting in the Indian Bazaar, the malady then spread to most of the densely inhabited places where Africans and Asians lived. Fifty-nine deaths occurred out of the reported seventy-nine cases.[110] Reported mortality rates were lower than during the 1904–1905 outbreak because of inoculations with Haffkene's serum. During the four months of plague prevalence, some 3,495 persons were inoculated with Haffkene's Prophylactic.[111] In addition to inoculation, when the disease had subsided and was claiming fewer victims than before, the government adopted the selective contact principle to check "social wanderings on the part of natives especially at night and such persons as harlots, tembo [beer] sellers, and women whose husbands were away."[112] This principle incorporated two erroneous beliefs that tainted European colonial officials' attitudes toward indigenous populations on the issue of infectious diseases. First, there was always the hidden conviction that the hygiene of colonial subjects made them suspect as a source of contagion. In this regard, they were considered "part of a dangerous environment that had to be controlled and contained."[113] Second, as Luise White has shown, men and women of no fixed abode in the townships were considered a threat to the colonial state's policy of controlling population in the cities.[114] In this context, the bubonic plague provided the state with the opportunity to use public health measures to contain what it considered a social control problem. This entailed the planning of cities in order to segregate the various racial groups inhabiting them. Public health became the foremost consideration in the planning of towns. Thus as Spear has noted, Europeans attempted to regulate land use in urban areas by imposing their own uses of land and space with a view to realizing particular social and moral visions.[115] Suffice it to remark that the struggle over land in colonial urban centers brought together many different visions of political and economic struggles as well as health and social issues.

The establishment of various residential zones in Kisumu illustrates the way the colonial state used public health to regulate land use in urban areas. After the 1908 bubonic plague outbreak, the state formally estab-

lished three zones, which were meant to ensure that groups lived within their designated areas, supposedly to prevent the spread of disease from one zone to another. The first zone comprised the *Milimani* (highland/raised) area overlooking the port and railway facilities. This was a European zone. The hospital was located in this zone. The second zone was the Indian Bazaar (or Indian quarter), which was predominantly inhabited by those of Indian origin. The third zone was where the African populations lived; it was slightly outside the main township. Separating these three zones was a disease buffer area where building was not permitted. The zoning had important medical and sanitary implications. According to Will, the Principal Medical Officer, the zoning was meant to reduce a "source of danger to public health."[116]

It is, however, difficult to envision how the zoning would have eradicated plague in the township, since the first zone was given preferential treatment through the provision of sanitation facilities. Furthermore, the African zone was congested, so the lack of adequate sanitation facilities made it prone to plague epidemics. The zoning scheme resulted in what Swanson aptly described as "the sanitation syndrome," whereby zones occupied by certain specific groups became associated with certain medical images and diseases, because the health care and sanitation infrastructure in the areas occupied by these groups remained undeveloped.[117] In the case of Kisumu, the third zone, primarily including Africans, became synonymous with epidemics in the township.

But the spatial definition and zoning of the residential locations did not constitute the only front in the campaign against the epidemic. Movement between the infant townships and the rural areas was an equally important factor. The movement of migrant labor caused colonial officials a lot of anxiety. By 1918, the colonial state had established camps where anti-plague measures were implemented. While some "experts" were of the opinion that Kisumu was an endemic focus for the disease, others, although they agreed with this opinion, also believed that the epidemic was reinforced by "rats brought from Lake Steamers carrying cotton from Uganda."[118] In any case, since the town of Kisumu was the presumed focus, British health efforts were aimed at preventing the spread of the disease from the township to the rest of the province. There were two important means of coming to grips with the outbreak of plague. One way was through the intervention of biomedicine, while the other concerned the way to solve the problem of human agency in the transmission of the plague.

Despite the lack of unanimity on the radiation of plague from the towns, the outbreak of plague in towns was quickly turned into a question

of law and order, around which arguments about segregation as a policy of political and economic control of non-white populations in the city was articulated. The rise of slums in urban areas came to be perceived largely in terms of color differences as race relations came to be dealt with in the imagery of epidemics and infection. Because of the presence of Indians in the towns, the politics of plague control in the towns became a topical issue of debate from the 1910s onward. In the townships the outbreak of plague was believed to be specific to certain zones inhabited by non-Europeans.[119]

Thus, colonial planning of towns in Kenya proceeded on the cardinal principle of the separation of various groups: Africans, Asians, and Europeans.[120] As a consequence, the Europeans occupied cordoned-off residential places separated from the other groups. The inferior housing conditions in the African and Indian urban residential areas resulted in environments conducive to epidemic outbreaks. Although they formed the majority of the population in the townships, most Africans lived in congested locations lacking basic sanitary facilities.[121] The plague was a significant occurrence. From the progressive recognition of its incidence through the management of randomness to the negotiation of public response, the plague contained within its interstices not only the political ecology of race but also that of space. Suffice it to remark, therefore, that the allocation of space according to race in urban as well as rural settlements remained intact, albeit under intense pressure from non-European groups.[122] Indeed, the colonial state's policies on such key issues as immigration, the settlement of the White Highlands, and segregation in the residential and commercial areas of townships became the topical issues around which questions of labor, health, and the economy revolved.[123] This triad will be further addressed in the next chapter.

Trail of Blood and Bodies: Hospitals, Culture, and Ethics

Besides the lack of precise knowledge about tropical diseases, the colonial state was also faced with two other main problems. The first was the laboratory factor, which as a critical ingredient of scientific medicine still faced many challenges in its linking of cause and effect, especially of pathogen to disease in the case of infectious diseases. For example, once transmitted from *Rattus rattus* to the flea, and thence to man, where exactly was the plague located in the human body? The laboratory revolution dictated that the cause of the disease be precisely determined. General observable fea-

tures such as the presence of buboes and swellings were in themselves not considered conclusive proof that the victim suffered from plague. Further evidence was required to prove "beyond reasonable doubt" that it was plague and not any other disease. Once again, the attempt by the state to move away from the general to the particular, by framing the body as both the victim of the infection and the host of the cause of the sickness, was a biological novelty introduced as a result of the late nineteenth-century laboratory revolution in Europe, and greeted with suspicion and doubt in the colony.

Local cultures were confronted by one of the most significant institutions that transformed scientific medicine: the laboratory. Rather than being viewed as unique and vague constellations of environmental and physical predispositions, epidemic and other diseases could now be viewed as caused by microbes, which could be located in the body of the sick individual and be made to present themselves objectively to microscopic inspection.[124] Where previously disease was seen as emanating from an individual or group of individuals, laboratory science illuminated the fact that sickness emanated from microbes that infested the physical realm of an individual. A sick individual was now translated into a slight smear of morbid body fluids, meaning that scientific medicine "treats the disease—more precisely, the cause of the disease, not the patient."[125]

The laboratory revolution in late nineteenth-century Europe had shifted the focus from the patient to the disease. The ailment had to be identified precisely for effective therapy to be administered; therefore, no longer were the general symptoms or the appearance of sickness determiners of the medical course of action. The laboratory was more than just a physical site or a composite of medical investigative equipment. It provided a space where a whole human body was read, tested, and diagnosed with a particular disease through collected specimens. The entire human body was reduced to a mere specimen that could be manipulated to determine the cause of disease. However, the collection of specimens such as blood, saliva, or urine became one of the most controversial and unsettling issues during the early years of biomedicine in colonial Kenya. These bodily fluids were not easily given away in the traditional society. The common conviction was that such fluids could be manipulated to harm the individual, particularly if they ended up in the hands of those who practiced witchcraft. All bodily specimens were safeguarded because they contained the individual's unique mark, but the most significant bodily fluid was blood.

Blood defined social and kinship relations and codes of conduct among generation groups. Most significantly, it defined a whole array of therapeu-

tic measures because it was considered a unique, cardinal principle of life.[126] These beliefs explain the many questions, doubts, and myths that surrounded the collecting of a specimen from a patient. Although the purpose was explained, because the physicians who collected the specimen were more concerned with determining the cause of the ailment than with the patient, suspicion as to their true intent was aroused. To the patient, some diabolical scheme appeared to be the real reason for collecting the specimen. Besides, the blood collected was never seen again.[127]

The significance of such misinterpretations depended less upon the fact that the specimens were used to determine the precise cause of illness, but more on the types of questions asked, the relationship between the physician and the patient, and the cultural basis of the misapprehensions that characterized the process. The individuals behind this project, especially the doctors, insisted on patients providing specimens for culture analysis without taking a holistic view of the traditional anxiety over the specimen being given to strangers whose motives were the subject of doubts and rumors. Because the diagnosis often came too late or lacked the precise information needed to save the patient, few trusted the medical establishment. In the final analysis, if the victim succumbed to the disease, the doubts increased.

The establishment of hospitals led to similar anxieties over the impression that "most people who went to the hospital for treatment were brought back dead, or never seen again."[128] These fears addressed the state of health care infrastructure during the initial four-plus decades of colonial governance, when hospitals were relatively few and lacked basic facilities (see Table 2.1). As Table 2:1 illustrates, the number of deaths among recorded admissions was quite high during the first few decades of colonial rule. In some cases the death rates were over 100 per 1,000 admissions. Yet despite the high numbers of deaths in hospitals, the number of patients receiving treatment increased, not just in African hospitals but also in European hospitals (see Tables 2.1 and 2.2).

The lack of mortuaries meant that the victims of epidemics in the hospitals were disposed of as fast as possible to avoid potential health hazards. But as noted above, the hospitals were few and far between. Besides, transport to and from the hospitals was inadequate. Thus, frequent visits to check on patients, particularly on a daily basis, were neither common nor practical. It was, therefore, not uncommon to have the deceased disposed of according to the public health regulations. Two critical factors coalesced here: death and the disappearance of bodies.

How could the numbers of apparently unexplained deaths and the "disappearance" of bodies, due to their disposal according to the public

Table 2.1 Patients Treated and Deaths in African Hospitals, 1911–1913

	1911		1912		1913	
	Inpatients	Outpatients	Inpatients	Outpatients	Inpatients	Outpatients
Patients	5,548	80,262	15,233	77,837	11,012	95,778
Deaths	592		522		764	
Death Rate per 1,000	106.70		34.26		69.37	

Source: EAP, *Colonial Annual Reports* (London: HMSO), 1911, 1912, and 1913.

Table 2.2 Patients Treated and Deaths in European Hospitals, 1911–1913

	1911	1912	1913
Admissions	230	276	347
Deaths	14	11	14
Death Rate per 1,000	6.09	3.99	4.03
Average Number of Beds Occupied Daily	8	11.05	16

Source: EAP, *Colonial Annual Reports* (London: HMSO), 1911, 1912, and 1913.

health regulations, be explained? Uncertainty increased, and rumors became rife. But the rumors were discourses based on real happenings and real, known people. They constituted a dialogue between the traditional and the emerging society, in which some good was recognized in the new biomedicine. That good is reflected in the numbers of hospital patients, which continued an upward trend throughout the colonial period. On the other hand, however, aspects of that good were compromised by the negative impact on culture, particularly the unexplained deaths and hasty burials away from home.

Hasty burials not only appeared suspicious but also went against cultural traditions since they were conducted away from the home and without the necessary burial rites and rituals.[129] In this regard, the colonial public health officials exhibited an uncaring attitude, a poverty of cultural knowledge, and a meanness of spirit that further alienated many patients, not only from the officials but also from the institutions associated with the officials' developing health and healing tradition.

Death was both an event and a process. It included an assessment of the individual's achievements and a decision as to the continuance of the individual's social identity. A decision was made as to whether the individual deserved to be remembered by the living or whether he or she should be erased from memory. Thus, "honorable" burial was important, because it affirmed the individual's continuance in the afterlife and in society's

memory. In addition, burial affirms the social identity of the group.[130] As Susan Whyte has stated: "dealing with the dead affirms a home: their burial, their ceremonies, the collections of their shades and the way they draw descendants to a place where they can be remembered are all crucial to this process."[131] Death was believed to complement life by bridging the spiritual and the mundane world through tradition, and by "conforming to the legacy of the dead, the living in turn recognize their authority and avoid dangerous undertakings."[132] While the social meaning of death is important,[133] the economic meaning of death is equally so. The burial place of an individual defined the property inheritance rights of the deceased's surviving relatives.[134] Burial and the performing of attendant rituals tied the deceased to a real home and accorded the survivors the rights to the property on which the deceased was interred. To die at home and to be buried among one's kinsmen was a great honor. It provided the surviving relatives with their inheritance. They could rightly claim that this or that place had been their property from time immemorial because of the graves on the property. Thus, it legitimized peoples' claim to the estate of their ancestors. This tradition explains the Principal Medical Officer's statement to the effect that Africans used all sorts of evasive tactics to keep their dead away from hospitals during the plague epidemic in 1908. The development of biomedicine's hospitals and laboratories was undermined not only by cultural contests, but also by the inadequate resources that heightened the level of suspicion of doctors and medical institutions among local people.

Conclusion

The concurrence of colonial conquest, epidemics, and public health campaigns in early colonial Kenya exhibited a perceived unity of purpose that resulted in a strained relationship between the colonizer and the colonized. The colonial state lacked any clear policy for coming to terms with the emergent challenges of public health. To choose preventative or curative measures as constituting the predominant policy would be mistaken. Instead, the colonial state kept on lurching from one method to another, in what it claimed was its determination to find a workable solution. However, certain facts are clear.

First, the time was an era of shadow-boxing in which the colonial state hardly had a firm grasp of the magnitude of the health problems it was facing. The insensitivity of some colonial administrative and medical personnel to the concerns of the indigenous people marginalized the constitu-

ency whose support the state needed most to limit the spread of epidemics. It is, however, significant to note that a few colonial officials critiqued the methods that were sometimes enthusiastically pursued by the state. Thus, the evidence of dialogue within the ranks of the colonial state officials is instructive of the apprehensions that plagued the implementation of biomedical procedures during the infancy of colonial governance. The appropriate practical methods that the state ought to pursue were the subject of debates between colonial administration officials and the medical establishment. Sometimes, disagreements over policy occurred even among the administrative officials, particularly between those who served in the field and those who operated from offices in Nairobi or London. Hence the colonial state was not a monolithic institution. Disagreement over policies helped to strengthen the position taken by the majority of Africans and paved the way for cooperation on certain matters of public health from the 1920s onward.

In addition, colonial officials acted with an awareness of the developments in biomedicine in their home country, some of which were out of context in the colony. The epidemics of sleeping sickness and bubonic plague exemplify the significance of space, culture, and identity in the contact between biomedicine and its proponents on the one hand and Africans and their traditions on the other. This chapter has shown how epidemics created a dramatic and compelling opportunity to institutionalize segregationist tendencies, colonial patronage of certain types of medical policies, and social control, all of which marginalized the Africans and the Asians, pushing them to the periphery of the evolving colonial health care system.

Finally, the attempts to institutionalize the new bacteriology as part and parcel of biomedicine in the colonial context were met with voices of dissonance, the majority of which belonged to Africans. They questioned the relevance of bacteriology in the unfriendly, understaffed, and facilities-starved health care system created by the new colonial order. The chapter has shown how and why Africans were reluctant to embrace the new bacteriology based on their assessment of the existing situation.

3

IN SEARCH OF COMPROMISE: ECONOMY, LABOR, WAR, AND RELATED EPIDEMICS

Introduction

In colonial health care debates during the shadow-boxing era, one recurrent theme was the persistent conflict over what would be the dominant culture of health and healing in the emergent state of Kenya. Another feature was the dire need for dialogue to facilitate accommodation and compromise in order to find solutions to the myriad health and healing challenges facing the state and groups and individuals in the country. During this period, the foundation of Kenya's colonial economy, which was to have far-reaching effects on the form and structure of health care, was laid. Participation in the colonial economy became critical in determining the developmental course of health care, both at the workplace and in the areas from which labor was recruited and to which it was returned. The outbreak of World War I in 1914 revealed the biased nature of colonial policies which failed to consider the health care needs of those who did not fall directly within the orbit of the colonial economy. By its end in 1918, the war had further contributed to the destruction of human lives through the spread of influenza.

Chapter 3 examines the impact of the economy, labor, and World War I on the development of colonial health care through African, Euro-

pean, and Asian voices. The role of the colonial commissions of inquiry is examined against the backdrop of the conflicts that characterized the evolution and development of colonial health care policies. I also show how the colonial commissions provided a forum in which various grievances were ventilated and decisions that were instrumental in shaping the form and structure of colonial health care in Kenya were reached.

Economy and Labor

The challenge that confronted the colonial state in its desire to institutionalize the colonial economy in Kenya was not just the need for an improved infrastructure but also the procurement of labor and its sustenance at the workplace.[1] The Kenyan economy was based on agriculture. It was a labor-intensive economy in which both the settler and the peasant sectors competed for African labor.[2] This competition for labor intensified during the first three decades of the twentieth century due to a number of factors ranging from the alienation of land and the establishment of the settler economy to the vibrant peasant sector that was also in need of labor as it became drawn into the colonial capitalist economy. But the retention of laborers who were recruited, by force or voluntarily, to work in colonial establishments was made more difficult by the lack of any basic health care infrastructure, both at source and the workplace.[3] By 1908, the Protectorate was witnessing an acute shortage of labor, which forced the Governor to convene a conference to discuss the labor issue.[4] The conference led to the introduction of the poll tax and the enactment of the 1910 Master and Servants Ordinance. The primary purpose of the tax and the ordinance was to force African labor to go and work in colonial establishments and on European settler farms. The Africans had to pay the tax in cash, which could be found either by selling their agricultural produce or by earning wages. The tax and the ordinance also helped to accelerate the pace at which African peasant households and labor were drawn into the colonial economy. The conference also recommended the provision of proper medicines and medical attention as well as sufficient food for migrant workers.[5] However, the recommendation on the provision of medical attention was not an act of benevolence on the part of a colonial state that was bent on extending much-needed services to the citizenry. The emphasis on the health of the laborers was significant in reference to their participation in defined sectors of the colonial economy; as wage laborers on settler farms and colonial projects. Not much attention was paid to peasant households in the coun-

tryside. Colonial health care during the formative stages of colonial governance was not envisioned as a social or welfare scheme among the general population.

In spite of the proposals contained in the 1910 Ordinance recommending improved health conditions for laborers, little was achieved in the next two years.[6] The colonial state was not an even arbiter. While it supported settlers and encouraged coercive methods of labor recruitment, it was conspicuously silent on low wages and only nominally committed to addressing harsh and unhealthy conditions in the workplace.[7] Complaints and defections on the part of migrant labor became common occurrences.[8] The problem was that the colonial system had intensified interaction among various races and ethnic groups in new work environments. In addition, the development of the colonial infrastructure had increased mobility. These developments widened the possibilities of disease expansion. A disease outbreak was bound to affect more people in more places than ever before. Laborers returning to their homes transferred diseases from the workplace to the rural areas and vice versa.

Thus, as the colonial economy increased in complexity and human mobility gained momentum, urban demographic composition became quite varied, and disease contexts widened in scope and space. There arose the need to restructure colonial health care in the attempt to meet the challenge of maintaining the continued flow of labor to colonial establishments. The establishment of the Native Labour Commission in 1912 was a response to this need.

The Native Labour Commission (hereafter NLC) heard from a broad spectrum of the population, ranging from colonial administrators and medical personnel to African and European missionaries. Its hearings mirrored the depth and complexity of the dialogue among the constituencies with a stake in the outcome. The presence of opposing forces within the administration itself was especially significant because it shows how the colonial decision-making process was characterized by dissenting views from within as well as from outside. In the hearings, the colonial state was criticized by some of its own administrators, who were in touch with the situation in the predominantly African areas. Presenting evidence before the Native Labour Commission, John Ainsworth, the Provincial Commissioner for Nyanza Province,[9] articulated the concern of the chiefs on the connection between migrant labor and the importation of disease into the reserves, the predominantly African areas, when he stated:

> Some Chiefs had objected to their young men going out to work because men who had already returned were found to be suffering from venereal

> disease which they were introducing into the reserves. Speaking generally the main objections of the Chiefs were based on this and sickness generally.[10]

Addressing the care of the laborers at the workplace, Ainsworth argued:

> Outside the Reserves they got as a rule only one kind of food, whereas in their own homes they had a varied diet. He pointed out that the Kavirondo in his country was usually a large eater; he normally had three meals a day and was constantly chewing something in between the meals. Those living near the Lake also ate a good deal of fresh fish.[11]

Ainsworth was not a lone crusader in his criticism of the colonial state. The Secretary for Native Affairs, A. C. Hollis, expressed similar sentiments when he averred that "a large number of Kavirondo [Luo and Luyia] had contracted syphilis and other venereal diseases when out at work, and the chiefs were averse to the young men leaving their Reserves and infecting the women also on their return."[12] Oscar F. Watkins, a colonial administrator and a postwar Acting Chief Native Commissioner, similarly described the sharp distinction between the conditions at the workplace and in the rural areas:

> If we proceed to a comparison of conditions in labor and native areas, it can, I think, be established that in his own areas the native is in the main better fed, better housed, is not driven to choose between celibacy and syphilis, has no need of warm clothing, and without working in all weathers under an overseer, can make sufficient for his simple needs.[13]

Within the medical establishment, Norman Leys, a medical doctor and a well-known humanitarian viewed by the colonial state as pro-African, told of the grim conditions that faced the laborer in colonial establishments in a written statement to the commission:

> The chief cause of this mortality is the absence of Sanitary Measures on plantations and in the Townships, such as are enforced by law in other tropical Colonies. Contributory causes are bad dietaries and poor housing, both of which are inferior to what was provided for slave labor a generation ago. The conditions which determine sickness and death rates vary greatly in different plantations. Food given by employers for the return journey is frequently so infested with weevils as to be dangerous to health.[14]

A fundamental question that arose from the evidence presented before the commission was this: if the conditions were as terrible as they were portrayed, why did Africans leave the rural areas, where they managed their

own production schedules, earned income from their farm produce, had three meals a day, were free from venereal disease, and were accustomed to freedom, to enter colonial labor service? Having received sufficient attention by various labor and economic historians, the question need not be belabored here.[15] The answers have included commoditization, monetization, taxation, and competition between the peasant and settler economies. There is no doubt that the differentiation between households and overt coercion were equally important reasons for the movement of some laborers to the workplace away from their homes. African witnesses to the commission attested to some of these factors.[16] Ocholla Omolo from Nyakach location in Central Kavirondo provided the following insights into the complexity of the push and pull factors:

> Had wanted money to pay tax and for that reason had come out. He sent a good deal of money home to help his father, and pay the taxes on his father's huts, of which he had several, but it was his own wish and not his father's that he should work. His chief always sent labour out when asked to do so, a proportion being ordered out from the different kraals. They could not disobey an order of the chief to go out; even if a boy was sick, and he had no brother to replace him, he would not refuse to go. . . . But the chief was making them to go out because the government wanted them to.[17]

Similarly, Onyango Ojolla from North Kavirondo asserted:

> If the chief received an order to send men out, he sent his own "askari" to get them from different kraals until the number required was obtained, and when they got the order from the chief to come out they never refused. ("How could I refuse if I get an order from my chief?") The chief only gave the order if the Government or a European required him to do so, and no one else. If a man was ordered out to work who was ill, and could not find anyone to replace him he would give the chief some rupees or stock to be allowed to stay home.[18]

Mulama wa Shundu, who was the President of Marama Council in North Kavirondo, expressed similar sentiments:

> If the Government wanted labour he always saw that it was got together and the unemployed were made to work. A man who refused to work was caught and forced to go. He had noticed that those who cultivated simsim spent more money on clothing than those who worked at Uasin Gishu, and thought that those who cultivated their own "shambas" made more money than wage earners for a man could get Rs. 30/- per month by selling bananas at 25 cents

> a bunch. Most of his section paid the tax from the sale of simsim. The majority returned from work in good condition, but some were thin and worn out and some had contracted syphilis; others again never came back at all.[19]

These sketches of push-and-pull factors elucidate the state of society and health in the reserves. Rural Kenya was not composed of households that were all exactly alike. This differentiation among households, which has been described by Allen Isaacman as "peasant diversity," was an important factor contributing to the migration of labor from the countryside.[20] While some peasants were quite prosperous, others needed cash to enable them to meet their tax obligations.[21]

Overt coercion and the epidemic consequences of labor migration are evident from the accounts of the colonial administration and the African witnesses. Small wonder then that the NLC recognized the biting shortage of labor in settler and government projects.[22] The commission noted that the monthly labor shortage during the period 1908 to 1913 never fell below the 1909 figure of 736.[23] In 1913, however, the monthly shortage stood at 1,205.[24] This steep rise may be accounted for by the increase in the number of European settlers as well as the state-sponsored public projects. But perhaps the most important explanation was the conditions existing at the workplace. There is little doubt that the adverse state of health and nutrition that plagued the laborers at the workplace was influencing the decision whether or not to voluntarily seek employment in colonial establishments outside the worker's immediate environment. Disease and hunger were labor's constant companions at the workplace.

In its final report, the NLC recommended that the "Government bring in legislation to provide for the inspection of the conditions under which labor works . . . and that such legislation shall provide for the enforcement of conditions affecting food, cooking, and medical attendance."[25] The commission based this recommendation on the finding that "wastage of labour has undoubtedly occurred through the insufficiency of medical attendance given, resulting in deaths and loss of vitality, and the latter by malnutrition."[26] Recommendations were made that provincial and district commissioners should not be involved in the recruitment of labor and that labor camps should be established to facilitate the medical examination of migrant labor.[27] The implementation of the recommendations, however, required boldness and impartiality on the part of the colonial state, particularly its leadership.

Ironically, Governor Sir Henry Belfield, during whose tenure the commission's report came out, lacked that boldness and impartiality be-

cause of the strong pro-settler views which he openly proclaimed.[28] Although he agreed in principle to the enactment of legislation subject to the Secretary of State's approval "for the inspection of labour and the enforcement of conditions affecting their health and well being," Belfield felt that it would be improper to divorce the administration from the exercise of labor recruitment.[29] True to that conviction, he informed the Secretary of State that he was "issuing a Circular instruction upon the subject," and "consulting the Provincial Commissioners regarding the establishment of labour camps."[30] The setting up of labor camps was conceived as a means of ensuring that labor was given sufficient medical attention during recruitment. On the issue of labor conscription, Governor Belfield took the view that it was of the "utmost importance that all officers entrusted with duties of administration should impress upon the people the desire of the Government that their young men should go out to work and should keep the fact always prominently before them."[31] Here, significantly, the latent agenda of the appointing authority conflicted with the recommendations of the commission. Governor Belfield positioned himself as a benevolent and compassionate custodian of African health interests, while maintaining that the provincial administration could not abdicate its supervisory role over the recruitment of labor.

The position of Belfield on the role of provincial administration in procuring labor not only ran contrary to the spirit and intent of the NLC, but also diametrically opposed the view held by the Secretary of State, Lewis Harcourt. Thus, in his reply to Belfield, the Secretary of State made clear his resolve on the issue by asserting that government officers should do nothing which could in any way suggest government compulsion:

> When a government officer urges the native to work the native does not always discriminate between advice and compulsion, and is apt to confuse a suggestion made by one in authority, whose orders on other subjects he must obey with an order.[32]

In rejecting Belfield's suggestion, the Secretary of State went further to define the role of the colonial administration on labor issues. He asserted that the administration ought to be the guardian of labor interests and not private interests, by

> Confining itself to what is necessary for the protection of the labourer, e. g. ensuring that the contract entered into by the native is regular, contains no false representation, and is understood by the native, and the proper treatment is given to the native before and after he is handed over to the actual

> employer. . . . It is definitely aimed at preventing anything in the nature of a systematic invitation to work.[33]

The Secretary of State prescribed the role that the administration ought to play; the reality was very different. There was a very thin line between advice and compulsion in a paternalistic relationship of "colonizer" and "colonized." The "native" could discriminate between the two terms; the truth of the matter was that government officials made no distinction between the two when exercising power and control over the local population. At any rate, some chiefs vigorously participated in the recruitment of labor in the name of the Crown.[34] Advice and compulsion were synonymous in application when it came to explaining and executing the labor recruitment procedures.

The exchanges between Belfield and Harcourt implied that as the guardian of labor interests, the colonial state was supposed to pay particular attention to the health of laborers, both on and off the job. The immediate, but hardly recognized, result of the Native Labour Commission's work was the extent to which it brought to the fore not just the shortage of labor and the ways of enhancing its procurement, but, more importantly, the elevation of health to pride of place in the debates on labor and economy.

The Politics of Health and Sanitation

By the end of 1914, the colonial administration intensified medical examinations at the various labor camps in the country. The number of those inoculated and vaccinated rose sharply, best illustrated in the case of Kisumu where the number of those inoculated rose from 7, 993 in 1912–1913 to 24,439 in 1913–1914.[35] The significance of Kisumu in the evolving colonial economy, as well as in the health care issue, was twofold. First, it was at the head of the only railroad that served Kenya and Uganda, thereby making it a vital point in the fledgling colonial trade. Any disease outbreak in Kisumu and the surrounding area was considered to be a potential hazard to the two territories, which would adversely affect the trade. Also, the town was the provincial headquarters of a region that supplied more labor to colonial establishments than any other zone in Kenya. Hence health campaigns were often intensified during epidemic outbreaks in the attempt to prevent the spread of disease to the labor destinations. It is hardly surprising, therefore, that the rapid growth in the number of those vaccinated represented an increase of over 300 percent within a period of just one year.

As the demand for labor gained momentum, health campaigns in the "labor provinces," Nyanza, Western, Central, and Rift Valley, began to receive considerable attention. These two developments also coincided with the commissioning of Dr. William J. Simpson with instructions to proceed to Kenya to inquire into the state of health and sickness in the country. He was to specifically "examine into the sanitary conditions of the Dependency, to advise the local government and to report on the form which the sanitary policy of the administration should take."[36] If credentials were anything to go by, Simpson's resume exhibited a distinguished record of commitment to imperial sanitation paralleled by very few, if any, among those who were known to the Colonial Office. On his enviable expertise and vast experience in tropical countries, Herbert Read, who was the principal clerk in the East African Department at the Colonial Office, recorded in his minutes, "He is certainly the best man to send out, and he did admirably for us in West Africa. His experience in Calcutta, South Africa, Hong Kong, Singapore and on the TAMS [Tropical Advisory and Medical Service] Committee will all come in useful."[37]

Thus, Professor Simpson was not a stranger to Africa. He had visited West Africa in 1908 during a major outbreak of plague in Accra, Gold Coast (Ghana). During the visit, and in response to a request by the Secretary of State, he investigated the sanitary condition of some principal towns of the Gold Coast, Sierra Leone, and Southern Nigeria. On the impact of his West African mission, Henry Lambert, the Under Secretary of State, noted:

> His report on this aspect of his mission was laid before Parliament (as Cd. 4718); and it is no exaggeration to say that it forms the basis on which the sanitary organisation of the West African Colonies is being built up, and that it is to Professor Simpson's suggestions and to the experience which he acquired by his visit that much of the striking improvement in the health of the European community is to be attributed.[38]

Professor Simpson was also described by Lambert as "one of the foremost authorities on bubonic and pneumonic plague," which were prevalent in the Protectorate.[39] Lambert's support for Professor Simpson is pertinent to the issue of Simpson's controversial recommendations, which led to many disputes in most of the places where his services had been requested on matters of sanitation and plague control.[40]

Simpson's "gospel" of segregation in urban planning and sanitation was well known.[41] The population of the EAP was quite diverse, composed

of Africans, who primarily resided in the countryside, and Europeans and Asians, most of whom lived in the townships. Simpson came to the EAP at a time when the sanitary conditions in the townships were inciting a lot of political debate pertaining to the issue of segregation in urban residential and business locations. In addition, the reserves were under constant threat of plague and smallpox.[42] The challenge facing Simpson was enormous. But if Simpson's previous prescriptions for such demographic, political, and epidemic terrain were anything to go by, this leading expert was in a familiar environment and his recommendations were surely predictable: separate and unequal development of health care facilities in the country.

Professor Simpson made several recommendations, often ignored in the analysis of his turbulent career, one of which was the hiring of more medical personnel. In the case of North Nyanza, for example, he noted, "in the District with a population of over 300,000 there is no European Medical Officer. It adjoins the Mbale and Bukedi District of Uganda in which plague prevails and it has trade relations with Kisumu in which plague also prevails."[43] He also recommended the creation of an autonomous sanitary department distinct from the Medical Department and the posting of sanitary inspectors to all the townships. Simpson's investigation affirmed the unhealthy state of Mumias. He noted the grim situation of the township in the following words: "Since June 1905, three Europeans and one Goanese have died of Blackwater fever and there have been sickness and deaths from the same cause among the Swahilis and Indians."[44] Simpson identified the problem of Mumias as being caused by the situation and conformation of the ridge on which the township stood, with its slabs of granite outcropping near the surface, and its streams of water issuing from different levels, rendering drainage ineffective.[45] As a result, he recommended the shifting of the district headquarters of North Kavirondo from Mumias to a more suitable place, Kakamega. The move was effected after World War I.[46] Mumias was abandoned in early 1919 after the death of two officers from blackwater fever. Mumias had reportedly "gained an unenviable notoriety as a death trap . . . the cemetery of which contains no less than eight European officers."[47]

Significantly, the main reason for the shift of the headquarters from Mumias was the number of Europeans who had died at the station. The number of European casualties had made the town notorious among health and administrative officials in the country. Both Shula Marks and Philip Curtin have ably addressed the theme of disease and race in the colonial setting, averring that the diseases that attracted most attention were those that claimed the lives of Caucasians in Africa and Asia.[48] Work on the new district headquarters at Kakamega began in February 1919.[49]

Suffice it to note, however, that the sad epidemiological history of Mumias predates colonial rule and was well known to the local people. The township had been a major center in precolonial times. Its sorry state forced its abandonment in 1870 by Nabongo Mumia, who shifted his capital to another spot altogether. However, Mumia gave it to European officials for use as a base for their activities when they made their appearance in Western Kenya in the 1890s.[50] In 1898, for example, an Assistant District Officer, D. Mallock, died of blackwater fever. In the next year, in a single incident, over fifty people perished:

> Mr. Grant's large caravan of Busoga transporting the Indian Regiment to railhead was a source of much anxiety especially on their return journey, owing to the awful mortality; some 50 men died in one night at Mumias of acute dysentery, and after the caravan had passed it left an epidemic among the natives along the route of march.[51]

The irony of the saga of Mumias lies in the fact that, despite local awareness about its sorry epidemiological status, it was the word of Simpson that forced the government's decision to shift the headquarters to another place. Although the conditions that plagued the township of Mumias were obvious to the local population, their knowledge was considered irrelevant in the colonial state's decision-making process. The state valued the expertise of those schooled in Western tradition and science. It doubted the knowledge of local people in spite of the fact that such expertise was based on years of accumulated experience.

Professor Simpson's most controversial recommendation pertained to the enactment of legislation to control the development of townships. He strongly recommended that urban segregation should be institutionalized by the enactment of a public health ordinance. This recommendation was to be the cornerstone of urban development in the Protectorate and a major issue of controversy between the colonial state, the Colonial Office, the India Office, and the local European and Indian communities. It was also a major cause of postwar militancy among the African population in the towns.

The controversial nature of the recommendation is best illustrated by the events following the promulgation of the Public Health Ordinance of 1913, which was heavily influenced by the politics of racial segregation. The view of Governor Henry Belfield was that it was "an interim measure pending the enactment of the General Public Health Ordinance for the Protectorate."[52] Nevertheless, Belfield emphasized the recommendation of

segregation to legitimize his preconceived notion of separate development by instituting the interim ordinance without consulting with the other interested parties. To strengthen his hidden agenda, which had now been given "scientific" credibility by Simpson, the interim ordinance was structured to give the Governor statutory powers to invoke the ordinance if and when it was deemed necessary to stop the transfer of private land in the townships from one group to another on the grounds of health. Once again, Belfield would be drawn into a controversy over the clauses he had enthusiastically embraced and sought to institutionalize.

The East Africa Indian Congress saw in the bill a deliberate move by the colonial state to institutionalize segregation in residential and commercial areas in townships.[53] The reaction of the East Africa Indian Congress was swift and forceful in protesting against what it viewed as outright discrimination against the Asian communities. The Congress demanded that the zoning provided for in the ordinance be revoked. However, Governor Sir Henry Belfield defended the status quo by arguing that

> The definition of Indian location in township is a measure which is essential to the maintenance of health and sanitation. In cases of epidemic disease no portion of our mixed urban community is more obstructive to ameliorative measures than the Indian members.[54]

Belfield went even further to suggest that the Secretary of State should write to the East Africa Indian Congress and reprimand its officials for agitation against segregation.[55] There is no evidence that the Secretary of State honored that request.

Moreover, the Indian Congress continued its attack on the interim ordinance, pointedly countering that the law could be made to deal with "individuals who ignore recognized canons of decency and sanitation" without espousing racial segregationist tendencies.[56] The Congress further argued that "the law is, or can be made, strong enough to deal adequately with all, without it being racial or class legislation, because it is a truism that no race or people has a monopoly of all the virtues or all the vices."[57] The outbreak of World War I resigned the debates on the framing of the colonial health care policy to limbo, as military campaigns came to occupy center stage for the next four years.

However, the debates were resurrected after the end of the war as the colonial state and the Colonial Office began to put into effect most of the recommendations of Professor Simpson. Thus, the war constitutes a watershed in the politics of restructuring the fledgling colonial health care sys-

tem. The experience of the course and conclusion of the war revealed an urgent need to review Simpson's report to establish a coherent, specific, and goal-oriented health care policy. Colonial health care policy until the end of the war involved mainly containment of epidemics by medical screening and segregating "at-risk" populations. Colonial health care enforcers tried to contain epidemics. One method of containment was the medical screening of those who were moving out of the reserves into colonial employment, to avoid the transfer of disease to their places of employment. Finally, the colonial state pushed for segregation to protect Europeans in urban areas from being "infected" by the other racial groups who were erroneously viewed as potential disease carriers.

These factors influenced the colonial state's "management by crisis" approach to prevention and control of disease. During the shadow-boxing era, ad hoc measures were instituted and aggressively pursued during epidemic outbreaks. However, the measures were less aggressively enforced as the virulence of a disease declined and were sometimes abandoned once the epidemic was contained or had run its course. Such stop-gap measures inhibited the formulation and implementation of a comprehensive and effective health care policy. In the case of plague, for example, Professor Simpson opined:

> The safety lies in a systematic and organised rooting out of the seeds of the disease from the country. This cannot be accomplished without a properly organised and effective health organisation endowed with adequate powers such as I have recommended.[58]

Thus, when Professor Simpson submitted his memorandum on the state of sanitary conditions in 1917, he revisited some major issues that were embodied in his 1914 report. He wrote:

> The most important matters for consideration are the continued prevalence of plague, the insanitary condition of the towns and trade centres and the great wastage from disease and the facilities afforded for the extensive spread of epidemics in connection with labour and its movements between different parts of the country. Each of these alone is capable of effecting much avoidable injury to human life, but when combined as they are in East Africa, the alliance is a most powerful one, and is a grave danger to the inhabitants and to the prosperity of the country. Further the lack of an efficient sanitary organization and administration in the country and the absence of a Public Health act practically leaves East Africa in an undefended condition.[59]

The contents of this memorandum and of Simpson's 1914 report, together with the experience of the war, constituted the immediate backdrop to the public health measures that were instituted during and after World War I.

The Agony of War and Related Epidemics

The outbreak of World War I, particularly the invasion of the East Africa Protectorate (now Kenya) from German East Africa (now mainland Tanzania), in September 1914, immediately drew the people of Kenya into a world conflict whose causes and origins were, to them, clouded in mystery, ambiguity, and contradictions. Initially seen as a European war, it became very African in terms of the massive recruitment for the Carrier Corps, the dislocation of local economies, the outbreak of epidemics, and the attendant high mortality rates. The colonial state instituted several measures aimed at mobilizing the population to contribute toward the war effort.[60] The Registration of Persons Ordinance, which made the registration of adults compulsory within the Protectorate, was introduced in the Legislative Council in September 1915 and passed in December of the same year.[61] Pursuant to the ordinance's objective, Governor Belfield mobilized and secured the support of the "military, civil and administrative authorities" in the registration process as well as the conscription exercise.[62] District committees worked closely with the War Council in ensuring that conscription proceeded uninterrupted.[63] But the colonial state's medical policy in the country before the outbreak of World War I had been primarily urban-focused. The countryside, where the majority of the population lived and farmed, came into the health spotlight only during epidemics of diseases such as plague, smallpox, or sleeping sickness. The conspicuous state of neglect and the disorientation that had developed over the years constituted a major obstacle to the realization of the measures to ensure African participation in the war. In an attempt to address the imbalance in the provision of medical services, massive vaccination campaigns were carried out in order to produce healthy conscripts (see Tables 3.1 and 3.2). During the process of registration, individuals perceived to be physically fit and of military age were identified and subsequently recommended for examination at designated camps. The number vaccinated against smallpox increased steadily from a low of 131,000 people in 1913 to a high of 977,055 in 1916 before dropping to 297,303 in 1917 (see Tables 3.1 and 3.3).[64] The administration's offensive against disease in the countryside, though ad hoc

Table 3.1 Summary of Smallpox Vaccinations Performed between 1913 and 1916 in the EAP

Year	Vaccinations
1913	131,747
1914	123,245
1915	162,184
1916	977,055

Source: EAP, *Annual Medical Report 1916* (Nairobi: Government Printer), 30.

