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**THE MAKING OF RURAL HEALTHCARE IN COLONIAL ZIMBABWE:  
A HISTORY OF THE NDANGA MEDICAL UNIT, FORT VICTORIA,  
1930-1960S**

**BY**

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## ABSTRACT

### **“The Making of Rural Healthcare in Colonial Zimbabwe: A History of the Ndanga Medical Unit, Fort Victoria, 1930-1960s”**

*BY GLEN NCUBE*

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This thesis adopts a social history of medicine approach to explore the contradictions surrounding a specific attempt to develop a rural healthcare system in south-eastern colonial Zimbabwe (Southern Rhodesia) from the 1930s to the 1960s. Influenced by a combination of healthcare discourses and models, in 1930, the colony's new medical director formulated the first comprehensive rural healthcare delivery plan, premised on the idea of 'medical units' or outlying dispensaries networked around rural hospitals. Beginning with a brief analysis of the policy dimension of the scheme, the thesis proceeds to trace its implementation in Ndanga District, Fort Victoria Province, by the frontier medical officer, Dr James Kennedy. A determined, independent-minded but also unorthodox character, Dr Kennedy attempted with partial success to adapt a curative biomedical model to the local social milieu.

Placing this attempt within a wider context and tracing its waxing and waning over three decades, the thesis illustrates the challenges of developing efficient rural healthcare services within a context of colonial and cultural encounters. Insights about these complexities are drawn from a relatively rich, but imperfect, collection of evidence, including a variety of policy documents, operational records and correspondence, annual health reports, reports of commissions of inquiry, memoirs, published eyewitness accounts, photographs and oral testimonies. The thesis explores this evidence for underlying motives, recurrent practices and the key structures and discourses that drove rural medical policy-making and practice.

The main argument of the thesis is that the Ndanga Medical Unit, as this pioneer medical unit was known, was a variant of a typical colonial project characterised by tensions

between innovative endeavours to control disease on the one hand, and the need to fulfil broader colonial ambitions on the other. It further argues that, precisely because of this dual motive, African communities' responses were equally ambivalent as they selectively embraced the beneficial aspects and attempted with mixed results to reject intrusive and ineffective practices. The aim of the thesis is to take the historiography of colonial medicine beyond the polarising and increasingly unproductive debates that have depicted colonial medicine as either a pernicious sword of empire or a benign force for good.

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## ABBREVIATIONS

BNA	British National Archives
BRO	Bristol Records Office
BSACo	British South Africa Company
CVO	Compulsory Vaccination Order
CNC	Chief Native Commissioner
DRC	Dutch Reformed Church
GEMSS	Gloucestershire Extension of Medical Services Scheme
MRO	Masvingo Records Office
NACE	Native Affairs Committee of Enquiry
NAZ	National Archives of Zimbabwe
NC	Native Commissioner
RG	Responsible Government
SRN	State Registered Nurse
TB	Tuberculosis

## GLOSSARY OF VERNACULAR TERMS

Baira	Open air consultation area
Buka (also tsvio)	Epilepsy
Chiremba	Doctor
Karanga	Local dialect spoken by majority of communities in Ndanga, Gutu and Bikita Districts
Mchapi/mchape	Anti-witchcraft herbs of Malawian origin
Mhiripiri	Peri peri (chilli pepper)

Nhova	Fontanelle
Njovera	Syphilis (also used for yaws)
Shangani (Shangaan)	Ndanga ethnic group formerly with ties to Soshangane
vaKaranga	Karanga dialect speakers

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## DEDICATION

*To my late mother, Sarah Mthimunye, who believed and invested in my potential but sadly died before I completed my doctoral studies.*

## **Introduction**

### **Rethinking colonial healthcare**

The main goal of this thesis is the systematic examination of the historically important case study of the Ndanga Medical Unit with the objective of re-thinking the precise nature of colonial healthcare within the context of ongoing scholarly debates. Launched in the early 1930s in rural Fort Victoria Province, colonial Zimbabwe (hereafter Southern Rhodesia), the Ndanga Medical Unit – which at its zenith comprised ten medical stations – was one of the first two experiments of the reformatory ‘medical units’ scheme. This innovative, albeit colonially inclined, model for delivering rural district healthcare services was formulated in 1930 by the British colony’s principal medical officer as he attempted to reform the colony’s enclavist medical services and address the existing health challenges among African communities.

In addition to the intrinsic historical value of the medical units model as a distinctive variation of colonial healthcare, the ongoing historical debates surrounding the ways in which colonial public health officials understood and dealt with African health problems motivated and profoundly shaped this thesis. What were the basic motives of colonial healthcare? Did colonial officials comprehensively understand the health challenges faced by Africans? Were colonial healthcare initiatives innovative or not? Were they ill conceived? These apparently simple questions have occupied scholars for a long time now and the output is dizzying in terms of both quality and quantity.

However, despite a great deal of painstaking research and theorising on the subject, pinning down colonial biomedicine’s full spectrum of ‘basic assumptions, its methods, its goals, and

its priorities',<sup>1</sup> has proven to be a challenging affair. To date, a wide range of interpretations have been proffered and theoretical and historiographical lines of inquiry have waxed and waned, leaving the subject essentially an 'unfinished agenda'.<sup>2</sup> Three successive scholarly currents are discernible: the triumphalist tradition, the critical postcolonial historiography and the newly emerging revisionist scholarship.

Whereas the earliest interpretations tended to be Whiggish and laudatory, mainly depicting colonial medicine as a benign force for good and empire as the 'white man's burden',<sup>3</sup> in the postcolonial historiography colonial medicine attracted scrutiny that was much more critical. A growing number of scholars started to depict colonial medicine as a 'sword of empire', a curatively-focused progeny of imperial tropical medicine, a handmaiden of evangelical Christian interests and civilising agendas, a conduit for colonial power and social control and a willing instrument of colonial capital.<sup>4</sup> Because these impulses tended to be essentially self-serving, 'the health of colonized people deteriorated under colonial rule'.<sup>5</sup> This is said to have been the case especially during the early colonial period.<sup>6</sup>

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<sup>1</sup> Phrase borrowed from John Farley, *Bilharzia: A History of Imperial Tropical Medicine* (Cambridge: Cambridge University Press, 1991), p.3.

<sup>2</sup> The idea of an unfinished agenda is borrowed from Maureen Malowany, 'Unfinished Agendas: Writing the History of Medicine of sub-Saharan Africa', *African Affairs*, vol. 99, no. 395 (2000), pp. 325-349.

<sup>3</sup> Examples include, Michael Gelfand, *Tropical Victory: An Account of the Influence of Medicine on the History of Southern Rhodesia, 1890-1923* (Cape Town: Juta, 1953); Lewis Gann and Peter Duignan, *Burden of Empire: An Appraisal of Western Colonialism in Africa South of the Sahara* (London: Pall Mall Press, 1967); Oliver Ransford, *Bid the Sickness Cease: Disease in the History of Black Africa* (London: J. Murray, 1983).

<sup>4</sup> Classic examples include Randall Packard, *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Pietermaritzburg: University of Natal Press; London: James Currey, 1990); Alexander Butchart, *The Anatomy of Power: European Constructions of the Africa Body* (London & New York: Zed Books, 1998); Farley, *Bilharzia*; David Arnold (ed.), *Imperial Medicine and Indigenous Societies* (Manchester: Manchester University Press, 1988); Roy MacLeod and Milton Lewis (eds), *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London & New York: Routledge, 1988).

<sup>5</sup> Meredith Turshen, *The Political Ecology of Disease in Tanzania* (New Brunswick: Rutgers University Press, 1984), p. xi.

<sup>6</sup> Helge Kjekshus, *Ecology Control and Economic Development in East African History*, Second Edition, (London: James Currey; Dar es Salaam: Mkuki na Nyota; Nairobi: EAEP; Kampala: Fountain Publishers; Athens: Ohio University Press, 1996), pp. xxiii-xxiv; 165-172.

Although departing from different theoretical and historiographical formations, including Marxist, Foucauldian and cultural theories, as well as the new imperial and social histories of medicine, the common platform that these analytical traditions have shared is that colonial healthcare systems were poorly conceived, either makeshift or overwhelmingly self-serving.<sup>7</sup> The health needs of the majority of colonial subjects were either poorly understood or totally ignored, particularly before World War I.<sup>8</sup> At the same time, because it was possessed by professionals with increasingly powerful scientific explanatory models,<sup>9</sup> biomedical knowledge provided colonial officials with the ‘skills and rules’ for colonial domination.<sup>10</sup> As Poonam Bala and Amy Kaler put it, ‘medical knowledge was part of colonial authorities’ armory of power over the indigenes’.<sup>11</sup>

Other scholars have emphasised its appetite for corporeal control, which David Arnold has defined as ‘colonizing the body’.<sup>12</sup> Megan Vaughan has also expertly addressed the colonial pre-occupation with the elaboration of notions of difference as one of the defining features of colonial medicine. In Vaughan’s own words, African spaces were perceived as repositories of ‘death, disease, and degeneration, inscribed through a set of recurring and simple dualisms – black and white, good and evil, light and dark’.<sup>13</sup> According to Anna Crozier, this ‘sensationalism favoured explanations for disease that confirmed implicit racial connections

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<sup>7</sup> Alan Jeeves, ‘Health, Surveillance and Community: South Africa’s Experiment with Medical Reform in 1940s and 1950s’, *South African Historical Journal*, vol. 43, no. 1 (2000), pp. 245-246; Randall Packard, ‘Visions of Postwar Health and Development and Their Impact on Public Health Interventions in the Developing World’, in Frederick Cooper and Randall Packard (eds) *International Development and the Social Sciences: Essays on the History and Politics of Knowledge* (University of California Press, 1998), p. 94.

<sup>8</sup> Kjekshus, *Ecology Control*, p. xxiv.

<sup>9</sup> Sandra M. Tomkins, ‘Colonial Administration in British Africa during the Influenza Epidemic of 1918-1919’, *Canadian Journal of African Studies*, vol. 28, no. 1 (1994), p. 61.

<sup>10</sup> Roy MacLeod, ‘Introduction’, in Roy MacLeod and Milton Lewis (eds), *Disease, Medicine and Empire*, p. 3.

<sup>11</sup> Poonam Bala and Amy Kaler, ‘Introduction: “Contested Ventures”: Explaining Biomedicine in Colonial Contexts’, in Poonam Bala (ed.), *Biomedicine as a Contested Site: Some Revelations in Imperial Contexts* (Lanham, MD: Lexington Books, 2009), p. 3.

<sup>12</sup> Butchart, *The Anatomy of Power*; David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993).

<sup>13</sup> Megan Vaughan, *Curing their Ills: Colonial Power and African Sickness* (Cambridge: Polity Press, 1991), p. 2.

between ill health and the African native....'<sup>14</sup> The colonial public health discourse was 'built around the colonial cultural and racial differentiation', which was in itself an important aspect of the colonial relationship.<sup>15</sup>

However, as Juanita De Barros et al have correctly noted, 'health and medicine in colonial environments is one of the most active, contested, and fascinating areas of the history of medicine'.<sup>16</sup> Indeed, some of the major pillars of this critical historiographical colossus are beginning to be challenged. An emerging brand of scholarship, which I have here labelled 'revisionist scholarship', has begun to point to some well-informed efforts made by colonial public health officials to deploy the proper tools of medical research and healthcare delivery to deal effectively with the recurrent colonial public health problems. Three particular scholars exemplify this newer historiography, which is yet to assume a distinctive paradigm. The first one is Miriam S. Chaiken, who has done work on the historical design of particular colonial healthcare programmes in eastern Africa. In a tellingly entitled article, 'Primary Healthcare Initiatives in Colonial Kenya', Chaiken has made the point that, 'while Kenyan colonial medical services were fundamentally hierarchical, and often paternalistic and coercive, they also managed to implement effective programs that were nearly identical to Primary Health Care programs today'.<sup>17</sup>

Although the perceived link between colonial health policy and the tenets of primary health care has had a relatively long postcolonial history, going back to the 1977 Oxford

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<sup>14</sup> Anna Crozier, 'Sensationalising Africa: British Medical Impressions of Sub-Saharan Africa, 1890-1939', *Journal of Imperial and Commonwealth History*, vol. 35, no. 3 (2007), p. 393.

<sup>15</sup> Kenneth S. Ombongi, 'The Historical Interface between the State and Medical Science in Africa: Kenya's Case', in P. Wenzel Geissler and Catherine Molyneux (eds), *Evidence, Ethos and Experiment: The Anthropology and History of Medical Research in Africa* (New York & Oxford: Berghahn Books, 2011), p. 356.

<sup>16</sup> Juanita De Barros, Steven Palmer and David Wright, 'Introduction', in Juanita De Barros, Steven Palmer and David Wright (eds), *Health and Medicine in circum-Caribbean, 1800-1968* (New York & London: Routledge, 2009), p. 3.

<sup>17</sup> Miriam S. Chaiken, 'Primary Health Care Initiatives in Colonial Kenya', in *World Development*, vol. 26, no. 9 (1998), p. 1702.

Symposium on 'Health in Tropical Africa during the Colonial Period',<sup>18</sup> in making this argument Chaiken has had the benefit of a large corpus of comparative literature. The argument made by Chaiken was clearly framed with the knowledge that colonial healthcare initiatives have long been criticised for overlooking the basic healthcare needs of the colonised populations.<sup>19</sup> Indeed, in interpreting the intentions behind some of the initiatives, Chaiken was cautious not to retrospectively rationalise what might be termed 'paternalistic haughtiness'.<sup>20</sup>

The second scholar who has attempted to rehabilitate certain aspects of colonial medicine is Michael Jennings. In the field of research focusing on colonial Tanganyika, Jennings has come out particularly in defence of missionary medicine which he reckons 'has suffered in the historiography from a series of broad generalisations and misconceptions'.<sup>21</sup> According to Jennings, one major misconception that has been peddled about missionary medicine is that it was 'overwhelmingly curative' in focus. In contrast, Jennings argues that the approach of missionaries to maternal and child healthcare in Tanganyika belies this claim, which was first disingenuously popularised by colonial state officials. According to Jennings, such work 'fell easily into the preventive medicine arena' and the missionaries demonstrated a commitment and sensitivity to socially acceptable mother and child health practices.<sup>22</sup>

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<sup>18</sup> E. E. Sabben-Clare, D. J. Bradley and K. Kirkwood (eds), *Health in Tropical Africa during the Colonial Period* (Oxford: Clarendon Press, 1980). Based on conference presentations by mainly colonial and immediate postcolonial healthcare officials and practitioners, this book features a chapter on 'Primary Healthcare in Uganda, 1894-1962', by B. E. C. Hopwood, once a doctor in colonial Uganda. Hopwood's choice of title might have been influenced by the emerging primary healthcare language, culminating with the 1978 Alma Ata Declaration on primary healthcare.

<sup>19</sup> One example is Lesley Doyal, with Imogen Pennel, *The Political Economy of Health* (London: Pluto Press, 1979), Chapter 7.

<sup>20</sup> Chaiken, 'Primary Health Care Initiatives in Colonial Kenya', p. 1704.

<sup>21</sup> Michael Jennings, 'A Matter of Vital Importance': The Place of the Medical Mission in Maternal and Child Healthcare in Tanganyika, 1919-1939', in David Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam & New York: Rodopi, 2006), p. 227.

<sup>22</sup> Jennings, 'A Matter of Vital Importance', p. 228.

The last and very latest scholar to challenge the radical critiques of colonial medicine is Helen Tilley, whose major ideas are embodied in a new book, *Africa as a Living Laboratory*.<sup>23</sup> In this book, Tilley argues that during the 1920s and especially the 1930s, colonial medical knowledge in British Africa began to witness some ‘epistemic shifts’ as ‘long-standing concerns with hygiene and public health were gradually being coupled to significant new insights within ecological science, immunology, nutrition, and epidemiology’.<sup>24</sup> Colonial healthcare policy thinkers started to engage in original and frank self-critique and to embrace holistic definitions of health, which recognised that ‘a modern approach to medicine meant collaborating across territorial departments, tackling cure and prevention simultaneously, and securing the trust and support of colonial subjects’.<sup>25</sup>

Taking particular aim at the political economy approach that has emphasised the fact that colonial healthcare initiatives were mainly structured by ill-conceived economic motives, Tilley argues instead, that there was a lot more at stake in colonial healthcare than mere crude economic considerations.<sup>26</sup> Moreover, according to Tilley, colonial officials were not ignorant of the fact that poverty and development were key determinants of health. Quoting the deliberations of the 1933 East African medical research conference where officials admitted that ‘ill-health in Africa is to no small extent a matter of poverty, poor nutrition, and fly-borne disease’, Tilley flags some notable ‘shift in perspective’. The widespread nature of this shift was exemplified by the second League of Nations Health Organisation’s 1935 Pan-African Health Conference, which emphasised the ‘economic advance’ of rural African communities as a way of stamping out endemic diseases such as malaria.<sup>27</sup>

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<sup>23</sup> Helen Tilley, *Africa as a Living Laboratory: Africa, Development, and the Problem of Scientific Knowledge, 1870-1950* (Chicago: Chicago University Press, 2011).

<sup>24</sup> Tilley, *Africa as a Living Laboratory*, pp. 214-215.

<sup>25</sup> Tilley, *Africa as a Living Laboratory*, p. 172.

<sup>26</sup> Tilley, *Africa as a Living Laboratory*, p. 209.

<sup>27</sup> Tilley, *Africa as a Living Laboratory*, pp. 210-211.

Tilley further argues that this groundswell of shifts in thinking was embodied in the two companion research compilations, E. B. Worthington's *Science in Africa* (1938) and Lord Hailey's *An African Survey* (1938). These works, especially the former, criticised the fragmentation of early colonial healthcare services and the ill-conceived interventions that tended to ignore local knowledge and customs.<sup>28</sup> Tilley concludes by arguing that colonial medical officials actually anticipated later radical assessments epitomised by scholars such as Lesley Doyal who argued in a 1979 political economy of health classic, that an overwhelmingly curative approach that ignored 'the fundamental social and environmental constituents of health' was severely defective.<sup>29</sup>

Tilley reckons that this critique is similar to the comment raised by Hailey's *An African Survey*, which stated that a great deal of sickness in Africa was caused by '... poor physical conditions, due to poverty and environment...'<sup>30</sup> Similar views, according to Tilley, were espoused by the leadership of colonial public health departments, such that, as Tilley says, 'they would probably have been surprised to learn that so many scholars and social critiques would later accuse them of being oblivious to these patterns, when they constantly confronted them'.<sup>31</sup> In Tilley's view, therefore, many of the issues raised by scholarly critics later in the postcolonial period were actually first raised by colonial medical officials themselves as they sought to reform their initially defective approaches.

This latest partial rehabilitation of colonial healthcare poses some new challenges to historians, mainly because, since the discrediting of the old, triumphalist historiography, the

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<sup>28</sup> Tilley, *Africa as a Living Laboratory*, p. 212.

<sup>29</sup> Doyal, with Imogen, *The Political Economy of Health*, p. 256.

<sup>30</sup> Tilley, *Africa as a Living Laboratory*, p. 215.

<sup>31</sup> Tilley, *Africa as a Living Laboratory*, p. 215.

social history of colonial medicine has been overwhelmingly dominated by scholars who have depicted it as mainly a ‘cultural artefact carrying its own assumptions and prejudices’.<sup>32</sup> More importantly, the works by Chaiken, Jennings and Tilley present historians with new opportunities by making it urgently necessary to revisit the historical record and carefully analyse new case studies to establish the validity of their claims and the possibility of generalising them. This thesis is an attempt to take up that challenge.

If it is true that colonial medical officials possessed valid knowledge about African healthcare challenges and attempted to formulate appropriate initiatives, the second task is to ask why, on the eve of decolonisation, African healthcare systems were severely defective.<sup>33</sup> And precisely why was this so at a time when medical science in general had shown enormous technical and conceptual capabilities? Indeed, why did preventive public health remain subordinate to curative medicine? Or, as Shula Marks and Neil Andersson showed in their postcolonial review of the health profile of southern Africa, why is it that the burdens of disease had ‘come to be differentiated according to skin colour’?<sup>34</sup>

Using the Ndanga Medical Unit case, this thesis systematically explores these questions. The history of the Ndanga Unit is traced from its emergence in the early 1930s to the 1960s when it had gone beyond its highest point and was out of step with convention. During this time, decolonisation was also beginning to take a definite shape thereby altering the dynamics of what used to be a colonial healthcare scheme. The decolonisation aspect deserves its own separate study. The greater part of the period covered in the thesis coincides with the time

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<sup>32</sup> Tomkins, ‘Colonial Administration in British Africa during the Influenza Epidemic’, p. 61.

<sup>33</sup> John Iliffe, *East African Doctors: A History of the Modern Profession* (Cambridge: Cambridge University Press, 1998), pp. 130-131.

<sup>34</sup> Shula Marks and Neil Andersson, ‘Issues in the Political Economy of Health in Southern Africa’, *Journal of Southern African Studies*, vol. 13, no. 2 (1987), p. 177.

spent at Ndanga by Dr James Kennedy, the long-serving district medical officer and chief developer of this pioneering scheme. An innovative, energetic but also controversial character, Dr Kennedy firmly imprinted his own stamp as he spearheaded the development of the Unit from its infancy in 1932.

Of particular interest here is Kennedy's attempt to implant his own biomedical model onto selected local social structures. Or, put differently, his efforts to run clinics along community lines in order to make biomedicine a popular issue. Therefore, in addition to the very important policy origins and framework, the scheme is analysed from its operational point of view, paying particular attention to the ways in which the medical officer blended his own 'frontier' biomedical vision with the mandate of developing a district healthcare system that he received from the Public Health Department. By frontier biomedical vision it is meant the determination by the district medical officer to present himself as a pioneer of modern medicine in an area that was to all intents and purposes regarded as *terra incognita*. The form of practice that resulted from this perception forms the backbone of the thesis.

The relations between colonial medical doctors, especially those medical officers in outlying districts, and Public Health Departments have become an issue of growing interest among historians.<sup>35</sup> Perhaps this is because of the nature of these relations and the insights they provide to understand the workings of colonial medicine. Because of the small size of the average colonial bureaucracy, or the 'thin white line' as A. H. M. Kirk-Greene described it,<sup>36</sup> colonial district medical officials were usually afforded a great deal of latitude, a situation

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<sup>35</sup> See for instance, Gerald C. Mazarire, 'A "Little England" in Chishanga: The Fate of a British Empire Leprosarium at Ngomahuru, 1925-1946', *African Historical Review*, vol. 39, no. 2 (2007), pp. 1-24; Anna Crozier, *Practising Colonial Medicine: The Colonial Medical Service in British East Africa* (London & New York: I. B. Tauris, 2007), especially chapter 7;

<sup>36</sup> A. H. M. Kirk-Greene, 'The Thin White Line: The Size of the British Colonial Service in Africa', *African Affairs*, vol. 79, no. 314 (1980), pp. 25-44.

that allowed for the flourishing of divergent visions and, inevitably, promoted conflicts. As Bala and Kaler have argued, there were always ‘clashes of interest between those who believed themselves intellectually qualified to prescribe and those who took healing as part of a wider administrative practice’.<sup>37</sup> It was in the instability of these relations that the true nature, intentions and motives of colonial healthcare systems were often clearly brought to the surface. This thesis therefore pays attention to the ways in which healthcare ideas and practices were forged both at national and local levels as healthcare policy was conceived and implemented by medical officers such as Dr Kennedy.

Moreover, the history of the Ndanga scheme is also explored from the perspective of the subordinate African medical staff and patients and their communities. The colonial experiences of African medical staff and patients alike have also become areas of growing scholarly interest, perhaps because of the increasingly felt need to project the African voice in postcolonial studies. Attempts to estimate the extent of the success of the project of colonial hegemony and the huge impact of subaltern theories are the other possible explanations for this interest.<sup>38</sup> The strategy used in this thesis was to draw analytical insights from these different African groups, based on their dynamic engagement and critique of colonial medicine. In other words, their voices are used here as a historical index with which to evaluate the quality and contemporary acceptability of the medical services examined in the thesis. At the same time, the thesis acknowledges that these people acted within a much

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<sup>37</sup> Bala and Kaler, ‘Contested Ventures’, p. 5.

<sup>38</sup> A few examples include, Sally Swartz, ‘Can the Clinical Subject Speak?: Some Thoughts on Subaltern Psychology’, Accessed from <http://tap.sagepub.com/content/15/4/505>, on 18 March 2010; Walima T. Kalusa, ‘Language, Medical Auxiliaries and the Re-interpretation of Missionary Medicine in Colonial Mwinilunga, Zambia, 1922-1951’, *Journal of Eastern African Studies*, vol. 1, no. 1 (March 2007), pp. 57-78; Maryinez Lyons, ‘The Power to Heal: African Auxiliaries in Colonial Belgian Congo and Uganda’, in Dagmar Engels and Shula Marks (eds), *Contesting Colonial Hegemony: State and Society in Africa and India* (London & New York: British Academic Press, 1994)

distorted colonial environment. Thus, their actions should be understood mainly as subaltern struggles for a voice in an environment of skewed power relationships.

Through this multifaceted analysis, the thesis makes the important observation that in an effort to discredit the unashamedly laudatory historiography, the majority of medical historians might have somehow overlooked the innovative side of biomedicine or, in some cases, overemphasised its selfish motives and controversial methodologies. Having explored the Ndanga case from different perspectives, the picture that emerges is that it indeed possesses some potentially progressive features. For instance, in the context of the interwar period the idea of a district healthcare system, which was embodied in the medical units scheme, was far ahead of its time. Attempting to develop a district healthcare system among subordinate populations was even more radical. In addition, Kennedy's attempt to adapt his curative biomedical model to the existing social milieu was novel.

Other scholars have found similar innovative ideas in other colonial contexts and the Pholela health centre of South Africa comes into mind. Pioneered in the late 1930s by Sydney and Emily Kark, the Pholela project of rural Natal was a community-oriented healthcare scheme organised on the tenets of social medicine, evidence that some colonial practitioners were indeed far-sighted.<sup>39</sup> South Africa had its brief but important experience with social medicine, which began in the late 1930s, flowered in the 1940s and atrophied in the 1950s.<sup>40</sup> As Alan Jeeves has noted, 'social medicine in South Africa challenged some of the central orthodoxies of modern medical practice'.<sup>41</sup> With all their oversights, such schemes like the Pholela and

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<sup>39</sup> Jeeves, 'Health, Surveillance and Community', p. 247.

<sup>40</sup> Shula Marks, 'Doctors and the State: George Gale and South Africa's Experiment in Social Medicine', in Saul Dubow (ed.), *Science and Society in Southern Africa* (Manchester and New York: Manchester University Press, 2000).

<sup>41</sup> Jeeves, 'Health, Surveillance and Community', pp. 248-249.

the Southern Rhodesian medical units model cannot therefore be ignored as examples of early forms of healthcare practice partly driven by innovative ideas.

However, the newer historiography is yet to answer some very important questions too. For instance, although the Ndanga Unit was partly founded upon particular forms of vision and energy, its wider outlook remained decidedly colonial. The reform discourse that kept it in existence remained couched in racial terms, the infrastructure was makeshift, and the staffing was organised on racial lines. The promotion of new health concepts among African communities was also invariably an onslaught on African habits and ways of life. Moreover, although a potentially good example of an early model of organised district healthcare, the Ndanga Unit was, by the 1960s, still suffering from too great a focus on curative care.

In this regard, it was not different from other schemes in British colonial Africa. Therefore, one could ask, what became of the 'epistemic shifts' emphasised by Tilley? Moreover, what happened to the valorised primary healthcare initiatives? The problems of an overwhelmingly curatively focused biomedical model cannot be over-emphasised. Almost invariably, this model of biomedical care leads to a gross maldistribution of facilities and resources.<sup>42</sup> Some colonial officials such as Southern Rhodesia's A. P. Martin (medical director, 1935-1945), as even Tilley correctly noted, did admit that curative medicine was bad medicine because it merely touched 'the fringe of the problem'.<sup>43</sup> However, such statements seemed to have remained mere rhetoric as very little was done to remedy the defective colonial healthcare systems.

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<sup>42</sup> Doyal with Imogen, *The Political Economy of Health*, p. 256.

<sup>43</sup> Southern Rhodesia, *Report on the Public Health for the Year 1938*, p. 7.

Therefore, as an attempt to orchestrate these debates in a new direction, this thesis argues that colonial medicine was essentially a dynamic tension between the colonial ambitions of colonists and the innovative ideas of different experts. That modern medicine, including its colonial variant, was as much driven by innovation as by colonial impulses cannot be gainsaid. As Nayan Shah has persuasively argued,

Public health investigation produced a repertoire of precautions and prophylactics to dampen the spread of contagious diseases. Through strategies of sanitation, vaccination, and therapeutic care, public health extended human longevity, increased the chances of childhood survival, and suppressed epidemic disease.<sup>44</sup>

As an emblem of modernity par excellence, medicine became the arena for the ‘deployment of diverse forms of expertise’.<sup>45</sup>

However, it was precisely because of these capabilities that modern biomedicine, as a recognisably autonomous body of knowledge, was enlisted for the purposes of state-making. Even in cases where knowledge was still weak, the hope that ‘at the intersections of medicine, science and public health, in areas of research and application, the tools will become available to reduce the burden of disease’,<sup>46</sup> was enough to make biomedicine an attractive tool in the hands of the colonisers. Medicine became a ‘tool of empire’<sup>47</sup> simply because it promised to conquer certain forms of infectious diseases and to extend ‘the biomedical model to the non-medical world’.<sup>48</sup> Indeed, it provided colonial officials with effective, although contested, discourses and categories for racial classification and segregation too.<sup>49</sup>

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<sup>44</sup> Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley, Los Angeles and London: University of California Press, 2001), p. 3.

<sup>45</sup> Bala and Kaler, ‘Contested Ventures’, p. 3.

<sup>46</sup> Malowany, ‘Unfinished Agendas’, p. 327.

<sup>47</sup> Concept popularised by Daniel R. Headrick, *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century* (New York: Oxford University Press, 1981).

<sup>48</sup> Roy MacLeod, ‘Introduction’, p. 2.

<sup>49</sup> Ombongi, ‘The Historical Interface between the State and Medical Science in Africa’, p. 356.

In that context, the colonial (medical) scientist had a dual mandate ‘to serve the state and to serve science’.<sup>50</sup> Furthermore, as the thesis seeks to show in the case of the Ndanga Unit, the responses of the African communities further illustrated the dual identity of biomedicine as an innovative body of therapeutic knowledge on the one hand, and a tool of colonial power and authority on the other. People selectively embraced and helped to develop those beneficial aspects of biomedicine, but rejected those that projected colonial power. Moreover, Vaughan was addressing the dual or dichotomous character of colonial medicine when she noted that, ‘In colonial medical discourse there was tension between an analysis of the social and cultural influences on disease, which naturalised “difference”, and a “scientific” model of disease, tended towards universalization and blurring of difference’.<sup>51</sup>

Through the Ndanga case study, therefore, this thesis attempts to show that the progressive and retrogressive aspects of colonial medicine were two sides of the same coin.<sup>52</sup> Moreover, the thesis further illustrates the argument first developed by Doyal that the retrogressive politics of colonial healthcare tended to eclipse the innovative ideas and reforms that came up from time to time. According to Doyal, although between the late 1920s and 1930s there was new awareness about the causal connections between poverty and disease within African communities – precisely the point reiterated by Tilley – the resulting reforms were set to ‘take place within the existing framework of [distorted] social relations – the structural constraints of colonialism were not challenged’.<sup>53</sup> Therefore, colonial healthcare reforms were always imbued with a split character.

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<sup>50</sup> Deepak Kumar, ‘Science and Society in Colonial India: Exploring an Agenda’, *Social Scientist*, vol. 28, no. 5/6 (2000), p. 33.

<sup>51</sup> Megan Vaughan, ‘Health and Hegemony: Representation of Disease and the Creation of the Colonial Subject in Nyasaland’, in Engels and Marks, *Contesting Colonial Hegemony*, p. 181.

<sup>52</sup> The two terms, ‘progressive’ and retrogressive, are used advisedly as they are historically loaded terms.

<sup>53</sup> Doyal, with Imogen, *The Political Economy of Health*, p. 246.

### Colonial Healthcare, African Voices: Historiographical Debates

Perhaps it is because of this duality that, as social historian of colonial medicine, Harriet Deacon, has perceptively noted, scholars often find themselves in a “Catch-22” situation, ‘arguing (a) that Western medicine was a detrimental agent of colonialism, but also (b) that black people were disadvantaged because they did not have equal access to its practitioners and therapies’.<sup>54</sup> This dilemma speaks to the challenges encountered by historians as they try to understand colonial medicine as a historical phenomenon. How can colonial subjects be disadvantaged when medicine was detrimental in the first case? This suggests a complex identity, which this thesis is attempting to disentangle and illuminate.

When the new social history of medicine increasingly assumed a paradigmatic structure from the 1970s through the 1980s to the 1990s, historians were keen to discredit the earlier, largely celebratory, ‘traditional’ historiography.<sup>55</sup> Apparently, the best way of doing this was to depict medicine as a surrogate of narrow colonial interests. Hence there emerged the now well-known narrative, that from the outset, colonial medicine was demographically and geographically enclavist in nature, focusing primarily on the health needs of white settlers and, in a minimal way, the health of Africans in employment.<sup>56</sup> The great majority of African communities had contact with biomedical services only through the unsolicited, but strictly enforced anti-epidemic campaigns.<sup>57</sup>

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<sup>54</sup> Harriet Deacon, ‘Racism and Medical Science in South Africa’s Cape Colony in the Mid-to Late Nineteenth Century’, in *Osiris*, 2<sup>nd</sup> series, vol. 15 (2000), p. 191.

<sup>55</sup> Frank Huisman and John Harley Warner, ‘Medical Histories’, in Frank Huisman and John Harley Warner (eds), *Locating Medical History: The Stories and their Meanings* (Baltimore & London: Johns Hopkins University Press, 2004), p. 2.

<sup>56</sup> Ombongi, ‘The Historical Interface between the State and Medical Science in Africa’, p. 355; David Arnold, ‘Colonial Medicine’, in W. F. Bynum and Roy Porter (eds) *Companion Encyclopaedia of the History of Medicine Volumes 1 and 2*, (London: Routledge, 1993), p. 1400.

<sup>57</sup> Packard, ‘Visions of Postwar Health and Development’, p. 94.

The concern with rural health, which became more pronounced after World War I, was a product of the enlightened self-interest of the colonial officials as it dawned on them that there was no surer way of guaranteeing a secure environment for colonists than dealing with the rural ‘reservoirs’ of disease. The needs to forestall demographic collapse and the deterioration of rural communities, as well as to ensure healthy labour supplies were the other pragmatic considerations.<sup>58</sup> As Randall Packard has put it, ‘European interest in the “health of the natives”... was shaped by narrow economic interests’.<sup>59</sup>

Others believe that colonial public health departments were jolted by the health ramifications of World War I as wartime recruitment exposed a great deal of hitherto unknown levels of disease among the Africans.<sup>60</sup> A few dissenting voices such as Osaak Olumwullah argues that the increasing attention to rural health was an ideological rather a material issue because the colonial state was keen to project its benign visibility through dispensaries. For Olumwullah, the aim was to take advantage of the post-war context of reconstruction and ‘invent a human face’ following long periods of neglect.<sup>61</sup> This argument ties in with John Iliffe’s view that the main aim of healthcare reform was to justify taxation.<sup>62</sup>

The overarching theme shaping these scholarly views is that the colonial healthcare system was initially operated along the lines of racial privilege before it was opened up, in a limited way, following the discovery that such an approach was self-defeating. The essence of this

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<sup>58</sup> Karin A. Shapiro, ‘Doctors or Medical Aids – The Debates Over the Training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 1930s’, *Journal of Southern African Studies*, vol. 13, no. 2 (1987), pp. 234-255; Shane Doyle, ‘Population Decline and Delayed Recovery in Bunyoro, 1860-1960’, *Journal of African History*, vol. 41, no. 3 (2000), pp. 429-458.

<sup>59</sup> Packard, ‘Visions of Postwar Health’, p. 94.

<sup>60</sup> Marc H. Dawson, ‘The 1920s anti-Yaws Campaigns and Colonial Medical Policy in Kenya’, *International Journal of African Historical Studies*, vol. 20, no. 3 (1987), pp. 417-435

<sup>61</sup> Olumwullah A. Olumwullah, *Dis-ease in the Colonial State: Medicine, Society, and Social Change among the AbaNyole of Western Kenya* (Westport: Greenwood Press, 2002), p. 172.

<sup>62</sup> John Iliffe, *East African Doctors*, p. 39.

argument is further emphasised in the literature that has depicted colonial medicine as an ‘integral element in the establishment and maintenance of European status and authority’.<sup>63</sup> The abiding interest of historians has been to explore the workings of colonialism through the healthcare archive. The unforeseen results of this have been that the exclusive focus on colonialism *in* medicine has led to the overlooking of certain epistemic changes in the planning and practice of medical care in colonial environments. In other words, the history of colonial healthcare has been somehow flattened, and perhaps understandably so, and seen mainly as a history of colonialism.

In addition, with a few exceptions,<sup>64</sup> the post-World War reforms have been depicted as solely colony-specific responses to changing local epidemiological circumstances or as adjustments to shifting notions of inter-racial public health and the minimum requirements of colonial labour welfare. The aim of this thesis is to show that the Southern Rhodesian reforms were partly influenced by a broader wave of international shifts in thinking about the healthcare of marginal population groups. Certainly, this was the case in interwar Europe.<sup>65</sup>

It also attempts to show that these changes were driven by a combination of incompatible factors.

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<sup>63</sup> Tomkins, ‘Colonial Administration in British Africa during the Influenza Epidemic’, p. 61.

<sup>64</sup> Anne Digby, ‘Vision and Vested Interests’: National Health Service Reform in South Africa and Britain in the 1940s and Beyond’, *Social History of Medicine*, vol. 21, no. 3, (2008), pp. 485-502; Shula Marks, ‘Common Sense or Utopian Dream? Part I: South Africa’s Practice of Social Medicine between 1940 and 1955 in Transnational Perspective’, Paper Presented at a Conference on The History of Health in Africa: Actors, Experiences, and Perspectives in the Twentieth Century, Basel, 12-14 September 2011.

<sup>65</sup> E. Rodriguez-Ocana and P. Zylberman, ‘Improving Public Health Amidst Crises’, *Dynamis*, vol. 28, (2008) pp. 19-27. Accessed from: <http://scielo.isciii.es/pdf/dyn/v28/01.pdf> on 12 Jan. 2010; Paul Weindling, ‘Health and Medicine in Interwar Europe’, in Roger Cooter and John Pickstone (eds), *Companion to Medicine in the Twentieth Century* (London & New York: Routledge, 2003), p. 41.

The thesis will also offer commentary on whether the responses of African communities profoundly altered the conduct of colonial medicine. The picture that emerges from much of the literature is that Africans selectively embraced aspects of biomedicine, rejected the most intrusive elements or those they did not understand or believe in, and contested and reformulated others. In fact, many scholars have tended to prefer ambiguity as the appropriate word to describe these complex responses, whereby biomedical elements were perceived as both potent and foreign, or even dangerous, all at once.<sup>66</sup>

Frantz Fanon, an avid critic of colonial power, argues that the colonised peoples used their reason to say ‘yes’ to certain biomedical innovations of the colonisers, but were cautious not to become a ‘prisoner of the entire system’.<sup>67</sup> On her part Hunt suggests that this cautious acceptance was filtered through symbolic practices and objects.<sup>68</sup> This reaction through domestic models of thought is also shared by Luise White, who, in her study of colonial Uganda, demonstrates how medical encounters were attended by rumours by which people tried to make sense of the newly emerging biomedical world.<sup>69</sup> In the same study, White speaks about ‘active ambivalence’ whereby ‘procedures were as feared as they were welcomed’.<sup>70</sup>

Fanon also talks about the issues of discontinuation of treatment and absconding as some of the actions by which the colonised patients registered their displeasure with colonial medicine.<sup>71</sup> In like fashion, in his study of the leprosy management initiative at Ngomahuru,

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<sup>66</sup> Bernhard Bierlich, ‘Injections and the Fear of Death: An Essay on the Limits of Biomedicine Among the Dagomba of Northern Ghana’, *Social Science and Medicine*, vol. 50, no. 1 (2000), pp. 703-713; Frantz Fanon, *A Dying Colonialism* [Trans. from French by Haakon Chevalier] (New York: Grove Press, 1965), p. 121.

<sup>67</sup> Fanon, *A Dying Colonialism*, p. 122.

<sup>68</sup> Nancy R. Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization and Mobility in the Congo* (Durham: Duke University Press, 1999).

<sup>69</sup> Luise White, ‘They Could Make Their Victims Dull’: Genders and Genres, Fantasies and Cures in Colonial Southern Uganda’, *The American Historical Review*, vol. 100, no. 5 (1995), pp. 1379-1402.

<sup>70</sup> White, ‘They Could Make Their Victims Dull’, p. 1391.

<sup>71</sup> Fanon, *A Dying Colonialism*, pp. 128-129.

Southern Rhodesia, Mazarire reveals that patient desertions were a corollary of enforced confinement of leper patients. As for the communities surrounding the institution, Mazarire says that they shunned the institution because they were never consulted when it was placed in their midst, and also because it fouled their spiritual and ecological environments.<sup>72</sup> Overall, Africans' responses to colonial medicine were conditioned by their wider outlook as many people remained resolutely pluralistic in their behavior.

However, the complicated question that begs to be answered is whether these varied responses cumulatively constituted some form of agency? In other words, how much of an impact did these various responses make have on the conduct of colonial medicine? Did they contribute to altering its conduct in profound or only superficial ways, or at all? How did they benefit the colonised peoples themselves, if at all? Scholars are very much divided on this question of African agency. Those who have approached the subject from the perspective of 'the weapons of the weak'<sup>73</sup> seem to suggest that Africans made a profound impact through their responses to colonial medicine or colonial rule in general. In her study of the history of domination and contestation in a South African society, Jean Comaroff argues that, in its efforts to anchor itself by supplanting pre-colonial systems, the colonial capitalist system was 'determined, in significant respects, by the local systems it ... sought to engulf.'<sup>74</sup> Frederick Cooper has also suggested that 'the institutions of the colonial state ... did not operate as their designers intended, but were being appropriated, contested, and transformed' by the colonised peoples.<sup>75</sup>

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<sup>72</sup> Gerald C. Mazarire, 'A New England in Chishanga: The Fate of British Empire Leprosarium at Ngomahuru, 1925-1946', *African Historical Review*, vol. 39, no. 2 (2008), pp. 16-18.

<sup>73</sup> Weapons of the weak is an analytical concept deployed by James Scott in his similarly titled book, *Weapons of the Weak: Everyday Forms of Peasant Resistance* (New Haven & London: Yale University Press, 1985).

<sup>74</sup> Jean Comaroff, *Body of Power, Spirit of Resistance: The Culture and History of a South Africa People* (Chicago & London: The University of Chicago Press, 1985), p. 2.

<sup>75</sup> Frederick Cooper, *Africa Since 1940: The Past of the Present* (Cambridge: Cambridge University Press, 2002), p. 4.

These profound conclusions have also been shared by some scholars of colonial medicine. White, for instance, has remarked that ‘the negotiations between African and European health-care workers were almost always shaped by African demands and resistances’.<sup>76</sup> Gorge Ndege also posits that African agency was central in shaping the colonial Kenyan health service delivery strategy during the interwar period.<sup>77</sup> This transformative agency has also been ascribed to African healthcare workers (orderlies or medical assistants). Although previously seen by others as either the success stories of colonialism’s hegemonic tendencies,<sup>78</sup> or as an ambiguous group of professionals who joined the colonial medical service for ‘altruistic service’, ‘power’, and ‘blatant self-interest’,<sup>79</sup> African colonial healthcare workers have recently begun to be presented as powerful ‘middle figures’ or ‘intermediaries’ in studies by historians such as Walima T. Kalusa.<sup>80</sup>

Kalusa strongly believes that, because of their unfamiliarity with African languages and cultures, the European medics abdicated to African auxiliaries the important task of translating their medicine and by so doing they ‘unwittingly rendered their medicine vulnerable to (re)interpretation in ways that they could neither imagine nor control’. The net effect of this was that, as Kalusa argues, biomedicine ended up being embellished with ‘pagan’ tropes that were detested by medical officials.<sup>81</sup> These views are echoed in the work by Benjamin N. Lawrence et al on colonial African intermediaries.<sup>82</sup>

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<sup>76</sup> White, ‘They Could Make Their Victims Dull’, p. 1384.

<sup>77</sup> George O. Ndege, *Health, State and Society in Kenya*, (Rochester: Rochester University Press, 2001).

<sup>78</sup> Lyons, ‘The Power to Heal’, p. 202.

<sup>79</sup> Iliffe, *East African Doctors*, p. 3.

<sup>80</sup> Kalusa, ‘Language, Medical Auxiliaries and the Re-interpretation of Missionary Medicine in Colonial Mwinilunga’, pp. 57-78.

<sup>81</sup> Kalusa, ‘Language, Medical Auxiliaries and the Re-interpretation of Missionary Medicine in Colonial Mwinilunga’, p. 59.

<sup>82</sup> Benjamin N. Lawrence, Emily Lynn Osborn and Richard Roberts (eds), *Intermediaries, Interpreters and Clerks: African Employees in the Making of Colonial Africa* (Madison: The University of Wisconsin Press, 2006).

These conclusions are built on updated notions of concepts such as ‘synthesis’, ‘accommodation’, ‘adaptation’ and ‘hybridity’, which were developed in the 1970s and 1980s, although they are now increasingly seen to be having limited applicability.<sup>83</sup> Ndege has particularly used the term ‘accommodation’ together with ‘compromise’ to suggest that there were colonial ‘negotiations’ – another term which is now being deployed widely by scholars. Although this thesis acknowledges that Africans certainly strove to appropriate, contest, and reform the colonial biomedical culture selectively, there is lesser conviction about the overall impact of these heroic struggles on the essence and conduct of colonial medicine *per se*.

There is a sense in which the postcolonial, subaltern turn in historical writing has tended to magnify African contestation of each and every aspect of colonial power excessively, and have, in the process, overstretched the instrumentality of such actions in ways that threaten to liquidate even colonialism itself. One should hasten to note that this complex question of African agency has increasingly compelled historians into the false situation of having to make an unequivocal judgment about whether the colonial state was strong (or hegemonic) or weak.

Yet, those who have closely applied their minds to this question of the ‘strength’ or ‘weakness’ of the colonial state have not found unequivocal answers to it. Bruce Berman was, for instance,

... struck by the two very different and apparently contradictory faces of the colonial state in Kenya that it depicts. On the one hand, there is the “weak” state, the paternalistic mediator struggling to maintain a precarious sovereignty over contending interests of colonial society ... it appears as a facade of power ... constantly threatened by crisis and struggle. On the other hand, however, there is the “strong” colonial state,

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<sup>83</sup> Julie Livingston, ‘Productive Misunderstandings and the Dynamism of Plural Medicine in Mid-Twentieth Century Bechuanaland’, *Journal of Southern African Studies*, vol. 33, no. 4 (2007), pp. 801-810, is one of those scholars who have questioned the total applicability of these concepts.

the potent bureaucratic agent of imperialism. By coercion, indirect pressure and material inducement it smashed the self-sufficiency of indigenous pre-capitalist societies and managed their articulation with metropolitan capital ... and containing and suppressing indigenous social forces. This state was a powerful instrument of political domination and structural transformation.<sup>84</sup>

If the colonial state defies categorisation as either weak or strong, how then can it be characterised in its engagement with indigenous African forces? Fanon's contention that colonialism essentially destabilised indigenous societies because of its negative processes such that 'the very life of the colonized can manifest itself defensively in a more or less clandestine way', will be found to be instructive.<sup>85</sup> Sandra E. Greene also shares similar sentiments, and has noted that 'the ability of the colonized to choose what to accept and what to reject was circumscribed by the power dynamics embedded in the colonial enterprise'.<sup>86</sup>

Thus, although colonialism was contested and fragmented, its visceral processes were inherently distorting. If, for instance, the need for medical assistants thrust Africans into the middle of colonial healthcare systems as cultural brokers, the medical hierarchies of (white) doctor- (black) nurse, imposed new professional structural constraints and cast these assistants to the margins of power. As for African doctors, we all know that colonial health departments were very slow in developing this category of elite health workers. It is therefore the contention of this thesis, that although Africans attempted to ameliorate their positions of subjugation, the environment was largely not permissive. However, the thesis also uses the Africans' engagement with colonial medicine as a commentary on the nature of the latter.

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<sup>84</sup> Bruce Berman, *Control and Crisis in Colonial Kenya: The Dialectic of Colonial Domination* (London: James Currey; Nairobi: Heinemann; Athens, OH: Ohio University Press, 1990), p. 424.

<sup>85</sup> Fanon, *A Dying Colonialism*, p. 130.

<sup>86</sup> Sandra E. Greene, *Sacred Sites and the Colonial Encounter: A History of Meaning and Memory* (Bloomington, IN: Indiana University Press, 2002), p. 5.

## Analytical framework

### *The Case Study*

The intrinsic historical value of the Ndanga Medical Unit lies on three levels. First, the Unit was the product of the pioneering rural healthcare delivery concept that was formulated out of a number of ideas drawn from different metropolitan, imperial and local sources. At policy level, therefore, the Ndanga Unit provides a rich case to explore the identity of colonial healthcare within a broader context. Secondly, the implementation of the Ndanga scheme mainly by Dr. Kennedy and his subordinate staff between 1932 and 1959, spawned rudimentary but enduring forms of curative medicine practised within community and family contexts.

Thirdly, the African communities interacted with the Ndanga Unit in various intriguing ways. During the implementation of the scheme, they provided the required resources and knowledge and then presented themselves at the medical stations as patients and/or patient-helpers. However, they also undermined those procedures that contradicted their own pluralistic beliefs. The Ndanga Unit, therefore, provides multiple perspectives from which to assess the nature of colonial healthcare and formulate concrete conclusions. One is able to move seamlessly from policy through practice to community responses.

Moreover, as the epitome of one of the most extensively organised and longest-surviving, district-based, rural medical schemes to emerge in interwar colonial southern and central Africa, perhaps rivalled only by the Belgian Congolese *foreami* experiment,<sup>87</sup> the Ndanga

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<sup>87</sup> According to Maryinez Lyons, 'Public Health in Colonial Africa: The Belgian Congo', in Dorothy Porter (ed.), *The History of Public Health and the Modern State* (Amsterdam & Atlanta: Rodopi, 1994), p. 371, the Foreami (*Fondation Reine Elisabeth pour l'Assistance Medicale aux Indigenes*) scheme was a Belgian Congo mobile public health programme launched in 1930 by that colony's Chief Medical Officer, Dr. G. Trolli. The scheme operated through an 'intensive, methodical, systematic, exhaustive and simultaneous campaign against

Unit may be of great comparative interest to both historians of colonial healthcare and contemporary health policy-makers. Choosing this case study was, therefore, based on both its own independent appeal and its capacity to illuminate the questions under review. Methodologically, using the case study as a research strategy enables us to address the ‘need for specific understanding through documentation of concrete details’.<sup>88</sup> Indeed, medical historians have often found it necessary to often resort to local case studies in their descriptions of broader historical phenomena.<sup>89</sup> In this case, although the broader context is an intrinsic part of the study, only a micro-historical study is capable of giving prominence to the voices of the local, subject communities.

### *The sources*

Important to the compilation of this thesis were the sources. With all their limitations and oversights, three main types of sources were used. These included different types of documents, oral testimonies and visual materials such as photographs. The documentary sources, which form the backbone of the thesis, were mainly collected from archives and document repositories in Zimbabwe and Britain. The documentary reconstruction of the history of the Ndanga Unit from the beginning of this research in 2008 was both challenging and rewarding. While the period up to the late 1940s was fairly well covered by different types of documentary material, the period thereafter tended to be sometimes patchy in documentary terms.

The accessible documentary materials, which included official operational records, correspondence, annual reports and reports of commissions of inquiry are housed at the

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all the diseases of a specified area’ for about a month, after which the team would proceed to another area, leaving the ‘cleansed’ area to a regular team.

<sup>88</sup> Erickson, quoted in Linda Mabry, ‘Case Study in Social Research’, in Pertti Alasuutari, Leonard Bickman and Julia Brannen (eds), *The Sage Handbook of Social Research Methods* (Los Angeles & London: Sage, 2009), p. 218.

<sup>89</sup> See for instance, Anne Digby, *Diversity and Division in Medicine: Healthcare in South Africa from the 1800s* (Bern, Oxford: Peter Lang, 2006), pp. 25-26.

National Archives of Zimbabwe (NAZ). During the greater part of the period when this research was undertaken, the NAZ, just like other public institutions in Zimbabwe, was going through difficult economic times. Therefore, research for this thesis, especially in 2009, was frequently interrupted by non-availability of electricity and the associated file retrieval challenges. Abrupt ends of documentary series, for instance, the Native Commissioners' annual reports, often frustrated the pursuit of certain trends. Patient admission and treatment records were also virtually non-existent.

However, at the end it was possible to piece together key policy and experiential issues from the available records and to make an unequivocal case about the duality of colonial healthcare as it was practiced in Ndanga. The National Archives of Zimbabwe's adjunct regional records office in Masvingo yielded some additional insights on epidemics covering the period from roughly the mid-1950s to the 1970s. Ongoing research in Cape Town, and stints at the British National Archives at Kew in London, the Bristol Records Office and the Bodleian Libraries (especially Rhodes House) in Oxford, yielded important international perspectives on the colonial health policy in general and Robert Askins' ideas in particular. Askins, the originator of the medical units scheme, had worked in the Bristol Public Health Department for many years before moving to Southern Rhodesia. Exploring his previous experience was therefore important.

However, the main weakness of these records is that they do not shed light on the private lives of the two key figures of this story, Askins and Kennedy. No personal papers for either could be found. Alas, outside the official memoranda and reports, the two did not spell out their ideas in medical journals, except for brief but historically valuable memoirs published

by Kennedy in 1957.<sup>90</sup> The other inherent weakness of the documentary sources is that they usually tend to reflect the views of the views of colonial medical officials.

Because of the lack of a writing tradition in rural Southern Rhodesia, the views of the communities that are projected in documentary sources are mostly the interpretations of those in positions of power. To make them useful as a source of the Africans' voices, these sources were read against the grain for subaltern perspectives. Although criticised by some for being limited by the range of issues 'determined in advance' by the dominant archive,<sup>91</sup> reading against the grain has remained the choice strategy in the absence of other viable sources. Indeed, as Carolyn Hamilton et al have argued, although archives 'are often both documents of exclusion and monuments to particular configurations of power' the 'traces of marginal lives are by no means absent from mainstream archives'.<sup>92</sup>

The second important source of insights were the oral testimonies of a few surviving informants who sometimes told the story of the Ndanga Medical Unit with nostalgia and with all the vividness they could possibly muster. Since Jan Vansina's pioneering attempt to codify the usage of African oral traditions,<sup>93</sup> this resource has been taken seriously in African historiography.<sup>94</sup> Although concerns have been raised about its reliability, there seems to be

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<sup>90</sup> James Kennedy, 'Bygones of a Bundu Bone Thrower – Part I-III', *Central African Journal of Medicine*, vol. 3, no. 6 (1957), pp. 235-240; vol. 3, no. 7 (1957), pp. 272-274; vol. 3, no. 8 (1957), pp. 315-323.

<sup>91</sup> Bridie Andrews and Mary P. Sutphen, 'Introduction', in Mary P. Sutphen and Bridie Andrews (eds), *Medicine and Colonial Identity* (London & New York: Routledge, 2003), p. 3.

<sup>92</sup> Carolyn Hamilton, Verne Harris and Graeme Reid, 'Introduction', Carolyn Hamilton, Verne Harris and Graeme Reid (eds), *Refiguring the Archive* (Cape Town: David Phillip, 2002), pp. 9-12.

<sup>93</sup> Jan Vansina, *Oral Traditions as History* (London: James Currey, 1985).

<sup>94</sup> For a critical appraisal of this methodology, see Luise White, Stephan F. Miescher and David Cohen (eds), *African Words, African Voices: Critical Practices in Oral History* (Bloomington & Indianapolis: Indiana University Press, 2001); Toyin Falola, *Sources and Methods in African History: Spoken, Written, Unearthed* (Rochester: University of Rochester Press, 2003).

consensus that such challenges are not insurmountable. Indeed, even ‘native nostalgia’ is now being taken seriously as a window into the complex world inhabited by colonial subjects.<sup>95</sup>

Lyn Schumaker called for oral histories of health that can uncover ‘the very different histories told by local people compared with those told by the scientists, the... experts and the archives’.<sup>96</sup> In the Ndanga case, a few key eyewitnesses had good memories of Kennedy, which were useful in the re-creation of his personal outlook as perceived from ‘below’, rather than only from above. To keep in line with ethical sensitivities guiding research on human subjects, the names of surviving patients interviewed were not reproduced in the main text.

The last form of evidence used here are the photographs. These were helpful in projecting a vivid visual image of particular aspects of the Unit’s history. Indeed, as the popular Chinese proverb says, a picture is worth a thousand words. Although visual images have become staple sources in other historical genres,<sup>97</sup> in medical history there is still hesitation, possibly because of the sensitivity of many of the photographs. Indeed, some of the patient photographs utilized in this thesis do raise ethical dilemmas relating to the fact that these pictures were taken by colonial doctors probably without the patient’s consent within a context of unequal power relations. The photographs in question mostly depict patients with particular conditions. However, some are already in the public domain as they have been published in colonial medical journals before. Drawing on them in this thesis is meant to raise, but perhaps not necessarily resolve, the issues of objectification involved.

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<sup>95</sup> Jacob Dlamini’s *Native Nostalgia* (Auckland Park, JHB: Jacana Media, 2009), an audaciously nostalgic record of life in apartheid Katlehong Township, is a good example.

<sup>96</sup> Lyn Schumaker, quoted in JoAnn McGregor, and Terence Ranger, ‘Displacement and Disease: Epidemics and Ideas about Malaria in Matabeleland, Zimbabwe, 1945-1996’, *Past and Present*, no. 167 (2000), pp. 206.

<sup>97</sup> For example, Paul S. Landau and Deborah D. Kaspin (eds), *Images and Empires: Visuality in Colonial and Postcolonial Africa* (Berkeley: University of California Press, 2002); Wolfram Hartman, Jeremy Sylvester and Patricia Hayes (eds), *The Colonizing Camera: Photographs in the Making of Namibian History, 1915-1950s* (Cape Town: UCT Press; Athens: Ohio University Press, 1998).

### *Chapter Outline*

The thesis is divided into seven chapters and a conclusion. Chapter 1 provides the historical background to healthcare reform in 1930, and therefore covers the period from colonization in 1890 to 1930. Its main concern is to trace the emergence and development of the African rural healthcare question, and the attempts made before 1930 to address it. It notes the failure of medical officials to formulate a comprehensive programme of rural medical care, and argues that by 1930 the colony indeed required a fresh approach. Chapter 2 focuses on the advent of Askins as the colony's new medical director and the shifting trajectory of rural healthcare under his administration. The chapter is particularly interested in the origin of the medical units scheme, and the international concepts from which he drew inspiration.

Chapter 3 and 4 both focus on the implementation of the pioneering medical unit in Fort Victoria Province by Dr. Kennedy from 1932. Chapter 3 focuses mainly on the struggle to commence the scheme in the context of the Great Depression, settler agitation, and the changing political landscape. The chapter illuminates the crucial role played by Kennedy and the support he received from local African communities in setting up the Unit's nine outlying dispensaries, especially after the death of Askins in 1935, and the virtual abandonment of the concept of medical units. Chapter 4 takes the story forward by focusing on the medical approach of Kennedy, with specific reference to his attempts to adapt his biomedical model to the existing social circumstances. This chapter explores the waxing and waning of Kennedy's 'very own special brand of social medicine'.

Chapter 5 explores the complex position of African medical orderlies (assistants) and attempts to understand their condition and agency in a new way that avoids over-glorifying their power, given the opportunities and constraints associated with their positions. Likewise, Chapter 6 looks at how patient histories can be understood as struggles within a pluralizing

but distorted therapeutic environment. Continuing with the perspective developed in chapter 5, this chapter acknowledges patient agency, but notes that, just like orderlies, they also encountered constraints because the system was either paternalistic, frugal or based on racial differentiation. Chapter 7 wraps up the thesis by looking at the public health aspects of the Unit's work. This chapter zooms in on the official perception of the disease and health situation in the Unit, and the limited efforts at health promotion and at disease prevention campaigns. The chapter notes that the Unit's public health system was notable for its narrow focus on health education and compulsory immunization, at the expense of broader community development. The thesis concludes with a review that asks about the possibilities of the success of reforms and innovative ideas in a racially divided colonial society.

## Chapter 1

### **Historical Background: Origins of the Rural African Healthcare Question in Colonial Zimbabwe, 1890s-1930**

#### **Introduction**

Although the main focus of this thesis will be the nature and aftermath of rural healthcare reforms introduced in 1930, and pioneered in Ndanga, Fort Victoria, from 1932, it might be useful to begin with a sketch of the historical background against which these important reforms emerged. This opening chapter provides that important background by outlining, in very broad terms, the origins and evolution of the rural African healthcare question from colonisation to 1930. The discussion is arranged in three chronological sections. The first section, which covers roughly the first two decades of colonial rule, identifies the taproot of the rural healthcare question and demonstrates that it emerged as a component of a larger 'native question'. The 'native question' was a referent for 'the questions colonial development raised concerning what the role of Africans was to be in the changed and changing society'.<sup>1</sup> The section will make it clear that, although rural healthcare entered policy debates relatively early, opinion remained divided over the correct approach.

The second part of the chapter gives an overview of the failed attempts made between 1912 and the end of British South African Company (BSACo) rule in 1922 to implement a rural dispensaries scheme which was an outcome of early debates about rural healthcare. This failure is ascribed to a number of factors, chief among them being the hesitant approach of the Public Health Department under Andrew Fleming who was the Medical Director from 1897 to 1930. The third and last section provides a brief outline of the policy changes and

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<sup>1</sup> Carol Summers, *From Civilisation to Segregation: Social Ideas and Social Control in Southern Rhodesia, 1890-1934* (Athens, OH: Ohio University Press, 1994), p. 133.

continuities in the 1920s and reviews the status of the rural healthcare question on the eve of reform.