Table 3.2 Smallpox Vaccinations Performed at the Major Stations in the Region Bordering Uganda, 1911–1917

Year	Kisumu	Mumias
1911	995	259
1912	4,527	91
1916	102,659	278,554
1917	12,348	95,456

Source: EAP, *Annual Medical Reports 1916 and 1917* (Nairobi: Government Printer); NPAR, 1911–1912 (KNA: PC/NZA/1/6), 1912–1913 (PC/NZA/1/7).

and belated, was significant in a number of ways. The reporting of disease outbreaks was intensified and regularized. Such reports were given prompt attention by the administration and the medical authorities. Table 3.3 is instructive with regard to the government's efforts in the vaccination campaigns against smallpox in 1917. The total figures for the entire Protectorate in the preceding years are also encouraging as shown in Tables 3.1 and 3.2. The exceptionally high figures for 1916 are due to the wide spread of smallpox in the area from the Bukedi District in eastern Uganda in the latter half of 1916.[65]

But despite these efforts, the figures also demonstrate the fact that out of a total of 297,303 vaccinations that were carried out, only 2,467 were described as definitely successful. First, vaccination is a preventative measure that works best when the individual has not been exposed to the disease. As discussed in chapter 2, reaching the target population was often a problem because of the undeveloped infrastructure, as well as the failure to gather information well in advance of the campaigns. Consequently, some of the victims were vaccinated when it was too late. Second, the number of "unknown" cases reflected the fact that there were no concerted efforts to examine the impact on those who had been vaccinated. In addition, the conditions under which the lymph, which was manufactured at the Bacteriological Laboratory in Nairobi, was stored and transported also constituted a problem.

Table 3.3 Vaccination Centers and Vaccinations Given at Each Station, 1917

Stations	Vaccinations			
	Number	Failed	Perfect	Unknown
Mombasa	3,920	86	139	3,695
Malindi	3,961	—-	—-	3,961
Machakos	2,441	277	634	1,538
Nairobi (Prison)	37,366	—-	—-	37,366
Nairobi	1,077	94	369	614
Kiambu	1,242	—-	—-	1,242
Makindu	50	6	40	4
Kitui	7,450	—-	—-	7,450
Naivasha	262	1	10	251
Nakuru	1,012	362	410	340
Eldama Ravine	2,223	—-	11	2,212
Kabarnet	51	12	31	8
Kacheliba	1,516	533	768	217
N. Turkana	60	15	43	2
Fort Hall	33,044	—-	—-	33,044
Nyeri	21,305	—-	—-	21,305
Embu	4,651	—-	—-	4,651
Meru	22,918	—-	—-	22,918
Kisumu	12,348	—-	—-	12,348
Mumias	95,456	—-	—-	95,456
Kericho	36,759	5	12	36,742
Nandi	2,523	—-	—-	2,523
TOTAL	297,303	1,386	2,467	293,450

Source: EAP, *Colonial Annual Report, 1917/18* (London: HMSO, 1919).

The bold public health steps taken by the colonial authorities were not without adverse consequences. For example, the risk from movements of conscripts intensified following the enactment of the Compulsory Service Ordinance, which came into effect in March 1917.[66]

Thousands of people from various epidemic zones mixed freely, with adverse results. The 1916 outbreak of smallpox in parts of Kenya bordering Uganda was attributed to such movements:

> In the North Kavirondo District (peopled mainly by the various groups that constitute the Luyia community) owing to the constant call for carrier Corps for the Military and also as a consequence of the Chiefs being informed of

> the contemplated increase of the Hut Tax from April 1st, 1916, a number of natives living in proximity to the Uganda Protectorate crossed the boundary to Uganda territory. This disease was reported as being prevalent in Uganda during the year and it is probable that the Mumias District was infected from here. From Mumias the disease spread to the northern locations of the Kisumu District (peopled mainly by the Luo) thence to Kisumu itself and southward through Nyakach to the Kisii District (home to the Gusii community).[67]

In the northeastern part of the district, a similar movement occurred amongst the Bukusu, a Luyia group, when "a number of natives . . . migrated to the Trans-Nzoia farms; a number of these have been returned back."[68]

Besides smallpox (for which, see also Table 3.4), bubonic plague, which had subsided after the initial invasions of 1902, 1904–1905, and 1908, surfaced again, particularly in the border regions of Kenya and Uganda. This increased incidence of pestilence had immediate effects on health, mortality, and disease patterns. The natural frontiers created by Africans to contain disease had since the beginning of colonial governance been continuously eroded as a result of forced movements, which gained momentum during the war.[69] Conscription aggravated a vulnerable and unstable

Table 3.4 Reported Cases of Smallpox and Related Deaths at Various Locations in the Border Region, 1916 and 1917

Location	1916		1917	
	Cases	Deaths	Cases	Deaths
Mumias	104	6	6	4
Yala	22	7	—-	—-
Gem	225	106	187	39
Alego	120	1	1	—-
Marama	227	37	37	7
Wanga	178	88	88	24
Wamia	129	23	760	272
Bukhayo	23	6	86	35
Marachi	42	8	4	—-
Ugenya	13	4	4	1
Mukulu	194	44	—-	—-
Samia	38	16	18	3
Buholo	7	2	71	20
TOTALS	1,322	442	1,272	406

Source: EAP, *Annual Medical Reports 1916 and 1917* (Nairobi: Government Printer).

epidemic environment that facilitated the spread of disease among the civilian population.

There was a shifting of resources from rural households to the war front and a "feminization" of the food production process as the majority of women assumed a wide array of domestic chores hitherto either shared with men or performed mainly by them. This change undermined the economic viability of the rural economies. Most households experienced difficulties in sustaining the rate of food production and in securing a means to cover any shortfall in production. As a result, production in the reserves underwent readjustment in response to the challenges brought about by the war. The demands made by the colonial state brought stress and crisis to the household economy.

The colonial administration requisitioned food from the local population. During the East African campaign, Kenya lost several thousand head of cattle through state-sanctioned requisitions.[70] The chiefs and elders in Nyanza Province, which was the home of the Luo, Luyia, Gusii, and Kuria communities, were reportedly making "spontaneous gifts of livestock as meat for Troops, and assisting very materially in sending out their men to join [the] Carrier Corps."[71] Whether the animals provided by these communities were gifts and the men going out to serve in the Carrier Corps were self-motivated volunteers, without any compulsion from the chiefs, is debatable. The agents of the colonial state were bestowed with powers to extract the supplies required for the war effort by force if necessary. When peaceful demands could not produce the desired results, compulsion was an acceptable alternative.

Besides providing direct military labor and food supplies for the war effort, the colonial administration also initiated direct cash payments to subsidize the government's expenditures. The East African War Relief Fund was started in September 1914 to care for disabled volunteers and dependents of Europeans killed in active service.[72] In the next year, John Ainsworth set up a separate fund meant to "provide extra medical comfort for African soldiers, stretcher bearers, and Carriers while actually in hospital."[73] The response to Ainsworth's visionary action was overwhelming. By mid-October 1915, "some 28,000 rupees had been collected with 17,000 of it coming from Africans."[74] At the same time as money was being collected for the War Relief Fund, the newly increased hut tax was being collected. The increase in the tax from three to five rupees was high, since wages stood at six rupees per month.[75] Even for those who were wage earners, meeting the tax obligation was not easy in the face of increasing prices and high tax rates. For those who farmed, more produce had to be sold to raise money

Table 3.5 Hut Tax Collections (in Rupees) in Nyanza, 1913–1914 to 1918–1919

	Central	North	South	TOTAL
1913–1914	270,939	383,565	250,965	905,469
1914–1915	303,354	417,126	263,928	984,408
1915–1916	308,556	426,357	253,326	988,239
1916–1917	501,460	661,245	429,685	1,592,390
1917–1918	548,920	639,000	478,120	1,666,040
1918–1019	565,835	626,970	496,790	1,689,595

Source: NPAR, 1918–1919, KNA: PC/NZA/1/14, 7.

for the tax. These adverse conditions resulted in the migration of a large number of people from the border districts of Central and North Kavirondo, occupied by the Luo and Luyia groups respectively, to Uganda to avoid paying the tax (see Table 3.5 for tax collection from these districts).[76] The options available to the local population were few: emigration or harassment and impoverishment.

Thus, as war demands and disease outbreaks continued to plague the country, their impact on the general economy began to engage the attention of Governor Sir Henry Belfield, who responded by establishing the 1917 East Africa Protectorate Economic Commission to inquire into the economic problems facing the country. Several passages from the commission's report address the state of economic and epidemic apathy existing in the countryside: the "drain on native stock has thus been severe and has resulted in a shortage of suitable bulls for breeding purposes. . . . The immense drain on the country for military labour affected conditions in the reserves and cultivation was beginning to decrease. . . . Public Health is also extremely bad in the reserves . . . [and] . . . the medical facilities are wholly inadequate."[77]

The economic and epidemic vulnerability of the country was compounded by the diseases brought into the reserves at the end of the war. The demobilization of the Carrier Corps was not undertaken with due consideration to the epidemiological impact of the carriers' return. They had been away for years in various environments, some of which were quite different from their regions of origin. Their service as carriers had made them susceptible to various infections and diseases. Disease had been their companion as well as a constant threat to their lives. Many of them had succumbed to disease and related problems rather than to wounds.[78] Even after demobilization, disease continued to claim its victims from among

the returning carriers.[79] The haphazard way in which the demobilization exercise was conducted demonstrated the laxity on the part of the colonial state in arresting the spread of disease to the reserves.

The Carrier Corps camps, which had played a pivotal role in the vetting of recruits during the conscription period, were not effectively utilized in the screening of those returning after the war. The Principal Medical Officer, in his report for the period ending 31 December 1918, noted the apparent inability to prevent the spread of diseases into the reserves:

> The return of large numbers is having an inevitable effect on the country; this in spite of the most admirable efforts of the medical work of the Carrier Corps. It was not possible for the civil department to take over the segregation of disease "carriers." Thus various diseases became especially prominent.[80]

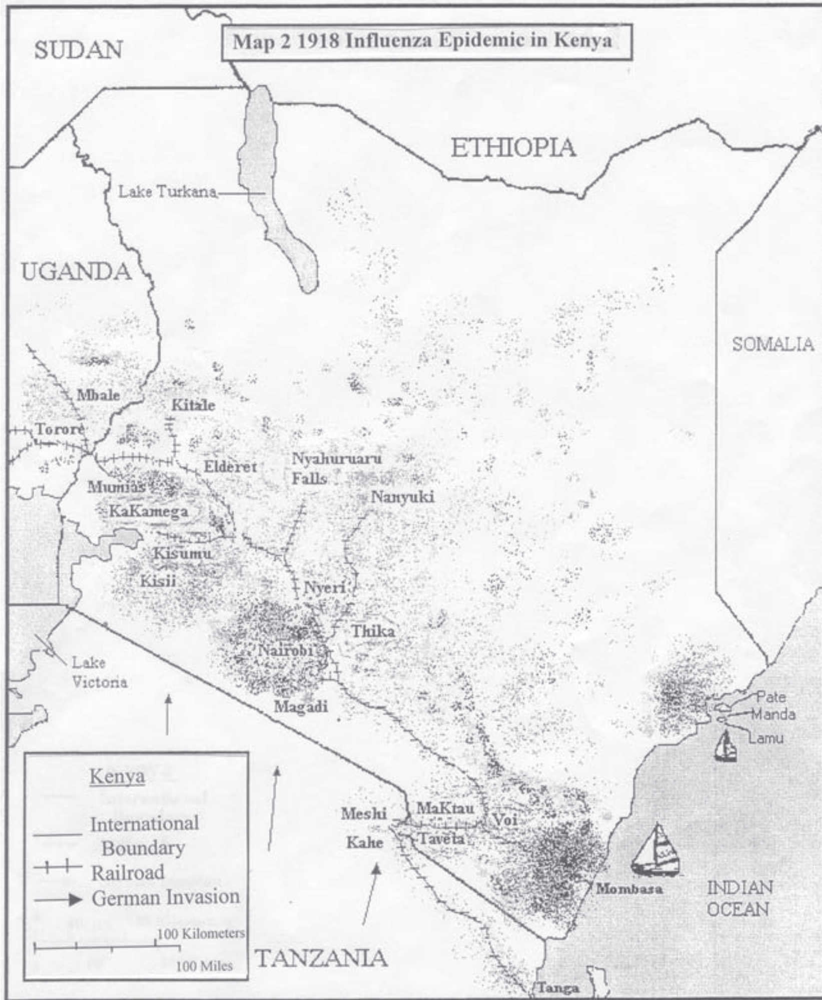
Essentially, the camps were meant only for controlling the spread of disease from the outlying districts to the townships and the places where the conscripts were deployed. They were neither primarily nor expressly meant to serve the reserves. As a consequence, the camps' significance temporarily declined following the end of hostilities. This laxity in enforcing the necessary medical procedures during the return of the Carriers Corps in 1918 precipitated the spread of the influenza epidemic in the countryside. From September through December 1918, the country was under siege by influenza (see Map 2). In the majority of cases, the epidemic reportedly manifested itself in a comparatively mild form during the initial stages when it was often misdiagnosed as bronchitis.[81]

The pattern of the spread of the influenza epidemic in the country is far from clear. According to one source,

> Towards the end of September, Influenza was notified at Mombasa, the condition apparently accounting for six deaths on board a vessel that had come from India, where the occurrence of the disease had been notified earlier in the year. Within a few days Nairobi was invaded and from then until the end of the year the epidemic swept through the country.[82]

But according to another source,

> Prior to the recognition of the condition there had been an universal amount of coryza "fever" observed among certain communities, i.e. police at Mombasa, Kings African Rifles in Nairobi, and Lamu, a coastal town that had no communication with other countries during September, reported fatal Influenza early in October.[83]



Some could argue that had the epidemic in India been reported early in the year, it could have reached the coast of Kenya much earlier than is suggested by the first source. The likely explanation, however, is that the epidemic manifested itself in Kenya more or less at the time when the deaths on board a vessel from India anchored at Mombasa were reported. The fact that the reported fever was identified with specific locations whose residents were closely tied to the recently concluded war is, in itself, an indication of the source of the epidemic. Although Lamu is reported to have had

no communication with other countries, the movement of people in dhows across the ocean cannot be ruled out. "No communication with other countries" does not necessarily mean that that there was no movement of people. At any rate, there is no evidence that Lamu was under quarantine or curfew during the time.

The spread of the epidemic upcountry was mainly due to the returning Carrier Corps. As they disembarked at the various railway stations, the epidemic began to spread first through the railway settlements then to the outlying districts. Furthermore, two major events occurred during this time, which also precipitated the spread of the influenza epidemic in various parts of the Protectorate. One incident was the Police Decoration Parade at Nairobi, which police from all parts of the country attended. The second was the Red Cross celebrations at the Stanley Hotel in Nairobi which were also attended by people from all parts of the country and at which "even people suffering from Influenza were present."[84] The epidemic, with an incubation period that varied from thirty-six hours to four days, swept through the country like a tidal wave. Within just a few months it turned into a major crisis in the entire Protectorate.[85] The Principal Medical Officer issued a circular to all medical officers in which they were advised on the precautionary and curative measures to be undertaken. Public meetings, as well as contact with infected persons, were to be avoided.[86] The precautionary measures were undermined by the haphazard nature of the demobilization of the Carrier Corps, which proceeded without due regard to the epidemiological impact of their return.[87]

Although the whole population was attacked, some groups were more vulnerable to the epidemic than others. Vulnerability varied according to race, gender, age, and lifestyle. Africans and Indians were reported to have suffered greatly, "almost to a man, owing to the very crowded mode of living and the lack of ventilation."[88] Among Europeans "there was a 70 percent incidence."[89] The difference in the susceptibility of the various groups stems primarily from the segregation in urban areas, which resulted in the banishment of Africans and, to some extent, Indians to densely inhabited, less desirable locations.[90] Such locations, though artificially created by the colonial state, naturally became prone to infectious diseases. Against this background of segregation in residential areas, the lower incidence of the epidemic among the Europeans is understandable given the submission by Dr. Hamilton in his report that "those who escaped infection" included "those who lived an open air life, and escaped any close contact with infected cases."[91]

As for gender and age, Dr. Hamilton reported that "women and children escaped infection more than men, and as a rule were much lighter

affected when attacked, though there were some bad cases of pneumonia among them."[92] Since the death toll registered in the townships and colonial medical establishments was only one-twentieth of the death toll reported nationwide (including figures supplied by missionaries and others for the reserves), it may not be possible to sustain Hamilton's thesis at the Protectorate level.

The lifestyles of the population were an important factor in mortality rates. It was reported that "those run down in health suffered worse."[93] The epidemic hit the Protectorate at a time when the communities in the region were experiencing stress brought on by famine and almost two years of plague and smallpox. The livelihood of local communities in Kenya had been adversely affected by changes in household economies as well as increased incidence of disease. People's resistance to epidemics became greatly compromised.

The Principal Medical Officer of Health reported that the certified number of cases of the disease through the end of December 1918 was 501,772, with 39,927 deaths.[94] These certified numbers, however, reflect only the deaths that occurred in the colonial medical establishments and townships. The Principal Medical Officer himself admitted that records compiled by administrative officers, missionaries, and elders put the number of deaths at approximately three times the number he cited. In addition, many deaths in the reserves may have gone entirely unrecorded.

The end of World War I saw a continuation of the battles among the various stakeholders in the colonial health care system. Of particular consideration was what should be done to improve the pathetic health situation brought about by postwar demobilization. To complicate matters, the colonial state was faced with the challenge of addressing the recommendations of several colonial commissions of inquiry on matters related to the health issue. Also, the colonial state faced an image crisis. Until the end of the war, the state had exhibited mean, secretive, and authoritarian tendencies that hardly afforded dissenting views any share in the discourse on health and healing.

Legislating the 1921 Public Health Ordinance

By the end of 1918, the colonial state, smarting from the various prewar commissions and reports on health care, as well as the need to recast its image, was on the verge of transforming itself into an interventionist and mediatory institution on issues of health. Critical to this transformation

were the debates and discourses on the 1921 Public Health Ordinance. Largely based on the Public Health Act of the Union of South Africa, No. 36 of 1919,[95] the 1921 Ordinance brought to the fore divergent and partisan interests, as well as the views of various groups, experts, and administrators from within Kenya and beyond.

The India Office attacked Simpson's proposal for the tripartite development of townships. This was a proposal about which Simpson was most definite, calling for "absolutely separate quarters or wards in every town or trade centre and a neutral belt of open unoccupied land at least 300 yards in width between European residences and those of Asiatics and Africans."[96] Simpson's word on this issue was considered final, and was never subjected to any consideration by other experts. In fact, as previously noted, Governor Belfield had, as early as 1914, effectively invoked it to enforce separate development in the townships.

The British India Association of East Africa attributed the insanitary plight of Indian residential areas in Mombasa, Nairobi, and Kisumu "to the Government's failure to allot land for the extension of the area for Indian dwelling houses and the prohibition against Indians in the areas reserved for Europeans."[97] Partly in response to these protests, the Secretary of State, Lord Milner, in April 1920 received a deputation of Indian representatives sent from East Africa to present Indian grievances.

Milner's meeting with the Indian deputation resulted in his reconsidering a whole range of issues affecting the Indian community in Kenya, but did nothing to change his attitude toward the privileged status of Europeans. Milner was cautious, but neither sympathetic to Indian concerns nor specific on how to address the problem at hand. Small wonder then, that Milner's reconsideration of the situation in the colony, particularly on the issue of segregation, did not result in any fundamental change of policy. Milner affirmed the relevance and significance of the policy of "race-segregation" in revealing terms:

> A . . . matter to which much attention has been directed is the policy which for convenience may be termed "race-segregation." I regret that this policy should have given offence to the Indian community, and I feel sure that they are under a misapprehension on the matter. There is no question here of discrimination against the Indians. In this case, as in that of land settlements, I have no wish to sacrifice Indian to European interests. But I am convinced that, as long as the Indians are fairly dealt with in the selection of sites, the principle that in the laying out of townships in tropical Africa separate areas should be allotted to different races is not only from the sanitary point of view but also on grounds of social convenience the right principle.

> It is in my opinion best for all races, European, Indian or native. I desire therefore that this principle should be adhered to in residential areas, and whenever practicable, in commercial areas also.[98]

Thus Milner simply affirmed what Governor Belfield had upheld as a sacrosanct principle, and one which his successor, Sir Edward Northey, wanted strictly adhered to in the Colony and Protectorate of Kenya.[99] Their concurrence was an affirmation of Simpson's report. However, the Secretary of State for India, Edwin Montagu, did not appreciate Milner's statement. He countered:

> If, then, the object in view is sanitation and social convenience, we submit that the criterion should be the class of business and not nationality. . . . These fears do not appear to us to be groundless. In the projected plans of Nairobi, Mombasa, and Kisumu in Professor Simpson's Report, the areas demarcated for European and Asiatic residence respectively, apart from any question of convenience are wholly disproportionate to the numbers of the two communities. It seems to us, indeed, almost inevitable that compulsory segregation will mean that the best sites will be allotted to the race which is politically most powerful.[100]

The comments of the Secretary of State for India, as well as protests from the two Indian associations, had some impact on both the Colonial Office and some medical officers within Kenya. The protests, which were also noted by the Principal Medical Officer, influenced the writing of the final Public Health Bill of 1921.

The Public Health Bill of 1921 was described by the Kenya Attorney General, Lyall Grant, as being the "outcome of the need generally recognised for some years past, for the provision of a general enactment regarding public health."[101] Such a need, Grant continued, "has been frequently demonstrated more especially in times of epidemic."[102] The country had been operating without comprehensive legislation on public health since the dawn of British colonialism. Several laws applying to specific diseases and institutions existed. The Township Ordinances, the Infectious Diseases Ordinance, and the ordinances dealing with specific diseases such as sleeping sickness, smallpox, and leprosy were examples. The existence of these various laws shows the ad hoc manner in which the colonial state grappled with disease control. Control measures were often legislated at the outbreak of epidemics without any long-term plan for fighting future epidemics. The active lifespan of such legislation was, in general, quite short.

The Public Health Bill of 1921, passed by the Legislative Council on 21 March, did not immediately receive the Governor's assent because of its

controversial nature, particularly the clauses pertaining to segregation in the townships. In a confidential note to Winston Churchill, the Secretary of State, the Acting Governor wrote: "In view of the contentious nature of the measure, I have not assented to the Ordinance, and I should be grateful if I might be informed by telegram whether your approval and his Majesty's assent will be given in this case."[103] The most controversial aspect of the document was Part XIII, which pertained to segregation. Though included in the final bill, Part XIII had not been unanimously agreed upon. Controversy over its inclusion had necessitated the establishment of a Special Committee of the Legislative Council to examine the significance of its inclusion in the final draft of the bill.

The Special Committee reported to the Legislative Council that the inclusion of Part XIII was unnecessary since there were already several stringent regulations in the bill which could be invoked with regard to maintaining sanitary conditions. Committee members submitted that the "segregation clauses were superfluous."[104] However, the recommendation of the Special Committee was ignored by the Legislative Council and subsequently rejected on the grounds that Professor Simpson was a scientist and expert of no mean repute whose input in the framing of that portion was final. Proponents of Part XIII further argued that the previous Secretary of State had concurred with Professor Simpson on that score and even publicly announced a policy to that effect.[105] The Legislative Council resorted to dubious precedents to retain that controversial section.

The Principal Medical Officer, in opposition to the inclusion of Part XIII, emphatically argued that "clauses dealing with segregation should not properly be included in a Public Health Bill but should be dealt with in a separate measure as a question of policy and social convenience."[106] The inclusion of the controversial section shows how a well-intentioned public legislative measure could be manipulated by the insertion of politicized clauses aimed at serving specific interests. The scenario also demonstrates how professional advice pitted against entrenched interests might be ignored. The colonial state was not a monolithic institution.

After consultations within the Colonial Office, the Governor in Nairobi was directed to resubmit the bill without the controversial Part XIII, and once it was passed, he was granted a mandate to assent to the revised bill at once. Two major considerations forced the Colonial Office to order the exclusion of Part XIII. One was the enormous controversy over the issue of segregation. Certainly the agitation by the India Office as well as the Indian associations in East Africa had yielded some positive results. The Colonial Office stated that "the Secretary of State does not consider it

desirable to prejudice the question of segregation which is still under consideration by placing Part XIII on the Statute Book."[107] The Principal Medical Officer's recommendation that clauses dealing expressly with segregation be excluded from the bill was also a major influence. In justifying its decision, the Colonial Office evoked the advice by the Principal Medical Officer that "segregation of races, if it is to be accepted as the policy, had far better . . . form the subject of a separate Ordinance."[108] The response and decision of the Colonial Office thus demonstrates its moderating influence on colonial legislation.

This turn of events speaks to the wider significance of commissions of inquiry as well as legislative councils in the colonial setting. While, by and large, such commissions and councils were used to resolve the dilemmas regarding public policy with a view to legitimizing the state's course of action, the colonial state was not a totally autonomous state. Some of its controversial decisions were subject to ratification by the Colonial Office. Consequently, minority concerns within the Legislative Council or countervailing views from professionals, as well as dissent from pressure groups, moderated the tempo, conduct, and outcome of controversial debates.

However, the non-inclusion of specific clauses dealing with outright segregation did not alter the fundamental principle of the separation of races in the residential locations. The Governor was granted powers, subject to approval by the Secretary of State, to direct the zoning of residential locations if he deemed it to be in the public interest.[109] What constituted the public interest was not precisely defined and hence left to the discretion of the Governor. This ambiguity resulted in the betrayal of the spirit of the legislation, since the Governor's discretion was often invoked in the zoning of residential locations within the townships.

The 1921 Public Health Ordinance, albeit legislated amidst controversy and containing loopholes, defined the role of the state in medical matters in the country. However, at a practical level, that role was still affected by the fact that the state and medical authorities believed they knew what was best for the general population. The new ordinance was an elitist piece of legislation, which like many others in the colonial setting was informed by the choices made by the colonial state and medical authorities on matters of health policies and priorities. In essence, the two concurred on how best to address the course of health care in the country. It is not surprising, therefore, that debates as well as competing visions emanating from the rest of the society not only persisted, but also became more forceful from the mid-1920s onward. And it is to these debates that we turn in the next chapter.

Conclusion

The provision of colonial health care was very uneven, and this unevenness was, by and large, politically and economically determined. Never dispensed as an act of social benevolence, colonial health care was provided in reference to African participation in the colonial economy. However, that participation had to be in the best interest of the state as defined by itself. As a consequence, migrant laborers working for the colony engaged the attention of the state more than peasants on the reserves. The health of the peasants was only relevant to the state during epidemics, which were perceived to present a grave danger to the rest of society because of the interdependent nature of the colonial economy.

The labor-intensive colonial economy and World War I were the two most important factors in the period between 1910 and 1920 in matters of health and disease control. It was these two factors that led to a rethinking of colonial health policy in the rural areas. The movement of labor to and from the workplace necessitated a shift in emphasis toward the provision of health care in the rural areas. The outbreak of the war and the subsequent conscription process further increased the need to reexamine the question of health care in the colony as a whole. Various commissions of inquiry before, during, and immediately after the war indicted the state for both the slow growth and the uneven nature of colonial health care in Kenya. Such commissions encapsulated the complex societal tensions and discourses that engaged all the involved parties in a dialogue that sought to find a compromise solution to the vexed issues of health care. The testimonies given before various commissions of inquiry constitute prisms through which the various voices, offices, and institutions which shaped the character of colonial health care can be objectively reclaimed and projected to show their latent, as well as their professed, intents. And it is to these latent, as well as professed, intents, that we turn in subsequent chapters.

4

CAREERS IN HEALTH AND HEALING: COMPETING VISIONS OF TRAINING AND PRACTICE

Introduction

The making of the colonial medical profession in Kenya was conditioned by the shifting political, economic, and cultural developments in the country. The usual means toward raising an occupation to professional status, such as standardization of training and claims to a distinct and exclusive body of knowledge, evoked intense debates, which revolved around the type and quality of education for Africans, the nature of medical training for Africans, gender and culture, and the theory and practice of biomedicine as perceived by both the physician and the patient. The colonial medical profession placed its emphasis on hospitals and laboratories. It also objectified the patient, both as host and as victim of disease. It maintained its insensitive posture to the patient's psychotherapeutic needs. What could not be determined through an array of tests on bodily fluids or sensed by stethoscope was considered not germane to the patient's treatment and recovery. The emphasis on specific data and diagnosis, the enormous faith in scientific investigation, and the claim to objectivity denied the subjective and sympathetic understanding of the patient any space in the colonial medical profession. By reducing the patient to an object that had to be acted upon according to established Western biomedical norms, the colo-

nial medical profession in fact helped institutionalize traditional therapeutic practices as a competitive and persistent alternative as well as a supplement to mainstream colonial health care.

This chapter examines the politics that informed the growth and development of the medical profession against the backdrop of the political, economic, and cultural conflicts and compromises that shaped its operational limits in colonial Kenya. The chapter is organized into four sections. The first section examines the basis of the selective issuing of licenses to physicians. In the second section, I discuss the politics of the training and placement of Africans in the colonial medical service. The relationship among patriarchy, state, and gender is examined in the third section. In the final section, I analyze the place of traditional healers and their services, which were based on the principle that the patient was first and foremost a subject and that medicine was both a science and an art. As an art, traditional healing projected the point of view that the practice of medicine required a grasp of the cultural and social ideas that enabled the healer to understand and appreciate the patient as a whole person.

The Politics of Licensing and Control

While the history of the colonial medical profession in Kenya dates back to the days of the Imperial British East Africa Company, it was not until World War I that streamlining the profession as well as formal training of Africans for careers in health care became a deliberate policy in the country.[1] The development of the colonial medical profession in Kenya resulted from a number of factors. The first two decades of British rule had exposed not only the inadequacy of colonial health care services but also the biting shortage of medical personnel. Also, by the early 1920s, the colonial state was under intense scrutiny over its policies, particularly its commitment to the welfare of Africans. As argued in the previous chapter, the colonial state was a lean and mean state. Its provision of such social services as education and health care was only undertaken in reference to their recipients' significance to the colonial economy. The period after World War I was characterized by increased interdependence among various peoples and between urban and rural areas, and an increase in the speed of the spread of disease. The health care needs of the country required a vibrant health care profession.

However, the foremost critical development leading to the determination to streamline colonial health care service was the influx of Europe-

ans into the Colony and Protectorate of Kenya under the Soldier Settlement Scheme after the war. The large number of settlers necessitated a supportive health care infrastructure. Indeed, the number of medical officers in the British protectorates and colonies was to be proportional to the European population. For every one hundred Europeans, there was to be one medical officer.[2] The shortage of medical officers was not unique to Kenya. Practically all the British colonies and protectorates were short-staffed. The number of vacancies that were to be filled, however, varied from one country to another in British tropical Africa. By the end of 1919, Cameroon had 2 vacancies, the EAP had 27, Zanzibar had 2, Uganda had 4, and Nyasaland (now Malawi) had 2.[3]

The exceptionally high number for the EAP was a consequence of the growth in the size of the European settler community in the colony.[4] That the number of medical officers was proportionally tied to the European population in the country is illustrative of the pride of place accorded to European health care needs.[5] Since Europeans lived in areas of high economic potential such as the White Highlands and the major townships, where they monopolized certain occupations of particular economic and administrative interest, the element of proportionality dictated that such areas would receive more medical officers than areas outside the orbit of economic interests as defined by the colonial state.

But filling the available vacancies was rendered difficult by inadequate pay as well as the politics of licensing physicians. [6] However, the issue of salary was resolved without much debate following combined pressure from the colonial administration in the colony and pressure groups within and outside the country. Writing to the Secretary of State in 1919, for example, Governor Northey requested the Colonial Office to ratify his proposal and accept the increase in the number of Senior Medical Officers from two to six and lay down certain rules to govern the promotion of medical officers.[7] He further requested that both the salary and the duty allowance for the medical staff be increased.[8]

Acting on Northey's appeal, the Colonial Office sought a conference with the Treasury on the question of improving the terms and conditions of service for medical officers.[9] The request by the Colonial Office was boosted by the support it received from the India Office. The Secretary of State for India, Edwin Montagu, received, at the India Office, a deputation from the British Medical Association headed by Sir Clifford Allbutt on 2 July 1918 in regard to the Indian Medical Service.[10] Montagu's purpose in meeting the deputation was to persuade the British Medical Association to assist in lobbying for improvements in the terms and conditions of colonial

medical officers.[11] A number of concerns similar to those raised by Governor Northey, such as low pay and frustration caused by a disorganized medical service, were discussed at the meeting. A consensus was reached between Montagu and members of the deputation that the colonial medical service needed to be reorganized and that attractive terms needed to be offered to medical personnel. They opined, "It would be folly not to prepare to offer sufficiently attractive conditions."[12] H. R. Read of the Colonial Office noted that the position taken by the Secretary of State for India was significant. He minuted that the strong views of Montagu and the British Medical Association "may be of use in the forthcoming conference with Treasury on the question of improving the condition of service of M.O.'s in East Africa. The I.M.S. [Indian Medical Service] appears to be discontented with the present terms."[13] It is not surprising, therefore, that Read minuted that "the situation is pretty hopeless, as there are no doctors available for E. Africa."[14] The pressure from the Colonial Office and the India Office, as well as internal demands within the Colony, prevailed. The Colonial Office eventually consented to Northey's 1919 proposals, but only in regard to medical officers and not those of lower ranks.[15] It may be argued that the emphasis on medical officers and those of equivalent rank in the sanitary division is intricately linked to the second factor that undermined the campaign to fill the available vacancies in the two divisions.

Besides the terms and conditions of service, the other controversy that reigned throughout the 1920s involved the licensing of doctors wishing to practice in Kenya. The state sought to live up to the provisions of the Medical Practitioners and Dentists Ordinance of 1910 that doctors who possessed British qualifications were to be given preference to practice in the colonial public medical service in the Protectorate. All other degrees and diplomas were suspect and had to be subjected to scrutiny by the Medical and Dentists Board before their holders could be allowed to practice medicine.

The legal provision which gave preference to British qualifications while subjecting other diplomas to vetting was often used by the colonial administration to limit the entry of non-British groups into the profession. Out of frustration, the voices of dissent became more and more vocal and distinct. The East Africa Indian National Congress fired the first volleys of criticism when it objected to the colonial state's selective and discriminatory treatment of its members. At its meeting in November 1919, the association passed two resolutions which called for the recognition of Indian degrees and demanded that Indians be allowed to set themselves up as independent medical practitioners.[16] But the Medical and Dentists Board

was monopolized by European doctors. Because of the tension and mistrust between Indians and Europeans, Indian degrees and diplomas were not easily registered and hence the acquisition of doctors for the colonial service from places such as British India was only accepted by the colonial state if they were to enter the service as assistants or as junior to their British counterparts, compared with whom they purportedly had similar qualifications. The 1910 Ordinance, however, allowed the holders of such diplomas and degrees to practice among their own communities. It stated:

> Nothing contained in this Ordinance shall be construed to prohibit or prevent the practice of systems of therapeutics according to Native, Indian or other Asiatic method by persons recognized by the Community to which they belong to be duly trained in such practice.[17]

This ordinance ensured that only the Western therapeutic system would be of universal application in the country. The African and Indian therapeutic systems were, by and large, confined to their ethnic or racial constituencies. Only those with qualifications that were deemed acceptable to the colonial state were to be registered and allowed to practice in the mainstream system of colonial health care. Indians and Africans would be accepted, but only in the lower ranks of the system.

The reason for this "professional apartheid" must be sought within the definition of mainstream medicine as part of Western biomedical science. As part of modern science, the colonial medical profession was structured and presented by its architects as the natural product of Western biomedicine with its claim to cultural dominance and authority. Western doctors were the personification of that scientific image. As Adell Patton, Jr., has argued in the West African context, this "professional apartheid" was deeply enmeshed in racial and cultural dogmatism.[18] The profession, particularly its higher ranks, remained the preserve of Europeans because they were the ones with the "right qualifications." Despite the presumed objectivity of biomedicine in terms of its laboratory and clinical methods, the hiring and promotion of those who controlled and managed the science of health and healing were anything but objective.

Nevertheless, the hiring of more medical officers did not automatically guarantee predominantly African areas the services of such personnel. Areas that were defined as vital to the colonial economy through the provision of labor or European settlement or proximity to urban centers received preferential treatment in the provision of health care personnel and services. The opening up of new positions in the Medical Department was

primarily a product of this unfolding economic reality, and only secondarily a desire to address the shortage of medical and sanitary staff. The Principal Medical Officers Conference of 1920, which was attended by the principal medical officers from the East African colonies of Kenya, Uganda, and Tanganyika, called for both the expansion of hospital facilities and a review of the Medical Practitioners and Dentists Ordinance. [19] The appeal, combined with the biting shortage of doctors as well as pressure from the East Africa Indian Congress, resulted in the enactment of the Medical Practitioners and Dentists (Amendment) Ordinance, 1922, which empowered the "Principal Medical Officer to license as Medical Practitioners such Assistant Surgeons and Sub-assistant Surgeons as have performed meritorious service."[20]

The Changing Times: Africans in the Colonial Medical Service

The argument over the development of careers in the colonial medical profession was not just about licensing and practice. The controversies also involved the access of both men and women to colonial education. Africans were, by and large, confined to the lower cadre positions as auxiliary staff: dressers, nurses, "sanitarian assistants," and "compounders." This was not so much the result of the direct instruction of the Medical Practitioners and Dentists Ordinance, but primarily the result of a lack of educational opportunities.

A significant number of Africans served in the medical service and offered invaluable service under the supervision of European physicians. A Dr. James Hutcheon Thomson, Medical Officer for Ukamba Province, provided a vivid sketch of the role Africans played in the prewar colonial medical service, in his address to the EAP Economic Commission. Drawing from his experience, he was impressed that "they thoroughly understood antiseptic methods, sterilizing and did not make mistakes."[21] Thomson further informed the commission that he was quite sure Africans could be trained as hospital dispensers. He described the outstanding work of his African assistant: "my head-boy in the operation theatre has given over a thousand injections of quinine without a single mishap."[22] Thomson also called for the training of Africans at the principal hospitals of Nairobi, Mombasa, and Kisumu.[23] Africans had served as auxiliary staff in the medical service since the days of the Imperial British East Africa Company.[24] That they did not constitute a formidable force within the profession was

due to a combination of factors, among which access to colonial education reigned supreme.

The colonial commissions instituted between 1913 and 1934 all emphasized the need to train Africans for careers in the colonial medical service for an obvious but compelling reason. The focus on European medical officers was only one step in the long war against pestilence. The state could win the battle against epidemics in the areas occupied by Europeans, but it was bound to lose the war at the national level because of the interdependent nature of the colonial economy. The focus on European medical officers was in essence a very incomplete reading of the scope and magnitude of the pestilential climate in Kenya. Indeed, both the Simpson and the EAP Economic Commission reports had recommended the hiring of more medical personnel, with the latter calling for the training of more Africans for deployment in the colonial medical service.

Although the EAP Economic Commission was heavily biased toward European interests, it was quite emphatic on the need to accord Africans more opportunities in a revamped organizational structure in the mainstream health care system. Thomson envisioned a medical organizational structure in which European medical officers and others would play complementary roles in the delivery of health care services:

> Medical Officer in charge, trained native compounders in the district, vaccinators and inoculators to go where required. It would be advantageous to have trained natives, who could work independently through the districts and furnish reports, also to visit any case of supposed infectious disease and report.[25]

The role of African vaccinators and inoculators in the evolving colonial health care system was not new. They had played vital roles in the campaign against smallpox and plague immediately before and during the war.[26]

By the end of 1922, the National Laboratory in Nairobi had formally begun the training of Africans in elementary laboratory techniques such as the making, staining, and examination of blood films. [27] The training of African medical assistants was begun by the end of the next year, with the trainees earmarked for posting to the outlying hospitals.[28] Despite these efforts, the numbers were still too few to satisfy the needs of the fast-growing colonial health care system.