The main observation of this chapter is that by 1930 the rural healthcare question had long entered policy debates although on the ground progress remained severely limited because of a stalemate over the ideal approach. The Public Health Department, which doubted the advisability of embarking on a large scale rural healthcare delivery programme, was pitted against a loose but resolute alliance of non-medical state officials, missionaries, settler and African associations, who favoured prompt action. That the Public Health was anti-reform even though the core colonial administration was pro-reform is one of the most intriguing paradoxes of Southern Rhodesia's early twentieth century medical history. As such, by 1930 it was clear that the colony required a fresh and innovative approach to break the policy impasse over an issue which, the world over, was becoming 'a first class political problem... full of questions, rich in promises and burgeoning professional administrations'.<sup>2</sup>

### **Colonisation, the 'native question' and rural healthcare, 1889- 1911**

Southern Rhodesia became a British colony from 1890 following its annexation on behalf of the Crown by an imperial chartered company and pioneering ruler of the colony, the BSACo. One of the immediate challenges that faced the Company administration was finding the best way of governing Africans. What were to be the main elements of a colonial 'native' policy? This question was formidable because the Company government immediately found itself caught in-between the relatively liberal African policy stipulations of the imperial government (and by extension the 'bogey of Exeter Hall') and the rather strident demands of

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<sup>2</sup> Esteban Rodriguez-Ocana and Patrick Zylberman, 'Improving Public Health amidst Crises', *Dynamis*, 28 (2008), p. 19. Accessed from: <http://scielo.isciii.es/pdf/dyn/v28/01.pdf> on 12 Jan. 2010.

the colonists.<sup>3</sup> In addition, during 1896-7 the Africans embarked on the well-orchestrated *Umvukela/Chimurenga* uprisings which rattled the tender foundations of the young colony.<sup>4</sup>

Whereas the initial encounters had tended to be ‘unsystematic and unstructured’,<sup>5</sup> although basic enough to sustain the earliest, rampant acquisition and exploitation of resources,<sup>6</sup> during the aftermath of the 1896-7 uprisings colonial officials began to look for overarching theoretical premises and hegemonic ideas that would allow the Company to maintain order, exploit and govern ‘with creative authority’.<sup>7</sup> This objective brought up questions about the nature and condition of African society, whether it could allow for the achievement of such aims. For instance, there were concerns that Africans were too primitive and their communities were prone to physical and moral degeneration. In addition, Africans were depicted in contradictory terms as either infantile, and therefore requiring tutelage, or rebellious and thus requiring taming.<sup>8</sup> Moreover, African communities were perceived to be

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<sup>3</sup> The bogey of Exeter Hall referred to a coalition of humanitarian groups led by the Aborigines Protection Society. Summers, *From Civilisation to Segregation*, p. 59. The earliest liberal stipulations of the imperial government were encapsulated in the 1889 Royal Charter, which gave the BSACo right of occupation, and the Southern Rhodesian Order in Council of 1898. For more see, Arthur Speight (ed.), ‘The Royal Charter’, *Statute Law of Southern Rhodesia from the Charter to 31 December 1898* (Salisbury, Government Printer); Speight (ed.), ‘The Southern Rhodesia Order in Council, 1898’, *Statute Law of Southern Rhodesia from the Charter to 31 December 1910*.

<sup>4</sup> For more on causes, cause and results, see Maurice K. K. Mutowo, ‘Animal Diseases and Human Population in Colonial Zimbabwe: The Rinderpest Epidemic of 1896-1897’, *Zambezia*, 28, 1 (2001), 15-18; Sabelo J. Ndlovu-Gatsheni, ‘Mapping Cultural and Colonial Encounters, 1880-1930s’, in Brian Raftopoulos and Alois S. Mlambo (eds), *Becoming Zimbabwe: A History from the Pre-colonial Period to 2008* (Harare: Weaver Press; Johannesburg: Jacana Media, 2009).

<sup>5</sup> Diana Jeater, *Law, Language, and Science: The Invention of the “Native Mind” in Southern Rhodesia, 1890-1930* (Portsmouth, NH: Heinemann, 2007), p. xiv.

<sup>6</sup> Murray C. Steele, ‘The Foundations of a “Native” Policy: Southern Rhodesia, 1923-1933’, (DPhil thesis, Simon Fraser University, 1972), p. 13.

<sup>7</sup> Summers, *From Civilization to Segregation*, pp. 56-8; Allison Shutt, ‘The Natives are Getting Out of Hand’: Legislating Manners, Insolence and Contemptuous Behaviour in Southern Rhodesia, c. 1910-1963’, *Journal of Southern African Studies*, vol. 33, no. 3 (2007), p. 655.

<sup>8</sup> Diana Jeater, ‘Imagining Africans: Scholarship, Fantasy, and Science in Colonial Administration, 1920s Southern Rhodesia’, *International Journal of African Historical Studies*, vol. 38, no. 1 (2005), p. 2; Sabelo J. Ndlovu-Gatsheni, ‘Re-thinking the Colonial Encounter in Zimbabwe in the Twentieth Century’, *Journal of Southern African Studies*, vol. 33, no. 1 (2007), p. 177.

afflicted by different tropical diseases which posed a threat to white society and labour supply.<sup>9</sup>

The solution was thought to lie in limited civilisation of African communities. In practice, this entailed walking a tight rope between ‘notions of incorporation and differentiation’ of the kind expertly explored by Ann L. Stoler and Frederick Cooper in *Tensions of Empire*.<sup>10</sup> On its part, the Native Affairs Department began to work out ‘its own mystique of administration’ which was anchored in notions of paternalistic guardianship.<sup>11</sup> Since some of the early Native Commissioners came from the Cape and Natal, the liberalism of the former and the ‘firm paternalism’ of the latter helped underpin this new ethos.<sup>12</sup> In addition to law, education, taxation and labour contracts, one of the specific tools that was increasingly relied upon to make African society governable and exploitable was biomedicine.

Although early healthcare initiatives ‘took little note of the mass of the African population’,<sup>13</sup> certain basic, narrowly-conceived aspects of African health became arenas of state action from the outset. For instance by 1899, the state was already subsidising mission schools to teach Africans hygiene.<sup>14</sup> Moreover, Africans were in principle allowed to access government

<sup>9</sup> Jock McCulloch, ‘The Management of Venereal Disease in a Settler Society: Colonial Zimbabwe, 1900-1930’, in Philip W. Steel, Milton Lewis and Maryinez Lyons (eds), *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa* (Westport, CT, London: Greenwood Press, 1999), p. 196.

<sup>10</sup> A. L. Stoler and F. Cooper, ‘Between Metropole and Colony: Rethinking a Research Agenda’, in F. Cooper and A. L. Stoler (eds), *Tensions of Empire: Colonial Cultures in a Bourgeois World* (Berkeley & Los Angeles: University of California Press, 1997), p. 10.

<sup>11</sup> Steele, ‘The Foundations of a “Native” Policy’, p. 13; W. A. Munro, *The Moral Economy of the State: Conservation, Community Development and State Making in Zimbabwe* (Athens, OH: Ohio University Centre for International Studies, 1998), p. 54.

<sup>12</sup> Steele, ‘The Foundations of a “Native” Policy’, p. 6; Diana Jeater, ‘Speaking Like a Native: Vernacular Languages and the State in Southern Rhodesia, 1890-1935’, *Journal of African History*, vol. 42, no. 3 (2001), p. 452.

<sup>13</sup> Michael Gelfand, *A Service to the Sick: A History of the Health Services for Africans in Southern Rhodesia, 1890-1953* (Gwelo: Mambo Press, 1976), p. 17.

<sup>14</sup> Central Statistics Office, *Official Yearbook of the Colony of Southern Rhodesia* (Salisbury: Rhodesia Printing and Publishing Company, 1932), p. 676; Speight (ed.), ‘Education Ordinance, 1903’, *Statute Law of Southern Rhodesia from the Charter to 31 December 1910*, p. 612.

hospitals built primarily for white colonists. As the Secretary to the Administrator, H. Marshall-Hole explained in 1904, ‘we realise that it is a public duty to receive anyone, European or native, who is found suffering from illness or injuries demanding treatment’.<sup>15</sup> However, these were mainly urban hospitals, which catered for those with access to money, as treatment was not free.

The control of epidemics among Africans was, however, the earliest main preoccupation of the state. Compulsory medico-legal codes such as the Cape Public Health Act of 1886 were used to enforce vaccination orders and the suppression of epidemics such as smallpox. By 1903/4, officials from the Native Affairs Department could round up and vaccinate more than 80,000 Africans for smallpox.<sup>16</sup> In addition to epidemics control, the health of African labourers also received limited attention from the outset. In 1903 and 1908, labour considerations compelled officials to enact rules for the provision of cottage hospitals in mines and laid down minimum standards in respect of hygiene, sanitation, and diet in mining compounds.<sup>17</sup>

By so doing, Southern Rhodesia was in keeping with the 1903 British imperial directive: ‘preserve the health of the European’, ‘keep the labour force in reasonable working condition’ and ‘prevent the spread of epidemics’.<sup>18</sup> The regular medical care of rural communities was left in the hands of the missionaries who recognised biomedical healing as an ‘integral part of the Christian witness... [and] an important evangelistic agency’.<sup>19</sup> These were however few and far in-between and their work was hampered by their miniscule

<sup>15</sup> NAZ, A3/12/14, Native Affairs, Health and Mortality, Marshall-Hole to Fleming, 9 Dec. 1904.

<sup>16</sup> Southern Rhodesia, *Report on the Public Health for the Year Ended 31 March 1904*.

<sup>17</sup> Charles van Onselen, *Chibaro: African Mine Labour in Southern Rhodesia, 1900-1933* (London: Pluto Press, 1976), p. 64-66; Gelfand, *A Service to the Sick*, p. 41.

<sup>18</sup> Leslie Doyal with Imogen Pennel, *The Political Economy of Health*, (London: Pluto Press, 1979), p. 241.

<sup>19</sup> Chengetai. J. Zvobgo, ‘Medical Missions: A Neglected Theme in Zimbabwe’s History’, *Zambezia*, vol. 13, no. 2 (1986), p. 109.

resources. Thus, for a long time they assiduously petitioned the state for financial assistance until a comprehensive subsidy system was worked out in the late-1920s.<sup>20</sup> Their tacit recognition as stakeholders in African colonial policy helped to keep them hopeful.

However, in Southern Rhodesia African policy was the ‘product of arguments, debates, and profoundly conflicting interests among the whites – administrators, missionaries, and settlers – who interacted with Africans on a daily basis’.<sup>21</sup> Therefore, besides missionaries, Native Commissioners were also keen believers in the notion of early development of rural healthcare services. Although African education and health, the two ‘specialist functions’, were not under the direct control of the Native Affairs Department,<sup>22</sup> healthcare commended itself to the Native Affairs Department officials because of the promise of disease control and the modernisation of African society. Through the provision of common treatments, the Native Commissioners were also keen to put up a positive face among Africans as a way of justifying colonisation and its concomitant demands.

Indeed, in 1909, following years of concern about diseases like syphilis,<sup>23</sup> the Superintendents of Natives (SoNs), a corps of senior Native Commissioners adopted an agenda-setting motion tabled by Herbert J. Taylor, the Chief Native Commissioner (1894-1928). Taylor’s proposal was ‘that provision be made in the estimates for increasing the vote for Native Education, and for special contributions to those Missions affording facilities for medical treatment of natives and for the teaching of hygiene’.<sup>24</sup> He also suggested that a grant

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<sup>20</sup> Michael Gelfand, *Godly Medicine in Zimbabwe: A History of its Medical Missions* (Gweru: Mambo Press, 1988), pp. 67-83.

<sup>21</sup> Jeater, ‘Imagining Africans’, p. 1.

<sup>22</sup> Steele, ‘The Foundations of a “Native” Policy’, p. 59.

<sup>23</sup> NAZ, NF2/1-4, Native Commissioner, Ndanga, to Chief Native Commissioner, 1 June 1900; NAZ, NF2/1-4, Native Commissioner, Umtali, to Chief Native Commissioner, 28 June 1900; NAZ, NF2/1-4, Native Commissioner, Victoria, to Chief Native Commissioner, 31 May 1900.

<sup>24</sup> NAZ, H2/10/1, Native Dispensaries, H. Marshall-Hole to Fleming, 26 Nov. 1909.

of £100 per annum be made to a satisfactory medical mission employing a qualified medical person. A further £100 should also be made where the state was satisfied that 'special facilities are afforded for the treatment of the sick by providing hospital accommodation for not less than ten patients, with a sufficient stock of drugs and ordinary surgical instruments on the premises'.<sup>25</sup>

Taylor's major motive for making this proposal was that 'any means which would induce natives to adopt European medicines should be encouraged, as the influence of witchcraft would thereby be gradually weakened'.<sup>26</sup> He added that,

The medical supervision and industrial education of the native may at first sight be considered subjects which should be dealt with on an entirely different basis but these matters are really essential to the general prosperity of the native and the country as a whole, and one can so materially assist the better working of the other.... It is not suggested that the work of the Medical Officer should be confined to the treatment of the sick and injured. His work must be considered as part of a scheme of the gradual development of a healthy industrious and law-abiding native population.<sup>27</sup>

Marshall-Hole, the Secretary to the Administrator, was supportive of Taylor's proposals and he envisaged that 'they practically amount to the creation of a sort of District Surgeon in reserves and the scheme might be a valuable aid to the Medical Department'.<sup>28</sup> However, the Medical Director, Andrew Fleming, opposed the proposal, citing lack of proper medical knowledge among both missionaries and Native. The government 'would be lending its countenance to the unqualified practice with all its dangers' if it allowed such a practice.<sup>29</sup> Moreover, if one denomination was offered assistance, all denominations would claim the same privilege. In addition, medical treatment was as an evangelising strategy which the

<sup>25</sup> NAZ, H2/10/1, Taylor to Marshall-Hole, 3 Dec. 1909.

<sup>26</sup> NAZ, H2/10/1, Taylor to Fleming, 26 Nov. 1909.

<sup>27</sup> NAZ, A3/3/18, Native Affairs Committee of Enquiry 1909-1912, Taylor, Proposals for Carrying into Effect the Suggestion of the Native Affairs Committee of Enquiry as Regards Medical Supervision and Industrial Education in Native Areas, 11 July 1911.

<sup>28</sup> NAZ, H2/10/1, H. Marshall-Hole to the Administrator, 8 Dec. 1909.

<sup>29</sup> NAZ, H2/10/1, Fleming to H. Marshall-Hole, 30 Nov. 1909.

government should not be expected to underwrite. According to Fleming, although the only ideal policy was for the government to establish its own dispensaries under district medical officers, he thought the time was 'hardly ripe for this yet' because there were no sufficient medical officers and there was no clear 'demand from the natives themselves'<sup>30</sup>

The next round of pressure came from the Southern Rhodesia Native Affairs Committee of Enquiry of 1910-11 (NACE) who requested him to make a comprehensive submission of a rural healthcare plan. Although he obliged, he did so with a warning that Africans still possessed a rooted objection to biomedicine and, therefore, 'any attempt... at assisting the natives and encouraging them to go to European institutions for treatment must be made gradually and with extreme caution'.<sup>31</sup> Surprisingly, the scheme he drew up proposed a rural dispensary system delivered through the agency of missionary societies, which he had earlier opposed.

Fleming explained his change of mind by saying he had realised that as opposed to a circular medical doctor an average missionary held superior knowledge about Africans and had the desire to learn more about their customs and habits of this nature than a circular medical practitioner would. Circular doctors were more inclined to prioritise advancement and openings in more comfortable areas of practice.<sup>32</sup> Accordingly, he proposed a sum of £9,250 for the first year to construct six mission medical stations, each under a qualified missionary doctor. Each of these medical officers would also run three outlying dispensaries within their districts.

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<sup>30</sup> NAZ, H2/10/1, Fleming to H. Marshall-Hole, 15 Dec. 1909.

<sup>31</sup> NAZ, H2/10/1, A. M. Fleming, Memorandum, 1909, p. 3.

<sup>32</sup> NAZ, H2/10/1, A. M. Fleming, Memorandum, 20 Dec. 1909, p. 4.

The NACE adopted wholesale Fleming's proposals and in the final report argued that the implementation of the scheme in 'purely African areas',

... would have a beneficial effect, not only for the restoration or preservation of health, but also for weaning the Natives from faith in witch doctors, diviners or soothsayers or men who profess to have supernatural power or knowledge whether as medicine men or otherwise<sup>33</sup>

The formulation of a rural healthcare service was therefore an integral part of the agenda of transforming African societies. In April 1911, the London Board of Directors of the BSACo gave added impetus to this issue through a directive issued to the colony's Office of the Administrator, which was the heart of the Company colony's administration. The Board suggested that,

... in addition to the existing measures for the care of natives who are employed at the Mines or in towns, more might be done at their own kraals to improve their physical condition.... It might be practicable to arrange for some simple means of medical inspection and dispensary aid which might, without inordinate expense, gradually introduce into the kraals some knowledge of the elementary rules of health; of treatment of ordinary complaints, and improve the conditions of the native in his own kraal.... In particular...attention might be given to the better care of women in childbirth and to infant life....<sup>34</sup>

A high-level conference of senior civil servants, including Taylor, Marshall-Hole and W. M. Eaton, the acting Medical Director, was held October/November 1911 to discuss both the NACE Report and the London Board recommendation.<sup>35</sup> Although Eaton had initially opposed the idea as 'impracticable, and one that should be discouraged', the conference resolved that the state would pioneer two sizeable dispensaries under the care of qualified medical officers. Subsidies would also be given to two missionary societies to do the same.<sup>36</sup>

Eaton's suggestion to start the scheme in the two big urban centres, Salisbury and Bulawayo, and include 'the more ignorant [rural] native' later, was criticised and rejected by the

<sup>33</sup> Southern Rhodesia, *Native Affairs Committee of Enquiry Report* (Salisbury: Government Printer, 1911), para. 277.

<sup>34</sup> NAZ, H2/10/1, A. H. Holland to Fleming, 3 April 1911.

<sup>35</sup> NAZ, H2/10/1, Minutes of Conference of Superintendents of Natives, Salisbury, 31 October - 3 November 1911.

<sup>36</sup> NAZ, H2/10/1, Minutes of Conference of Superintendents of Natives, Salisbury, 31 October - 3 November 1911.

delegates.<sup>37</sup> Instead, two rural areas – Ndanga in Mashonaland and Belingwe in Matabeleland – were selected as the sites for the first two government medical stations. Each medical station would comprise a dispensary and a main ward that could accommodate eight to twelve patients. From their main stations, medical officers would go around the outlying areas promoting hygiene and sanitation and treating the sick. African orderlies would also be trained in urban hospitals to assist in the running of these medical stations, which could be expanded if initial results were encouraging.<sup>38</sup>

### **Pioneering the dispensaries initiative, 1912-1922.**

After the conference, Fleming was directed to proceed with the preparations for the commencement of the agreed work.<sup>39</sup> However, what followed thereafter were essentially half-hearted attempts at implementing the scheme. Except for the Ndanga medical station which survived into the 1920s, albeit in a wobbly state,<sup>40</sup> the other three medical stations collapsed within a few years of their existence mainly because of disorganisation and lack of will. The circumstances surrounding the rise and fall of two of these medical stations will suffice to illustrate this point. The Mwembe dispensary in Belingwe was doomed to failure from the start. On his commencement of duty, the founding doctor, Neville S. Williams, was denied the four mules, a Cape cart and a horse which he had requested for his transport so that he could travel extensively around the district to advertise his presence.<sup>41</sup> Fleming said his Department could not afford his requests, which he thought were unnecessary. Instead, he suggested that a horse and a bicycle would be enough for him.<sup>42</sup>

<sup>37</sup> NAZ, H2/10/1, Minutes of Conference of Superintendents of Natives, Salisbury, 31 Oct. - 3 Nov. 1911.

<sup>38</sup> NAZ, H2/10/1, Minutes of Conference of Superintendents of Natives, Salisbury, 31 Oct. - 3 Nov. 1911.

<sup>39</sup> NAZ, H2/10/1, Marshall-Hole to Fleming, 28 Dec. 1911.

<sup>40</sup> Steele, 'The Foundations of a "Native" Policy', 277; NAZ, S246/571, Native Hospitals, 1920-1929, Fleming to Colonial Secretary, 24 July 1925.

<sup>41</sup> NAZ, H2/10/4, Native Dispensaries, N. S. Williams to Fleming, 16 Jan. 1913.

<sup>42</sup> NAZ, H2/10/4, Fleming to N. S. Williams, 18 Jan. 1913.

In addition to being denied these basic necessities, the medical officer commenced duty before the completion of his quarters, compelling him to live in a tent for three months, and thereafter in the kitchen while he awaited the completion of the house. In addition, he also spent two months without any means of transport. In June 1913 he was supplied with a mule which, according to the Acting Native Commissioner, Belingwe District, 'would disgrace a meat cart both on account of age and condition'.<sup>43</sup> The transportation of hospital supplies was also very poor and the doctor usually kept patients on placebos as he frequently ran out of medical supplies.<sup>44</sup> As a result, 'the patients got worse instead of better and lost confidence which has not been recovered since [the] arrival of a fresh supply [of medicines]'.<sup>45</sup> Matter-of-factly, the Acting Native Commissioner for Belingwe charged that,

In my opinion the whole administration up to the present has been a farce. So disgusted has Dr. Williams become with his treatment, that he has sent his resignation and until a more progressive, definite and liberal policy is formed, I fail to see how I can co-operate in its [medical station's] advancement.... Unless a more generous policy towards the Resident Surgeon is adopted the whole thing is foredoomed.<sup>46</sup>

A three-man fact-finding mission comprising Taylor, Fleming and H. M. Jackson, the SoN of Gwelo, toured the hospital and agreed in their joint report that the needs of the doctor had not been dealt with promptly or systematically.<sup>47</sup> As a remedy, some improvements were attempted but Williams was not willing to bear it any longer, and so left. Although his successor, McGowan was provided with a scotch cart, eight young oxen and a salted horse, he also reported difficulties in getting patients to come to him regularly for treatment, in addition to their being suspicious of treatment as in-patients.<sup>48</sup> It seems the use of placebos and the farcical experience under Williams had hurt the reputation of the institution.

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<sup>43</sup> NAZ, H2/10/4, Acting Native Commissioner, Belingwe, to H. M. Jackson, 3 July 1913.

<sup>44</sup> NAZ, H2/10/4, Acting Native Commissioner, Belingwe, to H. M. Jackson, 3 July 1913.

<sup>45</sup> NAZ, H2/10/4, Acting Native Commissioner, Belingwe, to H. M. Jackson, 3 July 1913.

<sup>46</sup> NAZ, H2/10/4, Acting Native Commissioner, Belingwe, to H. M. Jackson, 3 July 1913.

<sup>47</sup> NAZ, H2/10/4, Report on the Visit of Medical Director, Chief Native Commissioner and Superintendent of Natives, to Mwembe Hospital, 29 July 1913.

<sup>48</sup> NAZ, H2/10/4, McGowan to Fleming, 12 Jan. 1914.

By mid-1914, McGowan was also on his way out. The dispensary had started its protracted collapse. The ill-fated Dr Joynt, the third medical officer in the space of two years, replaced McGowan. In November 1914, nature quickened the collapse of the station when lightning struck the hospital and almost completely reduced it to ashes. Joynt's equipment was also destroyed; the government offered him £50 as an 'act of grace'.<sup>49</sup> What remained of the building was hard hit by severe summer storms and in May 1915 it was recommended that the institution be closed.

The medical stations attempted through missionary agency were not any more successful. Two dispensaries were established in Rusape and Kwenda under the auspices of the Church of England Missionary Society and Wesleyan Missionary Society respectively.<sup>50</sup> In both cases missionary doctors were employed. However, within a short period, the two stations were rocked by problems and they collapsed. Although in Rusape conflicts between Dr Homer and the priest-in-charge resulted in the dismissal of the former in 1914,<sup>51</sup> at Kwenda problems were between the medical missionaries and the Public Health Department.

Dr Sydney Osborne's application for leave in 1916 following three years of service at Kwenda led to a succession of events that led to the collapse of the dispensary. Approval of his application was delayed over the finding of a locum. When Dr Osborne mentioned the loneliness of the station and fluctuation of patient numbers as a way of suggesting that a locum might not be absolutely necessary<sup>52</sup> Public Health Department officials began to query the results coming from the dispensary. In their opinion, they did not appear to be

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<sup>49</sup> NAZ, H2/10/4, Secretary, Department of the Administrator, to Medical Director, 15 Jan. 1915.

<sup>50</sup> NAZ, H2/10/2, Proposals: The Establishment of a Native Hospital and Dispensary at Kwenda Mission Station in the Charter District, n.d; NAZ, H2/10/2, Fleming to Rev. Brigg, 13 Fe. 1913; Rev. Brig to Fleming, 27 Feb. 1913; Fleming to Brigg, 14 March 1913.

<sup>51</sup> Gelfand, *Godly Medicine*, 73.

<sup>52</sup> NAZ, H2/10/2, Osborne to Medical Director, 4 Oct. 1916.

commensurate with expenditure. Although the Rev. John White, the Superintendent of the Wesleyan Methodist Church in Southern Rhodesia pleaded for the continuation of the medical station as an educational instrument which Africans would gradually get used to, the Public Health Department took the drastic step of closing it.<sup>53</sup>

The foundering of these initial experiments and the fact that extremely low patient numbers were also cited as a major factor in the decision to close the Kwenda station seemed to vindicate Fleming's hesitancy and argument that the majority of Africans were still opposed to biomedical care. However, the Fleming administration seems to have lacked vision, tact or interest. The haste with which the closure of the clinic was recommended defied the logic of the Rev. White's reasoning that continuation of the work was a good option in the long term. Following the collapse of these dispensaries, Fleming and his Department failed to offer any innovative alternatives.

In 1915, the indefatigable SoNs had come up with another suggestion. They recommended that Native Commissioners be supplied with stocks of common medicines to help those Africans who sought treatment.<sup>54</sup> They cited ethical reasons as the basic motive of their recommendation. Although acknowledging the importance of the Ndanga and Belingwe experiments, they 'felt that, in view of the revenue contributed by the Natives, they should benefit as a whole'.<sup>55</sup> Using the agency of Native Commissioners was an effective way of ensuring equitable access because they were present in all corners of the colony. However, these Native Affairs officials appeared to be also motivated by the need to offer medical

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<sup>53</sup> NAZ, H2/10/2, W. M. Eaton, Acting Medical Director, to Rev, J. White, 22 March 1917; Rev. J. White to Eaton, 5 April 1917; Robertson, Secretary to the Administrator to Eaton, 4 May 1917.

<sup>54</sup> NAZ, N6/2/1, Superintendent of Natives Conference Minutes, 8-11 Dec. 1915; Chief Native Commissioner to Secretary, Department of the Administrator, 8 Jan. 1916.

<sup>55</sup> NAZ, N6/2/1, Chief Native Commissioner to Secretary, Department of the Administrator, 8 Jan. 1916.

treatment as a benign counterweight to tax collection and other forms of state control. The proposal was approved by the Administrator's Office and the colony entered the politically historic 1920s with this ad hoc measure as the backbone of the rural healthcare system.

### **Change and continuity in the 1920s**

From 1923, the administrative arrangements of the colony changed as the BSACo ceded administrative control to the Responsible Government (RG) of white settlers. The administrations of the colony's first two Premiers, Charles Coghlan (1923-1937) and Howard U. Moffat (1927-1933), inherited an unsettled rural healthcare question. Steele is correct in saying that 'the new settler administration installed in October 1923 inherited an African health service that may, not unreasonably, be described as rudimentary'.<sup>56</sup> But did anything change under RG?

Under Responsible Government, the pool of advocates for healthcare reform continued to expand as the new crop of political leaders began to redefine 'native' affairs in their own new ways. In part, this stemmed from concerns about deterioration in the reserves, which stoked fears of social unrest.<sup>57</sup> African proto-nationalist groups were beginning to emerge, inspired by older South African movements. Such groups like the Southern Rhodesia Native Association and the Bantu Voters Association among others, campaigned for reform, equal development and enfranchisement.<sup>58</sup> In 1924, an African teachers' group reportedly famously remarked that the government was providing medicine for their cattle (an allusion to dip tanks) but not for people.<sup>59</sup> Such developments forced the state to reconceptualise its

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<sup>56</sup> Steele, 'The Foundations of a "Native" Policy', p. 269.

<sup>57</sup> Summers, *From Civilization to Segregation*, p. 171.

<sup>58</sup> The Southern Rhodesia Native Association was formed in 1919 as an offshoot of the Union Bantu Vigilance Association. NAZ, Notes on Meeting between Chief Native Commissioner and Southern Rhodesia Native Association, 1 June 1927; Southern Rhodesian Native Association Conference Resolutions, 23 June 1928.

<sup>59</sup> NAZ, S1173/301, L. P. Hardaker to Fleming, 21 June 1924.

development approach partly as a way of stopping the perceived collapse of reserves and also undermining the power of African associations.

In addition, in keeping with the spirit of the reserved clauses in the RG constitution, which prescribed that Africans were Crown subjects, Coghlan and Moffat were keen to prove to the imperial government that white settlers were capable of running their affairs without jeopardising African welfare.<sup>60</sup> Moreover, there were also perceptions that syphilis was increasing among Africans.<sup>61</sup> Municipalities also became concerned about increasing numbers of venereal diseases sufferers coming from rural areas to seek treatment in municipal medical facilities, which in their view, did not receive adequate support from the national department.<sup>62</sup>

Furthermore, different settler organisations, including the Southern Rhodesian Women's League, which claimed to speak on behalf of the 'practically inarticulate' African women,<sup>63</sup> farmers and miners, all joined the chorus for rural healthcare reform. The self-styled 'guardians' of the 'natives', the Native Affairs Department, also continued their advocacy. In 1926 and 1927, NCs and SoNs held conferences where they passed resolutions, including the provision of free treatment and accommodation for venereal cases.<sup>64</sup> In June 1927, the Department of the Colonial Secretary sought the opinion of the Native Commissioners on the advisability of setting up dispensaries and facilitating periodic visits by medical officers in

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<sup>60</sup> Steele, 'The Foundations of a "Native" Policy', 24; Summers, *From Civilisation to Segregation*, p. 171.

<sup>61</sup> For more see, L. A. Jackson, 'When in the White Man's Town': Zimbabwean Women Remember *Chibaura*', in J. Allman, S. Geiger and N. Musisi, eds, *Women in African Colonial Histories* (Bloomington and Indianapolis: Indiana University Press, 2002), pp. 191-215.

<sup>62</sup> NAZ, S1173/330, Natives: Medical Examination, 1925-1930, Town Clerk, Salisbury, to Fleming, 14 November, 1925; Superintendent of Natives, Bulawayo, to Fleming, 19 May 1928.

<sup>63</sup> NAZ, S1173/332, Rhodesian Women's League to Moffat, 28 Feb. 1930.

<sup>64</sup> J. McCulloch, 'The Management of Venereal Disease in a Settler Society: Colonial Zimbabwe, 1900-1930', in P. W. Setel, M. Lewis and Maryinez Lyons, eds, *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa* (Westport and London: Greenwood Press, 1999), p. 201.

reserves.<sup>65</sup> Their responses were overwhelmingly supportive of the idea, with some describing medical treatment as ‘the most urgent native question of the day’.<sup>66</sup> Others went to the extent of proposing the introduction of the system of African doctors who would exclusively practice in reserves.<sup>67</sup>

Moreover, driven by their evangelising aspirations and religious humanitarianism, missionaries also continued their petitioning of the Public Health Department to work out a comprehensive policy of rural medical care. In 1924, and then again in 1926, they convened the Southern Rhodesia Missionary Conference where they discussed the further trial of the rural dispensary system, the introduction of training schemes for African orderlies and midwives and the granting of financial support to missionary initiatives.<sup>68</sup> The Moffat administration seems to have given missionaries a sympathetic ear. Born into a Kuruman-based missionary dynasty, Moffat was a product of Victorian missionary paternalism and a mentee of liberal South African segregationists such as C. T. Loram.<sup>69</sup>

However, Fleming maintained his cautious approach. He rebuffed concerns about the increase in the prevalence of syphilis as scientifically incorrect and as rather exaggerated. According to him, ‘a far higher proportion of venereal disease occurs amongst the white trooper as compared with natives’.<sup>70</sup> In Fleming’s view, there were simply more disclosures than before. On the question of attempting to re-establish dispensaries, he told the Colonial

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<sup>65</sup> NAZ, S1173/330, Colonial Secretary to Chief Native Commissioner, 10 June 1927; Taylor to Native Commissioners, 17 June 1927.

<sup>66</sup> NAZ, S1173/330, Native Commissioner, Umtali, to Chief Native Commissioner, 30 June 1927.

<sup>67</sup> NAZ, S1173/330, Native Commissioner, Chipinge, to Chief Native Commissioner, 18 July 1927.

<sup>68</sup> NAZ, S1173/301, Hardaker, to Fleming, 28 Aug. 1926; Gelfand, *Godly Medicine*, 75.

<sup>69</sup> Moffat’s grandfather, Robert Moffat, and father, John Smith Moffat, were missionaries. Steele, ‘The Foundations of a “Native” Policy’, 30.

<sup>70</sup> NAZ, H2/3/8/1, Public Health, Fleming to Assistant Commissioner, BSAP, 13 Oct. 1922.

Secretary, the new political head overseeing the Public Health Department, that ‘the establishment of dispensaries in native districts... have been tried, and proved a failure’.<sup>71</sup>

However, he could not totally ignore the pressure from different sections of colonial society without doing anything. In 1925 he committed himself to the fight against venereal and other infectious diseases. This was given impetus by the enactment, that same year, of the colony’s first Public Health Act that gave local authorities and medical officers wide-ranging powers for the suppression of what were termed ‘formidable epidemic diseases’, which included small-pox, cholera, plague, epidemic influenza and syphilis.<sup>72</sup>

In 1927, Fleming agreed to establish venereal diseases clinics in Native Commissioners’ camps.<sup>73</sup> Essentially, this was an extension of the work that Native Commissioners had started in 1916. In the 1920s it enhanced by the increasing availability of the more efficacious treatment such as salvarsan.<sup>74</sup> Through this, Fleming managed to assuage the concerns of the settlers while buying time. However, these clinics had a severely limited geographical scope as they seemed to depend more on the enthusiasm and willingness of each Native Commissioner to do or supervise such work. Although most Native Commissioners were supportive of the idea of setting up dispensaries in reserves, most of them were not inclined to supervise the work. Thus, by 1930, there were only seven venereal diseases clinics, catering for only 4,359 patients per year.<sup>75</sup> Native Commissioners and their wives acted as the

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<sup>71</sup> NAZ, S1173/301, Medical Missions, 1924-1928, Fleming to Colonial Secretary, 25 June 1924.

<sup>72</sup> Southern Rhodesia, ‘Public Health Act, Chapter 140 of 1925’, in *Statute Law of Southern Rhodesia*. Volume III (C. R. Foxworth Ltd, 1939), 308-310.

<sup>73</sup> Steele, ‘The Foundation of a “Native” Policy’, p. 276.

<sup>74</sup> Before salvarsan was commonly used, syphilis was treated using a less effective mixture of potassium iodide, mercury and arsenic. Gelfand, *A Service to the Sick*, pp. 26-27.

<sup>75</sup> Southern Rhodesia, *Report on the Public Health for the Year 1930* (Salisbury: Government Printer, 1931), p. 20; Editorial, ‘Medical Services for Natives: Dr Askins’ Views’, *Journal of Medical Association of South Africa*, 11 April (1931), p. 224.

‘superintendents’ and were supported by one or two African orderlies. Medical officers only paid periodic visits.

Fleming’s other concession was that, in 1927, he agreed to formulate a reasonable grant-in-aid scheme to support medical missions capable of employing qualified persons, whether doctors or nurses. These grants would cover salaries, maintenance and upkeep, and the cost of drugs and surgical instruments and dressings.<sup>76</sup> Although the Colonial Secretary, William M. Leggate, was satisfied with the scheme, he implored Fleming to go further and work out a comprehensive proposal for the provision of medical services that would encompass the whole colony, including the rural areas. He argued that the time was ripe for the state to give further medical assistance to Africans and that ‘the Government cannot escape the liability for this [rural medical] work which is of a national character’.<sup>77</sup>

However, Fleming did not share Leggate’s convictions. In his own words, although developing such a service might sound ‘humanitarian and progressive.... The native... is still too primitive to take advantage’ of such services.<sup>78</sup> A 1929 conference of senior government medical officers that was chaired by Fleming presented Leggate with another opportunity to make it known that the government was anxious to avail more medical services to Africans and that resources had been set aside for that purpose. He also emphasised the state’s view that Africans were ready for such services.<sup>79</sup> However, he left the conference astounded by

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<sup>76</sup> NAZ, S246/608, Medical Assistance to Natives by Government Medical Officers, 1927-1929, Proposals Fleming to Secretary, Department of the Colonial Secretary, 16 Feb. 1927.

<sup>77</sup> NAZ, S246/608, Leggate to Moffat, 29 March 1927; NAZ, S246/608, Colonial Secretary to Medical Director, 22 Feb. 1927.

<sup>78</sup> NAZ, S246/608, Fleming to Leggate, 21 March 1927.

<sup>79</sup> NAZ, S246/10, Minutes of Conference of Senior Government Medical Officers, 24 June 1929.

the divisions in opinion and the lack of firm commitments.<sup>80</sup> The colony was set to continue on its path of lack of a coherent rural medical policy.

## **Conclusion**

This chapter has demonstrated that by 1930 the issue of rural healthcare question was a longstanding one. Despite mounting pressure, Fleming and his administration did not offer any innovative ideas. The few schemes that were tried out were the ideas of other colonial departments. The sector was virtually stagnant. As Steele correctly observed, ‘the principal breakthrough in the field of African health, the establishment of medical units in reserves, was... the work of Askins, Fleming’s more imaginative successor’.<sup>81</sup> In early 1930, Fleming retired and he was replaced by Robert Askins who proactively engaged the rural healthcare question and introduced the reforms which form the main starting point of this thesis. The details about the reforms follow in the next, chapter 2.

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<sup>80</sup> NAZ, S246/10, Minutes of Conference of Senior Government Medical Officers, 24 June 1929.

<sup>81</sup> Steele, ‘The Foundations of a “Native” Policy’, p. 299.

## Chapter 2

### **Robert A. Askins and the shifting trajectory of rural healthcare from 1930: local, transcolonial and British influences**

#### **Introduction**

This chapter explores the shifting trajectory of Southern Rhodesia's rural healthcare policy from 1930 and serves as a critical outline of the policy origins of the Ndanga Medical Unit, the pioneering scheme which is closely examined from chapter three onwards. The reforms introduced by Robert A. Askins, the colony's second medical director, as he sought to deal comprehensively with the long-standing rural healthcare question, are the major focus of the chapter. Distinguishing himself from his dithering predecessor, Fleming, Askins made the control and eventual eradication of the colony's rural diseases the priority of his administration from the outset.<sup>1</sup> This he sought to accomplish through the systematic establishment of hospitals/dispensaries countrywide and the deployment of trained medical staff in rural areas. He thus set out to initiate a rural medical service scheme organised according to the pioneering model of district-focused medical units, of which the Ndanga Medical Unit was the pioneer.<sup>2</sup>

The chapter analyses this model and its underlying influences and illustrates that, among other things, (a) Askins' arrival signalled the beginning of a new focus on the district as the primary zone for African public health intervention; (b) that his model implied a discernible shift of focus from individual epidemics to a group of endemic rural diseases; and (c) that it received inspiration from emerging British and transcolonial models of health care delivery between the wars. The chapter notes too that Askins' medical units scheme contained both

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<sup>1</sup> Southern Rhodesia, *Report on the Public Health for the Year 1930*, p. 19.

<sup>2</sup> National Archives of Zimbabwe (hereafter NAZ), S1173/336, Scheme for the Medical Treatment of Natives, Training of Native Orderlies, R. A. Askins, 'Preliminary Report on the Treatment of Natives', 8 Sept. 1930.

progressive and retrogressive elements. On the progressive side, in addition to exemplifying the first concrete commitment by a leading public health bureaucrat to overhaul rural healthcare, the medical units scheme was also the first model with the potential to create a relatively well-organised district health care system for the colony's African communities. Also, to his credit, Askins acknowledged that disease caused a great deal of unnecessary suffering and avoidable death among Africans, and that this therefore required some, state-led, remedial action.<sup>3</sup>

However, on the negative side his major justification for urgent reform was mainly informed by the unfounded and yet popular colonial argument that, because of their supposedly primitive culture and non-scientific outlook, Africans were the inherent reservoirs of the many diseases that menaced white citizens and disrupted the colonial economy.<sup>4</sup> Conveniently ignored by Askins were the very conspicuous colonial determinants of ill-health, including colonial dispossession and the disruption of ecological equilibrium due to forced resettlements and colonial labour migration. The district health staff complement was also designed in such a way that the privileged medical turf was reserved for white doctors. Africans were consigned to the lower cadre of medical orderlies.

To explain this curious admixture of progressive and retrogressive elements in Askins' model, the chapter emphasises the fact that healthcare reform in interwar colonial Africa generally responded to an admixture of reformative, progressive and conservative impulses which had observable international and local, imperial and colonial dimensions. For instance, the reformative, progressive impulse was generated and emboldened by developments such

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<sup>3</sup> NAZ, S1173/336, Askins, 'Preliminary Report on the Treatment of Natives', 8 Sept. 1930.

<sup>4</sup> Southern Rhodesia, *Report on the Public Health for the Year 1930*, p. 19; NAZ, S1173/336, Askins, 'Preliminary Report on the Treatment of Natives', pp. 1-2.

as the increasing efficacy of biomedical cure following the germ revolution,<sup>5</sup> the emergence of rudimentary ideas of social medicine, and the increasing involvement of the state in healthcare. The intensity with which these factors were pursued and which one of these virtually trans-imperial and transnational factors received greater attention in any given colonial policy depended much on the personal outlook of the chief reformers and the institutions within which they worked.

However, counteracting these progressive impulses were the retrogressive features which had their origins in colonial racial prejudice. The main argument of this chapter is that the motives and content of colonial healthcare reforms were inherently contradictory and therefore that the major policy that brought the Ndanga Medical Unit into existence, was a double-edged sword. To explore these issues, the chapter begins with a historiographical overview that sets the scene for the analytical framework used here in placing the Southern Rhodesian reforms within a broader, international context. This theoretical scene-setting is followed by a brief outline of the changes in the management of Southern Rhodesia's Public Health Department, with the major highlight being the appointment and commencement of duty by the new medical director, Robert Askins, in August 1930.

After that, the chapter proceeds to outline and discuss the main elements of the new reforms which he introduced, paying particular attention to the broader context and the different formative influences and concepts from which he drew inspiration and specific models. Thereafter, the chapter offers a critique which illuminates the ways in which these

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<sup>5</sup> The argument here is that as biomedicine became more confident about certain treatments following, for instance, the discovery of drugs such as salvarsan, it became more feasible and justifiable to establish regular medical services than before.

increasingly necessary reforms were paradoxically structured and justified by pandering to colonial stereotypes and racial prejudice.

### **Social history of medicine ‘beyond the local’**

Historians of colonial health care have tended to explain the evidently widespread interwar healthcare reforms through localised, colony-centric perspectives. In contrast, this chapter recognises some broader influences on Askins’ ‘local’ reforms and proposes that a wider perspective is therefore necessary if these reforms are to be understood in their entirety. Available evidence indicates that Askins was motivated by (and borrowed from) trends and models pioneered in other dominions/colonies such as the Union of South Africa (which was essentially Southern Rhodesia’s regional metropole), French West Africa and the Belgian Congo. He was also inspired by models of rural, district health care delivery that were being tried out in south-west England where he spent much of his professional life before coming to Southern Rhodesia.

By highlighting these influences and the ways in which they coloured the lenses through which he viewed local systemic inadequacies and prompted him to develop a new, hybrid framework of healthcare delivery, this chapter establishes an inadequately recognised point, viz. that a combination of coalescing international and local factors underlay interwar colonial healthcare reform. Many historians have largely missed this important perspective, preferring to look at the reforms as solely colony-specific responses to changing local epidemiological circumstances or as adjustments to shifting notions of inter-racial public health and the minimum requirements of colonial labour welfare.<sup>6</sup> Even the latest revisionist

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<sup>6</sup> A few, illustrative examples include, David Arnold, ‘Medicine and Colonialism’, in W. F. Bynum and Roy Porter (eds), *Companion Encyclopaedia of the History of Medicine* (London & New York: Routledge, 1993). John Iliffe, *East African Doctors: A History of the Profession* (Cambridge: Cambridge University Press, 1998); Shane Doyle, ‘Population Decline and Delayed Recovery in Bunyoro’, *Journal of African History*, Vol. 41, No.

explorations of the origins of interwar colonial healthcare reform proffered by historians such as Osaak Olumwullah<sup>7</sup> and George O. Ndege<sup>8</sup> have ignored the important international dimensions of this subject. Seeing that the reforms took place across the various African empires almost simultaneously, solely local-bound explanations give a one-dimensional picture. Indeed, as Ilana Lowy reminds us, ‘Investigations limited to developments in a single country may fail to cover all the ways medicine is embedded in a larger social context’.<sup>9</sup>

Coming at a time when the historiography of modern medicine in the non-Western world is undergoing significant revision, with Hormoz Ebrahimnejad not very long ago calling for the jettisoning of ‘diffusionist’ perspectives in favour of localising historical narratives ‘that would address change in the medical or scientific outlook no matter the origin of such evolution, foreign influence or internal dynamics, or a combination of both’,<sup>10</sup> this chapter may well be considered as a significant counter-narrative. Based on unequivocal evidence, the chapter goes against the grain of this scholarship by highlighting the movement of ideas from other regions to Southern Rhodesia where they were clearly reformulated and adapted to suit the perceived local needs. The mere fact that medical concepts and models crossed boundaries during the interwar period is, however, no longer a novel observation; certainly, other historians of interwar healthcare reform in both imperial Europe and colonial Africa

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3, (2000), pp. 429-58; Michael Gelfand, *A Service to the Sick: A History of the Health Services for Africans in Southern Rhodesia, 1890-1953* (Gwelo: Mambo Press, 1976).; William M. Macmillan, *Africa Emergent: A Survey of Social, Economic and Political Trends in British Africa* (Revised Edition, (Harmondsworth: Penguin, 1949).

<sup>7</sup> Osaak Olumwullah, *Dis-ease in the Colonial State: Medicine, Society and Change among the AbaNyole of Western Kenya* (Westport, Connecticut, London: Greenwood Press, 2002).

<sup>8</sup> George O. Ndege, *Health, State and Society in Kenya* (New York: University of Rochester Press, 2001).

<sup>9</sup> Ilana Lowy, ‘The Social History of Medicine: Beyond the Local’, *Social History of Medicine*, vol. 20, no. 3 (2007), p. 466.

<sup>10</sup> Hormoz Ebrahimnejad, ‘Introduction: For a History of Modern Medicine in non-Western Countries’, Hormoz Ebrahimnejad, (ed.), *The Development of Modern Medicine in Non-Western Countries: Historical Perspectives* (Oxon; New York: Routledge, 2009), p. 2.

have already shown that certain, the ostensibly country-specific models benefited from trans-national exchanges and borrowing of ideas.<sup>11</sup>

However, what could be pioneering about this chapter is the call to apply this approach routinely in interwar health policy histories as these crossovers were not a rarity. Thus, this chapter provides a new example of a case where this exchange of ideas happened through both easily observable and less obvious ways. Selected both as an appropriate heuristic device and also an answer to the newly emerging calls for trans-boundary histories of medicine or histories of medicine ‘beyond the local’,<sup>12</sup> a range of comparative documentary sources from different repositories was carefully read and quarried for corresponding ideas.

This method led to the intriguing discovery of similarities and crossovers between Askins’ medical units concept for Southern Rhodesia and John Middleton Martin’s far-removed Gloucestershire Extension of Medical Services Scheme (GEMSS), for instance.<sup>13</sup> This discovery underpinned Katie Trumpener’s view that the imperial world was characterised by intricate ‘transcolonial circuits’ and ‘conduits’ that facilitated flows of people and ideas in

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<sup>11</sup> See for instance, Shula Marks, ‘Common Sense or Utopian Dream? Part I: South Africa’s Practice of Social Medicine between 1940 and 1955 in Transnational Perspective’, Paper Presented at a Conference on The History of Health in Africa: Actors, Experiences, and Perspectives in the Twentieth Century, Basel, 12-14 September 2011; Anne Digby, ‘Vision and Vested Interests’: National Health Service Reform in South Africa and Britain in the 1940s and Beyond’, *Social History of Medicine*, vol. 21, no. 3, (2008), pp. 485-502; Paul Weindling, ‘Health and Medicine in Interwar Europe’, Roger Cooter and John Pickstone (eds), *Companion Encyclopaedia to Medicine in the Twentieth Century* (London & New York: Routledge, 2003).

<sup>12</sup> Lowy, ‘The Social History of Medicine: Beyond the Local’; Anne Digby et al, ‘Introduction: Crossing Historiographies, Connecting Histories and their Historians’, Anne Digby et al (eds), *Crossing Colonial Historiographies: Histories of Colonial and Indigenous Medicines in Transnational Perspective* (Newcastle: Cambridge Scholars Publishing, 2010).

<sup>13</sup> As will be elaborated later in the chapter, the Gloucestershire Extension of Medical Services Scheme was a pioneering plan of extending medical services to the underserved rural communities of Gloucestershire County. Martin Gorsky, ‘The Gloucestershire Extension of Medical Services Scheme: An Experiment in the Integration of Health Services in Britain before the NHS’, *Medical History*, vol. 50 no. 4 (2006), pp. 491-512.

back and forth lines between the ‘periphery’ and the ‘centre’ and from one locality to another.<sup>14</sup>

Perhaps it should be clearly stated here that by emphasising the transfer of ideas from other regions to Southern Rhodesia, the aim is not to privilege the apparent source of the idea and undermine the recipient. A classical ‘core’ – ‘periphery’ flow of concepts from the imperial core to the colonial periphery is not implied; instead, the chapter takes a ‘decentred’ view of empire, in the manner suggested by Dane Kennedy and Dhuba Ghosh in *Decentring Empire*.<sup>15</sup> In this compelling study of the flow of concepts within the British empire, Ghosh and Kennedy strongly suggest an analytical shift from a static, top-down view of empire to a more dynamic one that incorporates ‘the multiple networks of exchange that connected colonies to one another as well as to Britain’, for such networks straddled ‘the geographical and political boundaries that normally delimit inquiries.’<sup>16</sup> As Ghosh and Kennedy further observe, the networks that emerged in the interstices of empire drew in and touched ‘areas and regions that ranged beyond the formal parameters of colonial relationships.’<sup>17</sup> The two scholars correctly characterise the British empire as a conduit for the globalisation of the modern world system ‘rather than the catalyst for it.’<sup>18</sup>

Anchored in these considerations, Askins’ 1930 reforms are treated as part of a circle of circulating ideas. However, as a matter of course, they should also be separately subjected to further critical scrutiny, focusing on the structural and discursive devices personally used by Askins to justify reform and promote his ideas. Although these reforms constituted a

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<sup>14</sup> Katie Trumpener, *Bardic Nationalism: The Romantic Novel and the British Empire* (Princeton: Princeton University Press, 1997), p. 290.

<sup>15</sup> Durba Ghosh and Dane Kennedy, ‘Introduction’, Durba Ghosh and Dane Kennedy (eds.), *Decentring Empire: Britain, India and the Transcolonial World* (New Delhi: Orient Longman, 2006).

<sup>16</sup> Ghosh and Kennedy, ‘Introduction’, p. 2.

<sup>17</sup> Ghosh and Kennedy, ‘Introduction’, p. 2.

<sup>18</sup> Ghosh and Kennedy, ‘Introduction’, p. 2.

significant improvement on the pre-reform state of affairs, they still fell far too short of the ideal. It needs to be re-emphasised that colonial health care was first and foremost meant to safeguard the health of people of European descent. Only by association did this entail dealing with the health of the Africans.

However, it would be a travesty of historical fact to suggest that, during all stages of development of colonial medicine, taking care of Africans' health needs was solely a measure to secure the health of the whites alone. Among many other considerations, there were also cultural and religious motives, as colonial officials were keen to render obsolete indigenous healing systems by popularising biomedical institutions and practices which were gaining strength because of state patronage, the germ revolution and chemotherapy. This was linked more to the pragmatics of colonial governance and biomedical hegemony than public health *per se*.

In addition, the objective of safeguarding the health of white settlers should not be taken at face value because quite often reformers evoked images of epidemic threats as a way of arousing colonists' fear. This would in turn force the holders of colonial finance to fund healthcare reforms, even those with no promise of immediate results. As such, colonial healthcare cannot be explained from one angle alone; indeed, as Michael Worboys has aptly noted, in addition to securing the health of the colonists, colonial healthcare consisted of a combination of uneven efforts towards the introduction of modern 'scientific' rationality, the consolidation of colonial rule, the promotion of material development, 'while at the same time protecting the welfare and health of indigenes'.<sup>19</sup> However, protecting the welfare and health of the indigenes was beset with its own set of complexities. As will be shown a little

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<sup>19</sup> Michael Worboys, 'The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940', *Osiris*, vol. 15 (2000), p. 208.

later in the chapter, colonial healthcare initiatives were also arenas for the reproduction of racialised discourses of difference and white privilege.

### **Leadership change and policy reform**

In 1929, the Southern Rhodesian government started searching for a new medical director as Fleming's thirty-three years long administration was about to come to an end. Although the colony had several senior contenders for the post, some of whom had acted as medical directors during Fleming's absences, an outsider, Robert Askins, landed the post. In the absence of any unequivocal evidence it is difficult to say why internal candidates were overlooked. It can, however, be speculated that the Colonial Secretary, William M. Leggate, was keen to appoint a candidate with new ideas on how to take the colony's health care sector forward. The previous chapter noted Leggate's unsuccessful call to Fleming to work out something akin to a national health service.

However, although he lacked colonial experience, Askins was not an inferior candidate. Born in 1880 in Clonmore, Ireland, he studied medicine at Trinity College, Dublin, where he graduated with first class Bachelor of Medicine and Surgery honours in 1907. Later he earned a Cambridge Diploma in Public Health (1912) and the degrees of M.A. and M.D. (1913), again in Dublin.<sup>20</sup> After a brief appointment as Assistant Medical Officer of Health for Merthyr Tydfil, in 1909 he became Assistant Medical Officer to the Lancashire Education Committee – a position he held up to 1914.<sup>21</sup> After that he was employed by the Bristol Education Committee as the first substantive Schools Medical Officer and held that position, together with other key portfolios in the city's public health sector, up to 1930, the year he left for Southern Rhodesia. During World War I he was recruited as specialist sanitary

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<sup>20</sup> 'Obituary – R. A. Askins', *The British Medical Journal* (Dec. 1935), p. 1235.

<sup>21</sup> 'Obituary – R. A. Askins', *The British Medical Journal* (Dec. 1935), p. 1235.

officer. In 1917, he had also enrolled for law studies and in 1920 was admitted to the Bar at Gray's Inn, a necessary qualification for someone with an interest in public health.<sup>22</sup>

**Fig. 2.1: Dr Askins, late 1920s.**



**(Photo Courtesy of the National Archives of Zimbabwe)**

In 1924, Askins was appointed to deputise for Dr D. S. Davies, the Bristol City and County Medical Officer of Health. Upon the latter's retirement in 1928, Askins was unanimously appointed to that vacant position which also included being the Medical Officer of the Port Authority. In that same year, he was also selected as lecturer-in-charge of Public Health at Bristol University.<sup>23</sup> He also continued with his appointment as the Schools Medical Officer. An active member of the British Medical Association and the Society for the Medical

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<sup>22</sup> 'A Passenger Missing', *The Times*, 5 September 1935, p. 9; *The Times* 2 Nov. 1917. <Digital Archive, 1785-1985, Accessed from Bristol Records Office in May 2010>

<sup>23</sup> 'A Passenger Missing', *The Times*, 5 September 1935, p. 9.

Officers of Health,<sup>24</sup> Askins held all these demanding appointments simultaneously up to May 1930 when he left Britain after accepting an appointment by Southern Rhodesia as the colony's new Medical Director.<sup>25</sup>

Having gone so far in his career, his decision to migrate to Southern Rhodesia is not easy to explain, but the issue of remuneration which should be understood against the background of the Great Depression should not be ruled out. When he informed the Bristol City and County Health Committee about his acceptance of an appointment in Southern Rhodesia, the Committee's Chairman, H. J. Maggs, made frantic efforts to retain him 'in view of the schemes for co-ordinating the medical and nursing services which are under consideration and the additional work and responsibility which would be taken over by him [Askins] on the 1<sup>st</sup> of April [1930].'<sup>26</sup> Available evidence shows that Askins took advantage of that overture to bid for a higher remuneration package. He requested the Committee to pay him an annual salary of £1, 800, rising by £100 per annum for the succeeding two years to eventually reach £2, 000 per annum. If that happened, he intimated, he would be willing to reconsider moving to Southern Rhodesia. However, these crisis negotiations to retain him in Bristol failed, leaving him to move to Southern Rhodesia where he was offered a salary of £1, 750 per annum and £60 transport allowance.<sup>27</sup>

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<sup>24</sup> In 1922, when the West of England Branch of the Society of Medical Officers of Health formed a Schools Medical Sub-group, Askins agreed to act as temporary secretary. In October 1924, he was elected the President of the West of England Branch of the Society of Medical Officers of Health. In 1922, the Branch had 78 members. Society of Medical Officers of Health, 'West of England Branch Meeting Report', *Public Health: The Journal of the Society of Medical Officers of Health*, vol. 37, no. 3 (Dec. 1924), p. 95; Society of Medical Officers of Health, 'Notes from Branches: West of England Branch', *Public Health: The Journal of the Society of Medical Officers of Health*, vol. 36, no. 3 (Dec. 1922), p. 103.

<sup>25</sup> City and County of Bristol, *Annual Report of the Medical Officer of Health for the Year Ended 31 Dec. 1930*, p. 5.

<sup>26</sup> Bristol Records Office (hereafter BRO), M/BCC/HEA/1/19, Health Committee Minute Book, Minutes of a Special Meeting of the Health Committee, 13 March 1930, p. 316.

<sup>27</sup> NAZ, S246/622, Medical Director, High Commissioner for Southern Rhodesia to William M. Leggate, 25 October 1929; Robert Askins: Undated Draft Conditions of Employment.

Askins took over the administration of the Southern Rhodesian Public Health Department in August 1930, and one of his immediate plans was to fix, in his own ways, the problems he perceived to be bedevilling the colony's medical services for the largely rural African population. As noted in the previous chapter, his predecessor, Fleming, had bequeathed to him only seven state-run venereal diseases dispensaries, one rural 'native' hospital, and five subsidised missionary dispensaries, for an estimated African population of 1,080,000.<sup>28</sup> As noted in Chapter 1, in 1930, state dispensaries had treated only 4,359 patients, mainly for venereal diseases.<sup>29</sup> Recognising the inadequacy of these services, on 8 September 1930 (that is, just over a month after his assumption of duty) Askins produced a green paper on rural healthcare, entitled 'Preliminary Report on the Treatment of Natives', in which he dealt extensively with the subject and proposed solutions.<sup>30</sup>

Making a case for reform, Askins argued that the colony was threatened by the many diseases that occurred in endemic and epidemic forms among the Africans. In his view, these diseases had to be controlled because of their 'liability to spread to Europeans' and the 'unnecessary destruction of life and lowering of health' which resulted from them among the Africans.<sup>31</sup> He argued that there was a very high likelihood of infection to be 'conveyed to European households by natives who had the disease and carrying the infection, though to all outward appearances perfectly well'.<sup>32</sup> He further elaborated this line of thought in his first substantive *Annual Report* as the colony's Medical Director, in which he asserted that,

The native is the reservoir of infective tropical disease, from which the European and his family is subject to invasion. Unfortunately the native carrier is commonly a

<sup>28</sup> This number was based on estimates as the first African census was only conducted in 1962. Ravai Marindo, 'Death Colonised: Historical Adult Mortality in Rhodesia', *Zambezia*, vol. 26, no. 2 (1999), p. 148.

<sup>29</sup> Southern Rhodesia, *Report on the Public Health for the Year 1930* (Salisbury: Government Printer, 1931), p. 20; Editorial, 'Medical Services for Natives: Dr Askins' Views', *Journal of Medical Association of South Africa*, 11 April (1931), p. 224.

<sup>30</sup> NAZ, S1173/336, Askins, 'Preliminary Report on the Treatment of Natives', 8 Sept. 1930.

<sup>31</sup> NAZ, S1173/336, Askins, 'Preliminary Report on the Treatment of Natives', p. 1.

<sup>32</sup> NAZ, S1173/336, Askins, 'Preliminary Report on the Treatment of Natives', p. 1.

perfectly healthy looking individual, so that the European may not have the opportunity of realising until too late the danger to which he is being subjected.<sup>33</sup>

He enumerated a list of diseases that he considered to be a threat to the colony. Beginning with syphilis, he argued that, although it was spread ‘almost entirely through the medium of sexual intercourse’, it was nonetheless ‘undesirable from an aesthetic point of view that there should be the risk of native boys being in European houses whilst they are suffering from this disease.’<sup>34</sup> In addition to syphilis, Askins also blamed malaria for a ‘large amount of death, and a lowering of health amongst the European population in the rural districts’.<sup>35</sup> He indicted Africans for spreading this disease to the white population, arguing that ‘malaria is a disease which is largely carrier borne by natives who are apparently healthy’.<sup>36</sup>

Going further, he noted that also frequently conveyed to the ‘unsuspecting’ European ‘victims’ by the African ‘carriers’ were amoebic and bacillary dysentery, both of which, he argued, were ‘endemic amongst the natives of Southern Rhodesia’.<sup>37</sup> Extending the list of the invasive ‘native’ maladies, he noted bilharzia (which he said infected six percent of European children), cerebro-spinal meningitis, and sleeping sickness as some of the menacing endemic diseases that were frequently communicated to Europeans by Africans. However, he did not offer any explanation as to how diseases such as sleeping sickness and bilharzia could be conveyed directly by Africans to the Europeans; in the case of the former he simply disputed the emerging view that big game was to blame. Instead, he blamed Africans for being the ‘cause of the [sleeping sickness] disease that remained endemic in the colony’.<sup>38</sup> As he later warned in his 1930 *Report*, this danger tended to increase as the colony was ‘becoming more

<sup>33</sup> Southern Rhodesia, *Report on the Public Health for the Year 1930*, p. 19.

<sup>34</sup> NAZ, S1173/336, Askins, ‘Preliminary Report on the Treatment of Natives’, p. 3. A full commentary on the sometimes mistaken diagnosis of syphilis is made on page 198.

<sup>35</sup> NAZ, S1173/336, Askins, ‘Preliminary Report on the Treatment of Natives’, p. 3.

<sup>36</sup> NAZ, S1173/336, Askins, ‘Preliminary Report on the Treatment of Natives’, p. 3.

<sup>37</sup> NAZ, S1173/336, Askins, ‘Preliminary Report on the Treatment of Natives’, p. 3.

<sup>38</sup> NAZ, S1173/336, Askins, ‘Preliminary Report on the Treatment of Natives’, p. 3.

closely settled by Europeans.’<sup>39</sup> In addition to that, he argued, ‘all our dysentery comes from native carriers’.<sup>40</sup>

His ideas were based on the prejudiced knowledge of the time. The focus on rural health was premised on the perception that civilisation had driven diseases away from urban areas and that most of the remaining scourges were rural and, by extension, African.<sup>41</sup> To buttress his ideas he cited evidence produced by the London School of Hygiene and Tropical Medicine field researchers who had been doing their work in the colony from 1925.<sup>42</sup> However, he also relied on his own observations and the opinions of other (mainly white) stakeholders he met during his tour of the country.<sup>43</sup> Askins was concerned that the colony’s healthcare infrastructure was virtually non-existent in rural areas, a situation that created dangerous social and geographical inequalities in health and healthcare.