Thus, following on the heels of the EAP Economic Commission, the Ormsby-Gore Commission, a parliamentary commission which was appointed by the Secretary of State for the Colonies in July 1924,[29] recognized the need to train more Africans for careers in the medical service.[30]

The commission's report, which was issued in 1925, commented adversely on the inadequate provision in Kenya for the training of African medical subordinates and recommended that every effort should be made to increase their number.[31] In response to the Ormsby-Gore report, a local departmental committee was appointed in 1925 to consider the question and recommend the formation of an African Medical Corps.[32]

The Corps, however, did not materialize, because of lack of sufficient funds and personnel to direct it.[33] Despite the focus on African training, it can be argued that by the mid-1920s the African personnel in the colonial medical service were few and confined to nonprofessional medical duties, if the establishment within Kisumu Municipality is anything to go by.[34] At the infectious diseases hospital in Kisumu, for example, there were fifteen African staff members, the majority of whom were not involved in direct medical duties.[35] Only six were involved in direct medical duties: one head dresser, one assistant head dresser, and four stretcher squad attendants. At the health office in the town there were three African vaccinators.[36]

A more aggressive approach was launched in 1926. The state increased the vote for medical services by 33 percent over the previous year's vote.[37] Governor Sir Edward Grigg declared his intention to "further in every possible way the training of Africans for careers in medical service," noting that a scheme had "been prepared by a committee of members of the Medical Department dealing with the whole matter of the recruitment, employment, pay and education of the native staff."[38] The government announced a scheme for the training and placement of African staff in 1926. The scheme provided for the institution of a Central Training Depot in Nairobi under the control of a Senior Medical Officer of the department with the necessary auxiliary staff. The depot was attached to the African hospital, Nairobi. The establishment of the Central Training Depot was in response to the lack of any organized mechanism by which African staff might be trained in the highly technical duties that they were required to perform. Before this centralization, African staff training was largely left to the individual efforts of the "officers of the Department who have little leisure to devote to such energies."[39] Training formally commenced at the depot in November 1929, and by June 1931 there were thirty-one pupils under instruction.[40]

At the depot, selected Africans took systematized technical courses of instruction in hospital duties over a period of three to four years. During their first year, the students were taught elementary anatomy, physiology, hygiene, first aid, and drill. In the next year, the trainees took courses in anatomy, physiology, medicine, nursing, surgery, and pharmacology. After their second year, the class members were employed in ward duties at the

native hospital for 90 percent of their time. Each student had charge of a ward for one month. The practical ward work included washing the patients, cleaning the ward, changing bed linen, serving food, preparing blood slides and specimens, and giving injections. Examinations were set from time to time and according to the Governor's Office, the results were "distinctly encouraging."[41] During the period of training, such trainees were termed medical apprentices. Upon completion of their training they qualified as hospital assistants.[42]

A conspicuous omission from the curriculum was any instruction on local society and culture, although the trainees were going to serve African patients. It cannot be argued that the curriculum designers simply forgot to include the social aspects that would aid in the treatment of the patient as both a social and a biological entity. The omission was not based on the fact that the students were Africans, and that therefore such knowledge was assumed. It was a deliberate omission, based on the projection of Western biomedicine as science. Consequently, social and cultural ideas were seen as irrelevant in the face of the power of science, which reigned supreme. It was assumed that African social and cultural values could neither reinforce nor replicate the objectivity of scientific medicine and hence had no place in the treatment of the patient. The patient had to be abstracted from the cultural milieu and subjected to biomedicine as defined by the language of the laboratory and hospital. The problem with this line of thought and training is that it ignored the idea of sympathy as an invaluable aspect of health and healing. Biomedical treatment based on the hospital and the laboratory was in stark contrast to the African understanding of disease, which was premised on the context of the patient as the product of a complex interplay of factors, biological, cultural, and spiritual. Western biomedical training drew a distinction between medicine as a science and other aspects that were outside the purview of Western biomedicine. In essence, therefore, Western biomedicine sought to treat the biological and not the social patient. A distinction was drawn between the two aspects of the patient. But as Judith Lorber aptly asserts,

> in order to understand the complexities of illness as a social experience, you cannot look only at the patient's body. Even adding emotional reactions is not enough. Illness takes place within a web of interaction that ties together the person concerned, . . . the physical setting . . . values, knowledge and beliefs.[43]

The state of sickness was more than just a biological malfunction of the body. Sickness was caused by many factors. Thus to stress one set of factors

to the exclusion of all others was not only undesirable but also alienating to the patient. It is not surprising, therefore, that Africans more often than not resorted to a strategy of "double healing," having recourse to both the traditional healing traditions and Western biomedicine in the attempt to find a holistic therapy. In a nutshell, Western biomedicine was not context-based because it did not look at the whole life of the patient.[44] "Double healing" helped the individual by providing context-based therapy, through a blend of two traditions.

Upon graduation, the trainees were to serve in African areas in accordance with the Medical Practitioners and Dentists Ordinance. Their remuneration was also subject to the colonial state's race-based pay scales. The terms of service for the Africans joining the Medical Department were reportedly to be "almost identical with those of the Arab and African Clerical Service."[45] The Deputy Governor was emphatic on the score of pay and noted that

> It is not considered necessary or desirable at the present moment to formulate any scheme that will qualify Africans for higher posts than those proposed for the Assistant Grade category, viz., a very efficient and capable Hospital Assistant. Advancement by natives to posts commensurate with those now held by Indian Sub-Assistant Surgeons is not contemplated.[46]

The critical issue is not the enlistment of Africans into the colonial medical service *per se,* but rather the extent of their involvement: would Africans continue to join the colonial medical service at any level without the benefit of an education that was still, by and large, outside the reach of the majority of the population? Would the available elementary education supply the cadre of personnel that would effectively manage the rural health facilities? Or was the attention to African personnel in the medical service aimed at reinforcing the maintenance of distinct categories in which Africans would constitute a permanent "hospital assistant" class, Indians would provide assistant surgeons, and Europeans would provide medical officers? The answer to these questions rests on the relationship among education, gender, and culture in the colonial context.

Patriarchy, State, and Gender and the Colonial Medical Profession

The critical shortage of African medical personnel was the subject of African presentations to the 1930 Joint Select Committee on East Africa whose

primary purpose was to inquire into the issue of "Closer Union," but which was forced to listen to and accommodate African grievances and insights into the problems that plagued health care in the countryside.[47] Both Chief Koinange of Kiambu and Ezekiel Apindi of the Kavirondo Taxpayers' Welfare Association cited congestion in hospitals, lack of wards for specific diseases, and the need for more personnel.[48] Koinange was even shocked by the contrast between the hospitals in England, which were well managed, and the ones in the reserves in Kiambu, his home district, which were lacking in facilities and personnel.[49] He submitted through an interpreter:

> There are many diseases in the reserves, many of which are infectious diseases and also their women wish to go to into the hospital for confinement. He says that at present there is so little room that they are all mixed up together, and he wishes that the place should be developed so that the different diseases could be isolated, and that the women wishing to go to the hospital for confinement should have proper accommodation. He wishes definitely more money should be spent, and that anything that can be done [should be done] to make it possible to improve the development of the medical services.[50]

While Koinange focused on funding as the factor inhibiting the development of colonial health care services in the reserves, Apindi directed attention to the kind of education provided by the state, as well as the level of commitment to the educational advancement of the African.

Apindi argued that the system of education and the prevailing labor policies made it impossible to produce African personnel for medical services:

> Nowadays, what happens in our country is this, that everyone is taken and given work to do before they have been given literary education. Now with regard to the hospitals which have been put up in the reserves, there are several hospitals in the reserves, but we have no people who can work in them and treat the patients who go there; we have no people who have been educated in the work properly, and in that matter too we want to be given more education in the Medical Department. The Medical Department must give more education to the people.[51]

Apindi's evidence made perfect sense in light of the fact that while emphasis was being placed on the production of African medical personnel, the pace of educational growth as well as the quality of education were incapable of producing African personnel at the level of sub-assistant surgeon. In fact, and as already noted, the majority of the African staff were dressers,

vaccinators, and inoculators. Without changes in the objectives and structure of the Western educational system, Africans were destined to be a permanent underclass in the medical profession. Apindi's commentary on the correlation between education and the production of students for medical training is instructive with regard to the intentions of the colonial educational system, whose primary purpose was to tap African labor for the development of the colonial economy.

The emphasis by Africans on African personnel speaks to the fact that most of the emerging elite saw some positive changes brought about by the new colonial medical service and desired to have some of their own join the ranks of the profession. It is arguable that the early unhappiness with Western biomedicine stemmed from the way in which it was introduced, as well as the political and military conditions that attended its introduction. Thus, as time wore on the number of Africans visiting the hospitals increased. Complaints gradually but consistently shifted to the scarcity of medical personnel, the congestion at the hospitals, the need for more dispensaries, and the need for more Western education for the youth, who would not only take up medical careers but also rise to higher ranks in the profession.

Although doubts about the practices of Western biomedicine persisted throughout the colonial period and beyond, the issue for most Africans from the 1930s onward, as will be argued in the next chapter, was not whether to embrace biomedicine but how to accommodate it within their own experience and environment. In this regard, the trio of Apindi, Koinange, and Mutua (the third Kenyan African who gave evidence to the committee) speak to the issues of progress and development as ingredients of social change in twentieth-century Kenya. This group of Africans saw African cultural values as reconcilable and compatible with Western notions of progress and development. In their view, Western biomedicine and its physical manifestations such as hospitals and laboratories could enrich the lives of Africans if they were open to dialogue and accommodation. Education was one sure way of achieving that compromise.

The demand for more African personnel by African witnesses is instructive of the intricate relationship between culture and professionalism in the colonial setting. In fact, Apindi's advocacy went beyond the general discussion of "African" medical personnel. He was also sensitive to the gender factor. The medical profession was largely male-dominated because of insufficient attention to the educational needs of women. Decrying this imbalance in the educational system and its impact on the general welfare of the family, Apindi asserted:

> We want education in our country, not only for males, but we want it also for females. Females are left far behind. . . . They seem to be as those who have not yet started to be educated and we want them to have education as well as the men, because they are the people who are an important part of the life. They are the people who are looking after the children and the house and the food, and if they are not educated what will happen? What will happen will be that our children will not be able to learn, because they have not been brought up properly by the mothers.[52]

Apindi's statement is significant because it addresses the complex issue of patriarchy in the colonial society, particularly as viewed by some of the African elite.

Many of the African elite were open to the need for literate women who understood European ways and were capable of participating in the emergent politics, economy, and health care system while still maintaining strong links with traditional values. They saw no conflict between Western education and traditional values. Oral evidence shows that most of the African elite of the 1920s and 1930s cherished and championed education for women, and hence Apindi's statement is representative of quite a number of people of his generation.[53] Musa Nyandusi , a senior chief among the Gusii community during the colonial period and the period immediately after independence, hired a tutor to teach some of his wives how to read and write.[54]

Western education and traditional values were not necessarily incompatible. They could comfortably coexist. Indeed, patriarchy was neither static nor an abstract construct. It was shaped and reshaped by individuals whose worldviews were influenced by a variety of social parameters. Thus, according to the likes of Apindi, Koinange, and Musa Nyandusi, literacy among women was something to be embraced and encouraged. The correlation between education and the delivery of colonial infant and maternal health care services, which constituted the core of Apindi's contention, stemmed from the fact that women requiring maternal clinical and confinement services in traditional societies were more comfortable with women healers who specialized in such services. The male-dominated medical field was not gender-sensitive, particularly to the cultural needs of women. This resulted in the exclusion of most women from certain services that were provided, though very inadequately, by colonial medical authorities. Apindi's concern was not a self-serving attempt to cast Western education in a positive light. It was an expression of a topical cultural conversation that sought to secure and accommodate emergent values with a view to addressing the real challenges brought about by the forces of the colonial economic order. Apindi campaigned for the education of women. A number of informants

vividly remember his famous rallying statement that "if you educate a man, you educate an individual, but if you educate a woman, you educate the community."[55] This emphasis on the need for the education of women as a prerequisite for community empowerment illustrates the fact that migrant labor not only intensified the burden of women but also sought to confine them to the homestead and the rural setting outside colonial establishments. The colonial system discouraged the migration of women to the workplace.[56] It confined them to the countryside where they not only began to head households but also assumed wide-ranging responsibilities that kept them in touch with the needs of the community.

The colonial state's policies encouraged the domesticity of women. The belief that a man was educated for the colonial establishment while a woman was educated for the community was in resonance with the patriarchal view that a woman's place is in the home and the community. Indeed, most of the labor migrants found it convenient to help their brothers and male cousins to secure jobs, but not their wives. In essence, the spatial separation between the household and the workplace constituted the conceptual foundation of Apindi's appeal to the Colonial Office to focus on the education of women. The woman became the de facto custodian of health care needs in the households from which men had migrated to the colonial workplace.[57] And herein lies the significance of Apindi's presentation to the Joint Select Committee.

Colonial education was not only exclusive by gender. Indeed, the colonial education system was far from inclusive: no education at all was available to the vast majority of Africans during the colonial period, regardless of gender. Access to education was determined in part by geography (proximity to a mission post or a colonial government center), in part by financial status (many could not afford the fees that were often charged by schools), and in part by luck (if a student happened to be singled out as particularly bright early on in his or her education). The system, furthermore, grew progressively more exclusive as the students progressed through primary school. The unmistakably elitist nature of the colonial educational system, however, should not minimize the sexist character of the system. While the system's blatant sexism was just one fault among many, it was one that has left an indelible mark on health care.

The problem of women's under-education was twofold: females not only had even less access than men to education, but once they did find their way into the schoolhouse the curriculum they were taught reinforced rather than challenged the colonial as well as the traditional patriarchal views about women. Of this twofold problem, access to education was the

most daunting obstacle. One obstacle to educational access was the role of young girls in gendered household chores. The traditional societies were necessarily labor intensive. So too was the colonial economic production sector. While the traditional society sought to retain the services of its members as far as possible, the colonial system waged an aggressive campaign to recruit African labor, particularly male. Consequently, most households jealously guarded female labor.[58]

The scarcity of economic resources further restricted girls' access to education, a situation that still persists at the beginning of the new millennium. Very few parents could easily do without the economic contribution of their daughters, or pay the fees and buy the school uniforms that were usually required for school enrollment. Thus when money was short, as indeed it was for most families, males were sent to school because the expected return was higher in light of the fact that they were more likely to be hired in well-paid positions in the colonial government.[59] Thus, the cultural values of the imperial powers reinforced traditional patriarchal ideas about educating women. The scarcity of economic resources further restricted girls' access to education. This decision, while it disadvantaged females, seemed logical to many households. Small wonder, then, that government-sponsored schools were particularly reluctant to open their doors to African girls and that mission schools actually took the lead in educating males. In sum, traditional African culture coalesced with the European brand of sexism to constitute a tollgate restricting women's access to education, a tollgate that let only a few women into the higher levels of education.

Attracting more women into the colonial medical profession would address the cultural concerns in maternal cases. Educated women as good homemakers, mothers, and nurses would bring into the profession compassion and sensitivity to the traditional culture. Judith Lorber points out that gender is an important consideration because "women and men doctors differ both in attention to women patients' symptoms, recommendations for tests and in communication styles."[60] In most traditional societies where men were forbidden to be present during delivery, women in the colonial medical profession were quite significant in attracting women to the maternity wings in hospitals. Thus, the education of women was deeply interwoven with both curative and preventive medicine.

Yet, the lack of educational opportunities for girls was conspicuously apparent. By 1934, there were still no government schools for African girls in the entire western region of Kenya.[61] Western education for girls was still the preserve of missions, although they often were supported by grants from the central treasury of the colonial state as well as the Local Native

Councils (LNCs).[62] By 1936, there were 100,218 pupils attending school in the entire country, of whom 96.77 percent were attending elementary schools. The rest, comprising 3.05 and 0.18 percent respectively, were in primary and secondary schools nationwide.[63]

In all the districts of Nyanza Province, there were only two government primary schools for Africans. These were at Kisii and Kakamega and were exclusively for males.[64] The available educational places were too few for the number of applicants. At the end of 1935, for example, "330 boys presented themselves for 35 vacancies" at Kakamega school.[65] By the mid-1930s, Western education at the primary and secondary levels was a scarce commodity desired by many but provided only to a few.

Three years after Apindi's testimony, lack of primary education among Africans was still a major factor affecting their recruitment into the medical service, not only in sufficient numbers but also at the higher levels. The Director of Medical and Sanitary Services, Dr. Carlyle Johnstone, more or less echoed Apindi's sentiments before the Joint Select Committee on East Africa when he opined in 1934 at a meeting of the Colonial Advisory Medical Committee:

> Owing to the lack of primary education they [medical stations] were only able to train the students to be nurses but they looked forward to obtaining better educated candidates who could be sent to Mulago [in Uganda] where they could be educated up to the standard of sub-Assistant Surgeon.[66]

On the issue of training African women in the nursing profession, Dr. Johnstone noted that one of the difficulties encountered was again "the poor standard of education among the people."[67] Although at the time the trained female nurses were sent back to work among their communities and to cater for female patients only, the Director hoped that their duties would be extended to cover all patients.

The colonial state's approach to the development of education was not in resonance with the challenges facing colonial health care. This inhibited both the training of African personnel in sufficient numbers and their placement in certain positions within the profession. It also adversely impacted the delivery of quality health care services. Advances in preventive measures also often failed to attain the desired goals because of inadequate education. Education and medical care were services whose interdependence was vital in furthering the cause of colonial health care. Unfortunately, they were often at variance because the colonial economy reinforced education for the production of manual laborers and white col-

lar workers and not for the provision of skilled personnel in such areas as medical services.

Holistic Healing Strategy: The Patient as a Subject

Every community best defines the subtle specificity of what constitutes good health in a given cultural context.[68] The concept of health as defined by most traditional societies in Kenya was an integrated one which not only included the biological malfunctions of the body but also embraced the religious, moral, political, and economic forces that impacted the body. The body must be situated in a specific context. This is epitomized by the Gusii phrase, *orogongo rwasarekire* (lit., "the place is spoilt").[69] According to David Nyamwaya, the phrase connotes a variety of conditions, which include general physical illness, disharmony among the members of a group, and a chaotic spiritual environment, all of which exist simultaneously.[70] A similar phrase among the Luo, *Richo ema kelo Chira* (lit., "sin breeds disease"), connotes the fact that sin as a causal factor is a product of organic malfunction in both the natural and spiritual realms.[71]

Health transcended the mere absence of disease or absence of contact with pathogens. The body and mind had to be in a state of well-being recognized and accepted by both the individual and society.[72] In consequence, disease was understood to be caused by the destabilization of that state of well-being which made both the body and the mind incapable of functioning well.[73] Disease was conceptualized as the simultaneous expression of both the physical and the psychological malfunction of the individual as defined by both the individual and the society.

This understanding of health and disease has parallels in other parts of Africa. Among the Zulu of South Africa, Ngubane has noted, "a Zulu conceives a good health not only as consisting of a healthy body, but as a healthy situation of everything that concerns him. Good health means the harmonious coordination of the universe."[74] This definition of health and disease is also similar to the World Health Organization's definition with its emphasis on the well-being not only of the individual but also of the society as a whole.[75]

Thus, the ecological, social, religious, economic, and political environment in which the people lived, produced, exchanged, and interacted was germane to their interpretation of what constituted health. It also underpinned their social construction of disease. It defined various therapies as well as the conduct and roles of healers and patients.

The dosage, mode of dispensation, and length of dispensation determined by the traditional healer were dependent on the nature and intensity of the ailment. The recognized healer, who attracted many patients, was a specialist whose mastery of the herbs used for the treatment of various ailments was hardly subject to doubt. Sofowora describes the traditional healer's expertise in herbal medicine in the following words: "he was expected to be highly knowledgeable in the efficacy, toxicity, dosage, and compounding of herbs."[76] A number of informants in this study testified to the significance of training, mastery of the diagnosis of various ailments, and mastery of medicinal herbs as prerequisites for a good healer. But those qualities alone did not suffice. A good healer also needed to be a good listener and understand the patient as a person living in a mundane world.

Jawuoyo Lihondo, a renowned herbalist, who lives in Harambee area in Migori District, described how ancestry, apprenticeship, empathy with his patients, and sensitivity to new therapies have coalesced to make his career a success.[77] Thus, Lihondo sees his skills as partly due to a gift from his forefathers dating back four generations. But his skills were perfected because he was apprenticed at the feet of other famous medicine men. His empathizing with his patients has resulted in some patients visiting him because they cannot get the necessary attention from physicians in the state-sponsored hospitals.

Similarly, Eliud Balla Nyamor, now eighty-eight years old, who was born in what is today Bondo District, asserts that he was the favorite grandchild of his grandmother.[78] He accompanied his grandmother on various missions to obtain herbs, during which he was taught about the correlation between each herb and each type of disease. He believes that transmitting the secrets of healing to a son, a daughter, or any other person involves a number of factors. The apprentice must have a deep interest in the craft and be prepared to undergo several years of training. Since the immediate return is low, it is the deep commitment to helping others that is paramount. Nyamor adds that such deep commitment is always sustained through love of the patient as well as willingness to share the patient's apprehensions and concerns as a person. He asserts that it is only in this way that patients will be comfortable with the healer. He argues that as an individual matures in the profession, the individual internalizes those values that are germane to proper diagnosis of the ailment. In his view, diagnosis and curative measures are determined through expertise and experience, which enables the healer to understand and interpret the patient's narrative, or in case of the patient's inability to speak, the relatives' account of the problem. The other method is through engaging spirits. This method

is quite common among those healers whose vocation to practice medicine was inspired by spirits. I observed that in this latter method, the healer possesses special paraphernalia that are used in communicating with the spirits.

Aringo Omer, who hails from Kanyimach, and Philister Apiyo Oyugi from Nyabisawa acquired the art of herbal medicine through what they described as inherited spirits of the ancestors. Aringo Omer says that although his mother was a herbalist, he did not take a lot of interest in the art.[79] It was not until 1955, when he was a migrant worker on a tea estate in Kericho, Rift Valley Province, that he began practicing herbal medicine after he was "caught by spirits." Meanwhile Philister Apiyo Oyugi was also inspired by "spirits," which were initially wild and had to be tamed.[80] These two herbalists believe that it is impossible to run away from the spirits of your ancestors and that if you are destined to wear the mantle of your ancestors by being of service to others there is hardly any way out of this. But this invocation by the spirits is accompanied by professional responsibility. The herbalist must provide for the spirits by invoking their names during treatment since they guide the healer on the nature of the ailment, the type of treatment, and the follow-up procedures to ensure that the patient is cured.

Taken in the context of health and medicine in both the colonial and the postcolonial eras, herbal healing was and still remains a significant institution that is fairly holistic in its conceptualization and approach to diagnosis and cure of ailments. The life histories of various traditional healers show not only that they were empathetic toward their patients but also that they were assiduous students of plant life and societal culture. Indeed, as Samuel C. Ramer has noted in another context: "the best of these herbal healers were skilled native pharmacists whose armory of medicines in any given case might be every bit as therapeutic as anything a trained physician could provide."[81]

The truth is that herbal medicinal therapy had a sound basis in both science and culture. It addressed the medical concerns of the population without damaging the cultural fabric of society. Contrary to the myth that precolonial therapies relied solely on supernatural forces, the scientific basis of these treatments can hardly be contested. As Gloria Waite has argued, there was elaborate use of a "pharmacopoeia derived from barks, leaves, roots, saps, and other natural products."[82] This is exemplified among the Luo and the Luyia of Bunyore where, respectively, *Yath* and *Omusala* imply both tree and medicine.[83] Some of the medicines were chewed raw while some were boiled in traditional pots before being taken.[84] The art of tradi-

tional medicine was the product of years of experience and experimentation with local plants. This experience and experimentation resulted in the development of "a store of empirical information concerning the therapeutic values of local plants."[85]

However, traditional healers did not confine themselves to the use of plants alone. The use of parts of animals, birds, and insects was equally important.[86] Besides being used in sacrifices to combat certain illnesses associated with unnatural causes, they were also used in the preparation of certain concoctions.[87] Though rarely taken on their own, they nevertheless formed an important ingredient in the concoctions that were dispensed.[88] As already noted, the traditional therapeutics operated on the premise that disease was more than a clinical problem. It was social, too. This basis of the traditional therapeutic system necessitated "medico-religious" treatment, which was simultaneously administered alongside the "biotech" therapy. Thus "biotech" and "medico-religious" treatments were, in most cases, not mutually exclusive.

"Medico-religious" treatment was primarily psycho-social therapy consisting of a number of elements. It included incantations, songs, clapping, confinement, spitting, and actions of a like nature primarily meant to help the patient regain health.[89] Of further significance was what was chanted or sung, as well as the time and place of such incantations or songs.[90] Normally, illnesses that required psycho-social therapy as treatment were believed to be caused by the individual violating certain taboos, or by spirits or sorcerers.[91] The offering of sacrifices was an important aspect of "medico-religious" therapy. Among the Luyia, sacrifices were as a rule offered in sickness as duly prescribed and directed by the medicine man and society.[92] This type of treatment cleansed and restored the individual not only to full health but also to the society of which he or she was a part. In a sense, cosmological balance was a major focus of this therapy.

Herbalists were not just "physicians." They were "sociologists," teachers, advisers, and confidants. The healer embodied all these roles because of the distinctive traditional philosophy of health, disease, and therapy. Thus, the personality of the traditional healer was a complex one, but it was well-suited to the scheme of addressing the "biotech" as well as "medico-religious" concerns of the patients. Belonging to this profession was both an honorable and a challenging exercise. Apprenticeships lasted several years. These specialists were therefore people who were revered in society because of the significance of their professions, their conduct, and most importantly their mastery of the necessary skills. Not surprisingly, therefore, the traditional healing system was "flexible and receptive to change."[93] The

system was dynamic and adaptable. New measures of prevention and cure were tested and incorporated into the system as epidemiological challenges emerged.

It was also the medicinal value of the various plants utilized that made the traditional medicinal practitioners vital in the world of health and healing. The effectiveness of the herbs inclined more people to traditional therapy. There was science behind the prescriptions. Although this was not clear to the colonial medical authorities, botanists today affirm that the herbs were quite effective and still play important roles in the development of modern drugs. On this score, Dr. Robert I. Bolla's statement on the medicinal value of these plants for medicinal purposes is instructive:

> African medicine men, Native Americans and even grandmothers use plants to treat illnesses and injury. These botanical preparations, passed down through the generations, work, even if the practitioner doesn't know why. . . . Digitalis, a heart medicine, derives from foxglove. Taxol, a cancer drug, has its roots in the Pacific yew tree. The twig of a willow is particularly high in salicylic acid, which is aspirin.[94]

Interviews with various herbal medicinal practitioners during my research revealed striking similarities in the types of medicine used and the manner of dispensing them. Most of their patients agreed that the medicines for the most part worked. The competitiveness of traditional therapies lay in their holistic approach to the treatment of the patient.

Conclusion

The training, employment, and remuneration of African personnel in the colonial medical service reveals the nature and context of the medical profession in colonial Kenya. Education and training was culturally prescriptive. In resonance with the prevailing climate of biomedical opinion in the colonial setting, the trainees were taught that the patient was primarily an object. Thus, despite major advances in biomedical science, the treatment provided was never holistic. By focusing on the competing visions of training, this chapter has revealed the discrepancy between Western-defined biomedical practices and practitioners on the one hand and the culturally patterned practices of local African healers on the other. The traditional society viewed the patient as a subject. This premise necessitated producing a healer who was not only a "physician" but also a sociologist, a teacher, an

adviser, and a confidant because disease had both clinical and social aspects. The significance of these two worldviews lay not in the fact that they were in conflict, but rather in the fact that they provided both traditions with life and energy in the emergent colonial world of healing in which pluralism thrived.

5

POLITICS, INNOVATION, REFORM, AND EXPANSION

Introduction

In the period before 1920, the colonial state operated on the premise that it was the sole authority on matters of public health. The rest of the society was projected merely as a group of passive victims or agents waiting to be told what to do or to be acted upon by the state. By the middle of the 1920s, the state opted for a combination of preventative, curative, and clinical approaches. The effectiveness of the shift and the adoption of a multifaceted approach necessitated winning the trust of the community and recognizing it as an invaluable partner in the campaign to eradicate epidemics. Thus, an inclusive approach based on the foundation of joint efforts among local communities, the colonial administration, medical authorities, and experts began to gain ascendancy in the middle of the 1920s, reaching its apogee in the 1930s during the height of the Great Depression. By the end of the 1930s, health care in colonial Kenya had, by and large, assumed the basic organizational structure that would not only outlive colonialism but also inform health care in the postcolonial period.

This chapter examines African proactive involvement in shaping the form and structure of colonial health care during the interwar period, against the backdrop of the Great Depression. The discussion is organized into three main sections. The first section focuses on how the community became involved in the colonial state's crusade-driven and curative public

health measures. In the next section, the onset of the Depression is examined, as are African initiatives, which sustained the tempo of expansion of colonial health facilities and services in an era of economic deprivation and scarcity. The last section examines the rise and fall of eugenics as social medicine in colonial Kenya against the backdrop of the politics and economics of the interwar period.

The Great Shift: Politics and Economics of Health Care Policy

The warm enthusiasm that inaugurated the introduction, by the adherents of Western biomedicine, of "germ" theory into the colonial health care discourse during the first two decades of the twentieth century began to wane once it was realized that the emphasis on the laboratory and the hospital was not yielding immediate results. The focus on the hospital and on the laboratory, at a time when the health care infrastructure in the country was quite undeveloped, meant that only residents in urban centers and very sick patients in the countryside, those who could not be relieved of their ailments by traditional therapies, were attended to at the mainstream hospitals and the laboratories. In essence, the pre-1920s colonial clinical and curative approach to disease control was elitist and hardly touched the lives of most of the population.

By the beginning of the second decade of the twentieth century, the vicious and brutal campaign of demolishing shanties in African and Asian neighborhoods had been considerably diminished in comparison with the high noon of plague control in the early period of colonial rule. A number of factors explain this shift. First, the colonial state's attempt to shed the image of a conqueror led attention to be directed to other approaches. Secondly, pressure from the Colonial Office, as well as a more assertive Medical Department, sought to assert control over public health matters, particularly after the shadow-boxing era of the pre-1920s period when hardly any distinction could be drawn between the state's pacification measures and the preemptive health campaigns designed to limit the spread of plague or smallpox. Meanwhile, the ascendancy of bacteriology, with its focus on the laboratory identification of specific micro-organisms, had overshadowed interest in general reform. The emergent bacteriological approach was assumed to constitute the most effective way of dealing with disease rather than worrying about environmental reform. However, this assumption proved to be an error in substance and in context. Bacteriology is

based on sophisticated techniques of collecting, preserving, and analyzing specimens, and therefore calls for specialized scientific training for the required personnel. That such a cadre of personnel was not available in the country in sufficient numbers to make a difference is a point that need not be belabored. There were not only few hospitals in the country, but insufficient laboratories as well.

The holistic approach resulted from experience of the problems caused by the sanitary methods previously adopted by the state, as well as the pressing need to direct attention to health reform in the countryside. Another compelling factor was the interdependent nature of the African and settler economies. With local economies existing as appendages to the buoyant estate agricultural economy before the Depression, rural health reform was of vital significance in ensuring the ability of households to produce the next generation of workers.

Although there was a general consensus on the new strategy of constructive engagement of all the parties concerned, the way to fund the many projects and the promotional campaigns inherent in the new holistic approach became a highly contested issue. While the colonial state was warming up to the prospect of giving increased medical attention to Africans, the state also exhibited serious concern over the means of procuring funds for the envisioned dispensaries, medical equipment, and personnel. The ardent pro-settler Governor Northey suggested very little government involvement because the state could not sustain the financial cost of the proposed expansion.[1] Instead, he reluctantly suggested that "owing to lack of funds Government is unable to place medical stations in native areas as freely as is desirable so that the policy of assisting Missions in their work has to be adhered to in certain areas."[2] The state needed services to the reserves to be extended and improved but wanted this to be done at minimal financial cost. The mission stations fulfilled this aim of the colonial state, although the state's reasoning was plagued with contradictions and haunted by irresponsibility, since African hut and poll taxes were paid to the colonial government and not to the missionaries. However, two critical considerations militated against leaving the missions to assume the role of sole providers of colonial health care in the reserves.

The first consideration stemmed from the idea of encouraging confidence "on the part of the natives in Government administration."[3] The colonial state needed to create the impression among Africans that the state was responsible for the provision of social services in the reserves. If the government transferred the responsibility of health care management in the reserves to the mission stations, it would abdicate one of its primary

functions, thereby encouraging the development of the emergent radical African nationalism. The state wanted to avoid this at all costs. The colonial state did not want to provide ammunition to the emerging elite who were beginning to question the authority and legitimacy of colonial governance, particularly in respect to the lack of educational and health care facilities in the predominantly African areas. The provision of colonial medical services was also considered as a means of legitimizing colonial administration by presenting a positive image of benevolence, particularly in the face of the growth of African political radicalism.[4] Colonial health care was multifaceted in its intentions and plans. It used public relations campaigns to hide some of the latent contradictions in its policy formulation.

Even if the state were to abdicate its responsibility and opt for subsidies to enable mission stations to provide health care in the reserves, there would still be a second problem, that of bias. This issue would crystallize opposition against the state by the disaffected churches and the Africans. On this score Governor Northey in a revealing statement averred:

> There is also to be considered the fact that financial assistance to a mission entails encouragement by Government of its particular religious tenets, a proceeding which is obviously inadvisable. It entails further the possibility of Government being involved in controversies with religious bodies whose stations are for some reason or another not in receipt of a subsidy.[5]

What this suggests is that even Governor Northey, who was initially in favor of financial assistance to the missions, saw such an arrangement as only a stop-gap measure, definitely not a permanent solution. The state had to assume responsibility for health care rather than manage the sector by proxy. Partly in response to these concerns, the state had by 1924 established a committee, under the chairmanship of the Colonial Secretary, to investigate the work done by the medical missions among the Africans, visiting and inspecting their facilities. A number of missions had undertaken medical work in the country. The missions included the Church Missionary Society, the Seventh Day Adventists, the Roman Catholic Church, the Africa Inland Church, the Methodist Church, and the Friends Mission. While most of these stations had given time and resources, their commitment to medical work was subordinate to their main mission of evangelization. Their aim was to capture the soul first before treating the body.

The church was not the only constituency whose criticism the government faced. Discontent was also brewing among the Africans. The shift

in medical policy occurred against the backdrop of rising African political militancy, as well as the interracial politics that culminated in the Devonshire White Paper of 1923.[6] The formation of associations such as the Young Kikuyu Association and the Young Kavirondo Association in 1921 unsettled many nerves in the corridors of power in the country and in the Colonial Office. While the Young Kikuyu Association was banned and its leaders arrested, the Young Kavirondo Association was effectively transformed from a militant organization to a welfare association willing to work alongside the colonial state.

At its inception, the Young Kavirondo Association was mainly preoccupied with issues such as the Native Registration System, the high rate of hut and poll taxes, the refusal of government to issue title deeds for land in African reserves, and the absence of a government school in Nyanza. However, right from the start, the Young Kavirondo Association was likely to be hijacked by the colonial state or its agents because it became receptive to the colonial administration officials who attended most of its deliberations and gradually, but consistently, proceeded to direct and to moderate its political course. The Provincial Commissioner had this to say about one meeting:

> Elders and young men . . . who spoke were so palpably acting under strong emotion that it was evident that it would have been both impolitic and inadvisable to have silenced them. In point of fact, the object of the meeting was attained. The grievances of the agitators were made known to Government and incidentally, the steam let off brought relief to both the speakers and auditors.[7]

The complete shift of the association from pursuing political issues to pursuing social issues was, however, largely the work of Archdeacon W. Owen, who was a Church Missionary Society clergyman based in Maseno. The leadership of the association was composed mainly of the mission-educated whose ties with the Maseno mission made them vulnerable to Archdeacon Owen's manipulation.[8] The association subsequently changed its name to the Kavirondo Taxpayers Welfare Association.[9] The Director of Education, J. R. Orr, praised Owen's efforts in toning down the political militancy which had characterized the association during its infancy:

> The Kavirondo Welfare Association is a remarkable organisation—an effort worthy of a great missionary. Archdeacon Owen, upon his return from leave in 1922, took control of it and diverted political agitation toward social development, with the result that the very Africans, who in earlier years

> sought to drive him from Kavirondo, now make him their refuge in trouble and the repository of their aspirations. Politics are now little heard.[10]

As a result of the transformation, the objective of the association was reduced to securing "by the best endeavours of its members better food, better clothing, better houses, better education, better hygiene."[11] The criteria of what constituted "better" were defined as building "proper" latrines, killing off rats as far as possible, reporting any found dead, not fouling the water in rivers, springs, or wells, and planting at least one hundred trees.[12] By the mid-1920s, Owen's social program had resulted in a close partnership between the members of the association and the Medical Department, particularly in the campaign to kill rats and reduce the prevalence of plague in the region patronized by the organization.[13] Besides the partnership, the association was also involved in a number of socioeconomic developments such as the making of coffee baskets, bricks, and tiles and the purchase of mills.

These changes occurred against the backdrop of the Phelps-Stokes Commission, which was mandated to inquire into the education of Africans in eight sub-Saharan colonies.[14] Dividing Africans into two groups, "masses" and "leaders," the commission recommended that the former group was to be taught in "day schools, middle schools, and at the community level in order to provide agricultural, industrial and health education."[15] Meanwhile the latter group, "the leaders," would have access to that and more—college education.[16] The Phelps-Stokes Commission envisioned an educational system that would not only be an integral part of the community but would also facilitate development by paying particular attention to the development of skills in trades and handicrafts, as well as health and hygiene.

The school, therefore, became a site of "modernization" in which students were not only taught the skills projected by the commission, but were also subjected to the "ethics of hygiene" by being inspected at least once a week. School uniforms were to be clean; nails and hair were to be cut short. Being in school entailed "acculturation." The school compound was to reflect those very values that were being espoused by the Departments of Education and Health. The Principal Medical Officer's memo to the Director of Education, J. R. Orr, is instructive with regard to this participatory agenda,[17] particularly the role of schools in the exercise:

> I would suggest that all your teachers in the village schools be directed to instruct their pupils about the destructive propensities of rats and their connection with plague and to urge the pupils to organize rat-hunts in their

> homes and to kill every rat they find. . . . I shall be glad if you can infuse a spirit of competition among the pupils of your schools in this matter.[18]

This "acculturation" process was based on the idea that the African had to be taught a defined standard of cleanliness, which was to be manifested in the siting and construction of homes.

To institutionalize this project of modernization through acculturation, the colonial state established the Jeanes School in Kabete near Nairobi to produce graduates who would work with their communities in realizing the state's prescribed agenda of development.[19] The school in colonial Kenya became a site of contest between indigenous and exogenous forms of development. It was not just a site where students were educated. It was also a site for inculcating the principles of hygiene as well as Western education and progress. The school mirrored the complexity of social change in twentieth-century Kenya. Small wonder, then, that the first generation of high school graduates from missionary and state schools were very much divided on the notions of progress and culture. Atieno Odhiambo has articulated this dilemma among the emergent Kenyan elite in central and southern Nyanza in the following words:

> As the first generation of high school graduates from missionary schools emerged in the early 1930s, Beneaiah Apolo Ohanga ("Bawo"), Isaak Okwirry ("Jusa"), Mariko Ohanga ("The") and Paulo Mboya ("Olwal Ja Nyakongo") being foremost among them, debate soon arose as to the compatibility between what they understood as the Luo cultural values on the one hand, and the missionary-Christian notions of progress, which they had embraced, on the other: For some the choices were easy: Ohanga became a Christian and an advocate of western "progress" and "development." Okwirry took the colonial administrators as his role model, complete with their contempt for the uneducated Africans, whom Okwirry condescendingly referred to as Odiango—Abuk-Dhana-Dhana—ordinary folks lacking book knowledge. . . . Others problematized the whole issue of compatibilities.[20]

The state took pride in the likes of Ohanga and Okwirry because they were considered "model" products of Western education and progress.[21] It was therefore in the best interest of the state to work with any missionary or group that would moderate the tempo of militancy and redirect the course of protest to the addressing of social and economic issues. The colonial state wanted the Kavirondo Association to be preoccupied with these issues of social and economic advancement. Nevertheless, this was merely an *ad hoc* palliative that was soon bound to run its course.

The immediate concern of the state was how to confine the expression of grievances within narrow geographical and ethnic boundaries and to prevent groups from uniting and presenting a formidable front to the state. The state was aware of the fact that there was no dispute as to the necessity of projecting colonial health care in a more compassionate and patient-friendly way, as well as making it available to the majority of the population.[22] In fact, the Ormsby-Gore Parliamentary Commission reinforced this point in its findings. The Parliamentary Commission was appointed in July 1924 to report on a number of issues, all of which were either directly or indirectly related to the issue of human health in the British imperial possessions in East Africa. The first two terms of reference required the commission to make recommendations on the means of securing closer coordination on policy and control of human diseases, and the steps necessary to "ameliorate the social condition of the natives of East Africa, including improvement of health and economic development."[23]

The other terms pertained to the economic relationship between Africans and non-Africans with "special reference to labour contracts, care of labourers, certificates of identification, employment of women and children, and the taxation of natives and the provision for services directed to their moral and material improvement."[24] The commission visited Kenya for the entire month of November 1924. When finally submitting its report in 1925, the commission included its findings on wide-ranging issues concerning medical services. Some of its recommendations, such as the training of Africans for medical services, the medical examination of Africans before leaving the reserves for colonial employment, and increased funding for medical services, had been addressed by earlier commissions and conferences. The commission's recognition of the significance of these areas redirected attention toward them. In line with the commission's recommendations, the colonial state in 1926 increased the vote for medical services by 33 percent over the previous year.

One of the new means to make medical services accessible to the majority of the population in the reserves involved the setting up of itinerant dispensaries and laboratories.[25] These would enable the medical staff to visit identified areas on specific days to attend to patients. Arising out of the debates on the best ways of raising funds in support of the envisioned expansion agenda without marginalizing the state, while still addressing the political concerns of the Africans, the formation of Local Native Councils (LNCs) provided a safe and honorable solution for the government.

The history of the LNCs in colonial Kenya has been examined primarily in terms of the political context of their emergence without due

recognition of their role in the development of health care in the colony. The fact that the establishment of the LNCs coincided with the banning and/or attempts at moderating the tempo of the emergent radicalism among the African elite points to the politics that influenced their establishment. The formation of such organizations as the East Africa Association, among many others in the country, sensitized the colonial state to the need to provide avenues for Africans, who were not directly represented in the major national decision-making institutions such as the Legislative and Executive Councils, to articulate their political grievances.

The marginalization and suppression of African political organizations (including the East Africa Association) created a political vacuum which was not in the state's best interests. Writing to the Secretary of State, the Acting Governor emphasized the need to forestall the revolutionary changes that could be precipitated by stifling African political agitation for change, asserting that

> I entirely endorse the view that there should be no revolutionary changes in native Organization. There is a continual process of modification and improvement, which is accompanied by an increasing sense of responsibility and duty to the State on the part of the Chiefs. It is with the intention of fostering this sense that an Ordinance was passed at the last session of Legislative Council providing for the establishment of Native District Councils.[26]

The implementation of the ordinance proceeded gradually with the establishment of the Local Native Councils, undertaken "in the first instance, only in the more advanced areas."[27] Such councils were established in most of the "advanced districts" by 1925.[28]

The creation of these councils not only had political implications but also constituted a decisive step in the growth and development of medical services in the reserves. The Local Native Councils were given some control over the revenues raised locally, which gave them a closer and more personal interest in the allocation of these revenues.[29] The newly formed councils began to levy rates, particularly for medical and educational purposes. The levying of rates for the development of health and educational infrastructure increased the burden of taxation on Africans, since the poll tax continued to be mandatory. Nevertheless, the funds procured by the LNCs produced some very positive developments in the growth of colonial health care services.

In 1926, for example, the North Kavirondo LNC voted 20,000 shil-

lings to build schools and another 4,000 shillings to build a maternity home.[30] In the same year, the Central Kavirondo LNC voted 40,000 shillings to build schools and 22,000 shillings to build dispensaries, while the South Kavirondo LNC voted 2,000 shillings to build schools and a further 2,000 shillings for the construction of a yaws hospital.[31] The local provision of funds for such social projects, moreover, could not have come at a better time for the colonial state. The state, wanting to spend as little as possible to develop medical and educational facilities for Africans, had reluctantly supported missionary involvement in these activities. The LNCs now shouldered the burden of levying rates for the expansion of dispensaries and schools, thereby partly resolving the financial problem that had often curtailed the provision of medical facilities. The LNCs became an institutional appendage to the colonial state in the financing of medical services in the reserves.

The shifting of most of the responsibility for financing colonial health infrastructure in the reserves created certain problems whose results would outlive colonialism in Kenya. LNCs that had greater resources and were financially well-endowed were able to establish and improve their medical institutions to a much greater extent than those that lacked resources. This disparity resulted in the uneven development of medical institutions and facilities, not only within the entire country, but also within the same region. As the developments in western Kenya in 1926 demonstrate, a district such as North Kavirondo or Central Kavirondo could commit more resources to the development of social projects than could South Kavirondo. Over time, this inequality became a major feature of the medical infrastructure of the region. By the end of 1927, Central Kavirondo had fourteen dispensaries, eleven of which were under the Medical Officer at Maseno while three were under the Senior Medical Officer at Kisumu.[32] Out of the fourteen dispensaries, reportedly four were "built in concrete from the Local Native Council Funds."[33] At the same time, North Kavirondo had ten dispensaries while South Kavirondo had eight.[34] Nevertheless, the colonial state had succeeded in finding some means of addressing what had been an elusive agenda since the end of World War I—financing the development of health institutions in the reserves. The LNCs became the major institution for financing the construction of dispensaries beginning in 1925. Essentially, therefore, Africans had to bear their own burden as disease victims.

The colonial state, however, continued to assist by paying salaries for doctors and other medical staff. Although the state was also expected to

supply medicine to the hospitals and dispensaries, this was not always done. The LNCs were often called upon to financially assist in the procurement of required medical supplies. Thus, the expansion of colonial health institutions in the African reserves from the mid 1920s was primarily undertaken by the LNCs, and was financed from local rates paid by Africans. In essence, therefore, the development of colonial health care institutions and services proceeded on the principle that the Africans had to take much of the responsibility for the development of health services in their areas, despite the fact that they paid taxes to the colonial state. What had begun as cost-sharing was soon turned into predominantly African funding.

The assumption of such a financial burden did not occur without its share of political controversy. The imbalance between tax payment and provision of services in African areas was echoed by African representatives Ezekiel Apindi and Koinange Mbiyu at the Joint Select Committee, who called for the need to distinguish a "native" budget from a national budget. Apindi opined: "We want a native budget, separate and distinct from the National budget. We would like to know how it is worked."[35] The issue of the "native budget" was a prominent concern because Africans felt that they were overtaxed without corresponding developments in educational and health care services in the rural areas. In addition to the poll and hut taxes, which went to the central government, they also paid local rates levied by the LNCs. Their argument, rightly, was that the development of schools and dispensaries was to a large extent a function of the LNCs, which financed such projects with revenue obtained from the rates. The poll and hut taxes that went to the central treasury, which was managed from Nairobi, were clearly not spent directly on development projects in the African areas. Although in his evidence at the Joint Select Committee, Governor Sir Edward Grigg attempted to sweep away the fact of over-taxation and neglect of the African areas, the committee was not persuaded, despite the fact that it contained a majority of conservative members.[36] The committee took into consideration the complaints about over-taxation and unequal allocation of resources to various races.[37] To further inquire into the complaints, the Secretary of State, Sir Philip Cunliffe-Lister, a member of the National Government that had replaced the Labour Party administration in Britain in 1931, appointed Lord Moyne to proceed to Kenya as Financial Commissioner and inquire into, among other things, "the contribution made to taxation, both direct and indirect, by the different racial communities, and the amount of money expended in the interests of each community, in particular on natives and non-natives."[38]

Table 5.1 Balance of Contributions and Services (in Sterling), 1931

	African	Asian	European
Population	2,950,000	56,903	17,285
Contribution (Sterling)	791,100	385,658	665,781
Services (Sterling)	331,956	46,080	171,247
Surplus (Sterling)	459,144	339,578	494,534
Expense/Head	0.3	1.2	38.5

Source: Great Britain, *Report by the Financial Commissioner (Lord Moyne) on Certain Questions in Kenya,* Cmd. 4093 (London: HMSO, 1932), in PRO: CO 533/421.

Lord Moyne's report, albeit heavily weighted with racial phraseology, was an indictment of most of the developmental policies of the colonial state, if the raw data is anything to go by. Lord Moyne argued that the existing type of taxation was not only a burden to the Africans but was also detrimental to the improvement of their lives. Accordingly, he suggested that the hut tax be "modified and replaced by a more scientific tax according to ability to pay."[39] He further advised that the hut tax be separated from the poll tax. The nature of the "scientific tax" was, however, not described. Lord Moyne also identified the inequality which typified the provision of services (see Table 5.1). The contributions in Table 5.1 do not include the LNC rates paid by the Africans in their various districts. The services are those that were directed to specific groups. The table demonstrates the inequality in expenditure on the various groups, with the European community enjoying a marked advantage over the other two groups. In interpreting the figures, however, Lord Moyne appears to have been heavily influenced by the principle of trusteeship, as defined by the Joint Select Committee to mean that native paramountcy must only be understood and pursued within the context of a multiracial Kenya. With regard to the principle of trusteeship, the committee noted that

> While any discrimination, by means of subsidies or other privileges, customs duties, railway rates, or otherwise, designed to favour unduly any one community is of necessity open to serious criticism, at the same time it is most important to give adequate security to those Europeans and other non-native races who have settled in the country, and who have made a permanent home there, often under very difficult and trying conditions.[40]

Overall, Lord Moyne's report strongly supported the evidence of the African representatives at the Joint Select Committee, but failed to recommend specific, substantive changes. Despite overwhelming evidence, the

Table 5.2 Local Taxation and Expenditure on Local Services by Province (in Sterling), 1930–1931

Province	Total Actual Expenditure	Total Actual Poll and Hut Tax	Excess of Expenditure over Tax Revenue	Excess of Tax Revenue over Expenditure
Ukamba	53,555	78,268	—-	15,713
Coast	94,446	40,859	53,587	—-
Nzoia	30,584	23,965	6,639	—-
Nyanza	127,951	229,248	—	101,297
Kikuyu	158,973	172,994	—	14 021
Rift Valley	17,319	17,602	—	281
Turkana	49,247	6,633	42,614	—-
Maasai	28,844	15,109	13,735	—
Naivasha	223	4,963	—	4,741
Northern Frontier	74,077	1,785	72,292	—
TOTAL	674,449	591,427	227,917	136,055

Source: "Native Taxation and Expenditure on Native Services, 1930–31," Enclosure in Governor Byrne to S of S, Major Sir Philip Cunliffe-Lister, 11 February 1932, PRO: CO 533/420.

report's recommendations merely sought to justify the status quo, without resolving the persistent problem of Africans having to shoulder the financial burden of development in the reserves. Thus, the LNCs and mission stations were responsible for most of the expansion of colonial health care services in the 1930s in the reserves, with only occasional subsidies from the central treasury to help meet expenses in certain provinces. As Table 5.2 shows, the subsidy was high in the Turkana and Northern Frontier Provinces, where administrative costs were much higher because of the pastoral way of life of the local populations.[41]

In response to the complaints registered by Africans over taxation as well as to the economic crisis of the Depression, Lord Moyne urged that the Europeans should pay income tax to alleviate the critical financial situation the country was facing. This proposal was supported by the Secretary of State, Sir Philip Cunliffe-Lister, who allowed Governor Sir Joseph Byrne to decide the best way of raising revenue: "It is for you to decide the means by which revenue may be increased or expenditure lowered, and I do not wish to fetter discretion."[42] However, the European settlers rejected attempts by Governor Byrne to introduce new taxes upon them. Instead, the settlers went further to insist that "expenditure should be cut from the civil service,

rather than by reduction of financial assistance to agriculture."[43] Yet a breakdown of the medical expenditure by district shows that urban areas were not only well staffed, but also better financed, as compared to rural areas (see Tables 5.3 and 5.4). As Table 5.3 indicates, Mombasa, Nairobi, Kisumu, and Eldoret received an allocation that was out of proportion to the size of their populations. Nairobi, with only about 10 percent of the population of Kikuyu Province, received more than 150 percent of the allocation for all the other districts combined. This supports my argument in chapter 3 that the allocation of funding for medical services favored urban areas over rural areas. This, as will be argued in the next chapter, outlived colonialism and persisted as a major feature of postcolonial budget allocations for medical services. While Tables 5.2 and 5.3 speak to the uneven and disproportionate allocation of resources, Table 5.4 highlights the distribution of medical personnel over the same period.

The refusal of the European settlers to accept the imposition of new taxes resulted in the maintenance of the status quo in which Africans continued to bear the burden of colonial taxation. Because they continued to

Table 5.3 Medical Expenditure by District (in Sterling), 1931

Province	Districts	Population	Expenditure on Native Service (Sterling)
Ulamba	Taita and Voi	44,100	3,506
	Kitui	140,807	2,351
	Machakos	222,285	5,853
			TOTAL 11,710
Coast	Lamu	16,462	} 1,144
	Tana River	13,420	
	Digo	50,881	3,850
	Malindi	28,146	} 2,863
	Kilifi	69,298	
	Mombasa	34,591	14,605
			TOTAL 22,462
Nzoia	Nandi	41,491	518
	Elgeyo-Marakwet	34,768	381
	Uasin-Gishu (including Eldoret)	20,661	4,058
	Trans-Nzoia	24,140	2,099
			TOTAL 7,056

Table 5.3 (continued)

Province	Districts	Population	Expenditure on Native Service (Sterling)
Nyanza	C.K. and Kisumu	343,205	14,909
	S. Kavirondo	312,226	6,579
	N. Kavirondo	341,232	7,002
	S. Lumbwa	92,525	2,347
			TOTAL 30,836
Kikuyu	North Nyeri	7,775	3,540
	South Nyeri	202,893	3,121
	Meru	160,721	2,675
	Fort Hall	187,278	3,259
	Kiambu	93,060	6,137
	Nairobi and Thika	67,710	22,351
			TOTAL 41,083
Rift Valley	Baringo	43,567	1,374
	Nakuru	23,346	3,651
			TOTAL 5,025
Turkana	West Suk	24,805	
	N. and S. Turkana	53,511	TOTAL 2,696
Maasai	Kajiado } Narok	50,402	TOTAL 1,299
Naivasha	Naivasha } Laikipia	29,630	TOTAL 40
Northern Frontier		80,000	TOTAL 2,435
			GRAND TOTAL £124,642

Source: Classification of 1931 Expenditure, Medical Department, PRO: CO 533/420.

NB: Expenditure on joint services for Europeans, Asians, and Africans is not included.

bear the burden, they began to dictate the pace of development of preventative and clinical services in rural areas. By the beginning of the Great Depression in 1929, Africans were major actors in colonial health care programs. Their proactive participation was manifested during the depression years, when contrary to expectations, the government's bureaucratic retrenchment and financial cuts slowed but failed to stop health care growth in parts of colonial Kenya, particularly in the districts that had viable peasant economies.

Table 5.4 Health Facilities and Medical Service Personnel Available by District, 1931

Province	Districts	Nature of Service
Ukamba	Taita and Voi	NH, MO, NS
	Kitui	NH, MO, SAS
	Machakos	NH, MO, NS, SAS
Coast	Lamu	}NH, SAS
	Tana River	
	Digo	MO, SI
	Malindi	}NH, MO, SAS
	Kilifi	
	Mombasa	EH, NH, MO, NS, PHO
Nzoia	Nandi	NH, Compounder
	Elgeyo-Mahrakwet	NH, Compounder
	Uasin-Gishu	NH, NS, SAS, SI
	Trans-Nzoia	NH, MO, SI
Nyanza	C.K. and Kisumu	NH, EH, MO, NS, SI, SAS
	S. Kavirondo	NH, MO, NS, SI, SAS
	N. Kavirondo	NH, MO, NS, SI
	S. Lumbwa	NH, MO, NS
Kikuyu	North Nyeri	NH, SAS, SI
	South Nyeri	NH, MO, NS
	Meru	NH, MO, SAS
	Fort Hall	NH, MO, SAS
	Kiambu	NH, MO, NS
	Nairobi and Thika	NH, EH, MO, NS, SAS, Asylum
Rift Valley	Baringo	NH, MO
	Nakuru	NH, DISP, MO, NS
Turkana	West Suk	} NH, MO, SAS
	N. and S. Turkana	
Maasai	Kajiado	
	Narok	} NH, MO, Compounder
Naivasha	Naivasha	
	Laikipia	ND, DISP
Northern Frontier		2NH, MO, SAS

Source: Classification of 1931 Expenditure, Medical Department, PRO: CO 533/420.

Key: NH—Native Hospital, EH—European Hospital, MO—Medical Officer, PHO—Public Health Officer, NS—European Nursing Sister, SI—Sanitary Inspector, SAS—Sub-Assistant Surgeon, ND—Native Dresser, DISP—Dispensary.

The Depression: Growth in the Midst of Economic Crisis

The impact of the Global Depression of 1929 to 1935 on the national economy was devastating. The value of national exports fell from £3,523,000 in 1930 to £1,918,000 in 1934, while imports fell from £5,309,000 in 1930 to £3,382,000 in 1933.[44] The Depression also adversely affected medical services and programs. Expenditure on medical services was reduced from £236,934 in 1930 to £222,897 in 1931.[45] In 1932, the health care budget was reduced to £197,260, not regaining its 1930 level until after 1936.[46] This reduced expenditure was contemporaneous with a low demand for labor as the settler economy collapsed, resulting in more people remaining in the reserves.[47] At the same time there was an increase in the number of patients treated in colonial medical institutions. Beneath these statistics lies the paradox of the hidden growth and expansion of health care facilities and services in the African areas, which has received little attention. This scanty attention can be explained by a number of factors.

Few historical studies have focused on the African embrace of Western biomedicine, its facilities, and its services. More often than not, the emphasis is on the conflictual relationship between the African and Western health and healing systems. In addition, colonial health care has been presented as a foreign import, whose visibility is conspicuous during the high noon of the colonial economy and labor migrancy.

Two alternative and opposing conceptual views of the situation of colonial health care during the Great Depression can be discerned. One view is grounded on the notion that during crises, people have to depend on government support. A corollary to this contention is that as the government adopts measures including bureaucratic and financial cuts to arrest the situation, health care, like the other social services, whose immediate economic return can be neither identified nor quantified, is bound to suffer. Indeed, the Depression forced the state to retreat from its fiscal commitment to public services. Expediency and calculation guided the state in its attempts to balance the budget through cuts in expenditure. These budgetary cuts, collectively referred to by Governor Sir Joseph Byrne as "Pruning Operations," entailed temporarily holding in abeyance several appointments, postponing all new services, and refusing any expansion of existing services.[48]

While, on the eve of the Depression, the Director of Medical and Sanitary Services had prepared a comprehensive program calling for the strengthening of anti-malarial measures, the extension of hospital and medical facilities in various districts and the employment of more staff to assist

in the carrying out of a medical campaign whose primary purpose was to be directed toward "the improvement of general health conditions in the reserves,"[49] these aims were temporarily consigned to limbo because of the economic situation, even though the 1929 budgetary select committee of the Legislative Council had been prevailed upon to approve the Director's recommendations.

The budgetary select committee had provided for additional staff, which included eleven medical officers, one sanitation officer, eight nursing sisters, one sanitary inspector, and one laboratory assistant.[50] Besides this staff increase, an appropriation of £3,000 had been included for antimalarial measures under the Medical Department's extraordinary vote, in order to obtain the services, on a temporary basis, of an expert on antimalarial measures.[51] The tone and message of the budgetary select committee reflected a change in the approach to combating malaria. The Legislative Council passed the Malaria Prevention Ordinance No. 19 in 1929, giving the state power to enforce measures for the removal of potential mosquito breeding places, directly or through a local authority in the interest of the public.[52]

The Colonial Development Fund offered a sum of £18,000 for the campaign against malaria in Nyanza.[53] The fund owed its origin to the Colonial Development Act that was passed by the British Parliament in July 1929.[54] Primarily legislated to enhance the long-term benefits to the British economy by investing in the colonies, the fund promoted "commerce with or industry in the United Kingdom."[55] To achieve that objective, the act empowered the British Treasury, in agreement with the Secretary of State for the Colonies and subject to the recommendation of an advisory committee, to loan territories money for the purpose of aiding development in agriculture or industry, as well as for "improvements in agricultural production and marketing, for the development of fisheries and forestry, of water supplies and water power, of mineral resources and electricity, and for the promotion of scientific research and public health."[56] If the use of the loans advanced under this act in Kenya is anything to go by, then Constantine could not have put it much better when he asserted that the act was more than an "*ad hoc* response to particular colonial needs."[57] In the same vein, however, the act illustrated the correlation between the colonial economy and the financing of health care programs.

Yet none of these pronouncements and provisions were put into effect until 1935, following the end of the economic crunch. Thus, it was not until 1936 that the £18,000 promised for the anti-malarial scheme was activated, upon the arrival of Dr. Alwen Evans from the Liverpool School

of Tropical Medicine, who spent most of the year in Kisumu and the surrounding region studying the local anopheles mosquitoes and their habits.[58] In Kisumu Township, the fund enabled the rebuilding of the Nubian village on a more healthy site, but still within the African sector.[59] The system of sewage and storm water drains in the township was also completed.[60] These developments, however, occurred during the immediate post-Depression years and should not detract from the state's belt-tightening measures during the critical years of 1930–1934.

The "Pruning Operations" had a direct impact on the central government's budget for medical services and health care personnel. While the net local expenditure was £180,206 in 1927, the figure rose to £195,326 and £298,348 in 1928 and 1929 respectively. Declining to £197,260 in 1932, expenditure increased again in 1933 to £215,116.[61] The number of medical officers in the country was reduced from seventy-five to fifty-eight at the height of the Depression between 1932 and 1935.[62] Undoubtedly, these measures increased the doctor/population ratio. One of the most densely populated districts in the country, Central Kavirondo, had only one medical officer for a population of 343,205 in the period 1932 to 1935.[63] Moreover, a number of services were also affected. The school inspection service was abolished, and the vote for health propaganda, important for the campaign against disease, was drastically reduced, from £3,150 in 1929 to only £60 in 1932.[64]

A most welcome piece of news for the state was the discovery of gold in Kakamega. The enthusiasm of Governor Byrne is quite evident in his statements on gold prospecting and mining. Recalling the contribution of the nascent gold industry, he reported: "Had the country been compelled to rely solely on agriculture during this critical period, our difficulties would have been enormously increased. But the gold industry has become established and is making an important contribution to the wealth of the country."[65] Governor Byrne noted that the increase in the value of the gold output was striking. In 1930, the figure was a meager £7,000, but by 1934 it had jumped to £83,000 and by 1935 to £163,000.[66]

The gold industry provided employment at a time when other demands for labor had drastically declined.[67] Between 1935 and 1939 an average of 10,500 Africans were annually employed in the mining industry.[68] Although surface and underground laborers constituted the majority of the labor force, a number of artisanal as well as clerical jobs were also available.[69] However, gold mining in western Kenya was not without some attendant problems.

The rush for gold resulted in a substantial increase in the African population around the mining areas. The European population in the min-

ing areas witnessed a marked increase as well. As early as 1933, the Medical Officer of Health in charge of North Kavirondo and Nandi reserves reported that "the number of Europeans in the gold fields is officially estimated at 1,200 and the number in the township as 300."[70] He further argued, rightly, that if the figures were correct, "North Kavirondo must contain one of the largest European populations in the country."[71] Outside North and Central Kavirondo, there were ninety-six Europeans at the various gold mines in South Kavirondo.[72]

As a result of the population influx, the Medical Officer noted that "the work of the hospital [Kakamega] has nearly doubled in the last two years and much of the native public health work in the district has been initiated during this time and is now being carried on with very much less supervision than formerly."[73] The increased workload at the hospital was due to "the mixing of native tribes"; the "employment of natives from outside" must have had "the effect of introducing virulent foreign strains of the sub-tertian parasite to a population which is not immune to them."[74] Although the intermingling of populations from various epidemic terrains was a significant contributory factor to the rise in sickness, there was another vital and equally compelling causal factor, which was directly related to the mining activities.

Reef and alluvial mining were the two major types of mining in the region. While reef mining was reportedly satisfactory, the same cannot be said of alluvial mining, which resulted in a series of excavations, providing a stable environment for mosquitoes. The mining companies made no attempt to fill in the pits. The result was destabilization of the epidemiological environment as prospecting pits and streams encouraged the growth of mosquito colonies, and thus the spread of malaria.[75] Speaking at the Colonial Advisory Medical Committee meeting in Nairobi in early 1934, the Director of Medical and Sanitary Services noted that "the malaria problem had been a little difficult and would have to be carefully watched."[76]

The companies' support in this endeavor was not impressive, viewed against the impact of the environmental change on the health of the population, some of whom were not directly employed by the mining companies and hence could not rely on the health facilities provided by the company for its employees. In 1935, the district Medical Officer of Health reported that the attempt to control the breeding of mosquitoes was not yielding positive results due to insufficient supervision and scarcity of money. He wrote that "an attempt has been made to control the breeding of mosquitoes within a mile radius of the township boundary, but so far this has not been a success because of lack of supervision. The total amount of money available for anti-malarial measures in the township and district is only £10."[77]

To solve the problems in Kakamega, the Medical Officer proposed

> The posting of an additional Sanitary Inspector for work in the gold fields, trading centres . . . the posting of [an] anti-malarial overseer principally for work in the township, but also for work in the gold field; the posting of a clerk for health office work; and the provision of adequate funds for anti-malarial work generally, and for essential services in Kakamega township.[78]

Belated and inadequate attempts were made to address the problems through the construction of an outpatient block in Kakamega to alleviate the congestion at the Kakamega hospital.[79] Even then, the construction of the block was funded by the LNC.[80] Although an anti-malarial campaign was carried out, it was not as intensive as the one that was conducted in Kisumu.

Some mining companies provided medical care for their employees at company-run health facilities. Hugh Fearn asserts that Rosterman, the major mining company in Kakamega, had its own hospital and at one time employed twenty-three Africans as hospital attendants.[81] In 1935, the Nyanza Provincial Commissioner reported that "an excellent 30 bed native hospital" had been built during the year "on the Roman Catholic Mission land at Kakamega with generous support from the Rosterman mine and in charge of Dr. Marshall and Dr. Holiday."[82]

South Kavirondo faced similar problems. Because it had only two hospitals, one in Kisii and the other, run by the Seventh Day Adventist Mission, at Gendia, the numbers of both Africans and Europeans working for the Kenya Consolidated Goldfield Company Limited at Kitere, Macalder, Kuria, and Lolgorien led to a demand for more medical facilities and institutions.[83] But the Kenya Consolidated Goldfield Company and the Kenya Gold Mining Syndicate paid little attention to the provision of health facilities for their workers. Available evidence does reveal, however, attempts by the companies to establish a hospital for Europeans near the gold mines. There was no European hospital in Kisii, and the only health facility available for Europeans was at Gendia. Until 1937, the European mine-employed patients from South Kavirondo requiring regular attention were attended to by the Medical Officer at the Kisii Hotel, which even according to the Field Manager of the Kenya Consolidated Goldfield Company was "not at all a desirable place to send patients to."[84] Consequently, a proposal was made by the provincial administration to establish a small European ward at Kisii.[85] The money for construction of the ward was provided by the colonial state, and construction of the ward began in 1938.[86]

Once again, the colonial state's determination to finance the con-

struction of a European ward in Kisii, from its central revenue, shows the partiality and arbitrariness that characterized the provision of colonial health care services as well as the development of related institutions. While the LNCs and the mining companies took the primary role in the construction of health facilities in the African reserves, the colonial state was the main provider of health services, funded from its central revenue, to the European community.

If one aspect of health care development during the Depression was the role of the state, another, and perhaps the more significant, involved African proactive measures. A discourse centered on the Depression vis-à-vis the state creates the false impression that the government is the sole, or the key, provider of funding for the development of health care services. Also, the assumption is made that there are no competing alternatives to mainstream health care. These assumptions are invalidated by the fact that over a period of nearly five years preceding the Depression, the colonial state had eased away from a preeminent position in the development of health care facilities and services in the rural areas. That role had been transferred to the local populations through the Local Native Council Ordinance. Catastrophes such as those brought about by epidemics or economic downturn provoke human reaction and breed strategies to resolve some of the emergent problems and catapult a society to its next higher level of development. Colonial western Kenya during the worst years of the Depression illustrates this fact.

Between 1926 and 1934, the number of LNC-constructed dispensaries rose to thirty-nine, surpassing the number of mission medical stations in the region. Out of this number, sixteen were in Central Kavirondo, thirteen in North Kavirondo, and ten in South Kavirondo.[87] Quite a number of these were permanent buildings.[88] The North Kavirondo LNC purchased a lorry principally for transporting patients to hospitals. Attempts were even made to provide facilities for treating diseases that, though prevalent in the region, had not been given consideration in the medical mainstream of colonial health care.

The North Kavirondo LNC constructed a treatment block for leprosy patients at the Kakamega leprosy settlement center, a school at the same site, and a dormitory and nursery for the use of the children of lepers who were themselves not yet infected.[89] A teacher who was "a burnt out leper" reportedly conducted the school.[90] Remarkably, such undertakings demonstrate the changing attitudes of local populations to some of the diseases that had hitherto carried with them stigma, neglect, scorn, and rejection.

In 1932, those parts of Nyanza under the Medical Officer for Maseno reported 297 leprosy cases.[91] In 1936, the leprosy camp at Kakamega had 150 residents.[92] However, reports estimate that there were more than 450 infected people in North Kavirondo outside the leper camp.[93] In South Kavirondo, the number of infected individuals could have been as high as 500.[94] The Karachuonyo Chief, Paul Mboya, stated that twenty-five years earlier people dreaded leprosy and drove out the lepers, but by the mid-1930s, the disease was no longer feared and attitudes toward lepers were beginning to change.[95] Lepers were no longer banished. Apparently, the traditional approach of banishing victims of the disease had served to contain the spread of leprosy. Yet, since times had changed, so, too, were attitudes changing. Rejection and banishment of lepers was no longer acceptable. The African initiatives in undertaking the construction of leprosy camps with a view to providing lepers with a life of dignity were, however, sometimes undermined by the lack of facilities necessary to determine the stage and possible likelihood of infection among the population.

Thus, when the head of the British Empire Leprosy Relief Association, Dr. Muir, visited Kenya in 1938 to inquire into the epidemic state of leprosy in the country, he raised concerns about the rapid spread of the disease despite the attempts by the local population to contain the situation through the construction of leprosy camps.[96] His findings indicated that the disease spread primarily because no measures were taken to isolate the infectious lepers. After visiting the Kakamega camp and examining the inhabitants, he came to the conclusion that one of every six patients "might be considered highly infectious," and that "probably one-third of the whole were infectious to a greater or less degree."[97] Because the disease was quite widespread, a number of leprosy camps existed in various parts of the province. By and large, however, resources from the local authority, not the state, sustained them.

Dr. Muir recommended the consolidation of the various camps into two. The first was to cater to South Kavirondo, and hence was to be located "about 30 miles from Kendu on a site lying south of the road to Kisumu, between Oyugis and Miriu River, and near the boundary between South Karachuonyo and Kisii."[98] The second site was to serve both North and Central Kavirondo and was to be located at the Bukura Agricultural Training School, which at the time was supposed to be relocated. The central location of these sites and the high incidence of the disease in these areas determined their selection as campsites. Dr. Muir was optimistic that if the two camps were established, the British Empire Leprosy Relief Association

would be able to supply trained European health workers. In essence, though there was much to be gained by the consolidation of the camps into two new sites, prompt and precise diagnosis by qualified personnel would be the real improvement.

The leprosy camps were supposed to be settlements where the lepers would not only be looked after but also receive training while participating in productive economic activities. Dr. Muir, after visiting the Ongino settlement in the Eastern Province of Uganda, saw it as a model that could be replicated in Kenya. The Ongino Leprosy Camp housed 400 lepers, out of whom 350 supported themselves by their own agriculture. Three miles away from the camp, at Kumi, a leper children's home housed 350 infected children, who, besides receiving treatment, were receiving vocational training as carpenters, builders, tailors, nurses, and teachers.[99] However, the establishment of the two suggested camps in South and North Kavirondo along the lines of Ongino required a heavy initial financial outlay which could hardly be shouldered by the LNCs because of their already heavy financial involvement in the social infrastructure of the province.

Meanwhile, some individuals took the initiative with regard to dispensaries, provided land for their establishment, and requested staff from the government. Cost-sharing was real during the 1930s. Headman Johana of Central Kavirondo was instrumental in the construction of a dispensary at Nyahera. Within one year of the dispensary's construction, the Nyanza Provincial Commissioner described it as "the most successful of all Dispensaries."[100] The Provincial Commissioner continued: "built by the Headman himself, it has beaten the records of all other Dispensaries with an attendance of over 13,000 patients during the year. A large number of Maragoli people have received treatment here and other patients from further afield."[101] The exceptionally large numbers may be attributed to the location of the dispensary which was situated close to the populous communities of the Maragoli, Luo, and Tiriki.

The number of patients visiting dispensaries, as well as hospitals, in the entire province and the entire country continued to rise throughout the 1930s. A combination of several factors explains this rise. Developments carried out by the LNCs, as exemplified by the case of Headman Johana, were the most significant factor in the expansion of colonial health care in the 1930s. More people than ever before gained access to colonial health care through the expansion of medical facilities and services. The establishment of mobile clinics beginning in 1930 constituted an important step on the road to expanded services. Mobile clinics enabled a medi-

cal officer and a nursing sister to make weekly visits to specifically designated places to attend to patients. In the course of the visits, patients who required more specialized attention than could be provided on site were transported to the hospitals for more extensive treatment.

Maternity and infant and child welfare work also began to receive some attention from colonial medical authorities. With more nursing sisters becoming available, maternity and child welfare work began to gain in popularity. In 1930, the Governor stationed European nursing sisters in Kisumu and Kakamega to promote maternal and infant welfare.[102] By 1935, maternity wards were attached to all government hospitals in the province.[103] The Kisii maternity wing witnessed an increase from 182 confinement cases in 1935 to 282 cases in 1936.[104] Kisumu maternity center showed a marked increase over a three-year period; the number of confinement cases jumped from 165 in 1935 to 265 cases in 1937.[105] The setting up of maternity wards brought health care to a group that had previously been ignored, but providing the buildings became the responsibility of the LNCs, while the central government staffed the facilities.[106]

By 1936, many maternity wings were under construction in various parts of the province, not only by the LNCs but also by the mission stations.[107] Mission medical maternity centers were opened at the Friends Mission at Kaimosi, the Church of God center at Kima, and at the Church Missionary Society Center at Butere, all in North Kavirondo. In 1936, the Provincial Commissioner of Nyanza reported that "a tendency is now observed for native women to attend dispensaries on the occasion of the medical officer's visits for pre-natal examination and abnormal cases are advised to come into hospital for delivery."[108]

Unfortunately, despite the positive developments, many problems remained. Increased facilities and personnel still had to battle with a variety of diseases, significantly yaws and syphilis. About 48 percent of the total dispensary cases reported in Central Kavirondo in 1932, for example, were yaws and syphilis cases (see Table 5.5). The fact that the dispensaries were all based in the reserves shows how diseases introduced as a consequence of colonization had gained a foothold in the region. Dr. John A. Carman, a colonial doctor who played a significant role in the campaign against yaws and syphilis during his tenure as the Medical Officer of Health at Maseno, described in his memoirs how, despite the well-known efficacy of NAB (a medication used widely in the 1930s) in curing the two diseases, the Medical Department was unable to supply the drug.[109] As a result, he asserted, "The Elders of the Central Nyanza Local Native Council voted an annual

Table 5.5 Dispensary Returns from Central Kavirondo, 1932

Dispensaries	Yaws	Syphilis	Other
Maseno	347	215	3,203
S. Gem	442	475	1,940
Asembo	315	492	1,284
Uyoma	420	631	1,468
Sakwa	486	589	2,546
Kadimu	250	312	1,991
Marenyo	353	140	1,862
Malanga	814	418	1,383
Alego	1,079	1,334	2,569
S. Ugenya	233	246	1770
N. Ugenya	218	300	1,774
Lumbwa	115	394	719
Nangina	463	157	1,474
Seme	560	337	1,372
TOTAL	6,095	5,950	25,295

Source: Maseno Medical Report, Maseno and Its Dispensaries, 1932, KNA: PH/5/2/1.

sum for the purchase of NAB to be used in the treatment of yaws and syphilis."[110] Less severe cases of the diseases were reportedly "given doses of injections with metallic bismuth," while serious cases were treated with NAB.[111] Additionally, those infected were persuaded to attend a course of treatment at the dispensaries which was essential for a complete cure.[112]

Increases in the number of cases of venereal disease by the end of the decade caused the colonial medical and administrative officials tremendous financial anxiety. As a result, by 1939, the District Commissioner for North Kavirondo wanted the 1921 Public Health Ordinance invoked to provide for the levying of fees on those who were suffering from venereal diseases.[113] However, the Public Health Ordinance made reporting venereal disease, as well as undergoing full treatment, statutorily necessary, but it had failed to provide for the charging of fees. The Governor, through powers conferred upon him by the ordinance was the only who could effect such a provision. The Governor did not hesitate to provide local officials with the power they needed to levy fees. The cost for treatment of syphilis and gonorrhea was fixed at 7/50 shillings and 6/00 shillings respectively, effective in 1940.[114] This measure presented venereal disease as a unique ailment and thereby furthered the stigmatization of those who had contracted such a disease.

Rise and Fall of Eugenics as Social Medicine

The issue of expanding health care services, though it was the dominant public health issue in the 1920s and 1930s, was nevertheless not the only issue discussed during the interwar period. Another issue, which acquired importance beginning in the late 1920s but fizzled out within the next decade, was the biological improvement of the African through the ideas of eugenics, which in the Kenyan context combined and blended ethnicity, heredity, environment, and race.[115]

From the late 1920s to the 1930s, the proponents of the eugenics movement struggled to legitimize their agenda in the hygiene movement that came to occupy a platform in colonial health care programs. H. L. Gordon, a visiting physician to Mathari Mental Hospital in Nairobi beginning in 1927, was the head of the eugenics project in colonial Kenya. For the next six years, Dr. Gordon carried out research work into African mentality and capacity. Although Gordon's research was supported by Dr. J. L. Gilks, Director of Medical Services, and Dr. F. W. Vint, Government Pathologist at the Medical Research Laboratory in Nairobi, who conducted anatomical research with regard to the African brain, the eugenics enterprise in Kenya, for the most part, remained a private undertaking.[116]

The research, nevertheless, received considerable attention from the medical and lay press, despite the fact that the experiments had not been publicized among the general population and had no basis in substance or in context. As Dr. Gordon was elevated to the limelight as a specialist in this topical "science" by his colleagues in the eugenics fraternity, he delivered a series of lectures in Kenya and in Britain on the subject of eugenics.[117] On the basis of the "preliminary results of the research," the eugenics fraternity strongly urged that "further and fuller investigation into the matter be undertaken at the earliest possible moment by a team of scientific experts, and that adequate financial provision be made for this object, which in our opinion, can be regarded as of imperial significance."[118]

The research and the accompanying lectures could not have come at a worse time for the eugenics proponents in their attempt to mobilize support among some British parliamentarians, as well as colonial officials in London and Nairobi, for the purpose of securing public funding. The economic times were hard. The research was pedantic and lacked scientific foundation, having nothing to offer as a solution to the major health care challenges Kenya faced during its hour of economic need. Neither could the project be rationalized in terms of any long-term benefit to the country. Both the Colonial Office and the Governor's Office in Nairobi were

forced by the urgent conditions to implement economic policies aimed at reducing government expenditures through retrenchment, the suspension of some essential health care services, and the active involvement of the citizenry in health care campaigns. The professed goals of the eugenics movement were at variance with the colonial state's attempts to stabilize the economic situation and streamline the administration and delivery of colonial health care services. Responses to the eugenics project varied from enthusiasm and overt support among its proponents and supporters to distaste and hostility from those who read its latent intentions. The latter rejected it outright as irrelevant to the debates on maximizing scarce resources to ensure maximum delivery of health care services.

The British and the East African Medical Associations, which passed resolutions to inaugurate research into the causes of "Native backwardness, mental and physical, in territories under British rule in East Africa," warmly embraced the project.[119] Voicing his support for the envisioned research, M. Clark Collision, Political Secretary of the British Commonwealth League, wrote to Secretary of State Cunliffe-Lister, requesting the appointment of a committee including competent women anthropologists to undertake the investigation.[120] Meanwhile, Sir E. Graham Little, an independent member of the British House of Commons, not only embraced the investigation but also emerged as the foremost proponent of the Kenya eugenics project in the British Parliament.

Little had forged close working relations with Dr. Gilks, Director of Medical Services, and his successor, Dr. Paterson, both supporters of Dr. Gordon's investigations. Gordon and his allies had one advantage. The release of their "findings" coincided with the high point of the eugenics movement in Europe. Doctors Gordon and Vint were thus able to gather a significant group within the medical and political fraternities in Britain to support their movement, particularly through the procurement of funds.