While acknowledging that Africans dwelling in townships and mining compounds had ‘ample’ access to medical facilities and that some isolated rural areas were being serviced by subsidised medical missions and the state’s own dispensaries, he was of the view that ‘excellent as the above institutions are, a careful examination of the position makes it is clear that only a small proportion of the native population are at present receiving medical treatment, and that the great majority are devoid of such care ....’<sup>44</sup>

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<sup>39</sup> Southern Rhodesia, *Report on the Public Health for the Year 1931*, p. 19.

<sup>40</sup> Editorial, ‘Jottings from the Recent Sitting of the Advisory Board of Native Development’, *Native Mirror*, 1 Jan. 1931, p. 23.

<sup>41</sup> Southern Rhodesia, *Report on the Public Health for the Year 1932*, p. 8.

<sup>42</sup> NAZ, S1173/336, Askins, ‘Preliminary Report on the Treatment of Natives’, p. 3.

<sup>43</sup> Editorial, ‘Jottings from the Recent Sitting of the Advisory Board of Native Development’, *Native Mirror*, 1 Jan. 1931, p. 23.

<sup>44</sup> Southern Rhodesia, *Report on the Public Health for the Year 1931*, p. 19.

He also viewed the existing approach to rural health care as being rather narrow because of too much focus on a single disease at a time. His alternative vision was that the health of African was to be ‘considered as a whole, and that the establishing of separate clinics for individual ailments, such as venereal diseases, should be avoided’<sup>45</sup> – an indication that his acknowledgement of the ‘excellence’ of the available institutions was nothing but diplomacy. He proposed the adoption of systematic planning and the comprehensive development of rural medical services. As he was still pondering over this subject, E. G. Howman, the Superintendent of Natives, Fort Victoria, submitted for his approval a proposal to build a venereal disease clinic in his region, much in line with the practice under Fleming. Askins, however, withheld approval, arguing, ‘I feel that some kind of definite policy is essential... a common policy [should be] worked out for the entire country’.<sup>46</sup>

Furthermore, he emphasised that it was ‘most essential that a policy be framed and adopted which will have in view the definite object of reducing, and ultimately eradicating these diseases which are endemic among the native population’.<sup>47</sup> He also registered his strong feeling that the health needs of the Africans should be dealt with, ‘not haphazardly but by a comprehensive scheme for the entire colony’<sup>48</sup>, since there was ‘no reason whatsoever why malaria, dysentery, pneumonia and everything else should not be treated together’.<sup>49</sup> For him, therefore, whatever method of medical care was adopted, the health of the African was to be considered in its entirety and not just in part.

To remedy the problems he observed, he proposed that:

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<sup>45</sup> Southern Rhodesia, *Report on the Public Health for the Year 1931*, p. 20.

<sup>46</sup> NAZ, S1173/336, Medical Treatment Scheme for Natives, 1930-1931, R. A. Askins to E. G. Howman, 15 September 1930.

<sup>47</sup> Southern Rhodesia, *Report on the Public Health for the Year 1930*, p. 19.

<sup>48</sup> NAZ, S1173/336, Askins, ‘Preliminary Report on the Treatment of Natives’, p. 3.

<sup>49</sup> Editorial, ‘Jottings from the Recent Sitting of the Advisory Board of Native Development’, *Native Mirror*, 1 Jan. 1931, p. 23.

1. the health of the African and many diseases from which he suffered 'should be considered as a whole' and that the establishment of clinics for individual diseases 'should be avoided';
2. the country be mapped out into sizeable districts, to which should be applied medical units, gradually and as circumstances (financial and logistical) of the colony could permit;
3. each medical unit should consist of a central hospital 'of the simplest possible type', with African patients dwelling 'as far as is possible' in huts and under conditions resembling their home life 'as closely as is consistent with efficiency'. To such a hospital was to be appointed a European government medical officer with a small cohort of European nursing staff, but the greater part of the nursing was to be carried out by trained African orderlies;
4. up to six dispensaries should be 'attached' to each central hospital. They were to be positioned at a maximum distance of fifty miles by road from the hospital.. Like the main hospital, these dispensaries were also to be of simple construction, and to be staffed by trained African nursing staff and directly supervised and visited by the central hospital medical officer at regular intervals, once every week or every ten days;
5. African men and women should be trained as orderlies and midwives in government hospitals before being deployed to serve in these medical units. They were to be Africans of 'known character', with an education of up to Standard VI or as close to that benchmark as was possible. These African medical aids were to complete a course in hygiene as part of their instruction, and would be expected to visit rural homesteads as part of their duties;

6. the new scheme should take advantage of existing hospitals and use them as springboards for beginning such work in districts where they were found.
7. the scheme should be managed in close co-operation with the Native Affairs Department and other departments dealing with Africans;
8. wherever possible, the African should bear the cost of his/her medical care.<sup>50</sup>

This became the first comprehensive plan for the development of rural medical services for Africans made by a medical bureaucrat in the colony. In summary, the new scheme's declared objectives included the bridging of the geographical inequalities in healthcare, the reduction and ultimate eradication of endemic diseases among the rural Africans, the prevention of disease through early treatment, the safeguarding of whites against infectious 'native' diseases, the promotion of biomedical precepts among Africans, and the securing of colonial development in general.<sup>51</sup> The mere fact of the scheme's existence, even though still on paper, and the difference it intended to make was welcomed by other high-ranking colonial officials such as the Chief Native Commissioner, Colonel Carbutt. At a Native Affairs Conference held in Victoria Falls in June 1931, attended by officials from Southern Rhodesia's neighbouring colonies, Carbutt noted that,

There has not been, until recently, any defined policy for the development of medical services for Natives; but within the last two years the Medical Director for the colony has evolved a definite scheme of development which will result in the gradual establishment of a chain of Native Hospitals throughout the colony, with a number of clinics attached to each hospital.<sup>52</sup>

An earlier sitting of the Advisory Board of Native Development had also passed a resolution that,

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<sup>50</sup> NAZ, S1173/336, Askins, 'Preliminary Report on the Treatment of Natives', p. 3.

<sup>51</sup> NAZ, S1173/336, Askins, 'Preliminary Report on the Treatment of Natives', pp. 1-3; Southern Rhodesia, *Report on the Public Health for the Year 1930*, p. 19.

<sup>52</sup> UK National Archives (hereafter UKNA), DO 35/389/10, Minutes of the Natives Affairs Conference, Victoria Falls, June 1931.

This Advisory Board, having heard with great pleasure and satisfaction the suggestions for the formulation of a definite scheme for medical service for the Natives of this country laid before it by the Medical Director, signifies its whole hearted approval of such a scheme which it feels can but greatly benefit both black and white races alike.<sup>53</sup>

Not only was the scheme pioneering as it set out, for the first time, to provide rural medical services in a systematic way, but also because it sought to transfer the actual running of the existing rural dispensaries from the firm grip of the Native Affairs Department officials to a district health team consisting of a medical officer and medical assistants.<sup>54</sup> However, the free assistance of Native Affairs officials was still desperately required to render medical service, especially in the mapping of districts and in arrangements related to initial construction. Although some Native Commissioners initially protested, the matter was resolved when the Chief Native Commissioner exhorted to cooperate 'in every way which will lead to the Natives gaining the benefit of qualified and skilled treatment'.<sup>55</sup>

### **Why reform?: Individual initiative in a broader context**

Given the fact that different sections of colonial society had been advocating the extension of medical services in rural areas as illustrated in the previous chapter, these reforms can incorrectly be taken as solely a direct outcome of such advocacy alone. Moreover, because during his initial tour of the colony as medical director, Askins had been requested by mostly white settlers to set up (mainly) clinics for the control of venereal diseases, Askins' initiative can misleadingly be seen only as an answer to these Southern Rhodesian-specific anxieties. Indeed, there was continuing direct pressure from missionaries and the Advisory Board of Native Development which comprised missionaries, Native Affairs officials, and such

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<sup>53</sup> Editorial, 'Jottings from the Recent Sitting of the Advisory Board of Native Development', *Native Mirror*, 1 Jan. 1931, p. 23.

<sup>54</sup> Southern Rhodesia, *Report on the Public Health for the Year 1930*, p. 20.

<sup>55</sup> NAZ, S138/56, Native Dispensaries, 1924-1933, Medical Director to Acting Native Commissioner, Bikita, 2 April 1933; Medical Director to Chief Native Commissioner, 5 May 1933; Chief Native Commissioner to Superintendent of Native, Fort Victoria, 30 May 1933.

individuals as the ‘outspoken negrophile’, F. L. Hadfield, the founder of the *Native Mirror*.<sup>56</sup> Some of the Board members went to the extent of encouraging Askins to motivate for the establishment of a separate division of African medical services (a sub-department of some sort) through which efforts focused on African healthcare could be channelled.<sup>57</sup> In addition, in 1929 Leggate had communicated government readiness to reform and therefore it can be assumed that Askins was just tapping into these ripe conditions.

However, looking at things from this angle alone is rather limiting as it gives only a partial picture of the issues involved. Firstly, as will be elaborated a little later in the chapter, there are very strong indications that Askins was personally interested in such reform. Even if allowing for differences in leadership between him and his predecessor, if he was not personally interested in such reform, the existing pressure for reform could have produced positive results within such a short space of time. Secondly, by late 1930 when Askins proposed his reforms, the colony’s political economy had radically changed because of the Great Depression. The Depression had led to a precipitous decline in national income, thrown many white citizens out of employment, converted many into virtual indigents and caused serious agitation over the ‘tepid’ Moffat government’s uninspiring handling of affairs during this crisis period.<sup>58</sup> In addition to postponing the planned ‘native development’ projects, the colonial Treasury was looking for both overt and less obvious ways of balancing its books on

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<sup>56</sup> Lewis Gann, quoted in Terence Ranger, *Bulawayo Burning: The Social History of a Southern African City, 1893-1960* (Suffolk: James Currey; Harare: Weaver Press, 2010), p. 109; Editorial, ‘Jottings from the Recent Sitting of the Advisory Board of Native Development’, *Native Mirror*, 1 Jan. 1931, p. 23.

<sup>57</sup> Editorial, ‘Jottings from the Recent Sitting of the Advisory Board of Native Development’, *Native Mirror*, 1 Jan. 1931, p. 23.

<sup>58</sup> Ian Phimister, *An Economic and Social History of Zimbabwe, 1890-1948: Capital Accumulation and Class Struggle* (London & New York: Longman, 1988), pp. 171-173.

the backs of African commodity producers and taxpayers, hence the introduction of new levies and control acts and the surreptitious debiting of the Native Development account.<sup>59</sup>

The implication was that, while Leggate had in 1929 indicated the availability of funds for health care development, by mid-1930 that position had altered markedly. Arguably, Askins' emphasis on what appeared to be a simple – and therefore cheap – scheme to address some important and urgent programmes was a necessary tactic if he entertained any hope of being listened to by a government that was presiding over its worst economic crisis ever. He was fully aware that, 'if we are going to extend the system at the moment, we come up against the question of finance'.<sup>60</sup> Thus, although the longstanding interest in reform certainly provided the necessary logic for his proposal, that alone was not enough.

It therefore necessary to reflect on the broader context within which Askins acted, and the individual agency he brought to bear on the issue as he appraised himself with changes in healthcare policy. This perspective is necessary because it helps us to understand why Fleming and Askins dealt with the same problem differently. This section thus seeks to show that Askins read the situation differently, perhaps because of his broader outlook. For him, reform was an urgent local (colonial), international and personal issue that required urgent action, however tentative, even during the Depression years.

Notably, Askins framed his ideas with developments in other colonies in mind. His reforms came against the background of similar developments which had been taking place in other

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<sup>59</sup> Phimister, *An Economic and Social History of Zimbabwe, 1890-1948*, pp. 183-184; C. F. Keyter, *Maize Control in Southern Rhodesia, 1931-1941: The African Contribution to White Survival* (Salisbury: The Central Africa Historical Association Local Series No. 4, 1978).

<sup>60</sup> Editorial, 'Jottings from the Recent Sitting of the Advisory Board of Native Development', *Native Mirror*, 1 Jan. 1931, p. 23.

African colonies after World War I. Such schemes which included the establishment of rural dispensaries, the commencement of training schemes for healthcare workers and the adoption of other special initiatives such as maternity work, have been widely discussed in the burgeoning historical literature focusing on different regions of colonial Africa.<sup>61</sup>

These essentially simultaneous, overlapping and cross-pollinating<sup>62</sup> developments indicated the gradual acceptance by colonial governments of the responsibility of providing medical care as a national service. Askins proved himself to be a person of wider outlook than his predecessor as he was quick to realise that Southern Rhodesia was already lagging behind in the area of rural health care, making it important that a scheme should be formulated and tried out. In prefatory remarks to his new scheme, he showed awareness of this fact and sought to also bring it to the attention of the other Southern Rhodesian officials:

The treatment of natives is a matter which has long received the attention of the authorities of the French African colonies and of the Congo. The matter has more recently received much consideration in Uganda and Nyasaland, and schemes are now under review in Northern Rhodesia and the Union of South Africa.<sup>63</sup>

Further arguing his case, he indicated that, while many aspects of colonial African life were still open to ‘doubt and discussion’, it had become clear that there was ‘unanimity of opinion

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<sup>61</sup> Marc H. Dawson, ‘The 1920s Anti-Yaws Campaigns and Colonial Medical Policy in Kenya’, *The International Journal of African Historical Studies*, vol. 20, no. 3 (1987), pp. 417-35; John Iliffe, *East African Doctors: A History of the Profession* (Cambridge: Cambridge University Press, 1998); Anna Crozier, *Practicing Colonial Medicine: The Colonial Medical Service in British East Africa* (London & New York: I. B. Tauris, 2007); M. Semakula Kiwanuka, ‘Colonial Policies and Administrations in Africa: The Myth of Contrasts’, *African Historical Studies*, vol. 3, no. 2 (1970), pp. 295-315; Jane Turriffin, ‘Colonial Midwives and Modernising Childbirth in French West Africa’, Jean Allman et al, (eds), *Women in African Colonial Histories* (Bloomington and Indianapolis: Indiana University Press, 2002); Nancy Rose Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization and Mobility in the Congo* (Durham & London: Duke University Press, 1999); Karin A. Shapiro, ‘Doctors or Medical Aids-The Debate over the Training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 1930s’, *Journal of Southern African Studies*, vol. 13, no. 2 (Jan. 1987).

<sup>62</sup> For instance, South African public health officials admitted having been inspired by the French model of African medical auxiliaries. See, Union of South Africa, *Report of the Hospital Survey Committee*, U.G. 25-1927, p. 9; League of Nations Health Organisation, ‘Report of the Pan-African Health Conference held at Johannesburg, Nov. 20-30, 1935’, *League of Nations Quarterly Bulletin of the Health Organisation*, vol. 6, no. 1 (March, 1936), p. 201.

<sup>63</sup> NAZ, S1173/239 Natives (Medical Attention), 1925-31, Askins to Colonial Secretary, 19 July 1931.

in regard to the need and desirability of the provision of medical treatment for their more urgent wants.’<sup>64</sup> He cited this as one of the major highlights of the conference of the South African Medical Association held in Durban in 1930 where, he learned, there was ‘complete agreement as regards the necessity, though there were wide differences of opinion as regards the correct method, for securing medical treatment of natives.’<sup>65</sup> Clearly, Askins had taken time to familiarise himself with developments in other parts of the colonial world and used such knowledge jointly with internal realities to justify reform. At the same time, his ideas pandered to popular stereotypes.

It is also possible that he immediately became aware of the fact that comparing Southern Rhodesia with other colonies that had programmes in place was a useful bargaining tool in a colony which, on account of its peculiar position, was extra-conscious about how it was perceived within the family of British colonies. Officials always took care to be seen to be doing better than other colonies in terms of their ‘native policy’, to avoid any embarrassing sanction by British public opinion.<sup>66</sup> Officials in Southern Rhodesia were thus always quick to tout the progressive nature of their ‘native policy’.

But why would reform be such an urgent matter for Askins personally? Together with urban planning<sup>67</sup> – perhaps an interest which he developed because of the nature of his previous, urban-focused public health work in Bristol – the development of new medical services in the underserved rural areas was an area where he could achieve distinction as a new colonial public health bureaucrat. His predecessor had trail-blazed in other areas, including the

<sup>64</sup> Southern Rhodesia, *Report on the Public Health for the Year 1930*, p. 19.

<sup>65</sup> Southern Rhodesia, *Report on the Public Health for the Year 1930*, p. 19.

<sup>66</sup> Carol Summers, *From Civilization to Segregation: Social Ideals and Social Control in Southern Rhodesia, 1890-1934* (Athens, OH: Ohio University Press, 1994), p. 171; Murray C. Steele, ‘The Foundations of a “Native” Policy: Southern Rhodesia, 1923-1933’, (DPhil Thesis, Simon Fraser University, 1972), p. 24.

<sup>67</sup> Askins was also Chairman of the Southern Rhodesia Town Planning Board. See *The Herald*, 6 Sept. 1935, p. 3.

initiation of a schools medical service for white children and the setting up of a London School of Hygiene and Tropical Medicine Field Station.<sup>68</sup>

It can therefore be argued that rural medical care provided him with an underdeveloped area where he could carve his own niche, and that developments elsewhere in Africa provided him with the necessary models. His compelling observation that only a few urban-based Africans and those capable of accessing medical services in mining hospitals and a few medical missions,<sup>69</sup> can be taken as a strategy in that direction. However, the urgency he showed also said something about him as a public health professional, recently arrived from reforming Britain. There are strong indications that he brought some of the reform momentum from his previous duty station, Bristol. Peering into his previous experience could therefore yield further insights into some enduring influences that could have been seminal in his determination to reform the colonial medical service. In doing this, it may also be helpful to keep in mind Lenore Manderson's relevant that some public health programmes were merely implemented in colonies 'soon after they were introduced in the centre, and reflected not government understanding of colonial needs, but rather contemporary changing ideas and practices in public health occurring within the United Kingdom'.<sup>70</sup>

Askins left England at a time when social reform schemes, of which public health was an integral part, were increasingly engaging the attention of the British society at large. There were emerging concerns about the health of the nation and Jane Lewis suggests that this was a result of eugenicist and imperial ideas, especially following the Anglo-Boer War which

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<sup>68</sup> NAZ, S881/446, London School of Hygiene and Tropical Medicine in Southern Rhodesia, Newton to R. W. Harris, 21 Jan. 1925: Central Statistical Office, *Official Yearbook of the Colony of Southern Rhodesia for 1932* (Salisbury: Rhodesian Printing & Publishing Co., 1932), pp. 644-50.

<sup>69</sup> Southern Rhodesia, *Report on the Public Health for the Year 1930*, p. 19.

<sup>70</sup> Lenore Manderson, *Sickness and the State: Health and Illness in Colonial Malaya, 1870-1940*, (Cambridge: Cambridge University Press, 1996), p. 11.

exposed the extremely poor quality of British army recruits.<sup>71</sup> This realisation increased focus on personal healthcare services and produced an associated push for the state to take a leading role in the provision of such services.<sup>72</sup> The 1906 assumption of power by the Liberal Party created an enabling environment for the rising tidal wave of social reform, especially those driven by the ‘radical reforming politician’, Lloyd George,<sup>73</sup> leading, *inter alia*, to the introduction of the National Health Insurance scheme in 1911.<sup>74</sup>

Further reforms were introduced soon after World War I, including the establishment of a Health Ministry was established in 1919 and the publication, in 1920, of the Dawson Report which advocated health centres and the increased availability of health services.<sup>75</sup> This report’s publication coincided with the formulation of schemes such as the Gloucestershire Extension of Medical Services Scheme (GEMSS) whose main premise was also the extension of personal health services through a locally coordinated healthcare delivery system.<sup>76</sup> Other pioneering experiments emerged in the 1920s, notably the Peckham Health Centre which sought to combine primary health care with recreation and the fostering of ‘a sense of community’.<sup>77</sup>

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<sup>71</sup> Jane Lewis, ‘Health and Health Care in the Progressive Era’, Roger Cooter and John Pickstone (eds), *Medicine in the Twentieth Century* (Harwood Academic Publishers, 2000), pp. 84-85.

<sup>72</sup> Jane Lewis, ‘Providers, “Consumers”, the State and the Deliverers of Health-Care Services in Twentieth Century Britain’, Andrew Wear (ed.), *Medicine in Society: Historical Essays* (Cambridge: Cambridge University Press, Reprint 1994), p. 318.

<sup>73</sup> Dorothy Porter, *Health, Civilisation and the State: A History of Public Health from Ancient to Modern Times* (London & New York: Routledge, 1999), p. 206.

<sup>74</sup> Lewis, ‘Providers, “Consumers”, the State and the Deliverers of Health-Care Services in Twentieth Century Britain’, p. 318.

<sup>75</sup> George C. Gosling, ‘“Co-operate, Co-ordinate, Unify!”: The 1920 Proposal to Amalgamate the Medical Charities of Bristol’, *Southern History: A Review of the History of Southern England*, vol. 29 (2007), p. 84; Lewis, ‘Providers, “Consumers”, the State and the Deliverers of Health-Care Services in Twentieth Century Britain’, pp. 331-2.

<sup>76</sup> Gorsky, ‘The Gloucestershire Extension of Medical Services Scheme’.

<sup>77</sup> Jane Lewis and Barbara Brookes, ‘A Reassessment of the Work of the Peckham Health Centre, 1926-1951’, *The Milbank Memorial Fund Quarterly: Health and Society*, vol. 61, no. 2 (1983), p. 308.

In all this push for reform, some historians have argued, medical officers of health played crucial roles both as innovators and implementers of such policies.<sup>78</sup> Indeed, some of them, such as Arthur Newsholme, have attracted scholarly attention because of the legacy of their ideas.<sup>79</sup> Going into detail about these interesting developments is outside the scope of this chapter; suffice it to say that medical officers of health were responsible for originating programmes designed to radically improve access to medical services. Also, personal health services expanded significantly under their agency as they oversaw the development of numerous welfare schemes in the early twentieth century.<sup>80</sup> Askins was one of those medical officers of health who were in the forefront of the implementation of these new schemes, an experience he carried over to the less developed Southern Rhodesia.

Askins' flirtation with this new aspiration to extend medical services to previously ignored risk groups had its beginnings in 1914, when the Bristol Education Committee appointed him as the inaugural head of the Schools Medical Service. Accordingly, it is important to briefly profile here his story from 1914 onwards, and gradually build towards the argument that his work in Bristol influenced his later work, in Southern Rhodesia. Initiated by the British Parliament in 1908,<sup>81</sup> the schools' medical service constituted one of the new areas for widened medical coverage in the early twentieth century. Working within that context in a leadership position placed Askins on the cutting edge of ideas that related children's health to national success and progress.

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<sup>78</sup> Martin Gorsky, 'Local Leadership in Public Health: The Role of the Medical Officer in Britain, 1872-1974', *Journal of Epidemiology and Community Health*, vol. 61, no. 6 (June, 2007), pp. 468-72.

<sup>79</sup> John M. Eyler, 'The Sick Poor and the State: Arthur Newsholme on Poverty, Disease and Responsibility', Dorothy Porter and Roy Porter (eds), *Politics and Society: Historical Essays* (Amsterdam & Atlanta, GA: Rodopi B. V., 1993), ch. 7.

<sup>80</sup> Gorsky, 'Local Leadership in Public Health', pp. 468-470.

<sup>81</sup> Anonymous, 'School Medical Service and the Ministry of Health', *Public Health*, vol. 35, no. 4, (Jan. 1922), p. 99.

In 1915, he went on war duty to France and returned to Bristol after demobilisation with increased confidence about the subject of youth health and national well-being. For instance, in his 1919 Annual Report of the Schools Medical Officer, he spoke about how the war had made him realise ‘the large amount of physical unfitness in adults due to want of care and treatment during childhood’.<sup>82</sup> This realisation, he revealed, gave him a ‘powerful incentive’ to enlarge and improve the schools’ medical work, with the objective of improving the standard of health of those children ‘who are to form the future of the race’.<sup>83</sup> He was certainly not the only one to realise this, but he worked within an enabling wave of reformative ideas which he increasingly became passionate about. During that period, systematic treatment as an important preventive tool was increasingly becoming an area of greater emphasis,<sup>84</sup> an issue he vigorously pursued in his schools medical work.

In 1924, Askins was appointed Deputy Medical Officer of Health of Bristol, and in 1928 when he succeeded Dr. Davies as Bristol’s City Medical Officer of Health. This put him in complete charge of an area of strategic importance, not only in terms of south-west England, but also nationwide. As a port city, Bristol occupied an important position in the country’s defence against imported diseases. In addition to coordinating the public health activities of the Port Authority in general, he was also solely responsible for the direct supervision of inspection of foreign immigrants.

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<sup>82</sup> Bristol Education Committee, *Annual Report of the School Medical Officer for Year ended December 31 1919*, p. 5.

<sup>83</sup> Bristol Education Committee, *Annual Report of the School Medical Officer for Year ended December 31, 1919*, p. 5.

<sup>84</sup> In her book *Marketing Health* Virginia Berridge talks about this trend which was an outcome of germ revolution which led to shifts in the basic approach of public health. As Berridge argues, although disease co-evolved with poverty, officials responded by expanding the range of personal treatment within the health services. Berridge, *Marketing Health: Smoking and the Discourse of Public Health in Britain, 1945-2000* (Oxford: Oxford University Press, 2007), p. 9.

With this background in mind, it is possible to argue that his advocacy in Southern Rhodesia was simply a continuation of his Bristol work in a different context. Although the language of justification differed between colony and metropole, in essence in both communities the aims of safeguarding the health of the elite from infection and ensuring a healthy nation were high on the agenda. Moreover, in drawing up his medical units scheme, Askins was inspired by certain specific healthcare schemes that were being tried out in some English counties in the 1920s. Notably, similarities between his scheme and John Middleton Martin's GEMSS scheme, strongly suggests that he drew some lessons from the latter.

### **The influence of the Gloucestershire Scheme**

The idea of the district being the focal point for organised medical care may have had other colonial origins, but the fact that it featured in Askins' proposed scheme had observable origins in Gloucester. In parts of Britain, the idea of organising health services on a district basis emerged very strongly during the early twentieth century as a result of concerns about the fragmentation of existing health care services.<sup>85</sup> Coordination schemes such as the regional hospital trusts had their origins in such concerns. As N. T. A. Oswald put it, the thinking behind these trusts was that,

If the whole population is to have access, when necessary, to highly specialized services which cannot, by definition, be provided at all locations, then there must be a formal referral system between hospitals from a wide area to a centre where skills and resources are concentrated.<sup>86</sup>

This may have been the influence behind Askins' proposed arrangement that there be a district hospital where the skills of the government medical officer would be accessed through a referral system of patients from the network of dispensaries, and through the medical officer's regular visits to such outlying medical stations.

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<sup>85</sup> A few examples include, Gosling, "Co-operate!, Co-ordinate!, Unify!"; N. T. A. Oswald, 'A Social Service Without Social Doctors', *Social History of Medicine*, vol. 4, no. 2 (1991), pp. 295-315.

<sup>86</sup> N. T. A. Oswald, 'A Social Service without Social Doctors', p. 300.

However, as already noted the British health-service coordination and extension scheme that seems to have had the most influence on Askins' medical units scheme was the GEMSS, a Gloucestershire County Council's public health project whose boundaries overlapped with Askins' Bristol City and County public health boundaries. The GEMSS was commenced in 1920 by John Middleton Martin, the County's medical officer of health, as an experiment in both the extension and co-ordination of rural medical services.<sup>87</sup> George C. Gosling suggests that, in similar spirit to its national counterpart, the Dawson Report of 1920, the GEMSS's aim was to deliver 'a network of local health centres as a means to bring about a co-ordinated regional health service'.<sup>88</sup>

The aim of the model was to set up a scheme that would be able to effectively deal with the different common cases found in the County, namely, defects of schoolchildren, maternity and child welfare cases, tuberculosis, venereal diseases, and orthopaedic cases.<sup>89</sup> The scheme sought to use the County's existing infrastructure and personnel, including hospitals, hospital staff, general practitioners, and district nursing groups to operate in a coordinated structure with out-stations that pivoted around central hospitals, to create an elaborate district health system. Martin Gorsky offers the best description of the main features of the scheme:

[I]ts innovative feature was the provision of "out-stations" in the rural parts of the county. These were small-scale health centres, either purpose built or situated in existing cottage hospitals, Poor Law institutions or tuberculosis dispensaries, and staffed by GPs paid on a contractual basis. Gloucestershire was divided into administrative areas (Bristol, Gloucester and Cheltenham), each with its general hospital, to which the out-stations were affiliated for patient referrals, and with its specialist institutions such as tuberculosis sanatoria.<sup>90</sup>

<sup>87</sup> Gorsky, 'The Gloucestershire Extension of Medical Services Scheme: An Experiment in the Integration of Health Services in Britain Before the NHS', *Medical History*, 50, (2006); Gosling, "'Co-operate!, Co-ordinate!, Unify!'"

<sup>88</sup> Gosling, "'Co-operate!, Co-ordinate!, Unify!'", p. 84.

<sup>89</sup> UKNA, Mh66/90, A. C. Parsons, Administrative County of Gloucester: Report on a Survey of Public Health Services, 1932, p. 90.

<sup>90</sup> Gorsky, 'The Gloucestershire Extension of Medical Services Scheme', p. 494.

A Survey Report compiled in the early 1930s praised the scheme for its full exploitation of local resources.<sup>91</sup> Each of the district hospitals had its allocated part of the County, and the allocation of personnel was arranged in such a way that consultants left their hospital bases and visited patients at their nearest outstations, whereas in most counties patients travelled to see consultants.<sup>92</sup> The goal of the originator of the scheme, Martin, was eventually to have an out-station within three miles of every section of the County, achieved on the basis of the rational usage of the County's available health resources.<sup>93</sup>

The Gloucestershire scheme is so closely echoed in Askins' scheme that it is not far-fetched to argue that the latter was a direct adaptation of the former. Firstly, the proposed division of Southern Rhodesia into 'medical districts' or medical units mirrored the division of Gloucestershire into Bristol, Gloucester and Cheltenham health administrative districts in which there were designated out-stations connected to the big hospitals in the centres of specialisation. Secondly, the idea of mobile consultants was also echoed in Askins' idea of running each medical unit on the basis of a designated medical officer who visited out-stations located at certain pre-determined distances from the district hospital. These were supported by a sedentary African auxiliary and white nursing staff. Thirdly, the use of 'existing agents' and institutions by the Gloucestershire scheme found its way into Askins' proposal of taking advantage of existing government infrastructure in launching the programme of medical units. In both schemes, the new institutions had to be purpose-built,

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<sup>91</sup> UKNA, Mh66/90, A. C. Parsons, Administrative County of Gloucester, Report on a Survey of Public Health Services, 1932, p. 91.

<sup>92</sup> UKNA, Mh66/90, A. C. Parsons, Administrative County of Gloucester, Report on a Survey of Public Health Services, 1932, p. 92.

<sup>93</sup> John Middleton Martin, 'Gloucestershire Scheme for Extension of Medical Services', *British Medical Journal*, vol. 2, no. 3128 (Dec. 1920), p. 916.

mainly to economise on resources, although Askins also rationalised his idea by saying that he required medical stations that were familiar to Africans.

The Gloucestershire scheme was certainly more elaborate and complex because it was grafted on a better-developed foundation. In contrast, the Askins scheme was mainly concerned with inaugurating services in areas where they were virtually non-existent. In addition, the Askins scheme had to negotiate a complex set of racial relations in addition to the professional and resource issues with which the Gloucestershire scheme was mainly concerned. Nevertheless, the two schemes clearly shared some profound similarities. Gorsky suggests that public health's affinity for well-planned and coordinated services during the period under review may have emerged as a result of the influence of notions of 'rationalization' and 'scientific management' spawned by the Taylorist management system pioneered in the American factories by Frederick W. Taylor.<sup>94</sup>

The influence of the Gloucestershire scheme on Askins' thinking is not hard to explain because of its relative success and popularity. Although the Gloucestershire scheme had its detractors, it had such widespread appeal that renowned advocates of social medicine, public health reformists and intellectuals such as Professor Charles-Edward Winslow of Yale University travelled to Gloucester in August 1932 to study the system of medical out-stations.<sup>95</sup> Within the United Kingdom, it was cited as one of the pre-eminent pioneering experiments in organised medicine.<sup>96</sup> As contemporaries, Askins and Martin had interacted in various forums, including the West of England Branch of the Society of Medical Officers of

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<sup>94</sup> Gorsky, 'The Gloucestershire Extension of Medical Services Scheme', p. 493.

<sup>95</sup> UKNA, Mh66/90, A. C. Parsons, Administrative County of Gloucester, Report on a Survey of Public Health Services, 1932, p. 90.

<sup>96</sup> Obituary, 'John Middleton Martin', *British Medical Journal*, vol. 1, no. 4123 (13 Jan. 1940), p. 74.

Health, of which Askins was elected President in October 1924.<sup>97</sup> Society meetings offered members opportunities to discuss new schemes in their districts and many of those schemes were noted for publication in the Society's official journal. This fostered exchange of ideas, and their adaptation in different areas.

Furthermore, Gloucester was Askins' preferred retreat and it was said of him that 'he was extremely fond of simple rural life, and whenever his duties permitted he sought the company of the Somerset and Gloucester Hills'.<sup>98</sup> If he had no experience in rural healthcare delivery, he had experience of rural life, and he apparently also had a valuable template from the Gloucester public health scheme on which to formulate his own ideas.

### **The reforms as colonial biomedical power**

Yet, Askins' reforms were as colonial, as they were innovative. Indeed, as David Arnold has famously said,

There is indeed a sense in which all modern medicine is engaged in a colonizing process.... It can be seen in the increasing professionalization of medicine and the exclusion of 'folk' practitioners, in the close and often symbiotic relationship between medicine and the modern state, in the far-reaching claims made by medical science for its ability to prevent, control, and even eradicate human diseases.<sup>99</sup>

Anna Crozier adds that one of the defining features of colonial medicine in British Africa was the continued 'sensationalisation' of the African as inherently pathological, and the valorisation and celebration of the colonial doctor as the hero who selflessly served the primitive African patients at great personal risk.<sup>100</sup> There was a tendency among many colonial medical officials to be unquestioning of their own self-proclaimed superiority and

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<sup>97</sup> Society of Medical Officers of Health, 'West of England Branch Meeting Report', *Public Health: The Journal of the Society of Medical Officers of Health*, vol. 37, no. 3 (Dec. 1924), p. 95.

<sup>98</sup> 'Obituary', *The British Medical Journal* (21 Dec. 1935), p. 1235.

<sup>99</sup> David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India* (Berkeley, Los Angeles & London: University of California Press, 1993), pp. 9-10.

<sup>100</sup> Anna Crozier, 'Sensationalising Africa: British Medical Impressions of Sub-Saharan Africa, 1890-1939', *The Journal of Imperial and Commonwealth History*, vol. 35, no. 3 (Sept. 2007), pp. 393-415. A good example of this celebratory hagiography is Oliver Ransford's *Bid the Sickness Cease: Disease in the History of Black Africa* (London: John Murray, 1983), p. 5.

essentialist moral obligations.<sup>101</sup> These insights aptly summarise some of the inner essences of Askins' reforms.

Firstly, Askins did not jettison the infamous colonial practice of framing Africans as reservoirs of infective disease. By resorting to the 'reservoir of disease' stereotype, Askins consolidated a prejudiced image that Africans had endured since the pre-reform era. Such views informed repressive disease control measures. A good example of this sensationalist view related to the syphilis scare, a disease that, because of its closer linkages with inter-racial sexual relations, endured the most widespread, elaborate and lingering attention of the colonists from the turn of the century onwards.<sup>102</sup>

Lynette A. Jackson remarks that a 'striking characteristic of the public health files on colonial Zimbabwe (Southern Rhodesia) is the frequency with which one encounters references to African women as disease hosts or agents'.<sup>103</sup> According to Jackson, at a conference held in 1928 to consider some new strategies against syphilis, Fleming indicted 'stray (African) women', 'girls on the move' and 'travelling prostitutes', as the main agents responsible for 'spreading disease all over the country'.<sup>104</sup> Such women were forced to submit to compulsory examination which they remembered as *chibeura* (to turn upside down).

Were the reforms, therefore, solely driven by self-interested and racist public health ideas? Were they only about averting the spill over effects of poor health among the Africans? There is no single answer to this question. In December 1930, when Askins addressed the Advisory

<sup>101</sup> Lenore Manderson, *Sickness and the State*, p. 6.

<sup>102</sup> For more, see Jock McCulloch, *Black Peril, White Virtue: Sexual Crime in Southern Rhodesia, 1902-1935* (Bloomington and Indianapolis: Indiana University Press, 2000), Ch. 9.

<sup>103</sup> Lynette A. Jackson, "'Stray Women' and 'Girls on the Move': Gender, Space and Disease in Colonial and Post-Colonial Zimbabwe", Paul T. Zeleza and Ezekiel Kalipeni, (eds), *Sacred Spaces and Public Quarrels: African Cultural and Economic Landscapes* (Trent, NJ; Asmara: Africa World Press, 1999), p. 149.

<sup>104</sup> Jackson, "'Stray Women' and 'Girls on the Move'", p. 150.

Board of Native Development, he told them that ‘we doctors feel the humane side’, but that ‘the purely selfish side is also of practical importance... because it will obviously commend public sympathy’.<sup>105</sup> Was this a conscience-salving ploy since he was speaking to a mainly missionary-dominated group?

The well-informed medical historian, Walter Bruchhausen has compellingly argued that not all colonial healthcare officials should be accused of ‘lacking a genuine sympathy for the sick and a wish to relieve their suffering’.<sup>106</sup> Indeed, Askins was concerned that the various diseases that occurred in endemic and epidemic forms in the colony were of importance both because of the likelihood that they would spread to Europeans and because of the unnecessary destruction of life and erosion of health which resulted among the Africans.<sup>107</sup> The latter reason clearly stemmed from a form of medical humanitarianism.

Arguably, sometimes invoking such popular, sensationalist images was an important strategy used by reform-minded officials to get the buy-in of colonial legislatures and treasury officials who held the keys to funding. Askins had dealt with complex funding issues during his time in Bristol, and was therefore aware of the difficulties involved in fund-raising for new projects. For instance, in 1925, he had a long list of items for which he required funds, including hospital treatment for children suffering from crippling conditions, operative treatment of enlarged tonsils and adenoids, increasing dental staff and the provision of open-air hospitals and schools accommodation.<sup>108</sup> In anticipation of official outrage at the amount

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<sup>105</sup> Editorial, ‘Jottings from the Recent Sitting of the Advisory Board of Native Development’, *Native Mirror*, 1 Jan. 1931, p. 23.

<sup>106</sup> Walter Bruchhausen, ‘Public and Child Health in German East Africa and Tanganyika Territory, 1900-1960’, *Dynamis*, vol. 23, (2003), p. 87. Accessed from <http://ddd.uab.cat/pub/dynamis/02119536v23p85.pdf> on 25 Oct. 2010.

<sup>107</sup> NAZ, S1173/336, Askins, Preliminary Report on the Treatment of Natives, p. 1.

<sup>108</sup> City and County of Bristol Education Committee, *Report of the Schools Medical Officer for the Year Ended 31 Dec. 1925*, pp. 7-8.

of funds required, he tactfully pre-empted criticism by noting that, ‘the treatment of illness in its commencing stages in childhood, is the most remunerative investment which the state can make’.<sup>109</sup>

If it was an issue to convince the authorities in richer England, Southern Rhodesia was even tougher terrain for him, given the complex, racialised structures of development the immense impact of the Depression on colonial coffers. However, as Bruchhausen also admits, in our efforts to understand the nature of colonial healthcare institutions and policies, we should look for answers beyond ‘just the personal’ and ‘moral’ feelings of the key players.<sup>110</sup> Even if we accept Askins’ explanation that he emphasised self-interest for pragmatic reasons, his entire treatise cannot escape critical assessment from many other angles. Firstly, in mimicking the popular stereotype of the African as a ‘reservoir of disease’, Askins fortified prejudice and distorted his own motives.

In *Mimesis and Alterity*, Michael Taussig perceptively argues that ‘The wonder of mimesis lies in the copy drawing on the character and power of the original, to the point whereby the representation may even assume that character and that power. In older language, this is “sympathetic magic”’.<sup>111</sup> Askins’ approach, as much as it was partly sympathetic, did exactly what is suggested by Taussig. That said, there is no compelling evidence to suggest that he did not believe these stereotypes himself.

Secondly, in his policy proposal he revealed that one of his reasons for developing rural medical services was to eradicate the influence of indigenous healers whose medical work, he

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<sup>109</sup> City and County of Bristol Education Committee, *Report of the Schools Medical Officer for the Year Ended 31 Dec. 1925*, p. 8.

<sup>110</sup> Walter Bruchhausen, ‘Public and Child Health in German East Africa and Tanganyika Territory’, p. 87.

<sup>111</sup> Michael Taussig, *Mimesis and Alterity: A Particular History of the Senses* (New York & London: Routledge, 1993), p. xiii.

disparagingly said, ‘must frankly be described as being of the most primitive character’.<sup>112</sup> He particularly took aim at indigenous midwifery, charging that there was a lot of ‘folly and superstition,’ and a ‘considerable admixture of cruelty’ that entailed the extreme suffering of African women in childbirth.<sup>113</sup> Indeed, Askins was keen to supplant African forms of healing and to impose Western biomedical institutions and practices. In January 1931, writing to the Chief Native Commissioner who had sought his opinion on the subject of doctoring by Africans, Askins showed that he looked forward to the eradication of this maligned practice ‘as soon as the government are able to substitute a scheme for the treatment of natives by a duly qualified medical practitioner’.<sup>114</sup>

In June 1931, Molala Milasi, described in the scant records as an African ‘doctor’, applied through the Native Affairs Department to try an experimental cure for leprosy, or alternatively for a permit to cure patients on his own. Askins’ response was that, ‘we cannot grant this native a room in which to experiment on leprosy. Neither will it be possible to issue him with a permit to “doctor” the sick’.<sup>115</sup> He added that if the African in question cared to ‘send in samples of his medicines and tell us his methods in using them, the Government Analyst has promised to experiment with the samples...’<sup>116</sup> It is not clear whether this leeway was an open-minded gesture or a ploy to stealthily take the medication in question and the methods of its usage under the cover of scientific analysis. Indeed, other biomedical practitioners would have rejected the request unequivocally.

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<sup>112</sup> Medical Association of South Africa, ‘Medical Services for Natives: Dr Askins’ Views’, *Journal of the Medical Association of South Africa (B.M.A.)*, (11 April 1931), p. 223.

<sup>113</sup> Medical Association of South Africa, ‘Medical Services for Natives: Dr Askins’ Views’, p. 223.

<sup>114</sup> NAZ, S1173/329, Natives (Medical Attention), 1925-1931, Askins to Chief Native Commissioner, 29 Jan. 1931.

<sup>115</sup> NAZ, S1173/329, Natives (Medical Attention), 1925-1931, G. A. Taylor (for Medical Director) to Chief Native Commissioner, 10 June 1931.

<sup>116</sup> NAZ, S1173/329, Taylor to Chief Native Commissioner, 10 June 1931.

However what was unfortunate, although not surprising, was that this budding therapeutic pluralism was suffocated by Askins at a time when biomedicine was still itself faced with pharmacological and epidemiological challenges in respect of African healthcare, some notable progress in other areas notwithstanding. Some medicines used by doctors were not any safer. For instance, between 1930 and 1932, a venturesome use of vermifuges like carbon tetrachloride, together with a purgative to cure hookworm and endemic helminthic disease caused a scare when patients vomited and became ill; a woman so treated miscarried and six Africans died on the Rand, and one in Salisbury.<sup>117</sup>

Thirdly, Askins also fortified racial privilege by pivoting the medical units scheme around European medical officers when he framed the structure of the district health team. In his policy documents he specifically referred to the South African Loram Committee Report, which had recommended, *inter alia*, the training of Africans as doctors to work in rural areas, but emphatically stated he would not recommend the scheme in Southern Rhodesia.<sup>118</sup> In his own words, Askins said,

I do not think the problem of Southern Rhodesia is a very difficult one. It is perfectly obvious that we want trained Native Orderlies and Native Midwives.... I think there is no doubt we do not want to fall in with Rockefeller's suggestion in regard to the Johannesburg University. I do not think it would be wise to adopt the proposition of Rockefeller for trained Native Doctors. Therefore we go back to this, that we have got to have white doctors with Native orderlies and Native nurses to assist them.<sup>119</sup>

For him, therefore, the correct course for Southern Rhodesia was the modification of the much-vaunted French West African system whereby Africans were trained and deployed to work under the supervision of a white doctor.<sup>120</sup> Perhaps what Askins wanted to be modified

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<sup>117</sup> Steele, 'The Foundations of "Native" Policy', p. 289.

<sup>118</sup> NAZ, S1173/336, Askins, Preliminary Report on the Treatment of Natives, p. 4.

<sup>119</sup> Editorial, 'Jottings from the Recent Sitting of the Advisory Board of Native Development', *Native Mirror*, 1 Jan. 1931, p. 23.

<sup>120</sup> The French scheme was hailed by Lord Hailey in his *African Survey* as being 'the most successful and certainly the largest effort in Africa to provide a colonial medical education with an acknowledged standard of

in the case of Southern Rhodesia was that, according to M. S. Kiwanuka, the French gave some of their best African medical assistants a chance to practise privately.<sup>121</sup> The system of medical orderlies supervised by white doctors also commended itself to him because the cost 'would be low per capita'.<sup>122</sup> In thinking about these issues he drew on the South African case where the liberal recommendations of the Loram Committee Report came under immense criticism by medical conservatives.<sup>123</sup> By dint of this, Askins' otherwise reformative scheme took on a conservative, colonial nature. Therefore, as he sought to extend the benefits of biomedicine to the rural Africans, he also promoted white privilege at the expense of the indigenous peoples.

## Conclusion

Askins came into the colonial African scene at a time when reformist ideas were floating around across the metropolitan and imperial borders, and so it would be a mistake to treat Southern Rhodesia as an isolated case. As has been demonstrated above, the Southern Rhodesian version of rural healthcare reform was influenced by developments elsewhere. By offering to reduce inequalities in healthcare provision, the reforms were progressive. However, the good intentions were muddled by numerous prejudices, including ethnocentrism and the entrenchment of racial privilege. This was perhaps indicative of the multiple, often incompatible aims of colonial biomedicine. In the interstices of these impulses were tensions between race, public health and colonial progress. And, as this chapter has attempted to show, these impulses had histories beyond the local and the colonial. The next

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efficiency'. Hailey, *An African Survey: A Study of Problems Arising in Africa South of the Sahara*, (London, 1938), pp. 1185-6.

<sup>121</sup> Editorial, 'Jottings from the Recent Sitting of the Advisory Board of Native Development', *Native Mirror*, 1 Jan. 1931, p. 23; M. S. Kiwanuka, 'Colonial Policies and Administrators in Africa: The Myths of the Contrasts', *African Historical Studies*, vol. 3, no. 2 (1970), p. 308.

<sup>122</sup> Editorial, 'Jottings from the Recent Sitting of the Advisory Board of Native Development', *Native Mirror*, 1 Jan. 1931, p. 23.

<sup>123</sup> NAZ, S1173/336, Askins, Preliminary Report on the Treatment of Natives, p. 4. For more on the South African debate, see Shapiro, 'Doctors or Medical Aids'; Digby, 'Visions and Vested Interests'; Anne Digby, *Diversity and Division: Healthcare in South Africa from the 1800s* (Peter Lang, 2006), pp. 191-198.

chapter which focuses on the pioneering of the medical units scheme in colonial Fort Victoria province illuminates these contradictions even more precisely, along with the negative impact they had on the development of a robust rural healthcare system.

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### Chapter 3

#### **‘The work had to be commenced, enlarged and carried on’: The pioneering of the medical units scheme in Fort Victoria Province**

##### **Introduction**

This chapter focuses on the pioneering of the medical units scheme in rural Fort Victoria and it pays particular attention to how the vision turned out on the ground. After his conception of the scheme and its approval by the relevant authorities, from 1931 Askins started preparing for its gradual implementation, beginning with delineation of two medical districts for the creation of the first two pilot medical units. The first medical district, which became known as the Ndanga Medical Unit, and which is the main focus of what follows in this and the rest of the chapters, encompassed Ndanga, Bikita and Gutu, the three contiguous districts making up half of Fort Victoria Province, in south-eastern Southern Rhodesia. The second medical district was mapped out around Mtoko, in the north-eastern part of the colony. The choice of Ndanga and Mtoko as the first two pilot districts was in line with one of the major pillars of his scheme, that is, to utilise existing government healthcare infrastructure and sites as launching pads.<sup>1</sup>

Ndanga and Mtoko were by then the only two rural districts with posts that were occupied by resident government medical officers primarily preoccupied with so-called ‘native medical work’. From 1926 Mtoko had been an area of growing leprosy control work under Dr. S. R. P. Montgomery.<sup>2</sup> Although Dr. Montgomery left the colony at the end of 1927, his post was not abolished, giving Askins an opportunity to appoint his own candidate, Dr. James Leggate, in 1931, to spearhead the setting up of the new Mtoko Medical Unit through the expansion

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<sup>1</sup> NAZ, S1173/336, Preliminary Report on the Treatment of Natives by R. A. Askins, 8 Sept. 1930; Southern Rhodesia, *Report on the Public Health for the Year 1930*, p. 20.

<sup>2</sup> Michael Gelfand, *A Service to the Sick: A History of the Health Services for Africans in Southern Rhodesia (1890-1953)* (Gwelo: Mambo Press, 1976), p. 38.

and diversification of the existing leprosy control work to include a general district hospital and several outlying dispensaries.<sup>3</sup>

Meanwhile, in Ndanga, Dr. T. J. Williams had been responsible since 1913 for running the only state-owned rural general hospital for Africans, as was illustrated in chapter 1. In addition, in 1926 the medically aware Native Commissioner for Bikita District, H. N. Watters, had successfully motivated for the setting up of a venereal diseases clinic in the vicinity of his administrative compound.<sup>4</sup> From its establishment the clinic was regularly visited by Dr. Williams, while much of the daily work was done by the Native Commissioner's wife and two African orderlies. The new plan was, therefore, to refurbish and expand the existing infrastructure before building more subsidiary dispensaries across the three selected districts, with Ndanga as the headquarters (hence the name of the unit) and Bikita and Gutu being the subsidiaries..

This chapter, and indeed the entire thesis from here, focuses on the Ndanga experiment for one historical reason. In 1935, Askins, the originator and initial promoter of the idea of medical units, was succeeded by Dr. A. P. Martin who was not enthusiastic about his predecessor's scheme. The Askins model consequently lost its currency and the Mtoko Unit was abandoned, while the third medical unit which was planned for establishment in Sebungwe, in the southwest of the colony, was not attempted at all. The Ndanga scheme was thus the only enduring story to emerge from the original vision of a comprehensively-organised, district-based African healthcare delivery system run by a fulltime government

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<sup>3</sup> Southern Rhodesia, *Report on the Public Health for the Year ended 1933*, pp. 11-12.

<sup>4</sup> NAZ, S1173/427, Native Dispensaries (Bikita Venereal Disease Clinic), H. N. Watters to Superintendent of Natives, Fort Victoria, 6 July 1926.

medical officer, white nurses and African medical auxiliaries.<sup>5</sup> Despite its many imperfections and the burden of being a product of abandoned plans, the development of the Ndanga Unit left behind an incomplete but sizeable collection of archives that can be used to probe the scheme of medical units and gain useful insights into the underlying concept's rather limited operational history.

Focusing particularly on the period from 1932 to 1959 – a period which corresponds with the time spent in Ndanga by the Unit's pioneer and chief developer, Dr. James H. Kennedy – this chapter uses this existing archive, augmented with oral sources, to trace the history of the development of the Unit's main facilities very closely. Exploring this particular aspect of the Unit's history is important for two reasons. Firstly, it introduces us to the particularities of the Unit's ten key nerve-centres which included the main Ndanga Hospital and its nine out-stations dotted across Ndanga, Bikita and Gutu. Secondly, probing first how each medical station came into existence is the logical starting point towards understanding the full spectrum of local and national factors which either advanced or limited the development on the ground of a district healthcare system as envisaged in Askins' medical units proposal. The chapter argues that while the scheme was hobbled by faltering state commitment to African healthcare in general and the medical units approach in particular, the role played by Kennedy was the single most important factor that explains the continued existence and expansion of the Unit.

Kennedy was determined to forge ahead with the scheme even after the abandonment of the idea of medical units after 1935. However, his mission became possible because of three reinforcing factors. Firstly, because the colonial state generally underfunded African

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<sup>5</sup> The Mtoko Unit, and the third unit that was proposed by Askins in December 1934, vanished into oblivion in the wake of his death in 1935.

healthcare and had too small a bureaucracy to be able to supervise practice in far-flung regions closely, district medical officers were generally afforded a great deal of leeway to organise things locally as they saw fit. Although Kennedy's position was not unique, he however utilised that latitude to an unusual, albeit controversial extent.

The second factor in explaining Kennedy's record was his unconventional character. As this chapter and the next one will show, Kennedy had low regard for bureaucratic authority and he often seemed oblivious to disapproval from the public health headquarters. His organisational skills and imperious zeal also worked to his advantage. However, his work could have been impossible without the third enabling factor: the co-operation of African communities and their willingness to either heed his calls to build the required dispensary facilities or their volunteering to do so out of perceived community need.

In formulating some of the opinions about the historical role played by the medical officer, the variable nature of African's participation in healthcare development and the way that these two interacted with each other and with the state, this chapter relies on a synthesis of different but reinforcing insights drawn from scholars such as Anna Crozier, Gerald C. Mazarire and George O. Ndege.<sup>6</sup> In a detailed description of the life experiences of mostly rural medical officers in colonial East Africa, Crozier illuminates several key themes, including rural doctors' relative independence and the extremely wide remit of their official and general responsibilities. According to Crozier, medical officers generally faced limited official superintendence and professional monitoring. Crozier reckons that their wide professional responsibilities were matched only by the equally huge size of their operational

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<sup>6</sup> Anna Crozier, *Practising Colonial Medicine: The Colonial Medical Service in British East Africa* (London: I.B. Tauris, 2007); Gerald C. Mazarire, 'A 'Little England' in Chishanga: The Fate of British Empire Leprosarium at Ngomahuru, 1925-1946', *African Historical Review*, vol. 39, no. 2 (2007), pp. 1-24; George O. Ndege, *Health, State, and Society in Kenya* (Rochester, NY: Rochester University Press, 2001).

districts. The average medical officer was expected to be an ‘all-rounder’ and a versatile ‘jack-of-all-trades’.<sup>7</sup> As a result, further argues Crozier, ‘doctors in the field were therefore left to their own devices to identify, adapt and coordinate their responsibilities as [best as] they could’.<sup>8</sup>

In a study of the Ngomahuru Leprosarium, Fort Victoria, Mazarire corroborates this view that colonial rural medical officers were generally allowed a great deal of latitude to plan certain things locally. This was partly because the state was often hamstrung by lack of funds,<sup>9</sup> and one could add, by a lack of political will, given the almost discretionary nature of colonial state schemes for Africans. As Mazarire ably demonstrates, while that leeway allowed medical officers to pursue their personal visions, there were also risks as the state tended to be heavy-handed when it felt that the manner in which a particular doctor was carrying out his duties was bringing western medicine and colonial governance into disrepute.<sup>10</sup> Although this was largely mirrored in the case of Ndanga, the clashes between the state and medical officers there seem to have been about more than just the state’s worries about the integrity of biomedicine. Instead, they mainly related to differences over the manner of the usage of state resources. To borrow Poonam Bala and Amy Kaler’s relevant statement, the Ndanga case was a conflict of priorities ‘between those who believed themselves qualified to prescribe and those who took healing as part of a wider administrative practice’, a situation which entailed that ‘divisions of labor and authority were often unstable and ambiguous’.<sup>11</sup> As this chapter will elaborate, these contradictions tended to present the colonial rural medical officer as both a colonial agent and an advocate of the poor.

<sup>7</sup> Crozier, *Practising Colonial Medicine*, pp. 87-89.

<sup>8</sup> Crozier, *Practising Colonial Medicine*, p. 87.

<sup>9</sup> Mazarire, ‘A ‘Little England’ in Chishanga’, p. 2.

<sup>10</sup> Mazarire, ‘A ‘Little England’ in Chishanga’, p. 3.

<sup>11</sup> Poonam Bala and Amy Kaler, ‘Introduction: “Contested Ventures”: Explaining Biomedicine in Colonial Contexts’, Poonam Bala (ed.), *Biomedicine as a Contested Site: Some Revelations in Imperial Contexts* (Lanham, MD: Lexington Books, 2009), p. 5.

In Ndanga, these indeterminate, complex relations transcended the interaction between the state and the medical officer to include the African communities. Although in Mazarire's Ngomahuru case Africans were generally not keen on the institution's existence in their midst because it tended to reflect the imperial mindset of disease control while also 'desecrating' the locals' ecology, in Ndanga the picture was far more complex. Communities there came forward to assist in the construction from scratch of most of the clinics and then participated in their maintenance. This important variation has a precedent in other comparable colonial contexts. In a refreshing study of the development of modern biomedical care in rural Kenya, Ndege has emphasised that relations between African communities and colonial officials were not perpetually characterised by conflict, as often believed. Instead, there were notable moments of compromise and accommodation whereby African communities provided the required resources and ideas for the development of healthcare facilities in their communities.<sup>12</sup>

However, while placing a premium on the contributions of African communities in the development of healthcare services in Ndanga, this chapter is less sanguine than Ndege's rather exuberant charge that through their 'proactive activities' Africans 'were the prime movers of health care development' in colonial contexts.<sup>13</sup> That could be peculiar to his western Kenyan case. In the case of Ndanga, it is argued that, despite the crucial role played by African communities in the development of the district healthcare system, in terms of the quality of facilities, the Unit remained on the margins of prime colonial healthcare. This illustrated the misplaced priorities of the colonial state and the limitations of localised initiatives that were not consistently matched by steady political will.

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<sup>12</sup> Ndege, *Health, State and Society*, p. 2.

<sup>13</sup> Ndege, *Health, State and Society*, p. xii.

At the same time, as an arena of the extension of the state's tentacles and professional medical practice, colonial medical care remained ensconced in the broader matrix of asymmetrical power relations surrounding colonial development, whereby Africans were treated as a different, inferior class of human beings. In the process, the few progressive elements and the inherent potential of certain aspects of biomedicine and district healthcare suffered heavily. The chapter is therefore a discussion of the possibilities and constraints of healthcare development in a divided, profoundly undemocratic society.

Having considered these issues, the chapter argues that the implementation of Askins' model of a district-based rural healthcare system turned out to be a tension between the broader colonial ambitions and the health-related imperatives of developing a functioning rural healthcare system. The chapter develops and illustrates through concrete examples the argument raised in the previous chapter, that colonial healthcare was a contradictory constellation of innovative and retrogressive forces. Nothing confirmed its partly alluring appeal than the proactive action taken by the Africans communities of Ndanga, Bikita and Gutu to provide the facilities for its practice. At the same time, nothing illustrated its limitations than its alignment with the whims of the privileged colonial classes.

To explore these issues, the chapter begins with a brief introduction of the chief protagonist of the Ndanga Unit story, Dr Kennedy, followed by an overview of the sub-region he was charged to oversee as a medical officer. It then proceeds to explore the initial attempts to set-up the Unit beginning from the early 1930s, illuminating particularly the challenges encountered in raising the initial funds for the refurbishment and expansion of the main hospital and the problems emanating from unsettled, local white politics. After that it turns to

trace the establishment of outlying dispensaries, and closes with an exploration of the limited modernisation (or further improvement) of the facilities of the main hospital in the 1940s.

### **The beginning of an epoch**

One of Askins' top priorities in the process of implementing the Ndanga Unit was finding a suitable medical officer to spearhead the process as Dr. Williams was due to leave Ndanga. His search for that candidate led him to Dr. Kennedy whose appointment to Ndanga can be regarded as the beginning of a distinct epoch in the medical history of rural Fort Victoria. While he lived and practised in Ndanga for almost three decades, Kennedy attained legendary status not only among his white and medical contemporaries, but also among the African communities of Ndanga who still have fond memories about their *Chiremba Kenende*, as he was known in local Karanga dialect.<sup>14</sup> In the oral histories of Ndanga, nostalgic memories of Kennedy's times are barely matched by those of Dr. Simon Mazorodze, the African doctor and well-known liberation war figure who was the medical officer in charge of Ndanga from the late 1960s to the early 1970s.<sup>15</sup> As Kennedy was a generally liberal-minded, generous, but also demanding frontier doctor, this popularity is in part understandable. He also seems to have minimised overt racial prejudice, which however appears in his memoirs.

Described by Dr. Dyson Blair, one of his contemporaries, as 'the despair of the administrator',<sup>16</sup> Kennedy was notorious for his disregard for official procedure, especially in relation to administrative requisitions and returns. For instance, for almost a decade he assiduously ignored numerous official protestations over his habit of proceeding to Meikles Stores, Fort Victoria, to get whatever he required for his clinics before forwarding the

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<sup>14</sup> *Chiremba* means doctor in local language.

<sup>15</sup> In 2010, when I carried out interviews for this thesis, I went into the field with certain preconceived ideas about colonial doctors which were challenged by the positive memories of Kennedy among the people of Ndanga.

<sup>16</sup> Colin Saunders, 'A Doctor in the Lowveld Wilderness: The Story of James Kennedy OBE of Ndanga', *Heritage of Zimbabwe*, no. 19 (2000), p. 17.

vouchers to the head office in Salisbury, for (often unbudgeted for) payment. This resulted in him being hauled before a Public Service Board disciplinary committee for a disciplinary hearing over his cases of administrative impropriety.<sup>17</sup> As one interviewee quipped, he was ‘his own headquarters’.<sup>18</sup> Ironically, it was this impropriety coupled with zeal which was essentially the lifeblood of the scheme; the Ndanga Unit emerged and continued to exist after the abandonment of the idea precisely because Kennedy chose to be his own ‘headquarters’.

But who was Kennedy? Born on 26 November 1899 in Salisbury, the Southern Rhodesian capital, Kennedy was the son of his similarly named father, an ex-Griqualand West Irishman who had distinguished himself as Southern Rhodesia’s first Master of the High Court. After matriculation, in 1921 he was awarded a Rhodes scholarship to study medicine at the University of Oxford, before entering St. Bartholomew’s Hospital in London where he qualified in 1926.<sup>19</sup> With this qualification, he became the first Southern Rhodesian-born doctor – an achievement which earned him respect and admiration as a history-making citizen of that part of the British Empire. A Diploma in Tropical Medicine gained from the Liverpool School of Tropical Medicine and Hygiene completed his complement of qualifications, which primed him for the Southern Rhodesia Medical Service. After some brief ‘junior’ postings at the colony’s urban hospitals and rural district outposts, he finally landed his own ‘independent command’ when, in October 1932, Askins appointed him to pioneer his new scheme of rural medical units in Ndanga.<sup>20</sup>

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<sup>17</sup> NAZ, S1173/337, Proceedings of an Inquiry Held by the Public Services Board Into Charges Against Dr James Hutchison Kennedy, 22 Sept. 1941.

<sup>18</sup> Interview with Dr. M. Chitiyo, Harare, 4 Oct. 2010.

<sup>19</sup> Saunders, ‘A Doctor in the Lowveld Wilderness’, p. 1.

<sup>20</sup> In his memoirs, Kennedy suggests that he did not like urban practice. James Kennedy, ‘Bygones of a Bundu Bone Throwing: Part 1’, *Central Africa Journal of Medicine*, vol. 3, no. 6 (June, 1957), p. 235. His trip to Ndanga in late 1932 was not his first as he had done a locum there in 1928. During that stint he had met his wife-to-be, Ino Skinner, who was matron during the time of Dr. Williams, and continued to perform her duties during Kennedy’s tenure.

**Fig. 3.1: Rhodes Scholar, Oxford – J. Kennedy, c.1920s**



**(Photo Courtesy of Rhodes House, Oxford)**

Kennedy's first responsibility was to transform the relic he inherited from his predecessor into what Askins envisaged to be a functioning 'headquarters' for 'a typical native medical unit' organised on the basis of a simple hospital block, 'consisting of an operating theatre, sterilising room, out-patient department and dispensary', and several outstations approximately 40km away.<sup>21</sup> The Unit was to serve as a model to illustrate 'how by this method medical facilities can be brought within reasonable distance of 80, 000 to 100, 000 natives by means of a number of cheap buildings and the services of a European doctor with a staff of native orderlies'.<sup>22</sup> This cheaply built Unit would be able to deal with 'all types of medical, surgical, and obstetric cases'.<sup>23</sup> Kennedy's initial task was therefore to spearhead the refurbishment and re-equipping of the district hospital before venturing into the extension of

<sup>21</sup> Southern Rhodesia, *Report on the Public Health for the Year 1933*, p. 14.

<sup>22</sup> Southern Rhodesia, *Report on the Public Health for the Year 1933*, p. 12. The total population of Africans in Ndanga, Bikita and Gutu districts was estimated to be in the range of 80, 000-100, 000.

<sup>23</sup> Southern Rhodesia, *Report on the Public Health for the Year Ending 1933*, p. 12.

the scheme by establishing outstations across the three sub-districts making up the Unit's catchment area.

It is perhaps necessary at this point to give an overview of the area in which he was supposed to establish this pioneer Unit. As a colonial administrative district, Ndanga was carved out of the Victoria district in 1899, following the creation of the Native Affairs Department.<sup>24</sup> In 1920, the eastern portion of what was then a sizeable district was in turn separated from it to create the new Bikita district. In addition to the fact that Bikita had a clinic that was earmarked as one of the Unit's first outstations, its administrative ties to Ndanga meant that it was the first to be included into the new medical district.

North of Ndanga and Bikita was Gutu district which was incorporated mainly to reach the ideal population size of 80, 000 to 100, 000 people to be served by one medical officer, as envisaged by Askins.<sup>25</sup> In terms of population, in the early 1930s Bikita had an estimated 31, 311 people, Gutu 35, 557 people, and Ndanga 40, 280 people, bringing the total to 107, 148 people.<sup>26</sup> These were however estimates, since no proper census of Africans was undertaken until the 1960s. African communities were scattered across an area covering approximately 25, 000 square kilometres (or one-twelfth of the colony), living mainly in reserves, although a few others lived in Native Purchase Areas (farms), in alienated lands and on Crown land. These three districts also shared a very rich pre-colonial history, a similar cultural milieu and a common dialect (Karanga), as well as an identical ecological zone. During the pre-colonial

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<sup>24</sup> Steven C. Rubert and R. Kent Rasmussen, *Historical Dictionary of Zimbabwe* (Lanham, MD & London: Scarecrow Press, 2001), p. 352.

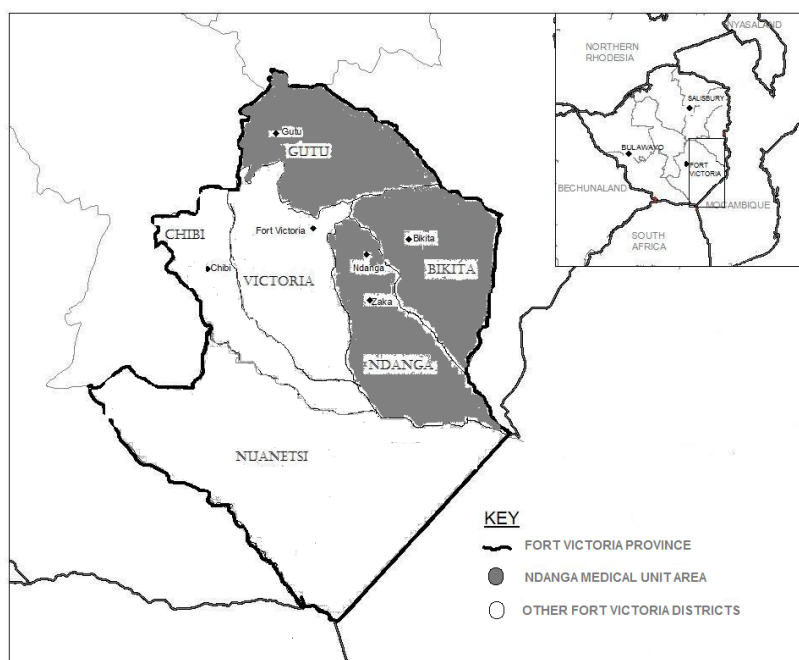
<sup>25</sup> Although Gutu Reserve was created in the late nineteenth century, Gutu district was created only in 1906.

<sup>26</sup> NAZ, S1563, Native Commissioners and Acting Native Commissioners Annual Reports, Report of the Native Commissioner, Bikita, for the Year Ended 31 Dec. 1934; Report of the Native Commissioner, Ndanga, for the Year Ended 31 Dec. 1934; Benjamin Davis and Wolfgang Dopcke, 'Survival and Accumulation in Gutu: Class Formation and the Rise of the State in Colonial Zimbabwe, 1900-1939', *Journal of Southern Africa Studies*, vol. 14, no. 1 (Oct. 1987), p. 64.

times, the Ndanga-Bikita-Gutu area was mainly inhabited by the Karanga-speaking Duma Confederacy, with its nucleus around Bikita,<sup>27</sup> although some parts were under the influence of the pre-colonial Rozvi Empire.<sup>28</sup>

However, the Shangani, a smaller and culturally distinct ethnic group, occupied the southern part of Ndanga district, stretching to the border with Portuguese East Africa (Mozambique). Although their proper ethnic identification is Hlengwe, from the nineteenth century they have been generally called the ‘Shangani’ because of their closer association with the Gaza kingdom of Soshangane.<sup>29</sup> This ethnic group shared similar cultural identities with the Tsonga people inhabiting the southern parts of Portuguese East Africa and the northern parts of South Africa.

**Fig. 3.1: Map showing the Ndanga Medical Unit area**



**Source:** Adapted from [http://en.wikipedia.org/wiki/File:Masvingo\\_districts.png](http://en.wikipedia.org/wiki/File:Masvingo_districts.png).

<sup>27</sup> Richard M. G. Mtetwa, ‘The “Political” and Economic History of the Duma People of South-Eastern Rhodesia from the Eighteenth Century to 1945 (DPhil Thesis, University of Rhodesia, 1976), p. 3.

<sup>28</sup> Joseph Mujere, ‘The Changing Patterns of Shona Kinship with particular reference to the Gutu People, c.1752’ (BA Hons. Dissertation, University of Zimbabwe, 2003).

<sup>29</sup> Rubert and Rasmussen, *Historical Dictionary of Zimbabwe*, p. 296.

The 'lowveld' has been the main geographical and regional descriptor used to encompass the greater part of the territory demarcated as the new Ndanga Medical Unit, especially the portion covered by Ndanga and Bikita. During the colonial period, the lowveld evoked competing visions as 'cattle country suitable for ranching; wild bush for game ranching or national park; potentially productive land for irrigated sugar estates or small holder farming; and the ethnic homeland of the Shangaan (sic) people and abode of their ancestral spirits'.<sup>30</sup> Thus, while the area to be covered by the Ndanga Unit mainly encompassed 'native districts', it was also interspersed with white farms such as the huge Devuli and Angus Ranches in Bikita because of its suitability for animal husbandry. Crown Lands also broke up parts of the Ndanga East Reserve.

Warm climatic conditions and the riverine nature of the topography made the lowveld a natural habitat for malarial mosquitoes. The provision of health services was therefore also presented as a way of taming the supposedly wild territory and possibly opening it up for white enterprise and civilisation. In line with this thinking, as late as the 1940s Kennedy still considered himself to be spending most of his time 'in the wilderness doing largely native work' in 'wild and remote country'.<sup>31</sup> He indeed wanted to be perceived as somebody engaged in the frontier, civilising the African communities on behalf of the British Empire.

However, by the 1930s this part of Fort Victoria had been gradually transforming towards modern and colonial forms of life and class differentiation as some sections of the three

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<sup>30</sup> William Wolmer, *From Wilderness Vision to Farm Invasions: Conservation and Development in Zimbabwe's Southeast Lowveld* (Oxford: James Currey; Harare: Weaver Press; Hollywood: African Academic Press, 2007), p. 2.

<sup>31</sup> Rhodes House, Rhodes Scholars File, James H. Kennedy, Rhodesia and Magdalen, Alumna Returns 21 Jan. 1949; Kennedy to Dr. Allen, 17 Oct. 1948.

districts were set aside as Native Purchase Areas, that is, farms set aside for purchase and occupation by middle-class Africans under the Land Apportionment Act, of 1930.<sup>32</sup> The process of change and differentiation was also accentuated by missionary evangelisation as the Dutch Reformed Church, the Church of Christ and the Roman Catholic Church competed to spread their brands of religion among the region's communities. Independent African churches such as the Zion Christian Church (ZCC) and the Zion Apostolic Church also started robust evangelisation in the 1920s,<sup>33</sup> effectively converting the region into a plural society.

Other agents of change were the labour migrants as the region was already a labour exporting zone by 1900, with most migrants trooping to both Southern Rhodesian and South African mines and farms.<sup>34</sup> This had the effect of gradually introducing industrial diseases, diseases of civilization and infectious diseases into the area. Thus, when the sub-region was selected to pioneer the medical units scheme in the early 1930s, it was far from being a *terra incognita* as it was claimed by others to be.<sup>35</sup> However, many people still held on to their hallowed therapeutic traditions, something which was important in their gradual encounter with biomedicine. Periodic epidemic outbreaks, spells of drought and famine and the tentacles of the state brought the Karanga and the Shangani into closer, albeit contested association with the biomedical world. Some of these themes will be elaborated in later chapters, after understanding first the initial process of setting up the main facilities of the Unit, which is the main purpose of the next sections of this chapter.

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<sup>32</sup> Bikita had two Native Purchase Areas, Nyahunda (72, 100 acres) and Mungezi (23, 800); Ndanga had no purchase areas but only Crown Lands which were thinly inhabited by so-called squatters; Gutu had Dewure, Nyazwidzi and Mazare Native Purchase Areas.

<sup>33</sup> M. L. Daneel, *Old and New in Southern Shona Independent Churches, Volume 1* (The Hague & Paris: Mouton & Co. 1971), pp. 288-291.

<sup>34</sup> Davis and Dopcke, 'Survival and Accumulation in Gutu'.

<sup>35</sup> For instance, Robert Tredgold, 'The Retirement of Dr. James Kennedy, O.B.E', *The Central African Journal of Medicine*, vol. 5, no. 7 (July 1959), p. 375.

### **Hopeless foundation, protracted beginning**

When Kennedy first took over Ndanga hospital the position, as he aptly put it, ‘appeared practically hopeless’ and therefore the work had to be ‘commenced, enlarged and carried on’ in line with Askins’ new idea of medical units.<sup>36</sup> The existing hospital was woefully maintained and was threatened by structural collapse that had started provoking official concern in the 1920s, but which remained unresolved until the early 1930s, and even then only temporarily so. It was a relic in a relic, having inherited in 1924 the Native Commissioner’s old and abandoned compound after its own original buildings had proved hopelessly inadequate. A Public Works Department official who visited the hospital in 1925 had condemned most buildings as unfit for normal use and a large proportion as unfit for renovation.<sup>37</sup> Fleming also admitted after his visit later that same year that ‘a building programme of some magnitude’ was required if the hospital was to continue providing the necessary services.<sup>38</sup>

However, two further years elapsed without any recognisable refurbishment. In 1927 the Acting Medical Director, A. J. Mackenzie, also visited the hospital and produced another instalment in a series of damning reports on the condition of the colony’s lone state rural hospital for Africans. Mackenzie described the hospital as a ‘collection of broken down pole and dagga shacks’.<sup>39</sup> In 1929, the nurses’ quarters were found to be in a ‘dangerous condition’ as the building was ‘overrun with white ants and in a state of collapse’ and ‘not worthy spending a penny on’ if any renovations were contemplated.<sup>40</sup> Yet, by 1932, major re-

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<sup>36</sup> NAZ, S1173/337, Ndanga Clinic, James H. Kennedy to Medical Director, 27 July 1941.

<sup>37</sup> NAZ, S533/T312/742, Ndanga Hospital, 1923-1934, District Surveyor to Director of Public Works, 18 Nov. 1925.

<sup>38</sup> NAZ, S533/T312/742, Ndanga Hospital, 1923-1934, Andrew Fleming to the Director of Public Works, 10 Dec. 1925.

<sup>39</sup> NAZ, S1173/316, Native Dispensaries, 1912; 1927-1932, A. J. Mackenzie [spelling?] to Chief Native Commissioner, 18 Dec. 1927.

<sup>40</sup> NAZ, S533/T312/742, A. H. Lamb to Director of Public Works, 16 Aug. 1929.

building had not taken place. This was partly because officials had become cautious about making any long-term infrastructural commitments, as the hospital had become the centre of conflicting, local white settler group interests. The conflict had its roots in Dr Mackenzie's 1927 visit. In the report he compiled after that visit he had shown concern about the hospital's location on the 'extreme northern end of the district' and recommended that it be relocated to the district magistracy in Zaka where it could be easily accessible to a bigger number of people.<sup>41</sup>

This suggestion was supported by the Greater Fort Victoria Settlers' Association (hereafter, the Settlers' Association), a group of white settlers who inhabited alienated lands on the south-eastern parts of the Unit's catchment area and who relished the idea of the proximity of a doctor. From 1928, the Settlers' Association had started to petition the government of Premier H. U. Moffat to urgently transfer the hospital to the new site for the benefit of the settlers in that part of the district. However, Fleming was not supportive of the idea of transfer as he anticipated resistance from another white settler organisation in the province, the Eastern Fort Victoria Farmers' Association (hereafter the Farmers' Association), representing individuals owning farming and cattle ranching business such as the Devuli and Angus Ranches in Bikita. As he told the Colonial Secretary, William M. Leggate, the interests involved in the case were too 'conflicting to arrive at a conclusion with ease and certainty' as he was aware that the Farmer's Association 'will hotly resist the removal of the medical officer and nurse from Ndanga to Zaka'.<sup>42</sup>

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<sup>41</sup> NAZ, S1173/316, Mackenzie to Chief Native Commissioner, 18 Dec. 1927.

<sup>42</sup> NAZ, S2410/16/3, Andrew Fleming to Secretary, Dept. of the Colonial Secretary, 1 Feb. 1929.

Indeed, as Fleming feared, in August 1929 a letter of inquiry arrived in his office from the Farmers' Association asking him to clarify the rumoured transfer of the hospital.<sup>43</sup> Perhaps to buy time, Fleming professed ignorance in his response to their query.<sup>44</sup> In the intervening period, he advised Leggate to call for a round table conference where the issue could be discussed with the conflicting parties,<sup>45</sup> but the conference did not take place and available sources do not shed any light on the reasons for the failure. At that conference Fleming was going to suggest improving lines of communication between urban Fort Victoria (where there was a hospital for whites) and the parts of the district occupied by the Settlers' Association and so obviate the need for the transfer of the hospital.<sup>46</sup>

However, the matter was complicated by the fact that Leggate seems to have accepted Mackenzie's administratively and financially attractive idea. The idea was alluring because a concentration of state institutions in one place would mean that the government would be relieved of costs incurred during the doctor's numerous visits from Ndanga to the Native Commissioner's Zaka District headquarters for government medical work. However, in his endeavour to explain the reasons for transfer to the Farmers' Association he, rightfully, placed emphasis on the fact that many more patients would be better served by a hospital positioned in Zaka rather than Ndanga. He rejected the view by the anti-transfer group that Zaka was an unhealthy site in terms of weather and altitude by arguing that such opinion could only apply in the case of a sanatorium and not a general hospital. To facilitate the doctor's unimpeded movement from Zaka to the north, he also offered to bridge the Chiredzi

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<sup>43</sup> NAZ, S2410/16/3, Eastern Fort Victoria Farmers' Association to Fleming, 28 Aug. 1929.

<sup>44</sup> NAZ, S2410/16/3, Fleming to Eastern Fort Victoria Farmers' Association, 30 Aug. 1929.

<sup>45</sup> NAZ, S2410/16/3, Fleming to Secretary, Colonial Secretary 25 Sept. 1929.

<sup>46</sup> NAZ, S2410/16/3, Fleming to Secretary, Colonial Secretary 25 Sept. 1929.

River, which usually became a natural barrier between the north and south during the rainy season.<sup>47</sup>

On its part, the Farmers' Association took that argument as undue prioritisation of African interests at the expense of white interests. Their response to his reasoning is worth quoting at length to illustrate verbatim not only the acrimony, but also some of the crude tactics used by the settlers to influence government policy in their favour. They argued that,

... [T]o depend upon medical assistance 40 miles away offers poor consolation and little consideration for the interests of the white element in the country....The consensus of white opinion of those residents below Zaka is for the hospital and medical officer to remain at Ndanga. The transfer will mean considerable expense which will be shouldered more by the European taxpayer than the Native – in fact, we have to bear the burden of helping to increase the Black numerical preponderance, which, in the long end, will become an insuperable obstacle to white supremacy....The native mind has not been educated up to the appreciation of medical science, in short, it is afraid of it and would preferably be without interference.<sup>48</sup>

They further reminded Leggate that,

In an era of depression which gives the profoundest and gloomiest thoughts on the future status of the European farmer of Rhodesia, the Government would seemingly add to the expenses of his exchequer and simultaneously jeopardise the security of his health. In conclusion ... [the Association] would appeal to the Colonial Secretary to weigh this matter on the scale of his own flesh and blood and colour – [and] not [to] pay the minutest attention to the lines of latitude and longitude with their respective numerical values in black integers.<sup>49</sup>

Fleming retired leaving this divisive issue unresolved, effectively passing it on to his successor, Askins, and it took the latter a further three years to resolve while the Ndanga scheme was kept on hold. This stand-off cast a dark cloud of uncertainty over the scheme until Askins, who was anti-transfer, managed to defuse the tension through his argument which emphasised the fact that Zaka was unsuitable on health grounds. Moreover, based on his new concept of medical units, Ndanga hospital would be central, while the outlying

<sup>47</sup> NAZ, S2410/16/3, G. A. Taylor to the Eastern Fort Victoria Farmers' Association, 5 Aug. 1930.

<sup>48</sup> NAZ, S2410/16/3, Eastern Fort Victoria Farmers' Association to the Medical Director, 15 Sept. 1930.

<sup>49</sup> NAZ, S2410/16/3, Eastern Fort Victoria Farmers' Association to the Medical Director, 15 Sept. 1930.

dispensaries would cover areas favoured by the feuding parties,<sup>50</sup> ensuring the accessibility of the doctor. He argued that malaria-bearing mosquitoes, which continuously menaced the Native Commissioner's entourage, infested Zaka.<sup>51</sup> Based on Askins' opinion, on 17 April 1934, Colin E. Duffy, the Secretary for Internal Affairs under whom the Public Health Department was now administered, therefore issued a final decision that the hospital would remain in its old location.<sup>52</sup>

In all these wrangles Africans were conspicuous by their absence – the strongest indication of how settler politics and colonial governance dominated African social and health care at most policy-making levels. Although as noted in Chapter 1 Africans had started proto-nationalist in the 1920s, their healthcare and other affairs remained in the thrall of white settler interests. For instance at one point when the Fort Victoria Branch of the Southern Rhodesia Native Association petitioned the state to provide them with a Superintendent of Natives who knew African customs, the response they got was, 'To this I can say that the government knows best what is good for you'.<sup>53</sup> Africans were perceived as children.

However, what worsened matters was the context within which much of debate over Ndanga took place: the Great Depression. The Great Depression caused a serious deterioration of relations between white settlers and the government of the unenthusiastic Moffat, as the former's enterprises were brought to the brink of ruin and employment opportunities virtually vanished, throwing many whites into near destitution.<sup>54</sup> The rancour that defined these

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<sup>50</sup> NAZ, S1820/8, Ndanga Hospital, 1933-1934, Askins to the Secretary, Department of Internal Affairs, 10 April, 1934.

<sup>51</sup> NAZ, S1820/8, Askins to the Secretary, Department of Internal Affairs, 10 April, 1934.

<sup>52</sup> NAZ, File S1820/8 Colin E. Duffy to Askins, 17 April 1934.

<sup>53</sup> NAZ, S1561/25, Native Councils Bill, 1926-1937, Chief Native Commissioner to Southern Rhodesia Native Association, Fort Victoria, 20 Nov. 1929.

<sup>54</sup> Ian Phimister, *An Economic and Social History of Zimbabwe, 1890-1948: Capital Formation and Class Struggle* (London & New York: Longman, 1988), p. 173; C. F. Keyter, *Maize Control in Southern Rhodesia*,

strained relations is exemplified in the letter from the Farmers' Association to the Leggate, quoted above. In the previous chapter it was also noted how, in the wake of the Depression-induced problems, the colonial state was forced to impose more demands on Africans to subsidise the survival of white citizens. In addition, the dominant discourse of African 'development' was temporarily recast to reflect and accommodate the immediate concerns of whites rather than the relatively long-term, theoretical premise of civilising the African upon which it was initially based.<sup>55</sup> To compound the already bad situation, African development programmes were dropped from the state's agenda. This brings us to the second and equally important challenge that led to considerable delay in the launch of the Ndanga scheme: a lack of funds.

In drawing up the scheme, Askins had showed concern about the difficulty of getting enough funds, hence the idea of pioneering it tentatively and on the basis of the cheap means of African orderlies. Indeed, he spent much of the time between 1930 and 1933 looking for a dependable funding mechanism to commence his much welcomed, but poorly-resourced scheme. He literally left no stone unturned as he enquired from his counterparts in neighbouring colonies how they funded their own schemes, suggested the introduction of a general health tax or re-allocating some funds from the existing African taxes and mooted the idea of introducing user fees so that Africans could bear the cost of their care.<sup>56</sup> In Askins' own words, it was 'clear that if the medical treatment of the native is to be developed, it is necessary to tap some source of income which is not at present available'.<sup>57</sup> However, the

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*1931-1941: The African Contribution to White Survival* (Salisbury: The Central African Historical Association, 1978), p. 2.

<sup>55</sup> Jocelyn Alexander, 'Technical Development and the Human Factor: Sciences of Development in Rhodesia's Native Affairs Department', Saul Dubow (ed.), *Science and Society in Southern Africa* (Manchester & New York: Manchester University Press, 2000), p. 214.

<sup>56</sup> Southern Rhodesia, *Report on the Public Health for the Year 1930*, p. 20; NAZ, S1173/333, Natives Medicines, 1930-1932, Askins to Leggate, 21 Dec. 1932; Askins to Principal Medical Officers, Nyasaland and Northern Rhodesia, 2 Nov. 1933.

<sup>57</sup> NAZ, S1173/333, Askins to Chief Native Commissioner, 2 Nov. 1933.

idea of user fees was dropped in March 1931, when he was convinced that it would spell doom for the new scheme.<sup>58</sup> Native Affairs authorities also turned down his suggestion of a new levy in the form of a health tax, arguing that both the African labour and produce markets were too depressed to allow for the introduction of new levies for the purpose of healthcare.<sup>59</sup>

Ironically, the same officials who rejected his funding plans oversaw the passage of legal instruments such as the Maize Control Act which was one of the vital, Depression-era linchpins used in the exploitation of Africans expressly for the purpose of cushioning the vocal white citizens.<sup>60</sup> Also, according to Ian Phimister, the existing Native Development Account – which was essentially a trust account – was ‘surreptitiously’ debited by the state for the purpose of saving the white population from ruin. Leaders such as the surgeon-cum-politician, Godfrey Huggins, flagrantly ignored the ethical dilemmas of such actions, arguing that Africans would actually ‘prefer an indirect to a direct stock tax’ for instance, ‘unless ill-intentioned people or agitators stir them up’.<sup>61</sup> Authorities also turned down a proposal by the Southern Rhodesian Native Missionary Conference of July 1931, that two-thirds of the dipping levies that were already in paid by Africans should be devoted to the medical treatment of Africans.<sup>62</sup>

This lack of consensus over the funding of the new rural healthcare initiative meant that there was no dedicated budget created for its commencement. The expressions of approval of the

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<sup>58</sup> Murray C. Steele, ‘The Foundations of a “Native” Policy: Southern Rhodesia, 1923-1933’, (DPhil thesis, Simon Fraser University, 1972), p. 296.

<sup>59</sup> NAZ, S1173/333, Askins to Chief Native Commissioner, 2 Nov. 1933.

<sup>60</sup> Keyter, *Maize Control in Southern Rhodesia*.

<sup>61</sup> Phimister, *An Economic and Social History of Zimbabwe*, p. 184. Although he was a surgeon, the assumption of power by Huggins in September 1933 through the victory at the polls of Reform Party did not offer any radical healthcare reforms to Africans as he initially showed signs of being an overzealous segregationist.

<sup>62</sup> NAZ, S1173/239 Natives (Medical Attention), 1925-31, Resolution on Askins’ Scheme by the Southern Rhodesia Native Missionary Conference, Bulawayo 4-8 July 1931.

scheme by the Colonial Secretary and the Chief Native Commissioner rang hollow.<sup>63</sup> The default official position was that, while the state recognised the need to extend medical services to Africans in rural areas, this had to be done gradually.<sup>64</sup> However, Askins was anxious to make a start and possibly demonstrate that the scheme could be implemented without inordinate expense. He thus began to draw on 'Vote 7C: Treatment of Venereal Diseases', which was created under his predecessor in the 1920s, and remained the main operational reserve for African medical work until the 1935/36 financial year when it was expanded and re-named 'Vote 31/C: Native Dispensaries and Clinics', in recognition of the expanding healthcare work.

However, Vote 7C proved to be so small that to make the first significant move towards the re-construction of the Unit's 'headquarters', Askins had to approach Treasury and the Minister of Internal Affairs in March 1933 to request a loan of £1, 750 for the reconstruction of the main hospital building and £1, 000 for improvements to the medical officer's house.<sup>65</sup> When the financial provisions for the following year were calculated, he managed to get a total allocation of only £1, 835 (£1, 115 for Ndanga Hospital and £726 for four dispensaries) to cover both construction and running costs during the 1934/5 financial year.<sup>66</sup> Thus, to cut costs, grass-thatched, pole-and-mud patient huts were constructed using free, locally available building materials, as well as locally mobilised, free labour. This strategy became the lifeblood of the Unit for a long time as it became clear to those on the ground that getting sufficient funds from the state was always going to be difficult.

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<sup>63</sup> NAZ, S1173/336, Medical Treatment Scheme for Natives, 1930-1, Leggate to Askins, 18 Nov. 1930; Chief Native Commissioner to Askins, 31 Dec. 1930.

<sup>64</sup> NAZ, S1820/9, Ndanga Clinic, 1933-1940, Askins to Kennedy, 14 July 1933.

<sup>65</sup> NAZ, S1820/8, Ndanga Native Hospital, 1933-34, Askins to Kennedy, 12 March 1933.

<sup>66</sup> NAZ, S2410/6/1, Ndanga Unit Estimates for the Year 1934/5.

However, after these initial difficulties reconstruction began to take shape in 1934. The main aim of the officials in Salisbury was to start with the refurbishment of the doctor's house, the white nurses' quarters and the construction of the main hospital block, which was to include a consulting room, a dispensary, a theatre and an out-patients' department. However, driven by the desire to have all the necessary facilities ready from the outset, Kennedy also went ahead with some additional construction work that he considered to be equally important, and this resulted in his overlooking of certain administrative procedures. Thus, in August 1934 authorities discovered that he had employed a local African builder, Moses, to construct 22 new patients huts, for which there was no provision in the estimates. In addition, this was done without following a proper tender process as the total cost exceeded the £50 threshold for a tender. As a corrective measure, Public Health Department officials barred any further expenditure on the required equipment during that financial year, while also pleading with Treasury officials to condone the irregular act.<sup>67</sup>

These seemingly banal developments are mentioned here because in them lay what became the default modus operandi in 'Jim Kennedy's kingdom', as his contemporaries called the Ndanga Unit.<sup>68</sup> A series of cases of improper purchases of unbudgeted for items ranging from small provisions to big equipment like electricity generators and, according to some accounts, even vehicles,<sup>69</sup> decorate Kennedy's administratively controversial career in Ndanga. Successive Medical Directors such as Askins' successor, A. P. Martin, and Kennedy's juniors in the medical service, Richard Morris and Dyson Blair, all tried but failed to stop him from

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<sup>67</sup> NAZ, S2410/6/1, Proctor to Kennedy, 21 Dec. 1934.

<sup>68</sup> Richard M. Morris, 'The Retirement of Dr. James Kennedy, O.B.E: A Tribute', *The Central African Journal of Medicine*, vol. 5, vol. 7 (July 1959), p. 378.

<sup>69</sup> The incredible story of the improper 'purchase' of a car from Fort Victoria is told by Colin Saunders in his memoir, 'A Doctor in the Lowveld Wilderness: The Story of James Kennedy OBE of Ndanga', *Heritage of Zimbabwe*, no. 19 (2000), pp. 16-17.

doing things his way. At the end they resigned themselves to the fate of having to live with Kennedy's well-known eccentricities.

Only once, in 1941, during Martin's tenure as Medical Director, was he formally charged and brought before a Public Service Board of Inquiry for his habitual overlooking of official procedures.<sup>70</sup> By touting his incomparable achievements in Ndanga and the impossibility of his work without an administrator, he escaped from the inquiry virtually unscathed. He was only warned officially and exhorted to regularise his administrative system, something he did not faithfully implement.<sup>71</sup> The breach of official procedure and the compromises reached during the 1934 construction work were therefore precursors to a series of future developments of similar nature. Relative isolation gave him the leeway to do things his own ways. Having found his own independent command in a frontier zone, Kennedy seems to have been very keen to rapidly transform the area by impressing upon it a biomedical model. Indeed, by 1934, Kennedy had already ventured into the establishing the first outstations. It is therefore useful to take a brief detour and reflect on this aspect before coming back to trace the further development and modernisation of Ndanga Unit from the late 1930s to the late 1940s.

### **The establishment of outstations**

From December 1932, Dr Kennedy started leaving the hospital under the care of a trusted 'lieutenant', his wife, the matron Ino 'Trix' Kennedy, as he ventured into the outlying areas first to build rapport with two important stakeholders first, Native Commissioners and African chiefs. Meetings were held with the highly-regarded Bikita Native Commissioner, H. N. Watters, and local chiefs to determine ideal locations for the new dispensaries (or sub-

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<sup>70</sup> NAZ, S1173/337, Proceedings of an Inquiry Held by the Public Services Board Into Charges Against Dr James Hutchison Kennedy, 22 Sept. 1941.

<sup>71</sup> This inquiry will be discussed further in chapter 6.

hospitals as they were sometimes called) and to get the assurance from chiefs that building materials and labour would be provided free of charge by their subjects.<sup>72</sup> Kennedy initially preferred locating these new dispensaries nearer to the Devuli and Angus ranches to give access to a large concentration of prospective patients who were employed at these ranches, as well as to have the closer presence of whites in case urgent supervision was required.<sup>73</sup>

Because the ranchers at Angus had previously petitioned the state for help in setting up a clinic for their employees,<sup>74</sup> Kennedy's proposal to establish the first clinics almost at the gates of these ranches was initially criticised by some senior Native Affairs Department officials who regarded the idea as a mere attempt by ranchers to get the doctor to set up his dispensary near to them.<sup>75</sup>

However, this opposition seems to have ended when officials realised that it would be better to have these clinics strategically located nearer to pockets of white settlement than to risk the independence of African orderlies who were to run these dispensaries under the distant supervision of the medical officer. Thus, a second outstation in Bikita District,<sup>76</sup> Chikuku Dispensary, was built along the main Victoria-Save road in Bikita Reserve, about 48km from the Native Commissioner's Camp and the Bikita Dispensary, and about 4km from the Devuli Ranch.<sup>77</sup> Certainly its location a victory for the Devuli proprietors, the new dispensary opened its doors on 17 August 1933. A third outstation in the district, Matsai Dispensary (later renamed Mashoko) was situated about 1/2 km from Mashoko Mission so that it could depend on the oversight of the missionaries there, as the Native Commissioner's Camp was about 64km away. Accordingly, in May 1933 eight huts were completed by local

<sup>72</sup> Kennedy, 'Bygones of a Bundu Bone Thrower: Part 1', pp. 272-273.

<sup>73</sup> NAZ, S2101/1/3, Bikita Native Clinic, 1928-36, Kennedy to Medical Director, 14 Dec. 1932.

<sup>74</sup> NAZ, S1173/332, Natives (Medicines), 1930.

<sup>75</sup> NAZ, S1173/332, Natives (Medicines), 1930.

<sup>76</sup> It will be recalled that Bikita already had a clinic started in 1927 near the Native Commissioner's compound.

<sup>77</sup> NAZ, S138/56, Native Dispensaries, 1924-1933, Chief Native Commissioner to Acting Superintendent of Natives, Fort Victoria, 18 May 1933.

communities under chiefs Mabika, Gudo, Ziki and the communities occupying the lower parts of the Mazungunye chieftainship.<sup>78</sup> After the delivery of basic equipment and supplies, the appointment of an orderly and a request to the missionary's wife to render some voluntary help, the dispensary saw its first patients on 4 August 1933.

A similar procedure was followed in the extension of the scheme in Ndanga District, southwards, towards the Native Commissioner's Zaka Camp and the Greater Victoria Settlers Association farms. In that area, the Unit's fourth outstation, Siawareba (Siawareva) Dispensary, was established at Chief Siawareva's old homestead, about 14km from Zaka Camp, and 41km south of Ndanga Hospital.<sup>79</sup> Built and completed in September 1933 under the eye of an African messenger,<sup>80</sup> this dispensary started with 10 huts, eight of which were set aside for a maximum of 50 in-patients, while the remaining two were used as quarters for the orderly and a dispensary.

In 1936, the number of outstations was increased with the establishment of Jichidza Dispensary in Ndanga District about 16km southwest of the main hospital. Another outstation, Chidumo Dispensary, was sited about 100km further south, among the Shangani. While the outstation in Jichidza was entirely constructed of pole-and-mud and grass thatch material, the one in Chidumo was distinct from others as only the patients' huts were similar to other dispensaries. Like Ndanga Hospital, the central block of the dispensary was a brick-and-mortar structure with corrugated iron roofing.<sup>81</sup> Another distinguishing feature was that Kennedy also built his own house there. Moreover, unlike at other dispensaries where the building programme was usually left in the hands of chiefs and African messengers, in the

<sup>78</sup> NAZ, S1820/9/2, Ndanga Clinic, 1933-40, Acting Native Commissioner, Bikita, to Acting Superintendent of Natives, Fort Victoria, 18 May 1933.

<sup>79</sup> NAZ, S1820/9/2, Native Commissioner, Zaka, to Superintendent of Natives, Fort Victoria, 27 May 1933.

<sup>80</sup> NAZ, S1820/9/2, Kennedy to Medical Director, 18 Oct. 1933.

<sup>81</sup> NAZ, S2407/17, Native Dispensaries and Clinics, 1936-1947, Secretary, Department of Internal Affairs to Secretary, Treasury, 2 July 1936.

case of Chidumo Kennedy closely supervised the ‘trained and competent’ African builder, identified as Chivanga, who was responsible for the actual construction work.<sup>82</sup>

Two factors explain why Chidumo was a more elaborate dispensary than the other outstations: its distance – some 120 km – from the Ndanga Hospital and Kennedy’s own personal interest in the area. Located at the confluence of the Chiredzi and Lundi rivers, the area was teeming with wild animals which appealed to Kennedy’s hunting interests. Accordingly, he decided to make his travels to Chidumo what Colin Saunders has aptly called ‘medical safari trips’.<sup>83</sup> Through this accomplishment, he established himself as a quintessential frontier colonist responsible for opening unexplored areas to white civilisation. According to some accounts, the Chidumo outpost hosted a number of colonial hunters, most of whom were Kennedy’s friends.<sup>84</sup>

The expansion of the Unit in Gutu District began with the establishment of Chikwanda Dispensary in 1935.<sup>85</sup> The district’s second dispensary was at Chingombe, which was taken over from the Dutch Reformed Church in 1938 under circumstances which suggested that local state officials were not happy with the Church’s work.<sup>86</sup> Following a visit arranged by the Gutu Native Commissioner, Kennedy wrote to Martin, the Medical Director, that ‘... if put on a somewhat different basis, [Chingombe dispensary] could be made to carry out a great deal more work, particularly as far as in-patients are concerned’.<sup>87</sup> He then proposed that ‘Chingombe Clinic be taken over by this Unit as soon as possible, and that its scope and usefulness, most particularly as regards in-patients (which are not satisfactory) be increased

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<sup>82</sup> NAZ, S2407/17, J. S. Blackwell to Secretary, Treasury, 2 July 1936.

<sup>83</sup> Saunders, ‘A Doctor in the Lowveld Wilderness’, p. 12. Apparently, Kennedy was given a shooting licence to supplement meat rations in his clinics.

<sup>84</sup> Saunders, ‘A Doctor in the Lowveld Wilderness’, p.15.

<sup>85</sup> NAZ, S1563/2, Native Commissioners Annual Reports, 1938, Report of the Native Commissioner, Gutu, for the Year Ended 31 Dec. 1938.

<sup>86</sup> The take-over was possible because the state subsidised mission dispensaries.

<sup>87</sup> NAZ, S1820/9/2, Ndanga Clinic, 1933-40, Kennedy to Medical Director, 8 Aug. 1938.

considerably'.<sup>88</sup> In addition to adding Chingombe to his network of dispensaries, he also managed to persuade Martin to approve the establishment of another dispensary at the Gutu District headquarters itself:

I beg to submit my suggestion...that in the event of it not being possible to erect at the moment the nucleus of a clinic at Gutu station itself (which nucleus, in the form of 20 Kimberley brick and thatch huts, would cost not more than £49) or in the event of a lesser sum not being available (and I submit that this lesser sum might without much difficulty be obtained) that the offer of the Native Commissioner (of 3 good Kimberley and thatch huts) be accepted, and that these be equipped to commence a skeleton service dealing largely, if not entirely, with immediate out-patient needs.<sup>89</sup>

Alas, the Gutu dispensary was located less than 10km away from an existing Dutch Reformed Church missionary dispensary at Gutu Mission, which had a fully qualified nurse as well as the services of a doctor who was based elsewhere. In addition, the Gutu Mission dispensary was a beneficiary of a government subsidy scheme commenced in 1927. The setting up of a rival state dispensary in Gutu may have had something to do with ethnic and administrative tensions between the British and the Afrikaner staff, known officially for ill-treating Africans in the Gutu area.<sup>90</sup> Inevitably, the location of the two dispensaries in close proximity led to competition for patients.<sup>91</sup>

The Unit's last two outstations were established in Sangwe and Chitsa in 1945 and 1946 respectively. The former was located on the southeast boundary of Ndanga and Bikita Districts to cater for communities in Ndanga East Reserve and Sangwe Reserve in Bikita. Its establishment followed a nutrition deficiency survey conducted by Kennedy among

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<sup>88</sup> NAZ, S1820/9/2, Ndanga Clinic, 1933-40, Kennedy to Medical Director, 8 Aug. 1938.

<sup>89</sup> NAZ, S1820/9/2, Ndanga Clinic, 1933-40, Kennedy to Medical Director, 8 Aug. 1938.

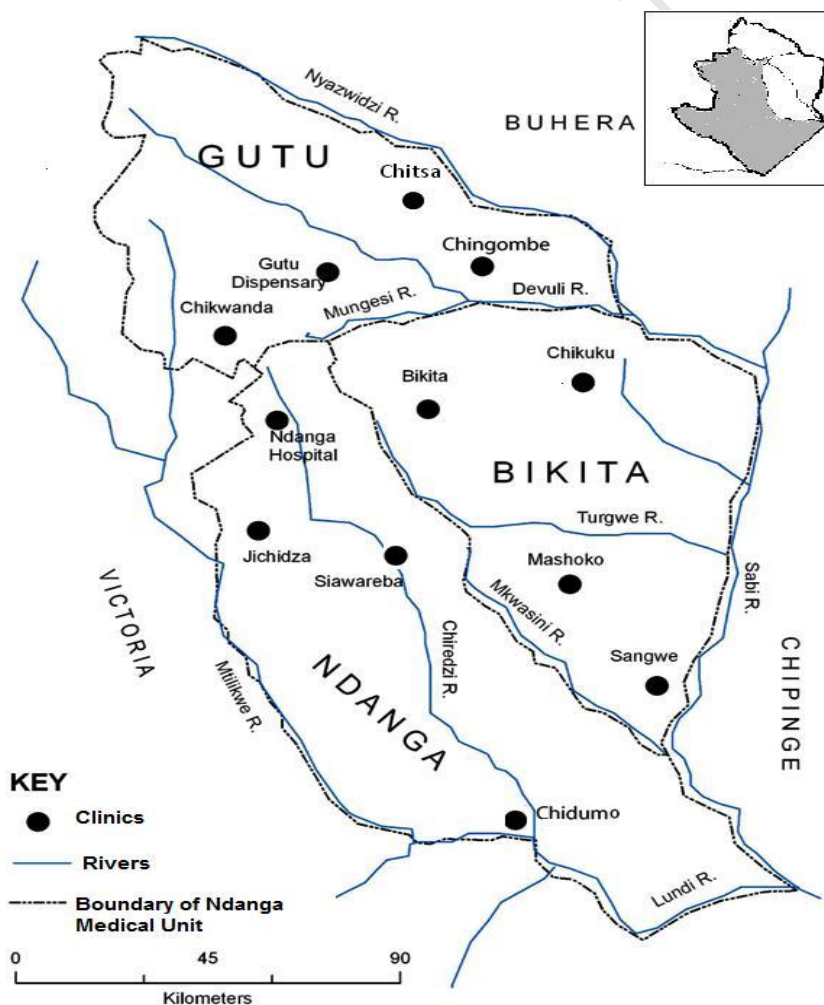
<sup>90</sup> Carol Summers, 'Giving Orders in Rural Southern Rhodesia: Controversies Over Africans' Authority in Development Programmes, 1928-34', *International Journal of African Historical Studies*, vol. 31, no. 2 (1998), pp. 290-1. Henry Orlandini a Dutch Reformed Church missionary based at Alheit Mission was expelled in 1934 by the colonial government for establishing 'a virtual dictatorship over the surrounding African population'. Benjamin Davies and Wolfgang Dopcke, 'Survival and Accumulation in Gutu: Class Formation and the Rise of the State in Colonial Zimbabwe, 1900-39', *Journal of Southern African Studies*, vol. 14, no. 1 (Oct. 1987), p. 64.

<sup>91</sup> NAZ, S1563, Report of the Native Commissioner, Gutu, for the Year 1944.

communities settled along the Mkwesine River.<sup>92</sup> According to the Native Commissioner for Ndanga District, that dispensary ‘was built by interested natives’ of Ndanga East and Sangwe Reserves.<sup>93</sup> Similarly, Chitsa Dispensary in Gutu was also a people’s project. In his 1946 annual report, the Native Commissioner for Gutu District, wrote that Chief Chitsa’s people,

[H]ave long been clamouring for a clinic to serve their needs. During this year having become tired of waiting for the government to provide a clinic the people got together and as a co-operative effort they have so far built a Kimberly brick dispensary and 8 Kimberly brick huts. Another 12 huts are still to be built and then the clinic will be equipped and staffed by the senior government medical officer Ndanga and come under his supervision. It is considered great credit is due to Chitsa and his people for their effort.<sup>94</sup>

**Fig 3.3: Location of Ndanga Hospital and Outlying Dispensaries**



<sup>92</sup> NAZ, S1563, Report of the Native Commissioner, Ndanga, for the Year 1945.

<sup>93</sup> NAZ, S1563, Report of the Native Commissioner, Ndanga, for the Year 1945.

<sup>94</sup> NAZ, S1563, Report of the Native Commissioner, Gutu, for the Year 1946.

In his 1947 report, the Native Commissioner again indicated that the clinic was built and completed, much to the embarrassment of the Public Health Department, which was initially not ready to equip it and commence treatment work.<sup>95</sup> Indeed, without the active participation of African communities in the pioneering of dispensaries in their communities, it is inconceivable that the Unit could have expanded in the way it did. Also not to be underestimated is Kennedy's own ability to put to greater use the autonomy he had as more or less a frontier doctor. He used the well-known difficulties of pioneering such work as a justification for his unorthodox actions.

In turn, Kennedy managed to accomplish most of his tasks because of the consistent help he received from his right-hand man, Benson Charovedza.<sup>96</sup> Charovedza was Kennedy's driver, interpreter and cultural broker from the latter's appointment in 1932 until the time he left Ndanga in 1959. To illustrate the much glorified Kennedy-Charovedza partnership, it may be illuminating to refer to some 'heroic' tales related by elderly eyewitnesses. A caveat should be issued, though, that these stories are not cited because of their assumed historical objectivity or truth, but because of the way they paint in heroic colours the relationship between the two men. This is taken as an example of how local people viewed and responded to the collaboration between an 'outsider' (Kennedy) and 'their own' man (Charovedza), and as an indication of what the relationship meant for community relations in general.

For instance, one couple told the story that, during one of their numerous hunting trips sometime in the late 1940s or early 1950s, Kennedy and Charovedza encountered at close range a wounded and angry buffalo which charged at Kennedy and nearly ran over him. The

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<sup>95</sup> NAZ, S1563, Report of the Native Commissioner, Gutu, for the Year 1947.

<sup>96</sup> Robert Tredgold, 'Obituary: Dr. J. H. Kennedy, O.B.E.', *Central African Journal of Medicine*, vol. 13, no. 12 (1967), p. 292.

‘brave and loyal’ Charovedza snatched the gun from the frightened doctor and gallantly shot at the angry buffalo until it collapsed. When they got back to the hospital, Kennedy decided to show his appreciation to his saviour by selecting Charovedza as the heir to his estate. Many possessions were bequeathed to Charovedza, including a car, a store, a grinding mill, money and guns – although the colonial government denied him possession of those guns when Kennedy died in 1967.<sup>97</sup> Although Charovedza’s surviving son confirmed that their father received a long of gifts from Kennedy’s estate, the store was not one of them as it was started in the 1950s the later was still alive. His own piece of intriguing story is that upon his retirement, Charovedza received a letter from Queen Elizabeth II.<sup>98</sup>

**Fig. 3.4: Deadly Alliance: In this undated photo, Dr Kennedy (behind) and Charovedza (front) after shooting an Elephant**



(Photo Courtesy of the National Archives of Zimbabwe)

<sup>97</sup> Interview with Mr and Mrs Chikumba, Bikita, 19 Sept. 2010. However, it is not clear from the records whether Kennedy owned a store.

<sup>98</sup> Interview with Gumatafa Charovedza, Harare, 4 Oct. 2010.

What these stories tell us is that, just like other pioneers, Kennedy had relied heavily on his close relationship with Charovedza as one of the pillars of the management of the Unit. As noted in the introduction to this chapter, the nature of rural medical officers' work entailed that they had to be local innovators.<sup>99</sup> Much of what Kennedy did was therefore the norm elsewhere in the colonial world. For instance, the partnership between popular Ugandan medical missionary, Albert Cook, and his right hand man, Yusuf Musajawaza, has been recorded by John Iliffe.<sup>100</sup> However, Kennedy's story has its own unique features. What distinguished him was that his own brand of innovation enabled him to press forward with the Ndanga Unit long after the policy of medical units had been abandoned by Askins' successor, Martin, who became Medical Director in 1935. As the Ndanga scheme had gained its own momentum, it could not be stopped.

Kennedy attempted to persuade Martin to continue implementing the scheme in other districts of the colony as planned by his predecessor. For instance, in February 1936, he wrote to Martin recommending an application for funds from the Beit Trust to set up a new medical unit.<sup>101</sup> Apparently, by that time he had already submitted a long memorandum advocating the establishment of a new medical unit, an indication that he was keen to see the dream of his fellow Irishman, Askins, taken forward. Onto the memorandum to Martin he attached a news item clipped from *The Bulawayo Chronicle*, containing the following words by Henry Birchenough, the Board Chairman of Beit Trust:

The native population has, however, an unmistakable claim to share in the benefits of the fund.... We have as a body of trustees still to solve the main problem, namely, how

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<sup>99</sup> See for example, Crozier, *Practising Colonial Medicine*.

<sup>100</sup> John Iliffe, *East African Doctors: A History of the Profession* (Cambridge: Cambridge University Press, 1998), pp. 22-23.

<sup>101</sup> NAZ, S1820/9/11, Ndanga Clinic, 1933-1940, Kennedy to Martin, 2 Feb. 1936.

and in what precise directions the benefits of the fund can most wisely and most fruitfully be extended to the natives.<sup>102</sup>

Kennedy took this as a ‘direct invitation to apply for assistance’, and he urged Martin to do so, attaching the newspaper clipping, his memorandum on the establishment of a new medical unit and annual reports to his letter.<sup>103</sup> Unfortunately there are no available records that shed more light on how Martin responded to this counsel, but the disappearance of the concept as the official operational ideology indicates that he was not in favour of its continuation. Martin, a man of the Fleming era, preferred what he called a Native Clinic System.<sup>104</sup> Launched in 1936, this system entailed the establishment of individual clinics at Native Commissioners’ district headquarters, loosely taken as subsidiaries to the exiting district surgeon system that catered for white settlers in outlying districts. Through this approach, he sought to revive the system begun in 1927 of locating clinics in the vicinity of Native Commissioner’s offices, as discussed in chapter 1. District surgeons made visits to these clinics, but their priority was the health of white settlers.

The problem with this approach was that, as noted in 1945 by the colony’s first Preventive Field Officer and future Secretary of Health, Dyson M. Blair, ‘Even if a medical officer is interested in his native clinic work he must on his own and because of its effect on public opinion, give native clinic work second place to his functions as medical practitioner attending the European community’.<sup>105</sup> Blair’s candid view was therefore that, even though a number of clinics had been established under Martin’s Native Clinics System by 1945, ‘the only work of real lasting value to the African is being carried out by one medical officer who

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<sup>102</sup> NAZ, S1820/9/11, Kennedy to Martin, 2 Feb. 1936 (enclosing *The Bulawayo Chronicle* clipping)

<sup>103</sup> NAZ, S1820/9/11, Kennedy to Martin, 2 Feb. 1936.

<sup>104</sup> Southern Rhodesia, *Report of the Public Health for the Year 1937*, p. 2.

<sup>105</sup> NAZ, S2406/1, Historical Notes on Medical Services, 1942-46, Dyson Blair, ‘A Personal Statement of Personal Views on Preventive Medicine and its Practical Application in Southern Rhodesia, 1935-1945’, 13 April 1945.

works whole-time with Africans', a clear reference to Kennedy.<sup>106</sup> Indeed, in 1945 the National Health Services Commission reckoned that the Ndanga Unit accounted for 37 percent of the 1,224,851 in-patient 'units' of recorded in government clinics in 1944.<sup>107</sup>

The value of the idea behind the Ndanga scheme was also realised later by medical bureaucrats such as Mark H. Webster, a Secretary for Health, who, in 1973, ruefully lamented that 'it is indeed a pity that this very logical pattern of development was not followed completely in the years that came after'.<sup>108</sup> Although Webster acknowledged the logical nature of the district healthcare system as envisaged by Askins, he was also convinced that the Ndanga Unit did not develop into the model scheme that it was initially envisaged to be. In his 1966 annual report he had damningly remarked that,

A very special problem of development is presented by the Ndanga group of hospitals, which is [an] expanded medical slum, in spite of all the valiant efforts of the District Medical Officer who is, incidentally, in charge of more inpatients and outpatients than the Medical Superintendent of Mpilo Central Hospitals.<sup>109</sup>

Certainly, that appalling state was not a recent development in 1966. As the last section of this chapter will show, the continued existence of the Ndanga scheme exemplified two important factors: (a) Kennedy's determination, endurance and foresight and (b) the limits and fragility of colonial healthcare schemes for Africans in Southern Rhodesia.

### **Fig. 3.5: Patients or Slum Dwellers?: Dr Chitiyo with a Group of Patients, mid-1960s**

<sup>106</sup> NAZ, S2406/1, Blair, 'A Personal Statement'.

<sup>107</sup> Southern Rhodesia, *Report of the National Health Services Commission 1944-1945*, p. 66.

<sup>108</sup> Mark H. Webster, 'A Review of the Development of the Health Services of Rhodesia from 1923 to the Present Day', *The Central African Journal of Medicine*, vol. 19, no. 1 (Jan. 1973), p. 9.

<sup>109</sup> Rhodesia, *Report on the Public Health for the Year 1966*, p. 18.



(Photo Courtesy of Dr M. Chitiyo)

**Fig. 3.6: Worn Buildings: A Part of an Unnamed Clinic, mid-1960s**



Photo Courtesy of Dr M. Chitiyo

### **Struggles over the improvement of facilities**

Although in documents meant for public consumption at the time, the launch of the Ndanga Unit in the early 1930s was clad in grandiose discourse as a model scheme,<sup>110</sup> this public show masked private concern and the complexities associated with developing healthcare services for Africans. In private correspondence, he frankly admitted right from the outset that, ‘the upkeep of the native clinics has turned somewhat more expensive than we anticipated’.<sup>111</sup> The difficulty of finding a ready funding did not dampen his spirits though. Indeed, he continued to use his position to find ad hoc funding for the scheme. However, after his death in 1935, his scheme was bound to suffer because Kennedy, a non-policy maker, had remained as its sole advocate. To illustrate the difficulties encountered, it may be useful to trace developments surrounding two key services that were central to the success of the scheme, viz. water and electricity services. The discussion will also be extended by a look into struggles over the maintenance and improvement of the Unit’s facilities.

When the scheme was launched in the early 1930s, water was provided through an ox-drawn cart which was ‘now entirely worn’.<sup>112</sup> Although the logical thing to do was to replace the water cart immediately, both Askins and Kennedy were aware that for a hospital that was envisaged to grow significantly into a district headquarters, providing water by such means was not sufficient. An initial attempt to sink a well in the vicinity of the hospital failed.<sup>113</sup> At the beginning of 1934, therefore, Askins commenced negotiations with the Irrigation Department, aimed at the installation of a water engine.<sup>114</sup> That process took almost three years to complete as a 3H.P. engine was only installed towards the end of 1936, after much effort and disappointment, including the deletion of this item from the 1934/5 financial

<sup>110</sup> Southern Rhodesia, *Report on the Public Health for the Year 1933*, p. 12

<sup>111</sup> NAZ, S1820/8, Askins to Kennedy, 20 Oct. 1933.

<sup>112</sup> NAZ, S1820/8, Kennedy to Askins, 16 Feb. 1933.

<sup>113</sup> NAZ, S1820/8, Kennedy to Askins, 2 Aug. 1933.

<sup>114</sup> NAZ, S2410/16/2, Ndanga Hospital: Buildings, 1934-48, Askins to Chief Irrigation Engineer, 31 Jan. 1934.

estimates, without the medical director's knowledge.<sup>115</sup> However, the 1936 installation of the pump proved to be the proverbial too little, too late, because the hospital's water woes continued unresolved. Indeed, in 1946, a senior public health official admitted that 'water supply at this hospital is not satisfactory'.<sup>116</sup>

Efforts to install electricity also encountered difficulties. Although Kennedy's request for the installation of an electricity generation engine began soon after his arrival at the hospital in 1932, his need for electrical power became stronger in 1935, following the delivery of the long-awaited theatre equipment by the Public Health Department. In February 1936, he requested the new Medical Director, Dr. Martin, to seriously consider electrifying the hospital because 'I have recently had occasions on which I performed some operations with the aid of hurricane lamps, and the contrast of [a] nice operating theatre illuminated by a few natives swinging hurricane lamps was incongruous'.<sup>117</sup> However, that did not produce rapid results and further petitioning followed later that year, when the Beit Trustees donated an X-ray unit to the hospital.

Perhaps irritated by the persistent requests from Ndanga, at one point the Internal Affairs Minister coldly said that, 'the hospital has been in existence for years without electric light or X-ray plant'.<sup>118</sup> Eventually, however, a 2,000-watt, 110-volt electricity generation plant was installed in 1937.<sup>119</sup> It can be inferred that it was because of the difficulties encountered in achieving the initial set-up of electricity generation that, when another engine destined for the urban Fort Victoria Hospital was delivered to Ndanga by mistake, Kennedy did not hesitate

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<sup>115</sup> NAZ, S2410/16/2, Askins to Secretary for Internal Affairs, 4 June 1934.

<sup>116</sup> NAZ, S2410/16/2, W. F. Wayne to Director of Irrigation, 27 June 1946.

<sup>117</sup> NAZ, S2410/16/1, Ndanga Hospital (General File I, 1934-1937), Kennedy to A. P. Martin, 10 Feb. 1936.

<sup>118</sup> NAZ, S2410/16/1 Ndanga Hospital (General File II, 1936-1938), Secretary for Internal Affairs to Medical Director, 5 Oct. 1936.

<sup>119</sup> NAZ, S1563/2, Native Commissioners Annual Reports, 1937, Report of the Native Commissioner, Bikita, 1937.

to encase it and connect it to his hospital's power system.<sup>120</sup> When the mistake was later discovered 'it was impossible to relocate the efficiently installed generator from Ndanga'.<sup>121</sup>

Further difficulties were encountered in the maintenance of the infrastructure, which required frequent renovation and expansion to cater for the increase in patient numbers. Already within a few months of their establishment, in the Chikuku and Siawareba dispensaries patients were resorting to erecting their own huts because of inadequate accommodation.<sup>122</sup> By early 1936, all the existing clinics had become an eyesore, and Kennedy concluded that the time for the abolition of the original pole-and-mud huts and their replacement with Kimberley brick and grass thatch huts had arrived:

I think the time has now come in this Unit to have something a bit better than the old pole and dagga units. It is going to save me a lot of trouble and worry – with probably no result in the end – if I could put up say 14 Kimberley brick and thatched huts, 12 foot square, at each of the 4 clinics.<sup>123</sup>

However, four years later, these pole-and-mud huts were still the backbone of the Unit's patient accommodation because the funds for initiating a more durable form of accommodation were not easily forthcoming.<sup>124</sup> It is not clear why the system started in 1936 of building rural clinics through pre-cast and corrugated iron material did not cover Ndanga. Thus, to stretch the little funds he was getting from treasury, Kennedy turned his hand to local brick-making and fund-raising arrangements. He started selling the cattle hides and mealie meal sacks which were residues of the Unit's patient rations programme, and used the money to fund maintenance work in the Unit. However, this practice was criticised and stopped by state administrators in 1941 because it was done without the knowledge of

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<sup>120</sup> Saunders, 'Doctor in the Lowveld Wilderness', p. 17.

<sup>121</sup> Saunders, 'Doctor in the Lowveld Wilderness', p. 17.

<sup>122</sup> NAZ, 1820/9/2, Kennedy to Medical Director, 18 Oct. 1933.

<sup>123</sup> NAZ, S1820/9/2, Kennedy to Martin, 10 April 1936.

<sup>124</sup> NAZ, S1820/9/2, Kennedy to Martin, 27 April 1940.

Treasury officials and was therefore considered to be an improper disposal of state property.<sup>125</sup>

In 1944, following his return from wartime service, Kennedy expressed his intention to build a modern hospital with wards accommodating about 100 patients. His wish was to have a centralised hospital with four wards, each with 20 beds, and an additional children's ward with ten beds and a ten-bed maternity ward with labour and sluice rooms. In addition to that, he also wanted new accommodation for eight married orderlies and 23 other staff with families.<sup>126</sup> Budget estimates were submitted in time for the 1944/45 financial year. However, in April 1945, it was discovered that those estimates had been deleted from the final estimates, and therefore the Public Works Department could not proceed with the work.<sup>127</sup> When he attempted to proceed with the work through the agency of the Public Health Department's Contractor of Native Clinics, he was warned that it is 'highly probable that European artisans will refuse to carry out maintenance work, or install electric lighting and plumbing.'<sup>128</sup>

During 1945 Prime Minister Huggins instructed the Public Health Department to hand over its construction unit and clinic buildings to the Engineering Unit of the Native Affairs Department and the Public Works Department, in a move designed to centralise all construction work because of war-induced shortages of building materials. Rather unwisely, but perhaps normal for him, Kennedy began addressing his construction-related memos directly to the Native Affairs Department's Engineering Unit instead of channelling such communication through the Public Health Department. This provoked the ire of the Public

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<sup>125</sup> NAZ, S1773/337, Proceedings of an Inquiry Held by the Public Services Board into Charges Preferred against J. H. Kennedy, 22 Sept. 1941.

<sup>126</sup> NAZ, S2410/16/2, W. F. Wayne to Director of Public Works, 20 Jan. 1945.

<sup>127</sup> NAZ, S2410/16/2, W. F. Wayne to Kennedy, 20 April 1945.

<sup>128</sup> NAZ, S2410/16/2, Director of Public Works to Medical Director, 28 March 1945.