The medical establishment in Kenya initially supported the eugenicists' appeal. In a lengthy memorandum to the Colonial Secretary, the new Director of Medical Services, Dr. A. R. Paterson, listed a host of scientific and social benefits to be derived from the research.[121] Dr. Paterson contended that the determination of the nature and causes of physical and mental differences among the various races in the country, as well as the condition of "backwardness" among the Africans, were critical to the research. Also pertinent to the project was the general question of heredity in humans, and in particular the role of heredity as against environment. The Director argued that the data obtained from the project could be harnessed by the state and utilized for the "social and economic advantage of the people, and

with special values for medicine, education, law and administration in regard to the physical, mental and social advance of the East African races."[122] The objectives outlined by the Director open a window into the meaning of eugenics in colonial Kenya. Its broad agenda lacked specifics as to how the project would enhance the quality of life during the financial crisis brought on by the Great Depression. This reduced the project's prospect of gaining a place of importance in the health care discourse of the interwar period.

Despite the warm embrace of eugenics by a handful of professionals as well as politicians, the eugenicists failed to articulate a precise and relevant agenda to meet the developmental challenges of the late 1920s and 1930s. Their project embraced multiple meanings as well as disciplines ranging from genetics to medicine and anthropology. The investigation had to do with race, ethnicity, environment, culture, and governance. By casting such a wide net and delving into such a host of issues, the eugenics movement set insurmountable obstacles on its own developmental path. The first criticism of the movement in Kenya pertained to the scientific legitimacy of its preliminary results, which were clouded in ambiguity, dubiousness, and bias. If the movement sought to anchor its legitimacy on the scientific nature of the investigation, this criticism raised doubts which compromised that very foundation.

In their tentative findings, Doctors Gordon and Vint had revealed the "existence of a definite degree of inferiority in the average brain of at least certain native tribes as compared with the average European."[123] What constituted this "definite degree of inferiority" was not even defined. Neither were the "tribes" identified. In a sense, Gordon and Vint reflected the existing climate of opinion, which defined and delineated Africans as members of collectivities. African individuality was subsumed under the rubric of "tribe." Megan Vaughn has provided a perceptive analysis of the intent and import of this classification system: "Africans were always conceived of as members of a collectivity as colonial people, and beyond that, as members of collectivities in the form of 'tribes' or cultural groups. Consequently, when classification systems were elaborated to account, for instance, for the incidence of insanity in Africa, the psychiatric categories became secondary to the 'ethnic' categories, and beyond that to the overriding difference ascribed to colonial people, the signifier of which was skin color."[124] Even though collectivity was the accepted idea, there was a significant coterie of administrators and medical professionals that were not persuaded to uncritically accept the eugenics movement's "scientific" claims.

The movement's program was tainted with a rhetorical appeal that merged pseudoscientific and social factors in an attempt to legitimize the

movement as a development project that would benefit society. Indeed, Patterson and his allies in the eugenics project portrayed the image of a discipline capable of providing knowledge and economic regeneration. However, the overwhelming lack of specificity and the silences in the pronouncements were persuasive enough to lead objective observers to dismiss the project as an expression of biological othering that had nothing to do with the health care problems facing the country. While Drs. Vint and Gordon argued in their preliminary findings that they had observed differences in the brain sizes of Africans, they failed to establish any real correlation between brain size and intellectual capacity.

The Colonial Office and the Depression-era representative of the Crown, Governor Byrne, went on the offensive against the eugenicists. Contesting both the methodology and the tentative conclusions of the eugenicists, the Colonial Office and the Governor in Kenya argued that the term "native backwardness" was problematic since it was open to dispute whether the Africans were "primitive."[125] Mr. Flood of the Colonial Office and Governor Byrne were not alone in their conclusion that the eugenicists' "findings" were suspect. They were supported by Dr. W. H. McLean, a doctor in Tanganyika during the 1930s, who stated that the Africans he had kept in touch with over three decades were professionally successful, intelligent, and responsible.[126] The Colonial Office and Governor Byrne called for pragmatic proposals that would have a direct and immediate bearing on the lives of the populace. Their focus was on improving the general physical condition of Africans by concentrating on workable tasks like the improvement of sanitation and education and the prevention and treatment of disease, which would have a measurable effect on the lives of many.

The colonial administration portrayed the eugenics project as an impractical undertaking whose intention was to show that the social and material conditions of people were caused by biology and therefore could not be addressed through programs of improvement. By defining the eugenics project as a theoretical and impractical venture, the Colonial Office dismissed the chief proponents of the movement as inconsequential individuals who were out of touch with reality. Flood mused, "If you get a body with psychologists and psychiatrists on it, the resulting conclusions are sometimes apt to be impractical."[127]

Where eugenics did flourish it was because it was domesticated. Being challenged from within the country as well as from the Colonial Office, the eugenics movement in Kenya was starved of internal support and solid external patronage. In addition, the movement did not establish the urgency of its own research in the catastrophic conditions of the 1930s.

This failure to appreciate the economic challenges facing the country provided J.E.W. Flood of the Colonial Office, a major opponent of the project, with the ammunition needed to shoot it down by exposing its irrelevance to the overall colonial health care development strategy at work in Kenya. He reported: "The whole thing boils down to attempts to rush the Government of Kenya into spending money which it cannot afford upon various schemes of research, which, however admirable, cannot be regarded as matters of immediate urgency."[128] Governor Sir Joseph Byrne, whose budgetary cuts, or "Pruning Operations," resulted in holding back several appointments, suspending new services, and curtailing many existing ones, shared Flood's sensitivity to the financial implications of the eugenics project. His prudence during a time of immense crisis resulted in the resolution of dilemmas regarding financial policy.[129] In essence, therefore, its own internal contradictions, superficiality, and ambiguity, as well as local administrators and leaders at the Colonial Office, dampened the eugenics movement in Kenya.

Conclusion

The interwar period saw a shift in both the working and the funding of the colonial health care system. The African factor in the development of colonial health care services has constituted the major theme of this chapter. The colonial state became interested in a partnership with the Africans, a development that furthered the expansion of health care services in the countryside. The partnership was structured and manifested in a number of ways. Some of the emergent African elite identified with the notions of Western progress and development. As the case studies outlined in the chapter illustrate, some of the elite were instrumental in the construction of health care facilities in the countryside. The establishment of the Jeanes School, as well as the increase in the number of grammar (high) schools, enhanced the quality of dialogue and quickened the pace of identifying the real needs of the local populations. As the development of colonial educational infrastructure changed, so too did the ways in which Western biomedicine was perceived in Kenya. Interaction became intense and began to reduce the conflicts between the state and the biomedical practitioners on the one hand and the Africans on the other.

By the beginning of the Depression, therefore, Africans were poised to play the preeminent role in steering colonial health care out of the economic morass that bedeviled the country at a time when the state was

financially weak. Indeed, it was during the Depression that Africans spear-headed infant and maternity care in the mainstream health care facilities. Their proactive measures belie the notion of passive Africans involved in perpetual conflict with Western biomedical ideas, practices, and facilities. The relationship between African and Western healing strategies was complex. It defies the either/or dichotomy. Thus by the 1930s the issue for most Africans was not whether to use Western strategies or not, but rather what was in their best interest to embrace in Western biomedical practices. Africans did not embrace Western therapeutic practices as replacements for their own practices, but rather as supplements to them. The majority did not see an opposition between their own "medical culture" and that of the mainstream health care service.

African participation in the development of health care institutions and facilities in the 1930s parallels the cost-sharing initiatives of the 1980s and the 1990s. As will be argued in the next chapter, the theme of the financially weak state and the crisis in the delivery of health care services is a persistent one; but nevertheless one that highlights the role of Africans in supporting themselves rather than being supported by the state. Thus this chapter has focused attention on Africans' proactive measures.

6

GRAPPLING WITH CHANGE IN THE AGE OF TRANSITION AND ANXIETY: DECOLONIZATION, INDEPENDENCE, AND AIDS

If the interwar period was characterized by a major shift in both the working and the funding of the colonial health care system, the postwar era saw the colonial state criticized for the interwar financing of health care, which disproportionately burdened the Africans by shifting the financial responsibility of maintaining educational and health institutions and services from the central government to the local authorities. It was also argued by some colonial officials that the state was still focused on repetitive curative work, as opposed to preventative measures directed at improving African living conditions, both in the townships and the rural areas. The criticisms came in the wake of the modernization agenda that was pursued by the colonial state after the war. While the state sought to reinvent itself as the custodian of African health and education needs by investing more funds in the development of health and education facilities, it still hoped to build on the cost-sharing arrangement that had evolved during the interwar period. Hence, Africans had to pay, both as individuals and through their local authorities, to help extend services to African locations in urban and rural areas.

However, the attempt to push through reforms after the war occurred against the backdrop of a very turbulent period in Kenya's history. African militancy reached its explosive height in the Mau Mau uprising.[1] In addition,

the politics of decolonization and trade unions' agitation for better terms and conditions of service for their members challenged the colonial state to deliver on the critical issues of wages, school places, access to health care, and housing in the townships. Once again, discourses on health care during the 1940s and 1950s mirrored the most fundamental tensions that had characterized British colonial rule in Kenya, as well as the immediate pre-independence challenges that both the citizenry and the state faced on the eve of decolonization.

The attainment of independence in 1963, rather than mark the end of the various policy debates of the 1940s and 1950s, reignited them as the postcolonial state sought to assert control over the key sectors: the economy, health, and education. Moreover, the postcolonial period has also seen the subject of health care delivery caught in the larger discourse of the role of international financial institutions and donor agencies in the formulation and implementation of domestic policy by the sovereign state. Thus, this chapter is divided into four sections reflecting the transitions and anxieties in the period after 1940.

The first section examines the development of health care during the period of political transition from colonial to postcolonial Kenya. The section is set against the backdrop of World War II and the politics of decolonization. The second section explores how, why, and with what consequences the postcolonial state became actively involved in health care development by emphasizing the continuities as well as discontinuities that characterized health care delivery until 1986. The specification of the year 1986 is based on the fact that the government promulgated the *Sessional Paper No. 1 of 1986: Economic Management for Renewed Growth,*[2] which was a retreat from the principles that had been outlined in the *Sessional Paper No. 10 of 1965.*[3] Due to external pressure the government was forced to withdraw from its deep involvement in the economy, health, and education due to external as well as internal factors. Thus the third section of this chapter examines the course and consequences of this forced retreat against the backdrop of a weak economy and a collapsing public health care system, which coincided with the AIDS pandemic. The last section focuses on proactive activities and responses to the crises by individuals, the state, and nongovernmental organizations.

The Turbulent Transition: From Colonialism to Independence

As with most wars, the end of World War II was marked by a number of challenges. The demobilized servicemen were more or less unified on the issues of resettlement, jobs, urban housing, educational opportunities, access to health

care and, most important of all, freedom and independence. These were huge agendas, whose realization required commitment, planning, resources, and a reevaluation of previous projects. Opposition to colonial governance crystallized around these grievances and, by so doing, turned the immediate postwar years into a commentary and finally a verdict on the undesirability of colonial governance.

An explicit theme running through the literature on decolonization is that the colonial powers faced very challenging times, in many ways very different from the prewar years. The restive African population, the cash-strapped colonial powers, the influx of people into the urban centers, and the wind of decolonization that was sweeping across the empire seemed insurmountable challenges. As a result, a number of studies have rightly argued that Britain began to invest in social programs in its colonies with a view to stemming the tide of discontent and, by so doing, legitimizing colonial governance during the age of anxiety.[4] Kenya was no exception to this scheme of colonial reinvention. What has so far been missing, in the context of Kenya, is the story of how the discourse on colonial health care reflects this shift in British colonial policy and the controversies that surrounded the financing of the envisioned projects of more health centers and hospitals, public health campaigns, sanitation in urban areas, and housing projects to ease congestion in the African areas of the major townships.

After the war, the science of social medicine in colonial Kenya was redefined in terms of ultimate rather than immediate causes.[5] While the growth of health centers had been a major factor in extending the delivery of services to the rural areas during the interwar years, the new thinking was that the role of health institutions had to be redefined and the dispensaries turned into effective instruments for education and propaganda. Although the dispensaries were sited within the local communities, their influence in preventing the outbreak of disease was, at best, minimal. The medical personnel hardly ventured into educational programs that would help prevent disease. The concerns and lifestyles of their local constituents were not considered critical to the aim of preventing disease outbreaks. In a sense, the local populations were considered as irrelevant until a disease broke out and until some people became sick and went to seek treatment in the health centers. Thus, the work of health professionals revolved around the patients at the health centers.

However, the focus on ultimate factors signified a philosophical shift from the medical paradigm to a blend of the medical and materialist paradigms. In the medical paradigm, health care is primarily the province of physicians, nurses, and other "health personnel."[6] The thrust of policy, under this paradigm, is a disproportionate focus on the training of more and more highly skilled personnel, as well as on the construction of hospitals

and clinics. In contrast, the materialist paradigm sees health care as a collective enterprise that has to be socially and collectively produced.[7] The materialist view is that good health care has to transcend the existence of hospitals, clinics, and skilled personnel. It has to be linked with the general agitation for a better, more equitable, and more humane society.

The policy that the colonial state began to pursue after the war was one that blended these two paradigms: an attempt to strike a balance between the expansion of health care institutions and facilities on the one hand, and an emphasis on a management strategy that focused on the community and on prevention of disease outbreaks on the other. While the health center concept was still considered critical, an attempt was made to avoid multiplying dispensaries for outpatients or increasing the numbers of beds in African hospitals. Thus, while the implementation of social preventative medicine measures lay within the health center concept, the state sought to prevent the health centers from degenerating into enlarged outpatient departments. As a result the public health campaign became an important aspect of the work of health care personnel, particularly health visitors, African health inspectors (AHI), health assistants (HA), dressers, and "mid-wife nurses" (Table 6.1). Phrases emphasizing propaganda and

Table 6.1 Duties of Health Care Personnel

Health Visitor	AHI and HA
• *Home propaganda* • Notification of ill-health • Home details survey • Domestic economy and dietetics • Food preparation and economy • Arts and crafts • School visiting • Cooperation with local population	• Houses: siting, construction, ventilation, lighting, and keeping records • Water supplies • *Disease reporting and control propaganda* • *Nuisance propaganda and control* • Market and trading center construction and sanitary control • Cooperation with particular reference to agriculture
Dresser	**Mid-Wife Nurse**
• Essentially to assist a nurse • Vaccinations, inoculations, and records • *Health propaganda* • Clinics	• Antenatal and postnatal clinics • Child Welfare clinics with Health Visitors • Domiciliary midwifery • *Domestic propaganda* • Cooperation with local population

Source: Medical Department Circular No. 26/50, 18 May 1950, KNA: PH/1/2/1.

cooperation began to feature prominently in the job descriptions of the health care personnel operating at the local community level.[8]

Meanwhile, the campaign in the townships was even more aggressive than the campaign in the rural areas since it was expanded to include easing congestion in the African locations by providing more housing units. The *Report* of the East Africa Royal Commission of 1953–1955 stated that conditions in the townships were quite unsatisfactory and that "Overcrowded and insanitary conditions are a direct cause of ill-health, helping to spread tuberculosis and giving rise to such diseases as malaria and dysentery."[9] The commission agreed that "It was disheartening to see legitimately employed Africans sleeping under the verandas in River Road, in noisome and dangerous shacks in the swamp, in buses parked by the roadside and fourteen to the room in Pumwani, two to a bed and the rest on the floor."[10] It attributed the deteriorating conditions in the towns to poverty, lack of adequate housing, and problems of social development.

The wages of the majority of African workers were too low to enable them to obtain accommodation which was adequate by any standard. Although the 1950s saw both government and local authorities embark on their own separate schemes, the demand outstripped supply, particularly among low-paid workers. The population of Africans in Nairobi, for example, doubled between 1947 and 1958. While in 1947 the population of Africans stood at 77,032, by 1958 it had risen to about 150,000.[11] In 1947 the difference between the population figures and the capacity of the housing available for Africans was approximately 26,000.[12] In addition, most of the housing was aimed at the middle class; a development that saw the townships moving away from the concept of "bed space" toward family housing. The result was the development of slums, where those who could not afford to pay for other types of housing lived without basic amenities.

The outbreak of the Mau Mau uprising in 1952 and the launching of "Operation Anvil" in 1954 temporarily eased congestion in Nairobi as the government held any people believed to be associated with Mau Mau, in any way, responsible for Mau Mau's actions, and punished them accordingly.[13] Thousands of Africans, particularly members of the Kikuyu ethnic community, were arbitrarily arrested and held in detention camps. But it was during the height of the Emergency that the government embarked on massive housing projects.[14] Between 1952 and 1957, the government revealed the great importance it attached to an early solution to the African housing problem by putting the Deputy Governor in control of the general direction of the whole program. The colonial state was warming to the

fact that urban renewal had to be undertaken if the frequent outbreak of disease in the African locations was to be stopped.

Issues pertaining to education, health care, and housing and sanitation, particularly in urban areas, could hardly be dealt with in isolation from the political circumstances of the times. The issues collectively constituted what Cooper has aptly described as the "burden of the declining empire." Addressing the issues was an important step in stabilizing labor and shoring up colonialism. The issues reflected the inequity and inhumanity of colonial society. Throughout the 1950s the urban population continued to swell so much that social projects such as those involving education, health, and housing were no longer considered peripheral. The nationalists interpreted the inadequacy of these projects as the clearest reflection of the social organization that had been nurtured by the colonial state. Thus, as the rights of Africans decreased, due to arbitrary arrests, Africans became increasingly politicized.[15] It is therefore not surprising that the government sought to stem the tide of African militancy both through force, as in "Operation Anvil," and through social programs aimed at improving the welfare of Africans.

Ironically, however, Governor Sir Evelyn Baring rejected the East Africa Royal Commission's recommendation that a high-level expert body be appointed as soon as possible to examine the problems of public health.[16] He argued that there was no need to appoint a high-level expert body, since the country had its own medical experts, and that much information about the needs of the different areas was already available to the Medical Department.[17] Instead, Governor Baring contended that what was needed was sufficient finance.[18] He held the view that the effectiveness of colonial institutions, as well as the effectiveness of medical personnel in delivering services to the citizenry, was hampered by financial shortfall, and not by lack of focus and direction.

Governor Baring's argument contradicts the idea that post-World War II "colonial development" was marked by an unprecedented injection of metropolitan funds into the colonies to help foster social welfare programs. The investment of funds was not uniform across the board. Besides, the injection was only unprecedented in relation to the hitherto minimal investment of funds into the periphery, particularly in such sectors as public health. Thus, although the post-World War II situation witnessed renewed efforts in public health matters, funding for the sector came primarily from funds raised within the country through taxation, or from loans guaranteed by the colonial state, which had to be repaid by the African taxpayer.

The well-intentioned new government approach, focusing on the community by building partnerships through propaganda and education, failed to attain the envisioned goals because of inadequate resources. It is against this setting that the African nationalists looked beyond colonialism into the postcolonial period when they would fight the three "enemies of development": disease, ignorance, and poverty. But that fight turned out to be painful and protracted, graced with only a few periods of hope and optimism.

The Era of Hope and Promise, 1963–1986

Postcolonial Kenya bears the scars of its colonial past at the same time as it has to face the challenges of the present. At independence in 1963, Kenya inherited a health care system that reflected its long colonial history. The health care system was elitist in its orientation, curative in its emphasis, uneven in its geographical distribution, and fragmented into two sectors, private and public/government. The efforts of the transitional years, 1960 to 1965, were halting and uncertain as the postcolonial state sought to assert its authority over the key sectors: the economy, health, and education.

The first decisive step in directing the health care system to a more purposeful and compassionate course was taken in 1965 when the government issued *Sessional Paper No. 10, African Socialism and Its Application to Planning in Kenya.*[19] The *Sessional Paper* provided the basic guidelines for realizing the independence manifesto of reducing poverty and illiteracy and combating disease. The time of the arrival of independence was quite euphoric, if the hopes and desires of the citizenry were anything to go by. Economic well-being, free health care, and free educational services were identified as vital to the postcolonial era. Independence was associated with improvements in the quality of life for the citizenry. The optimism was not without foundation. The colonial state was a lean and mean state on the critical issues of health and education. Access to health care services was not considered a basic right. Health care was framed in the context of the colonial economy and colonial health care was anything but a social welfare scheme. Attempts to recast that image, particularly after World War II, were overshadowed by the turbulent politics leading to independence.

In the colonial society, urban and European-settled areas engaged more of the attention of colonial medical authorities than rural peasant households. More than six decades of colonial rule strengthened the urban areas as economic enclaves. Resources were directed to the urban and high economic potential areas to provide clean water, electricity, and other social

amenities. Urban areas witnessed the growth of more private hospitals, maternity clinics, nursing homes, and ambulance services than did the rural areas. Both the private and the public health care services reflected various emphases as well as the contradictions that attended the provision of health care services in colonial Kenya.[20]

The private sector comprised the missionaries, private trusts, and individuals in the business of health care. The missionary health care system was itself not a unified system since it followed a denominational pattern. The establishment of mission hospitals and dispensaries depended on the following that the church had in a particular locality. The significant aspect of this type of health care is that it was mainly rural oriented since the majority of the people from which the denominations drew their supporters were in the countryside. This system was therefore accessible to the rural population. The personnel managing the health facilities were mainly white missionaries. Meanwhile, the provision of government/public system facilities was quite sparse in the rural areas.

The pyramidal structural arrangement of health care management and delivery was inherited intact from the colonial era. At the apex of this structure is the national referral Kenyatta Hospital in Nairobi, which also serves as the provincial hospital for Nairobi area, and which from 1970 doubled as a teaching hospital for the University of Nairobi. At the second level are the provincial hospitals, which are located at the provincial headquarters. Below the provincial hospitals are the district hospitals. The pyramidal arrangement was meant to ease congestion at the national and provincial hospitals. Except for emergency cases, all cases sent to the national and provincial hospitals were, in theory, to pass through the district hospitals. The medical personnel at a district hospital included a physician, a number of registered clinical officers, nurses and nursing assistants, and an administrative officer. As the person in charge, the District Medical Officer had managerial authority over all the health institutions, facilities, and personnel in the district.

The health centers and the dispensaries served as the critical connections between the local community and hospital-based medical care. They were the ideal locations and sites for dialogue with the patients. It is not surprising, therefore, that the health centers provided the primary location at which curative and preventative services were coordinated at the local level. The medical personnel at the health centers and dispensaries responded to the spontaneous demands of the community during sickness or epidemics. A health center would consist of one preventative and one curative clinic bloc with supporting services and an inpatient block with twelve

beds. In addition one medical assistant, four community nurses, one health assistant, one or two family planning field workers, one statistical clerk, and an attendant would constitute the main staff members at the facility. The employment of a statistical clerk was crucial because one of the major impediments to addressing health care concerns was lack of data from the field. Hence, the work of the clerk was aimed at strengthening the Epidemiological Unit in the ministry, which was charged with the responsibility of collecting data. Below the health center would be a health sub-center and then a dispensary. While a sub-center would have clinics and supporting services like those of the health center but no inpatient block, a dispensary would have one clinic block and service facilities.

The deployment and the availability of personnel were and still remain critical factors. Reflecting the pyramidal structure, qualified medical personnel are few and unevenly distributed. The majority of physicians are based in Nairobi and their numbers decrease as one approaches the base of the pyramid, with very few, perhaps one or two, at each district hospital. The irony, however, is that the majority of the people live in the rural areas, while the quality of health care tends to deteriorate as one moves away from the major urban centers.

Although at independence the government in theory professed a socialist ideal, in practice it was committed to liberal economic policies. Nevertheless, in the key sectors of health care and education, the government's approach was quite pragmatic, as it rejected the capitalist approach in which the private sector would be allowed to assume dominance. In the same vein, neither would market forces be allowed to directly determine accessibility to health care.[21] The government, however, was unwilling to wholeheartedly embrace socialized medicine. The private health care providers, trusts, missionaries, and individuals, would be allowed to be partners in the provision of health care services. The attainment of universal free public health care was to be a gradual process dictated by the availability of financial resources. Tom Mboya, then Minister for Economic Planning and Development and the General Secretary of the ruling party, KANU, articulated the government's position in the following words:

> It is the policy of the government to move progressively towards the elimination of school and medical fees. But to shout about these things without considering their full implications is merely to play politics and to try to exploit the ignorance of our people. . . . As we increase our revenues from taxes so shall we move quickly to creating the foundations for a welfare state which we all desire.[22]

Mboya's statement epitomizes the intense debates on the idea of the "welfare state," the foremost topical issue of the 1960s in Kenya. A number of development issues revolved around the role of the state in national development.

The postcolonial state, like its predecessor, was not a monolithic institution. While there was general agreement on the need to strengthen the role of the state as the provider of free health care services, there was disagreement on the pace of implementation. The radical wing of the ruling party, KANU, wanted immediate implementation. The moderate wing of the party wanted a gradual approach. Tom Mboya's assertion, therefore, was an affirmation of the official party position as well as a response to the radical wing of the party.[23] The instructive point, however, is that the postcolonial state defined health care as a basic necessity for which the state was to shoulder the financial responsibility. The first concrete step in attaining this goal was realized sooner than had been expected when the government introduced free medical services for outpatients and all children in 1965.[24] Examined within the turbulent politics of the period that later led to the formation of the opposition party, the Kenya Peoples Union (KPU), the political pressure from within KANU must have been a determining factor in the decision of 1965, for the obvious purpose of denying the radical wing of the party the opportunity of accusing the moderates of perpetuating the colonial legacy.[25]

Whatever the other factors contributing to the decision, it is significant that the government did not relent until the mid-1980s in its declared policy of being the premier provider of medical services to the citizenry. The various development plans best illustrate this commitment. The 1966–1970 Development Plan was an ambitious one in relation to the health sector. It emphasized curative services. More health centers were planned for the rural areas with a view to addressing the imbalance in the quality of health care between the various districts in the country. It also sought to intensify staff training in order to alleviate the shortage of doctors, nurses, midwives, and other trained medical personnel. Recognizing the unevenness in the distribution of both private and government hospitals, the plan also sought to increase the number of public hospitals and other health facilities as well as to increase aid to nongovernment hospitals through provision of grants. Disease control also featured prominently in the plan. The eradication of sleeping sickness and control of malaria, leprosy, and tuberculosis were high priorities on the governmental agenda.[26]

Three major developments graced this ambitious plan and helped in the realization of some of its targets. The development of Harambee dis-

pensaries and health centers became a major aspect of the provision of health care. The concept and spirit of Harambee, which meant pulling together resources and financing the construction of health and educational facilities based on individual contributions as well as communal contributions according to ability, was not new. As this study has shown, individual and community participation in the development of health care facilities had been in place since the 1920s.[27] What was new was the intensity of individual and community involvement. It became the state's means of identifying with local communities in a wide array of development projects in the rural areas. The money was contributed directly to the project and not to the local authority. Harambee became institutionalized as a major developmental rallying force in postindependence Kenya. Numerous schools and health institutions would be constructed in the country through Harambee efforts.

Despite the Harambee efforts, the problems that plagued individual- and community-financed development not only persisted but intensified as politics became intertwined with development. Economically vibrant regions, as well as politically well-connected ones, enjoyed advantages over areas that lacked comparable wealth and were not politically supportive of the ruling elite. The upshot of this was that rich county councils (previously "native" councils) were able to mobilize their local populations to establish more health centers, a development that was beyond the financial reach of poor councils. This perpetuated the unevenness that had characterized the colonial health care system. Also, as ethnicity came to occupy a central place in the allocation of resources, areas that were less well endowed with resources and were considered not politically supportive of the regime in power lost out to the ethnic groups and regions that did support the regime. Harambee projects under both the first President, Jomo Kenyatta (1963–1978), and his successor, Daniel Arap Moi (1978–), were not immune from ethnic and political considerations. The construction of "Nyayo wards," particularly in the 1980s, under Moi's leadership increased the number of health care facilities in the country, but hardly addressed the imbalance.[28]

The problem of unevenness is manifested in the disparities among various regions in terms of such key indicators as access to education and clean water, and infant mortality rates. Attaining low infant mortality rates is a multidimensional accomplishment that does not depend on the activities of the Ministry of Health alone. Access to fresh water for drinking, a developed communication infrastructure that will enable patients to reach health centers, and high literacy levels, which largely depend on the avail-

ability and accessibility of schools, are critical in reducing infant mortality rates. However, all this depends on the internal allocation of resources to various regions by balancing economic and social needs. In low-income economies such as Kenya, resources are scarce and subject to bureaucratic and ethnic manipulation.

The external factor brought into the health care sector by the international agencies is another vital aspect in the development of health care in postcolonial Kenya. The deep involvement of international agencies such as WHO, UNICEF, UNDP, IPPF, USAID, and DANIDA in various health care projects provided much-needed financial, human, and material support for a wide array of programs ranging from those combating specific diseases such as measles, whooping cough, and smallpox to the major preventative projects of providing clean water and training of personnel for the promotion of primary health care, particularly from 1978 onward. The enhanced investment in preventative and curative health care by international bodies and agencies was a result of the World Health Organization (WHO) conference held at Alma-Ata in the Soviet Union in 1978. The conference identified primary health care including immunization, nutrition and food supply, water and sanitation, drug supplies, and health education as the strategy for achieving WHO's goal of "Health for All by the Year 2000." In order to actualize this WHO goal, the government set up the Kenya Expanded Program on Immunization (KEPI) to better coordinate the immunization exercise along the lines agreed at Alma-Ata. The global consensus on the broad parameters of primary health care for all helped to mobilize financial resources, which allowed for expansion in the areas of infant and communicable diseases.

It is not surprising, therefore, that health issues attracted a number of international agencies, thereby easing the burden on the government, which by the mid-1980s was providing nearly 60 percent of recurrent expenditure in health care. The rest was left to churches and other private concerns, including international agencies. The government as early as 1970 transferred responsibility for health services from the various agencies to the Ministry of Health. The transfer was meant to bring about closer supervision and integration of all services by the Ministry of Health and not to circumscribe the activities of the private sector or the international agencies in health care. Henceforth, the ministry would coordinate assistance. In essence, the role of international agencies became institutionalized as an important means to the realization of the health care agenda. What this meant was that the country would benefit from this working partnership so long as the relationship between the government and the international

agencies remained cordial and sustainable through policies acceptable to both.

The third factor that facilitated the success of the government in ridding itself of the lean and mean image that was associated with the colonial state was the vibrancy of the economy, particularly during the 1960s and 1970s despite occasional downturns. The buoyant economy that characterized the first decade of independence enabled the government to devote quite substantial resources to health care. According to the 1975 *World Bank Report* the real growth rate in GNP between 1965 and 1970 was 8.2 percent per annum while the domestic savings rate averaged 15 to 20 percent of gross output.[29] The overall impact of this economic buoyancy was that the budget showed a surplus of receipts over expenditures. Against this economic setting, it is significant to note that both the recurrent and development expenditures of the Ministry of Health increased tremendously. From 1960/61 to 1968/69 the recurrent expenditure of the ministry rose from K£2.6 to K£4.6 million, while the development expenditure rose from K£141,000 in 1963/64 to K£872,000 in 1967/68.[30] All in all, the accomplishments of the postcolonial state were remarkable if the number of hospitals and personnel are anything to go by (see Tables 6.2, 6.3, and 6.4).

The number of health care facilities increased tremendously beginning in the 1970s. As Table 6.2 demonstrates, the number of hospitals, health centers, and dispensaries more than tripled between 1973 and 1992. Similarly, Table 6.3 shows that the number of medical personnel increased over the same period. Although the number of registered personnel per 100,000 people is still far from adequate, the gains reflect governmental as well as private efforts in the training of medical personnel. Meanwhile, Kenya's population tripled between 1963 and 1999. Rising from not more than 9 million in 1963, the population of Kenya is now estimated at 31 million. But the spatial distribution of this population shows that the majority of Kenyans still reside in rural areas (see Table 6:4).

Table 6.2 Increase in the Number of Health Care Facilities in Kenya, 1973–1992

	1973	1983	1992
Hospitals	132	216	301
Health Centers	131	288	477
Dispensaries	735	1,717	2,637

Source: Republic of Kenya, *Development Plan, 1994–1996* (Nairobi: Government Printer, 1994), 33–34.

Table 6.3 Registered Medical Personnel per 100,000 Population, 1978–1992

	1978	1979	1983	1984	1988	1989	1991	1992
Doctors	9.50	10.07	12.60	13.26	13.75	14	5.10	15.00
Registered Nurses	41.41	42.76	45.52	46.91	43.65	44	44.80	46.90
Enrolled Nurses	52.36	54.36	54.15	61.06	61.38	65	81.70	82.90
Clinical Officers	9.46	10.03	10.23	10.24	10.74	11	11.70	11.80

Source: Republic of Kenya, *Development Plan, 1994–1996* (Nairobi: Government Printer, 1994), 34.

Table 6.4 Distribution of Population between Rural and Urban Locations (in Millions), 1990–2000

	1990	1995	2000
Urban Population	4.07 (18%)	5.28 (19.2%)	7.44 (23.4%)
Rural Population	19.43 (82%)	22.2 (80.8%)	24.36 (76.6%)
TOTAL	23.6	27.5	31.8

Source: Republic of Kenya, *National Development Plan, 1997–2001* (Nairobi: Government Printer, 1997), 75.

Indeed, until 1986 and despite economic constraints, there is no doubt that the efforts of the government in the health sector were generally successful. As Table 6.5 illustrates, various improvements had been achieved by the government in areas such as increase in lifespan, decline in infant mortality rates, and decrease in crude death rates. Meanwhile, the number of doctors and hospital beds and cots increased more than fivefold between 1963 and 1992. However behind these statistics there are problems that the government has addressed with varying degrees of success over the past

Table 6.5 Some Indicators of Health Care Growth, 1963–1992

	1963	1992
Lifespan	40	60
Infant Mortality Rate per 1,000	126	74
Underfives Mortality Rate per 1,000	211	104
Crude Death Rate per 1,000	20	12
Doctors (Numbers Available)	339	3,550
Hospital Beds and Cots (Numbers Available)	6,708	34,000

Source: Republic of Kenya, *Development Plan, 1994–1996* (Nairobi: Government Printer, 1994), 229.

four decades. Besides the already outlined uneven distribution of health facilities in the country and the shortage of manpower, some of the problems included a high average population growth rate of nearly 4 percent per year and a rapid expansion of urban centers at about 6 percent per year.

The 1970–1974 Development Plan detailed the approach to be adopted in attaining effective maternal and child health care and family planning services. The training of community nurses was to be intensified. Immunization programs were to be expanded to cover all districts. Meanwhile, the high population growth rate was to be curbed through voluntary means by increasing awareness among the population. The government thus strengthened the National Population Council to coordinate the approach to population issues. Population officers were posted to some districts. Similarly, the government strengthened the National Department of Adult Education. This department was charged with the responsibility for improving adult literacy, which was viewed as one of the main ways of increasing awareness of family planning and population issues, as well as making public health campaigns effective. In all these measures, the government had the financial support of nongovernmental organizations within and outside the country. Nevertheless, voices of dissent came from the Catholic Church and related organizations on the specifics of some methods that the state pursued, particularly in the area of family planning. The major bone of contention surfaced when the state sought to include the use of contraceptives as part of the population planning campaign. The Catholic Church emphasized natural methods of family planning and rejected outright the use of contraceptives and other related methods and devices as unnatural and likely to promote promiscuity. Nevertheless, the major population campaigns coupled with the onset of the AIDS epidemic have led Kenya's population growth rate to stabilize at about 3 percent.[31]

The government's emphasis on preventative health care programs received a boost with the shift to the District Focus for Rural Development.[32] When President Moi launched the District Focus for Rural Development in 1982, he sought to dismantle the top-down organizational approach to development in which Nairobi, as the capital, constituted the nerve center where most development activities were initiated and coordinated.[33] In this system, the ministry headquarters coordinated the planning and implementation of most health projects with the various districts as junior partners in that endeavor.

The shift to the District Focus for Rural Development was intended to democratize the delivery of services to the rural population by empower-

ing them as active participants and to reverse the perception that they existed merely as consumers of services designed and delivered by Nairobi without their input. The program basically introduced a decentralized form of planning in which the district would become the focal point of the planning and implementation of the projects within its jurisdiction. As a bottom-up approach, the concept was not new. Its history dates back to 1965 when District Development Committees were formed, followed a year later by the establishment of the Special Rural Development Program. However, what made it more forceful was the firm political support it was given by President Moi when, in June 1982, he directed that "From now on money will be allocated to each district and planning will be done at the district level. Each district will spend its allocation as outlined by the District Development Committee."[34] What this meant was that the District Development Committees, which had since the 1960s been operating as extension agencies of the ministries, would now occupy a central place in developing the districts. They would not only produce their own development plans, but would prioritize and supervise the projects as well.

One of the areas that the District Focus for Rural Development impacted enormously was health care. In accordance with the shift to District Focus, the government allocated a large amount of funds to the medical facilities in rural areas. According to the 1984–1988 Development Plan the recurrent expenditure for rural services was to grow at 15.6 percent, which was faster than any other category of recurrent expenditure. This was primarily aimed at redressing the imbalance between rural and urban health facilities. Coupled with the construction of Nyayo wards in various districts, there was a move aimed at easing congestion in the district hospitals. It is arguable that the impact of the District Focus for Rural Development was beginning to be felt just at the time when it faded due to both internal and external contradictions.

The major internal weakness of the District Focus for Rural Development was that the districts had no control over tendering for drugs and for other equipment necessary for the expansion of the health care infrastructure at the district level. All this was still controlled from Nairobi. Thus the legal and financial restructuring needed to ensure the success of the strategy and the realization of its objectives was not carried out. In addition, the funds to be disbursed from Nairobi were subject to political and ethnic manipulation. The conflict also stemmed from an all-powerful President who would direct the ministry to undertake a project, at the request of a

local political broker, without consulting the relevant officials in the ministry to ensure the availability of funds. Some projects had neither been planned nor provided for in the national budget. Districts were only nominally in control because they did not have their own independent sources of revenue.[35] They still relied heavily on the central government. The financing of Harambee health facilities also became politicized as the Ministry of Health became unofficially "duty-bound" to donate money to all Harambee fund-raising functions presided over by the President. With a weak parliament and a timid judiciary, financial scandals involving health equipment or delivery of drugs were hardly investigated, despite revelations by the Controller and the Auditor General. Thus corruption and lack of financial autonomy began to bite from the late 1980s, when the Central Medical Stores in Nairobi were reduced to a cesspool of corruption. Drugs disappeared, and it was not uncommon for funds to be paid out for drugs that were never delivered. Drug shortage began to be a persistent feature in most public hospitals and health facilities. The envisioned bottom-up approach was not entirely successful, therefore, primarily because the policy called for reform and democratization in the culture of financial management that the Kenyan leadership was unwilling to institute because it would undermine its control and its disbursement of resources according to the loyalty exhibited by a region, district, or influential local power broker. In essence, the projected reforms went beyond the sphere of health care. They were deeply involved in the politics of state control and patronage.

The problems could not have arisen at a worse time. The external funding that had become institutionalized as part of the health care budget began to dry up, following external pressures exerted on the government to abandon its compassionate position as the major financier of public health care. Instead, the government was advised by the International Monetary Fund (IMF) and the World Bank to institute cost-sharing in health care services as well as other wide-ranging economic reforms or lose external funding for its programs. Thus health care came to be drawn into the orbit of the politics of economic reforms in what were packaged as Structural Adjustment Programs (SAPs). The state was forced to retreat from its compassionate welfare agenda to a market-oriented approach. The irony, however, was that the market was not only quite unstable, but also unfavorable to the developing countries. In essence, it was anything but democratic. The externally prescribed market approach became highly contentious at the level of implementation.

The State on the Retreat: Reliving the Past in the Emergent Present

Sessional papers as political and economic policy statements by the government are emblematic of the state of the economy and the political developments at a specific time. If *Sessional Paper No. 10 of 1965* signified a commitment to the basic fact that health care is a right that the state must protect, *Sessional Paper No. 1 of 1986* undermined that commitment.[36] *Sessional Paper No. 1* was a step backwards, particularly with its emphasis on cost-sharing, which weakened the bond between the state and its citizenry over basic services such as education and health care since the government was forced to retreat from its benevolent posture as well as its deep involvement in the provision of social services.[37] This was an indirect return to the lean and mean policy of the colonial state on health care. The government levied inpatient as well as outpatient fees for services rendered in government hospitals. The amount was far less than the amount that was charged in private and mission hospitals. But the economic conditions that coincided with the introduction of fees made the levies a painful experience with an adverse impact on the public health system.

These externally induced changes in health care cannot be examined effectively without considering global economic forces. In the early 1980s, publicizing the benefits of a free enterprise system became a major theme in the agenda of the industrialized countries, particularly in their approach to the question of aid to Third World countries.[38] The Third World countries argued for the democratization of the international economic system to ensure more direct aid to poor countries, access to markets in the rich states for poor countries' products at fair prices, and international financial and economic institutions that would be more responsive to their plight.[39] The developed world, particularly the United States and Britain, rejected these arguments. Instead, they directed the focus to the structure and performance of the economies of Third World countries.[40] The debate began to revolve around what Khapoya has aptly described as the "magic of the marketplace."[41] The developed world's argument was that there was nothing wrong with the international economic system and that since it had worked for the developed countries, it could work for the developing countries as well. The Third World countries were advised to restructure their economies and to embrace and institutionalize the magic of the marketplace as an invaluable means of curing their economies of the persistent ailment of underdevelopment.[42]

The problem with this externally prescribed measure lies in the sponsors' choice of ideas and ways of knowing. It was premised on the mistaken view that what is successful in one country must also be successful in another, whatever the cultural, economic, and political differences. There is no doubt that some of the developing countries were bedeviled by overbureaucratization, corruption, state-managed parastatals, and a lack of vibrant democratic political structures, all of which combined to undermine meaningful economic growth.[43] Nevertheless, African countries were haunted by their colonial past, harmed by the bipolar Cold War world order, and pressured by international economic forces.[44] They had not been the sole masters and shapers of their own destinies. They were very much a part of the global system. Thus, instituting the Structural Adjustment Programs without looking at the historical experience of African countries, as well as the domestic constraints on and challenges to such key social sectors as education and health care for the vulnerable sections of the population, caused severe and relentless suffering for the majority of the citizens who had no safety net to fall back on.[45] In actuality, there may have been nothing wrong with the general principles behind the Structural Adjustment Programs. It was the inhuman features that they exhibited, together with the manner and pace of their implementation, that constituted the issue.[46]

Health care became one of the areas heavily impacted by deep cuts in spending. Government's allocation of recurrent expenditure for health in 1996/97 was 9.6 percent. This was the highest allocation since 1980/81 when it was 9.82 percent. In the 1979/80 financial year the recurrent expenditure was 9.26 percent.[47] Meanwhile, per capita expenditure declined by 36 percent in U.S. dollar terms between 1980 and 1996.[48] If inflation and population increases over the preceding fifteen years are taken into account, this was far from satisfactory. Meanwhile, by 1996 the government was providing approximately 43 percent of the funding and the remaining costs were being shared among religious organizations, other nongovernmental organizations, and private providers.[49] The partnership between the state and other agencies had latent aspects that are instructive in revealing the areas of focus of both the state and other funding agencies.

The state and the agencies tended to have their own areas of emphasis, although they were quite complementary: "while nongovernmental providers focus on curative measures with limited provision of preventive services, Government provides preventive, promotive, curative and rehabilitative services, and other essential public health activities with limited provision of preventive services."[50] If the political and economic domestic and external factors of the 1990s are anything to go by, inherent in

Table 6.6 Projected Financing of the Budget Deficit, 1993/94–1996/97

	93/94	94/95	95/96	96/97
Total Deficit	938.1	418.8	0.0	0.0
Financed by External Loans	484.2	418.8	62.0	61.0
Net Internal Loans	453.9	0.0	162.0	161.0
Loans Memorandum Items*				
Gross External Loans	1,447.5	1,439.0	200.8	277.5
External Loan Redemption	963.3	1,020.2	1,038.8	1,166.5
Deficit % of GDP at Market Prices	5.1	1.9	0.0	0.0

*Heading as in original text.

Source: Republic of Kenya, *Development Plan, 1994–1996* (Nairobi: Government Printer, 1994), 63.

this partnership between the state and non-state organizations are a number of problems which impact the delivery of health services.

From the early 1990s, government revenues began to dwindle because of the weakening economy which was caused by corruption, by the ethnic violence that undermined the tourism industry, which had been the foremost foreign exchange earner, and by disagreement between the government and the donors over the issue of political and economic reforms. As Table 6.6 shows, the government had been highly dependent on external loans. The government's failure to secure such loans to finance its expenditure forced it to resort to domestic borrowing, which resulted in a depressed economy. By 1996, the public health sector was in a state of decay since "70 percent of the recurrent health budget was tied to staff emoluments, leaving only 30 percent for supplies."[51] Political and economic factors had coalesced and adversely impacted the ability of doctors to render service to patients because of lack of supplies. Most dispensaries and hospitals lacked basic drugs. Even when such drugs reached the dispensaries and hospitals, it was not uncommon for them to be sold to private clinics. Indeed, the doctors' strike in 1996 was as much a verdict on the general state of the public health care system as it was an issue of pay.[52]

But the dislocation of health care, particularly in the rural areas, is also a product of the preferential treatment that urban populations enjoy over their rural kin. The 1997–2001 National Development Plan decried the imbalance in the allocation of the available resources between the urban and rural areas in the following words:

> With respect to distribution, curative care accounted for a projected 67 percent of total recurrent expenditure for 1996/97 while rural and preventive health care accounted for 21 percent. This expenditure mix discriminates against rural and poor populations. With respect to the allocation of expenditure, the Kenyatta National Hospital (KNH) accounted for 16.3 percent of total recurrent expenditure, while all rural health centres, the first point of contact for rural populations, accounted for 21 percent. Hence, health expenditures clearly favour the urban areas.[53]

Thus, the budget of Kenyatta National Hospital alone is close to the total allocation to rural areas, where 80 percent of the population live. Thus because of lack of sufficient funds, the preventative, curative, and rehabilitative services that the government used to provide have been neglected. Meanwhile, the non-state organizations within the country, churches and private trusts, do not deliver their services free. Patients pay their way into these hospitals. The private hospitals are fairly expensive and outside the reach of most patients. Yet the economic crunch hit the poor more than any other group since these adverse developments occurred against the backdrop of retrenchment, a key demand of the IMF and World Bank as a condition for aid resumption. The irony, however, is that the corruption that characterized government's divestment from parastatals left many workers out in the cold. Worse still, most of the workers could not even retrieve the contributions which they had invested with the National Social Security Fund (NSSF) because the fund has been the subject of major financial scandals involving politicians and bureaucrats. The poor, whether in urban or rural areas, were subjected to the misery brought on by the triad of SAP, corruption, and a scarcely surviving public health care system.

Meanwhile, the non-state agencies have not succeeded in filling the gap left by the retreating state. In fact, the partnership that had characterized the two until the mid-1980s was compromised by clouds of mistrust that appeared against the backdrop of demands for political and economic reforms, particularly with the shift of emphasis to nongovernmental organizations as a partner to government in development projects. The nongovernmental agencies received most of their assistance from the countries that were pressurizing the government to institute reforms. Since this pressure coincided with donors' emphasis on the need to promote nongovernmental organizations in order to facilitate development and escape corruption in the high echelons of government, state support for direct funding to such agencies became the subject of criticism by the leadership of the country. The leadership saw the invisible hand of subversion in direct aid,

particularly from Western countries, to the nongovernmental agencies. In response, the government sought to assert its authority over such agencies with a view to controlling their activities. A critical look at the performance of the nongovernmental organizations clearly demonstrates that they have been ineffective as an alternative to the government in matters of medical services.

The nongovernmental organizations perform best when the government is also at its best. Their roles are complementary. Neither can replace the other. Neither can one exhibit vibrancy in the face of a weak other, particularly during times of economic stress. It is their combined efforts that were instrumental in the gains of the first twenty-five years after independence. And if there is any lesson that has been learned over the last decade, it is that the role of the state in the public health system is critical in a developing country such as Kenya where 46.4 percent of those in the rural areas and 29.3 percent of the urban population live below the poverty level.[54] Privatizing health care services and expecting to achieve gains through the magic of the marketplace or nongovernmental agencies that are not accountable to either the citizenry or the state makes little economic or social sense. The magic of the marketplace only accentuates misery. Thus, even though the private hospitals have continued to exist as enclaves of excellence in the midst of an ailing public health care system, only a small fraction of the population is capable of paying for treatment in the private hospitals. The public health care system is trapped in an engulfing economic crisis and the politics of external funding.

It is not surprising, therefore, that the gains of the first twenty-five years of independence are under siege and threatened, mainly by poverty and AIDS. Infant mortality rates have begun to spiral, the lifespan is projected to decrease nearly ten years by 2010 unless the spread of the AIDS pandemic is arrested and opportunistic infections such as tuberculosis and preventable, vector-borne diseases decline. Indeed, the concurrence of the tumultuous economic and political changes with the onset of the AIDS pandemic and its ravaging effects show how the magic of the marketplace can be quite irrelevant to issues of life and death. Table 6.7 shows the actual figures for AIDS cases for the years 1990 and 1993 and the projected numbers for 1994, 1995, and 1996. However, by 1996, the government asserted that the prevalence rate of 7 percent was expected to rise to 10 percent by the turn of the century.[55] By 1997, HIV prevalence as a percentage of the 15–49 age group population stood at 11.64.[56] Meanwhile infant and child mortality rates are on the rise because of the pandemic. Child mortality rates stand at 53.9 per thousand with AIDS, while without AIDS the

Table 6.7 HIV Positive Population and AIDS Related Deaths by Age, Sex, and Rural/Urban Locations, 1990–1996 (in Thousands)

	1990	1993	1994	1995	1996
HIV Positive Population					
Rural	151	284	334	383	428
Urban	298	558	655	752	842
Male	244	457	537	617	689
Female	205	387	452	518	581
TOTAL	449	841	989	1,135	1,270
HIV Related Deaths					
Rural	7	15	19	25	30
Urban	13	29	37	46	56
Male	11	24	30	38	56
Female	9	20	26	33	40
TOTAL	20	44	56	71	96

Source: Republic of Kenya, *Development Plan 1994–1996* (Nairobi: Government Printer, 1994), 255.

number drops to 32.9. The under-fives' mortality rate is 105.2 per thousand, while without AIDS the rate drops to 45.4.[57] But the impact of AIDS is not only reflected in infant and child mortality levels. AIDS is also blamed for the high worker attrition rates by sickness and death.[58] AIDS accounted for nearly 8 percent of the workers leaving the workforce as a result of sickness and death. It is also estimated that AIDS causes the loss of three-fifths of an infected person's productive life, or approximately twenty-two years. It is further estimated that the total direct and indirect costs of AIDS to the country could be as high as 15 percent of the Gross Domestic Product.[59] The impact of the pandemic on the general health care infrastructure cannot be overemphasized. More opportunistic infections related to AIDS, as well as more hospital beds being occupied by the victims of AIDS, fueled by economic downturn and attendant hardship, constitute major challenges for the state, the citizenry, and the nongovernmental organizations.

Coping with Poverty and Diseases

The struggle to alleviate poverty and the fight against AIDS are the two crises that touch every soul and household in Kenya, either directly or indirectly, at the dawn of the new millennium. Coping with these challenges has invigorated discussion of the colonial past, the relevance of the

postcolonial state, and the significance of tradition and culture in contemporary society. These memories are varied because the experiences of informants looking at the same society varied according to age, economic status, profession, and gender. Even so, there are overlapping anecdotes, which blur any strict dichotomization.

Most of the informants interviewed for this study agree that the economic downturn and AIDS have been major factors in morbidity and mortality in Kenya. People die from preventable and curable diseases such as malaria and cholera. But many also succumb to AIDS. Thus while the focus is on AIDS, and rightly so, the victims succumb to death sooner rather than later not so much because of AIDS *per se,* but because of their inability to fight opportunistic infections through a good, balanced diet and access to drugs that can provide relief of symptoms. In this regard, incomes and the availability of services and drugs at local health facilities are critical factors. In the context of the health care system, the focus has not only been on the number of facilities but also on their accessibility, as well as the quality of services offered at the facilities that are available. A wide array of questions pertaining to the role of the postcolonial state in equipping the health facilities and the general development of infrastructure, particularly in the closing decade of the twentieth century, beg for answers.

Susana Obunga Omulo, now about eighty years old, sadly reminisced about how the times, and indeed the world she has known, have changed:

> When I was growing up we used wheelbarrows in a number of agricultural and household chores. How things have changed! These days we seek wheelbarrows neither for agricultural nor household chores, but as a medical necessity for emergency cases. That is our main transport facility for patients to the hospitals. Unlike bicycles, they are more "comfortable" means of taking patients to the hospitals, where they can hope to get some help. You know with a patient, you must never give up hope.[60]

The distance to a health facility and the means of reaching it are critical issues. Many people must travel several kilometers to reach the nearest health facility.[61] The "wheelbarrow factor" speaks to the collapsed road infrastructure in most rural areas with the result that vehicles can hardly reach remote places. Furthermore, the four-wheel drive vehicles that used to be available at the health centers during the good economic times of the 1960s, 1970s, and early 1980s are permanently grounded. While the transport infrastructure has been examined in relation to the agrarian economy, very little attention has been paid to the correlation between the collapse of the

road infrastructure and the delivery of health care services. The inability to reach a health facility fast enough has resulted in deaths that could otherwise have been prevented.

But reaching the hospital is just one step on the long road to seeking and obtaining effective therapy. Even if the patient reaches a health facility, the lack of availability of services and drugs constitutes another major problem in contemporary Kenya. While medical personnel are normally available at the health facility, the patient's relatives must be ready with money for such varied items as kerosene and prescriptions. A number of my informants asserted that the medical personnel are quite willing to help, but they lack basic drugs and the equipment they need to meet patients' needs. Yet, and notwithstanding these shortcomings, many patients still see the hospital as a site where they can be provided with relief. This is because the majority of those who have to be taken to hospitals in critical condition have found treatment at home to be unsuccessful.

Home treatment is generally a blend of traditional medicine and Western biomedical practices. Traditional medicine is provided by family members or, when family members cannot provide relief, a specialist. There are also itinerant "doctors" who readily administer a wide array of injections as part of home treatment. Such itinerant "doctors" also sell an array of medicines, particularly antibiotics. The majority of such "doctors" are retirees from the private and public medical service, including enrolled/community nurses and auxiliary staff. However, it is not unusual to find people who have been apprenticed through a "participant-observer" method administering injections without having undergone formal medical training. The significant point, though, is that patients are referred to the mainstream health institutions after home treatment has failed to provide relief. The purpose of referral, as one informant put it, "is to have the person tested for the precise cause of the ailment."[62] Others are haunted by the fear that the "patient might die in their hands."[63] In the latter case, my informant believed that such a catastrophic incident would weaken the power of his medicine and scare his present as well as would-be patients. In such a case, referral is an act of professional self-preservation on the part of the healer as much as it is an admission that he has failed to offer the necessary remedy and cure. But not all those who are referred to a hospital are convinced that it is the only solution. There is movement to and from hospitals in the search for what works.

Rose Akinyi was born in Kanyamwa in 1980.[64] In 1998, she dropped out of high school when she contracted elephantiasis. With no idea of what she was suffering from, Akinyi visited dispensaries where she received in-

jections and pain-killers. But she did not experience any relief. She had to buy her own disposable needles and syringes, mistrusting the ones that were available in the health centers because of her fear of contracting AIDS, a fear that is a result of the education campaign and the stories that she had heard of people being infected through the use of nonsterile needles. Akinyi had also witnessed the sorry state of the victims of AIDS, their painful, protracted suffering, and the frequency of victims' funerals. But it was not only the specter of contracting AIDS that bothered Akinyi. It was also her constant pain. Her parents did not mind spending money. The problem, she asserts, was that relief was not forthcoming. She was referred to a herbalist, Joshua Okola.[65] Having been under Okola's care for eight months, Akinyi asserts that she is feeling much better and hopes to be cured fully within a reasonable period of time.

Akinyi's case illustrates the fear and optimism that are the two persistent themes in the memories not only of patients but also of physicians, society in general, and the government. The fear stems from the realities of a present that is plagued by poverty and AIDS. However, beyond fear and desperation, there is hope and optimism. But there is hardly any consensus on the means to actualize the hope and optimism. In the case of AIDS, a number of nongovernmental organizations have focused on outdated aspects of tradition and loose lifestyles as the significant factors in the spread of the disease. Poverty as a precipitant factor is a term rarely used in campaigns against epidemics. Ways of alleviating poverty as a means of curbing disease were not even mentioned by the government until 1999. In fact, even the AIDS pandemic was not declared a national disaster until the same year. The correlation between poverty and AIDS has hardly received any serious scholarly attention.

Susana Obunga, for example, sees the major problem not through the prism of AIDS but through the prism of the economy. She asserts that poverty has made most people, both men and women, vulnerable. Young women are forced to choose between moral uprightness and starvation. Both men and women are easily lured into sexual relations or levirate marriages not because of tradition or sexual desire but because of economic need. A woman whose husband, or a man whose wife, has died from AIDS in the city and who is fairly well off economically will not fail to get a partner if she/he still looks healthy. In the same vein, Susana asserts that "a woman will not let her children die of starvation, while she can get money by [any] means." But in this case, Susana appears to miss a fundamental point, which Jane Auma Okola and Jasters Onyango captured in the questions they posed in the course of their narratives.[66]

Jane Auma, a herbalist who practices with her husband, poses the question, "How do you know a person has AIDS?" She asserts that it takes quite some time to produce sufficient evidence to show that one has the killer disease. Auma and her husband Okola contend that they try to treat the symptoms, and when this fails, then they will be inclined to believe that the patient has the killer disease. To their credit, Auma and her husband Okola are firmly convinced that AIDS is a reality and does exist. They assert that it is distinct from *chira*—a disease that exhibits some of the symptoms associated with AIDS such as fatigue, loss of appetite, the wasting away of the body, and eventually death. *Chira* is caused by a combination of non-specific factors, of which violation of certain prescribed societal taboos reign supreme.[67] As opposed to AIDS, the couple concurs that *chira* is curable. AIDS is not.

Jasters Onyango believes that although AIDS is incurable, its causes cannot be entirely distinguished from the causes of *chira.* The victims must have violated some societal taboos, whether by engaging in unwarranted sex or refusing to heed moral prescriptions. He supports his view by the fact that *ayaki,* as AIDS is now known, was initially a disease of the elite, *jonanga,* [68] who thought there was "some good out there to be gained by distancing themselves from their culture." In a reflective mood he notes:

> When I was growing up most of the people who died were old people or very young kids. These days they are not the very old. They are those who are still young and strong. During those years, they would be the leaders. Look at what has happened to this our land. Grandparents are now parenting their grandchildren. You young people have abused and abandoned our ways.[69]

These narratives present a complex picture that weaves together the past and the present and shows a world in which epidemic symptoms and diagnosis, economy, culture, and morality are inextricably linked.

In the second chapter of this work, I discussed how the concurrence of many epidemics with the dawn of British colonialism raised questions about specific epidemics, their causes and spread, and their diagnosis and symptoms. I also raised questions about apprehensions pertaining to the role of hospitals and laboratories in the Western biomedical therapeutic process. Those questions are as relevant in this new millennium as they were at the beginning of the twentieth century. How is AIDS distinguished from other diseases that exhibit more or less the same symptoms, particularly during the early stages? How can the distinction be communicated to a lay person, not just so that he or she can comprehend the diseases, but

also so that he or she can detect them? Is it possible to identify a person with the HIV virus during the incubation period? What is the role of traditional therapies in the fight against AIDS? Can the subaltern voices be heard and incorporated into the campaign strategy?

Some men and women who are HIV positive but have not developed AIDS engage in sexual liaisons without their partners realizing the danger they are being exposed to. Also, surviving spouses of AIDS victims sometimes continue to appear healthy and hence give the erroneous impression of being uninfected. Consequently some people march to their deaths through "sex" unknowingly and prompted primarily by a need for economic well-being, rather than mere lust for sex. Even where an individual has been diagnosed as HIV positive, the privacy of the individual's health record is often invoked. In essence, therefore, the very nature of the disease, its diagnosis, prognosis, and the late development of symptoms constitute major problems for its prevention and containment, particularly when the struggle to meet the basic needs of life is a continuous nightmare.

Rose Akinyi's fear about the hospital and the available instruments such as needles and syringes re-echoes the apprehensions that characterized society-state relations in the opening decades of the twentieth century when biomedicine and the laboratory revolution had yet to win the confidence of the population. If one means of spreading the AIDS pandemic is sexual contact, the other is the inadequate provision of equipment and facilities that would drastically reduce, if not eliminate, the spread of the disease. Indeed, there is also the serious need to recognize that beyond the world of biomedicine there are "itinerant doctors," and hence the availability at affordable rates of items such as disposable needles and syringes, which are prerequisites in any effective grassroots-based campaign against AIDS and other diseases as well.

While certain aspects of tradition such as levirate marriages and polygamy undoubtedly contribute to the spread of the epidemic, it is a mistake to focus on tradition to the exclusion of the economic forces that explain the persistence of tradition. Tradition does not exist in a vacuum. No society will hold onto a tradition if that tradition signifies its death. To examine tradition as merely an instinctive attachment to aspects of the culture of the past is unreasonable. It is an easy way out of investigating a complex process. Levirate marriages and leisure sex are less often given as reasons for sexual encounters than is the desire for money. A brilliant study by A.B.C. Ocholla-Ayayo attests to this fact. Table 6.8 shows that, in the study, of all the responses by girls who professed reasons for their involvement in sex with men in their community, economic factors were the most

Table 6.8 Reasons Given by Respondents for Girls Having Sex with Men in Their Community

Reasons	Number of Cases	%
Money (Economic)	4,635	44.8
Gifts (Economic)	989	9.6
Sexual Experience	818	7.9
Leisure (Social Satisfaction)	1,128	10.9
Love (Socio-Psycho-Instinctual)	1,010	9.8
Sociocultural Motive	751	7.2
Don't Know	1,009	9.8

Source: A.B.C. Ocholla-Ayayo, "HIV/AIDS Risk Factors and Changing Sexual Practices in Kenya," in Thomas S. Weisner et al., eds., *African Families* Crisis of Social Change (Westport, Conn.: Bergin and Garvey, 1997), 118.

important. The sociocultural motive, which is often emphasized in the campaign, accounted for only 7.2 percent of cases. The numbers lured to levirate marriage by tradition are thus far fewer than those driven by economic need. Thus the increase in the number of new HIV infections is not so much a result of culture, but rather a symptom of the deteriorating economic situation.

While herbalists like Okola, Onyango, and Auma rely on generally vague and unfocused diagnoses that are hardly reliable, they nonetheless have an important role to play in providing ad hoc relief to properly diagnosed patients. There is one area in which their expertise can be harnessed to reinforce governmental as well as nongovernmental activities in coming to grips with not just AIDS but other diseases as well. There is no doubt that herbalists do provide effective herbal medicinal cures for a host of opportunistic infections such as diarrhea, tuberculosis, sore throats, and skin infections among many others. Already, in the face of the fragility of the country's Western health system, traditional medicines are becoming the predominant alternatives. The sale of traditional medicines in the open marketplace, as well as in shops, is quite widespread. Traditional medicines are being sold alongside antibiotics and other manufactured drugs. Local authorities anxious to raise revenue to help finance local services readily issue licenses for the sale of traditional medicines. It appears, however, that the demand for such licenses is partly motivated by the need to raise money for subsistence. Thus it is not uncommon to find young people in their early teens claiming to represent their parents and claiming knowledge of the medicines they sell. The changes in the material base of society are

giving traditional medicine a new lease on life. One point is abundantly clear. Traditional medicine will continue its renewal, potency, and presence in Kenya.

Conclusion

This chapter has identified the attempts by the colonial state to shape the development of public health care during the turbulent period of the 1950s. The attempt of the colonial state to realize its envisioned agenda was handicapped by its inability to invest sufficient funds in the health care sector. Also, the nationalists' demand for independence undermined the state's credibility in resolving the problems it had failed to address during the seven decades of its existence. The issue of health care delivery became enmeshed in the struggles of the 1950s as the nationalists capitalized on the prevalent inadequacies to indict the colonial state for its inability to cater to the needs of Africans. The inadequacies were politicized and presented as manifestations of the failure of the colonial system. It is not surprising that the independence manifesto promised free health care services to the citizenry. Thus the chapter has delved into the ways in which the state in postcolonial Kenya has sought to conceptualize and implement policies aimed at enhancing the quality of public health care. Beginning strongly, the postcolonial state was able during its first twenty-five years to infuse life and compassion into a public health care system that had hitherto been defined primarily in economic terms. The expansion of health care facilities, increase in the numbers of medical personnel, and increase in funding attest to the pragmatic approach of the postcolonial state. The close partnership between the state and the nongovernmental organizations provided the support and partnership that was undeveloped during the colonial era. Indeed, within a relatively short time the results became manifest in many ways: increase in life span, decline in mortality, decline in crude death rates, and availability of more hospital space for patients.

But the chapter is also testimony to the fact that the postcolonial state inherited a health care system whose basic parameters had been molded by nearly seven decades of colonial rule. Consequently, removing the scars from the colonial era entirely was impractical because the postcolonial society had roots which were deeply embedded in the colonial past. The postcolonial society was not a replica of its predecessor. Neither was it an entirely newborn society. It continued to operate within a global world system that still wielded enormous influence over its development policies.

Thus the chapter has shown how by the mid 1980s, the state was forced to yield to the pressures exerted by external forces. Faced with daunting internal economic problems as well, the state was forced to renounce its earlier investment in the economy, health, and education. This forced retreat coincided with the expansion of the AIDS pandemic.

With the state passively disengaged, the chapter has revealed the persistence of questions, ambiguities, and dilemmas that have hovered over public health care in its twentieth-century journey in Kenya, as well as responses from individuals, the state, and nongovernmental organizations. Focusing on AIDS, for example, a number of questions emerged, pertaining to the meaning, diagnosis, and prevention or cure of the disease, that evoked memories of state-society relations during the early days of Western biomedicine in colonial Kenya. In both periods, the study has revealed the assumptions, real and imagined, that have undermined campaign measures against the many diseases that have plagued the population in the twentieth century.

7

CONCLUSION

The construction and crystallization of Kenya from a polyglot collection of communities to a colonial terrain, though gradual and uneven, was brought about by a combination of force, diplomacy, and epidemics. A number of communities in Kenya caught the first glimpse of a colonial state through the prism of wars of pacification and taxation, as well as governmental inoculation and vaccination campaigns against epidemic outbreaks of bubonic plague and sleeping sickness. The campaigns against the epidemics, which were the first major tests of the colonial state's choice of methods and monopoly of ideas, proved ineffective. At the beginning of the twentieth century, the suddenness of most epidemics, the rapidity of their spread, and the high mortality rates often astounded both local populations and colonial officials. While the geographical extent of the epidemics was quite often ascertained without much debate, containing the pestilence often called forth several competing strategies and various interpretations.

The state's efforts to contain epidemics produced intense debates among local populations on ways of preventing deaths as well as on the intentions and limitations of the state's methods. In the debates, communities naturally drew from their own past experience. A major issue that has been addressed in this book is the existence of a concept of health and healing in precolonial societies in which indigenous populations envisioned a balanced ecosystem not only as part of their economic and cultural reproduction but also as part of their health and healing tradition. The maintenance of that balance was not achieved merely by the human population's response to the whims of nature, but also by the population's gradual and

constant transformation of the environment. As part of that transformation, traditional controls, which often limited the adverse effects of epidemics, evolved. Thus, the challenges presented by epidemics provided situations in which the skills and experiences of indigenous populations were evoked, enriched, and applied with varying success.

Yet with the introduction of the new biomedical and political order, these traditional skills were hardly valued by the colonial state. The irony, however, is that the implantation of British colonialism coincided with the onset of some of the most devastating epidemics ever witnessed in Kenya. Epidemics of sleeping sickness, smallpox, and bubonic plague fell upon Kenya before any colonial medical infrastructure was instituted. This state of unpreparedness during the infancy of colonial rule resulted in the development of ad hoc measures of disease control, with the state proving ineffective in setting priorities in its efforts to address the effects of the epidemics. This period of shadow-boxing saw the state and the proponents of biomedicine emerge as the preeminent creators of policies that were not well thought-out and, worse still, were haphazardly executed. The traditional therapeutic skills and experiences of the indigenous populations were marginalized, not because they were ineffective or had nothing to offer but because they were considered "unscientific" and dismissed as rituals of a bygone age that needed to be replaced by biomedical science, which signified progress and modernity. This study has shown how the colonial state's preoccupation with the monologue on biomedicine to the exclusion of all other views produced distorted priorities that were not only alienating but also the subject of cultural critique.

The state's plans and measures were too ambitious for its limited resources and the sparse knowledge of biomedical practitioners about local environments and cultures. Alan Williams noted that "the priority-setting problem arises because our ambitions outrun our resources."[1] In the context of state-society relations in early colonial Kenya, it was ambition and the alienation of traditional views that were the critical factors causing the schism between state and society. Once again, Williams' argument reveals the dilemma of the colonial state: "Whatever pragmatic solution is adopted, the fact remains that systematic priority-setting in health care requires the rigorous comparison of very diverse responses to very diverse people in very diverse circumstances. So we must ask how systematic and how rigorous and how comprehensive are the alternatives proposed, compared with the status quo."[2] The colonial state was reluctant to listen to the responses from the indigenous population in circumstances that differed greatly from the metropolitan country where the methods of prevention, control, and

containment had been conceived. Small wonder, then, that until the 1920s the colonial state failed to forge a coherent health care policy that was in resonance with reality in Kenya and that would endear itself to those whose suffering the state sincerely sought to alleviate. The measures that were put in place were formulated by the biomedical experts, without any collection and sifting of evidence about traditional values. The parallel discourses of "them and us" and "their and our" ways which emerged during the shadow-boxing period are, therefore, a manifestation of the presumed supremacy of the newly instituted biomedical ways of knowing over the traditional ways of experience, testing, and doing.

Moreover, Africans and the colonial state differed in their perceptions of the nature and role of traditional and Western therapeutic systems in the evolving colonial health care system. The colonial state viewed traditional medicinal practices as constituting a major obstacle to the expansion of colonial health care services. Consequently, the colonial state sought to replace traditional medicinal practices with Western therapeutic practices. The attempt by the colonial state to replace traditional medicinal practices was further motivated by the prevailing climate of opinion in Western science, which was premised on the stereotypical notion that non-Western medicinal practices were inadequate and lacking in substance. This notion bestowed on Western therapeutic practices a presumed supremacy over other medicinal practices. As a consequence, Western medicinal practices erroneously came to be seen as constituting the basis of any viable therapeutic system.

However, by 1939, African medicinal practices still maintained their viability and paralleled state-patronized mainstream colonial health care. The former ministered to more patients than colonial health care. The resiliency of African medicinal practices was primarily caused by three main factors: the inadequacy of colonial health care in Kenya; the inability of colonial health care to adopt, incorporate, and exercise both the "biotech" and the "medico-religious" aspects of traditional healing practices; and finally the failure colonial health care to transcend the stereotypical dichotomies of "superior" versus "inferior," "scientific" versus "pseudo-scientific," and "medicine" versus "witchcraft" which were frequently used in colonial references to Western and traditional therapeutic practices respectively. The Africans, on the other hand, were comfortable with living in the worlds of both the traditional and the Western therapeutic systems. Their popular medicine was homegrown. It defined the sick as subjects. It incorporated two very vital concerns, individual health and the necessity for individual healing to be in harmony with the community. Colonial health care was

deeply embedded in the culture of the colonizer and thus not only failed to evolve a distinct space outside the boundaries of the state but also proved not to be comprehensive enough to address the broad conception of health, sickness, and cure as understood in traditional society.

The state-patronized biomedical procedures and methods, just like the traditional practices, found it difficult to cope with diseases such as sleeping sickness, bubonic plague, and smallpox which caused high mortality rates during the formative period of colonial governance. The pestilences were not easily amenable either to the traditional or to the Western therapeutic system. Also, changed resource management practices increased vulnerability to disease, rapidity of spread, and rate of infection. The havoc wreaked by disease impacted precolonial socioeconomic patterns by changing lineage and ethnic identities as the population migrated to epidemic-free areas. Similarly, the movement of the population, voluntary or forced, into areas perceived to be epidemic-free often resulted in the spread of disease into these areas. In essence, just as disease influenced socioeconomic changes, so too did such changes impact epidemiological patterns. The relationship between disease and socioeconomic change was complex, dynamic, and interactive. As a result, the development of colonial health care was uneven in Kenya because of epidemiological patterns and variations in resource endowments and infrastructural development.

Epidemics created a dramatic and compelling opportunity to institutionalize segregationist tendencies, colonial choices, and social control, all of which resulted in the marginalization of Africans at the periphery of colonial health care. The "germ theory " of disease was politicized and subsequently contextualized within the parameters of the colonial setting by the construction of the pseudo-scientific image of Africans and Asians as inherently "unhealthy." It has been shown how the colonial state constructed the image of the African and Asian communities as potential "disease carriers." Legally confirming the image of "disease carriers," the colonial state established separate health institutions and residential places for various racial groups in the country. The colonial state used public health concerns to justify segregation in urban commercial and residential areas. The struggle for health, in part, entailed a contest for political and economic dominance. The Public Health Ordinance of 1921 epitomized the intersecting relationship between public health legislation and the political and economic interests of various groups in the country. Thus, colonial health care embraced within its orbit deeply entrenched political and economic interests which reflected the contradictions existing in the wider Kenyan society.

Moreover, the development of transport infrastructure was not necessarily coterminous with improvement in colonial health care. In early colonial Kisumu, for example, the outbreak of bubonic plague was attributed to the immigration of an infected person into the township via the Uganda Railway. The location of Kisumu at the terminus of the railroad necessitated aggressive measures and concerted efforts to limit the spread of the disease to centers along the railway. The mobility of population increased with the development, albeit uneven, of colonial transport infrastructure. Such mobility enhanced the vulnerability of the population in colonial Kenya to diseases that emerged outside their traditional areas of settlement. Thus, the development of colonial infrastructure resulted in the opening up of precolonial Kenya, while simultaneously it increased the vulnerability of the Kenyan populations to more diseases.

The expansion of colonial health care in Kenya was underpinned by many factors and furthered by various agents. For the colonial state, political and economic interests were most critical. The need to stop the perceived spread of disease from the reserves to the townships and European-settled areas as well as to provide healthy workers for the labor-dependent colonial economy forced the colonial state to expand colonial health care into the outlying districts. Africans' health fitted within the framework of colonial health care because of their role in supporting the colonial economy as migrant laborers. At the political level, the colonial state was engaged in a public relations campaign to present itself as the benevolent provider and custodian of African health rights. This campaign, however, was primarily meant to legitimize colonial control and stem the tide of African agitation for social welfare improvements. For the colonial state, health care in Kenya was neither conceived nor envisioned as a social welfare scheme. It was fashioned and conducted within the framework of the needs of the colonial economy and colonial political interests.

On the other hand, humanitarian motives often underpinned the mission medical stations' interest in colonial health care. Most mission medical stations were attached to churches. Health, healing, and education were vital ingredients in the missionization of western Kenya by the various Christian groups: the Roman Catholics, the Church Missionary Society, the Africa Inland Church, the Church of God, the Friends Mission, and the Seventh Day Adventists. Health and healing constituted part of the churches' social agenda, which was pursued during evangelization.

The gradual expansion of colonial health care was effected through a number of agents and institutions. The missionaries, Africans educated in missionary as well as colonial schools, chiefs, workers in colonial establish-

ments, the colonial administration, and the medical authorities all in one way or another helped further the expansion of colonial health care in the reserves. In the metropolitan country, the Colonial Office, the India Office, and humanitarian groups in Britain often exerted pressure on the colonial state to address the health concerns of African communities. The LNCs became the major institutions of colonial health care transformation in Kenya beginning in 1925. The expansion of colonial health care in Kenya was primarily financed by the indigenous population through the payment of local rates to the LNCs. Thus the people of Kenya were not only the victims of disease, they also shouldered the burden of constructing and sustaining the institutions for fighting it.

Despite the significant role of the LNCs in the expansion of colonial health care, the colonial state tried to control the deliberations of the councils with a view to limiting the growth of militant politics among Africans. The colonial state erroneously believed that social and political agendas were separable and that Africans would pursue social programs pertaining to health and education without embracing politics. As the evidence presented to the Joint Select Committee demonstrated, the colonial state's view was a mistaken one. Colonial health care was very much a political issue that was closely tied to the way power was being exercised. Power determined the allocation of resources to be invested in the development of the colonial health care infrastructure.

This study has shown the significance of political factors in colonial health care in other ways, as well as in the example of the LNCs. A prime example is provided by the impact of the various colonial and imperial commissions of inquiry in the development of colonial health care. The commissions, often established during or immediately after periods of political, economic, or epidemic crisis, frequently indicted the colonial state's management of health care. The crises provided opportunities for a renewed focus on the question of colonial health care, which often resulted in innovation and expansion. Indeed, the 1912–1913 Native Labour Commission, the 1913 Simpson Report, the 1917 EAP Economic Commission, the 1924 Ormsby-Gore Commission, and the 1931 Joint Select Committee on East Africa were all accompanied or followed by major changes that resulted in the expansion and improvement of colonial health care in Kenya.

In essence, therefore, colonial commissions of inquiry encapsulated complex societal tensions and discourses that impacted all the involved parties. They were not just merely conduits for the ideas of the state. Neither were the commissions, whether political or professional, merely in-

struments for marketing measures to which the colonial state or the Colonial Office were committed. Some commissions engaged in research, collected information, and considered dissenting views from stakeholders in the health project, both inside and outside the country, transcending the racial, economic, political, and professional divides. The debates that followed the presentation of commissions' findings clearly show that no recommendation would see the light of day as a policy without being subjected to rigorous critique by the stakeholders in the health care sector. Going beyond the general, faceless construct of the impersonal colonial state and the Colonial Office, the study has shown that decision making in the colonial setting was far more complex than is sometimes appreciated in the literature.

The role of the colonial state in mediating the emergent contradictions in colonial health care as well as in the wider society reveals the complexity and dilemmas of the institution. The colonial state was invested with enormous powers of governance. Headed by the Governor, the colonial state had at its service an executive council, a legislative assembly, and a bureaucracy of administrative officials and professional staff. However, the organizations and officials in the service of the colonial state were not always in agreement on public health policy issues. Disagreements between administration officials and medical officers were not uncommon. The disagreements were sometimes caused by personal differences, professional and ethical considerations, and pressure brought to bear on officials by forces such as the European settler community, the Colonial Office, African associations, Indian associations, the India Office, and humanitarian groups in the metropolitan country. The attempt to reconcile these diverse and sometimes conflicting interests resulted in open conflict between the colonial state and various forces. Furthermore the nature and consequence of such conflicts and their reconciliation varied by time and place. The ad hoc health policies which were adopted and then discarded as soon as conveniently possible epitomize the contradictions and dilemmas of the colonial state in addressing public health concerns in the face of diverse and sometimes antagonistic forces both from within the state and outside it.

These contradictions and dilemmas persisted into the postcolonial period. The state in the immediate postindependence period attempted to expand and improve the quality of health care through the provision of free basic medical services. The efforts were in general successful, at least during the first two decades of independence. However, from the mid-1980s onward, the postcolonial state encountered external forces which criticized its benevolent approach. As the state's revenue resource base weakened be-

cause of external pressures and internally inflicted financial and economic mismanagement, it retreated from its commitment to the provision of free health care services. The result is a fragile public health care system that for the most part, in many parts of the country, exists only nominally. The concurrence of the postcolonial state's shift from active engagement to passive disengagement with the ascendancy of the forces of globalization and the power of the Bretton Woods institutions poses a fundamental question pertaining to the future of the public health care system in Kenya. The present situation is disappointing, particularly with the wide spread of AIDS, the rise of opportunistic infections, and the persistence of a weak economy that can hardly support the provision of basic health care services for the majority of the citizens who are below the poverty line.

NOTES

Notes to Chapter 1

1. The colonial state was both a foreign import and a local creation. It was both an institution and a process. Thus it was not an exact copy of the metropolitan British state, but rather an adaptation of it. Since the conditions existing in Kenya were different from those obtaining in Britain, the colonial state secured itself as the dominant institution through force and cooption of local agents. Hence, although the colonial state reigned supreme, various interests, both inside and outside the country, influenced its nature and policies. But the colonial state was also a process since it went through various developmental phases in the seventy-plus years of British colonial governance in Kenya. For a detailed examination of the subject of the colonial state in colonial governance in Kenya, see John Lonsdale, "The Conquest State, 1895–1904," in William R. Ochieng', ed., *A Modern History of Kenya* (Nairobi: Evans Brothers, 1989), 6–34; Bruce Berman and John Lonsdale, "Coping with the Contradictions: The Development of the Colonial State in Kenya, 1895–1914," *Journal of African History* 20, 4 (1979): 487–505; John Lonsdale, "States and Social Processes in Africa: A Historiographical Survey," *African Studies Review* 24, 2/3 (1981): 139–225; Bruce Berman, *Control and Crisis in Colonial Kenya: The Dialectics of Domination* (Athens: Ohio University Press, 1990); Crawford Young, *The African Colonial State in Comparative Perspective* (New Haven, Conn.: Yale University Press, 1994). Suffice it to note that the postcolonial state retained the basic outlines of its predecessor and embraced the material, political, and ideological interests of the ruling class. See Robert Fatton, Jr., "The State of African Studies and Studies of the African State: The Theoretical Softness of the 'Soft State,'" *Journal of Asian and African Studies* 24 (1989): 170–187. Thus the state has been a major factor in the development of health care policies in the twentieth century.