Health administrators, who angrily reminded him that no expenditure in his Unit would be incurred without the approval of the parent Department.<sup>129</sup> At that point there were 103 huts at Ndanga hospital alone requiring refurbishment and 14 more requiring construction. On top of that, all the outlying clinics had about 20 huts each requiring repair.<sup>130</sup> Some of these huts had no doors, and patients ‘hung up dried cattle hides over the opening in an attempt to keep out the elements and obtain some privacy’.<sup>131</sup>

Concrete plans to reconstruct Ndanga Hospital along the lines envisaged by Kennedy were eventually made in 1947. The directorship of the Public Health Department had by then been taken over by Dr Richard Morris, Kennedy’s junior in the service, who later wrote a warm tribute to his senior in years when he retired from Ndanga in 1959.<sup>132</sup> In 1948, the construction of a new, modern hospital was begun. The hut system was not immediately phased out, however; it continued as the backbone of the Unit, especially in outlying dispensaries. The only improvement was the gradual phasing out of the pole-and-mud huts and their replacement with Kimberley brick and grass thatch huts. In the early 1960s the number of huts in the Unit as a whole was reckoned to be as many as 800.<sup>133</sup> In this regard, Ndanga was a unique entity. Other state clinics that followed the model introduced by Martin in 1936 were smaller and mainly catered for out-patients. The reasons why Kennedy continued to pursue his own model of sub-hospitals will be addressed fully in the next chapter.

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<sup>129</sup> NAZ, S2410/16/2, W. F. Wayne to Kennedy, 30 Nov. 1946.

<sup>130</sup> NAZ, S2410/16/2, Kennedy to Acting Chief Engineer, 21 Nov. 1946.

<sup>131</sup> NAZ, S1563, Report of the Native Commissioner, Gutu, for the Year 1946.

<sup>132</sup> R. M. Morris, ‘Dr James Kennedy-A Tribute’, *Central African Journal of Medicine*, vol. 5, no. 7 (1959), p. 378.

<sup>133</sup> Ndanga Hospital Registry, Miscellaneous Papers, R. W. Doy to District Surveyor, 2 Oct. 1963.

**Fig. 3.7: A Part of an Unnamed Clinic, mid-1960s**



**Photo Courtesy of Dr M. Chitiyo**

### **Conclusion**

This chapter has served to demonstrate the possibilities and constraints associated with the pioneering and further development of the Ndanga Unit. It has done so by tracing the complex, multiple, micro-histories surrounding the development of the Unit's physical facilities. The main conclusion of this chapter is that the scheme's imperfections notwithstanding, the persistent, albeit controversial, efforts made by Kennedy explain the continued existence and expansion of the Unit which was all that could be pointed to as the colony's own half-hearted efforts at delivering district healthcare services to Africans. The chapter also noted that, while Kennedy's determination held the fragile system together for so long, his task would have been impossible without the support of the African communities.

However, a full picture on Kennedy's work in Ndanga cannot be drawn from this aspect only. Instead, struggles over the provision of infrastructure constituted one strand of a complex, fragile and yet distinctive rural medical practice. The next chapter explores the type of

medical practice espoused and practised by Kennedy within the institutions he strove so much to set up and run. Like this present chapter, the next chapter also continues to look out for the openings and constraints encountered during the process of developing a rural healthcare system for Africans. What this chapter has attempted to show is that the development of rural healthcare was susceptible to settler politics, the changing interests of the medical directors and the personal interests of the presiding medical officer. Local communities also played their part.

University of Cape Town

## Chapter 4

### **‘His own very special brand of social medicine’: The medical approach of Dr. James H. Kennedy**

#### **Introduction**

‘Having thus created the physical facilities, he then introduced his own very special brand of social medicine’, noted one contemporary reviewer of Kennedy’s accomplishments when he retired from Ndanga in 1959.<sup>1</sup> Another eyewitness observer added that while at Ndanga, ‘Dr Jim Kennedy was practising family and community medicine... long before the concept became fashionable, as it did after the 1939-45 war’.<sup>2</sup> These claims made on behalf of Kennedy are both profound and vexing at the same time. In his own memoirs published in 1957 in the *Central African Journal of Medicine* at Michael Gelfand’s request, Kennedy described what he did at Ndanga but never referred to his approach as social, community or family medicine.<sup>3</sup> Unfortunately, he did not write much else besides these brief memoirs.

However, the greatest risk for the historian writing on his medical approach does not lie in incorrectly certifying that his approach indeed contained some of the basic elements of community healthcare and family medicine (or social medicine). As we know them today, the specialties that were later formalised as community/family medicine in the post-war period originated from different practical experiences and evolved in connection with the knowledge and skills of the general practitioner – or the ‘all-rounder’ as opposed to the specialist. As

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<sup>1</sup> Richard M. Morris, ‘Dr James Kennedy: A Tribute’, in *Central African Journal of Medicine*, vol. 5. No. 7 (1959), p. 378. The Ndanga Medical Unit was the only surviving experiment of an abandoned concept of medical units which was formulated by Robert A. Askins (medical director, 1930-1935) in 1930 as part of his determined efforts to introduce organised medical services to the rural Africans.

<sup>2</sup> Dyson M. Blair, ‘Obituary: Dr. J. H. Kennedy, O.B.E’, in *Central African Journal of Medicine*, vol. 13, no. 12 (Dec., 1967), 294.

<sup>3</sup> James Kennedy, ‘Bygones of a Bundu Bone Thrower: Part I’, *Central Africa Journal of Medicine*, vol. 3, no. 6 (June, 1957), pp. 235-240; Kennedy, ‘Bygones of a Bundu Bone Thrower: Part II’, *The Central African Journal of Medicine*, vol. 3, no. 7 (July, 1957), pp. 272-274; Kennedy, ‘Bygones of Bundu Bone Thrower: Part III’, *Central African Journal of Medicine*, vol. 3, no. 8 (Aug., 1957), pp. 315-323. Michael Gelfand, a colonial doctor and medical academic of liberal and philanthropic inclinations was the founder and editor of the Journal until his death in the early 1980s.

Steven Dennis has noted, the contemporary field of family medicine emerged out of the need for an all-embracing ‘new physician’ trained in the ‘old fashioned relationship’, that is, ‘a physician who would not only appreciate the patient as a total person, but who would also appreciate the patient in the context of a social unit known as the family, and by extension, in the context of the patient’s environment as well’.<sup>4</sup> Kennedy’s medical approach at Ndanga fits this description very well; for him therefore it was a matter of systematically practising the rudiments of something that was later correctly characterised by his biographers.

Instead, the risk lies in either rehearsing the maligned great man medical histories of the bygone historiographical era or completely dismissing his approach as smacking of colonial and biomedical ethnocentrism, paternalism and a sense of superiority. Indeed, in recognition of his unique innovations, Kennedy was elegantly decorated by his contemporaries as Southern Rhodesia’s own Albert Schweitzer, while that part of Fort Victoria where he rendered his services ‘became Jim Kennedy’s kingdom, and almost every facet of its life is indebted to him in some way or another’.<sup>5</sup> While these claims are certainly overly celebratory and sensationalist,<sup>6</sup> it is however true that Kennedy did much in advocating and personally organising resources by himself on behalf of the communities he served. He also sought to build good relations with the communities served by the Ndanga Unit, although his ‘decidedly unorthodox’ mannerisms and habits could have undermined some of these efforts, especially in the eyes of those who scarcely knew him.<sup>7</sup>

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<sup>4</sup> Steven Dennis, ‘The History of Family Medicine’, Slide no. 30. Available from: <http://www.docstoc.com/docs/2193005/The-History-of-Family-Medicine>. Accessed on 29 July 2011.

<sup>5</sup> Richard M. Morris, ‘Dr James Kennedy: A Tribute’, in *Central African Journal of Medicine*, vol. 5. No. 7 (July, 1959), p. 377.

<sup>6</sup> On the sensational nature of colonial medicine, see Anna Crozier, ‘Sensationalising Africa: British Medical Impressions of Sub-Saharan Africa, 1890-1939’, *Journal of Imperial and Commonwealth History*, vol. 35, no. 3 (Sept., 2007), pp. 393-415.

<sup>7</sup> Colin Saunders, ‘A Doctor in the Lowveld Wilderness: The Story of James Kennedy OBE of Ndanga’, *Heritage of Zimbabwe*, no. 19 (2000), p. 18.

The aim of this chapter is, therefore, to wade through this complicated account, recognising the pragmatism of Kennedy's ideas without at the same time accentuating the sensationalist and heroic gloss encapsulated in contemporary reviews. The chapter notes that the gradual extension of regular medical services into the hitherto underserved rural areas during the mid-twentieth century offered innovative frontier medical practitioners like Kennedy opportunities for pioneering ideas formulated from a mosaic of floating concepts and models of care. Within the complex matrix of colonial power relations such doctors, to a certain extent, became the 'attorney to the poor'.<sup>8</sup> At the same time, that process raised new sets of questions and complications related to the distorting colonial environment wherein the white doctors were both professionals and colonisers.<sup>9</sup> While Kennedy's understanding of the nature of rural diseases did reflect a creative understanding, he at the same time overlooked the complicity of colonialism and concentrated on promoting biomedical precepts and institutions among the supposedly 'wild' and 'primitive' people.

The chapter begins with an outline of the different aspects of Kennedy's 'own very special brand of social medicine', and then proceeds to explore the paradoxical origins of these ideas amidst the high-tide of curative biomedicine and the uncertain methodological approaches to rural healthcare in the colony. This section is followed by a critique of his approach and accomplishments. In the final analysis, the chapter argues that Kennedy's approach was more one of basic pragmatism laced with benevolent ethnocentrism rather than any concerted effort to profoundly change the social and cultural bases of colonial biomedical practice. The chapter advances from another angle the ideas raised in earlier chapters about the bifurcated

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<sup>8</sup> The idea of a physician being the advocate for the poor is traced back to the father of cellular pathology and advocate of socio-political change, Rudolf Virchow. See Dorothy Porter, 'Introduction', Dorothy Porter (ed.), *Social Medicine and Medical Sociology in the Twentieth Century* (Amsterdam – Atlanta, GA: Rodopi, 1997), p. 5.

<sup>9</sup> Frantz Fanon, *A Dying Colonialism* (New York: Grove Press, 1965), pp. 21-40, notes this ambiguity in colonial medicine. Fanon believed that medicine was not inherently bad as it concerns itself with man's health and the relief of pain, but he sharply criticised its insidious elements.

nature of colonial healthcare and the tensions between innovative practice and colonial ambitions.

### **On Kennedy's innovations**

Kennedy's initial pragmatic realisation was that his initial priority was to develop facilities capable of treating 'large numbers from a very large area for prevalent endemic diseases rather than for the treatment of individual cases, interesting though many of the latter might be'.<sup>10</sup> The previous chapter dealt with this aspect of his work extensively, indicating how he went about setting up the required facilities and the extent of his success in that regard. Therefore here it may be useful to rather focus on some of the major diseases that he encountered and sought to overcome. Since a later chapter will return to a full exploration of this subject from a public health perspective, this present reflection will be confined to the early data about the prevailing diseases around which Kennedy might have began forming his initial opinions. Where possible, it will also focus on his opinions and reflections over the years.

Sparse and crudely collated data for the period from the 1920s to the 1940s gives some rough indications of the prevalent diseases encountered by Kennedy. Epidemic smallpox outbreaks were reported to be a common feature in the region, particularly in Bikita, which, for most of the period under review, continued to be the epicentre of such outbreaks within the Unit.<sup>11</sup> However, the two leading diseases that frequently recur in the public health writings of the time were syphilis and yaws (known to local Africans as *njovera*). Syphilis is 'very prevalent', 'venereal diseases are prevalent' and the 'government medical officer [Kennedy]

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<sup>10</sup> Kennedy, 'Bygones of a Bundu Bone Thrower: Part I', p. 235.

<sup>11</sup> NAZ, NVB1/1/2, Native Commissioner, Bikita, Monthly General Reports, 1917-1921, Health Report for the Month of August 1921; NAZ, S1618, Quarterly Review of Native Affairs, 4 Nov. 1930; NAZ, S1563/2, Native Commissioners Annual Reports, 1937, Report of the Native Commissioner, Ndanga, for the Year Ended 31 Dec. 1937.

estimated that it [syphilis] was the cause of at least 78% of the cases treated by him', were diagnoses regularly reported during the early 1930s.<sup>12</sup> According to reports sent to the Public Health Department by Kennedy around 1933/4, yaws was 'very prevalent' and affected a 'large portion of the population', leaving many of them with 'grave mutilations of the skull and other bones'.<sup>13</sup>

Malaria was also discovered to be prevalent and the southern parts of Ndanga and Bikita were regarded as the malaria hotspots because of the humid and riverine nature of the area. One report stated that, 'towards the end of the rainy season it is difficult to find a child without splenic enlargement'.<sup>14</sup> Many children also tested for broncho-pneumonia. Other diseases which were found to be common included enteric fever (typhoid), dysentery, bilharzia, hookworm, measles, whooping cough and epidemic influenza.<sup>15</sup> Advanced cases of tuberculosis were also frequently encountered. Nutritional deficiency diseases such as scurvy were also commonly reported, and Kennedy did some nutrition surveys during some years.<sup>16</sup>

Moreover, a great many injuries and maternity work were also dealt with. Also, in addition to the mainly acute, infectious diseases, maternity cases and injuries, Kennedy also frequently encountered neurological, degenerative and genetic or hereditary diseases. Common among them were leprosy and epilepsy (also commonly known as burns). In 1932 a medical survey was done in Gutu and nine leprosy cases were discovered among 9, 608 people examined.<sup>17</sup>

Although the norm was to refer lepers to either Ngomahuru Leprosarium or Morgenster

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<sup>12</sup> NAZ, S1563, Native Commissioners and Acting Native Commissioners Annual Reports, 1934, Report of the Native Commissioner, Ndanga District, for the Year Ended 31 Dec. 1934; NAZ, S1563/2, Report of the Native Commissioner, Ndanga, for the Year Ended 31 Dec. 1936.

<sup>13</sup> Southern Rhodesia, *Report on the Public Health for the Year 1934*, p. 12.

<sup>14</sup> Southern Rhodesia, *Report on the Public Health for the Year 1934*, p. 12.

<sup>15</sup> NAZ, S1563/2, Reports of Native Commissioners, Bikita, Gutu and Ndanga, 1932-1945.

<sup>16</sup> NAZ, S1563/2, Report of the Native Commissioner, Ndanga, for the Year Ended 31 Dec. 1944.

<sup>17</sup> NAZ, S1618, Chief Native Commissioner's Quarterly Review of Native Affairs, 1927-1936, Quarterly Review, 30 Sept. 1932.

Mission (near Fort Victoria), some refused, and deaths were frequently reported. Cases of cancer were also encountered. Therefore, as Askins correctly put it, commonly found in the Ndanga Unit were 'all types of medical, surgical and obstetric cases'.<sup>18</sup>

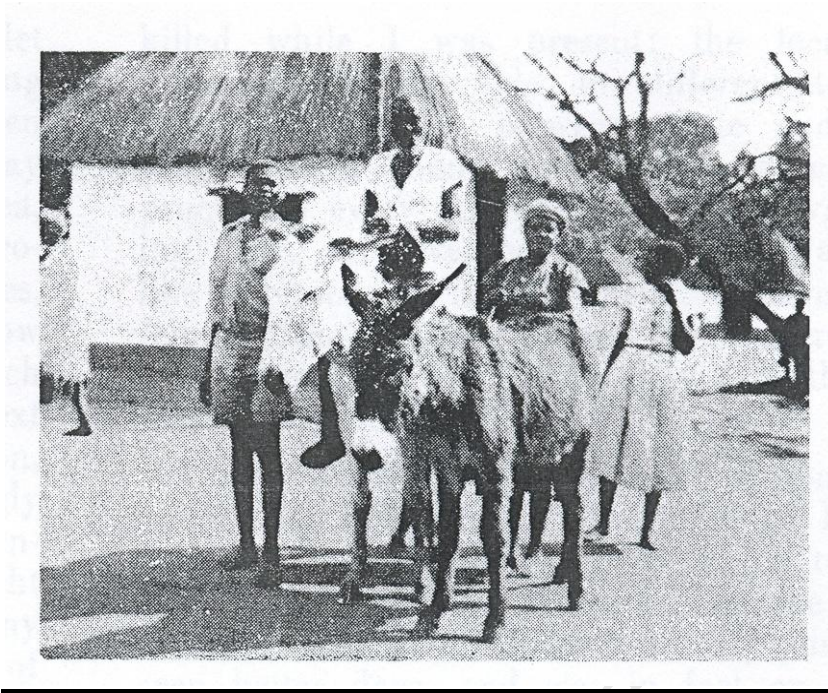
In his memoirs, Kennedy published some graphic images of some disfiguring maladies he encountered in Ndanga (see Fig. 4.1-4.4 below). The publication of such grotesque images, which certainly raise ethical questions given the fact that their publication did not serve an immediate medical educational purpose, might have been motivated by the desire to paint himself as having been up against horrific, disfiguring health conditions. Accompanying his heroic memoirs, these images were certainly meant to present an image of a heroic pioneer. In addition, the images also fed into the obsession with physical health since a great deal of the diagnosis in rural areas was done through eyesight. Indeed, some interviewees recall that Dr Kennedy was 'good in diagnosis using his eyes. If you went to hospital with a sore leg he would look at it and immediately know what to use to treat you'.<sup>19</sup> These photographs are therefore part of the physical culture of colonial medicine and they give some indication as how colonial medical practitioners formulated their opinions.

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<sup>18</sup> Southern Rhodesia, *Report on the Public Health for the Year 1933*, p. 15.

<sup>19</sup> Interview with Kwasara, Ndanga, 15 July 2010.

**Fig 4.1: A Leper at an Outlying Clinic**



**Source:** Kennedy, 'Bygones of a Bundu Bone Thrower: Part III', p. 315.

A disease that evoked pathos, horror, segregation and enjoyed a British, empire-wide control attempt in the form of British Empire Leprosy Relief Association (BELRA),<sup>20</sup> leprosy was bound to excite Kennedy's imagination as a frontier doctor. 'The arrival of a good leper, plus entourage, at an outlying clinic', as his caption to the photograph reads, suggests that the occasion could not be missed as a photo opportunity to illustrate the confidence people had in his biomedical knowledge. Another disfiguring disease that he sought to illustrate photographically, was Ascites, a disease physically recognised through abdominal swelling as indicated in the photograph below (Fig. 4.2).

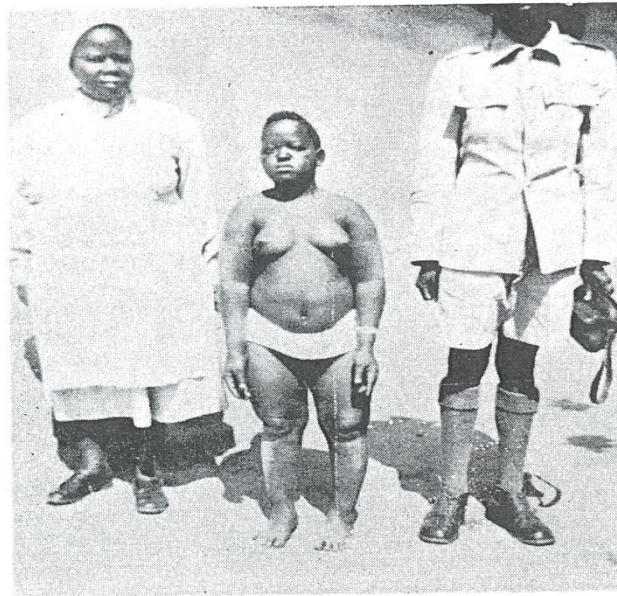
<sup>20</sup> Michael Worboys, 'The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940', *Osiris*, Second Series, vol. 15 (2000), pp. 207-218; Gerald C. Mazarire, 'A 'Little England' in Chishanga: The Fate of British Empire Leprosarium at Ngomahuru, 1925-1946', *African Historical Review*, vol. 39, no. 2 (2007), pp. 1-24

**Fig. 4. 2: A Case of Ascites**



**Source:** Kennedy, 'Bygones of a Bundu Bone Thrower: Part I', p. 238.

**Fig. 4.3: A Case of Frohlich's Syndrome**



**Source:** Kennedy, 'Bygones of a Bundu Bone Thrower: Part I', p. 238.

The two other cases paraded by Kennedy were those of Frohlich's Syndrome (Plate 4.3), a syndrome of obesity and disturbed hormonal growth, and Neurofibromatosis or von

Recklinghausen (Plate 4.4), a genetic disorder that manifests itself through some malignant tumours all over the body.

**Fig. 4.4: A Case of Neurofibromatosis (aka von Recklinghausen)**



**Source:** Kennedy, 'Bygones of a Bundu Bone Thrower: Part I', p. 238.

With this wide range of maladies both described in word and illustrated in picture, Kennedy formed his opinion around the fact that many of the diseases found in the Unit affected families rather than individuals, and also that cases of co-infection were frequent and required probing. He thus set out to organise a district healthcare system, with one of the priorities being the recruitment of the necessary staff. These would help him and his wife who was the matron to run the hospital and its outlying stations. He devised a local recruitment and training scheme through which he trained his own African medical assistants as apprentices at the main hospital, before deploying some of them to run the clinics. The colony's national

medical training scheme for Africans only took off in the late 1930s, and even then on a very modest scale, enrolling a very small number (8-10 per year) of orderlies well into the 1940s.<sup>21</sup>

However, there is a dearth in detailed sources on the main features of the training scheme. The few available sources include Kennedy's own memoirs which are problematic not only because of the propensity to exaggerate, but also because they gloss over the scheme. However, in some cases they are corroborated by the few oral testimonies of the few surviving former trainees. In these memoirs, Kennedy says the training was done 'on eminently practical lines', focusing on the diagnosis of common diseases, measuring dosages, the various techniques of administering injections, dressing wounds, the making of common stocks of medicines, dispensing medicine and later on, midwifery.<sup>22</sup> Ninety-one year old Rebecca Shoko, a surviving trainee in Kennedy's apprenticeship programme, recalled her own fading memories of the informal recruitment and training process. Shoko's memories give some vague but useful pointers on the programme.

Shoko recalled that sometime in the 1940s her child had been admitted to the hospital from Gutu clinic. Kennedy had personally brought her and the sick child during one of his return trips from the Gutu clinics. Like other people taking care of their sick relatives, she was expected to take part in the routine cleaning of the hospital grounds. One day while she was doing that, Sister Dale, the matron, said to her, 'this lady seems to be smart, call her'. She was then taken to the matron's office and was shown some medicine bottles and instructed to clean them every morning. Thereafter, Sister Dale started asking her the names of the medicines written on the containers and when the responses satisfied her, she was offered an

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<sup>21</sup> Michael Gelfand, *A Service to the Sick: A History of the Health Services for Africans in Southern Rhodesia, 1890-1953* (Gwelo: Mambo Press, 1976), p. 138; NAZ, S482/152/41, Native Medical Education, Acting Medical Director to Prime Minister, 31 Sept. 1941.

<sup>22</sup> Kennedy, 'Bygones of a Bundu Bone Thrower', pp. 239-240.

opportunity to train as an orderly. Her husband who was then a migrant worker in Johannesburg had to be informed first before she started the training.<sup>23</sup>

Rebecca Shoko is certainly too old to remember all the details and their chronology with precision. Nevertheless, her memories give some hint about the informal recruitment process and the practical training involved, including the memorisation of drug names. Another apprentice, stayed in the African workers' quarters with his father who was a general hand at the main hospital. When he came of age, Kennedy enlisted him for training as an orderly.<sup>24</sup> His training involved instruction and demonstration of all the necessary first aid and nursing duties. A kind of 'postgraduate' training in midwifery was also offered to the seniors. John Iliffe talks about a similar apprenticeship programme in East Africa where most would-be medical assistants were first given menial responsibilities and then gradually introduced to medical work.<sup>25</sup>

That during the first decade of the scheme the local apprenticeship scheme was the mainstay of the staffing programme in the Unit can be illustrated by the staff statistics for the 1940s. In 1941, the entire Unit had a total of twenty-three African orderlies, with twelve of these being senior orderlies (or orderlies-in-charge of outstations) and the rest assistant orderlies.<sup>26</sup> Among those listed as head orderlies in charge of outstations, six were trained at Ndanga hospital, four were immigrants from Nyasaland, two were graduates of Southern Rhodesia's newly-established government training schools in Salisbury and Bulawayo, and two were trained at the American Board Mission's Mount Selinda Hospital located in Melsetter, east of

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<sup>23</sup> Interview with Rebecca Shoko, Bikita, 19 Sept. 2010.

<sup>24</sup> Interview with Badza Jr., Ndanga, 15 July 2010.

<sup>25</sup> John Iliffe, *East African Doctors: A History of the Profession* (Cambridge: Cambridge University Press, 1998), p. 2.

<sup>26</sup> NAZ, S1173/337, Ndanga Clinic, 1936-1948, List of Native Orderlies and Native Labourers at Ndanga Hospital and Outlying Clinics, 1941.

Ndanga.<sup>27</sup> Most of the assistant orderlies were also local apprentices. In other words, the local training scheme was the single largest source of orderlies employed in the Unit. The major advantage of such a scheme was that the orderlies so-trained were conversant with local culture and were also competent in dealing with the specific diseases affecting that district. One of the main disadvantages, as will be elaborated in a later chapter, was that such orderlies tended to be subject to the whims of their trainer, the medical officer.

Kennedy's other innovation was the organisation of in-patient life along family and community lines. Ndanga hospital and its satellite clinics did not operate like other conventional medical institutions. For nearly two decades of its existence as the Unit's district headquarters the hospital did not have formal beds like other hospitals. Its central building, as noted earlier, consisted of a private consultation room, a theatre, an open air consultation and dressing shade and a dispensary. Patients were housed in purpose-built patients' villages which were teeming with one-room, pole-and-mud and (later) Kimberley brick and grass thatch huts whose number reached hundreds. This patients' village system was replicated in the outstations, which were essentially sub-hospitals because they also admitted large numbers of in-patients (see Table 4.1 below). Their main difference from Ndanga hospital was that the outstations did not have operating facilities and a resident doctor. They also had lesser capacity than the main hospital.

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<sup>27</sup> NAZ, S1173/337, List of Native Orderlies and Native Labourers at Ndanga Hospital and Outlying Clinics, 1941.

**Table 4.1: Patient Returns for Ndanga Medical Unit, Jan. – June 1940**

<b>Hospital/Dispensary</b>	<b>In-patients</b>	<b>Out-patients</b>	<b>Daily units*</b>
Mashoko	656	1 066	23, 095
Siawareba	287	579	9, 700
Chikuku	785	947	21, 984
Chikwanda	560	441	14, 908
Gutu	680	1, 200	14, 604
Bikita	510	469	13, 622
Chichidza	335	438	13, 142
Chiduma	188	209	6, 152
Chingombe	348	257	9, 310
Ndanga Hospital	1, 438	347	34, 467
<b>Grand Totals</b>	<b>5, 787</b>	<b>5, 953</b>	<b>160, 984</b>

**Source:** NAZ, S1820/9/1 Ndanga Clinic, 1933-1940, Ndanga Unit Returns, Jan. – June, 1940. \* One patient maintained (admitted) for one day.

In these villages, patients were allowed to bring their family helpers who provided around-the-clock care to their sick relatives. If big enough, each family was given a hut and allowed to bring their pots, blankets and other necessary personal effects.<sup>28</sup> Free food rations consisting of mealie-meal, beans, salt, nuts and beef were issued to cater for both the patient and family helpers who prepared the food in their own ways and fed the patients. Meat rations were run on the hoof and, periodically, beef cattle were slaughtered and rations distributed to patients and orderlies alike.<sup>29</sup> Sometimes buffalo meat hunted by Kennedy was used to supplement these rations. A garden and an orchard were planted to provide vegetables

<sup>28</sup> Each hut was designed to accommodate about eight patients at a time.

<sup>29</sup> Interview with P. Badza, Ndanga, 15 July 2010; Blair, 'Obituary: Dr. J. H. Kennedy, O.B.E', p. 294.

and lemon juice for the production of ascorbic acid used in the treatment of scurvy cases. Milk cows were also hired from local African peasants to produce milk, mainly for children and babies.<sup>30</sup>

In addition to cooking, helpers were also responsible for helping patients with bathing, cleaning in-patient huts, as well as the hospital precincts.<sup>31</sup> During medication times, a whistle was blown and family helpers were expected to bring patients to the medication shade where treatment was administered.<sup>32</sup> However, in 'Jim Kennedy's kingdom' these patient helpers also became subjects of the determined, frontier doctor's third innovation: family diagnosis. When family members brought their sick relatives, he encouraged all of them to submit to medical examination and in the majority of cases they also ended up being patients. All were then fed and treated for similar or different diseases while living in the teeming patient quarters.<sup>33</sup>

This system was deprecated by administrative officials from the Public Health Department as it tended to significantly increase the number of people who were considered to be suffering from minor illnesses that could be dealt with as out-patients cases but who were instead being kept in hospital and fed at government expense. In October 1936 W. Proctor, a Public Health Department official queried the returns from Bikita clinic, which showed that during each month 800-1,000 'units' (in-patients admitted for one day) were entered as 'helpers'.<sup>34</sup> While Proctor admitted that the practice could not be entirely avoided, he was of the view that if

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<sup>30</sup> NAZ, S1820/8, Ndanga Hospital, 1933-1934, Native Commissioner, Zaka, to Superintendent of Natives, Fort Victoria, 21 Sept. 1933. The hospital was provided with pastures where the heads of beef cattle for patient rations grazed while awaiting slaughter.

<sup>31</sup> Interview with Rebecca Shoko, Bikita, 19 Sept. 2010.

<sup>32</sup> Interview with P. Badza, Ndanga, 15 July 2010; Interview with J. Zingoni, 13 July 2010.

<sup>33</sup> Colin Saunders, 'A Doctor in the Lowveld Wilderness: The Story of James Kennedy OBE of Ndanga', *Heritage of Zimbabwe*, no. 19 (2000), p. 7.

<sup>34</sup> NAZ, S1820/9/2, Ndanga Clinics, 1933-1940, W. Proctor to Kennedy, 22 Oct. 1936. 'Units' refer to each patient kept or seen in hospital per day.

‘figures reach these proportions it is evident that the custom is being abused’.<sup>35</sup> He exhorted Kennedy to ‘endeavour to reduce the number of ‘helpers’ at Bikita and at any other dispensaries where the same system is in practice’.<sup>36</sup>

However, Kennedy defended the practice,

A native woman, presenting a gross syphilitic ulcer, arrives with two or three children. Of these, one is a most obvious congenital syphilitic child; another, she will inform you, had sores at the angles of the mouth or in the groins, etc, while the third never had any sores. Of these four, the woman will be entered as syphilitic, and the three children as *perekedzas* or helpers, whereas, actually, three of the four are definitely syphilitic and are treated as such.... My difficulty at all my clinics is not that I have people with minor (or no) troubles, but it is the endeavour to keep obviously infectious cases sufficiently long to be, at least, rendered non-infectious.<sup>37</sup>

As such, he considered these helpers to be a ‘necessary evil... comparable to outpatients, whose treatment is merely a waste of time and drugs and dressings in the majority of instances, in that it is spasmodic and under no control’.<sup>38</sup> The system therefore continued as long as Kennedy was at Ndanga. Thus, in 1941, another Public Health Department official, W. F. Wayne, raised the issue with R. D. Williams, the Unit’s white orderly who performed administrative duties:

It has been noted that in the Ndanga clinics a large number of people are brought in as helpers and also that a large number of people are kept in the clinics with minor illnesses. I have to advise you that in the interests of economy and efficiency of the clinics the number of helpers brought in and fed by the government must be reduced to the absolute minimum and patients with minor complaints must attend as outpatients whenever possible. It is not the policy of the government to feed and maintain native patients unless they are sufficiently ill to be considered as in-patients.<sup>39</sup>

However, the practice had become entrenched and therefore difficult to terminate. It will be recalled from the previous chapter that Kennedy’s relations with Public Health Department officials were often unstable. Sometimes his responses to officials’ expenditure-related

<sup>35</sup> NAZ, S1820/9/2, W. Proctor to Kennedy, 22 Oct. 1936.

<sup>36</sup> NAZ, S1820/9/2, W. Proctor to Kennedy, 22 Oct. 1936.

<sup>37</sup> NAZ, S1820/9/2, Kennedy to Proctor, 25 Oct. 1936.

<sup>38</sup> NAZ, S1820/9/2, Kennedy to Proctor, 25 Oct. 1936.

<sup>39</sup> NAZ, S2410/16/2, Ndanga Hospital, 1941-48, W. F. Wayne to R. D. Williams, 6 May 1941.

queries were designed to mock the apparently inconsiderate reasoning of the Public Health Department administrators. For instance, at one point he quipped, ‘the number of patients are by no means constant and, unlike a leper settlement, I cannot [fore]tell how many there will be in any given day’.<sup>40</sup> The food bill continued to be a source of friction between the Unit and the Public Health Department because Kennedy saw it as the surest way of keeping patients in hospital while they received treatment. Indeed, his liberal food rations still colour the memories of the people of Ndanga.

Moreover, Kennedy tried another innovative way of cultivating rapport between the hospital and the surrounding communities. Oral testimonies indicate that every year-end he sponsored Christmas parties which were held at the hospital precincts. Grain was distributed to selected households which were responsible for brewing indigenous beer for drinking during such parties. Beef cattle were also slaughtered for meat rations. Children, especially those who stayed in patient villages and staff quarters, were given gifts of sweets and toys.<sup>41</sup>

Another valorised strategy was to go hunting with local communities, especially the Shangani people who inhabited the area surrounding the elaborately built Chidumo clinic. In Kennedy’s own words, ‘[I]t became immediately obvious to me that the most satisfactory and quickest method of becoming known to – and possibly appreciated by – these people [the Shangani] was to hunt with their men folk’.<sup>42</sup> He further stated that ‘it was the wives and children of those with whom I hunted – and to whom I was, in consequence, known – who subsequently became my first patients’.<sup>43</sup> As already noted in the previous chapter, Chidumo

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<sup>40</sup> NAZ, S1820/9/2, Kennedy to Proctor, 15 May 1938.

<sup>41</sup> Interview with J. Zingoni, Ndanga, 13 July 2010; Interview with Mr Kwasara, Ndanga, 15 July 2010.

<sup>42</sup> Kennedy, ‘Bygones of a Bundu Bone Thrower: Part III’, p. 237.

<sup>43</sup> Kennedy, ‘Bygones of a Bundu Bone Thrower: Part III’, p. 237.

clinic was, in Saunders' terms, Kennedy's 'medical safari'. But where did Kennedy get these ideas which were critiqued as much as they were welcomed?

### **On the origins of Kennedy's ideas**

Kennedy's method of patient care and management originated from a number of ideas and developments. First was the increasing confidence in curative medicine and the associated search for the best ways of getting Africans to submit to such biomedical treatment. As one medical officer, James Leggate put it,

[I]n the last resort the ultimate appeal is just to vindicate white medicine and surgery by a series of cures so that the preponderance of our successes over native herbalists speaks sufficiently loudly to convince even the most superstitious and the most timid.<sup>44</sup>

Second, was the conviction that it was almost impossible to treat Africans as out-patients and, thus, ways had to be devised of treating them as in-patients as much as possible. This was a common belief among colonial medical officials in Southern Rhodesia. For instance, talking about how initiating a large-scale medical service for Africans would invariably lead to the development of a large hospital service, Fleming said:

You cannot tell an ignorant native mother whose child is suffering from an acute and dangerous disease that she is to give it a dose of the prescribed remedy every hour, for she does not know what an hour is, and cannot calculate the dose. I think it may be generally accepted that the maladies of indigenous and uneducated natives cannot satisfactorily be treated by European methods except under supervision, and preferably in hospitals.<sup>45</sup>

Thirdly, Kennedy's ideas were also founded on colonial public health's failure to formulate successful preventive measures. The corollary to this was the effort to make hospitals take on preventive, promotive and curative functions – all at once. For instance, in 1932, a government medical officer for Melsetter District argued that it was difficult to change (supposedly risky) African living habits and, therefore, 'it is not easy to devise any hopeful

<sup>44</sup> NAZ, S1173/333, Natives (Medicines), 1930-32, J. Leggate to Askins, 18 Dec. 1932.

<sup>45</sup> NAZ, S246/608, Medical Assistance to Natives by Government Medical Officers, 1927-1929, Fleming to Colonial Secretary, 21 March 1927.

preventive measures. Increased investigation and treatment [in clinics and hospitals] must remain the method of election, now and for some time to come'.<sup>46</sup> What the medical officer in question, and many like him, did not realise though was that their medical training had actually handicapped them because of its exclusive focus on curative medicine. To compensate for this deficiency, many of them had to use their clinics and hospitals in limited ways to perform certain functions related to disease prevention and health promotion. For instance, Andrew P. Martin (Medical Director, 1935-1945) wrote that,

I hope to see these clinics assuming, in addition to their curative function, a broader health relationship to the people they serve. I look forward to the day when each clinic will be the fountain-head of knowledge of antenatal and child welfare work, sanitation, nutrition, housing, personal and communal.<sup>47</sup>

Kennedy had imbibed these ideas. As he told the Public Health Department in 1936, 'it was felt that treatment of natives as out-patients would, for obvious reasons, be thoroughly unsatisfactory in the vast majority of the cases, and would spell disaster'.<sup>48</sup> For him, therefore, the major task was to 'persuade patients particularly women and children, to come for treatment',<sup>49</sup> as 'to the vast majority, European medical services were unknown – and by them distrusted'.<sup>50</sup>

Having formed the opinion that Africans had to be treated as in-patients, the next step was to find ways of managing in-patient life on a large scale. The idea of patients' villages met this need very well. This system had been practised on a very small scale by his predecessor, Dr. Williams, who had also realised that to encourage patients to remain in hospital for as long as it was necessary, he had to find a way of accommodating patients and a small number of their helpers. As Dr Williams wrote back then in 1913,

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<sup>46</sup> NAZ, S1173/332, Government Medical Officer, Melsetter, to Medical Director, 30 April 1932.

<sup>47</sup> Southern Rhodesia, *Report on the Public Health for the Year 1937*, p. 3

<sup>48</sup> NAZ, S1820/9/2, Kennedy to Proctor, 25 Oct. 1936.

<sup>49</sup> Kennedy, 'Bygones of a Bundu Bone Thrower', p. 237.

<sup>50</sup> Kennedy, 'Bygones of a Bundu Bone Thrower', p. 237.

The native has a great dislike to remaining as in-patients, and treatment as out-patients is very unsatisfactory, if for no other reason than that they do not return when pain and discomfort are relieved. In order to induce patients to remain in hospital two huts have been built so that friends may stay with them for a time.<sup>51</sup>

However, the consolidation of the system under Kennedy was designed to be a solution to another challenge, namely, getting enough nursing orderlies to deal with all the patients admitted. Given the fact that each dispensary was run by two orderlies, it was best to use patient helpers to perform duties related to patient care, while the former did the actual treatment. In that context, food became an important aspect of the management of patient life in the patients' villages. The system of patients' villages therefore made it possible to accommodate several family members as opposed to what was possible in a conventional hospital.

The idea of family diagnosis or screening seems to have naturally developed as an off-shoot of the patients' village system. This one can deduce from Kennedy's words that 'it was perhaps only two or three of a family who actually complained of some illness or other, but it did not take long to discover that each of the whole family suffered from more than one disease'.<sup>52</sup> With only Kennedy's memoirs available on the subject, it can only be speculated that the close interaction that resulted from the system of helpers brought more than one family member to the attention of the observant doctor. Since much of the diagnosis during that time was based on physical observation of symptoms, it could be argued that such initial observations were a first, pragmatic step towards a family screening system.

In adopting all these methods, Kennedy's aim was to reach out to a large number of potential patients by using home life systems. Keen to advance the influence of the biomedical model

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<sup>51</sup> NAZ, H2/4/16, Ndanga District Surgeon, Dr Williams, Report on the Ndanga Native Hospital for the Year Ending 31 Dec. 1913.

<sup>52</sup> Kennedy, 'Bygones of a Bundu Bone Thrower', p. 240.

and civilisation, Kennedy strove to achieve spectacular success as often as possible. As he later revealed, it was ‘very necessary to achieve success, if possible spectacular, or of a kind which, at least, could be *seen*’ (emphasis in original).<sup>53</sup> All this was done with African indigenous healers in mind, the aim being to supplant them. As he explained revealingly, ‘[W]e were up against powerful opposition in the shape of witchcraft and tribal customs of all kinds: we were not [initially] popular, nor were hospitals’.<sup>54</sup> It can therefore be argued that much of what Kennedy did was a combination of pragmatic common sense and ethnocentric and paternalistic biomedicine.

Without confirming his religious credentials it is hard to compare him with other colonial, missionary medical patriarchs such as Albert Cook. However, as the first Southern Rhodesian-born doctor, Kennedy seems to have been aware that, although by dint of that he was a history-making colonial citizen, he however wanted to chart his own course of history through practical means. Moreover, his wife, Ino Kennedy (nee Skinner), was a veteran of the two world wars. She was also Southern Rhodesia’s first woman major.<sup>55</sup> Mrs Kennedy was the matron at the old Ndanga Native Hospital from 1926 and Dr Kennedy had met her in 1928 while he was on locum in Ndanga. Ndanga was therefore an area where these two could establish their own ‘independent command’, as Kennedy put it, and distinguish themselves.<sup>56</sup> His Southern Rhodesian contemporaries compared him to Albert Schweitzer, an interesting comparison that warrants fuller elucidation.

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<sup>53</sup> Kennedy, ‘Bygones of a Bundu Bone Thrower: Part I’, p. 240.

<sup>54</sup> Kennedy, ‘Bygones of a Bundu Bone Thrower: Part I’, p. 240.

<sup>55</sup> Editorial, ‘Death of Mrs Kennedy – Colony’s First Woman Major’, *The Rhodesian Herald*, 15 April 1947, p. 5.

<sup>56</sup> Kennedy, ‘Bygones of a Bundu Bone Thrower: Part I’, p. 235.

### **Southern Rhodesia's own Albert Schweitzer? A Critique**

In an editorial introduction to a joint tribute on the retirement of Dr. Kennedy from Ndanga, the editor of the *Central African Journal of Medicine (CAJM)* spoke glowingly about him, claiming among other things that, 'In his service Jim Kennedy was an Albert Schweitzer. He gave gladly. He never sought high office, but preferred the quieter land of his Vakaranga and Shangani friends'.<sup>57</sup> This comparison of Kennedy to Schweitzer was predicated on the then glorious image of the much-acclaimed medical missionary who was recognised as an embodiment of personal sacrifice. Schweitzer's abandonment of his European comforts to become a 'jungle doctor' in colonial Gabon where he founded a hospital and a leprosarium was regarded as unparalleled individual commitment to the relief of suffering among African communities in the twentieth century.<sup>58</sup>

However, his celebrated individual commitment, Christianity and humanitarianism zeal for the 'alleviation of suffering and pain'<sup>59</sup> began to tail off in the early 1960s when Schweitzer became 'fair game for debunkers'.<sup>60</sup> A June 1963 edition of *Time* magazine declared: 'Africa: Albert Schweitzer: An Anachronism!'. The *Time* correspondent, Jon Randall, concluded a candid review of Schweitzer with a revealing statement that 'Schweitzer has made his own reality; he lives in the Africa of 1913, hardly knowing or caring that a continent and a century have passed him'.<sup>61</sup> The bitter irony in the *CAJM* editorial is that, while the intention was to put Kennedy in the league of the great in medical and humanitarian service, both men were by then anachronisms. Like Schweitzer, Kennedy's 'own very special brand of social medicine' later proved to be a static form of 'benevolent racism'. Ali A. Mazrui has given

<sup>57</sup> Editorial, 'Introduction: The Retirement of Dr James Kennedy, O.B.E', *Central African Journal of Medicine*, vol. 5, no. 7 (July 1959), p. 375.

<sup>58</sup> Anthony P. Polednak, 'Albert Schweitzer and International Health', *Journal of Religion and Health*, vol. 28, no. 4 (1989), p. 324.

<sup>59</sup> Polednak, 'Albert Schweitzer and International Health', p. 324.

<sup>60</sup> Manuel M. Davenport, 'The Moral Paternalism of Albert Schweitzer', *Ethics*, vol. 84, no. 2 (1974), p. 125.

<sup>61</sup> Jon Randal, 'Africa: Albert Schweitzer: An Anachronism', *Time*, 21 June 1963, para. 9. (Accessed from <http://www.time.com/time/magazine/article/0,9171,874897-2,00.html> on 7 Sept. 2011.

three types of racism: ‘malignant racism (racial hostility or contempt towards others), benign racism (racial ethnocentrism without aggression) and benevolent racism (racial paternalism and altruistic ethnocentrism).<sup>62</sup> Kennedy fits into the last typology.

In the late 1940s and 1950s he still described his patients as ‘wild’ and ‘primitive’, and regarded the entire area covered by the Unit as ‘wild and remote country’.<sup>63</sup> But before going further into that, it may be useful to assess the overall impact of his methods, which is a difficult thing to do given the vastness of the district he served and the paucity of systematic evidence. What is certainly clear though, is that his strategies partly led to a significant increase in the popularity of clinics as patient numbers treated in the Unit’s clinics increased steadily from the late 1930s (see table 4.2 below).

In other words, people were encouraged to take their illnesses to clinics as health care facilities became available on very liberal terms (including free food and treatment). Moreover, not to be forgotten was the advent of antibiotics which significantly boosted the efficacy of biomedical treatment of infectious diseases from the 1940s, hence raising patient confidence. As the same table also shows, parallel to the growth in patient attendances was also an increase in the number of recorded hospital births although these were still low by any standards.

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<sup>62</sup> Ali A. Mazrui, ‘Dr. Schweitzer’s Racism’, *Transition*, vol. 53 (1991), p. 97.

<sup>63</sup> Rhodes House, Rhodes Scholars File, James H. Kennedy – Rhodesia and Magadlen, 1920, Annual Scholar Return, 21 Jan. 1949; Kennedy, ‘Bygones of a Bundu Bone Thrower: Part I’, p. 235.

**Table 4.2: Returns for the Ndanga Medical Unit, 1937-1954**

Year	Admissions	Daily units*	Out-patients	Births	Deaths†
1937	7, 134	260, 625	11, 173	79	-
1938	9, 933	350, 896	11, 657	106	-
1939	10, 762	350, 896	11, 386	139	-
1940	10, 794	335, 207	11, 663	122	-
1941	11, 535	404, 928	12, 722	160	-
1942	10, 305	349, 746	11, 730	125	-
1943	11, 137	391, 862	16, 917	157	-
1944	14, 844	451, 377	19, 579	172	-
1945	14, 938	493, 092	27, 393	193	-
1946	17, 765	560, 390	30, 246	231	-
1947	25, 428	741, 922	35, 272	258	401
1948	26, 583	706, 853	34, 454	366	481
1949	27, 282	750, 422	40, 230	339	668
1950	38, 039	994, 481	46, 810	368	831
1951	43, 251	1, 107, 813	45, 597	425	1, 132
1952	39, 635	725, 540	46, 256	392	1, 271
1953	38, 353	530, 698	63, 387	381	1, 199
1954	48, 977	698, 601	73, 310	384	1, 503

**Source:** Kennedy, 'Bygones of a Bundu Bone Thrower: Part III', p. 322.

\* One patient maintained (admitted) for one day. † Only available for the years indicated.

However, although confidence was certainly growing, death statistics, which increased consistently between 1947 and 1954, might suggest that there were still challenges. The statistics show that while 1.5 percent of those admitted in 1947 died, the percentage had increased to 3 percent in 1954. With no systematic admission and autopsy records, it can only be speculated that the system might have been failing to cope with very sick patients who came to Unit's clinics with hopes of recovery. The late 1940s and early 1950s were also drought years, a situation which increased hospital admissions due to nutrition-related and

waterborne diseases.<sup>64</sup> The scramble for a few, contaminated water sources increased enteric fevers such as typhoid in places like Gutu.<sup>65</sup> The peak in admissions during 1951 indicates that there was something seriously wrong.

However, the hut system itself did not guarantee aseptic conditions. Whitewash and cow dung were commonly used to keep the floors and walls in good repair, methods which might have promoted the spread of pathogens. Moreover, since the Unit was run on a shoestring budget, it was common to issue patients with used mealie-meal sacks in lieu of blankets because of shortages. Hides were also used as doors.<sup>66</sup> Inevitably, this created a conducive environment for vermin of different kinds. In his annual report for 1946, the Gutu Native Commissioner reported that the Gutu Dispensary was heavily infested with a type of tick that caused relapsing fever. Most patients who were undergoing treatment for other illnesses contracted the disease. The Native Commissioner blamed the huts, which had no doors and forced patients to improvise with cattle hides as doors. He concluded that 'altogether the position appears to be most unhygienic and urgently in need of improvements'.<sup>67</sup> Indeed, such conditions might have contributed to hospital deaths as many people became crowded in patients' huts that often did not keep up with demand. What could have worsened this was the fact that until the 1960s the Unit had functioned with only one matron or fully qualified nurse at a time. Although medical assistants found themselves doing much of the delicate nursing work, their training did not fully prepare them for that.<sup>68</sup>

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<sup>64</sup> NAZ, S1173/337, Kennedy to Medical Director, 11 March 1948; Southern Rhodesia, *Report on the Public Health for the Year 1950*, p. 18.

<sup>65</sup> Masvingo Records Office (MRO), Box 1533, Provincial Medical Director, Gutu Reserve: Enteric Fevers, 1951-1952.

<sup>66</sup> NAZ, S1173/337, Proceedings of an Inquiry Held by the Public Services Board Into Charges Preferred Against Dr. James H. Kennedy, Salisbury, 22 Sept. 1941, p. 2.

<sup>67</sup> NAZ, S1563/2, Native Commissioners Annual Reports, 1946, Annual Report of the Native Commissioner, Gutu for the Year Ended 31 Dec. 1946.

<sup>68</sup> Interview with Mrs Chitiyo, Harare, 7 Oct. 2010.

The 1945 National Health Services Commission referred to the inferiority of the Ndanga medical work which was ‘carried out in rows of dark and smoky huts’, as opposed to that in the ‘compact, well-lit, well ventilated huts’.<sup>69</sup> Although the Commissioners generally tried hard to present in good light the ‘sketchy’, ‘rough and ready’ methods used by Kennedy in Ndanga, it was clear that they found the conditions to be largely unsatisfactory. In his annual report for 1945, A. P. Martin, the Medical Director, also expressed his reservations, noting that the Ndanga hut system was ‘not suitable for the nursing of the seriously sick’.<sup>70</sup> However, it is surprising why he did not make an effort to improve the system because, in contrast, his clinic system that was launched in 1936, was in his own words, ‘an organised system based upon the construction of specially designed buildings, in harmony with native ideas, but planned on a hygienic basis which allows the use of appropriate modern methods in the diagnosis and treatment of disease’.<sup>71</sup>

Kennedy’s downfall was his own obsession with his own ‘independent command’. By the mid-1950s Kennedy had indeed become an anachronism.<sup>72</sup> Younger medical administrators could not put up with his brand of medicine, let alone his disregard for official procedures. Because of his obsession with the physical appearance of hospital precincts, the amount of money he once spent on whitewash which he used to paint the huts, became ‘a standing joke throughout the [medical] service’.<sup>73</sup> After the death of his wife in 1947, he also seems to have developed depression and gradually became less coherent and more forgetful. Coupled with his trademark unorthodox mannerisms, that condition proved to be too risky. Some of his referral notes are said to have alarmed other medical officers in the service. For instance, his request to ‘please remove this woman from the fibroid’, or ‘this child has 3 legs, which one

<sup>69</sup> Southern Rhodesia, *Report of the National Health Services Commission*, 1945, p. 66.

<sup>70</sup> Southern Rhodesia, *Report of the Public Health for the Year 1945*, p. 6.

<sup>71</sup> Southern Rhodesia, *Report of the Public Health for the Year 1945*, p. 6.

<sup>72</sup> Blair, ‘Obituary: Dr. J. H. Kennedy, O.B.E’, p. 294.

<sup>73</sup> Ndanga Hospital Registry, Miscellaneous Papers, R. W. Doy to Director of Medical Services, 16 Dec. 1963.

would like to remove’ and ‘please take the axe-head out of this chap’s brain. It is giving him a headache’.<sup>74</sup> In addition,

He carried with him at all times a silver-tipped Irish shillelagh, with which he cleared a path through crowds of people or livestock, poked dead bodies in cursory examination, or demonstrated points he was trying to get across to an audience. After use he would hold out the tip of this shillelagh to be cleaned by an attendant who carried a screw-top bottle of methylated spirits swabs specifically for this purpose.<sup>75</sup>

When it became very clear to Public Health officials that Kennedy’s eccentric behaviour was worsening and negatively affecting the reputation of biomedicine, he was exhorted to retire ahead of time.<sup>76</sup> When he failed to heed that, he was eventually forced to retire and was relocated to a farm provided by a companion. While there his condition deteriorated until he was referred to a nervous diseases hospital.<sup>77</sup> He died in 1967.

**Fig. 4.5: Undated photo of Dr. Kennedy (with shillelagh under his arm) and African staff at Matsai (Mashoko) clinic**



(Photo courtesy of the National Archives of Zimbabwe.)

<sup>74</sup> Dr. Minto Stover, quoted in Gelfand, *A Service to the Sick*, p. 62.

<sup>75</sup> Saunders, ‘A Doctor in the Lowveld Wilderness’, p. 19.

<sup>76</sup> Saunders, ‘A Doctor in the Lowveld’, p. 20.

<sup>77</sup> Saunders, ‘A Doctor in the Lowveld’, p. 20.

His scheme was gradually dismantled during the 1960s. Patient feeding in all outlying clinics was phased out during the mid-1960s by Dr McLeod Chitiyo, the Unit's first black doctor.<sup>78</sup> In Ndanga hospital, cooking was centralised and the remaining huts were gradually phased out. Fittingly, one of the contributors to Kennedy's multi-authored obituary revised the earlier, glowing comparison to Schweitzer by noting that, 'Jim may be thought to have been an anachronism very much like Schweitzer in the way he thought Africans should be treated. His very practical brand of paternalism may be anathema to-day, but it did more to produce a feeling of kinship between the races than most political theories'.<sup>79</sup>

However, Kennedy's very own special brand of social medicine was certainly an idiosyncratic one. It did not go much beyond the liberal provision of curative services to needy patients in family or community contexts. Although there were indications that he could be a good family doctor in a permitting context, his system was not supported by a good public health structure. This theme will be fully addressed later in chapter 7.

## Conclusion

'Now the epoch is ending, as epochs must', is how one contemporary writer aptly summed up Kennedy's final years in Ndanga.<sup>80</sup> As a more or less a pioneer, Kennedy had formulated pragmatic methods of practising medicine in a large area, with the main aim being to reach out to families and treat their different maladies on very liberal terms. The unfamiliar encounters between biomedicine and African communities forced him to consolidate the system of patient villages which allowed for medical practice resembling an incipient form of community medicine. To his credit, Kennedy demonstrated that he was a pragmatic thinker,

<sup>78</sup> Interview with Dr M. Chitiyo, Harare, 4 Oct. 2010.

<sup>79</sup> George Ross, 'Obituary', *Central African Journal of Medicine*, vol. 13, no. 12 (1967), p. 295.

<sup>80</sup> Robert Tredgold, 'The Retirement of Dr. James Kennedy, O.B.E', *Central African Journal of Medicine*, vol. 5, no. 7 (1959), p. 377.

although his apparent lack of tact in dealing with medical administrators was a double-edged sword. Although he ended up being out of step with historical times, statistics show that communities increasingly made use of his district medical service. Although the provision of medical services in areas where there is an acute need is an aspect of social medicine, Kennedy's brand of social medicine was no more than curative medicine practiced in a community context that he had helped foster for that purpose.

But the story of the Ndanga Unit cannot be solely told from the perspective of Dr. Kennedy alone, important as that may be. As this chapter and the previous one have deliberately placed much emphasis on him and referred to other key players such as the orderlies and patients only passively, the next two chapters will attempt to balance the narrative, and indeed the history of the Unit, by focusing on these two key players. They dig deeper into their role to uncover what biomedical reform and the development of a district healthcare system meant from their perspectives. However, these two chapters also provide further commentary on Kennedy and colonial medicine in general, especially how its structures were contradictory and distorting.

## Chapter 5

### **On the margins or in the middle? Subordinate African healthcare staff of the Ndanga Unit**

#### **Introduction**

Thus far, the Ndanga Unit story has been told mostly from the perspective of Dr. Kennedy, mainly referring to other key local actors in the passive voice. This and the succeeding chapter will shift the focus from Kennedy and illuminate the history of the medical units scheme in general and the Ndanga Unit in particular from the perspectives of, firstly medical assistants or orderlies and secondly, patients. The present chapter serves as a commentary on one of the main elements of Askins' scheme, that is, the creation of a category of orderlies subordinate to white medical officers and nurses. It will be recalled that the medical units scheme as proposed by Askins assigned Africans to the lowest category of medical auxiliaries in order to reserve the medical turf exclusively for white doctors and nurses. The idea of African doctors was jettisoned, while a policy of training African nurses was not even mentioned.

The chapter asks whether this subordinate class of African medical staff could be said to have profoundly shaped the essence of colonial medicine as much of the recent literature seems to suggest. Alternatively, is this group of professionals better viewed as a vital cog in the evolution of colonial medicine, being mainly shaped by the distorting colonial public health environment in which they operated? To answer these questions, the chapter begins with a literature review that assesses some of the main ideas that have emerged thus far on the subject of African auxiliaries. It then proceeds to explore the colonial origins of this subordinate class of African healthcare staff and reflects on the possibilities and constraints associated with their coming into existence. After that, it turns to consider the actual

experiences of African medical assistants in Ndanga, paying particular attention to their recruitment, roles and their engagement with other district healthcare actors.

In the final analysis, the chapter suggests that, because of the rudimentary and distorting nature of medical practice in Ndanga, medical assistants could easily find themselves either on the margins or in the middle of the Unit's structures. In other words, their position could be taken as variable or changeable, depending on whether one looks at their position from the perspective of the vicissitudes of their colonial employment, intermediary responsibilities or the pervasive hierarchies within the medical fraternity. In short, they occupied a very tenuous position.

### **Historiographical debates**

In 1994, when Megan Vaughan suggested that 'further work is required on the crucial role of African medical personnel, the ways in which they practised and represented biomedicine, their interaction with other forms of healing and healers, and the popular perceptions of them in African communities',<sup>1</sup> there were indeed only a few extant works on this very important issue.<sup>2</sup> Since then, there has been encouraging growth in publications on the subject. Possibly captivated by either the current global public health emphasis on the lower cadre of medical personnel and the imperative of searching for antecedents in the historical record, or the seminal intersections between the social and cultural histories of colonial medicine, or the surging post-colonial interest in the subaltern voices, historians have, since the turn of the century, certainly begun to pay increasing attention to African medical personnel (including

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<sup>1</sup> Megan Vaughan, 'Health and Hegemony: Representation of Disease and the Creation of the Colonial Subject in Nyasaland', in Dagmar Engels and Shula Marks (eds), *Contesting Colonial Hegemony: State and Society in Africa and India* (London & New York: British Academic Press, 1994), p. 196.

<sup>2</sup> One example is Karin A. Shapiro's, 'Doctors or Medical Aids - Debates Over the Training of Black Medical Personnel for the Rural Black Population in the 1920s and 1930s', *Journal of Southern African Studies*, vol. 13, no. 2, (Jan., 1987), pp. 234-255.

doctors) of the colonial period.<sup>3</sup> It could as well be that, as Gerald C. Mazarire says, historians are beginning to extend the earlier, popular histories of epidemics to include the social histories of the institutions set up to control those diseases,<sup>4</sup> in the running of which African medical personnel loomed large.

With methodological approaches encompassing a fusion between group biography and social history<sup>5</sup> and cultural history,<sup>6</sup> innovative perspectives have been canvassed, broadening and deepening our knowledge about the subject. For some scholars, African medical personnel demonstrated their utility as culture brokers who mediated the transfer and translation of ideas, concepts and therapies between the Western and African models of healthcare.<sup>7</sup> In this role, not only were they able to help colonial medical officials establish and adapt the relevant aspects of their therapies and techniques, but they also inscribed Africans' own concepts on the practice of biomedicine through, *inter alia*, linguistic translation and local negotiations over acceptable nosology and therapy,<sup>8</sup> while also contributing to the emergence of medical pluralism.<sup>9</sup> Moreover, they facilitated conversations between the two medical

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<sup>3</sup> A few examples include, John Iliffe, *East African Doctors: A History of the Profession*, (Cambridge: Cambridge University Press, 1998); Anne Digby, 'Early Black Doctors in South Africa', *Journal of African History*, vol. 46, no. 3 (2005), pp. 427-454; Markku Hokkanen, *Medicine and Scottish Missionaries in the Northern Malawi Region 1875-1930: Quests for Health in a Colonial Society* (Lewiston: The Edwin Mellen Press, 2007), Ch. 8.

<sup>4</sup> Gerald C. Mazarire, 'A Little England in Chishanga: The Fate of a British Empire Leprosarium at Ngomahuru, 1925-1946', *African Historical Review*, vol. 39, no. 2 (2007), p. 1.

<sup>5</sup> Approach used by Digby in her article on 'Early Black Doctors in South Africa'; and by Iliffe, *East African Doctors*.

<sup>6</sup> A good example is Hokkanen's *Medicine and Scottish Missionaries*.

<sup>7</sup> Anne Digby and Helen Sweet, 'Nurses as Culture Brokers in Twentieth Century South Africa', in Waltraud Ernst (ed), *Plural Medicine, Tradition and Modernity, 1800-2000* (London & New York: Routledge, 2002); Markku Hokkanen, 'Towards a Cultural History of Medicine(s) in Colonial Africa', in Anne Digby et al (eds), *Crossing Colonial Historiographies: Histories of Colonial and Indigenous Medicines in Transnational Perspective* (Newcastle-upon-Tyne: Cambridge Scholars Publishing, 2010).

<sup>8</sup> Walima T. Kalusa, 'Language, Medical Auxiliaries and the Re-interpretation of Missionary Medicine in Colonial Mwinilunga, Zambia, 1922-1951', *Journal of Eastern African Studies*, vol. 1, no. 1 (March 2007), pp. 57-78; Markku Hokkanen, 'Quests for Health and Contests for Meaning: African Church Leaders and Scottish Missionaries in the Early Twentieth Century Presbyterian Church in Northern Malawi', *Journal of Southern African Studies*, vol. 33, no. 4 (Dec. 2007), pp. 733-50.

<sup>9</sup> Markku Hokkanen, 'Towards a Cultural History of Medicine(s) in Colonial Africa', p. 151.

systems by helping patients to understand and ‘navigate the process of access to, and understanding of care’.<sup>10</sup>

This new historiography which elevates African agency in ways not initially envisaged offers both subtle and overt challenge to an older school of thought represented by scholars such as Megan Vaughan and Maryinez Lyons who, in their own studies, had found that the working of colonial medical hegemony was at its strongest in the training and management of African health personnel.<sup>11</sup> As Vaughan put it, ‘If one can locate any hegemonic function for colonial medicine... it is... in the education of medical assistants, midwives and nurses undertaken for the most part by the missions in the practice of mission medicine, and in the welfarist and educational activities of the Jeanes School’.<sup>12</sup> While Lyons averred that African medical personnel ‘largely accepted the values attached by colonizers to their medical intervention and carried them beyond the confines of the colonial enclaves’.<sup>13</sup>

This line of thinking has been most overtly contested by Walima T. Kalusa who feels that it tends to undermine the power and agency of the African medical assistants, which power was particularly derived from their linguistic and cultural advantages over their European medical overseers. According to Kalusa, African medical auxiliaries profoundly reformulated the essence of colonial medicine using terms anchored in their own indigenous ‘grammar, vocabulary, and ritual discourse’, and ‘invariably filtered colonial/missionary medicine

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<sup>10</sup> Digby and Sweet, ‘Nurses as Culture Brokers’, p. 113.