2. Adam Ashforth, "Reckoning Schemes of Legitimation: On Commissions of Inquiry as Power/Knowledge Forms," *Journal of Historical Sociology* 3 (1990): 1–22; and also Ashforth's book, *The Politics of Official Discourse in Twentieth Century South Africa* (Oxford: Clarendon Press, 1990).

3. For an overview of the development of the medical profession in Kenya, see John Iliffe, *East African Doctors: A History of the Modern Profession* (Cambridge: Cambridge University Press, 1998).

4. For a detailed treatment of this theme, see John M. MacKenzie, ed., *Imperialism and the Natural World* (Manchester: Manchester University Press, 1990); Roy MacLeod

and Milton Lewis, ed., *Disease, Medicine and Empire: Perspectives on Western Medicine and Experience of European Expansion* (New York: Routledge, 1988); and David Arnold, ed., *Disease, Medicine and Empire* (Manchester: Manchester University Press, 1988).

5. Andrew Cunningham and Bridie Andrews, eds., *Western Medicine as Contested Knowledge* (Manchester: Manchester University Press, 1997). This volume contains excellent studies on the conflictual encounters between Western medicine and indigenous cultures. In the Kenyan context, see the chapter by Richard Waller and Kathy Homewood, "Elders and Experts: Contesting Veterinary Knowledge in a Pastoral Community," 69–93.

6. In a brilliant essay, Stoler and Cooper assert that such a perspective is critical in evaluating how limited and unhegemonic the imperial authorities actually were in colonial social formations. See Ann Laura Stoler and Frederick Cooper, "Between Metropole and Colony: Rethinking a Research Agenda," in Frederick Cooper and Ann Laura Stoler, eds., *Tensions of Empire: Colonial Cultures in a Bourgeois World* (Berkeley: University of California Press, 1997), 21–22.

7. Luise White, *Speaking with Vampires: Rumor and History in Colonial Africa* (Berkeley: University of California Press, 2000), 89.

8. Ibid., 151.

9. The best general studies on this theme of resistance include Ann O'Hear, *Power Relations in Nigeria: Ilorin Slaves and Their Successors* (Rochester, N.Y.: University of Rochester Press, 1997), 4–20; and Allen F. Isaacman, "Peasants and Rural Social Protest in Africa," in Frederick Cooper et al., *Confronting Historical Paradigms: Peasants, Labor, and the Capitalist World System in Africa and Latin America* (Madison: University of Wisconsin Press, 1993): 205–317.

10. Also see Dennis Ityavyar, "Health in Precolonial Africa," in Toyin Falola and Dennis Ityavar, eds., *The Political Economy of Health in Africa* (Athens: Ohio University Center for International Studies, 1992), 35–46; World Health Organization, *The Promotion and Development of Traditional Medicine,* Technical Report Series 622 (Geneva: World Health Organization, 1978).

11. Maynard Swanson, "The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900–1909," *Journal of African History* 17, 3 (1977): 346–357.

12. John Anderson, *The Struggle for the School* (London: Longman, 1970); Sorobea N. Bogonko, *A History of Modern Education in Kenya, 1895–1991* (Nairobi: Evans Brothers, 1992).

13. Ann Beck, *A Medical History of the British Medical Administration of East Africa, 1900–1950* (Cambridge: Harvard University Press, 1970).

Notes to Chapter 2

1. Roy MacLeod and Milton Lewis, eds., *Disease, Medicine and Empire: Perspectives on Western Medicine and Experience of European Expansion* (New York: Routledge, 1988); John M. MacKenzie, ed., *Imperialism and the Natural World* (Manchester: Manchester University Press, 1992); David Arnold, ed., *Disease Medicine and Empire* (Manchester: Manchester University Press, 1988); Philip Curtin, *Death by Migration: Europe's Encounter with the Tropical World in the Nineteenth Century* (Cambridge: Cambridge University Press,

1989); Megan Vaughn, *Curing Their Ills: Colonial Power and African Illness* (Stanford, Calif.: Stanford University Press, 1991).

2. Among the excellent works that have questioned the "master linear narrative" by emphasizing the role of the colonized in their encounters with the colonizers, see Andrew Cunningham and Bridie Andrews, eds., *Western Medicine as Contested Knowledge* (Manchester: Manchester University Press, 1997) 13; Susan Reynolds Whyte, *Questioning Misfortune: The Pragmatics of Uncertainty in Eastern Uganda* (Cambridge: Cambridge University Press, 1997). Luise White has shown how subaltern conversations, particularly rumor and gossip, can be harnessed to illuminate the way individuals and communities perceived and expressed their contacts with the colonial state and the world of biomedicine it patronized. See Luise White, *Speaking with Vampires* (Berkeley: University of California Press, 2000).

3. Albert R. Cook, "Further Memories of Uganda," *Uganda Journal* 2, 2 (1934): 112–114. Sir Albert Cook was an eyewitness to the outbreak of the disaster and one of the first doctors to report the existence of this fatal disease. In February 1897 when the epidemic first broke out, Western Kenya was still part of the Eastern Province of Uganda, which was the most devastated by the epidemic. Also see Jonathan Musere, *African Sleeping Sickness: Political Ecology, Colonialism and Control in Uganda* (Lewiston, N.Y.: The Edwin Mellen Press, 1992); and H. G. Soff, "A History of Sleeping Sickness in Uganda: Administrative Response 1900–1970," Ph.D. diss., Syracuse University, 1971.

4. Stewart to Principal Secretary of State for Colonies, 7 March 1905, Public Record Office, London (PRO): CO 533/1.

5. Kisumu Province Annual Report (KPAR) 1905–1906, Kenya National Archives, Nairobi (KNA): PC/NZA/1/1.

6. South Kavirondo Annual Report (SKAR) 1908–1909, KNA: DC/KSI/1/1.

7. KPAR 1907–1908, KNA: PC/NZA/1/3.

8. Ibid.

9. SKAR 1908–1909, KNA: DC/KSI/1/1.

10. North Nyanza Political Record Book (NNPRB), 1900–1916, KNA: DC/NN/3/1.

11. KPAR 1906–1907, KNA: PC/NZA/1/2.

12. Governor to Secretary of State (S of S), 25 May 1908, PRO: CO 533/44.

13. Helge Kjekshus, *Ecology Control and Economic Development in East African History: The Case of Tanganyika 1850–1950* (London: Heinemann, 1977), 168.

14. Staff List, East Africa Protectorate, 1 April 1905, PRO: CO 533/1. It is important to note that up to that time, Uganda and the East Africa Protectorate (EAP) had only one Principal Medical Officer, Major J. Will, who was in charge of both countries.

15. Ibid.

16. KPAR 1908–1909, KNA: PC/NZA/1/4. The Kisii camp was closed in June 1909 following the death of Dr. C. J. Baker who was in charge. It was reopened in 1910 by Dr. John Pugh. See SKAR 1910–1911, KNA: DC/KSI/1/1.

17. KPAR 1908–1909, KNA PC/NZA/1/4.

18. F. Jackson, Deputy Governor, to S of S, telegram, 22 April 1907, PRO: CO 533/28. In the telegram, Jackson urged the immediate posting of medical officers since the Principal Medical Officer of Health lacked personnel to use in containing the ravages of the epidemic. The British Treasury later sanctioned an expenditure not exceeding £2,000 for the purpose of checking the spread of sleeping sickness in South Kavirondo. Treasury to Under Secretary of State, Colonial Office, 2 July 1908, PRO: CO 533/51.

19. SKAR 1908–1909, KNA: DC/KSI/1/1.

20. KPAR 1906–1907, KNA: PC/NZA/1/2.

21. For details of the origin, development, and impact of the Gusii-British conflict, see Robert M. Maxon, *Conflict and Accommodation in Western Kenya: The Gusii and the British, 1907–1963* (London and Toronto: Associated Press, 1989), 45.

22. Minutes by Churchill, 3 February 1908, on Sadler to Elgin, telegram, 31 January 1908, PRO: CO 533/41, cited in Maxon, *Conflict and Accommodation,* 44.

23. John Lonsdale, "The Politics of Conquest: The British in Western Kenya, 1894–1908," *The Historical Journal* 20, 4 (1977): 845–859; and John Lonsdale, "The Conquest State, 1894–1904," in William R. Ochieng', ed., *A Modern History of Kenya, 1895–1980* (Nairobi: Evans Brothers, 1989), 6–34.

24. Osaak Olumwullah, "Disease and Socioeconomics among the Abanyole," Ph.D. diss., Rice University, 1995.

25. Warwick Anderson, "What Is the Postcolonial History of Medicine?" *Bulletin of the History of Medicine* 72, 3 (1998): 522.

26. M. Durey, *The Return of the Plague: The British Society and the Cholera 1831–32* (Dublin: Gill and MacMillan, 1979), 77, 88; R. Lambert, *Sir John Simon 1816–1904 and English Social Reform Administration* (London: MacGibbon and Kee, 1963).

27. Two major works detailing the nature and extent of such resistance are Paul McHugh, *Prostitution and Victorian Social Reform* (London: Croom Helm, 1980); and Mary Spongberg, *Feminizing Venereal Disease: The Body of the Prostitute in Nineteenth Century Medical Discourse* (New York: New York University Press, 1997), 73–84. Also see Luise White, *The Comforts of Home: Prostitution in Colonial Nairobi* (Chicago: University of Chicago Press, 1990).

28. Also see David Arnold, "Cholera and Colonialism in British India," *Past and Present* 113 (1986): 118–151; Richard J. Evans, "Epidemics and Revolutions: Cholera in Nineteenth-Century Europe," *Past and Present* 122 (1988): 123–146.

29. J. Brunet-Jailly, "Introduction," *International Social Science Journal* 161 (September 1999): 272; Also see Harrie' van Balen and Monique van Dormel, "Health Service Professionals and Users," *International Social Science Journal* 161 (September 1999): 313–326.

30. Cuthbert Christy, "Sleeping Sickness," *Journal of the Royal African Society* 9 (October 1903): 5.

31. Memorandum by A. D. Milne, Ag. Principal Medical Officer, 19 January 1910, PRO: CO 533/57.

32. Report on Sleeping Sickness by Dr. B. W. Cherrett, October 1910, enclosure in Girouard to Crewe, 31 May 1911, PRO: CO 533/87.

33. The Anglo-German Sleeping Sickness Agreement was signed by Germany and Britain, both colonial powers in the region. Britain's imperial possessions were Uganda and the EAP (Kenya), while Germany controlled German East Africa (Tanganyika). Because of the proximity of the three territories and the sleeping sickness epidemic that hit all three dependencies more or less at the same time, the two imperial powers agreed to collaborate in the attempt to stem the epidemic. One of these efforts was the establishment of camps. See Description of Boundaries of Areas Infected by Sleeping Sickness on Lake Victoria, Principal Medical Officer, British East Africa, enclosure in Girouard to Crewe, 31 May 1911, PRO: CO 533/87.

34. NPAR 1911–1912, KNA: PC/NZA/1/7.

35. J. Pugh, Medical Officer Kanyamkago Sleeping Sickness Camp, to A. D. Milne, Principal Medical Officer, 7 November 1910, enclosure in Girouard to Crewe, 31 May 1911, PRO: CO 533/87. The Luo, for example, had elaborate rituals that were to be performed if a person died and/or was buried away from home. For details, see Paul Mboya, *Luo Kitgi gi Timbegi* (Kisumu: Anyange Press, 1983).

36. Governor to S of S, 25 May 1908, PRO: CO 533/44.

37. Memorandum in Connection with Sleeping Sickness, 27 April 1908, by John Ainsworth, enclosure in Governor to S of S, 25 May 1908, PRO: CO 533/44.

38. Ibid.

39. Ibid.

40. *The Times* (London), 29 June 1906, 6.

41. Ibid.

42. John M. MacKenzie, "Experts and Amateurs: Tsetse, Nagana and Sleeping Sickness in East and Central Africa," in John M. MacKenzie, ed., *Imperialism and the Natural World* (Manchester and New York: Manchester University Press, 1990), 195.

43. Ibid.

44. Ibid.

45. Ibid.

46. Ibid.

47. Ibid.

48. W. D. Foster, *The Early History of Scientific Medicine in Uganda* (Nairobi: EALB, 1970), 93–109.

49. One of the experts consulted was the renowned German scientist Robert Koch. See Heinrich Brode, *British and German East Africa: Their Economic and Commercial Relations* (London: E. Arnold, 1911), 78–79.

50. Lyttelton to Stewart, 13 March 1905, PRO: CO 533/1.

51. Will, Principal Medical Officer of Health, to Stewart, 18 February 1905, PRO: CO 533/2.

52. Ibid.

53. "An Address by Sir William MacGregor on Problems of Tropical Medicine," delivered at the London School of Tropical Medicine, 3 October 1900, Ross Archives, London School of Hygiene and Tropical Medicine: Rnum/12/078.

54. KPAR 1907–1908, KNA: PC/NZA/1/3.

55. H. H. Johnston, "The Sleeping Sickness," *Journal of the Royal African Society* 5 (1905–1906): 415.

56. Johnson, "The Sleeping Sickness."

57. Oral interview, Duado Omiti, Koluoch, September 1987.

58. Ibid.

59. Mboya, *Luo Kitgi gi Timbegi,* 53.

60. Gunter Wagner, *The Bantu of North Kavirondo, Vol. II* (New York: Oxford University Press, 1956), 82; A.B.C. Ocholla-Ayayo, *Traditional Ideology and Ethics among the Southern Luo* (New York: Africana Publishing Company, 1976), 104; David Cohen and E. S. Atieno Odhiambo, *Siaya: The Historical Anthropology of an African Landscape* (Athens: Ohio University Press, 1989), 9–14.

61. Oral interviews, Eliakim Nyatuga, Obama, August 1987; Eliakim Omolo, Kangeso, September 1987; Celestinus Mwango, Kotieno, September 1987; and Stanslaus Ong'onga Ofuo, Kabuoro, September 1987. Also see Wagner, *The Bantu of North Kavirondo,*

Vol. II, 82; P. Muronji Shilaro, "Kabras Culture under Colonial Rule: A Study of the Impact of Christianity and Western Education," M.A. thesis, Kenyatta University, 1991, 77.

62. Ocholla-Ayayo, *Traditional Ideology,* 125; Wagner, *The Bantu of North Kavirondo, Vol. II,* 84–85.

63. Ocholla-Ayayo, *Traditional Ideology.*

64. Shilaro, "Kabras Culture under Colonial Rule," 53; Ocholla-Ayayo, *Traditional Ideology,* 50, 153, 158–159.

65. Shilaro, "Kabras Culture under Colonial Rule," 50.

66. Ocholla-Ayayo, *Traditional Ideology* , 50, 208–214.

67. William R. Ochieng', *A Precolonial History of the Gusii* (Nairobi: EALB, 1974), 194–198.

68. Sometimes these two roles were performed by one person. Ocholla-Ayayo, *Traditional Ideology,* 158–159.

69. According to Ogot, cooperation among the settling clans was of enormous significance in taming the land. See Bethwell A. Ogot, *A History of the Southern Luo* (Nairobi: EAPH, 1967). 104.

70. Wagner, *The Bantu of North Kavirondo, Vol. II,* 6–7; C. W. Hobley, *Eastern Uganda: An Ethnological Survey* (London: Anthropological Institute of Great Britain and Ireland, 1902), 15–16; Cohen and Odhiambo, *Siaya,* 9–14.

71. Cohen and Odhiambo, *Siaya,* 10.

72. Joyce M. K. Olenja, "Food and Culture: Anthropology and Its Relevance in the Study of Nutrition," *Mila: A Biannual Newsletter of Cultural Research* 6, 2 (1983): 20.

73. Paul Mboya, *Richo Ema Kelo Chira* (Nairobi: EAPH, 1986).

74. Ibid. See also Gloria Waite, "Public Health in Precolonial East-Central Africa," in Steven Feierman and John M. Janzen, eds., *The Social Basis of Health and Healing* (Berkeley: University of California Press, 1992), 216.

75. Whyte, *Questioning Misfortune,* 20.

76. G. D. Hale Carpenter, "Report on an Investigation into the Epidemiology of Sleeping Sickness in Central Kavirondo, Kenya Colony," *Bulletin of Entomological Research* 15 (1924): 187.

77. K. C. Willett, "Some Observations on the Recent Epidemiology of Sleeping Sickness in Nyanza Region, Kenya and Its Relation to the General Epidemiology of Gambian and Rhodesian Sleeping Sickness in Africa," *Journal of the Royal Society of Tropical Medicine and Hygiene* 59, 4 (1965): 374; William R. Ochieng', *A History of the Kadimo Chiefdom of Yimbo in Western Kenya* (Nairobi: EALB, 1975), 18.

78. Ochieng', *Kadimo,* 18–19.

79. Ibid.

80. G. Whitehouse, "To the Victoria Nyanza by the Uganda Railway," *Journal of the Society of Arts* 50, 2 (1902): 172–173.

81. D.J.B. Wijers, "The History of Sleeping Sickness in Yimbo Location (Central Nyanza, Kenya) as Told by the Earliest Inhabitants of the Location," *Tropical and Geographical Medicine* 21, 3 (1969): 323–337.

82. George Oduor Ndege, "The Transformation of Cattle Economy in Rongo Division," Staff Seminar Paper No. 5, University of Nairobi, 1989.

83. Springhouse Corporation, *Professional Guide to Diseases* (Springhouse, Pa.: Springhouse Corporation, 1986), 183–184.

84. Major Will, Principal Medical Officer, to F. J. Jackson, H. M. Deputy Commissioner in Nairobi, 7 March, 1905, PRO: CO 533/1.

85. A. D. Milne, Deputy Principal Medical Officer, to D. Stewart, H. M. Commissioner, Report on Outbreak of Plague in Kisumu, 15 February 1905, PRO: CO 533/1.

86. Ibid.

87. Ibid.

88. A. D. Milne, "Plague in the East Africa Protectorate: Plague Report No. II, Kisumu and Endemic Area," *Journal of Tropical Medicine and Hygiene* 8 (1905): 178–179.

89. Ibid.

90. Ibid.

91. Ibid.

92. Marc Dawson, "Socioeconomic and Epidemiological Change in Kenya: 1880–1925," Ph.D. diss., University of Wisconsin-Madison, 1983, 87–88.

93. Will to Jackson, 7 March 1905, PRO: CO 533/1.

94. Ibid.

95. Stewart to Lyttelton, 29 March 1905, PRO: CO 533/1.

96. Bagge to Stewart, 13 March 1905, PRO: CO 533/1.

97. Plague Report, 14 February 1905, PRO: CO 533/1.

98. Ibid.

99. Ibid.

100. Ibid.

101. Ibid.

102. Bagge to Stewart, 13 March 1905, PRO: CO 533/1.

103. Milne to Stewart, 2 February 1905, PRO: CO 533/1.

104. Ross to Will, 25 January 1905, PRO: CO 533/1.

105. Bagge to Stewart, 18 February 1905, PRO: CO 533/1.

106. Under Secretary of State to Commissioner, British East Africa Protectorate, 24 April 1905, PRO: CO 533/1.

107. Enclosure in Sadler to S of S, 16 November 1906, PRO: CO 533/18.

108. East African Plague and Cholera Ordinance 1906, enclosure in ibid.

109. Jackson to S of S, 8 December 1908, PRO: CO 533/48.

110. Milne to Jackson, 21 December 1908, PRO: CO 533/48.

111. Haran, "Narrative Account of the Outbreak of Plague at Kisumu: June–October 1908," enclosure in ibid.

112. Ibid.

113. Carol Benedict, *Bubonic Plague in Nineteenth Century China* (Stanford, Calif.: Stanford University Press, 1996), 169.

114. White, *Speaking with Vampires,* 46; White, *Comforts of Home: Prostitution in Colonial Nairobi.*

115. Thomas Spear, " A Town of Strangers," in David Anderson and Richard Rathbone, eds., *Africa's Urban Past* (Oxford/Portsmouth, N.H.: James Currey/Heinemann, 2000), 110.

116. Enclosure in Jackson to S of S, 8 December 1908, PRO: CO 533/48.

117. Maynard W. Swanson, "The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900–1909," *Journal of African History* 17, 3 (1977): 387–410.

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119. For example, in the 1912–1913 EAP Medical Report, the Principal Medical Officer identified the areas frequently infected by plague in Kisumu as the Indian Bazaar, the Swahili location, the police lines, the Nubian location, and the cattle boma, all of which were non-European locations. See 1912–1913 EAP Medical Report, enclosure in Belfield to Harcourt, 26 November 1913, PRO: CO 533/124.

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121. CNPRB, KNA: DC/CN/4/3.

122. See Lonsdale, "The Conquest State," and his other article, "States and Social Processes in Africa: A Historiographical Survey." *African Studies Review* 24, 2/3 (1981): 139–225.

123. Robert M. Maxon, *Struggle for Kenya: The Loss and Reassertion of Imperial Initiative, 1912–13* (London and Toronto: Associated University Presses, 1993), 160–174; Robert G. Gregory, *Sidney Webb and East Africa: Labour's Experiment with the Doctrine of Native Paramountcy* (Berkeley: University of California Press, 1962).

124. For a detailed treatment of the impact of the laboratory revolution on medicine, see Andrew Cunningham and Perry Williams, eds., *The Laboratory Revolution in Medicine* (Cambridge: Cambridge University Press, 1992); and John V. Pickstone, *Medical Innovations In Historical Perspective* (London: MacMlllan, 1992).

125. "Introduction," in Cunningham and Andrews, eds., *Western Medicine,* 5.

126. Oral interview, Joshua Okola Apuka, Damar Achola Agola, and Jasters Onyango, Asego, Homa Bay, August 1999.

127. Oral Interview, Tobias Omondi and Agutu Gonga, Nyarago, July 1997.

128. Ibid.

129. David W. Cohen and E. S. Atieno Odhiambo, *Burying SM: The Politics of Knowledge and Sociology of Power in Africa* (Portsmouth, N.H.: Heinemann, 1992); Bethwell A. Ogot and F. B. Welbourn, *A Place to Feel at Home* (London: Oxford University Press, 1966); Wagner, *The Bantu of North Kavirondo, Vol. II*; Mboya, *Richo.*

130. For details of the significance of death and burial in African societies, see John S. Mbiti, *African Religions and Philosophy* (Portsmouth, N.H.: Heinemann, 1990); and Mbiti's other book, *Introduction to African Religion* (Portsmouth, N.H.: Heinemann, 1992).

131. Whyte, *Questioning Misfortune,* 92.

132. Dominique Zahan, *The Religion, Spirituality, and Thought of Traditional Africa* (Chicago: University of Chicago Press, 1979), 48. Also see E. M. Zuese, *Ritual Cosmos: The Sanctification of Life in African Religions* (Athens: Ohio University Press, 1979); Mary Douglas, *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo* (London: Routledge & Kegan Paul, 1966).

133. Zahan, *Religion, Spirituality, and Thought,* 87.

134. A.B.C. Ocholla-Ayayo, "Death and Burial: An Anthropological Perspective," in J. B. Ojwang' and J.N.K. Mugambi, eds., *The S.M. Otieno Case: Death and Burial in Modern Kenya* (Nairobi: Nairobi University Press, 1989), 30–51.

Notes to Chapter 3

1. For a detailed treatment of labor, the economy, and European settlement in colonial Kenya, see M.P.K. Sorrenson, *Origins of European Settlement in Kenya* (Nairobi: Oxford University Press, 1968); and A. Clayton and D. C. Savage, *Government and Labour in Kenya, 1895–1963* (London: Frank Cass, 1974), 20–80.

2. R.M.A. Van Zwanenberg with Anne King, *An Economic History of Kenya and Uganda, 1800–1970* (Atlantic Highlands, N. J.: Humanities Press, 1975); William R. Ochieng' and Robert M. Maxon, eds., *An Economic History of Kenya* (Nairobi: East African Educational Publishers, 1992); Pearson Scott et al., *Agricultural Policy in Kenya: Applications of the Policy Analysis Matrix* (Ithaca, N.Y.: Cornell University Press, 1995).

3. Sharon Stichter, *Migrant Labour in Kenya: Capitalism and African Response, 1895–1975* (London: Longman, 1982).

4. This conference was mainly precipitated by the fact that the Secretary of State for the Colonies (S of S) had ordered the practice of government involvement in the recruitment of labor for private companies and settlers to be stopped. Furthermore, for a time before 1912, the people of western Kenya were restricted from going east of Nairobi because of the sleeping sickness epidemic. The Native Labour Commission was appointed on 13 August 1912 with fourteen areas of reference of which the most pertinent for this study include the reasons for the shortage of African labor, the accommodation supplied to African labor, including the kinds and quantities of food and also privileges and rights given, and the medical attendance. For details of other terms of reference, see East Africa Protectorate, *Report and Evidence of the Native Labour Commission, 1912–13* (Nairobi: Government Printer, 1913), 321.

5. EAP, *Report and Evidence of the Native Labour Commission (NLC*), 324.

6. Ibid.

7. Robert M. Maxon, *Struggle for Kenya: The Loss and Reassertion of Imperial Initiative, 1912–13* (London and Toronto: Associated University Presses, 1993), 31; Marc H. Dawson, "Health, Nutrition, and Population in Central Kenya, 1890–1945," in Dennis D. Cordell and Joel W. Gregory, eds., *African Population and Capitalism: Historical Perspectives* (Madison: University of Wisconsin Press, 1994), 202–212; evidence of Ocholla Omollo from Central Kavirondo, witness No. 119, Onyango Ojola from North Kavirondo, witness No. 123, and Rev. W. Chadwick of Kisumu, witness No. 137, *NLC,* 129–131, 143–144.

8. Stichter, *Migrant Labour,* 158, 162–165. Also see Frederick Cooper, *On the African Waterfront: Urban Disorder and the Transformation of Work in Colonial Mombasa* (New Haven, Conn.: Yale University Press, 1987).

9. Ainsworth was one of the pioneer administrators whose career in the Kenya colonial service dated back to the days of the Imperial British East Africa Company. At the time of the commission, Ainsworth was the Provincial Commissioner (PC) in one of the most densely populated parts of Kenya, and by far the largest source of migrant labor in the country. For a detailed treatment of John Ainsworth's career in the colonial service in Kenya, see Robert M. Maxon, *John Ainsworth and the Making of Kenya* (Lanham, Md.: University Press of America, 1980).

10. *NLC,* 137.

11. Ibid., 136.

12. Evidence of witness No. 1, The Hon. A. C. Hollis, Secretary for Native Affairs, in ibid.

13. *NLC,* 286. For details pertaining to O. F. Watkins' colonial service, see Elizabeth Watkins, *Oscar from Africa: The Biography of O. F. Watkins* (London and New York: Radcliffe Press, 1995).

14. *NLC,* 271.

15. For example, see Stichter, *Migrant Labour*; Karim Janmohamed, "African Laborers in Mombasa, c. 1895–1940," in Bethwell A. Ogot, ed., *Hadith 5: Economic and Social History of East Africa* (Nairobi: EALB, 1975), 154–176.

16. Nyanza Province Annual Report (hereafter NPAR) 1911–1912, KNA/NZA/1/7.

17. *NLC,* 129.

18. Ibid., 130.

19. Ibid. 150.

20. Allen F. Isaacman, "Peasants and Rural Social Protest in Africa," in Frederick Cooper et al., *Confronting Historical Paradigms: Peasants, Labor, and the Capitalist World System in Africa and Latin America* (Madison: University of Wisconsin Press, 1993), 220.

21. For details pertaining to differentiation among households, see Peter Anyang' Nyongo', "The Development of a Middle Peasantry in Nyanza," *Review of African Political Economy* 20 (1980): 108–124; M. Hay, "Economic Change in Late Nineteenth Century Kowe, Western Kenya," in Bethwell A. Ogot, ed., *Hadith 5: Economic and Social History of East Africa* (Nairobi: EALB, 1975), 92–109; M. G. Whission, *Change and Challenge: A Study of Social Change among the Kenya Luo* (Nairobi: National Christian Council of Kenya, 1964).

22. Also see *NLC,* Appendix.

23. Ibid., 312.

24. Ibid.

25. Ibid., 324.

26. Ibid.

27. Ibid.

28. For details of Governor Belfield's administration during the period just before the war, his administration's sympathy for settler grievances, and contentious issues between his administration and the Colonial Office, see Maxon, *Struggle for Kenya,* 43–78.

29. Belfield to Harcourt, S of S, 9 March 1914, PRO: CO 533/138.

30. Ibid. In fact, Belfield had just concluded his tour of western Kenya where he, in his own words, "alluded to this subject at every baraza [public meeting] I held . . . telling the people that it is my desire that they should supply as large and regular labour force as possible for outside employment."

31. Ibid.

32. Harcourt to Belfield, 20 May 1914, PRO: CO/533/144.

33. Ibid.

34. Most witnesses who presented evidence before the Native Labour Commission attested to this fact. Also see Maxon, *Struggle for Kenya,* 31.

35. NPAR 1913–1914, KNA: PC/NZA/1/9; Also see Great Britain, *East Africa Protectorate Annual Report 1913–14* (London: HMSO, 1915), 46–51.

36. EAP, *Annual Medical Report, 1913–14,* PRO: CO 533/140

37. Minute by Read on "Sanitary Expert," 10 April 1913, PRO: CO 533/117.

38. Lambert to Secretary of Treasury, 15 March 1913, PRO: CO 533/117.

39. Ibid.

40. See Adell Patton, Jr., *Physicians, Colonial Racism, and Diaspora in West Africa* (Gainesville: University Press of Florida, 1996), 131; Mark Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine 1859–1914* (Cambridge: Cambridge University Press, 1994), 212–214; Mary Preston Sutphen, "Rumored Power: Hong Kong, 1894 and Cape Town, 1901," in Andrew Cunningham and Bridie Andrews, eds., *Western Medicine as Contested Knowledge* (Manchester: Manchester University Press, 1997), 241–261.

41. Sutphen, "Rumored Power."

42. The year 1913, for as yet unclear reasons, was characterized by widespread smallpox and plague outbreaks, particularly in Nyanza. PC, NZA, to Acting Chief Secretary, 9 June 1914, and Principal Medical Officer to Governor, 29 May 1914, enclosures in Acting Governor to Harcourt, 13 June 1914, PRO: CO 533/138.

43. Simpson to Harcourt, 21 November 1913, enclosure in Belfield to Harcourt, 9 December 1913, PRO: CO 533/125.

44. Ibid.

45. Ibid.

46. NPAR 1919–1920, KNA: PC/NZA/1/15; Minute by Read, 11 June 1914, on Belfield to Harcourt, telegram, 6 June 1914, PRO: CO: 533/136.

47. NPAR 1919–1920, KNA: PC/NZA/1/15.

48. Shula Marks, "What Is Colonial about Colonial Medicine? And What Has Happened to Imperialism and Health?" *Social History of Medicine* 10, 2 (1997): 211; Philip D. Curtin, *Disease and Empire: The Health of European Troops in the Conquest of Africa* (Cambridge: Cambridge University Press, 1998).

49. NPAR 1919–1920, KNA: PC/NZA/1/15.

50. Eric M. Aseka, "Urbanization," in William R. Ochieng', ed., *Themes in Kenya History* (Athens: Ohio University Press, 1990), 47.

51. CNPRB, KNA: DC/CN/4/3.

52. Belfield to Harcourt, 23 October 1913, PRO: CO 533/123.

53. Ibid.

54. Belfield to Harcourt, 1 May 1914, PRO: CO 533/136.

55. Ibid.

56. Minutes of Meeting of the East Africa Indian Congress, enclosure in ibid.

57. Ibid.

58. Memorandum by Professor W. J. Simpson on Plague and the Unsanitary Conditions in British East Africa, enclosure in Simpson to S of S, 2 May 1917, PRO: CO 533/192.

59. Ibid.

60. NPAR 1914–1915, PC/NZA/1/9.

61. Information transmitted to the Colonial Office to assist in the compilation of a book, *The Empire at War,* by Sir Charles Lucas, Northey to Milner, 27 October 1920, PRO: CO 533/237.

62. Ibid.

63. Ibid.

64. EAP, *Annual Medical Report 1916* (Nairobi: Government Printer).

65. Principal Medical Officer to Acting Chief Secretary, 18 November 1918, PRO: CO 533/199.

66. Northey to Miller, 27 October 1920, PRO: CO 533/237.

67. Major Bodeker's Report on the Outbreak and Spread of Smallpox Epidemic in Mumias, 1915–17, enclosure in C. C. Bowring, Acting Governor, to Walter Long, S of S, 5 December 1918, PRO: CO 533/199.

68. Ibid.

69. For a detailed treatment of the disruption of precolonial natural frontiers during colonial rule, see Helge Kjekshus, *Ecology Control and Economic Development in East Africa, 1850–1950* (Athens: Ohio University Press, 1996); Meredith Turshen, "Population Growth and Deterioration of Health in Mainland Tanzania, 1920–1960," in Dennis Cordell and Joel W. Gregory, eds., *African Population and Capitalism: Historical Perspectives* (Madison: University of Wisconsin Press, 1987), 192–195.

70. NPAR 1917–1918, KNA: PC/NZA/1/13.

71. NPAR 1915–1916, KNA: PC/NZA/1/11.

72. Northey to Milner, 20 October 1920, PRO: CO 533/237.

73. Robert M. Maxon, *John Ainsworth and the Making of Kenya* (Lanham, Md.: University Press of America, 1980), 267.

74. Ibid.

75. Stichter, *Migrant Labour,* 31.

76. NPAR 1915–1916, KNA: PC/NZA/1/11.

77. The East Africa Protectorate Economic Commission Final Report, enclosure in Northey to Milner, PRO: CO 533/210.

78. Geoffrey Hodges, *The Carrier Corps: Military Labour in the East African Campaign, 1914–18* (New York: Greenwood Press, 1986), 119–142; Bethwell A. Ogot, "British Administration in the Central Nyanza District, 1900–1960," *Journal of African History* 4, 2 (1963): 258–259; Ann Beck, *A History of the British Medical Administration of East Africa, 1900–1950* (Cambridge: Harvard University Press, 1970), 63–64.

79. NPAR 1918–1919, KNA: PC/NZA/1/14.

80. Enclosure in Bowring to Milner, 2 October 1919, PRO: 533/214.

81. "Report on Influenza Epidemic," by Dr. M. F. Hamilton, enclosure in Bowring to Milner, 2 October 1919, PRO: CO 533/214.

82. Enclosure in Bowring to Milner, 2 October 1919, PRO: CO 533/214.

83. Ibid.

84. Ibid.

85. Ibid.

86. "Circular, Re: Influenza," Principal Medical Officer to All Medical Officers, 21 November 1918, Appendix IV in ibid.

87. Ibid.

88. Ibid.

89. Ibid.

90. Also see Maynard Swanson, "The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900–1909," *Journal of African History* 17, 3 (1977): 387–410.

91. "Report on Influenza Epidemic," by Dr. M. F. Hamilton, enclosure in Bowring to Milner, 2 October 1919, PRO: CO 533/214.

92. Ibid.

93. Ibid.

94. Ibid.

95. Also see Shula Marks and Neil Anderson, "Issues in the Political Economy of Health in Southern Africa," *Journal of Southern African Studies* 13, 2 (1987): 177–186.

96. Enclosure in Belfield to Harcourt, 1 May 1914, PRO: CO 533/136.

97. Statement of Grievances by British India Association of East Africa, enclosure in Government of India to S of S, 15 August 1919, PRO: CO 533/219.

98. Milner to Northey, 21 May 1920, PRO: CO 533/219.

99. In 1920, the East Africa Protectorate became the Colony and Protectorate of Kenya.

100. Montagu to Milner, 24 December 1920, PRO: CO 533/245.

101. "The Public Health Ordinance, 1921: Statement of Objects and Reasons, 11 March, 1921," enclosure in Acting Governor to S of S, 26 March 1921, PRO: CO 533/257.

102. Ibid.

103. Acting Governor to Churchill, 26 March 1921, PRO: CO 533/257.

104. Ibid.

105. Milner to Northey, 21 May 1920, PRO: CO 533/245.

106. Enclosure in Acting Governor to Churchill, 26 March 1921, PRO: CO 533/257.

107. Minute by Parkinson, 27 April 1921, on Public Health Bill, PRO: CO 533/257.

108. Ibid.

109. Minute by Read, 6 February 1921, PRO: CO 533/257.

Notes to Chapter 4

1. In late 1888, the Imperial British East Africa Company was granted a royal charter by the British government over much of the area today known as Kenya. It established its headquarters at Mombasa, its control being at best nominal. The doctors in the employment of the company ministered primarily to company employees. Company rule ceased on 1 July 1895, when Kenya was declared the British East Africa Protectorate, thereby transferring control from the company to the British government. See Robert M. Maxon, *East Africa: An Introductory History* (Morgantown: West Virginia University Press, 1994), 133–136; For details of some medical challenges under company rule, see W. J. Ansorge, *Under the African Sun* (New York: Longmans, 1899).

2. Minute by Bottomley, 24 June 1918, on Reorganization of Medical Service, PRO: CO 533/203.

3. Ibid.

4. W. McGregor Ross, *Kenya from Within: A Short Political History* (London: Frank Cass & Co. Ltd., 1968), 81–82; M.P.K. Sorrenson, *Origins of European Settlement in Kenya* (Nairobi: Oxford University Press, 1966).

5. Also see John Iliffe, *East African Doctors: A History of the Modern Profession* (Cambridge: Cambridge University Press, 1998), 43–47.

6. Minute by W. C. Bottomley on Reorganisation of Medical Service, 24 June 1918, PRO: CO 533/203.

7. Northey to Milner, 15 May 1919, PRO: CO 533/209.

8. Ibid.

9. Minute by Read, 3 July 1919, in ibid.

10. *The Times* (London), 3 July 1918, enclosure in ibid.

11. Ibid.

12. Ibid.

13. Minute by Read, 3 July 1918, on Reorganisation of Medical Service, PRO: CO 533/203.

14. Minute by Read, 26 July 1918, on Medical Staff, PRO: CO 533/203.

15. Minute by Read, 13 August 1919, on Northey to Milner, 15 May 1919, PRO: CO 533/209.

16. Resolutions 5 and 6 of the East Africa Indian National Congress, Second Session, Meeting held on 15 and 16 November 1919, enclosure in Acting Governor, Bowring, to S of S, 15 March 1920, PRO: CO 533/231.

17. The Medical Practitioners and Dentists Ordinance 1910, cited in the Statement of Grievances by British India Association of East Africa, enclosure in Government of India to S of S, 15 August, 1919, PRO: CO 533/219.

18. See Adell Patton, Jr., *Physicians, Colonial Racism, and Diaspora in West Africa* (Gainesville: University Press of Florida, 1996).

19. Report of the P.M.O. Conference of December 1920, enclosure in Northey to Churchill, 31 March 1922, PRO: CO 533/276.

20. Attorney General, The Medical Practitioners and Dentists (Amendment) Ordinance, 1922: Statement of Objects and Reasons, 31 March 1922, PRO.

21. Evidence of Dr. James Hutcheon Thomson, Medical Officer Ukamba Province, to the East Africa Protectorate Economic Commission, enclosure in Northey to Milner, 5 June 1919, PRO: CO 533/210.

22. Ibid.

23. Ibid.

24. Ansorge, *Under the African Sun.*

25. Evidence of Dr. James Hutcheon Thompson, Medical Officer Ukamba Province, to the East Africa Protectorate Economic Commission, enclosure in Northey to Milner, 5 June 1919, PRO: CO 533/210.

26. "Major Bodeker's Report on the Outbreak of Smallpox Epidemics in Mumias, 1915–17," enclosure in Bowring to Long, 5 December 1918, PRO: CO 533/199.

27. Deputy Governor to S of S, 17 December 1923, PRO: CO 533/299.

28. Ibid.

29. Great Britain, *Colony and Protectorate of Kenya Annual Report for 1924* (London: HMSO, 1925).

30. Ibid.

31. Ibid.

32. Ibid.

33. Colony and Protectorate of Kenya, *1927 Medical Report* (Nairobi: Government Printer).

34. Outline of Medical and Sanitary Work Being Attempted, with Proposals for Its Extension, and Details of Additional Staff Required, enclosure in Principal Medical Officer to Acting Colonial Secretary, 12 May 1925, PRO: CO 533/332.

35. Ibid.

36. Ibid.

37. Governor Sir Edward Grigg to S of S Amery, 31 May 1926, PRO: CO 533/350. Grigg was appointed Governor by Amery in 1925, following the death of his predecessor, Sir Robert Coryndon.

38. Grigg to S of S, 31 May 1926, PRO: CO 533/350.

39. Memorandum on the Training of African Staff of the Medical Department, enclosure in M. M. Moore, Governor's Deputy, to S of S, Cunliffe-Lister, 6 August 1932, PRO: CO 533/426/8.

40. Ibid.

41. Ibid.

42. Ibid.

43. Judith Lorber, *Gender and the Social Construction of Illness* (London: Sage Publications, 1997), 95. Also see Phil Brown, "Naming and Framing: The Social Construction of Diagnosis and Illness," *Journal of Health and Social Behavior* (1995): 34–52, and Bernice A. Pescoslido, "Beyond Rational Choice: The Social Dynamics of How People Seek Help," *American Journal of Sociology* 97 (1992): 1096–1138.

44. Lorber, *Gender and Social Construction,* 99.

45. Memorandum on the Training of African Staff of the Medical Department, enclosure in M. M. Moore, Governor's Deputy, to S of S, Cunliffe-Lister, 6 August, 1932, PRO: CO 533/426/8.

46. Ibid.

47. For details pertaining to the appointment of this Joint Select Committee, see Robert G. Gregory, *Sidney Webb and East Africa: Labor's Experiment with the Doctrine of Native Paramountcy* (Berkeley: University of California Press, 1962), 114–120; and Jidlaph G. Kamoche, *Imperial Trusteeship and Political Evolution in Kenya, 1923–1963* (Washington D. C.: University Press of America, 1981), 81–118. The committee heard evidence from fifty-one witnesses out of which three were Kenyan Africans: Chief Koinange Mbiyu from Kiambu, Chief James Mutua from Ukambani, and Ezekiel Apindi, the leader of the Kavirondo Taxpayers Welfare Association. For details pertaining to Koinange's role in the colonial establishment as a chief, also see Marshall S. Clough, *Fighting Two Sides: Kenyan Chiefs and Politicians, 1918–1940* (Niwot: University Press of Colorado, 1990), 154–155. Chief Koinange, Chief Mutua, and Deacon Apindi were selected by the colonial government to testify on behalf of the Africans before the Joint Select Committee. Koinange was a chief in Kiambu, while Mutua was a chief in Ukambani. Apindi was a deacon with the Anglican Church and had forged a close working relationship with Archdeacon Owen in promoting community development in western Kenya. The three were selected for their perceived loyalty to the colonial state. Their critique of the system, therefore, came as a surprise to the colonial authorities.

48. Evidence of Chief Koinange and Mr. Ezekiel Apindi before the Joint Select Committee on East Africa, 28 April 1931, PRO: CO 533/410.

49. Evidence of Koinange in ibid.

50. Ibid.

51. Evidence of Apindi before the Joint Select Committee on East Africa, 28 April 1931, PRO: CO 533/410.

52. Ibid.

53. Oral interviews, Tobias Omondi, 3 July 1997, and John Owuor Anindo, 6 July 1997.

54. Paulina Bosibori, the fourth wife of the late Senior Chief Musa Nyandusi, remi-

nisced: "The Chief was a lover of knowledge. He cherished education and strived to ensure that *all people under him* became literate. That is why he offered to pay fees for so many children. *He employed a teacher for his wives* and children and through that arrangement, I learnt how to read, write and speak Kiswahili. He insisted that all his wives must speak Kiswahili" (emphasis mine). Interview with Bosibori, conducted by Joe Ombuor and Peter Angwenyi, *Daily Nation,* 24 February 1999.

55. Oral interview, Tobias Omondi, Uradi, 3 July 1997.

56. Also see Angeline Janssens, "The Rise and Decline of the Male Breadwinner Family? An Overview of the Debate," *International Review of Social History* 42 (1997): 1–23; and Samita Sen, "Gendered Exclusion: Domesticity and Dependence in Bengal," *International Review of Social History* 42 (1997): 65–86.

57. For details pertaining to the rise of women-headed households, see David William Cohen and E. S. Atieno Odhiambo, *Siaya: The Historical Anthropology of an African Landscape* (Athens: Ohio University Press, 1989), 85–92.

58. R. J. Mason, *British Education in Africa* (London: Oxford University Press, 1959), 109.

59. Office for UN Affairs and the National Catholic Welfare Conference, eds., "African Women Speak," *World Horizon Reports,* 26 (New York: Catholic Foreign Mission Society of America, Inc., 1960).

60. Lorber, *Gender and Social Construction,* 97.

61. Colony and Protectorate of Kenya, *Education Department Annual Report, 1934* (Nairobi: Government Printer, 1935), 39, in PRO: CO 533/461.

62. Ibid.

63. Colony and Protectorate of Kenya, *Annual Report on Native Affairs, 1936* (Nairobi: Government Printer, 1937), 53, in PRO: CO 533/479.

64. Ibid., 36.

65. Ibid.

66. Extract from the Minutes of the Meeting of the Colonial Advisory Medical Committee held on 16 January 1934, enclosure in Governor Byrne to S of S, Sir Philip Cunliffe-Lister, 22 February 1934, PRO: CO 533/444.

67. Ibid.

68. For a detailed treatment of this theme, see G. Lewis, "A View of Sickness in New Guinea," in *Social Anthropology and Medicine,* ed. J. B. Loudon (London: Free Press, 1976), 49–103.

69. David Nyamwaya, "Causation of Illness in African Traditional Medicine," *Mila: A Biannual Newsletter of Cultural Research* 6, 2 (1983): 4.

70. Ibid.

71. Paul Mboya, *Richo Ema Kelo Chira* (Nairobi: EAPH, 1981). Mboya emphasizes the fact that living in society entails following the societal prescriptions about what ought to be done and what ought not to be done. Failure to live according to this cultural ideology results in far-reaching repercussions on the individual and the society in terms of the physical sickness and biological degeneration of the individual in particular and society in general. Also see A.B.C. Ocholla-Ayayo, *Traditional Ideology and Ethics among the Southern Luo* (New York: Africana Publishing Company, 1976), 153–155, 176–177.

72. Mboya, *Richo*; Ocholla-Ayayo, *Traditional Ideology,* 153–155, 176–177; Nyamwaya, "Causation of Illness," 4.

73. Nyamwaya, "Causation of Illness."

74. H. Ngubane, *Body and Mind in Zulu Medicine* (London: Academic Press, 1977), 27–28, cited in Nyamwaya, "Causation of Illness," 4.

75. The World Health Organization's definition of health is cited in John M. Janzen, "Changing Concepts of African Therapeutics: A Historical Perspective," in Brian M. Du Toit and Ismail H. Abdalla, eds., *African Healing Strategies* (New York: Trado-Medic Books Ltd., 1985), 66.

76. Abayomi Sofowora, *Medicinal Plants and Traditional Medicine in Africa* (New York: John Wiley and Sons Ltd., 1982), 6.

77. Oral interview, Jawuoyo Lihanda, Harambee, Suna, 17 December 1998.

78. Oral interview, Eliud Balla Nyamor, Waundha, Sakwa, 19 December 1998. This informant migrated to his present location in 1959. He exhibits a deep knowledge of traditional medicine. He is a member of the Church of Christ in Africa. Unlike most of the other interviewees, he does not have much faith in hospitals and rarely refers his patients to them.

79. Oral interview, Aringo Omer, Kanyimach, Kamagambo, 18 December 1998. Aringo Omer was born around 1925 in what is today Kisumu District. He migrated with his parents to his present location in 1927. Omer has a deep knowledge of diseases and their cures. He is a member of the Seventh Day Adventist Church (SDA) and sees no conflict at all between Christianity, hospitals, and his medicinal practice. He has treated many members of the SDA Church. He sends some of his people to hospitals just as he receives and treats some who have not been cured at hospitals. In his view, the traditional and hospital-based therapies coexist out of necessity.

80. Oral interview, Philister Apiyo Oyugi, Nyabisawa, Suna, 26 December 1998. Oyugi was born in Kadem-Nyoro, but moved to her present location after she got married. She argued that some traditional medical skills such as surgery were fairly effective, but were abandoned because of the introduction of Western biomedical surgical practices. Like most of the interviewees, she believes that the two systems can coexist but that people have little regard for the traditional therapies. She is, however, optimistic because of the latest developments in the health sector in Kenya in which mainstream health care has deteriorated so much that getting medicine from the hospitals is not guaranteed. She now sees more patients than she used to when mainstream health care was vibrant.

81. Samuel C. Ramer, "Traditional Healers and Peasant Culture in Russia, 1861–1917," in Esther Kingston-Mann and Timothy Mixter, eds., *Peasant Economy, Culture, and Politics of European Russia, 1800–1921* (Princeton, N. J.: Princeton University Press, 1991), 220.

82. G. Waite, "Public Health in Precolonial East-Central Africa," in Steven Feierman and John M. Janzen, eds., *The Social Basis of Health and Healing* (Berkeley: University of California Press, 1992), 214.

83. C. W. Hobley, *Eastern Uganda: An Ethnological Survey* (London: Anthropological Institute of Great Britain and Ireland, 1902), 72, 80.

84. Ibid., 34–35.

85. J. O. Kokwaro, *Medicinal Plants of East Africa* (Nairobi, EAPH, 1976), 1. Kokwaro's book details the medicinal functions of various local plants of East Africa.

86. Waite "Public Health," 214–215; Ocholla-Ayayo, *Traditional Ideology,* 153–155.

87. Ibid.

88. Ibid.

89. Waite, "Public Health," 214–215; Hobley, *Eastern Uganda,* 32–33; Ocholla-Ayayo, *Traditional Ideology,* 162–164. Also see Sofowora, *Medicinal Plants and Traditional Medicine,* 4–5.

90. Waite, "Public Health," 214–215; Hobley, *Eastern Uganda,* 32–33; Ocholla-Ayayo, *Traditional Ideology,* 162–164. Also see Janzen, "Changing Concepts of African Therapeutics," 70–81. Janzen emphasizes the centrality of *Ngoma* therapy in health and healing among most of the Bantu communities of Central and Southern Africa. According to Janzen, this therapy is used to identify the "drum type, rhythm, song and dance, or a combination of all these in a therapeutic fashion" (70).

91. White, "Public Health," 215; Ocholla-Ayayo, *Traditional Ideology,* 163–164; P. Muronji Shilaro, "Kabras Culture under Colonial Rule: A Study of the Impact of Christianity and Western Education," M.A. thesis, Kenyatta University, 1991, 60.

92. Rev. Father N. Stam, "Bantu Kavirondo of Mumias District (near Lake Victoria)," *Anthropos* 14–15 (1919–1920): 974–975.

93. P. Stanley Yoder, "Issues in the Study of Ethno-Medical Systems in Africa," in P. Stanley Yoder, ed., *African Health and Healing Systems: Proceedings of a Symposium* (Los Angeles: Crossroads Press, 1982), 2.

94. Botanist Dr. Robert I. Bolla, quoted in Barbara Ponder, "Medicine, Industry Benefit form Study of Plant Biology," *Saint Louis County Journal* (Saint Louis, Mo.), 7 September, 1997, 7.

Notes to Chapter 5

1. Colony and Protectorate of Kenya, Annual Report 1920–1921, enclosure in Northey to Churchill, 31 March 1922, PRO: CO 533/276.

2. Northey to Churchill, 13 April 1922, PRO: CO 533/276.

3. Ibid.

4. Robert M. Maxon, *East Africa: An Introductory History* (Morgantown: West Virginia University Press, 1994), 196–199.

5. Northey to Churchill, 13 April 1922, PRO: CO 533/2276.

6. This paper was a statement by the Colonial Office that Kenya was primarily an African country and that African interests were paramount. The British government declared itself the trustee for the African population. The Africans were to be provided with colonial choices by the British government through the Governor. However, Africans could not be trusted to determine their own destiny. See Maxon, *East Africa,* 197–198.

7. Enclosure in Northey to Churchill, 13 April 1922, PRO: CO 533/276.

8. See K. M. Okaro-Kojwang', "Origins and Establishment of the Kavirondo Taxpayers Welfare Association," in B. G. McIntosh, ed., *Ngano* (Nairobi: EAPH, 1969), 114.

9. Objects of Kavirondo Taxpayers Welfare Association, enclosure in Acting Governor to S of S, 14 February 1924, PRO: CO 533/308.

10. Report of the Director of Education to the Colonial Secretary, Social Education in Kavirondo: The Kavirondo Welfare Association, enclosure in Acting Governor to S of S, 4 July 1924, PRO: CO 533/312.

11. Objects of Kavirondo Taxpayers Welfare Association, enclosure in Acting Governor to S of S, 14 February 1924, PRO: CO 533/308.

12. Ibid.

13. Report of Director of Education to Colonial Secretary, "Social Education in Kavirondo: The Kavirondo Welfare Association," enclosure in Acting Governor to S of S, 4

July 1924, PRO: CO 533/312. However, the association lost much of its popularity after Owen assumed leadership and redirected its agenda to social issues: NPAR 1924, KNA: PC/NZA/1/19.

14. Great Britain, *Advisory Committee on Native Education in the British Tropical African Dependencies, Education Policy in British Tropical Africa,* Cmd. 2374 (London: HMSO, 1925).

15. Robert Collins, "Educating the African," in Robert Collins et al., eds., *Historical Problems of Imperial Africa* (Princeton, N.J.: Markus Weiner Publishers, 1996), 190.

16. Ibid.

17. "Participatory" in the sense that the school curriculum was intended to be responsive to the needs of society by ensuring that students and teachers were involved in programs that promoted the "ethics of hygiene" in their homes.

18. Principal Medical Officer to Director of Education, "Health and Sanitation in Native Reserves," 4 April 1924, KNA/PH/2/105.

19. The Jeanes School project was based on a model of education among African Americans in the southern states of the United States in which the Jeanes teachers were to foster efforts to teach people how to preserve food, practice good hygiene, and combat illiteracy. The teachers were to coordinate and organize the building of schools and the raising of funds, gradually altering the lives of the oppressed group. See Valinda Littlefield, "To Do the Next Needed Thing: Jeanes Teachers in the Southern United States 1908–34," in Kathleen Weiler and Sue Middleton, eds., *Telling Women's Lives: Narrative Inquiries in the History of Women's Education* (Buckingham, England, and Philadelphia: Open University Press, 1999), 130–146; National Association of Supervisors and Consultants Interim History Writing Committee, *The Jeanes Story: A Chapter in the History of American Education 1908–1968* (Atlanta: Southern Educational Foundation, 1979).

20. E. S. Atieno Odhiambo, "Japuonj Samuel G. Ayany Onyango: Critical Perspectives on Knowledge and Development for and about the Luo of Kenya at Mid-Twentieth Century," paper presented at the International African Institute Seminar on African Philosophy and Critical Inquiry, Nairobi: Kenya, 26–28 April 1993.

21. See Florida Karani, "The History of Maseno School, 1906–1962, Its Alumni and the Local Society," M.A. thesis, University of Nairobi, 1974; E. S. Atieno Odhiambo, "The Movement of Ideas; A Case Study of Intellectual Responses to Colonialism among the Liganua Peasants," in Bethwell A. Ogot, ed., *History and Social Change in East Africa* (Nairobi: EAPH, 1976); and David W. Cohen and E. S. Atieno Odhiambo, *Siaya: The Historical Anthropology of an African Landscape* (Athens: Ohio University Press, 1989), 111–116.

22. Governor Sir Edward Grigg to S of S Amery, 31 May 1926, PRO: CO 533/350.

23. Terms of reference for the Ormsby-Gore Parliamentary Commission, enclosure in ibid.

24. Ibid.

25. Outline of Medical and Sanitary Work Being Attempted, with Proposals for Its Extension, and Details of Additional Staff Required Therefore, enclosure in Principal Medical Officer to Acting Colonial Secretary, 12 May 1925, PRO: CO 533/332.

26. Acting Governor to S of S, 4 July 1924, PRO: CO 533/312.

27. Ibid.

28. See M. Omusule, "Political and Constitutional Aspects of the Origins and Development of Local Government in Kenya, 1895–1963," Ph.D. dissertation, Syracuse University, 1975.

29. Ibid.

30. Colony and Protectorate of Kenya, Native Affairs Department Annual Report, 1927, Schedule B, PRO: CO 533/382.

31. Ibid.

32. Ibid.

33. Ibid.

34. Ibid.

35. Evidence of Apindi before the Joint Select Committee on East Africa, 28 April 1931, PRO: CO 533/410.

36. Evidence of Lieut. Colonel Sir Edward W. M. Grigg before the Joint Select Committee on East Africa, 3 March 1931, PRO: CO 533/410.

37. Ibid., paragraph 105. Also see George Bennett, *Kenya, a Political History: The Colonial Period* (Oxford: Oxford University Press, 1963).

38. Great Britain, *Report by the Financial Commissioner (Lord Moyne) on Certain Questions in Keny*a, Cmd. 4093 (London: HMSO, 1932), 1, in PRO: CO 533/421.

39. Ibid., 8.

40. Report of Joint Select Committee on Close Union, Vol. 1, paragraph 74, PRO: CO 533/421.

41. Governor Byrne to S of S, Major Sir Philip Cunliffe-Lister, 11 February 1932, PRO: CO 533/420.

42. Cunliffe-Lister to Byrne, 8 August 1931, PRO: CO 533/415.

43. Peter Odhiambo Ndege, "Struggles for the Market: The Political Economy of Commodity Production and Trade in Western Kenya, 1929–1939," Ph.D. diss., West Virginia University, 1993, 161.

44. H.E. Joseph Byrne's Address to the Kenya Legislative Council (Budget Session), Nairobi, 28 October 1936, enclosure in Byrne to Bottomley, 29 October 1936, PRO: CO 533/471.

45. Great Britain, *Report by the Financial Commissioner,* 33.

46. Estimates Approved by the Legislative Council for 1929, 1932, and 1933, PRO: CO 533/382, 533/402 ADN 533/440. Also see Beck, *A History,* 217.

47. Sharon Stichter, *Migrant Labour in Kenya: Capitalism and African Response 1895–1975* (London: Longman, 1982), 82.

48. Colony and Protectorate of Kenya, *Legislative Council* Debates, 24 October 1930 (Nairobi: Government Printer), 720.

49. Enclosure in Grigg to Amery, 4 January 1929, PRO: CO 533/382.

50. Report of the Select Committee on Draft Estimates for 1929 adopted in Legislative Council on the 9th of November, 1928, enclosure in Grigg to Amery, 4 January 1929, PRO: CO 533/382.

51. Ibid.

52. Great Britain, *Colony and Protectorate of Kenya Annual Report for 1929* (London: HMSO, 1930), 78.

53. NPAR 1936, KNA: PC/NZA/1/31.

54. For details pertaining to the politics as well as the economic rationale that underpinned this legislation, see Stephen Constantine, *The Making of British Colonial Development Policy, 1914–1940* (London: Frank Cass, 1984), 164–194.

55. Ibid., 187.

56. Ibid., 188.

57. Ibid.

58. NPAR 1936, KNA: PC/NZA/1/31.

59. Ibid.

60. Ibid.

61. Estimates Approved by the Legislative Council for 1929, 1932, 1933, PRO: CO 533/382, 533/402, and 533/440 respectively.

62. Great Britain, *Report by the Financial Commissioner,* 33.

63. Ibid.

64. Ibid.

65. Byrne's Address to the Legislative Council, enclosure in Byrne to Bottomley, 29 October 1936, PRO: CO 533/471.

66. Ibid.

67. Stichter, *Migrant Labour,* 82.

68. Hugh Fearn, *An African Economy: A Study of the Economic Development of Nyanza Province, 1903–1953* (London: Oxford University Press), 130.

69. Ibid., 138–139.

70. Public Health-North Kavirondo, enclosure in Medical Officer of Health, North Kavirondo and Nandi Reserves, to Director of Medical and Sanitary Services, 10 May 1933, KNA: PH/1/1/2/1.

71. Ibid.

72. Memorandum On Provision for European Sick in South Kavirondo, enclosure in District Commissioner, South Kavirondo, to Provincial Commissioner, Nyanza, 8 October 1937, KNA: PH/2/1/5.

73. Public Health-North Kavirondo, enclosure in Medical Officer of Health, North Kavirondo and Nandi Reserves, to Director of Medical and Sanitary Services, 10 May 1933, KNA: PH/1/1/2/1.

74. Ibid.

75. Ibid; NPAR 1935, KNA: PC/NZA/1/30.

76. Extract from the Minutes of the Meeting of the Colonial Advisory Medical Committee held on 16 January 1934, enclosure in Byrne to Cunliffe-Lister, 22 February 1934, PRO: CO 533/444.

77. Public Health-North Kavirondo, enclosure in Medical Officer of Health, North Kavirondo and Nandi Reserves, to Director of Medical and Sanitary Services, 10 May 1933, KNA: PH/1/1/2/1.

78. Ibid.

79. NPAR 1937, KNA: PC/NZA/1/32.

80. Ibid.

81. Fearn, *An African Economy,* 148–149. Fearn further asserts that there was a time when a number of mines supported a joint hospital at Chief Milimu's camp.

82. NPAR 1935, KNA: PC/NZA/1/30.

83. The Lolgorien gold mines were not actually in South Kavirondo District, although, according to the records, they were considered as part of the Nyanza gold mines. The Lolgorien mines were geographically in Maasai/Southern Rift Valley, which is now in Rift Valley Province.

84. Field Manager, Kenya Consolidated Goldfield Limited, to District Commissioner, South Kavirondo, 18 September 1937, KNA: 3571/PH/2/1/5.

85. District Commissioner, South Kavirondo, to Provincial Commissioner, Nyanza, 7 September 1937, KNA: 3571/PH/2/1/5; Provincial Commissioner, Nyanza, to District Commissioner, South Kavirondo, 18 September 1937, KNA: 3571/PH/2/1/5.

86. District Commissioner, South Kavirondo, to Provincial Commissioner, Nyanza, 26 May 1938, KNA: 2189/PH/2/1/5.

87. NPAR 1934, KNA: PC/NZA/1/29. Two more had been added in North Kavirondo and one in South Kavirondo.

88. NPAR 1930, KNA: PC/NZA/1/25.

89. Ibid.

90. Ibid.

91. NPAR 1932, KNA: PC/NZA/1/27.

92. Leprosy Report on Kenya, enclosure in Acting Director of Medical Services to Provincial Commissioner, Nyanza, 19 July 1938, KNA: PH/1/6.

93. Ibid.

94. Ibid.

95. Ibid.

96. Ibid.

97. Ibid.

98. Ibid.

99. Ibid.

100. NPAR 1929, KNA: PC/NZA/1/24.

101. Ibid.

102. NPAR 1930, KNA: PC/NZA/1/25.

103. NPAR 1935, KNA: PC/NZA/1/30.

104. NPAR 1936, KNA: PC/NZA/1/31.

105. Medical Officer of Health, Kisumu, to Acting Director of Medical Services, 5 March 1938, KNA: 1046/PH/5/2/1.

106. NPAR 1936, KNA: PC/NZA/1/31.

107. Ibid.

108. Ibid.

109. John A. Carman, *A Medical History of the Colony and Protectorate of Kenya: A Personal Memoir* (London: Rex Collings, 1976), 35, 49.

110. Ibid.

111. Ibid.

112. Maseno Medical Report, Maseno and Its Dispensaries, 1932, KNA: PH/5/2/1.

113. District Commissioner, North Kavirondo, to Provincial Commissioner, Nyanza, 19 December 1939, KNA: 67/PH/3/1/5.

114. Government Notice on Public Health Ordinance Chapter 124 Laws of Kenya, enclosure in District Commissioner, Nyanza, 4 January 1940, KNA: 67/PH/3/1/5.

115. The word "eugenics" was first coined by the Englishman Francis Galton in 1883 to refer to a wide array of human physical, mental, and moral traits that were inherited. During the subsequent five decades, the eugenics movement spread to various countries with the result that it came to acquire multiple meanings and endeared itself to various professions, as well as appearing on a range of ideological and political platforms. For details of the development of eugenics, see Mark B. Adams, ed., *The Wellborn Science: Eugenics in Germany, France, Brazil, and Russia* (Oxford: Oxford University Press, 1989); Robert N. Proctor, *Racial Hygiene* (Cambridge: MIT Press, 1988); Edward J. Larson, *Sex, Race, and Science: Eugenics in the Deep South* (Baltimore: Johns Hopkins University Press, 1995); and Larson, *The Black Stork, Eugenics and the Death of "Defective" Babies in American Medicine and Motion Pictures since 1915* (Oxford: Oxford University Press, 1996).

116. Letter from the Eugenics Society, entitled "East African Native: Brain Structure and Mental Capacity," to Under Secretary of State for Colonies, 21 November 1933, PRO: CO 822/61/14.

117. "Eugenics and the Truth about Ourselves in Kenya," enclosure in East African Medical Association to Secretary of State for Colonies, PRO: CO 822/72/8.

118. Ibid.

119. Enclosure in ibid. Also see Ann Beck, *A History of the British Medical Administration of East Africa, 1900–1950* (Cambridge: Harvard University Press, 1970), 184.

120. M. Clark Collision, Hon. Political Secretary, British Commonwealth League, to S of S, Cunliffe Lister, MP, 21 September 1934, PRO: CO 822/61/14.

121. A. R. Paterson, Director of Medical and Sanitary Services, to the Hon. Colonial Secretary, 23 January 1934.

122. Ibid.

123. Ibid.

124. Megan Vaughn, *Curing Their Ills: Colonial Power and African Illness* (Stanford, Calif.: Stanford University Press, 1991), 202.

125. Minute by J.E.W. Flood, 10 November 1936, PRO: CO 822/72/8. Educated at Trinity College, Dublin, where he graduated with a B.A. degree, J.E.W. Flood was a career administrator, having served as a military assistant secretary, as vice chairman of the Colonial Advisory Medical and Sanitary Committee, and as a member of the West African Currency Board.

126. Private memo by Dr. W. H. McLean to Flood, PRO: CO 822/79/19, 2 May 1937. McLean sought to publish the contents of his memo in the *Times,* to which Flood consented with appreciation. In his response to McLean, Flood was quite critical of Dr. Gordon. He described Gordon in uncharacteristically harsh and demeaning words as "an old man who is now over seventy and has been dealing with lunatics all of his life, has got it from them, and is probably [as much] in need of a psychiatrist as any of his patients. He has lost all sense of proportion and I don't think anybody need worry very much about him." Flood to McLean, 3 May 1937, PRO: CO 822/79/19.

127. Flood to McLean, 3 May 1937, PRO: CO 822/79/19.

128. Ibid.

129. Colony and Protectorate of Kenya, *Legislative Council Debates,* 24 October 1930 (Nairobi: Government Printer), 720.

Notes to Chapter 6

1. Research into the origins of the Mau Mau uprising and its impact on political and economic developments in Kenya has yielded many monographs and articles. See David W. Throup, *Economic and Social Origins of Mau Mau 1945–1953* (Athens: Ohio University Press, 1990); Tabitha Kanogo, *Squatters and the Roots of Mau Mau 1905–1963* (Athens: Ohio University Press, 1987); Frank Furedi, *The Mau Mau War in Perspective* (London: James Currey, 1989); Wunyabari Maloba, *Mau Mau and Kenya: An Analysis of a Peasant Revolt* (Bloomington: Indiana University Press, 1993), Marshall S. Clough, *Mau Mau Memoirs: History, Memory and Politics* (Boulder, Colo.: Lynne Rienner Publishers, 1998); Frederick Cooper, " Mau Mau and the Discourses of Decolonization," *Journal of African*

History 29 (1988): 313–320; and John Lonsdale, "Mau Maus of the Mind: Making Mau Mau and Remaking Kenya," *Journal of African History* 31 (1990): 393–421.

2. Republic of Kenya, *Sessional Paper No. 1 of 1986: Economic Management for Renewed Growth* (Nairobi: Government Printer, 1986).

3. Republic of Kenya, *Sessional Paper No. 10 of 1965: African Socialism and Its Application to Planning in Kenya* (Nairobi: Government Printer, 1965).

4. Ronald Robinson, "Andrew Cohen and the Transfer of Power in Tropical Africa, 1940–51," in W. H. Morris-Jones and Georges Fischer, eds., *Decolonization and After: The British and the French Experience* (London: Frank Cass, 1980); D. A. Low and J. M. Lonsdale, "Towards the New Order, 1945–63," in D. A. Low and Alison Smith, eds., *The Oxford History of East Africa, Vol. 3* (Oxford: Clarendon Press, 1976), 12–16; D. K. Fieldhouse, *Black Africa, 1945–1980: Economic Decolonization and Arrested Development* (London: Unwin Hyman, 1986).

5. "On the Implementation and Interpretation of Social Medicine in the Native Reserves," Memorandum by Director of Medical Services, 16 May 1950, KNA: PH/76/8/22/109.

6. S. Ogoh Alubo and Franklin Vivekananda, *Beyond the Illusion of Primary Health Care in an African Society* (Stockholm: Bethany Books, 1995), 50–51.

7. Ibid.

8. "Minutes of a Meeting of Provincial Commissioners held at the Secretariat on 13th, 14th and 15th March, 1951," KNA: PH/76/8/22.

9. Great Britain, *East Africa Royal Commission, 1953–1955, Report,* Cmd. 9745 (London: HMSO, 1961), 208.

10. *Report of the Municipal African Affairs Officer Nairobi, 1948,* p. 11, quoted in ibid. 207. Also see Throup, *Economic and Social Origins of Mau Mau,* 171–202.

11. Great Britain, *East Africa Royal Commission, 1953–1955,* 211; Nairobi District Annual Report, 1958, KNA: PC/CP4/3.

12. Great Britain, *East Africa Royal Commission, 1953–1955,* 211.

13. Clough, *Mau Mau Memoirs,* 114–115.

14. Oliver Lyttelton, S of S of Colonies, Statement on African Housing Schemes to the House of Commons, 29 July 1953. According to the Secretary of State, between 1953 and 1957, Nairobi City Council had a capital program of £2 million for developing units to house 25,000 people, Mombasa £250,000 for 3,000 to 4,000 people, Nakuru £300,400 for 5,000 people, Eldoret £85,700 for 1,500 people and Kisumu £20,000 for 400 people. To supplement those schemes, the Kenyan government negotiated a loan of £2 million from the Colonial Development Corporation to finance direct government construction of African housing under the aegis of the Central Housing Board.

15. Ann Laura Stoler and Frederick Cooper, *Tensions of Empire: Colonial Cultures in a Bourgeois World* (Berkeley: University of California Press, 1997), 34–35.

16. Great Britain, *East Africa Royal Commission, 1953–1955,* 174.

17. Despatch from the Governor of Kenya, 17 February 1956, in Great Britain, *Despatches from the Governors of Kenya, Uganda and Tanganyika and from the Administrator, East Africa High Commission, Commenting on the East Africa Royal Commission* (London: HMSO, 1956), 58.

18. Ibid.

19. Republic of Kenya, *Sessional Paper No. 10 of 1965: African Socialism and Its Application to Planning in Kenya* (Nairobi: Government Printer, 1965).

20. F. M. Mburu, "The Impact of Colonial Rule on Health Development: The Case of Kenya," in Toyin Falola and Dennis Ityavyar, eds., *The Political Economy of Health in Africa* (Athens: Ohio University Center for International Studies, 1992), 95–99; and Ann Beck, *A History of the British Medical Administration in East Africa, 1900–1950* (Cambridge: Harvard University Press, 1970).

21. Republic of Kenya, *Sessional Paper No. 10 of 1965.*

22. Tom Mboya, *The Challenge of Nationhood* (Nairobi: Heinemann, 1972), 80.

23. This group was led by Oginga Odinga, who later resigned from KANU to found the opposition party, the Kenya Peoples Union (KPU). Oginga Odinga, *Not Yet Uhuru* (Nairobi: Heinemann, 1967), 253–315. For the ideological as well as power struggles that characterized this period, see also David Goldsworthy, *Tom Mboya: The Man Kenya Wanted to Forget* (London: Heinemann, 1982); and William Attwood, *The Reds and the Blacks* (New York: Harper and Row, 1967).

24. Republic of Kenya, *Development Plan, 1966–1970* (Nairobi: Government Printer, 1966), 314.

25. When Oginga Odinga broke away from KANU to found KPU, his argument was that KANU had fallen prey to neocolonial interests and had, therefore, betrayed the cause for which the independence struggle was fought. It is not surprising that his major book, which was published one year after the founding of his party, was titled *Not Yet Uhuru* (not yet independence).

26. Republic of Kenya, *Development Plan, 1966–1970.*

27. Also see J. Owino-Ombudo, *Harambee, Its Origin and Use* (Nairobi: Transaction Publishers, 1972); and Norman Miller and Rodger Yeager, *Kenya: The Quest for Prosperity* (Boulder, Colo.: Westview Press, 1994), 42–44.

28. Nyayo wards were basically hospital wards that were built through Harambee efforts. President Moi took a keen interest in the construction of these health facilities. He often presided over functions that raised funds for the construction of the wards. Besides giving generous donations, he ensured that that these wards were equipped with the necessary facilities. The name "Nyayo" that is linked to these Harambee constructed health facilities is a tribute to his active participation in the project. "Nyayo" is a Kiswahili word, which means "footsteps." The term also has political undertones. President Moi initially used the term to reassure the country that he would follow in the footsteps of his predecessor. Later the term was elevated by Moi and his political cohorts to mean peace, love, and unity. Whether the "footsteps" actually exhibited peace or war, love or hatred, unity or disunity is outside the orbit of this work. Nevertheless, Moi's reign is often referred to as the Nyayo era, from which the wards also derive their identity. For details of Nyayo as a philosophy, see Daniel T. Arap Moi, *Kenya African Nationalism: Nyayo Philosophy and Principles* (London: Macmillan, 1986).

29. World Bank, *World Bank Development Report 1975* (New York: Oxford University Press, 1975). Also see Republic of Kenya, *Development Plan, 1994–1996* (Nairobi: Government Printer, 1994), 1–4.

30. Republic of Kenya, *Development Plan, 1970–1974* (Nairobi: Government Printer, 1969), 489.

31. Douglas C. Earbank and James N. Gribble, eds., *Population Dynamics of Sub-Saharan Africa: Effects of Health Programs on Child Mortality in Sub-Saharan Africa* (Washington, D.C.: National Academy Press, 1993).

32. Republic of Kenya, *District Focus for Rural Development* (Nairobi: Government Printer, 1983).

33. Joseph Makokha, *The District Focus: Conceptual and Management Problems* (Nairobi: Africa Research Bureau, 1985), 1–54.

34. Quoted in ibid., 33.

35. Joel Barkan with Michael Chege, "Decentralizing the State: District Focus and the Politics of Reallocation," *Journal of Modern African Studies* 27, 3 (1989): 431–453.

36. Republic of Kenya, *Sessional Paper No. 1 of 1986: Economic Management for Renewed Growth* (Nairobi: Government Printer, 1986).

37. Also see Robert Maxon and Peter Ndege, "The Economics of Structural Adjustment," in Bethwell A. Ogot and W. R. Ochieng', eds., *Decolonization and Independence in Kenya, 1940–1993* (Athens: Ohio University Press, 1995), 151–158.

38. John Toye, "Structural Adjustment: Context, Assumptions, Origin and Diversity," in Rolph Van Der Hoeven and Fred Van Der Kraaij, eds., *Structural Adjustment and Beyond in Sub-Saharan Africa* (Portsmouth, N. H.: Heinemann, 1994), 18–35. World Bank, *World Bank Report: Sub-Saharan Africa—From Crisis to Sustainable Growth, 1989 (*Washington D.C.: World Bank, 1989).

39. Vincent Khapoya, *The African Experience* (Upper Saddle River, N. J.: Prentice-Hall, 1998), 297; Ben Turok "Towards A Democratic Coalition against SAP," in Peter Anyang' Nyongo,' ed., *30 Years of Independence in Africa: The Lost Decades* (Nairobi: Academy Science Publishers, 1992), 131–144.

40. Richard Jeffries, "The State, Structural Adjustment and Good Government in Africa," *Journal of Commonwealth and Comparative Politics* 31(1993): 20–35.

41. Khapoya, *African Experience,* 297.

42. Toyin Falola, "The Crisis of African Health Care Services," in Toyin Falola and Dennis Ityavyar, eds., *The Political Economy of Health in Africa* (Athens: Ohio University Center for International Studies, 1992), 6.

43. Samir Amin, "Ideology and Development in Sub-Saharan Africa," in Peter Anyang' Nyongo,' ed., *30 Years of Independence in Africa: The Lost Decades* (Nairobi: Academy Science Publishers, 1992), 40–46.

44. Christopher Clapham, *Africa and the International System: The Politics of State Survival* (Cambridge: Cambridge University Press, 1996), 163–186; Basil Davidson, *The Black Man's Burden: Africa and the Curse of the Nation-State* (London: Currey, 1992); William R. Ochieng', "Structural and Political Changes," in Bethwell A. Ogot and William R. Ochieng', eds., *Decolonization and Independence in Kenya, 1940–93,* (Athens: Ohio University Press, 1995), 83–109.

45. Tiyambe Zeleza, "The Global Dimensions of Africa's Crisis: Debts, Structural Adjustment, and Workers," *Transafrican Journal of History* 18 (1989): 3–7.

46. Kighoma Malima, "Structural Adjustment: The African Experience," in Van Der Hoeven and Fred Van Der Kraaij, eds., *Structural Adjustment and Beyond in Sub-Saharan Africa* (Portsmouth, N.H.: Heinemann, 1994), 9–15.

47. Republic of Kenya, *National Development Plan, 1997–2001* (Nairobi: Government Printer, 1997), 157.

48. Ibid.

49. Ibid.

50. Ibid., 157.

51. Ibid., 158.

52. John Iliffe, *East African Doctors: A History of the Modern Profession* (Cambridge: Cambridge University Press, 1998), 198–199.

53. Republic of Kenya, *National Development Plan, 1997–2001,* 158.

54. Ibid., 151.

55. Ibid., 156.

56. World Bank, *Policy Research Report, Confronting AIDS* (Oxford: Oxford University Press, 1999), 320–338.

57. U.S. Census Bureau, *The Official Statistics, 1999* (Washington, D.C.: U.S. Census Bureau, 2000).

58. World Bank, *Policy Research Report.*

59. Republic of Kenya, *National Development Plan, 1997–2001,* 161; World Bank, *Policy Research Report,* 35.

60. Oral interview, Susana Obunga Omulo, Ayuyu, August 1999. Susana Obunga was married on the eve of World War II. She was widowed in 1959. She has two daughters and a son, several grandchildren, and great grandchildren. She is a specialist in gynecological and infertility cases. She inherited the art from her mother and has helped many women. She is not as active as she used to be, a development that she attributes to age, as she cannot move to faraway places to obtain some of the medicines that she uses.

61. Republic of Kenya, *National Development Plan, 1997–2001,* 156.

62. Oral interview, Leonard Opiyo, Uradi, July 1997.

63. Oral interview, Jasters Onyango, Asego, August 1999.

64. Oral interview, Rose Akinyi, Asego, August 1999.

65. Oral interview, Joshua Okola Apuka, Homa Bay, July 1999. Joshua Okola Apuka hails from Alego, Siaya, but he currently resides at Homa Bay with his two wives. His second wife, Jane Auma, is also a healer. At Joshua Okola's two rented houses live two people being apprenticed into the art and a number of patients suffering from various ailments.

66. Jasters Onyango hails from Kano in Nyando District. Onyango is a member of the Legio Maria sect, which broke off from the Roman Catholic Church. Oral interview, Jasters Onyango, September 1999. Oral interviews, Jane Auma Okola, July 1999; Susana Obunga Omulo, August 1999.

67. Paul Mboya, *Richo Ema Kelo Chira* (Nairobi: EAPH, 1986), 1–35.

68. The *jonanga* were the emergent elite among the Luo during the colonial period. They acquired Western education, worked as clerks in colonial establishments, and/or traveled to the cities. Upon their return they saw themselves as torch bearers for the new order epitomized by the European ways of doing things. E. S. Atieno Odhiambo, "The Movement of Ideas: A Case Study of Intellectual Responses to Colonialism among the Liganua Peasants," in Bethwell A. Ogot, ed., *History and Social Change in East Africa* (Nairobi: EAPH, 1976). Also see David William Cohen and E. S. Atieno Odhiambo, *Siaya: The Historical Anthropology of an African Landscape* (Athens: Ohio University Press, 1989), 111–116.

69. Oral interview, Jasters Onyango, September 1999.

Notes to Chapter 7

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