<sup>11</sup> Megan Vaughan, ‘Health and Hegemony’; Maryinez Lyons, ‘The Power to Heal: African Auxiliaries in Colonial Belgian Congo and Uganda’, in Engels and Marks (eds), *Contesting Colonial Hegemony*.

<sup>12</sup> Megan Vaughan, ‘Health and Hegemony’, p. 191. The Jeanes teacher movement originated from the American South and its leitmotif was the training of indigenous community teachers or demonstrators for, inter alia, crucial public health roles. For more, see Carole Summers, ‘Giving Orders: Controversies Over Africans’ Authority in Development Programs in Rural Southern Rhodesia, 1928-1934’, *International Journal of African Historical Studies*, vol. 32, no. 2 (1998), pp. 279-300.

<sup>13</sup> Maryinez Lyons, ‘The Power to Heal’, p. 202.

through existing medical culture, logic and meaning'.<sup>14</sup> For Kalusa and others, therefore, African medical auxiliaries distinguished themselves not primarily as conduits for western medical precepts, but as champions of the adaptation and reinterpretation of these precepts in Africans' own lexicon.

Perhaps working within a social constructionist framework, Vaughan and Lyons may have overlooked certain factors by insinuating that African medical assistants were not much more than active agents of (biomedical) imperialism. However, the essence of their argument, that is, the influential role played by colonial ideology in medical training and care, is certainly enduring and can be used alongside the newer socio-cultural historiography without contradiction. In fact, Vaughan's view was an extension of the central argument elaborated earlier in her *Curing their Ills* that, 'in British colonial Africa, medicine and its associated disciplines played an important part in constructing "the African" as an object of knowledge, and elaborated classification systems and practices which have to be seen as intrinsic to the operation of colonial power'.<sup>15</sup> Except noting that such construction was always contested, the central essence of this argument has not been successfully challenged, except if one is prepared to view colonialism in parenthetical terms as a non-event.

Partly in an attempt to bridge this apparent fissure in historiography, but also to present new perspectives on the subject, this chapter uses the case of the Ndanga Medical Unit's African medical staff to illustrate that, with all its prospects, uncertainties and pitfalls, the world inhabited by African medical personnel was a complex and ambiguous one. The chapter suggests that, perhaps rather than seeing African medical personnel as belonging only to the margins of colonial medicine as 'auxiliaries' or 'subordinates' or, as the latest language

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<sup>14</sup> Walima T. Kalusa, 'Language, Medical Auxiliaries and the Re-interpretation of Missionary Medicine', p. 59.

<sup>15</sup> Megan Vaughan, *Curing their Ills: Colonial Power and African Sickness* (Cambridge: Polity Press, 1991), p. 8.

suggests, only at the centre as powerful ‘medical middles’ or ‘intermediaries’, it may be useful to imagine them traversing both worlds, depending on the historical circumstances as well as their relationship with other key players in the colonial health sector. They were as much cultural brokers as they were marginalised, fledgling professionals. They indeed brokered mutually beneficial communication between colonial doctors and African communities. But they also endured the professional disadvantages of being the lowest cadre of medical staff in colonial conditions.

This alternative, more complex picture only emerges when one innovatively pulls together the medical, cultural, economic and professional aspects of the work of African medical assistants under a single analytical framework. For instance, in Ndanga, some nursing orderlies were locally recruited and trained by the senior district medical staff before being deployed to run a network of outlying dispensaries under the distant supervision of the medical officer (based at the main district hospital) and/or the local Native Commissioner. Local training certainly helped them to be apprentices of local, practical socio-medical pedagogy. Post-apprenticeship, relatively independent work in outlying dispensaries also allowed them a degree of latitude to be decision-makers within the broader biomedical framework and, in the process, mediating between two therapeutic and cultural worlds and relatively modifying the culture of biomedicine.

However, this also had its fair share of disadvantages. Local recruitment and training bred a system of localised paternalism whereby medical assistants served at the whim of the local government medical officer or the Native Commissioner, who had the responsibility of an oversight role over clinics in his district. As shown in the previous two chapters, with the presiding medical officer, Dr Kennedy, famously acting as his own headquarters, for most medical assistants Ndanga was a virtually circumscribed space, practically speaking. Rural

isolation also prevented useful group interaction. Colonial control mechanisms, although subject to subversion, made independent practice outside the colonial medical service extremely difficult. Upward mobility and the acceptance of Africans as doctors was unduly delayed, a development which limited the application of African medical talent to the lower rungs of the medical fraternity. With this in mind, it will be difficult to dismiss Vaughan's succinct observation that, although the discourse of colonial medicine was 'fragmented and contested', at the same time it 'constituted a powerful influence on the creation of the "colonial subject", an influence which is still felt'.<sup>16</sup>

Furthermore, taking a cue from Markku Hokkanen, this chapter argues that it may also be useful to think about the ambivalent position of medical assistants vis-a-vis patients and therapy managers.<sup>17</sup> The concept of therapy managers, that is, those core relatives close to the patient who decided on behalf of, or in consultation with the patient, the best therapeutic choices, was first popularised by anthropologist John M. Janzen.<sup>18</sup> Hokkanen has argued that in the case of Nyasaland, although medical assistants were better placed than their European supervisors to occupy central roles in therapy negotiation as they were more easily approachable, they nevertheless also 'could remain outsiders in issues connected to family therapy'.<sup>19</sup>

Moreover, viewed sociologically as a group of emerging subordinate professionals who, as Iliffe and Lyons have showed, joined the service because of the 'promise of power and profit', the prestige wrought by medical technologies, 'the promise of altruism and trustworthy care' based on their genuine belief in the benefits that could accrue to African

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<sup>16</sup> Vaughan, 'Health and Hegemony', p. 173.

<sup>17</sup> Hokkanen, *Medicine and Scottish Missionaries*, p. 428.

<sup>18</sup> John M. Janzen, *The Quest for Therapy in Lower Zaire* (Berkeley: California University Press, 1978).

<sup>19</sup> Hokkanen, *Medicine and Scottish Missionaries*, p. 428.

communities,<sup>20</sup> and perhaps even Christian conviction, it may be wise not to draw conclusions on the basis of only one aspect of their complex history. To all intents and purposes, they were part of the newly emerging African middle class brought into existence by colonial medical policy.

### **Overview: the colonial origins of African medical work force**

Although colonial public health departments could have managed to serve the interests of the white settler enclaves with little help from African medical personnel, the extension of colonial medical facilities to incorporate the largely underserved rural communities, which took a definite shape in the interwar period, entailed the recruitment and training of multitudes of Africans in medical care. The medical, cultural and economic advantages of inaugurating an African medical service became so self-evident that the major disagreements during that time revolved around the nature of such a service rather than its necessity.<sup>21</sup> Should Africans be trained as doctors or medical assistants? If they were trained as doctors, what would be the impact on the exclusively white medical turf? If they were trained as assistants, what should such training involve? What would they be allowed to do? What would be their position in the medical hierarchy? What would be the colonial advantages of such a category over doctors? These are some of the questions that occupied the minds of colonial medical officials as they sought to create an African medical service.

The idea of training African medical doctors, as is now well known, was strongly opposed in most colonies, while those who were lucky to qualify often found it extremely hard to practice their trade. Only in some regions did the idea of training Africans as medical aids or medical assistants, a category which was just below doctors and was equivalent to the Indian

<sup>20</sup> Iliffe, *East African Doctors*, p. 3; Lyons, 'The Power to Heal', p. 218.

<sup>21</sup> See for instance, Shapiro, 'Doctors or Medical Aids', pp. 234-255; Iliffe, *East African Doctors*; Anne Digby, *Diversity and Division: Healthcare in South Africa from the 1800s* (Oxford, Berlin, New York: Peter Lang, 2006), pp. 191-8.

Sub-Assistant Surgeons, gain much early support.<sup>22</sup> In French West Africa, where the idea gained much popularity, a few outstanding candidates were allowed private practice,<sup>23</sup> although in most cases these medical assistants worked in state medical services under the supervision of white medical officers. In places like South Africa, the many practical difficulties – some historically peculiar to that country – hobbled the policy of training medical aids in the 1930s.<sup>24</sup> In many colonies, therefore, Africans were mainly formally trained or apprenticed as orderlies, dispensers, hospital attendants or hygiene demonstrators – depending on the priorities and nomenclature chosen by each colonial power. These occupied the lowest category in the colonial medical hierarchy. However, without understating the power and agency of these men and women as key players in the evolution of colonial healthcare, whether medical assistants or orderlies, the fact is ‘Within colonial society... they were still merely assistants, embittered by subordinate status and unrewarding conditions of work’.<sup>25</sup>

In Southern Rhodesia, when the reform-minded Medical Director, Dr Askins, made a definite proposal in 1930 to embark on a process of setting up district health care facilities covering the entire colony, his main concern was to be cautious so as not to rehearse the quintessential South African debate which pitted the liberal officials who were pro-training of black doctors against the conservative and powerful elements within the white medical establishment favouring a lower cadre of trained African medical aids.<sup>26</sup> Askins warned against the importation of the recommendations of South Africa’s Loram Commission which had argued

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<sup>22</sup> This was mainly the case in East Africa and French colonial Africa. For more, see M. S. Kiwanuka, ‘Colonial Policies and Administrators in Africa: The Myths of the Contrasts’, *African Historical Studies*, vol. 3, no. 2 (1970), p. 308; Iliffe, *East African Doctors*, Chapter 3 & 4.

<sup>23</sup> Kiwanuka, ‘Colonial Policies and Administrators in Africa’, p. 308.

<sup>24</sup> Digby, *Diversity and Division*, pp. 191-8.

<sup>25</sup> Iliffe, *East African Doctors*, p. 60.

<sup>26</sup> NAZ, S1173/336, Medical Training Scheme for Natives, 1930-1, R. A. Askins, Preliminary Report on the Treatment of Natives, Sept. 1930. The South African debate is well covered by Shapiro, ‘Doctors or Medical – Aids’.

in favour of the training of black doctors; instead, in anticipation of acrimonious opposition from the colony's entrenched white doctors, he decided that the acceptable approach would be to train subordinate African orderlies who would then work under the supervision of white doctors.<sup>27</sup> This approach was also supported by the influential pan-African Health Conference convened under the auspices of the League of Nations Health Organisation in 1932 and 1935.<sup>28</sup> This idea commended itself to medical officials because it was also inexpensive.<sup>29</sup>

Needless to say, the scheme pandered to the popular racial ideologies of the day. To rationalise the approach, medical authorities argued that Africans' standard of education had not sufficiently developed to meet the requirements for full medical training yet. The minimum educational standard for training as an orderly (as they were to be known) was therefore set at Standard V. Although the key figures of the liberal Moffat government approved the scheme immediately, without any reservations, it was not until 1935 that the full training of Africans as nursing orderlies took a definite shape.<sup>30</sup> Initial challenges encountered ranged from the financial to the logistical. When the scheme eventually commenced, it progressed slowly, picking up momentum only in the late 1940s with a notable increase in the number of orderlies trained per year.

While in the early 1940s the colony was still training about 8-10 orderlies per year,<sup>31</sup> in 1947 a total of 49 candidates sat for the final examination.<sup>32</sup> As both entrance requirements and the curriculum were upgraded, the nomenclature was also remodelled to 'medical assistants'.

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<sup>27</sup> NAZ, S1173/336, Medical Training Scheme for Natives, 1930-1, R. A. Askins, Preliminary Report on the Treatment of Natives, Sept. 1930.

<sup>28</sup> League of Nations Health Organisation, 'Report of the Pan-African Health Conference held at Johannesburg, 20-30 Nov. 1935', *League of Nations Quarterly Bulletin of the Health Organisation*, vol. 5, no. 1 (March 1936), pp. 198-208.

<sup>29</sup> Southern Rhodesia, *Report on the Public Health for the Year 1932*, p. 19.

<sup>30</sup> Michael Gelfand, *A Service to the Sick: A History of the Health Services for Africans in Southern Rhodesia, 1890-1953* (Gwelo: Mambo Press, 1976), p. 138.

<sup>31</sup> NAZ, S482/152/41, Native Medical Education, Acting Medical Director to Prime Minister, 31 Sept. 1941.

<sup>32</sup> Gelfand, *A Service to the Sick*, p. 143.

Some candidates took additional courses in midwifery and qualified as maternity assistants. Others were selected from among the qualified assistants and trained in basic microscopy. The idea of training Africans for a better rank of medical aids was skirted. In 1941, the Acting Medical Director had indicated that,

No very serious discussion has so far taken place on the policy of creating a “sub-assistant surgeon” type in the colony but it seems to have been tacitly agreed that when the New Salisbury Native Hospital is completed that it will include a training school for native males who will be nearer in status to medical practitioners than the present class of native nursing orderlies, of whom we train some 8-10 a year, and place in native clinics under the periodic supervision of Government Medical Officers. I have always envisaged the possibility of giving the more promising of these a “post graduate” course.<sup>33</sup>

However, in reality nothing of that sort happened. The training of full doctors was also actively discouraged by the Medical Director, A. P. Martin, who argued that ‘the medical services of this colony have not yet been sufficiently organised to warrant encouragement being given to natives to qualify as doctors and then to practice in Southern Rhodesia’.<sup>34</sup> Because this issue had come as a result of an African who had requested state assistance to study medicine in South Africa, the Minister of Native Affairs was worried that if Africans were continuously denied such opportunities, ‘this government would lay itself open to a charge of insincerity with regard to its policy of parallel development if it refused to give encouragement to natives who sought to advance to the utmost limit available in any particular direction’.<sup>35</sup> However, the idea had no support among medical officials who argued that the colony had no training facilities and sending such candidates to South Africa would

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<sup>33</sup> NAZ, 482/152/41, Native Medical Education, Acting Medical Director to Prime Minister, 31 Sept. 1941.

<sup>34</sup> NAZ, 482/152/41, Financial Assistance: Native Medical Students, Minute for Submission to Cabinet by the Minister of Native Affairs, 3 Oct. 1942.

<sup>35</sup> NAZ, 482/152/41, Financial Assistance: Native Medical Students, Minute for Submission to Cabinet by the Minister of Native Affairs, 3 Oct. 1942. However, contrary to the impression given in Southern Rhodesian records, South Africa did not offer a full medical qualification to black candidates during the early 1940s.

render them useless as they will learn the bad habits of the Union 'native' and lose the virtues and allegiances of the Southern Rhodesian 'natives'.<sup>36</sup>

Due to lack of consensus, the issue was postponed. L. J. J. Orpen, a trusted South African medical expert who had worked in Southern Rhodesia up to the early 1930s before moving to join the medical aids training programme of the South African Native College in Fort Hare, also advised against the idea. He noted that in South Africa there was a feeling that such candidates were highly trained and might be a threat to white doctors. Instead, he advised that 'it would be better if they were trained more as propagandists on lines completely divorced from those of the ordinary medical course'.<sup>37</sup> Indeed, as if to belatedly respond to this recommendation, in 1946 the category of public health assistants (also called 'hygiene demonstrators') who mainly worked outdoors among communities, doing propaganda public health work, was introduced. This innovation was the brain child of Dr. Dyson Blair, Southern Rhodesia's first Field Officer and Director of Preventive Services.<sup>38</sup>

The advanced nursing and medical training of Africans only started taking shape in the early 1950s when the state started sending a few African females with scholarships to study as state registered nurses (SRNs) at McCord Zulu Hospital in South Africa.<sup>39</sup> SRN training took long to set up in Southern Rhodesia itself, becoming a reality only in 1958 with the commencement of a training scheme at the newly constructed urban African hospitals, namely Harari (in Salisbury) and Mpilo (in Bulawayo). It was then that the McCord arrangement was terminated, together with the training of the lowly medical assistants in

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<sup>36</sup> NAZ, 482/152/41, Financial Assistance: Native Medical Students, Minute for Submission to Cabinet by the Minister of Native Affairs, 3 Oct. 1942.

<sup>37</sup> NAZ, 482/152/41, L. J. J. Orpen to Godfrey Huggins, 12 Dec. 1942.

<sup>38</sup> Michael Gelfand, *Proud Record: An Account of the Health Services Provided for Africans in the Federation of Rhodesia and Nyasaland* (Salisbury: Government Printer, 1960), p. 30.

<sup>39</sup> NAZ, F122/FH/67, Medical Training of Africans, 1955-1959, Acting Director of Native Education to Divisional Inspector, Matabeleland, 5 Aug. 1955.

Southern Rhodesia itself. It was also in 1950 that, after warming to the idea of having black doctors, the first two black medical students, T. S. Parirenyatwa and E. J. Pswarayi, were sent on scholarships to the Witwatersrand University in Johannesburg, to study towards medical degrees.<sup>40</sup> These were followed by a few others such as McLeod Chitiyo, Oliver Munyaradzi, Simon Mazorodze, Sidwell Musengezi and Emilio Mazhindu, who qualified as doctors in the early 1960s in Natal. A national training scheme for doctors was only commenced in the early 1960s, following the opening of the Godfrey Huggins Medical School in Salisbury.

The late commencement and slow development of training schemes for qualified African medical personnel meant that Southern Rhodesian hospitals and clinics, especially the isolated rural ones, had to work out alternative means of meeting their urgent needs for personnel. For a long time the colony's medical institutions depended on immigrants such as the nursing orderlies from Nyasaland where there were early training schemes in Blantyre and Livingstonia Mission. Also, the state medical service depended on local mission establishments to supply it with some of its certified nursing orderlies. In Ndanga, the situation compelled Kennedy to formulate an in-service training scheme or apprenticeships whereby suitably-qualified Africans were invited to join the Unit and trained locally but not certified. Such individuals, who made up a significant proportion of the Ndanga Unit's corps of medical assistants, generally became known, rather incorrectly, as 'untrained' or 'unqualified' orderlies. In actual fact, they were trained but uncertified.

### **The making of African healthcare staff in Ndanga**

For the greater part of the period under study, that is, 1930 to the early 1960s, the Ndanga Medical Unit was serviced by a mixed cohort of trained and the so-called untrained, local and

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<sup>40</sup> NAZ, F122/400/6/1, African Medical Training and Higher Education, 1955-1961, Deputy Secretary for Education to Director of Medical Services, 27 Oct. 1955.

foreign orderlies, and it is with this mixed group that the chapter is mostly concerned. The Unit only managed to recruit its first state-registered African nurse and doctor as late as 1964 when Dr. Chitoyo and his wife (both trained in Natal) were posted to Ndanga following a stint in Port Harold, Nyasaland, during the Federal period. African nurses and doctors therefore came at the tail end of the period covered in this chapter, hence the main focus on orderlies or medical assistants, as they were later known.

**Fig. 5.1: The First Cohort of Black State Registered Nurses, mid-1960s  
(Matron with a green belt)**



**Photo Courtesy of Dr M. Chitiyo.**

On the eve of the launch of the Unit, the old Ndanga hospital had only two orderlies, Wazanda (senior orderly) and Diran (junior orderly).<sup>41</sup> Bikita clinic also had two orderlies around the same period.<sup>42</sup> As already noted in Chapter 4, by 1941, about ten years after the launch of the Unit, Ndanga hospital and its outlying clinics had a total of 23 nursing orderlies, with twelve of these being senior orderlies (or orderlies-in-charge of those in clinics) and the

<sup>41</sup> NAZ, S1820/6, Ndanga Hospital, 1930-1931, T. J. Williams to Medical Director, 6 June 1931.

<sup>42</sup> NAZ, S1173/425, Native Dispensaries (Bikita), 1927-1929, W. Proctor to Chief Native Commissioner, 14 Dec. 1928; NAZ, S2101/1/3, Bikita Native Clinic, 1928-1936, Native Commissioner to Medical Director, 7 Feb. 1934.

rest, assistant orderlies.<sup>43</sup> Their places of training were discussed in the same chapter. As the headquarters of the scheme, Ndanga hospital had the lion's share of the orderlies, while the nine clinics had two each, a head orderly and an assistant.

Although the list is not specific on gender, from the common names listed, it appears that most of them were males. In outlining his medical units scheme, Askins had proposed 'the training of male African orderlies and possibly female nurses'.<sup>44</sup> However, although women were also required in the service, there were gendered difficulties associated with their education during these early years.<sup>45</sup> To illustrate the need for women orderlies, during recruitment the Unit's medical officer did specify a preference for orderlies with wives who would perform certain duties as required of them by the matron. In 1934, Kennedy put up an advertisement inviting applications by a married male candidate. The orderly's wife would be required to carry out certain duties among children and women as assigned by the matron.<sup>46</sup> Indeed, in 1945, the main hospital had eight orderlies with wives.<sup>47</sup> Although with time women began coming through the public training scheme, it is very likely that the women who began to appear in Ndanga came from the ranks of these wives.

As for the Nyasaland expatriates, it is very possible that these were part of a wave of migrant labourers from Britain's central African colony, which later became part of the Federation of the two Rhodesias and Nyasaland. Southern Rhodesia was both destination and conduit for waves of migrants from Nyasaland – a colony that distinguished itself as an unceasing

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<sup>43</sup> NAZ, S1173/337, Ndanga Clinic, 1936-1948, List of Native Orderlies and Native Labourers at Ndanga Hospital and Outlying Clinics, 1941.

<sup>44</sup> NAZ, S1173/336, Medical Treatment Scheme for Natives, 1930-1931, Askins to Colonial Secretary, 31 Oct. 1930.

<sup>45</sup> Southern Rhodesia, *Report of the Public Health for the Year 1937*, p. 2.

<sup>46</sup> NAZ, S1820/8, Ndanga Native Hospital, 1933-1934, Kennedy to Askins, 2 Oct. 1934.

<sup>47</sup> NAZ, S2410/16/2, Ndanga Hospital, 1941-1948, W. F. Wayne to Director of Public Works, 20 Jan. 1945.

fountain of labour for its richer southern African neighbours.<sup>48</sup> As the terminus of some missionary establishments linked to popular figures such as the influential missionary-explorer David Livingstone, Nyasaland had an early edge in the training of Africans for hospital work, and Markku Hokkanen's work on the medical work of the Livingstonia Mission provides recent perspectives on the subject.<sup>49</sup> The expansion of the clinic system in Southern Rhodesia from the 1930s gave most of the Nyasaland orderlies opportunities unrivalled in their own home territory. So dependable were these expatriates that half of those who were part of the Ndanga establishment were, in the early 1940s, heads of outlying clinics.<sup>50</sup>

For example, orderly Morton Kaunda who trained at Livingstonia Mission was head orderly of Bikita clinic, having joined in 1931, just before the inclusion of the clinic into the new Unit. Another Nyasaland orderly, Elliot, who joined the Unit in mid-1933 and was, in 1941, the head orderly at Siawareba (Siawareva) clinic, trained at the Universities Mission in Central Africa, Zomba, in Nyasaland.<sup>51</sup> Did the local people accept them? Michael Gelfand suggests that for some time there was a belief among the Shona people of Southern Rhodesia that orderly work was for the people from Nyasaland as they 'possessed charms that prevented them from contracting serious diseases when nursing the sick'.<sup>52</sup> Moreover, there was also a sense in which the healing beliefs of the local Shona people and Nyasalanders were gradually finding some common ground. In the early 1930s, *mchapi* (or *mchape*) herbal

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<sup>48</sup> For more on this subject, see F. E. Sanderson, 'The Development of Labour Migration from Nyasaland, 1891-1914', *Journal of African History*, vol. 2, no. 2 (1961), pp. 259-271; Bill Paton, *Labour Export Policy in the Development of Southern Africa* (Basingstoke, Hampshire: Macmillan in association with the Institute of Social Studies, 1995), Ch. 2.

<sup>49</sup> Markku Hokkanen, *Medicine and Scottish Missionaries in the Northern Malawi*.

<sup>50</sup> NAZ, S1173/337, Ndanga Clinic, 1936-1948, List of Native Orderlies and Native Labourers at Ndanga Hospital and Outlying Clinics, 1941.

<sup>51</sup> NAZ, S1173/337, Ndanga Clinic, 1936-1948, List of Native Orderlies and Native Labourers at Ndanga Hospital and Outlying Clinics, 1941.

<sup>52</sup> Gelfand, *A Service to the Sick*, p. 139.

and charm healers from Nyasaland traversed most parts of the eastern and south-eastern parts (including Fort Victoria) of Southern Rhodesia, peddling their therapies.<sup>53</sup>

If anything, this illustrated the general acceptance of *varapi* (as healthcare providers are known in local Karanga dialect) from distant territories. That said, doubt must be cast on Gelfand's view that the early dominance of expatriate orderlies owed much to Southern Rhodesian Africans' own prejudices against nursing work. Instead, it may be useful to view the expatriate orderlies as part of a general wave of indigenous biomedical therapy providers who were seeking for better prospects in the Southern Rhodesian market. Although the early start of orderly training schemes by Southern Rhodesian mission establishments compensated for the colony's late commencement of a public scheme, local missionaries were generally poorly endowed with funds and their training schemes were therefore very small.

Thus, as result of the severely limited training opportunities in Southern Rhodesia during the 1930s and indeed the early 1940s, expatriates and local apprentices dominated the Ndanga Unit. In the early 1940s, the local apprentices headed four of the Unit's clinics. . The local training of orderlies by Kennedy and his white staff commenced soon after the launch of the Unit in 1932.<sup>54</sup> Although there is a dearth of sources covering the essential details of the training scheme, it is evident that suitable candidates who could read and write were recruited and trained 'on eminently practical lines', as Kennedy put it.<sup>55</sup> While it was customary for prospective trainees like Rebecca Shoko, whose story was told in the previous chapter 4, to be specifically invited by hospital officials, it was also common for prospective apprentices to

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<sup>53</sup> NAZ, S1563/2, Native Commissioners' Annual Reports, Annual Report of the Native Commissioner, Ndanga, for the Year Ended 31 Dec. 1934, p. 15.

<sup>54</sup> NAZ, S2101/1/3, Bikita Native Clinic, 1928-1936, Native Commissioner, Bikita, to Superintendent of Natives, Fort Victoria, 3 Jan. 1933.

<sup>55</sup> James Kennedy, 'Bygones of a Bundu Bone Thrower', *Central African Journal of Medicine*, vol. 3, no. 6 (June 1957), p. 239.

come forward on their own, seeking opportunities to be trained as orderlies, as it was regarded as a prestigious occupation.

In June 1931, for instance, the Native Commissioner for Ndanga reported having been approached by an African from his district who was a former teacher at Morgenster Mission near Fort Victoria. The unnamed African asked the Native Commissioner whether there were any tuition opportunities in hospital work, as he was willing to work as an orderly at an African clinic.<sup>56</sup> There were other reports of similar enquiries from other districts: for instance, Sikwiliti of Matobo district, who possessed a Standard 4 qualification, also approached the Native Commissioner, Fort Usher, to enquire about opportunities for training in medical work.<sup>57</sup> This happened before Southern Rhodesia had its own national training scheme, and such candidates ended up being trained locally in hospitals such as Ndanga.

According to Kennedy's account, the training at Ndanga involved the observation and diagnosis of the common diseases, the techniques (subcutaneous, intramuscular and intravenous) and dosages of various injections, and the required lengths of the different treatment courses.<sup>58</sup> Apprentices were also taught how to apply different types of dressings, how to perform minor operations, and a range of basic obstetrical skills. Dr Kennedy commended many of the Unit's senior for being 'expert[s] at such complications as breech deliveries, presenting arms, retained placenta, and low forceps delivery under intravenous barbiturate anaesthesia'.<sup>59</sup> Moreover,

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<sup>56</sup> NAZ, S138/56, Native Dispensaries, 1924-1933, Native Commissioner, Ndanga, to Superintendent of Natives, Fort Victoria, 13 June 1931.

<sup>57</sup> NAZ, S138/56, Native Commissioner, Fort Usher, to Superintendent of Natives, Matabeleland, 29 July 1931.

<sup>58</sup> Kennedy, 'Bygones of a Bundu Bone Thrower', p. 239.

<sup>59</sup> Kennedy, 'Bygones of a Bundu Bone Thrower', p. 240.

With a view to their being competent later to take charge of a distant outlying clinic, they had also to be taught dispensing, and had to be able to make up the common stock of medicines in use at that time without the aid of the dispensing lists.<sup>60</sup>

Together with that, the apprentices were also equipped with other essential aspects of hospital work, namely record-keeping and admission and discharge procedures.

As the Ndanga Unit's outlying clinics operated in a peculiar way as mini-hospitals, that is, admitting as many inpatients as the ambulatory patients they dealt with, orderlies were also trained in keeping records of food supplies for inpatients received from the Unit's main hospital. It is not clear how long the training took to complete before an apprentice was deployed to run an outlying clinic, but everything seems to have revolved around the satisfaction of the medical officer and his white staff. Some of those who, in 1941, were listed as head orderlies in clinics had signed up for work in different years: Mutambo, who was head of Chidumo clinic, joined the Unit in 1934; Murombo of Bikita clinic started in 1937; Wilson Dondowedzai, the head of Gutu clinic, also first signed up for work in September 1937.<sup>61</sup> Dondowedzai and Murombo's cases show that they had been with the Unit for barely four years, but were already entrusted with running clinics. It should be added that another important test that Africans had to pass was that of gaining the total trust of the officials. Kennedy emphasized that 'honesty, resourcefulness, and ability to act reasonably in emergencies or difficult situations' were vital components of the training scheme.<sup>62</sup>

For formally-trained and locally-apprenticed orderlies, both local and foreign, joining the Unit represented a multi-sided process of shaping and being shaped by the forces of colonial

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<sup>60</sup> Kennedy, 'Bygones of a Bundu Bone Thrower', p. 240.

<sup>61</sup> NAZ, S1173/337, List of Native Orderlies and Native Labourers at Ndanga Hospital and Outlying Clinics, 1941.

<sup>62</sup> NAZ, S1173/337, List of Native Orderlies and Native Labourers at Ndanga Hospital and Outlying Clinics, 1941.

healthcare history. Their ambivalent position oscillated between being medical cultural brokers and decision-makers on one hand, and professionally insecure subordinates of a racialised medical system on the other.

### **Intermediaries, screening agents, marginal interlocutors**

The role of African medical assistants as cultural brokers has been well covered by other scholars,<sup>63</sup> and Ndanga does not offer any radically new or unexplored perspectives in that regard. Rather than re-treading what appears to be a well-trodden path, therefore, it may be useful to comment only on a few aspects. It will be recalled that the Ndanga Unit operated as a group of networked medical institutions, with the main hospital dealing with complicated cases from the outlying clinics in addition to offering treatment to its own surrounding communities. Before channelling cases to the secondary hospital, the clinics were required to deal with most common illnesses by providing what could be considered frontline care. This function of clinics as screening centres endowed orderlies with considerable decision-making power as they played a central role in determining secondary hospital cases and separating them from those that could be dealt with at primary level. That mediatory role required not only cultural understanding of a patient's backgrounds but also good clinical judgement.

Interestingly, from the late 1940s when public health assistants were deployed into communities, screening sometimes actually started in homes. The role of public health assistants, as the last chapter of the thesis will show, was to visit homes to teach hygiene and sanitation, carry out vaccinations and encourage the sick to visit the nearest clinics for treatment.<sup>64</sup> The intermediary role of African auxiliaries therefore extended from

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<sup>63</sup> See for instance, Digby and Sweet, 'Nurses as Culture Brokers in Twentieth Century South Africa'; Hokkanen, *Medicine and Scottish Missionaries in the Northern Malawi*; Kalusa, 'Language, Medical Auxiliaries and the Re-interpretation of Missionary Medicine'.

<sup>64</sup> Masvingo Records Office (MRO), Box 1533, Provincial Medical Director, Health Assistants, 1960s.

communities to clinics, making them at once advocates of modern therapy-seeking and conduits for funnelling patients through the two main levels or tiers of the district healthcare system. In a way the system anticipated what would later be known as primary health care, and was part and parcel of the widening practices of social medicine witnessed in places like Pholela (South Africa), China and Yugoslavia.<sup>65</sup> Many of the common illnesses such as malaria, venereal diseases and colds (among others), could be dealt with by orderlies at the local level, while cases such as those requiring surgical and X-ray procedures, for instance, were referred to Ndanga.<sup>66</sup>

The mediatory role played by orderlies as screening agents was, however, only part of a larger story. As the reality was that the Unit's outlying clinics were mini-hospitals in their own right, orderlies found themselves having to deal with sizeable numbers of in-patients who stayed with their relatives in the patient villages, as was the case at Ndanga hospital. Diagnosis, dispensing of medicines and the distribution of food and beef rations slaughtered locally, gave the presiding orderlies great leverage over issues of patient welfare without daily supervision by the district medical officer. The medical officer was scheduled to visit each clinic at least once every ten to fourteen days at most.<sup>67</sup> However, with ten medical stations covering a very wide area to run, in practice some clinics were visited only once per month. Even before there were many clinics, the road network was poor and some rivers were impassable during summer months.<sup>68</sup> This meant that much of the day-to-day influence and decision-making remained virtually in the hands of the head orderlies. Close supervision by some unenthusiastic Native Commissioners was sometimes weak, causing the medical

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<sup>65</sup> For more on these wider, international trends in social medicine, see Shula Marks, 'Common Sense or Utopian Dream? Part I: South Africa's Practice of Social Medicine Between 1940 and 1955 in Transnational Perspective', Unpublished Paper to The History Of Health Care in Africa: Actors, Experiences, and Perspectives in the Twentieth Century, University of Basel, 12-14 Sept. 2011.

<sup>66</sup> Interview with Rebecca Shoko, Bikita, 19 Sept. 2010.

<sup>67</sup> Southern Rhodesia, *Report on the Public Health for the Year 1934*, p. 12.

<sup>68</sup> NAZ, S1820/9/2, Ndanga Clinic, 1933-1940, Kennedy to Askins, 3 Nov. 1933.

officer some anxieties.<sup>69</sup> The decisions relating to patient admissions, treatment management, referral and discharge were thus mainly theirs to make.

Moreover, there were times when orderlies were virtually on their own for months on end. For instance, during World War II a number of clinics went for long periods without the doctor visiting because Kennedy was called up for service with the Rhodesian African Rifles in October 1940.<sup>70</sup> His locum, Dr. Minto Strover, who was based in Fort Victoria itself, had a large area to cover which included his own medical district and Kennedy's own vast 'kingdom'. Strover found it difficult to visit all the far-flung clinics unless his services were 'urgently required on the spot'.<sup>71</sup> It was thus reported in early 1941, that the doctor had last visited some clinics in Gutu in December 1939.<sup>72</sup>

Admittedly, R. D. Williams, the white steward orderly who had been appointed in 1938, visited the clinics that Strover could not reach and removed to Ndanga hospital those cases requiring a doctor's attention. However, for much of this wartime period the orderlies were practically the sole medical overseers of sizeable communities comprising patients and their relatives. For instance, in 1940 Bikita clinic recorded a total of 29,608 'units' or each patient treated per day.<sup>73</sup> On its part, Chikwanda clinic in Gutu recorded 31,028 units.<sup>74</sup> In 1944 alone, as noted in chapter 4, the whole Ndanga Unit recorded a total in-patient total of 451,377 'units'.<sup>75</sup> These statics illustrate the number of cases that came under the direct influence of orderlies, not only as screening agents but also as semi-independent managers of outlying stations, which kept many in-patients of their own.

<sup>69</sup> NAZ, S1820/9/1, Ndanga Clinic, 1933-1940, Kennedy to Martin, 5 June 1938.

<sup>70</sup> NAZ, S1173/337, Kennedy to Medical Director, 27 July 1941.

<sup>71</sup> NAZ, S1173/337, Kennedy to Medical Director, 27 July 1941.

<sup>72</sup> NAZ, S1173/337, W. F. Wayne to Medical Director, 21 Feb. 1941.

<sup>73</sup> NAZ, S1563/2, Annual Report of the Native Commissioner, Bikita, for the Year Ended 31 Dec. 1940.

<sup>74</sup> NAZ, S1563/2, Annual Report of the Native Commissioner, Gutu, for the Year Ended 31 Dec. 1940.

<sup>75</sup> Southern Rhodesia, *Report of the National Health Services Commission*, 1945, p. 66.

However, although orderlies indisputably played a crucial intermediary role, if not semi-independent role, the degree of their influence over patient life and therapy management was far from being absolute. This was the case because, unlike modern hospitals where patients could be isolated in wards with family members only being allowed brief visits, in the Ndanga Unit's clinics – and indeed at Ndanga hospital itself – family members continued to hold a great deal of power over patients and therapy management as they stayed with their sick relatives in the patient villages. While S. K. Sayenda says that in the modern, colonial hospitals in Nyasaland medical assistants became the patients' 'semi-relatives'<sup>76</sup> because of the removal of patients' actual relatives, at the Ndanga Unit the existence of patient villages where patients lived with their family helpers also meant that much of the closer care of patients remained the responsibility of their relatives. They cooked and fed patients in their own ways. Orderlies found their roles being confined to the general inspection of patients' huts and the actual administration of treatment during medication times. In essence, patient care and therapy management were joint activities shared by orderlies and patient helpers for the greater part of the period under review.

Moreover, as patients became acquainted with the functioning of the system, they began to differentiate between doctors and orderlies. This differentiation between the doctor and orderly can be observed in a practice that tended to embarrass many orderlies: on the days when the doctor was known to be visiting a local clinic, patients came in their big numbers. During such days, the screening of patients was a difficult exercise for orderlies, as everybody wanted to be seen by the doctor and preferred to be given even pain killers by the

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<sup>76</sup> Quoted in Hokkanen, *Medicine and Scottish Missionaries in the Northern Malawi*, p. 430.

doctor rather than by an orderly.<sup>77</sup> Although some orderlies were initially viewed as doctors some patients, with time, that illusion could not be sustained. Moreover, because of their training or apprenticeships in biomedicine, they were also mainly viewed as part and parcel of the new socio-medical order. However, their greatest challenge came from their superiors, the medical and district officials. This point is elucidated in the following section.

### **Officials' attitudes towards orderlies**

Although their positioning in isolated clinics afforded orderlies relative independence, that arrangement had its own risks for them because colonial officials were always wary of letting Africans wield untrammelled medical power, especially in isolated places where there was no immediate white official oversight. In the absence of the medical officer, the district Native Commissioner was required to exercise oversight over clinics in his district. As most Native Commissioners were sticklers for 'native' order and fond of exercising paternalistic authority over Africans,<sup>78</sup> orderlies usually found their conduct, morality and characters constantly under the spotlight. What was even more damaging was that a genuine mistake or an act of dishonesty by one individual was taken as being representative of the entire racial group's mentality. Native Commissioners often expressed their misgivings in very candid terms. In 1941, the Gutu District Native Commissioner said, 'I suppose I am not as enthusiastic as I could be over a system that leaves most of the activity in the hands of the Native Orderly, no matter how competent he may be'.<sup>79</sup> Perhaps the comment was made with an incident that had happened the previous year in mind. In 1940, an orderly from the district had been

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<sup>77</sup> Interview with Ivy Shoshore, Jichidza Mission, 14 July 2010.

<sup>78</sup> For more on the paternalism of Native Commissioners see William A. Munro, *The Moral Economy of the State: Conservation, Community Development, and State Making in Zimbabwe* (Athens, OH: Ohio University Centre for International Studies, 1998), pp. 53-4.

<sup>79</sup> NAZ, S1563, Native Commissioners Annual Reports, Annual Report of the Native Commissioner, Gutu, for the Year Ended 31 Dec. 1941.

brought to court, prosecuted and fined after considerable stores of medicines were found at his home.<sup>80</sup> He was however, allowed to continue with his duties.

African orderlies were often suspected of being thieves, as illustrated by the Bikita District Native Commissioner's remark, that 'it is surprising how quickly the wrong orderly can empty a clinic'.<sup>81</sup> As indicated in chapter 3, clinics were strategically sited near any settlement where there were white people so as to allow for regular supervision because, as medical officials said, without that 'these institutions would readily lose in efficiency and indeed might easily become the centres of undesirable practices'.<sup>82</sup> Several assistants at Ndanga suffered summary dismissals or spot fines by Kennedy and other doctors who came to Ndanga as his locums. Quizzed by authorities for imposing such a fine on an African medical assistant for what appeared to be 'small misdemeanour',<sup>83</sup> Kennedy revealed that he had found the unidentified man 'hopelessly drunk on two occasions'.<sup>84</sup> In further defence of this decision, he reminded his superiors that he operated in an isolated place where he had to try by all means to 'preserve order and discipline' without spending time and mileage prosecuting an African orderly at the nearest Native Commissioner's court in Zaka.<sup>85</sup>

Dr. Strover, who covered for Kennedy during World War II, dismissed another orderly, Makaya, for 'some mischief'.<sup>86</sup> Makaya had trained at Mt. Selinda, in neighbouring Melsetter District, and worked at the Unit's Matsai and Chitando clinics. Those orderlies who worked alone in outlying clinics were, ironically, the most vulnerable because the discovery of any

<sup>80</sup> NAZ, S1563/2, Annual Report of the Native Commissioner, Gutu, for the Year Ended 31 Dec. 1940.

<sup>81</sup> NAZ, S1563/2, Annual Report of the Native Commissioner, Bikita, for the Year Ended 31 Dec. 1938.

<sup>82</sup> Southern Rhodesia, *Report of the Public Health for the Year 1937*, p. 2.

<sup>83</sup> NAZ, S1173/337, Medical Director to Kennedy, 17 June 1941.

<sup>84</sup> NAZ, S1173/337, Kennedy to Medical Director, 27 July 1941.

<sup>85</sup> NAZ, S1173/337, Kennedy to Medical Director, 27 July 1941.

<sup>86</sup> NAZ, F242/400/63/3, Rural Clinics and Dispensaries, 1959-1961, Dr. Parker to Director of Medical Services, 20 Jan. 1961. Dr. Parker mentioned this incident when he was arguing for the appointment of Makaya, then a shop owner, as a home-based first aider.

mishap raised suspicions of endemic incompetence or ‘mischief’, which invariably often led to dismissals or transfers in the case of the fortunate ones.

However, officials’ concern with African orderlies’ characters was not a peculiarly Rhodesian phenomenon. Even among the most liberal of colonial institutions – missions – there was obsession with close control and the inculcation of Christian values among African assistants as a way of civilising or transforming them. Prominent missionary-doctor, the Nyasaland-based Rev. Robert Laws, had argued for strict supervision of African orderlies because ‘the temptations to go astray would be far greater for a native medical than a native pastor’.<sup>87</sup> As Lyons has argued in the case of Uganda and the Belgian Congo, the fixation with control and strict supervision of African medical assistants was born of the colonial view that access to medical knowledge and techniques equalled access to power. In Lyons’ words, ‘a medical system can be a potent means of controlling the *total* person, mind and body; consequently access to medical systems is often jealously guarded’<sup>88</sup> (emphasis in original). This was, of course, the key motivation behind the delayed training of Africans as fully-licensed doctors in most colonies, including Southern Rhodesia.

In Ndanga, orderlies were always plagued with insecurity of tenure because of the atmosphere of official mistrust and a system of localised paternalism. Most of them entered employment under informal, local contracts that could be easily terminated by Dr Kennedy. For instance, an investigation carried out in early 1941 by authorities from Salisbury discovered that the Unit had on the ground more orderlies than were indicated on the official government pay sheet records and that there were other orderlies who were drawing

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<sup>87</sup> Hokkanen, *Medicine and Scottish Missionaries in the Northern Malawi*, p. 416.

<sup>88</sup> Lyons, ‘The Power to Heal’, p. 204.

government salaries under the names of those who had long left the Unit.<sup>89</sup> Although, to his credit, Kennedy made local funding arrangements to remunerate some of the additional orderlies in line with general levels (or even better in some cases), his explanation of how he ended up employing orderlies but not registering them formally with the Public Health Department, or having some of them drawing salaries against the names of those who had left the Unit, is revealing. Kennedy explained,

That came about this way. First of all I hadn't sufficient staff and it was difficult to get any more. Secondly they were always changing, and I had to let one go sometimes or push him out because he had done various things he should not do and I had to get him replaced. I was having constant changes, and instead of notifying Head Office of every change and then waiting for authority to come out I carried on on my own because it seemed to me the only way to keep you going, and I not only paid out what was set down but more.<sup>90</sup>

In an earlier memorandum he had revealed that 'it was felt that unnecessary labour would be involved at my end and the Head Office if every change of herd boy, grass cutter, or junior untrained orderly had to be reported by name'.<sup>91</sup> Thus, without authority and approval from the department's head office, Kennedy dismissed orderlies and hired others at his discretion. In the eyes of many orderlies he was, therefore, medical officer, supervisor and employer, which could have complicated interaction. Those who operated in outlying clinics were particularly the targets, making their isolation not so splendid after all.

The paternalism of the doctor over orderlies was further enhanced by the fact that the former often fought on behalf of the latter in cases of government affront and neglect of their rights. In 1934, Kennedy petitioned authorities for funds to build new quarters for his orderlies as one of them lived among patients, a second in one of the hospital buildings, and the third at

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<sup>89</sup> NAZ, S1173/337, W. F. Wayne to Medical Director, 29 April 1941.

<sup>90</sup> NAZ, S1173/337, Proceedings of an Inquiry Held by the Public Services Board Into Charges Against Dr James Hutchison Kennedy, 22 Sept. 1941.

<sup>91</sup> NAZ, S1173/337, Kennedy to Medical Director, 27 July 1941.

his homestead.<sup>92</sup> Over the years, he had to work hard to reduce the gap between the trained and the so-called untrained orderlies. According to government schedule issued in 1941, the former's starting salary was £2 per month, rising to a ceiling of £5 after many years of service, while the latter's starting salary was a paltry 30/- per month, rising to a ceiling of 60/- per month after many years of service.<sup>93</sup> Kennedy considered this 'manifestly unfair'.<sup>94</sup> By force of circumstances, however, he did not endeavour to reduce the gap between and African and a European orderly who was drawing a salary of £300 per year during 1938.<sup>95</sup>

It would be a grave mistake, however, to think that in all this African medical assistants were passive players. An incident that transpired in 1941 is a good illustration of the struggles of the orderlies to make their voices heard, and proof that they could indeed stand up for their rights when opportunity presented itself. About three months after the departure of Kennedy to the war front, the Unit's orderlies apparently convened and wrote an explosive letter to the colony's Medical Director.<sup>96</sup> In their opening line the orderlies said, 'We most respectfully beg to apply for another boss in charge of the Ndanga Native Hospital and the clinics surrounding it, instead of Mr. Richard Donald Williams'. Further developing their justification for the replacement of Williams, the white orderly who had joined Ndanga in 1938, the orderlies noted that, while Dr. Kennedy was in charge of the Unit, 'there was great quiet', but since he left 'there are so many disturbances in the clinics'. They then proceeded to list what they called 'Mr Williams' cunning plans':

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<sup>92</sup> NAZ, S1820/8, Ndanga Native Hospital, 1933-1934, Kennedy to Askins, 2 Oct. 1934.

<sup>93</sup> NAZ, S1173/337, W. F. Wayne to European Orderly, Ndanga Hospital, 19 Feb. 1941.

<sup>94</sup> NAZ, S1173/337, Proceedings of an Inquiry Held by the Public Services Board Into Charges Against Dr James Hutchison Kennedy, 22 Sept. 1941.

<sup>95</sup> NAZ, S1820/9/1, Ndanga Clinic, 1933-1940, Requirements for the Unit during the 1937/1938 Financial Year.

<sup>96</sup> NAZ, S1173/337, Ndanga Orderlies to Medical Director, 27 Jan. 1941.

1. They charged that he 'disturbs the orderlies in order to find faulty (sic) with them and discharges (sic) them'. If the dismissed orderly was an assistant who earned £2, Williams would proceed to employ a new person and starts him with 10/- 'yet on the pay sheets there is written £2 for the assist. (sic)'. The new orderly would spend the whole year earning 10/-.
2. If the dismissed orderly was a senior earning £2.15 per month, Williams would put 'a raw man as the orderly and starts him with £1'. The orderlies wondered if 'this money [the difference] returns to Salisbury'.
3. 'Apart from that', they further noted, 'there is a system of killing cattle for inpatients and the skins from beasts are sold and he is getting a considerable amount of money because each skin is bought for 5/-'. The irate orderlies charged that Williams 'collects all [the money] for his own use'. They found this to be irregular because, while Kennedy was around, he would allow orderlies to use the money to buy requirements for patients such as milk 'for bad cases and little coffee as stimulants etc'. They acknowledged that they knew that 'the time is very bad' because of the war, but they demanded to know whether 'this money helps in the war fund'.

In concluding their letter, they said there were many complaints among orderlies relating to matters of leave, among others. Wittily, they brought the attention of the Medical Director to an African proverb that says 'a baby who doesn't cry when not at ease dies on the mother's back'. 'Being so black skinned', they further argued 'or although we are natives we have feelings as other human beings'. In their opinion, 'since we are ruled by Justice we cannot let this object hidden from the authorities [sic] knowledge'!

Clearly, this hard-hitting letter was not about Williams alone. Indeed, in oral interviews Williams features prominently as a harsh and unkind white man.<sup>97</sup> That *Mhiripiri*, a Karanga language term for chillies or pepper, was his nickname says it all. Available documents are silent about his end, but there is consensus in oral sources that he committed suicide in one of the Unit's clinics, apparently because he had 'eaten people's money', as the local informants put it.<sup>98</sup> It is, however, unlikely that what is contained in the letter could be a record of developments that took place barely three months after Kennedy's departure in October 1940. Williams may have started his apparently imprudent dealings from the time of his arrival in 1938, and may have done some of the things without Kennedy's knowledge. Williams was employed as a steward orderly to deal with the administrative issues. It seems that in executing his duties, he sometimes did so in very unkind and inconsiderate ways. Kennedy's departure was therefore taken as a good opportunity to lift the lid.

In response to the stinging letter, the Public Health Department dispatched W. F. Wayne, a high-profile administrator in the Department, to investigate the accusations. Wayne uncovered serious administrative irregularities within the Unit. Some of the defects have already been referred to earlier in the present chapter as well as in chapter 3. These included the employment of orderlies irregularly, the signing of pay sheet certificates which were not in accordance with facts, failure to remit to Treasury funds accrued from the sale of 'government property' (hides and sacks), use of government money for personal purposes by the medical officer, spending of government money without going to tender, and only intermittent visits to outlying clinics.<sup>99</sup>

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<sup>97</sup> Interview with Mr and Mrs Kwasara, Ndanga, 15 July 2010.

<sup>98</sup> Interview with Mr and Mrs Chikumba, Bikita, 19 September 2010; Interview with Mr and Mrs Kwasara, Ndanga, 15 July 2010.

<sup>99</sup> NAZ, S1173/337, Medical Director to Kennedy, 17 June 1941; W. F. Wayne to Medical Director, 19 February 1941.

After compiling his report, Wayne forwarded it to the Auditor-General who ruled that the irregularities constituted gross negligence by a public official, and recommended that action be taken against Kennedy in the form of an official reprimand and the postponement of his impending pay rise by a whole year.<sup>100</sup> The Acting Medical Director took up the matter, a charge sheet was sent to Kennedy, and he was called back from his regiment for a Public Services Board inquiry, on 22 September 1941. The Board found him guilty, but after taking into consideration some of his achievements, he was only reprimanded and told to organise his affairs when he returned to Ndanga after the war.<sup>101</sup>

Unfortunately, the Board Inquiry focussed mainly on the grievances of the state and less on the grievances of the orderlies. Asked about the letter right at the end of the session, Kennedy dismissed it thus:

Actually that letter was written by the wife of a native whom I happen to know. It was not written by the orderlies. The others whom I have had for years are all rather down on this fellow for having written it. The complaint was that this man was using patients for bringing up his own wood and water to his hut and was making them do bits of work in his garden, all of which was stopped by Williams. I had warned him before and he was transferred to another clinic nearer us where he could be watched.<sup>102</sup>

Although the couple were not named, indications are that it could have been Mr and Mrs Makaya. As mentioned earlier in the chapter, Makaya was dismissed by Kennedy's locum, Strover, for 'some mischief'. It is inconceivable that such a striking incident could have passed without casualties on the part of the orderlies themselves. The only silver lining was that, as part of the process of putting back the Ndanga system on a regular administrative

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<sup>100</sup> NAZ, S1173/337, C. H. Davies (Acting Auditor General) to Medical Director, 13 Aug. 1941.

<sup>101</sup> NAZ, S1173/337, Proceedings of an Inquiry Held by the Public Services Board Into Charges Against Dr James Hutchison Kennedy, 22 Sept. 1941.

<sup>102</sup> NAZ, S1173/337, Proceedings of an Inquiry Held by the Public Services Board Into Charges Against Dr James Hutchison Kennedy, 22 Sept. 1941.

footing, the Public Health Department recognised all the ‘unofficial’ orderlies and issued a directive for the effecting of wage increments to all those due for such pay rises.<sup>103</sup> That notwithstanding, orderlies remained a vulnerable group, not least because they were considered to be useful on the one hand, and problematic on another.

Moreover, there was little support outside the state medical service as private practice was a preserve of the better trained white medical staff. Some orderlies or medical assistants tried to establish private clinics or first aid stations. In the 1960s there were several reports of these attempts, including a private clinic in Gutu and a first aid station in Bikita.<sup>104</sup> However, there were many challenges as the state was not supportive of such initiatives; in fact, it proscribed them. In April 1964, one Ruvengano, a qualified medical orderly who was married to a qualified nurse, was told by medical officials that he could not practice medicine for profit unless he was a medical doctor, and also that the government would not offer him any assistance in his endeavours except through a recognised local authority.<sup>105</sup>

Another applicant was given an ambiguous answer that he could open a private clinic, but will not be allowed to give injections or to admit patients.<sup>106</sup> As a result, some African orderlies resorted to illegal medical practice. For instance, Mr and Mrs Makaya, who were dismissed by Dr Strover in the 1940s, were in 1961 denied state assistance to operate a first aid station at their store even though they had the support of Dr A. Parker, Kennedy’s successor. In 1966, they raised anxiety among officials as they were reported to be conducting ‘unsupervised private medical practice’ in Murwira Township, in Bikita.<sup>107</sup>

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<sup>103</sup> NAZ, S1173/337, W. F. Wayne to the Accountant, Division of Internal Affairs, 27 March 1941.

<sup>104</sup> MRO, Box 1533, Inspection Report by Health Assistant Madziwanyika, 30 June 1965; NAZ, F242/400/63/3, Rural Clinics and Dispensaries, 1959-1961, Parker to Director of Medical Services, 20 Jan. 1961.

<sup>105</sup> MRO, Box 1533, Provincial Health Inspector to District Commissioner, 2 April 1964.

<sup>106</sup> MRO, Box 1533, Provincial Medical Officer of Health to A. H. Style, 25 May 1965.

<sup>107</sup> MRO, Box 1533, Provincial Medical Officer of Health to District Medical Officer, 6 Oct. 1966.

Although such actions illustrated African frustration with the system and their own efforts to subvert it, lack of such support and even the proscription of such initiatives meant that their comprehensive growth would never be achieved. Medical assistants were therefore marginalised both in government service and in the private sector.

### **Conclusion**

This chapter has demonstrated the importance of thinking about the positioning of colonial orderlies in interconnected ways. It has illustrated that it is useful to think about them as intermediaries or screening agents at the centre of the evolution of a colonial healthcare system. At the same time, when one looks at their professional situation it will be discovered that they were also vulnerable. A holistic depiction that ascribes to them relative power rather than absolute power allows us to see them as dynamic historical actors who were both shaped by their circumstances as much as they tried to shaped them. Such an approach leaves us with room to manoeuvre in assessing their conduct, that is, we are able to sympathise with them where appropriate and to be critical where need be. Instead of seeing them as fixed in the middle or on the margins, this chapter has depicted them as actors who moved between both poles. A similar approach could be applied in the case of patients who are the subject of the next chapter. More importantly, it should be reiterated that they were actors in a field that was determined in advance by the policy-makers, which field they entered as subaltern subjects.

## Chapter 6

### **‘It takes two to make a medical encounter’: The patient perspective in the history of the Ndanga Unit**

#### **Introduction**

Owing to the belated realisation by historians that the sum total of any healthcare system does not only consist of doctors (and nurses), their scientific discoveries, actions and views alone, but ‘a historically formed network comprising all concerned’,<sup>1</sup> it is now axiomatic that comprehensive histories of healthcare systems should seek to account for ‘all actors, structures and forms of knowledge’ that contribute in equal measure to the functioning of any system.<sup>2</sup> One integral, and by far the largest, group of actors in any healthcare system are the patients whose representation in the burgeoning historiography of medicine is still considered to be unsatisfactory.<sup>3</sup> Perhaps because of medical history’s initial interest in medical advances and great doctors, and the widely known methodological difficulties of writing patient histories, until recently, mainstream histories of healthcare systems have mainly been told from the perspective of providers. Yet, as Roy Porter memorably remarked in his influential 1985 article on the challenges and prospects of writing patient histories, ‘it takes two to make a medical encounter – the sick person as well as the doctor’.<sup>4</sup>

Working from this Porterian view, this chapter puts together fragments of evidence and explores the Ndanga Unit story from the perspective of patients. Its main objective is to use the patient voice to explore the potential strengths and fundamental weaknesses of the

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<sup>1</sup> Eberhard Wolff, ‘Perspectives on Patients’ History: Methodological Considerations on the Example of Recent German-Speaking Literature’, *Canadian Bulletin of Medical History*, vol. 15, no. 1 (1998), p. 208.

<sup>2</sup> Flurin Condrau, ‘The Patient’s View Meets the Clinical Gaze’, *Social History of Medicine*, vol. 20, no. 3 (2007), p. 257.

<sup>3</sup> Howard Phillips and Kirsten Thomson, ‘The Gaze from Below: Patient Experiences’, in Anne Digby and Howard Phillips (with Harriet Deacon and Kirsten Thomson), *At the Heart of Healing: Groote Schuur Hospital, 1938-2008*, (Auckland Park, JHB: Jacana Media, 2008), p. 135.

<sup>4</sup> Roy Porter was very much aware of the fact that, historically, much healing took place with little involvement of doctors. Porter, ‘The Patient’s View: Doing Medical History from Below’, *Theory and Society*, vol. 14, no. 2 (1985), p. 175.

emerging rural healthcare system in Ndanga. Closely examining first the patients' views, attitudes, conditions of life and behaviour, and then exploring the ways and extent to which their ideas and interests were taken into consideration by the healthcare staff leadership, will be the main approach of the chapter. What meanings did the medical staff ascribe to lay nosologies, prognosis and therapy-seeking behaviour? How did such perceptions change over time, if they did? Can we say that the Ndanga Unit developed a patient-centred ethos based on a careful consideration and accommodation of patients' views and interests? The objective is therefore to go beyond the mere recovery of the patient voice by examining the responsiveness of the system to their perspectives, taking into consideration the contemporary historical context. Indeed, the success of any medical system should partly be assessed through a closer look at how patients' ideas and actions were perceived, received and acted upon.

Although like other histories from below this chapter reveals the patient footprint in the changing history of the Ndanga system, the aim is not to shape the chapter solely from the narrow perspective of power relations. Because the history of patient experiences during the colonial period can seldom be detached from the larger question of colonial power relations – a subject which, in postcolonial studies, has witnessed a great deal of both measured and doctrinaire revisionism – it is very easy to fall into the now discredited imposition-and-resistance trap.<sup>5</sup> Although illuminating if properly used, in the case of patient histories such a framework may mask the patients' own un compelled choices to use biomedical services by unduly concentrating on the impositions of officials, which were most pronounced during

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<sup>5</sup> The simplicity of this framework has been noted by an increasing number of scholars, including, quite recently, Femi J. Kolapo and Kwabena O. Akurang-Parry, 'Introduction', in Femi J. Kolapo and Kwabena O. Akurang-Parry (eds), *African Agency and European Colonialism* (Lanham: University of America Press, 2007), p. 1.

epidemic emergencies. Although important, patient-centred histories should not be confined to that level alone.

Moreover, although it has been qualified, albeit cautiously, that colonial officials failed to fully impose their will on African societies, the question that is yet to be asked is how far the Africans, who had their own set of expectations of their rulers, managed to impose their will on the latter. For instance, did patients manage to influence decision-making by doctors and nurses often or did they only manage to sometimes thwart the latter's nefarious or even un-understood designs during some clinical encounters?

Much of the recent literature has begun to revise the earlier historiographical and sociological approaches developed in the 1970s and 1980s, which emphasised colonial hybridity and synthesis as the main outcomes of colonial power relations and negotiations.<sup>6</sup> For instance, although admitting that there was always communication across the two systems, Julie Livingston has argued in the case of colonial Botswana that medical relations were imbued with 'productive misunderstandings [which] served to reinforce the boundaries' between indigenous and biomedical systems, 'even as they facilitated patient movement between systems'.<sup>7</sup> In other words, the two medical systems continued to function parallel to each other, although each borrowed aspects from the other. In such a scenario, hybridity might be a problematic concept to use.

The main argument of this chapter is therefore that, although oftentimes the medical staff were forced to act in ways that were preferred by patients, they often perceived this as an

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<sup>6</sup> See for instance, Sandra E. Greene, *Sacred Sites and the Colonial Encounter: A History of Meaning and Memory* (Bloomington: Indiana University Press, 2002).

<sup>7</sup> Julie Livingston, 'Productive Misunderstandings and the Dynamism of Plural Medicine in Mid-Century Bechuanaland', *Journal of Southern African Studies*, vol. 33, no. 4 (Dec. 2007), p. 802.

inferior type of medical practice. They mainly regarded it as a necessary strategy for achieving the civilising agenda rather than a rational adaptation of clinical practice flowing from the deliberate creation of a patient-centred biomedical system. Although patients gradually espoused medical pluralism and replaced some of their own ineffective indigenous healing methods with new biomedical ideas, in the main, medical officials saw the alteration of their own practices to accommodate patients as inferior medical practice. However, their views of patients were also suffused with contradictions: at one turn, patients were perceived as primitive and unchanging, at another, as enthusiastic and transforming. The many genuine efforts notwithstanding, the discourse of colonial healthcare thus remained largely self-serving and continuously condescending to patients' ideas.

To both exemplify and elaborate on these issues, the chapter begins with a brief reflection on the methodological issues pertaining to the history of patients and an outline of the relevant approach that delimits the themes chosen for consideration in the chapter. It then proceeds to give an overview of the patients' changing conditions of health, as well as their evolving ideas about health and disease. This might serve to illuminate what underpinned their dynamic and fraught engagement with biomedicine, as exemplified by their resistance, ambivalence, pluralism and selective embrace of its precepts. This is followed by a detailed examination of selected cases that illustrate the complex relations between patients and the district medical staff, paying attention to patients' actions and the medical staff's interpretations and responses to such actions. The chapter concludes with a reflection on the meaning and implications of these developments.

### **Can the patient speak?**

One of the acknowledged difficulties in the writing of comprehensive histories of healthcare systems and clinical encounters is recovering the apparently muffled patient voice, and

presenting it in meaningful ways. ‘Can the clinical subject speak?’, asked the historically-minded psychologist, Sally Swartz.<sup>8</sup> Underlying this question is a theoretical and methodological exploration of alternative ways of recovering the patient voice given the skewed nature of the medical archive. Historians often find themselves at the mercy of the archives that are dominated by the voices of, primarily, medical doctors and, to a certain extent, other allied healthcare professionals and general administrators. The overwhelming dominance of medical encounters by what has come to be known as the ‘clinical gaze’,<sup>9</sup> has largely contributed to the muting and marginalisation of the patient voice in historiography, in profound ways.

As Swartz has aptly put it, the voices of patients are often lost in the ‘louder resonances of theories and trainings’ of clinicians.<sup>10</sup> Commenting specifically on clinical records, Swartz says that they ‘serve as a memory for the clinician, and as a regulatory device within and between institutions. They place the clinical subject forever under construction for various purposes, none of which allow her to speak for herself’.<sup>11</sup> This difficulty is even more pronounced in former colonies where the voices of medical professionals held sway in addition to their belonging to the dominant group of colonial rulers. The colonial sick were not just patients, but ‘sick Africans’,<sup>12</sup> suggesting that they were perceived differently from sick Europeans. The experience of disease was expressed in ethnocentric terms.

These difficulties notwithstanding, historians have not been content to let the patients remain obscure in medical historiography. After all, as Howard Phillips and Kirsten Thomson have

<sup>8</sup> Sally Swartz, ‘Can the Clinical Subject Speak?: Some Thoughts on Subaltern Psychology’, Accessed from <http://tap.sagepub.com/content/15/4/505>, on 18 March 2010.

<sup>9</sup> Condrau, ‘The Patient’s View Meets the Clinical Gaze’.

<sup>10</sup> Swartz, ‘Can the Clinical Subject Speak?’, p. 507.

<sup>11</sup> Swartz, ‘Can the Clinical Subject Speak?’, p. 515.

<sup>12</sup> The idea of the ‘sick African’ forms the title and backbone of Michael Gelfand’s colonial medical textbook, *The Sick African: A Clinical Study* (Cape Town: Post Graduate Press, 1944).

made it clear, patients form the largest part of the medical and public health enterprise.<sup>13</sup> This therefore means that they should not form the smallest part of medical historiography, as is currently the case. Gleaning subaltern patient voices from the dominant sources, as well as doing oral histories – or being ‘a patient listener’<sup>14</sup> – where possible, have thus become the main methodological strategies used to recover the important histories of patients. Although criticised for being limited by the range of issues ‘determined in advance’ by the dominant archive,<sup>15</sup> reading the dominant sources ‘against the grain’ has been found to be possible nonetheless. ‘Suitably interrogated’, argues Porter, ‘what doctors recorded can often be decoded to reveal what the sufferers dreaded or demanded’.<sup>16</sup> Through such efforts, patients have ceased to a degree to be the terra incognita of medical historiography.<sup>17</sup>

As this chapter focuses on a rural, colonial case where patients seldom, if ever, personally recorded their own experiences of sickness and hospital and clinic care, using these explorative methods arguably useful in uncovering traces of patient agency in the evolution of the Ndanga system. The aim of the chapter is therefore to try to build a narrative that maps the patient footprint, however small, in the history of the Ndanga Unit. It considers a range of possible traces of the patient perspective, and builds on the understanding that the history of patients can encapsulate a range of key issues such as their ‘condition, perceptions, attitudes, behaviour, expectations, experiences and relationships’.<sup>18</sup> To unpack these issues, Porter’s comprehensive, four-part patient history schema has been used. In the model, Porter suggests that a patient-centred historical approach should ideally begin by an appraisal of the ‘terra

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<sup>13</sup> Phillips and Thomson, ‘The Gaze from Below’, p. 135.

<sup>14</sup> Howard Phillips, ‘On Being a Patient Lister: Oral Evidence and the Historical Experience of Hospital Patients’, Conference Paper, XVI International Oral History Conference, Prague, 7-11 July 2010.

<sup>15</sup> Bridie Andrews and Mary P. Sutphen, ‘Introduction’, in Mary P. Sutphen (eds), *Medicine and Colonial Identity* (London & New York: Routledge, 2003), p. 3.

<sup>16</sup> Porter, ‘The Patient’s View’, p. 183.

<sup>17</sup> Wolff, ‘Perspectives on Patients’ History’, p. 208.

<sup>18</sup> Phillips and Thomson, ‘The Gaze from Below’, p. 136.

firma of the material conditions of communities in times past'.<sup>19</sup> This ideally includes ploughing through the vital statistics that can give us insights about the nature of the populations we are dealing with, from 'cradle to grave'.<sup>20</sup> However, a caveat should be issued here, that in the case under review, the statistics are far from being comprehensive, and some colonial officials were the first to admit that.

The second part, Porter says, should focus on the patient's cosmology, that is, 'their belief systems, images and symbols'.<sup>21</sup> This should incorporate what patients thought about issues of life, death, the body and the various stages of life. The third aspect should encompass what can be classified as 'lay nosologies', that is, how people viewed, experienced, explained and categorised different types of illnesses they encountered. This helps to illuminate how they comprehended issues surrounding 'cause, type, prognosis, and remedy'.<sup>22</sup> Lastly, Porter suggests that we should explore the laws and cultural traditions that governed therapeutic choice.<sup>23</sup> In other words, when, how and where did the sick seek succour? In pluralistic medical situations, this entails looking at how patients sought treatment from health practitioners representing different healing systems.

Eberhard Wolff, whose four-part model mirrors Porter's framework except for one addition, further developed and landed credibility to the schema. Wolf's schema calls attention too to patients' circumstances, relationships, behaviour and ideas.<sup>24</sup> While Porter seems to have thought that patients' beliefs about issues of bodily processes, life, and death could be separated from their ideas about nosology, Wolf combined these and added another

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<sup>19</sup> Porter, 'The Patient's View', p. 185.

<sup>20</sup> Porter, 'The Patient's View', p. 185.

<sup>21</sup> Porter, 'The Patient's View', p. 186.

<sup>22</sup> Porter, 'The Patient's View', p. 187.

<sup>23</sup> Porter, 'The Patient's View', p. 187.

<sup>24</sup> Wolff, 'Perspectives on Patients' History', p. 209.

perspective that is absent from Porter's model, viz. patient relationships among themselves and with family and community members. Nevertheless, the line-up of questions that Wolf says should lie at the heart of any effort to probe patient histories essentially mirror the issues marked out by Porter earlier:

How did people behave with regard to what in their time was understood as the health, sickness, or healing, either of themselves or of those close to them? How did they perceive these phenomena? What were their attitudes to the various healers? What were their notions of sickness and health? How did they evaluate diagnostic, therapeutic, or preventive offers from others, and how did they use them?

Using the Porter-Wolff schema as a general guide, the following section discusses a range of issues that serve as a background to the Ndanga patients' worldview. However, rather than discussing these issues in separate sections strictly following the Porter-Wolff model, the chapter builds these strands into one section that traces the changing conditions of health and the shifting attitudes to health, disease and healing. This is necessary to capture in one examination the multiple dynamics of patienthood.

### **Changing attitudes to health, disease and medicine**

The African peoples' experiences as patients, including the ways in which they responded to episodes of sickness, were underpinned by their changing health status, coupled with their transforming attitudes to disease and healing. Although African society was never static, the advent of colonial rule profoundly transformed rural communities' conditions of health as well as their ideas about therapy. A number of scholars have underscored the importance of the early colonial period as a turning point in the epidemiological histories of most African regions.<sup>25</sup> In Southern Rhodesia, the advent of colonial rule was accompanied by the outbreak

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<sup>25</sup> Helge Kjekshus, *Ecology Control and Economic Development in East African History: The Case of Tanganyika, 1850-1950* (London: James Currey; Dar es Salaam: Mkuki na Nyota; Nairobi: EAEP; Kampala: Fountain Publishers; Athens, OH: Ohio University Press, 1996); Juhani Koponen, 'Population: A Dependent Variable', in Gregory Maddox et al (eds), *Custodians of the Land: Ecology and Culture in the History of Tanzania* (London: James Currey; Dar es Salaam: Mkuki na Nyota; Nairobi: E.A.E.P; Athens: Ohio University

of a devastating rinderpest epizootic which coincided with drought and swarms of locusts that destroyed crops. Africans interpreted these disasters as a consequence of white colonial rule, which led to an uprising that sought to roll it back.<sup>26</sup>

Although the epizootic affected humans mainly indirectly, by causing them to lose many of their cattle, it was the first dramatic indication of a rapidly changing disease environment.<sup>27</sup>

Following colonisation, locales such as Ndanga began to experience a high prevalence of infectious diseases, mainly triggered by colonial population movements. Many of the diseases that afflicted the Ndanga area during the 1930s onwards were discussed in Chapter 3. However, what should be restated here is that the increasing prevalence of some of them was an early twentieth century phenomenon associated with the colonial presence. For instance, at the turn of the century, Ndanga district officials reported being informed by Africans that there was a new wave of syphilis that had been brought from Kimberley and Johannesburg by Africans from the district who had gone there in search of work. The areas that had 'before been free from this disease [were] now being infected'.<sup>28</sup>

Obviously some of the cases may have been yaws which to look at was indistinguishable from syphilis. Nevertheless, some officials were struck by the increasingly common occurrence of sexually transmitted diseases in the rural districts of Fort Victoria, of which Ndanga was one. In 1911, the Native Commissioner for Makoni District remarked that 'syphilis was unknown when I first came into the country. The first cases which came to my

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Press); Shane Doyle, 'Population Decline and Delayed Recovery in Bunyoro, 1860-1960', *Journal of African History*, vol. 41, no. 3 (2008), pp. 429-58.

<sup>26</sup> Sabelo J. Ndlovu-Gatsheni, 'Mapping Cultural and Colonial Encounters, 1880s-1930s', in Brian Raftopoulos and Alois S. Mlambo (eds), *Becoming Zimbabwe: A History from the Pre-colonial Period to 2008* (Harare: Weaver Press; Johannesburg: Jacana Media, 2009), p. 49; Maurice K. K. Mutowo, 'Animal Diseases and Human Population in Colonial Zimbabwe: The Rinderpest Epidemic of 1896-1897', *Zambezia*, 28, 1 (2001), 15-18.

<sup>27</sup> Mutowo, 'Animal Diseases and Human Populations in Colonial Zimbabwe', pp. 1-21.

<sup>28</sup> National Archives of Zimbabwe (hereafter NAZ), N1/1/1-4, Venereal Diseases Among Natives, Native Commissioner, Ndanga, to Chief Native Commissioner, 1 June 1900.

knowledge as taking place among natives, occurred in Victoria District and are traceable to Europeans.<sup>29</sup> Fort Victoria was exposed because of its geographical proximity to South Africa where most labour migrants went to seek employment.

Domestic mines also became important sources of syphilis and other sexually transmitted diseases like gonorrhoea and non-STIs such as silicosis. Following the rinderpest disaster, Gutu witnessed a 'surge of labour migration to the mines at Gwelo and Selukwe'.<sup>30</sup> By the end of the second decade of colonial rule, parts of Ndanga district had become notorious for illicit labour recruiters or so-called 'black birders'.<sup>31</sup> From very early in the colonial period, Ndanga, Bikita and Gutu had all been re-organised into labour reserves and therefore recipients of industrial diseases rejects since colonial employers returned most sick labourers to their homes with little medical treatment. This was done to save costs. Already by 1911, the Bikita monthly district reports were recording returnees from domestic mines who came back to the district on health grounds.<sup>32</sup> With poor healthcare facilities in the mines, these returnees were conduits responsible for the conveyance of a great deal of sickness which gradually changed the health conditions of their communities.

Besides syphilis, other complications which came from industrial areas and caused havoc in what later became the Ndanga Unit as the century progressed included tuberculosis and silicosis. By the end of the first decade of the twentieth century silicosis was already a huge concern in the colony, leading to the promulgation of the 1913 Southern Rhodesia Miners'

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<sup>29</sup> NAZ, A3/3/18, Native Affairs Committee, 1909-1912, Native Commissioner, Makoni, to Chief Native Commissioner, 7 July 1911.

<sup>30</sup> Benjamin Davis and Wolfgang Dopcke, 'Survival and Accumulation in Gutu: Class Formation and the Rise of the State in Colonial Zimbabwe, 1900-1939', *Journal of Southern Africa Studies*, vol. 14, no. 1 (1987), p. 67.

<sup>31</sup> William Wolmer, *From Wilderness Vision to Farm Invasions: Conservation and Development in Zimbabwe's Lowveld* (Oxford: James Currey; Harare: Weaver Press; Hollywood: African Academic Press, 2007), p. 25.

<sup>32</sup> NAZ, NVB1/1/1, Native Commissioner, Bikita, Monthly General Reports, 1911-1914.

Phthisis Ordinance.<sup>33</sup> In the monthly records covering the period from around 1911 to the 1920s, chest complaints which were occasionally identified as either silicosis or consumption (or pulmonary tuberculosis), accounted for the largest number of deaths of tax payers in Ndanga and Bikita districts.<sup>34</sup> An epidemic of chest complaints was reported in Bikita in mid-1916.<sup>35</sup>

Many other diseases can be cited to illustrate the fact that the African people's health status was rapidly changing during the first three decades of the twentieth century, in consonance with the growth of the colonial economy and society. Changes among African communities that were induced by colonial incursion triggered many flare-ups of diseases that were previously kept at bay through, for instance, careful settlement patterns. Malaria is one such example. Although colonial officials described the lowveld, which included Ndanga and its neighbouring districts, as a land of 'languor, malaria and heat', they proceeded to create reserves to which Africans were confined after their healthier lands had been alienated to white settlers.<sup>36</sup> The Southern Rhodesian malaria story has been told expertly by JoAnn McGregor and Terence Ranger elsewhere.<sup>37</sup> But how did the African patients and their communities respond to these changes?

Africans' responses to these changing disease conditions were premised on three considerations: their evolving understanding of the origins and course of different diseases; the nature and efficacy of the available therapeutic options; and their interpretations of the attitude and aims of the colonial state and its agents. With regard to all three factors, it is not

<sup>33</sup> NAZ, A3/12/11-3, Mortality, Health and Labour Matters Amongst Natives on Mines, Acting Secretary, Department of the Administrator to Chairman, Miners' Phthisis Board, 3 Sept. 1920.

<sup>34</sup> NAZ, NVB1/1/1, Monthly General Reports, Ndanga and Bikita, 1911-1921.

<sup>35</sup> NAZ, NVB1/1/1, Bikita, Monthly Report, August 1916.

<sup>36</sup> Wolmer, *From Wilderness Vision to Farm Invasions*, p. 33.

<sup>37</sup> JoAnn McGregor and Terence Ranger, 'Displacement and Disease: Epidemics and Ideas about Malaria in Matabeleland', 1945-1996', *Past and Present*, no. 167 (2000), pp. 203-237.

the aim of this chapter to be exhaustive; neither is there space for a wide-ranging discussion. Instead, sufficient explanation of each is offered in preparation for more focused examination of selected cases in the next section of the chapter.

With regard to the first consideration, Sandra Greene observed in her illuminating study of the comparative case of colonial encounters in Ghana, that the Anlo understood the human body to be ‘a material entity that could experience pain and sickness, health and death from natural causes. But it too was intimately associated with separate spiritual forces that had the power to induce both sickness and health, life and death in the physical itself and in others’.<sup>38</sup> This observation has relevant application to Ndanga and other African communities, and belies colonial thinking that African notions of illness were bound up only in the spiritual realm.

In the 1970s, Herbert Aschwanden, a Swiss medical doctor carried out medical-anthropological research in association with African nurses working for a mission hospital near Zaka, Ndanga district’s administrative centre. The aim of the research, which was published in three companion volumes, was to determine the Karanga people’s notions of sickness, health and death and the symbols they used to express these.<sup>39</sup> The Karanga were the bulk of the local population. The major finding was that the Karanga people conceived of disease and illness as closely linked to beliefs in ancestral spirits, God, their relationship with nature, place and culture.<sup>40</sup>

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<sup>38</sup> Greene, *Sacred Sites and the Colonial Encounter*, p. 1.

<sup>39</sup> Herbert Aschwanden, *Karanga Mythology: An Analysis of the Consciousness of the Karanga in Zimbabwe* (Gweru: Mambo Press, 1989); *Symbols of Death: An Analysis of the Consciousness of the Karanga* (Gweru: Mambo Press, 1987); *Symbols of Life: An Analysis of the Consciousness of the Karanga* (Gweru: Mambo Press, 1982).

<sup>40</sup> Aschwanden, *Symbols of Life*, p. xiii.

It showed that the Karanga did not blindly ascribe all manner of illness at all its stages to ancestral spirits, as was often believed by colonial officials. For instance, epilepsy – which was called *buka* (animal related) or *tsvio* because of the resemblance of the sudden seizures to the movements of a certain animal – was mostly ascribed to spirits at the latter stage of its course, when all remedies had failed.<sup>41</sup> But epilepsy in children could also be blamed on the mother's culinary behaviour during pregnancy; thus, to avoid epilepsy, mothers were forbidden to eat eggs from the gestation period onwards. The thinking behind this was that eggs were fragile and thus could be an underlying cause of epileptic seizures.<sup>42</sup> Those trained in science were quick to dismiss this as superstition, but at the bottom of this belief was heredity as cause, which carries striking parallels with biomedical explanations of epilepsy.

Although witchcraft was normally blamed for many illnesses among people, this does not seem to have meant that it was viewed as a spiritual source of disease beyond the realm of the material. Witchcraft was viewed as a malevolent practice that was responsible for the conveyance of diseases, perhaps just like vectors do in scientific medicine, in the material realm. Likewise, remedies for diseases caused by witches could also be material in form, and they could include biomedical therapy.<sup>43</sup> The materiality of disease was also illustrated in the Karanga people's conception of the origins of some of the venereal diseases. For instance, they observed moral prohibitions against adultery as that had the risk of bringing sickness to the family.<sup>44</sup> Indeed, the erosion of most of these prohibitions fuelled the rapid spread of venereal diseases. Moreover, the Karanga were generally wary of cavalier exchange of bodily fluids such as blood, which made them suspicious of blood transfusion in hospitals. In their

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<sup>41</sup> Aschwanden, *Symbols of Death*, pp. 78-79.

<sup>42</sup> Aschwanden, *Symbols of Life*, p. 248.

<sup>43</sup> Aschwanden, *Symbols of Death*, p. 85.

<sup>44</sup> Aschwanden, *Symbols of Life*, pp. 226-7.

view, this led to too much mixing of blood groups which, in essence, meant the mixing up of incompatible ancestral worlds.<sup>45</sup>

However, the picture was complicated by the advent of western scientific and Christian conceptions of sickness. As Julie Livingston has observed in the similar case of colonial Botswana, the growth of biomedical services ‘was a central factor in changing patient experiences and understandings of health and the human body’.<sup>46</sup> Biomedicine was a major change agent in the area of remedy, which brings us to the second point on African patients’ conceptions of therapy. As the twentieth century progressed, patients gradually incorporated selected precepts of biomedicine into their healing cosmologies. The process was uneven as some procedures became popular while others were received with caution, if not outright suspicion. By the 1930s, the Ndanga communities had been gradually exposed to a variety of biomedical therapies, although the ongoing provision of these was still very limited. In addition to the fact that, by the 1930s the district already had a few medical centres, as indicated in Chapter 3, the many people who went to mines and towns obviously brought back information about biomedical cures and rehabilitation techniques.

As an illustration, in 1932, Chipengo, a mineworker from Bikita had his leg amputated following an accident at the Globe and Phoenix plant, one of Southern Rhodesia’s biggest mines in Que Que (Kwekwe). Through the Native Commissioner (NC) of that district, Chipengo wrote a letter to the Chief Native Commissioner (CNC) saying, ‘I wish to go back to my kraal [home] but I can do nothing with only one leg’.<sup>47</sup> Chipengo demanded an artificial limb as he had seen a certain white man with one. Citing prohibitive costs, mining

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<sup>45</sup> Aschwanden, *Symbols of Death*, p. 85.

<sup>46</sup> Livingston, ‘Productive Misunderstandings’, p. 803.

<sup>47</sup> National Archives of Zimbabwe, (hereafter NAZ), S1173/333, Native (Medicines), 1930-1932, Chipengo to Chief Native Commissioner, 22 May 1932.

officials forced Chipengo to accept a wooden peg. It is not far-fetched to suggest that such procedures filtered back to the communities where labourers like Chipengo came from and contributed in the transformation of people's ideas about rehabilitation

Mission stations, the Native Commissioners' administrative centres and entourages, farms and trading stores were the other conduits that facilitated the propagation of biomedical ideas. For instance, by 1911 the Dutch Reformed Church (DRC) was in charge of two main missions at Pamushana (Bikita) and Jichidza (Ndanga), as well as fourteen 'kraal' schools.<sup>48</sup> In Gutu, the DRC had two main missions at Gutu and Alheit, which were opened in 1907 and 1909 respectively. In addition, about eleven 'out schools' were opened in 1915. Ten years later, the number had increased to 46.<sup>49</sup> Health and hygiene were part of the school curriculum.<sup>50</sup> In addition, by 1920 Ndanga had seventeen trading stores, while the Native Commissioner's administrative entourage boasted a total of 25 Africa 'messengers' who often performed medical duties as they were required to escort sick patients to clinics, to act as watchman in quarantine villages during epidemic suppression campaigns, and also to perform vaccinations.<sup>51</sup>

Obviously, the process of the propagation and assimilation of new biomedical ideas was contested and uneven. However, by the 1930s, there was a discernible therapeutic pluralism among Africans as the uptake of biomedicine gradually taking root and African chiefs were calling for the construction of clinics in their communities.<sup>52</sup> Yet, these new biomedical ideas were grafted upon existing indigenous knowledge and they competed for attention with it.

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<sup>48</sup> NAZ, NVF2/1/1, Native Commissioner, Ndanga, Miscellaneous, 1911-1922.

<sup>49</sup> Davis and Dopcke, 'Survival and Accumulation in Gutu', pp. 75-6.

<sup>50</sup> Central Statistical, *Office Yearbook of the Colony of Southern Rhodesia for 1924* (Salisbury: Art Printing and Publishing, 1924), p. 676.

<sup>51</sup> NAZ, NVF2/1/1, Native Commissioner, Ndanga, Miscellaneous, 1911-1922.

<sup>52</sup> NAZ, S1563, Native Commissioners' Annual Reports, Report of the Native Commissioner, Gutu, for the Year Ended 31 Dec. 1934.

For instance, in 1934, officials in Gutu were alarmed by the fact that a team of *mchapi* anti-witchcraft medicine peddlers from Nyasaland had traversed the region selling their medication. Because colonial officials were against such practices, the *mchapi* healers were tracked down and they were found in possession of ‘no less than £174’, which they had obtained from selling their medicine.<sup>53</sup>

Thus, African patient communities’ approach to biomedical care was ambivalent; their aim was not to totally abandon African forms of healing, but to supplement. In addition, patients analysed and selectively embraced medical and surgical procedures. Often, they tried out several therapies during the course of one illness.<sup>54</sup> Indeed, as Steven Feierman and John Janzen have observed elsewhere, during one course of sickness, an African patient could consult a coterie of healers, including medical doctors, religious healers, spirit possession healers, and herbalists, among others.<sup>55</sup> Feierman and Janzen’s observation that ‘what patients see in Africa as in many other parts of the world, is a diverse, heterogeneous set of options for treatment – options that vary from place to place’,<sup>56</sup> is borne out in the oral histories of Ndanga.<sup>57</sup>

However, other biomedical procedures were rejected outright. This was normally the case when colonial officials and practitioners forced people to submit to biomedical cure, which takes us to the third and last premise that defined how sick Africans reacted to their changing health conditions. The attitudes and actions of colonial medical officials constituted an important variable in patient behaviour. From the time when Southern Rhodesia depended on the Cape medical codes and a battery of its own compulsory ordinances, to the period after

<sup>53</sup> NAZ, S1563, Report of the Native Commissioner, Gutu, for the Year Ended 31 Dec. 1934.

<sup>54</sup> Interview with SM, Bikita, 20 Sept. 2010.

<sup>55</sup> Steven Feierman and John Janzen, ‘Introduction’, in Feierman and Janzen (eds), *The Social Basis of Health and Healing in Africa* (Berkeley & Oxford: University of California Press, 1992), p. 2.

<sup>56</sup> Feierman and Janzen, ‘Introduction’, p. 2.

<sup>57</sup> Interview with Mr Chiona, Bikita, 20 Sept. 2010.

1925 when the colony enacted its own sweeping Public Health Act, infected Africans were usually compelled to submit to involuntary medical examination and vaccination. Their personal effects could be destroyed, their movements restricted and their villages quarantined.<sup>58</sup> A number of Africans thus viewed some biomedical approaches and procedures with suspicion for a long time.

By the time of the launch of the Ndanga Unit in the 1930s therefore, the African communities from which patients were drawn, exhibited ‘a much more varied, perhaps chaotic, picture of therapeutic ideas and practices’, to borrow from Feierman and Janzen’s articulate assessment of African communities in general. Luise White’s concept of ‘active ambivalence’ best describes their approach, as ‘procedures were as feared as they were welcomed’.<sup>59</sup> This ‘chaotic’ picture confounded officials and practitioners alike. The next section of the chapter takes a closer look at how this turned out in practice.

### **The patients’ ‘active ambivalence’**

African patients’ engagement with the emerging biomedical system in Ndanga was dynamic. It ran the gamut from enthusiastic embrace through ambivalence to total rejection. Hospital/clinic attendance statistics, officials’ reports and oral testimonies show an eclectic range of actions by patients. Starting with the affirmative, attendance records show that people presented themselves in increasing numbers at clinics for biomedical treatment, as was also indicated in Chapter 4. The number of patients attending the Unit’s medical centres

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<sup>58</sup> Southern Rhodesia, ‘Public Health Act: Chapter 140, 1925’, *Statute Law of Southern Rhodesia* (London: C. F. Roworth Ltd, 1939). For further examination of Act, see Jock McCulloch, ‘The Management of Venereal Disease in a Settler Society: Colonial Zimbabwe, 1900-1930’, in Philip Steel et al (eds), *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa* (Westport & London: Greenwood Press, 1999).

<sup>59</sup> Luise White, ‘“They Could Make Their Victims Dull”’: Genders and Genres, Fantasies and Cures in Colonial Southern Uganda’, *American Historical Review*, vol. 100, no. 5 (1995), p. 1391.

grew significantly between 1937 and 1954: from 7,134 inpatients and 11,173 outpatients in 1937 to 48,977 and 73,310 respectively seventeen years later.<sup>60</sup>

Although this may be taken to be a misleading comparison, given the fact that in 1937 the Unit had fewer clinics than was the case in 1954, the statistics for 1954 were significantly up on even those for 1947, by when all the clinics had been built. In 1947, 25,428 in-patient admissions were recorded, while 35,272 were seen as outpatients, just half the number of those treated in 1954.<sup>61</sup> Statistics for individual clinics also indicate some notable increases in patient attendance. For instance, in 1931 Bikita clinic, which was in its fourth year of existence, treated 728 patients, with 352 of these being inpatients and the rest outpatients.<sup>62</sup> In 1934 the total annual figure had increased to 3,094,<sup>63</sup> a sharp increase in the uptake of biomedical services within a short space of time.

Subsumed under these statistics were generations of families who received treatment and bore children at Ndanga hospital that, among many, became source of succour and employment and even a home. One informant, Mrs JZ, who was born to a general worker at Ndanga hospital in the early 1940s, told the story of her father who was an orphan and was admitted for a wound on his leg by Kennedy in the 1930s and remained there until he was cured. He stayed on there as a general hand, married, and had children, including Mrs JZ, who grew up in the hospital village. In the late 1950s, Dr Kennedy recommended Mrs JZ for nursing training at Morgenster, near Fort Victoria urban, before she even turned eighteen

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<sup>60</sup> James Kennedy, 'Bygones of a Bundu Bone Thrower: Part III', *Central African Journal of Medicine*, vol. 3, no. 8 (1957), p. 322.

<sup>61</sup> Kennedy, 'Bygones of a Bundu Bone Thrower: Part III', p. 322.

<sup>62</sup> NAZ, S2101/1/3, Bikita Native Clinic, 1928-1936, Native Commissioner, Bikita, to Medical Director, 1 Jan. 1932.

<sup>63</sup> NAZ, S1563, Native Commissioners Annual Reports, 1934, Report of the Native Commissioner, Bikita, for the Year Ended 31 Dec. 1934.

years old. She became a nurse at Ndanga in the early 1960s.<sup>64</sup> This beneficiary of Kennedy's indigent policy is, not surprisingly, still grateful: 'Dr Kennedy was a person who cared for black people. During those days, it was tough to the extent that if he was not a caring person, even my father would not have survived. Even us we would not be here today. So he was able to care for the sick', she reminisced.<sup>65</sup>

After successful treatment, such individuals like Mrs JZ's father became key agents in the recruitment of other patients among their families and friends. One good example is Mr PB who narrated the story of his first admission at Ndanga, in 1935, with a swollen leg and fever. Mr PB fell sick while working at a farm and his employer took him to Ndanga hospital. After two months' stay at the hospital, he was successfully cured. In 1953, he was back at Ndanga with his thirteen-year old son who was suffering from tonsillitis. Soon thereafter, Mr PB was employed as a general hand at the hospital and his son was later recruited and locally trained as an orderly.<sup>66</sup>

To others, Ndanga hospital and some of its clinics became attractive as sources of food. Both written and oral sources corroborate each other in indicating that some people feigned sickness in order to access hospital food. One informant, Mr CK of Bikita, related an astonishing story of his brother who would sit in the sun for a long time so that his temperature would rise above normal.<sup>67</sup> This, he said, would allow him to get hospital food, as he would go to hospital under the pretext of sickness. Another interviewee recalls that there were people who were known to be regular visitors to hospitals not because of *bona fide*

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<sup>64</sup> Interview with Mrs JZ, Ndanga, 13 July 2010.

<sup>65</sup> Interview with Mrs JZ, Ndanga, 13 July 2010.

<sup>66</sup> Interview with Mr PB, Ndanga, 15 July 2010.

<sup>67</sup> Interview with Mr CK, Bikita, 19 Sept. 2010.

sickness but because of the need for food. Such people would spend some nights away from the hospital attending beer parties in communities and in the morning go back to hospital.<sup>68</sup>

These stories sound almost incredible, but they are corroborated by written documents. During times of famine, officials complained of being swamped by patients. In his report for 1950, the Medical Director said that Kennedy had noted to him that, ‘in times of food shortage, his institutions become more than overcrowded with a flood of patients seeking treatment for ailments, which every African can deal with at home.... The real reason’, he observed, ‘being the desire to feed themselves at the clinics with food provided to patients free of charge by Government’.<sup>69</sup> Speaking in specific reference to indigents, Kennedy noted that,

Such cases are not infrequent, but it is hardly the function of native hospitals and clinics to treat or care for such cases indefinitely. As an instance, cripples, usually the result of repeated burns sustained during epileptic fits, are not an uncommon sight, while individuals who have for one reason or another no means of subsistence are, I think, more common than is generally recognised.<sup>70</sup>

Indeed, the early 1950s were record years in terms of patient admissions at the Ndanga Unit’s clinics. In 1949, the number of patients admitted was 27,282. This number increased to 38,039 in 1950, and then spiked to 43,251 in 1951 before dropping to 39,635 in 1952. The year 1951 was known to be a starvation year and the number of ‘units’, that is, one patient in hospital for one day, reached a record 1,107,831.<sup>71</sup> Certainly, times of food shortage are also almost invariably epidemic times, which serve to explain the spike in patient numbers during such times. Although these numbers overwhelmed Kennedy, he had himself to blame as he had created a situation whereby food was at the centre of the Unit’s medical approach.

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<sup>68</sup> Interview with CM, Bikita, 19 Sept. 2010.

<sup>69</sup> Southern Rhodesia, *Report on the Public Health for the Year 1950*, p. 18.

<sup>70</sup> Southern Rhodesia, *Report on the Public Health for the Year 1953*, p. 16.

<sup>71</sup> Kennedy, ‘Bygones of a Bundu Bone Thrower’, p. 322.

Indeed, tales of Dr Kennedy's generous food rations, his organisation of hospital space on communal lines and the successful cures he achieved, colour the memories of his former patients and community members. Although with the benefit of hindsight some enlightened witnesses have come to realise that the liberal offer of food by Kennedy was a strategy used by a pioneer to attract patients,<sup>72</sup> others remember those times with nostalgia. The 82-year old Mr MH, a former patient of Kennedy's, spoke expertly from first-hand experience about colonial medical staff at Ndanga hospital and whites in general, differentiating their economic oppression from their medical compassion. 'Those people had compassion for people, even though oppression was there.... In the area of [medical] treatment, in caring for you so that they could then exploit you, they were experts', he said. 'Here in hospital', he continued, 'they would care for you and treat you until you got well'.<sup>73</sup> These positive sentiments were generally shared by Mr PB and his son whose story was cited a little earlier in the chapter.

Some of those former patients with good memories remember pain relief and successful cures with medicines such as penicillin and aspirin.<sup>74</sup> However, others remember being given only very bitter medication. For instance, one former patient in Bikita recalled that he fell ill because of stomach pains and,

So I went to hospital and, ah, I was given very bitter medicine, it was not nice. The tablets during those days were not like the ones we have now. Most of the tablets were very bitter as if they originated from our indigenous Karanga medicines, because most of the Karanga medicines are very bitter.<sup>75</sup>

For such patients, the similarities in the bitterness of indigenous therapeutics and biomedicines might have facilitated seamless transition. Others remember the relative strength of hospital surgery over indigenous treatment systems because of the successful

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<sup>72</sup> Interview with Mr CD, Ndanga, 30 Sept. 2010.

<sup>73</sup> Interview with Mr MH, Ndanga, 25 Sept. 2010.

<sup>74</sup> Interview with Mr BJ, 15 July 2010.

<sup>75</sup> Interview with Mr CM, Bikita, 19 Sept. 2010.

operations they had.<sup>76</sup> Few former patients remember what it was like in the wards, perhaps because formal wards were a late development and their memory was overshadowed by the popular patients' villages. A few exceptions are those who remember the red floors and the physical cleanliness of the wards as opposed to the patient huts, or the figure of Kennedy pacing up and down the wards in apparent prayer, fuelling the unconfirmed perception that he was Catholic.<sup>77</sup>

The *baira*, as the open air dressing and medication shade was known, is also popularly remembered as the main arena for clinical encounters.<sup>78</sup> The name *baira* is a derivative of the Karanga term *baya*, which means 'prickle' or 'pierce'. Therefore this shade might have been called *baira* because that is where injections were administered. 'Patients would come to the shade to receive their injections. Sometimes they would be treated in their huts', recalled Mr PB whose first encounter with the hospital was during the mid-1930s. For his sore leg Mr PB remembers receiving an injection and some ointment.<sup>79</sup> His son who suffered from tonsillitis added that, 'I used the medicines here. We were not allowed to take them home because they thought people would not be able to use the medication properly on their own'.<sup>80</sup> Although these two now understand that such procedures were undertaken because biomedicine was as yet unfamiliar, it is not clear how they felt back then. However, according to Ivy Shoshore, a former nurse aid, with time most people preferred to be inpatients as they knew that they would be cared for very well, although some remained sceptical.<sup>81</sup>

Punctuating the generally positive memories of Kennedy are comparisons with his three successors A. Parker, R. W. Doy and M. Chitiyo, who presided over the gradual phasing out

<sup>76</sup> Interview with Sekuru M., Bikita, 20 Sept. 2010.

<sup>77</sup> Interview with Mr and Mrs KS, 15 July 2010.

<sup>78</sup> Interview with Mrs JZ, 13 July 2010.

<sup>79</sup> Interview with Mr PB, Ndanga, 15 July 2010.

<sup>80</sup> Interview with Mr BJ, Ndanga, 15 July 2010.

<sup>81</sup> Interview with Ivy Shoshore, Jichidza, 14 July 2010.

of rations in all clinics except the Ndanga Hospital.<sup>82</sup> Also starkly contrasted with Kennedy is R. D. Williams, the infamous white orderly discussed in the previous, chapter 5. Mr *Mhiripiri* ('Mr Chillies') as he was nicknamed is remembered as being very unkind to patients. As Mrs CK put it, 'He did not have deep love for patients. Sometimes when a patient was failing to eat, he would say to the orderly "no, no, no, feed him, give him the food".<sup>83</sup> However, Kennedy did also have his blind spots. Some eyewitnesses remember him forcing people to drink castor oil or an aloe solution as punishment for coming late to the *baira* after the blowing of the whistle to alert patients that it was time for medication.<sup>84</sup> Mr and Mrs KS also recall that 'Kennedy was very strict about cases of domestic violence and child negligence. For instance, in cases of a husband beating his wife or a burnt child, he would demand to know where you were when the child got burnt. He would beat you up'.<sup>85</sup>

Among other things, these 'insider' memories tell us that the people of Ndanga and surrounding districts patronised the Ndanga Unit and closely observed it as it emerged and developed. It shows that people were increasingly embracing biomedical institutions. Officials took this as an indication of the fact that Africans were abandoning their own therapeutic traditions and that biomedicine was gaining popular appeal among patients. In a discussion of the Ndanga and Mtoko Medical Units in the 1934 annual public health report, the Medical Director noted that,

The idea that the native is unwilling to accept European medicine can be discarded. Experience in the two native medical units shows that he is quite willing to undergo both medical and operative treatment, and further, is willing to entrust the treatment of maternity cases and young babies to European care.<sup>86</sup>

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<sup>82</sup> Interview with Mr and Mrs KS, Ndanga, 15 July 2010.

<sup>83</sup> Interview with Mrs CK, Bikita, 19 Sept. 2010.

<sup>84</sup> Interview with Mr CD, 20 Sept 2010; Interview with Mr and Mrs KS, Ndanga, 15 July 2010..

<sup>85</sup> Interview with Mr and Mrs KS, Ndanga, 15 July 2010.

<sup>86</sup> Southern Rhodesia, *Report on the Public Health for the Year 1934*, p. 12.

Also, obviously speaking the mind of the medical officer who drafted the district's medical reports, the Native Commissioner, Ndanga, noted in 1942 that, 'From remarks by natives it is evident that modern surgery and obstetrics appeals to them and the X-raying of every patient, no matter what the ailment, would probably embarrass the Medical Department with applications for treatment'.<sup>87</sup> Always yearning for approval, colonial and health officials took these developments as a sign of growing confidence and goodwill by the normally sceptical Africans. Some of them gloated, seeing this as an inevitable triumph of scientific medicine against African healing systems, long described as superstition and witchcraft.<sup>88</sup>

However, this apparent enthusiasm for biomedical institutions and procedures tells only part of a rather complicated story. Patients showed themselves to be highly selective and unpredictable in their resort to these institutions. Initially many of them shunned hospitalisation. Others were not inclined to be left in the care of strangers in hospital, preferring to be looked after by their close relatives, while some mothers refused to leave their children in hospital for treatment. Mass or total commitment to biomedical institutions was always elusive. In addition, patients considered a range of other options before, during and after seeking biomedical care.

Oral sources reveal, for instance, that while pregnant women did not generally heed exhortations to attend antenatal clinics, at the last minute they came to the hospital to deliver their babies.<sup>89</sup> McLeod Chitiyo, the first black doctor to be appointed at Ndanga in 1964 remembers that he had to deal with many cases with a ruptured uterus as women in advanced

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<sup>87</sup> NAZ, S1563/2 Native Commissioners' Annual Reports, Report of the Native Commissioner, Ndanga, for the Year Ended 31 Dec. 1942.

<sup>88</sup> NAZ, S1618, Chief Native Commissioner's Quarterly Reviews of Native Affairs, 1927-1936, Quarterly Review of Native Affairs for the Fourth Quarter Ended 30 Dec. 1934.

<sup>89</sup> Interview with Alice J. Mazorodze, Harare, 2 Oct. 2010.

labour were brought to hospital from very far.<sup>90</sup> Available statistics show that in 1954 a paltry 384 babies were delivered in the Unit.<sup>91</sup> The number had never been higher. This shows that many people still considered home birth to be a desirable option, even though this was very much maligned by colonial medical officials who often sought to use mother and child health care as a way of reaching out to African communities.

Dr Kennedy often issued pleas exhorting patients to seek 'early treatment rather than wait until the disease or complaint was so bad that it took a long time to effect [a] cure'.<sup>92</sup> In the clearest indication that patients held on to some of their own hallowed therapeutic practices, some officials expressed concern that,

European medicine is certainly handicapped by family spirits and witchcraft because in the majority of cases the sick do not reach the hospital or clinics until the diviner has had his say and by that time it is not a matter of the hospital rendering medical aid but having to perform miracles.<sup>93</sup>

Viewed from a biomedical point of view, this behaviour by patients was fatal; but viewed from a pluralistic point of view, it was reasonable. Another apparently fatalistic practice by patients was absconding from treatment prematurely. In some cases, patients presented themselves in good time, but absconded when hospital medicine either took long to induce cure while a patient's condition deteriorated or when particular medicines caused grave discomfort. Syphilitics, tuberculosis sufferers, bilharzia patients and mothers with babies suffering from fontanelle-related disorders were particularly prone to abscond from hospital. The first three did so because the treatment regimen tended to be long and painful, while the last group (mothers) absconded because they had different explanations for fontanelle-related sickness.

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<sup>90</sup> Interview with Dr M. Chitiyo, Harare, 4 Oct. 2010.

<sup>91</sup> Kennedy, 'Bygones of a Bundu Bone Thrower', p. 322.

<sup>92</sup> NAZ, S1563/2, Report of the Native Commissioner, Ndanga, for the Year Ended 31 Dec. 1938.

<sup>93</sup> NAZ, S1563/2, Report of the Native Commissioner, Ndanga, for the Year Ended 31 Dec. 1942.

During the pre-penicillin era, syphilis patients were notorious for absconding as the drugs used then were such that sufferers had to endure a long and painful course of treatment. As Shane Doyle has noted in a comparative case study of Uganda for instance, because of ‘unpleasant side-effects... few patients ever completed their courses’.<sup>94</sup> This challenge confronted Southern Rhodesia too. Although Ndanga officials appreciated that ‘... there can be no doubt that the Native is beginning to realise the necessity for and the benefits received from the treatment of this scourge [syphilis] and the position undoubtedly continues to improve materially every year’, premature discontinuation of treatment continued to be their major concern.<sup>95</sup>

Elsewhere in colonial Africa, syphilitic patients were so observant that they preferred arsenical (salvarsan or 606) drugs to mercury. Colonial governments, including the Southern Rhodesia one, were not inclined to use costly anti-syphilis drugs on Africans.<sup>96</sup> In Nyasaland, officials often had to battle patient selectivity after the latter discovered that there was a two-tier treatment scheme and that they were on the second tier. According to Megan Vaughan, ‘when arsenical treatments became available in hospitals but not in rural dispensaries, attendance at the latter fell off’. Patients refused treatment with mercury as soon as they discovered that arsenical drugs were in stock.<sup>97</sup> In Southern Rhodesia, patients preferred the injectable drug novarsenobillon to the orally administered storvasol and mercury ointments.<sup>98</sup>

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<sup>94</sup> Shane Doyle, ‘STDs and Welfare in East Africa’. Accessed from

<http://www.history.ac.uk/ihr/Focus/welfare/article/doyles.html>. on 26 Sept. 2009.

<sup>95</sup> NAZ, S1563, Report of the Native Commissioner, Ndanga, for the Year Ended 31 Dec. 1934.

<sup>96</sup> Southern Rhodesia, *Report on the Public Health for the Year 1930*, p. 12.

<sup>97</sup> Megan Vaughan, ‘Health and Hegemony: Representation of Disease and the Creation of the Colonial Subject in Nyasaland’, in Dagmar Engels and Shula Marks (eds.), *Contesting Colonial Hegemony: State and Society in Africa and India* (London & New York: British Academic Press, 1994), p. 191.

<sup>98</sup> Murray C. Steele, ‘The Foundations of a “Native” Policy: Southern Rhodesia, 1923-1933’, (DPhil thesis, Simon Fraser University, 1972), p. 292.

Syphilis was certainly not the only disease with an unpleasant therapeutic regimen. Other prevalent diseases such as bilharzia also had notably controversial treatment regimens. For a long time, physicians in colonial Africa, as was the case elsewhere, utilised antimony compounds such as tartar emetic (potassium tartrate) and stibophen (Fuadin) as a cure for bilharzia. Discovered by John Brian Christopherson in 1918,<sup>99</sup> the tartar emetic cure for bilharzia was the most widely used in Southern Rhodesia. Its anti-bilharzia pharmacological properties notwithstanding, antimony tartar emetic was notorious for its toxicity and the relatively long, repetitive intravenous treatment regimen which was distasteful to patients. Thus, there was a sense of hope in 1945 when a Southern Rhodesian physician, W. M. Alves, pioneered intensive treatment which entailed the increase of antimony dosages to try and reduce the treatment course.<sup>100</sup> Alves' new treatment schedule, which was locally known as the 'blitz method', was premised on a compressed 'two-day course of 6-8 injections of sodium tartrate (12 mg./kg. total dose'.<sup>101</sup>

The unveiling of the 'blitz' method was welcomed by officials of the Ndanga Unit. Writing in his annual report for 1945, the Native Commissioner for Bikita expressed confidence that, 'The new 'Blitz' treatment for bilharzias will have far reaching effects. Natives get tired of long courses necessitating numerous injections, and I feel certain that when the new method is in general use, many more Africans will avail themselves of it'.<sup>102</sup> Officials were clearly anxious for effective treatment of this common ailment. The situation was compounded by the fact that there were several diseases with lengthy treatment schemes. Tuberculosis patients were, for instance, also notorious for deserting as their treatment with isoniazid and

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<sup>99</sup> Ann Crichton-Harris, *Poison in Small Measure: Dr Christopherson and the Cure for Bilharzia* (Leiden: Koninklijke Brill, 2009). Accessed from <http://books.google.co.za> on 13 April 2011.

<sup>100</sup> Harry Most, 'Treatment of Schistosomiasis', *American Journal of Tropical Medicine and Hygiene*, vol. 4, no. 3 (1955), p. 456. Accessed from <http://www.ajtmh.org/cgi/reprint/4/3/455.pdf> on 13 April 2011.

<sup>101</sup> Most, 'Treatment of Schistosomiasis', p. 456.

<sup>102</sup> NAZ, S1563, Annual Report of the Native Commissioner, Bikita, for the Year Ended 31 Dec. 1945.

streptomycin, at least from the 1940s, was much longer than what syphilitic and bilharzia patients had to endure.

On their part, lactating mothers had different interpretations of fontanelle-related sickness from the views espoused by biomedical practitioners. Those mothers who discovered, when already in hospital, that their children were suffering from what was locally known as *nhova*, that is, a sunken fontanelle, usually requested to be discharged or to be allowed to go and consult indigenous experts.<sup>103</sup> There was serious divergence of opinion between biomedical specialists and indigenous tradition around this issue. The latter believed that, soon after birth, infants had to have their fontanelle medicinally-cum-spiritually fortified using indigenous therapeutic paraphernalia as a preventive measure against danger.<sup>104</sup> When this was not done and the child developed fontanelle-related complications, a finger was used to tenderly push up the sunken fontanelle. Remedies were then applied to keep it there.

However, doctors such as Kennedy abhorred the practices and chided African mothers for exposing their children to death through them.<sup>105</sup> Biomedical theories normally blame dehydration or some other anatomical disturbance for any illness related to the fontanelle. Thus, comprehensive patient care was emphasised. However, this did not stop many mothers stealthily taking their babies from the hospital to consult traditional healers and then bringing them back if necessary.<sup>106</sup> This was made possible by the fact that for the greater part of the period covered here patients stayed in huts. In all these processes of therapy selection, African patients and their helpers, unlike the officials who were schooled in biomedical

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<sup>103</sup> Interview with Mrs Chikumba, Bikita, 19 Sept. 2010.

<sup>104</sup> Aschwanden, *Symbols of Life*, pp. 268-9.

<sup>105</sup> Interview with Mrs C., Bikita, 19 Sept. 2010.

<sup>106</sup> Interview with Mrs C., Bikita, 19 Sept. 2010; Interview with Sr. Muchine, Gutu, 22 Sept. 2010.

theories, did not see any contradictions in using these ostensibly different healing systems concurrently as it fitted well into their hierarchy of resort.

Patient's preference of productive co-existence between biomedicine and indigenous therapies is borne out in their memories of Dr Simon Mazorodze, the second black doctor to practice in Ndanga from 1967. Dr Mazorodze is popularly remembered for recognising that there were illnesses that could not be treated in hospital and for recommending that such patients be taken to indigenous healers.<sup>107</sup> In that context, biomedicine was perceived as a specific intervention, dealing with only a circumscribed portion of an otherwise teleological sickness, that is, a sickness with a broader-than- physical meaning.<sup>108</sup> To borrow Luise White's apt expression, African voices 'cried out to be modern in one breath and traditional in the next'.<sup>109</sup>

In addition, patients wanted to use biomedical services on their own terms. A good example is the ambulance service. In the 1950s, there was public official outcry that patients abused the ambulance service by lodging calls for minor illnesses. Although, as eyewitness remembers, hospital authorities emphasised that for an ambulance to be called, the patient had to be very sick and unable to walk,<sup>110</sup> the apparent abuse drove Kennedy to despairingly tell the Medical Director that, 'compared with reasonable and legitimate use [of native ambulances], the number of instances of abuse make one wish, quite frankly, that such a service had never been instituted'.<sup>111</sup> Because of the widespread perception of abuse of this

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<sup>107</sup> Interview with SM., Ndanga, 25 Sept. 2010; Interview with Mrs C., Bikita, 19 Sept. 2010; Interview Mrs Alice J. Mazorodze (Dr Mazorodze's widow), Harare, 2 Oct. 2010.

<sup>108</sup> Caroline Kangwa, 'Traditional Healing and Western Medicine', p. 6. Accessed from <http://www.milligan.edu/academics/writing/pdfs/Kangwa.pdf> on 11 April 2011.

<sup>109</sup> Luise White, 'They Could Make Their Victims Dull': Genders and Genres, Fantasies and Cures in Colonial Southern Uganda', *American Historical Review*, vol. 100, no. 5 (1995), p. 1382.

<sup>110</sup> Interview with Mrs C., Bikita, 19 Sept. 2010.

<sup>111</sup> Southern Rhodesia, *Report on the Public Health for the Year 1952*, p. 16.

service, national medical officials were thus anxious to abdicate the service to another authority such as Native Councils.<sup>112</sup> What seems to have been at stake here were the different notions of what constituted serious sickness. Colonial officials always had this notion that Africans could walk long distances in search for therapy, without any problem. Therefore, their concerns about the abuse of ambulance services should be understood against this context.

Furthermore, as clinicians endeavoured to ‘expand their effectiveness, their clientele, and their social influence’;<sup>113</sup> patients also demanded certain patterns of behaviour and attitudes, especially from nurses. One retired nurse has memories of the difficulties of having to deal with, especially, tuberculosis patients who were very selective in their eating habits and very particular about the attitude of the nurses. Ninety-one years old Rebecca Shoko who worked as an orderly in the Unit remembers that,

TB patients were very difficult to deal with. They were very selective in their food habits, they would throw away food in your presence, whether meat, milk or anything.... They were also particular with your attitude as a nurse; they did not want you to appear as if you were shunning them. If a TB patient coughed while you were at their bedside they did not want you to shun that.<sup>114</sup>

It is possible that many other patients with different conditions were particular about the way they were handled by nurses. Kennedy is said to have been equally particular about the way patients were treated by nurses,<sup>115</sup> which could have put many of them in a quandary in cases such as the one narrated by Shoko. Among other things, this showed that the world of the patients was a very complex one.

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<sup>112</sup> NAZ, F122/400/63/3, Rural Clinics and Dispensaries, 1942-1959, D. Blair to Under-Secretary, Office of the Secretary of Native Affairs, 20 Sept. 1957.

<sup>113</sup> John Burnham, *What is Medical History?* (Cambridge: Polity Press, 2005), p. 6.

<sup>114</sup> Interview with Rebecca Shoko, Bikita, 19 Sept. 2010.

<sup>115</sup> Interview with Joyce Zingoni, Ndanga, 13 July 2010.

The question that the last part of this chapter therefore seeks to address relates to how officials handled such a complicated situation. How far were patient ideas, fears, interests and behaviour factored in the workaday running of the Unit? In short, to what extent did the Unit develop a patient-centred approach?

### **Officials' attitudes and actions**

Recognising that there was a great deal of scepticism, especially during the early days, district health officials adopted different strategies aimed at inducing patients to present themselves for treatment at the earliest stage of illness, as well as to gain their continuous confidence because treatment regimens tended to be long. Treatment was offered on very liberal terms, but patients' pluralistic behaviour was not welcomed, cultivated, or at least thoroughly explored for deeper understanding. The next few paragraphs will expand on and explain these key points.

To overcome patients' initial fear of the care by strangers, medical officials used subtle persuasion and inducements. The creation of patient villages, discussed at length in Chapter 4, was done on the principle of subtle inducement. In his first report as Medical Officer of Ndanga district, the pioneer of Ndanga Native Hospital, Dr Williams, wrote that,

The native has a great dislike to remaining as in-patients, and treatment as outpatients is very unsatisfactory, if for no other reason than that they do not return when pain and discomfort are relieved. In order to induce patients to remain in hospital two huts have been built so that friends may stay with them for a time.<sup>116</sup>

Kennedy further developed this system when he took over from Williams in the early 1930s. In his memoirs, Kennedy confessed that, 'One had to persuade patients, particularly women and children, to come for treatment – by some means or other'.<sup>117</sup> From the onset, 'it was

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<sup>116</sup> NAZ, H2/4/16 Ndanga District Surgeon, Report on the Ndanga Native Hospital for the Year Ending 31 Dec. 1913.

<sup>117</sup> James Kennedy, 'Bygones of a Bundu Bone Thrower: Part 1', *Central African Journal of Medicine*, vol. 3, no. 6 (June 1957), p. 237.

obvious that liberal and varied food was half the battle'.<sup>118</sup> Indeed, it was Dr Kennedy's practice to keep patient cases, even those considered by national public health officials to be minor cases, in hospital until they were cured. During the pre-penicillin days, syphilis cases were usually kept in hospital for the duration of the treatment, as they were prone to abscond from the course. It was usual for hospital officials to ask these convalescents to perform tasks such as grass cutting and the cleaning of hospital precincts. As elaborated in Chapter 4, the keeping in hospital of such patients was the source of constant friction between Kennedy and his Public Health Department superiors.

Another inducement, that was hailed by interviews such as Mr MH was the offer of free treatment to all patients. Although contemporary Zimbabwean patients' nostalgia about the good old days of free medical treatment should be understood against the background of the current decline in health services and the unaffordable hospital fees underpinned by economic collapse, it goes without saying that, even during the colonial period, free treatment was a boon for many families who were saddled with numerous tax commitments. Colonial district officials also understood this, and they thus fought hard to dissuade national authorities from introducing hospital fees, as they sought to do so from time to time. In 1938, the Native Commissioner for Bikita warned that,

It is greatly to be hoped that no charge will be made and I am quite convinced that the introduction of, even a small fee, at these clinics would do immense harm and years of effort expended in encouraging the Native to make use of European drugs and treatment of disease, would be wasted.<sup>119</sup>

The Native Commissioner repeated this plea in 1942 when he remarked that 'there is little doubt that this [practice of free treatment and food rations] contributes considerably to the popularity of the clinic'.<sup>120</sup> It was only in the 1970s that patients in hospitals such as Ndanga

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<sup>118</sup> Kennedy, 'Bygones of a Bundu Bone Thrower: Part 1', p. 229.

<sup>119</sup> NAZ, S1563/2, Report of the Native Commissioner, Bikita, for the Year Ended 31 Dec. 1937.

<sup>120</sup> NAZ, S1563/2, Report of the Native Commissioner, Bikita, for the Year Ended 31 Dec. 1941.

started paying fees, the details of which decision are outside the scope of this thesis. In addition to offering treatment on liberal terms, the district's officials also strove to care and successfully cure patients as a way of competing successfully with indigenous healers and gaining the confidence of many patients. It was hoped that notable success in clinical treatment would change African patients' attitudes to non-biomedical forms of healing. The Chief Native Commissioner was expressing this view when he confidently stated that,

There can be no doubt that there is no surer means of breaking down prejudice and of overcoming superstitious beliefs than that offered by medical service. The value of medicine and surgery cannot be overestimated, not only as a means of alleviating human suffering, but also as an educational agency, by which we gain confidence and goodwill of the native community.<sup>121</sup>

On his part, Kennedy confessed in his memoirs that he perceived himself as being in competition with 'witchcraft and tribal customs of all kinds'. As he reminisced, 'It was evident that we had to make these people feel "at home" and treat them under conditions they understood. It was also very necessary to achieve successes, if possible spectacular, or of a kind which at least, could be *seen*' (emphasis in original).<sup>122</sup> According to Kennedy, where treatment was not known, 'we would forecast for them, with some degree of accuracy, the course of illnesses.'<sup>123</sup> This strategy of outdoing or outperforming indigenous healers possessed a long colonial history and had been tried in other contexts before but never really succeeded, even with the official proscription of indigenous healing practices.<sup>124</sup>

This begs the question of whether, in using these strategies, district medical officials were concerned about developing patient-centred approaches or only vindicating biomedical culture or both. Did Ndanga develop a patient-centred approach? A plausible answer is that it

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<sup>121</sup> NAZ, 1618, Quarterly Review of Native Affairs for the Fourth Quarter Ended 30 Dec. 1934.

<sup>122</sup> Kennedy, 'Bygones of a Bundu Bone Thrower: Part I', p. 240.

<sup>123</sup> Kennedy, 'Bygones of a Bundu Bone Thrower: Part I', p. 240.

<sup>124</sup> David Gordon, 'A Sword of Empire? Medicine and Colonialism at King William's Town, Xhosaland, 1856-91', in Mary P. Sutphen and Bridie Andrews (eds.), *Medicine and Colonial Identity* (London, New York: Routledge, 2003).

did so only partly and to a limited extent. Both Kennedy and the Native Commissioners fought to keep liberal offers of treatment in place, not only because food is an important aspect of medical treatment and recuperation. Kennedy's endeavouring to achieve spectacular success did indeed bring benefits to patients and their families as illustrated by the testimonies quoted earlier. Also noble was the aim of making patients feel 'at home'.

However, the discourse surrounding these strategies was self-serving, while the practice was perceived as inferior medicine. The paramount aim of the officials was to vindicate biomedicine and thereby spread 'civilization'. Although that was also done as a way of attracting more patients, it ended up being pursued doggedly. As the next chapter will elaborate, the focus on achieving spectacular cures led to the neglect of other necessary public health strategies. More importantly, however, the patients' pluralistic outlook was dismissed as smacking of primitivism because they continued to hold on to their indigenous treatments. In his memoirs published in the late 1950s, Kennedy condescendingly said that, 'Even as recently as 25 years ago our particular clients were a wild and primitive tribe'.<sup>125</sup> These particular memoirs were heavily infused with caricature as the title, 'bygones of a bundu bone thrower' illustrates. The 'bundu' is untamed bush and the implication is that he was a bush doctor. Although he might have been looking for humorous alliteration, his description of himself as a 'bone thrower' and not a 'doctor' also indicates that he perceived himself as somehow having been indigenised by practising among people who often resorted to indigenous bone throwers for diagnosis. What he did was therefore an 'inferior' type of medicine, whose major aim the civilising of the 'primitive' races.

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<sup>125</sup> Kennedy, 'Bygones of a Bundu Bone Thrower: Part 1', p. 240.

Earlier, writing a report as a Rhodes scholarship alumna, he said that ‘Most of my time is spent in the... wilderness doing largely native work’.<sup>126</sup> During the following year, he reiterated that he was still ‘consolidating and expanding this Unit of Native Hospitals and clinics in Southern Rhodesia on a very large area. A good deal of this work is in wild and remote country’.<sup>127</sup> Given that he was writing this in a context in which other Rhodes scholars would be reporting their great achievements in different endeavours, he seems to have wanted to spell out his own achievements in spreading biomedicine and civilisation in a backward part of the British Empire. His intolerance of alternative, indigenous views is also borne out in the interviews.<sup>128</sup> Although ‘resistance to innovation and rejection of new technologies are common in all societies’,<sup>129</sup> among the patients at Ndanga this was taken as an act of primitivism and not rational mental thinking.

However, as the perceptive doctor, Herbert Aschwanden, noted in his research cited earlier in the chapter, in pursuit of their own ways of doing things, most practitioners forgot that before the advent of biomedicine Africans lived on the basis on their own knowledge. Writing specifically about indigenous maternity procedures, Aschwanden correctly noted that, ‘African women gave birth successfully long before the white man introduced sterility founded on science and, with the bacteria, also banished from the maternity-ward the human aspects of the act of childbirth’.<sup>130</sup> Although African childbirth could be improved, most white medics tended to be one-sided in their approach.

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<sup>126</sup> Rhodes House, James H. Kennedy – Rhodesia and Magdalen, 1920, Kennedy to Dr Allen, 17 Oct. 1948.

<sup>127</sup> Rhodes House, James H. Kennedy – Rhodesia and Magdalen, 1920, Kennedy, Scholar Report, 21 Jan. 1949.

<sup>128</sup> Interview with Mrs C., Bikita, 19 Sept. 2010.

<sup>129</sup> Kumar Deepak, ‘Science and Society in Colonial India: Exploring an Agenda’, *Social Scientist*, vol. 28, no. 5/6 (May/June 2000), p. 33. Accessed from <http://www.jstor.org/stable/3518179>. on 12 Jan. 2010.

<sup>130</sup> Aschwanden, *Symbols of Life*, p. 257.

## Conclusion

This chapter has attempted to sketch the ways in which African patients unofficially participated, through their own forms of agency, in the process of the transformation of rural healthcare delivery. Although reluctant to use this narrative to make a grand statement about the now fashionable anti-hegemonic discourse, the chapter nonetheless argues that patients were not just passive participants in a process that was clearly dominated by the interests of providers of care and healing. The reason why a crude counter-hegemonic narrative is eschewed, even when there are illustrative examples of patient power and agency, is that, because of colonial conditions, biomedicine tended to be an inherently distorting phenomenon in which patients participated to benefit from its beneficial knowledge and skills, but not to change it or alter its broader features *per se*.

The patient perspective forms only part of the story of biomedical transformation – and that story has a larger plot. Running the gamut between scepticism of and confidence in biomedicine, patients left a footprint in Ndanga. They, to a certain extent, contributed in the fashioning of its culture and ethos through the bargaining power they held as a result of medical pluralism and their conditions of illness. Alas, their perspectives were only partly taken into consideration; even then, this was done as an expedient to push other agendas. Thus, as the next chapter on public health will also show, the Unit's officials failed to overcome their own prejudices. They had a low regard for what they considered to be 'native' medical work.

## Chapter 7

### **Colonial ethnocentrism and public health: Assessing disease prevention and health promotion approaches in the Ndanga Unit**

#### **Introduction**

Thus far, this thesis has illustrated the potential strengths and fundamental weaknesses of the Ndanga Medical Unit by looking at the nature of the policy that brought it into being, the character and efforts of the pioneering medical officer, the role of African society and the administrative and local politics surrounding the Unit's emergence and development. This last chapter closes the thesis by focusing on some important, but often very difficult to accomplish aspects of public health: disease prevention and health promotion. The aim of the chapter is to assess the nature and effectiveness of the public health discourses, structures and contents upon which the Ndanga Unit was established. It proceeds from the premise that for the Ndanga Unit to eventually make a discernible impact on district health, it required a strong public health support structure and contents. Two companion questions are posed. First, what were the main components of the Unit's public health structure and contents? Second, what were the strengths and weaknesses of these?

Available evidence indicates that public health ideas and initiatives were not totally absent during the period under review. However, these initiatives were seriously defective because they tended to be framed in prejudicial, ethnocentric terms and triggered conflict between state agents and the communities, especially when it came to immunisations. Some of the initiatives were also severely underdeveloped. Some of these deficiencies were noted by contemporary observers within white settler society, but little was done to improve the situation. The main problem therefore seems to be that the public health service was framed as a *native* service, catering for a non-developed, subject population. What worsened things

was that, internationally at this time, the public health discourse was narrowing its focus because of the influence of bacteriology, and in the process it neglected issues to do with inequality which was at the heart of much ill-health in the colonial world.

The chapter has three main sections and a conclusion. It begins by contextualising the Ndanga Unit within the broader colonial and international public health discourses in order to show, as part of the background, the frame of mind that was at work in the formulation of the initiatives dealt with in the chapter. In the second section the chapter proceeds to outline and explore the various defects within the Unit's public health system. The third section illustrates the tensions generated in the processes of implementing some of the initiatives such as public immunisation. The concluding section ties up the chapter by reflecting on the key problems posed by the Unit's public health system.

### **Contextualising Ndanga: Disease, colonial public health and history**

Colonial disease outbreaks were complex phenomena which provoked ambiguous reactions from the dominant groups. In their delineation of the bifurcated character of the public healthcare approach in South Africa, Shula Marks and Neil Andersson noted that African epidemics provoked 'drastic interventions in the case of diseases which it was feared "would know no colour bar"' and the turning of a blind eye on those diseases confined to blacks in rural areas'.<sup>1</sup> Also to receive attention were those diseases in African areas which posed a threat to labour supply. This is not to say that the many debilitating and endemic diseases that occurred among the rural Africans were totally ignored.

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<sup>1</sup> Shula Marks and Neil Andersson, 'Typhus and Social Control: South Africa, 1917-1950', in Roy M. MacLeod and Milton J. Lewis, (eds.), *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London & New York: Routledge, 1988), p. 263.

On the contrary, the general conditions of sickness among African communities often provided opportunities for the propagation and institutionalisation of biomedical enlightenment and Christianity among the colonised peoples.<sup>2</sup> Also, as Michael Worboys has pointed out, colonial medicine was not totally insulated against a notable measure of welfarist, paternalist humanitarianism upon which some of the public health initiatives were premised.<sup>3</sup> Other scholars such as Douglas M. Haynes, Roy MacLeod and Milton Lewis have also noted that colonial disease control initiatives actually contributed to boosting the power and authority of Western medicine and the perceived moral superiority of Western institutions and ideas.<sup>4</sup> Disease prevalence, therefore, provided opportunities that were exploited for various purposes serving the agendas of colonial rule.

However, in addition to being subject to uneven development, these virtually discretionary healthcare impulses served the interests of their originators and, only tangentially, did they partly address the needs of the sick Africans *per se*. The social and geographical inequalities in health and healthcare in colonial Africa that a growing number of scholars have examined,<sup>5</sup> attest to the validity of this observation. Despite the often grand rhetoric, many of the programmes pursued by public health departments, as Miriam S. Chaiken has correctly

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<sup>2</sup> For instance see David Gordon, 'A Sword of Empire: Medicine and Colonialism at King William's Town, Xhosaland, 1856-91', in Mary P. Sutphen and Bridie Andrews (eds.), *Medicine and Colonial Identity* (London and New York: Routledge, 2003).

<sup>3</sup> Michael Worboys, 'The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940', *Osiris*, 2<sup>nd</sup> Series, vol. 15 (2000), p. 208.

<sup>4</sup> Douglas M. Haynes, *Imperial Medicine: Patrick Manson and the Conquest of Tropical Disease* (Philadelphia, Penn: University of Pennsylvania Press, 2001), p. 8; MacLeod and Lewis, (eds.) *Disease, Medicine and Empire*, pp. 10-11.

<sup>5</sup> Examples include Alan Jeeves, 'Delivering Primary Care in Impoverished Urban and Rural Communities: The Institute of Family and Community Health in the 1940s', in Saul Dubow and Alan Jeeves, (eds.), *South Africa's 1940s: Worlds of Possibilities* (Cape Town: Double Storey Books, 2005); Shula Marks and Neil Andersson, 'Issues in the Political Economy of Health in Southern Africa', *Journal of Southern African Studies*, vol. 13, no. 2, Special Issue on the Political Economy of Health in Southern Africa (1987), pp. 177-186; Maryinez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in northern Zaire, 1900-1940* (Cambridge: Cambridge University Press, 1992).

observed, were never adequate to fix basic healthcare defects in the colonies.<sup>6</sup> Only a few apologists of colonialism and colonial medicine have stated otherwise.<sup>7</sup>

The other major problem with colonial public health discourses around which policies were formulated was that much of the ill-health was considered to be inherently African, and biological and cultural theories were framed to advance such perceptions. Sandra M. Tomkins notes, for instance, that the persistence in the colonial world of diseases such as cholera and smallpox following their eradication in the temperate world, was perceived as ‘evidence of indigenous inadequacy and backwardness’.<sup>8</sup> As Randall Packard has also noted, the scandalous deaths of Central African labour migrants in South African mines in the early twentieth century was, for instance, explained through a ‘typologising’ medical discourse which presented their mortality as resulting from the ‘cultural and ultimately biological susceptibilities of “tropical” workers, rather than from the working and living conditions on the mines’.<sup>9</sup>

As such, instead of substantially reforming social conditions in the mines and the surrounding compounds, officials sponsored research into drug development – that is, curative rather than preventive medicine – a much cheaper option than social reform. The net effect of this stereotypical approach was that the important subject of African healthcare was not

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<sup>6</sup> Miriam S. Chaiken, ‘Primary Health Care Initiatives in Colonial Kenya’, *World Development*, vol. 26, no. 9 (Sept. 1998), p. 1701.

<sup>7</sup> For instance, see Michael Gelfand, *Tropical Victory: An Account of the Influence of Medicine on the History of Southern Rhodesia, 1890-1923* (Cape Town: Juta and Co., 1953); Lewis Gann and Peter Duignan, *Burdens of Empire: An Appraisal of Western Colonialism in Africa South of the Sahara* (London: Pall Mall Press, for The Hoover Institute, 1968).

<sup>8</sup> Sandra M. Tomkins, ‘Colonial Administration in British Africa during the Influenza Epidemic of 1918-19’, *Canadian Journal of African Studies*, vol. 28, no. 1 (1994), p. 62.

<sup>9</sup> Randall Packard, ‘The Invention of the “Tropical Worker”: Medical Research and the Quest for Central African Labour on the South African Gold Mines, 1903-36’, *Journal of African History*, vol. 34, no. 2 (1993), p. 274.

approached objectively and holistically, but rather piecemeal and with prejudicial inclinations.

While African healthcare suffered in general because of the predominantly self-serving theories and perceptions of colonial officials, the prevention of disease and improvement of health among rural communities through, among other things, community development, environmental health, and other non-biomedical measures, also failed to blossom because of the general decline in influence in public health of the environmental impulse. According to Virginia Berridge, during the twentieth century the 'ideology' and 'aims' of public health 'narrowed' as a result of the growing influence of bacteriology.<sup>10</sup> Personal prevention and personal services took the place of environmental health. 'Ignorance' gained prominence as an explanatory category as ill-health came to be increasingly viewed as an 'avoidable flaw',<sup>11</sup> and health education promoted as the main preventive tool. Although poverty and inequality (the social determinants of ill health) loomed large as factors in poor health status, officials responded by deploying 'health visitors, personal services and health education'.<sup>12</sup> There was obsession with what was known as *higienismo* in the Latin American world. Under *higienismo*, the focus was on infection control, narrow notions of nutrition and other population health initiatives and hygienic interventions mainly linked to labour productivity, national development and settler public health.<sup>13</sup>

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<sup>10</sup> Virginia Berridge, *Marketing Health: Smoking and the Discourse of Public Health in Britain, 1945-2000* (Oxford: Oxford University Press, 2007), p. 7.

<sup>11</sup> Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001), p. 4.

<sup>12</sup> Berridge, *Marketing Health*, p. 9.

<sup>13</sup> Howard Waitzkin et al, 'Social Medicine Then and Now: Lessons from Latin America', *American Journal of Public Health*, vol. 91, no. 10 (Oct. 2001), p. 1594. Accessed from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446835/pdf/0911592.pdf>. on 10 Feb. 2011.

As public health became strongly influenced by bacteriology, treatment increasingly became a dominant element of disease prevention. For instance, while still a Medical Officer in Bristol, Askins (who later became a key public health figure in Southern Rhodesia) stated that ‘The extension of clinic treatment must be regarded as a notable advance in preventive medicine’.<sup>14</sup> In the same curative vein, he later opined that the implementation of the British Public Health Act of 1875 had, up to c. 1900, only focused on environmental aspects, ‘neglecting’ medical treatment.<sup>15</sup>

The general view that disease control through investigation and treatment was to be the cornerstone of modern healthcare found much fertile ground in colonial contexts where the organisation of *bona fide* preventive services, especially in rural areas, was considered to be a logistically difficult and futile exercise. ‘[H]aving regard for the kraal conditions under which the native lives, and the difficulty of changing his traditional habits – it is not easy to devise any hopeful preventive measures’, argued one Southern Rhodesian medical officer in 1932.<sup>16</sup> In this medical officer’s view, ‘increased investigation and treatment must remain the method of election, now and for sometime to come’. In addition, medical officials were to prioritise ‘the time-honoured’ approach of ‘dealing with individual cases, or epidemics, as they arise’.<sup>17</sup>

In this warped thought, this medical officer was not alone. Making his own intervention on this subject more than ten years later, Godfrey Huggins, the colony’s Prime Minister who was a surgeon by training, admitted that, ideally, the government was supposed to focus on providing food, shelter, safe water, efficient sanitation and the elimination of scourges such

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<sup>14</sup> Bristol Records Office (hereafter BRO), Bristol Education Committee, *Report of the School Medical Officer for the Year Ended 31<sup>st</sup> Dec. 1920*, p. 5

<sup>15</sup> BRO, City and County of Bristol, *Annual Report of the Medical Officer of Health 1928*, p. 4.

<sup>16</sup> National Archives of Zimbabwe (hereafter NAZ), S1173, Government Medical Officer, Melsetter, to Medical Director, 30 April 1932.

<sup>17</sup> NAZ, S1173, Government Medical Officer, Melsetter, to Medical Director, 30 April 1932.

as malaria and bilharzia, in order to reduce hospitalisation and the expensive resort to doctors.<sup>18</sup> Alas, Huggins dithered, opining that this constituted a long-range vision that would take a long time before turning into reality. He thus suggested that, ‘meanwhile our curative services must be greatly increased’.<sup>19</sup> Earlier, the Chief Native Commissioner, C. L. Carbutt, had also thrown his weight behind curative care by stating that: ‘[I]n the last resort the ultimate appeal is just to vindicate white medicine and surgery by a series of cures so that the preponderance of our successes over native herbalists speaks sufficiently loudly to convince even the most superstitious and the most timid’.<sup>20</sup>

This consensus between medical officers, politicians and bureaucrats was obviously driven by the growing influence of curative medicine which dominated medical training and was itself increasingly confident that it could overcome disease thanks to therapeutic innovations like salvarsan (1920s) and antibiotics (1940s). Curative institutions were also thought to be affording colonial officials the visibility they desperately desired among African communities in order to justify colonisation, something which was not possible with purely preventive services. Thus, some historians have found the hospital to be the most potent catalyst for the globalisation of and institutional dominance of Western biomedicine.<sup>21</sup>

Indeed, hospital care continued to dominate the healthcare discourse in Southern Rhodesia. The 1959 Report of the Commission of Inquiry into the Health and Medical Services of the Federation (of the Rhodesias and Nyasaland), claimed that the hospital was a foremost active agent of health education for rural communities, through services such as maternal and child

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<sup>18</sup> NAZ, Gen-P/Hug, Godfrey Huggins, ‘National Health Service: Prime Minister’s Survey of Conditions in Southern Rhodesia’, An Address to a Public Meeting, Bulawayo, 1 Feb. 1944, p. 1.

<sup>19</sup> Huggins, ‘National Health Service: Prime Minister’s Survey of Conditions in Southern Rhodesia’, p. 2.

<sup>20</sup> NAZ, S1173/333, C. L. Carbutt quoted in J. Leggate to R. Askins, 18 Dec. 1932.

<sup>21</sup> Mark Harrison, ‘Introduction’, in Mark Harrison et al (eds.), *From Western Medicine to Global Medicine: The Hospital Beyond the West* (New Delhi: Orient Black Swan, 2009), p. 1.

care, child guidance and physiotherapy, among many other services.<sup>22</sup> Pushing further the idea that hospitals and clinics ‘are proving as agents for such aspects of both curative and preventive’ services, the authors of the report averred that the flow of ‘primitive’ patients through clean wards had instructive qualities as they would be influenced to adopt habits of cleanliness, hygiene and the general benefits and comforts of biomedicine.<sup>23</sup>

Only in the 1960s and 1970s did the chickens begin to come home to roost in Southern Rhodesia and in many parts of the world. Officials began to accept that the colony had been building a very unsustainable healthcare system. The Secretary for Health, Charles Webster, lamented the fact that ‘at least 90 percent of the cost of the medical services is related to the cost of running hospitals and clinics very largely for the treatment of preventable diseases’.<sup>24</sup> Gloomily, Webster warned: [We] are standing today at cross-roads – one way leads to disaster, the other is fraught with many difficulties....<sup>25</sup> That the colony had developed to that poor state of public health is rather surprising given the fact that during the late 1930s, the Public Health Department was signalling a shift of focus to disease prevention. The Medical Director, A. P. Martin, admitted in 1937, that,

On the preventive side... progress has not been so steady and satisfactory. Prevention is neither exciting nor spectacular, and the assets of prevention are largely invisible; there are no fine hospitals, marvellous operating theatres or awesome X-ray plants to catch the eye, nor is there the dramatic thrill of snatching an individual life right from the jaws of death, to excite imagination.<sup>26</sup>

However, as Martin further argued, the ‘concentration on the curative side of medicine to the exclusion of the preventive side is not only bad medicine but unsound finance’.<sup>27</sup> Martin

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<sup>22</sup> Federation of Rhodesia and Nyasaland, *Report of the Commission of Inquiry into the Health and Medical Services of the Federation* (Salisbury, 1959), p. 24.

<sup>23</sup> Federation of Rhodesia and Nyasaland, *Report of the Commission of Inquiry into the Health and Medical Services of the Federation* (Salisbury, 1959), p. 24.

<sup>24</sup> Mark H. Webster, ‘A Review of the Development of the Health Services of Rhodesia from 1923 to the Present’, *Central African Journal of Medicine*, vol. 19, no. 3 (1973), p. 50.

<sup>25</sup> Webster, ‘A Review of the Development of the Health Services of Rhodesia from 1923 to the Present’, p. 51.

<sup>26</sup> Southern Rhodesia, *Report on the Public Health for the Year 1937*, p. 2.

<sup>27</sup> Southern Rhodesia, *Report on the Public Health for the Year 1937*, p. 2.

realised that sound public health knowledge and measures were required among ‘all classes and races in the Colony’, but especially among mothers and children and the African communities producing labour.<sup>28</sup> He noted some of the public health challenges that had been brought to his attention by government medical officers. These included poor housing conditions and lack of sanitary facilities, which were responsible for intestinal diseases. He also noted nutrition-related troubles. Although taking the responsibility for inordinate focus on curative care, Martin also chided both races for ignoring the very basic laws of disease prevention and health promotion, including hygiene, sanitation, prophylactic measures, nourishment and housing. In his opinion, ‘at least two-fifths of the ills that beset them arise from preventable causes and causes whose prevention lies entirely in their [public’s] own hands’.<sup>29</sup>

Broadly speaking, Martin’s understanding of public health was progressive for his time.

Martin was of the view that,

Medical knowledge must be linked with the life of the people and this can only be achieved when public health ceases to be regarded as an isolated science concerned only with drains and sewage disposal and dependent solely upon its supervision of hospital and medical services for its contact with the people. Public health is national health, the science of the prevention of disease, and to achieve its purpose public health must be linked up with every form of national activity... only by concerted planning – planning which invites and secures the willing co-operation of the agricultural industry, the mining industry, commerce and trade, the townsman and the rural dweller, the European and the native – can the national health be built up and the knowledge of the means of prevention brought home to every inhabitant of this Colony.<sup>30</sup>

Coordinated planning and the wider conception of health to include economic activity, are some of the hallmarks of preventive public health. To begin to shift the focus towards

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<sup>28</sup> Southern Rhodesia, *Report on the Public Health for the Year 1937*, p. 2.

<sup>29</sup> Southern Rhodesia, *Report on the Public Health for the Year 1938*, pp. 1-2.

<sup>30</sup> Southern Rhodesia, *Report on the Public Health for the Year 1938*, p. 6.

preventive health, in 1938 a Field Officer responsible for surveys had been appointed.<sup>31</sup> Martin also proposed the division of the colony into six 'public health districts' operated by medical officers trained in public health administration. These officers would be responsible for conducting surveys among African communities in respect of housing, nutrition and disease. In essence, they would study local conditions and make recommendations.<sup>32</sup>

These progressive ideas by Martin fit into the positive review of colonial healthcare by Helen Tilley. Tilley has correctly argued that colonial healthcare officials were not oblivious of public health challenges and ideas, as many scholars have argued. Instead, they engaged in auto-criticism and challenged the status quo as it related to curative care.<sup>33</sup> However, Tilley failed to separate rhetoric from action. The undeniably progressive ideas were not matched with equally progressive action. In fact, some of Martin's ideas were contradictory and condescending of African life. He condemned Africans as people of 'unhygienic habits' and their indigenous housing as 'breeding-ground of many forms of sickness and death'.<sup>34</sup> Moreover, he continued to see African health through the eyes of European healthcare. Martin was worried that African communities continued to throw up epidemics that threatened Europeans. The major effect of this was that the focus tended to be propaganda about hygiene, the rapid re-orientation of people's ideas about healthcare-related issues and the enforced suppression of epidemics. As the next two sections will show, there was little development and improvement in life conditions. This too was recognised but little was done, perhaps because the Africans were disenfranchised subjects.

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<sup>31</sup> Southern Rhodesia, *Report on the Public Health for the Year 1938*, p. 1.

<sup>32</sup> Southern Rhodesia, *Report on the Public Health for the Year 1938*, p. 3.

<sup>33</sup> Helen Tilley, *Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge, 1870-1950* (Chicago: University of Chicago Press, 2011), pp. 214-215.

<sup>34</sup> Southern Rhodesia, *Report on the Public Health for the Year 1938*, pp. 7-8.

### The Unit's public health profile

As a first step towards the appraisal of the Ndanga Unit's public health system, it may be useful to recall what some contemporary witnesses observed and said about it. The first known contemporary critique of the Ndanga Unit system was offered by Dr. Dyson Milroy Blair<sup>35</sup> who, in 1938, made history by becoming the colony's first Field Officer and, in 1948, the inaugural Director of Preventive Services. On a few occasions Blair acted as a locum for Dr Kennedy. As already pointed out, writing in a personal statement drafted in April 1945, Blair noted critically that,

Even now the only work of real lasting value to the African population is being carried out by one medical officer [Dr. Kennedy] who works whole-time with African patients. However, even in this well-managed scheme so far little attempt has been made to prevent disease. The Ndanga system in conjunction with a public health survey to include vital statistics and practical control in all aspects of health would achieve a result similar to that obtained by the Foreami scheme.<sup>36</sup>

While welcoming the increase in the number of rural clinics between 1935 and 1945, Blair lamented that these clinics were largely biased towards curative functions and little was done in pursuing 'the cause' of 'the effect'.<sup>37</sup> Blair's critical sentiments were echoed in 1945 by the Southern Rhodesian National Health Services Inquiry Commission (or Saint Commission).<sup>38</sup>

The Saint Commission Report refrained from condemning the Ndanga scheme outright, even

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<sup>35</sup> Born in Fiji of Scottish parents, Blair joined the Southern Rhodesia medical service in late 1931. He rose through the ranks to become a Secretary for Health in 1958. Blair was also well known for his work on schistosomiasis which earned him recognition by international organisations such as the World Health Organisation. R. M. Morris et al, 'Obituary: Dyson Milroy Blair', *Central African Journal of Medicine*, vol. 24, no. 5 (1978), p. 103.

<sup>36</sup> NAZ, S2406/1, Historical Notes on Medical Services, 1942-46, Dyson M. Blair, 'A Personal Statement of Personal Views on Preventive Medicine and Its Application in Southern Rhodesia, 1939-1945', 13 April 1945, p. 1. As explained in the introduction, the foreami was a Belgian Congo initiative. For more see Maryinez Lyons, 'Public Health in Colonial Africa: The Belgian Congo', in Dorothy Porter (ed.), *The History of Public Health and the Modern State* (Amsterdam & Atlanta, GA: Rodopi B. V., 1994), p. 371.

<sup>37</sup> NAZ, S2406/1, Blair, 'A Personal Statement of Personal Views on Preventive Medicine', p. 1.

<sup>38</sup> This Commission, whose recommendations were never implemented, came hot on the heels of South Africa's own National Health Service Commission (1944) which, in turn, might have been partly inspired by the British Beveridge Report of 1942. See, Anne Digby, 'Vision and Vested Interests': National Health Service Reform in South Africa and Britain During the 1940s and Beyond', *Social History of Medicine*, vol. 21, no. 3 (2008), pp. 485-502.

though admitting that its overall strategy exhibited serious inadequacies.<sup>39</sup> Restrained by the acknowledgement that the scheme was until then the only example of organised rural medical care in the colony, developed ‘when there was little else... to bring some form of health service to all those [Africans] who needed it’, the Saint Commission opted for circumspection. Nevertheless, the Commissioners’ main concern with the Ndanga system was that, in addition to being makeshift, it was also wittingly or unwittingly promoting increased hospitalisation, downplaying the ‘paramount importance of preventive work’.<sup>40</sup> The Saint Commission called for significant improvements in general African health conditions within the Unit’s catchment area so that services ‘of a higher standard than Ndanga has been able to give’, could be provided.<sup>41</sup>

The Saint Commission adopted Blair’s suggestion of an expanded *Foreami*-like scheme and suggested that it be pioneered in Ndanga. Calling it ‘[H]ealth and [S]ocial [D]evelopment’, the Commission recommended that the ruling colonial government of Huggins should make a ‘concerted effort to improve, not only the health, but also the well-being of the inhabitants’. Such an effort should, of necessity, give attention to: health measures, both preventive and curative; agricultural development (conservation, irrigation, afforestation); animal husbandry; nutrition; housing; sanitation; water supplies; vital statistics; education (practical and theoretical); development of communications; transport facilities; development of townships (marketing, health and educational centres); and establishment of inland fisheries.<sup>42</sup> The Commission’s suggestion that Ndanga be the pioneer station was premised on the fact that Dr

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<sup>39</sup> Southern Rhodesia, *Report of the National Health Services Inquiry Commission*, 1945.

<sup>40</sup> Southern Rhodesia, *Report of the National Health Services Inquiry Commission*, 1945, pp. 66-7.

<sup>41</sup> Southern Rhodesia, *Report of the National Health Services Inquiry Commission*, 1945, p. 67.

<sup>42</sup> Southern Rhodesia, *Report of the National Health Services Inquiry Commission*, 1945, p. 57.

Kennedy had already started ‘tackling the health of the family’ and that the ‘potentialities for improvement of agriculture, by education and irrigation, appear considerable’.<sup>43</sup>

However, this elaborate programme seems to have been doomed by Huggins’ 1944 pre-emptive strike cited earlier in the chapter. Although he acknowledged that these were noble ideas, in terms of implementation they had to be postponed. Nevertheless, the Saint Commission’s approach struck at the heart of what was missing in the Ndanga Unit. Instead of improving conditions of living through development, officials sought to change people’s living habits through what appeared to be ethnocentric ideas or *higienismo*.

To further understand this concept of *higienismo* which was briefly explained earlier in the chapter, it may be helpful to refer to a similar concept of ‘surveillance medicine’ which emerged out of the growing influence of bacteriology in the twentieth century.<sup>44</sup> According to Virginia Berridge, in surveillance medicine ‘the individual patient became the locus of infection’, while ‘education and personal hygiene’ became the golden remedies.<sup>45</sup> This impulse gained currency in political circles in many parts of the world because it was amenable to ‘a circumscribed notion of appropriate intervention’.<sup>46</sup> In colonial Africa, such notions and approaches tended to be ethno-specific. Megan Vaughan has demonstrated in her work that the construction of the ‘African’ and ‘African sickness’ was a central element of colonial medical discourse.<sup>47</sup> In such cases officials were pre-occupied with tracing the sick, especially those with infectious and loathsome diseases, and forcing them to submit to treatment.

<sup>43</sup> Southern Rhodesia, *Report of the National Health Services Inquiry Commission*, 1945, p. 57.

<sup>44</sup> This concept was first developed by David Armstrong and Dorothy Porter. Virginia Berridge, ‘History in Public Health: A New Development for History’, p. 28. Accessed from: <http://www.ep.liu.se/ej/hygiea/ra/003/paper.pdf>, on 30 April 2010.

<sup>45</sup> Berridge, ‘History in Public Health: A New Development for History’, p. 28.

<sup>46</sup> Berridge, ‘History in Public Health: A New Development for History’, p. 28.

<sup>47</sup> Megan Vaughan, *Curing their Ills: Colonial Power and African Sickness* (Cambridge: Polity Press, 1991).

Within the colonial African version of *higienismo*, many of the preventable diseases were blamed on African mentality and living habits. A mind frame of difference and cultural superiority guided the views of the colonial officials. Rural diseases were framed as inherently African, hence labels such as ‘kaffir itch’, ‘kaffir sores’, ‘kaffir ulcer’, for instance. These supposedly ethno-specific diseases were blamed on ‘kraal’ (as African homesteads were then known) conditions and the unchanging traditional habits of the Africans.<sup>48</sup> In line with this thinking, the Ndanga Unit’s Native Commissioners who occupied an important position within the three districts’ public health structures blamed the continuous prevalence of preventable diseases in their districts on what they perceived to be Africans’ slow acceptance of sanitary and hygienic ideas.<sup>49</sup> Indeed, in 1936, one of the main areas of concern flagged by the Native Commissioner, Ndanga, was that ‘no progress in sanitation is noted’ among the Africans, despite official efforts in that area.<sup>50</sup>

Helminthic diseases such as bilharzia (or schistosomiasis) were blamed on African bathing habits. In 1945, reporting on this very prevalent disease, the Native Commissioner, Bikita, said, ‘on arrival at this station, one is struck by the vast number of people seen bathing in streams. Unfortunately, this very pleasant habit is the cause of many people being infected with bilharzias’.<sup>51</sup> Writing on malaria, the same Native Commissioner drew a link between African living habits and the prevalence of this disease by opining that ‘it is only by teaching natives to improve their methods of living that this disease [malaria] will be stamped out’.<sup>52</sup>

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<sup>48</sup> NAZ, S1173/333, Government Medical Officer, Melsetter, to Medical Director, 30 April 1932.

<sup>49</sup> NAZ, S1563, Native Commissioners and Acting Native Commissioners Annual Reports, Annual Report of the Native Commissioner, Ndanga, for the Year Ended 31 Dec. 1934.

<sup>50</sup> NAZ, 1563/2, Report of the Native Commissioner, Ndanga, for the Year Ended 31 Dec. 1936.

<sup>51</sup> NAZ, S1563, Annual Reports, Native Commissioners, Annual Report of the Native Commissioner, Bikita, for the Year 1945.

<sup>52</sup> NAZ, S1563, Annual Reports, Native Commissioners, Annual Report of the Native Commissioner, Bikita, for the Year 1945.

Perceived African prejudice and superstitious beliefs were also sharply criticised.<sup>53</sup> Weighing in, Huggins stated publicly that, as far as health was concerned, ‘the native is his own worst enemy. He prefers the witch doctor to the European doctor.’<sup>54</sup>

Framing disease as inherently African prefigured the specific responses that were perceived to be suited to deliver the basic health needs to the African communities, as determined by colonial officials. One of the ways in which colonial officials sought to deal with rural health problems was to embark on spreading ‘civilising’ propaganda – a very ambiguous process which fronted a corps of moderately educated Africans as the propaganda staff. In 1929, Harold Jowitt, a reform-minded education expert, had introduced the Jeanes Teacher scheme, which was a community education scheme formulated on the example of the American South’s community teaching scheme.<sup>55</sup> Organised and funded by the state and implemented through the managerial agency of missionaries, the Jeanes Teacher Programme’s aim was to equip moderately educated and mainly Christianised Africans with ‘basic skills of community development, including hygiene, school improvement, industrial skills, medical aid and domesticity’.<sup>56</sup> These Jeanes teachers were trained as demonstrators at Domboshawa, near Salisbury and Hope Fountain, near Bulawayo. In addition to the supervision of rural schools, these community modernisers, were required to supervise community clean-ups and the digging of pit latrines.<sup>57</sup>

An outcome of the early colonial period’s linkage between African education and health, this programme was used by officials as part of the healthcare propaganda, focusing on basic

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<sup>53</sup> NAZ, S1618, CNC, Quarterly Review of Native Affairs, 30 Dec. 1934.

<sup>54</sup> NAZ, Gen-P/Hug, Huggins, ‘National Health Service’, p. 5.

<sup>55</sup> Carol Summers, ‘Giving Orders in Rural Southern Rhodesia: Controversies Over Africans’ Authority in Development Programmes, 1928-1934’, *International Journal of African Historical Studies*, vol. 31, no. 2 (1998), pp. 279-300.

<sup>56</sup> Summers, ‘Giving Orders in Rural Southern Rhodesia’, p. 280.

<sup>57</sup> Summers, ‘Giving Orders in Rural Southern Rhodesia’, p. 280.

forms of rural sanitation and hygiene among other things. In the Ndanga Unit area, the Jeanes Teacher scheme ran into serious problems because of petty jealousies among different departments. The Native Affairs Department officials, who generally regarded themselves as the 'guardians of the natives', were particularly unhappy that the programme was not under their direct control. E. G. Howman, the Fort Victoria-based Superintendent of Natives, warned that,

I do not want the Jeanes Teacher [Lysias Mukahleyi] to do anything for me as long as he remains outside my control. I do not know what community work means exactly but if it consists of pestering the village dwellers to adopt European methods of hygiene, sanitation, etc., I do not think it worthy of our support.<sup>58</sup>

This did not mean that Howman was in principle opposed to the idea of spreading knowledge of hygiene and sanitation. Instead, he was opposed to the idea of such work being done by an African outside his administrative control. When the Jeanes Teacher Programme collapsed, the state introduced another special scheme of to train health assistants (initially called hygiene demonstrators). The scheme was inaugurated with the aim of promoting preventive community healthcare work, including hygiene and sanitation, disease surveillance, vaccination, and environmental health.<sup>59</sup> The health assistants' scheme reached its apogee in the 1960s, with the Ndanga Unit having a team of ten members. They inspected schools, housing, and water supply, rubbish disposal, business premises, investigated sickness in homes and outbreaks of epidemics, and also helped people initiate community development projects such as the securing of water points.

For instance, in December 1950, A. B. Mashingaidze, a health assistant responsible for covering parts of Gutu, broke news of an outbreak of smallpox in the Chitsa area in northern Gutu. In a handwritten note to the Government Health Inspector for Fort Victoria province,

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<sup>58</sup> Quoted in Summers, 'Giving Orders in Rural Southern Rhodesia', p. 293.

<sup>59</sup> Michael Gelfand, *A Service to the Sick: A History of the Health Services for Africans in Southern Rhodesia, 1890-1953* (Gwelo: Mambo Press, 1976), pp. 144-5.

Mashingaidze noted that, since 25 December 1950, the disease had killed four children of the same family, one child from a different family, while four other members were ‘badly attacked which will result in death.... As they carry these children the disease is spreading because most of these people were not treated due to the fact that medicines got finished ....’<sup>60</sup> Mashingaidze was concerned that if urgent action was not taken, ‘these four will die again and it [smallpox] will spread badly’.<sup>61</sup>

Ostensibly to expand the work of health assistants, in 1966 the Fort Victoria provincial medical directorate introduced a community nursing scheme under the auspices of the Rhodesia Freedom from Hunger Campaign, a local programme of a United Nations initiative, started in 1960. The inauguration in Ndanga of a community nursing scheme also chimed in with the general shift towards community development by the Rhodesian state.<sup>62</sup> For its part, the Rhodesian state was also aligning itself with international developmental trends which were increasingly foregrounding community development initiatives.

The community-nursing scheme was first introduced in Ndanga, with two partly trained community nurses appointed to specialise in home-based maternal and child welfare.<sup>63</sup> As their focus was child nutrition and health, this inevitably entailed dealing with the entire home environment, including housing, location of kraals, home gardens, rubbish disposal, and food provision. Community nurses particularly targeted homes with newly-born infants, and gave lectures and demonstrations on baby feeding, child illness and welfare, food values

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<sup>60</sup> Masvingo Records Office (hereafter MRO), Box 1534, Provincial Medical Director, 1956-1983, A. B. Mashingaidze, Health Assistant, Gutu, to Government Health Inspector, Fort Victoria, 30 Dec. 1950

<sup>61</sup> MRO, Box 1543, Mashingaidze to Government Health Inspector, 30 Dec. 1950

<sup>62</sup> In 1962, under political and economic pressure, the colonial state sought ways of ‘divesting the state of responsibility for the delivery of rural services’. Michael Bratton, ‘Settler State, Guerrilla War and Rural Underdevelopment in Rhodesia’, *Journal of Opinion*, vol. 9, no. 1/2 (1979), p. 57.

<sup>63</sup> MRO, Box 1534, C. Phillips, Public Health Nurse, to G. H. Woodlands, Provincial Health Inspector, Fort Victoria, 14 Sept. 1967.

and cooking, causes of malnutrition and the use of supplementary foods such as powdered milk.<sup>64</sup> Those who were found sick were encouraged to visit the nearest clinic.

The main differences between health assistants and community nurses was that the former had a larger remit as their work included the inspection of prospective and existing business premises to determine any public health concerns and to inform the authorities accordingly. They worked from the Native Commissioner's compound, but reported to the Government Health Inspector. Community nurses focused more on mother-and-child welfare. Their work thus involved tracking those homes with expecting mothers and those with recently-born babies, conducting child care demonstrations and lecturing on other necessary child care issues. In such homes they also spoke about hygiene and sanitation. Community nurses mostly worked from local hospitals or clinics, and their arrival coincided with the emergence of well-baby clinics.

All these initiatives were good and relevant. However, the focus tended to be on surveillance while community development was neglected. As a result, they had limited impact. The noble suggestions of the Saint Commission were ignored. A telling example that can be explored here is the issue of water development in Gutu. With erratic rainfall and a soil type that is 'predominantly coarse-grained sandy loams...with low organic and mineral nutrients...poor water retention capacity and friable characteristics that make them susceptible to soil erosion',<sup>65</sup> Gutu was a likely environment for enteric fevers and gastroenteritis. Available sources covering the period under review are replete with reports drawing attention to typhoid cases.

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<sup>64</sup> MRO, 1534, Phillis A. Makore, Community Nurse, Monthly Report 31 May 1966.

<sup>65</sup> Hamasai Hamandawana et al, 'Population Driven Changes in Land Use in Zimbabwe's Gutu District of Masvingo Province: Some Lessons from Recent History', *Applied Geography*, vol. 25 (2005), p. 249. Accessed from [www.sciencedirect.com](http://www.sciencedirect.com), on 12 March 2010.

In 1937, Native Commissioner for Gutu reported that, during hot weather and prior to the beginning of the rains, stomach and bowel problems were very prevalent due to the problem of water supply.<sup>66</sup> In 1938, the Native Commissioner again drew attention to the inadequate water supply, which precipitated an epidemic of stomach problems and dysentery.<sup>67</sup> In 1946, Mutema School was hit by an epidemic that was only diagnosed as typhoid after 37 serious cases had been removed to Ndanga where an examination was done.<sup>68</sup> Typhoid continued to be a menace in Gutu throughout the 1950s, and its widespread existence is confirmed by both written documents and oral sources. A key informant revealed that the current tuberculosis isolation ward at Gutu Mission Hospital used to be an isolation ward for typhoid cases.<sup>69</sup> Although the state continued to blame African communities, it was the state which failed to provide safe water sources.

Indeed, the state was guilty of many other omissions. While officials often condemned Africans for being filthy, the state also failed dismally to keep its institutions in good condition. In 1945, following his sharp criticism of African living habits, the Native Commissioner for Bikita had to admit that '[I]t is useless, however, preaching to the people on improving their conditions when messengers and Government employees are housed in dilapidated pole and dagga huts'.<sup>70</sup> Sending out a similar message, in the late 1950s the two health assistants at Ndanga Hospital were reported to be without proper accommodation.<sup>71</sup> Moreover, the community nursing programme collapsed within two years of its operation

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<sup>66</sup> NAZ, S1563/2, Report of the Native Commissioner, Gutu, for the Year Ended 31 Dec. 1937.

<sup>67</sup> NAZ, S1563/2, Report of the Native Commissioner, Gutu, for the Year Ended 31 Dec. 1937.

<sup>68</sup> NAZ, S1563, Report of the native Commissioner, Gutu, for the Year Ended 31 Dec. 1946.

<sup>69</sup> Interview with Sr. Muchine, Gutu Mission, 24 Sept. 2010.

<sup>70</sup> NAZ, S1563, Annual Report of the Native Commissioner, Bikita, for the Year 1945.

<sup>71</sup> NAZ, F400/108/38, Lewis to Director of Medical Services, 26 Nov. 1957.

because of funding problems. Over the two years of its operation, the officials had managed to recruit and train only three community nurses in total.

In addition to poor housing for state employees, patient housing in the Ndanga Unit was always appalling. In Chapter 3, the challenges encountered by Kennedy when he tried to improve patient accommodation were discussed at length, which precludes any further discussion here. Suffice it to say that during the mid-1940s, Gutu clinic was rocked by patient desertions because of the serious infestation of patient housing with ticks that caused relapsing fever.<sup>72</sup> In both Ndanga hospital and Gutu clinic, patient huts had no doors and so patients hung cattle hides and sacks over the openings to secure themselves from the elements.

In addition to these infrastructural failures, the state and its district representatives also failed to collate vital statistics. Anecdotal evidence, patchy statistics and ‘sensationalist’<sup>73</sup> generalisations often took the place of accurately collected statistics. With no thorough census of Africans undertaken until 1962, assessing the prevalence of disease and the impact of medical interventions were bound to remain poor attempts. Up to 1962, the total population of Africans was computed through the inadequate method of extrapolation, in terms of which the total African population was estimated to be three and a half times the number of taxable males. Only taxpayers were enumerated and tracked. Only a few officials deplored the exercise openly. Making specific reference to mortality statistics, for instance, the Native Commissioner for Gutu, lamented in 1938 that ‘it would appear that apart from tax

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<sup>72</sup> NAZ, S1563, Annual Report of the Native Commissioner, Gutu, for the Year 1946.

<sup>73</sup> As Anna Crozier has eloquently showed in a journal article, sensationalist impressions were an integral part of British colonial medical discourse. See Crozier, ‘Sensationalising Africa: British Medical Impressions of Sub-Saharan Africa, 1890-1939’, *Journal of Imperial and Commonwealth History*, vol. 35, no. 3 (2007), 393-415.

purposes the present system of native death registration is valueless and should, for the wider purpose of statistics accuracy, be replaced....<sup>74</sup>

In similar vein, Garfield Todd, the missionary-turned-politician who later became a Prime Minister, complained bitterly in the Legislative Assembly about this slovenly attitude towards African statistics. In 1946, in a contribution to the debate on the National Health Service Commission Report, Todd taunted the responsible officials, especially the Medical Director, Martin, for his inclination towards ‘general statements’ when it came to African healthcare issues.<sup>75</sup> Todd demanded accurate African statistics, as was the case for Europeans.

In addition to patchy vital statistics, surveys were few and were done by the already over-worked district medical officer. Some of the notable surveys included the 1932 medical survey conducted in Gutu to determine the prevalence of leprosy, the 1944 deficiency survey in north of Ndanga Reserve to determine cases of beriberi and scurvy and the 1945 deficiency survey in Ndanga East Reserve which led to the establishment of Sangwe clinic.<sup>76</sup> Although these surveys did produce some localised results, the overall strategy remained questionable because of lack of a comprehensive approach. The surveys led only to curative biomedical interventions. Although the development of medical services where there is a need is an important aspect of social medicine, the main problem is that such services were bound to perform badly in a context where conditions of life were poor. Even the ‘civilising’ gospel would not stick in such contexts. The next section will examine how Africans responded to some of these initiatives.

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<sup>74</sup> NAZ, S1563/2, Report of the Native Commissioner, Gutu, for the Year Ended 31 Dec. 1938.

<sup>75</sup> Southern Rhodesia, *Debates of the Legislative Assembly*, vol. 26, no. 54 (5 Nov. 1946), Col. 2511.

<sup>76</sup> NAZ, S1618, Chief Native Commissioner’s Quarterly Reviews of Native Affairs, 1927-1936, Quarterly Review, 30 Sept. 1932; NAZ, S1563/2, Report of the Native Commissioner, Ndanga, for the Year Ended 31 Dec. 1944; NAZ, S1563/2, Report of the Native Commissioner, Ndanga, for the Year Ended 31 Dec. 1945.

### African responses

Several scholars have shown that the colonial project of fostering healthy societies mainly through the rulers' own actions 'could be challenged, ignored or accepted in part'.<sup>77</sup> George O. Ndege has used the idea of conflict, compromise and accommodation, to illuminate this development.<sup>78</sup> The various public health messages and ideas about sanitation, hygiene and nutrition, were domesticated in different ways by different African communities. Social status, attitudes and levels of education determined the extent to which community members imbibed the new health culture. The gradual adoption of cultures of using cesspits and pit-latrines, of pasteurising milk and boiling water, of washing with hygienic 'vanities' like soap, and of entering hospitals and clinics bear testimony to the fact that elements in communities took the messages of the healthcare proselytisers seriously. Indeed, some Jeanes Teachers reported noticeable improvements in general cleanliness and disposal of refuse in rural districts.<sup>79</sup>

In general, though, as the development of healthcare overlapped with other contentious colonial social processes and trespassed upon certain indigenous practices, people seem to have sampled and adopted mainly those ideas which improved their well-being while not clashing with their other hallowed interests. It was not uncommon to hear officials reporting that 'efforts... to teach Africans sanitation and hygiene as preventive measures, achieved negligible and discouraging results'.<sup>80</sup> In 1935, Wilson Mtetwa, the Jeanes Teacher covering the Ndanga district, reported having encountered opposition in his community health work.

The opposition encountered by Mtetwa centred on the placement of cattle enclosures (kraals)

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<sup>77</sup> See for instance Markku Hokkanen, 'Towards a Cultural History of Medicine(s) in Colonial Central Africa', in Anne Digby et al (eds.), *Crossing Colonial Historiographies: Histories of Colonial and Indigenous Medicines in Transnational Perspective* (Newcastle-upon-Tyne: Cambridge Scholars Publishing, 2010), p. 148.

<sup>78</sup> George O. Ndege, *Health, State and Society in Kenya* (Rochester, NY: University of Rochester Press, 2001).

<sup>79</sup> NAZ, S1542/J1/1, Jeanes Teachers, 1933-1943, V. R. Rickland to the CNC, Half Yearly Report on the Work of Jeanes Teacher E. Akapiwa, 24 July 1934.

<sup>80</sup> NAZ, S1563, Report of the Native Commissioner, Ndanga, for the Year Ended Dec. 31<sup>st</sup> 1934.

which health workers advised should be located far from homes. Although the Africans were informed that having kraals nearer to their homesteads brought bovine dirt and flies, they were loath to position these kraals far from their huts because of fear of carnivorous animals. They argued that it was only by proximity to their domestic animals that they could protect them.<sup>81</sup> Indeed, the 1960s reports of the community nurses in Ndanga made recurrent reference to cattle kraals that were located near homes, bringing plenty of flies into houses.<sup>82</sup>

However, it was the public health system's most stringently enforced interventions such as compulsory vaccination, which were met with overt resistance. Documents are replete with religious-based forms of resistance, which added to the non-religious forms of resistance. As one of the foremost rural epicentres of independent African churches, it is not surprising that southeast Fort Victoria was a theatre of religious-based anti-biomedical resistance. Independent churches such as Samuel Mutendi's Zion Christian Church (ZCC) and David Masuka's Zion Apostolic Church emerged in the sub-region in the 1920s,<sup>83</sup> and popularised the alternative discourse of faith healing, which had wide appeal among growing numbers of converts who became sceptical of biomedicine. In fact, as M. L. Daneel argues, the popularity of these churches owed much to their faith-healing activities: the headquarters of the ZCC in Bikita Reserve gained fame as a *hospitara* (hospital), and more than 200 huts were built to accommodate pilgrims and the sick.<sup>84</sup>

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<sup>81</sup> NAZ, S1542/J1/1, Report on the Work of Jeanes Teacher, Wilson Mtetwa, for the Half Year Ending 30 June 1935.

<sup>82</sup> MRO, BOX 1534, Reports by Phillis A. L. Makore and Marsellina Kanyemba, Community Nurses, Zaka, May-July 1966.

<sup>83</sup> M. L. Daneel, *Old and New in Southern Shona Independent Churches, Volume One: Background and Rise of the Major Movements* (The Hague; Paris: Mouton & Co. 1971), pp. 288-9. These congregations were offshoots of South African congregations with similar names. Labour migration was the conduit through which inspiration was channelled.

<sup>84</sup> M. L. Daneel, *Zionism and Faith-Healing in Rhodesia: Aspects of African Independent Churches* (The Hague: Mouton & Co., 1970), pp. 12-3.

By the 1940s the Zionist churches had spread to Ndanga and Gutu and other districts around Fort Victoria. This was a source of concern for officials who initially tried, but failed, to proscribe the movement. In 1942, Ndanga's Native Commissioner noted two challenges that faced European medicine: 'magic' which contributed in keeping patients at home until disease had developed to critical levels, and the followers of the Zionist movement who did not believe in biomedicine.<sup>85</sup> The Native Commissioner, Bikita, expressed a similar concern. While noting that free treatment and free rations had contributed considerably to the popularity of clinics in his district, he was concerned that 'the spread of the Zionist cult has... had repercussions on their popularity' as 'the followers of this sect are opposed to any medical remedies'.<sup>86</sup>

During outbreaks of virulent epidemics such as smallpox, officials used threats of prosecution to force people to present themselves for vaccination. Reporting on a vaccination campaign in Bikita in 1951, the Government Health Inspector noted how 'attendance at the first lot of gatherings was not what it could have been but increased as the news about the prosecutions spread'. Forty-eight people were prosecuted for non-attendance and fined between £3 and £5 each.<sup>87</sup> Most dissidents came from among the ranks of the Zionist churches. In a memorandum to the Provincial Health Inspector, the Secretary of Geo H. Nolan, a mining company in Bikita, expressed fear that, during scheduled vaccinations, 'we may have difficulty with certain religious groups on the mine'.<sup>88</sup> In 1959, in a memorandum to the Fort Victoria Provincial Magistrate, the Provincial Medical Officer of Health noted an outbreak of smallpox in Bikita Reserve in a locality where most people 'belong to some faith healing

<sup>85</sup> NAZ, S1563, Report of the Native Commissioner, Ndanga, for the Year Ended 31 Dec. 1941.

<sup>86</sup> NAZ, S1563, Report of the Native Commissioner, Bikita, for the Year Ended 31 Dec. 1941.

<sup>87</sup> MRO, Box 1533, Government Health Inspector to Regional Medical Officer, 13 Nov. 1951.

<sup>88</sup> MRO, Box 1533, Secretary, Geo H. Nolan, to Provincial Health Inspector, 8 Aug. 1956.

sect, the members of which normally refuse to be vaccinated'. The Magistrate was exhorted to invoke Section 76 of the revised Public Health Act (Chapter 140).<sup>89</sup>

A similar compulsory vaccination order (CVO) was requested in respect of Gutu following an outbreak of smallpox in the north-eastern parts of the district early in 1959. Justifying the call for the CVO, the Provincial Government Health Inspector noted that the outbreak took place in an area 'where the majority of inhabitants are faith-healers and for that reason it will be essential to have a Compulsory Vaccination Order ... in order to suppress the outbreak'.<sup>90</sup> The local magistrate obliged (See a copy of a CVO in Appendix 1). Chief Munyikwa, in whose area the outbreak took place, was prosecuted for failing to report the outbreak of the outbreak as required by Section 36 of the Public Health Act.<sup>91</sup> Chiefs were required by law to report disease outbreaks under the system of infectious diseases notification. Some chiefs obliged, but others did not cooperate.

Likewise, the threat of prosecution did not force ardent Zionist adherents to willingly submit to medical officials in times of epidemic outbreaks. Indeed, in 1962, Dzosayi, an ordained preacher of the Zion Apostolic Church under Rev. J. D. Masuka, refused to be vaccinated during a smallpox vaccination campaign in Bikita. Dzosayi had been found in a church service by vaccination teams.<sup>92</sup> Following this incident of defiance, the overseer of the congregation, the Rev. Masuka, was summoned to Fort Victoria to face the jury.<sup>93</sup> Unfortunately, there is no reference to the case and its outcome in the available documents.

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<sup>89</sup> MRO, Box 1533, Provincial Medical Officer of Health, Midlands, to Magistrate, Fort Victoria, 7 April 1959.

<sup>90</sup> MRO, Box 1533, Provincial Government Inspector to Provincial Medical Officer of Health, 27 Feb. 1959.

<sup>91</sup> MRO, Box 1533, Provincial Government Inspector to Provincial Medical Officer of Health, 27 Feb. 1959.

<sup>92</sup> MRO, Box 1533, Senior Health Inspector to Government Health Inspector, 9 Nov. 1962.

<sup>93</sup> MRO, Box 1533, Government Health Inspector to Rev. J. D. Masuka, 6 Dec. 1962

However, the general practice was to impose fines and, in case of religious figures, threats of withdrawal of preaching licences were also issued.

### **Conclusion**

This chapter has outlined the different disease prevention and health promotion strategies that were preferred by colonial officials, and explored their weaknesses. It has made it apparent that it may be wrong to suggest that public health was virtually non-existent by tracing its patchy record and ethnocentric formulation. Indeed, a discernible pattern can be delineated: in the 1930s, colonial health officials were still trying to find a foothold for rural public health. Thus, rural health promotion and disease prevention, such as they were, tended to fall within the amorphous ambit of Jeanes Teacher programme. The 1940s witnessed a shift towards the agency of health assistants, which was a more focused cohort of health propagandists. From the early 1960s, the concept of community nursing began to appear in rural healthcare.

However, under the thin veneer of these changes was a constant thread which played a decisive role in determining the direction and quality of public health, and that is, the distorting perception that rural sickness was inherently African and therefore there a notion that the strategies deployed by the state were either sufficient or undermined by Africans themselves. And yet, as this chapter has attempted to show, the state's methods were problematic in their own right, and the conceptualisation of the problem was severely defective. The paucity of methods used to survey health conditions and collect vital statistics meant that knowledge about the prevalence of disease among the rural Africans remained haphazard, subjective and tentative. Moreover, differences in perception about the meaning of wellbeing, as shown by clashes between public health officials and Zionists, also destabilised the district public health system.

The main conclusion of this chapter is that the Ndanga Unit was badly served by the existing conception and structure of public health. Indeed, in the 1960s and 1970s, the Unit's medical institutions were battling many preventable diseases. Amoebic dysentery, gastro-enteritis, various forms of malnutrition-related diseases such as kwashiorkor and hookworm, among others, were some of the major health conditions the Unit was battling with.<sup>94</sup> Only belatedly, under the UN's Freedom from Hunger Campaign, did the colonial state begin distributing seedlings, fertilisers and other ready-made supplements to try and bring down such cases related to malnutrition. Mark Webster was correct, in the 1960s the Ndanga Unit had become a medical slum.<sup>95</sup>

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<sup>94</sup> Masvingo Records Office, Box 3385, Rural Clinics: Chiredzi, Bikita, Gutu, 1976-1983.

<sup>95</sup> Rhodesia, *Report on the Public Health for the Year 1966*, p. 18.

## Thesis Conclusion

One of the apt reviews of the limitations of colonial biomedicine is that it helped to reproduce the ‘very conditions of underdevelopment’ that were the cause of so much ill-health that it set out to deal with in the first place.<sup>1</sup> The story of Ndanga, which has been told from various angles in this thesis, seems to fit this candid appraisal. This was one of the greatest ironies of colonial healthcare. A recap of some of the major points raised in the thesis might help to re-establish this point. As the thesis showed in chapter 2, the Ndanga Unit was an offshoot of Dr Askins’ medical units scheme which was developed in 1930 to reform the colony’s defective healthcare system. In formulating his ideas, Askins was inspired by newly emerging ideas of organising health services. The main elements of the scheme were framed from a combination of ideas drawn from both the metropole and the colonial world.

However, in what appeared to be a reformative scheme were also sowed the seeds of a reactionary, typically colonial programme. What was colonial about Askins’ medical units scheme? Firstly, his ideas were premised on the problematic models of imperial scientific thought and the emergent germ theory of disease which gave colonial officials the pretext to eradicate or, at the very least, to assimilate non-Western therapeutic cultures and practices.<sup>2</sup> This thinking was behind Askins’ denigration of indigenous medical practices, including midwifery. Secondly, his ideas on the composition and pecking order of the district healthcare team enhanced white privilege and undermined African professional advancement. Although the many African orderlies who were employed by the Ndanga Unit became vital culture and biomedical brokers, as this thesis showed particularly in chapter 5, their

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<sup>1</sup> Lesley Doyal, with Imogen Pennel, *The Political Economy of Health* (London: Pluto Press, 1979), p. 290.

<sup>2</sup> Idea borrowed from Juanita de Barrons, Steven Palmer and David Wright, ‘Introduction’, in Juanita de Barrons, Steven Palmer and David Wright (eds), *Health and Medicine in the Circum-Caribbean, 1800-1968* (New York: Routledge, 2009), p. 4.

professional position was tenuous. They were perceived as Africans first, and then healthcare workers, second.

The implementation of the medical units scheme in Fort Victoria by Dr Kennedy further illustrated that colonial medicine was a double-edged sword. Although in pioneering the Ndanga Unit Dr Kennedy had his own personal vision, he was nonetheless informed by Askins' mandate and the broader developments in biomedical culture and science. To his credit, he endeavoured to practice curative medicine in family and community contexts. As illustrated in chapter 3 and chapter 4, in addition to making singular efforts to boost the popularity of the Ndanga Unit's institutions – which, as shown by the increasing patient numbers, paid dividends – Dr Kennedy also acted as an advocate for the disenfranchised communities when the state's commitment showed signs of faltering. To a larger extent, the Ndanga Unit survived because of his commitment to Askins' vision.

However, colonial medical practice was always a complex mix of contradictory motives and strategies as the doctor was both a professional and a coloniser, as Fanon aptly observed.<sup>3</sup> Working among exoticised African communities, colonial doctors tended to dabble in amateur ethnography and the civilising agenda, often perceiving themselves as bearers of light in a dark world. Colonial and cultural encounters cast medicine in an evangelical and civilising role.<sup>4</sup> Indeed, Kennedy saw himself as being engaged in a civilising mission. His sarcastic self-presentation in his memoirs as a 'bundu bone thrower' tells us all about his motivations. His practice was premised on the paternalistic and evolutionist tendencies of

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<sup>3</sup> Frantz Fanon, *A Dying Colonialism* (New York: Grove Press, 1965), p. 127.

<sup>4</sup> David Arnold, 'Medicine and Colonialism', in W. F. Bynum and Roy Porter (eds), *Companion Encyclopaedia of the History of Medicine* (London, New York: Routledge, 1993), p. 1396.

biomedical civilisation. At the tail end of his career he was trapped in an outdated medical practice and presided over a sprawling medical slum.

But as one of the foremost critics of colonialism and colonial medicine, Fanon, also admitted, biomedicine is not inherently bad as it essentially concerns itself with man's health and relief of pain.<sup>5</sup> Yet, it was the innovative edge of biomedicine and its ability to structure society in new ways which unfortunately helped to drive colonial medical ethnocentrism. Many of the therapeutic and preventive victories achieved by biomedicine were undermined by the retrogressive ethnocentric attitudes and the arrogance of colonial public health officials and practitioners. Public health reforms that threatened the racial order of colonial society and white privilege were given scant attention; while other potentially useful policies were pursued piecemeal through racially informed biomedical policies, discourses and practices, as shown in chapter 7. Under Kennedy's watch, therefore, the Ndanga Unit did not do much beyond the provision of medical services to rural communities on very liberal terms. But this problem was not solely a personal one. Rather, it was a systemic issue.

With these considerations in mind, the main conclusion of this thesis is that, seen through the perspective of the Ndanga Unit, colonial biomedicine seems to have had a double, if not multiple, identity. It was a dynamic tension between innovative and retrogressive impulses. Although due care has to be taken not to retrospectively rationalise and sanitise what might look farsighted to us today,<sup>6</sup> allowing the vocabulary of an innovative biomedicine to partly inform our analysis is important in that it helps us to separate contemporary approaches from inherent racism. Also, it is useful to appreciate the historical dynamism of biomedicine as an

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<sup>5</sup> Fanon, *A Dying Colonialism*, p. 121.

<sup>6</sup> Miriam S. Chaiken, 'Primary Health Care Initiatives in Colonial Kenya', *World Development*, vol. 26, no. 9 (1998), p. 1704.

autonomous body of knowledge.<sup>7</sup> The partial autonomy of biomedicine can help us to understand the schisms between Dr Kennedy and officials from the Public Health Department, addressed mainly in chapter 3 and 4.

In this thesis, the complex, multiple identity of colonial biomedicine was pinned down not only through a close interrogation of the motives and strategies of the public health officials and medical practitioners alone, but also more importantly by taking a cue from the actions of the African communities and patients. Africans critiqued, partially rejected and partially embraced biomedicine – all at once. Chapter 6 on patient experiences caps this important observation that essentially runs through all the sections of this thesis. Therefore, a caveat has to be issued here that a total rejection or total embrace of the Ndanga Unit as a model of colonial healthcare negates the actions of the people who were served by it. This is one of the major methodological innovations of this thesis.

It may be useful to also close by reiterating an important point discussed in the introduction, which point reinforces what has been said above, that in reality colonial healthcare was a tension between broader colonial ambitions and the routine interests of the different stakeholders involved in the delivery and consumption of healthcare services. The Ndanga Unit emerged as a model scheme but ended up as what others called a medical slum because the broader imperatives of colonialism *in* healthcare interacted with, and were both enhanced and challenged by quotidian individual interests, community views and governmental procedures.

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<sup>7</sup> Christopher Ellis Hayden, 'Of Medicine and Statecraft: Smallpox and Early Colonial Vaccination in French West Africa' (PhD thesis, Northwestern University, 2008), p. 41.

In other words, although as part of the broader 'native question' and the colonial developmental agenda the rural healthcare question seemed imperative, progress on the ground depended on availability of funds, the enthusiasm of those responsible for the implementation of policy and the cooperation of local communities. While the state was on the offensive targeting Africans for urgent healthcare provision as the latter were considered to be a public health nuisance, as illustrated in chapter 3, many of the facilities ended up being constructed by the pluralistic-minded Africans themselves as they required such services in their communities.

Clearly, the intentions of the state were ambiguous and capabilities limited, although the rhetoric suggested otherwise. In evaluating colonial healthcare initiatives, a sharp eye must be kept on these ambiguities. As Chaiken has noted, 'while many colonial medical officers expressed sincere dedication to improving the welfare of the African masses, colonial policies sought to eradicate "backwardness" and to "elevate" the African masses, making such approaches as improving the sanitation and public education an appealing blend of preventive medicine and paternalistic haughtiness'.<sup>8</sup> Fresh histories of colonial medicine might do well by reflecting on how these forces co-evolved.

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<sup>8</sup> Miriam S.; Chaiken, 'Primary Healthcare Initiatives in Colonial Kenya', *World Development*, vol. 26, no. 9 (1998), p. 1704.

**Appendix 1: Compulsory Vaccination Order, Gutu, 1959**

PUBLIC HEALTH ACT (CHAPTER 140) of  
SOUTHERN RHODESIA.

Compulsory Vaccination for Smallpox :  
Gutu Native District.

WHEREAS there is an occurrence of SMALLPOX in the Gutu Native Reserve, Victoria District :

IN my capacity as local authority for the rural areas of the Victoria Magisterial District and in terms of section 76 (b) of the Public Health Act (Chapter 140) of Southern Rhodesia, as amended and adapted, I hereby require all persons within the area defined in the Schedule to attend at centres according to instructions issued by the Director of Medical Services for Southern Rhodesia of the Federal Ministry of Health and to undergo inspection, vaccination or re-vaccination as circumstances require.

Dated at FORT VICTORIA this 2nd day of MARCH, 1959,

SCHEDULE.

GUTU NATIVE DISTRICT.

  
MAGISTRATE.

**Appendix 2: A Collection of Photographs**

**2(a): Medical Directors: Andrew P. Martin (Askins' successor), Andrew M. Fleming (Askins' predecessor) and Richard M. Morris (Martin's successor), 1953.**



**(Photo Courtesy of National Archives of Zimbabwe)**

**2 (b): Serving their Own: a group of nurses and medical assistants, mid-1960s**



**(Photo Courtesy of Dr. M. Chitiyo)**

**2(c): The First Black Doctor in Ndanga: Dr M. Chitiyo, mid-1960s**



**(Photo Courtesy of Dr M. Chitiyo)**

**2(d): A mid-1960s Version of Ndanga Hospital**



**(Photo Courtesy of Dr M. Chitiyo)**

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### **3      THESIS AND UNPUBLISHED CONFERENCE PAPERS**

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