A Failure to Care: Colonial Power and Healthcare in Africa, 1850-1939

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The colonization of Africa was a pivotal and transformative period in the modern era, especially for the indigenous people who felt the weight of colonial oppression. From the late nineteenth to the early twentieth centuries, European powers scrambled to acquire territories and establish colonies in Africa. For example, the notorious King Leopold II of Belgium referred to the continent as a "magnificent cake" before annexing large portions of the Congo in West Central Africa.[1] In establishing colonies across Africa, European powers transformed these societies in countless ways, from the introduction of new education systems, religious beliefs, patterns of labor organization, and more. Among the major expansions of colonialism was the implementation of new forms of healthcare and health services across the continent. This paper assesses European colonial health initiatives in Africa. It argues that European medical services in Africa were ineffective and provided inadequate care to African colonial subjects.

Missionary healthcare services represented the first examples of European influence over healthcare in Africa, but they failed to provide adequate care to indigenous populations. The Church Missionary Society (CMS) stands as the precursor to colonial medicine in Africa. They attempted to acquire a European foothold in Africa through the establishment of missionary medical services. Their goal was not to heal local native populations, but instead to evangelize and convert as many Africans as possible. For example, when the CMS founded its first hospitals in nineteenth-century Yorubaland, a region within West Africa, missionaries acknowledged that the Yoruba people believed in a connection between their own religion and healing. In fact, the colonizing British wrote that the Yoruba "heathen mind" could only understand healing as akin

[1] *The Magnificent African Cake*, (Arts International /African Video Centre, 1983).

to religion.[2] Therefore, the missionaries believed one of the best ways to attract more converts was to preach evangelism alongside providing healthcare services. Also, in order to gain favor with local populations, the missionaries slandered indigenous priests and doctors to discredit them. CMS officials specifically branded indigenous healers as "frauds, tricksters, and money hungry deceivers."[3] With such an active focus on converting Africans, the CMS rarely focused on practicing medicine because they viewed it as just another evangelical tool. The religious mission of CMS' medical officials is perhaps best exemplified by the fact that surgeons were told that medicine "was only to be an occasional occupation."[4] In other words, surgeons were instructed to provide medical care only if it would guarantee a new convert. Due to the indigenous natives' strong beliefs that their medicine was sufficient, the CMS came to understand that they needed to actually put effort into their healthcare services if they wished to attract more Africans to the church.

Because medical resources and services were often only deployed to meet the needs of Europeans, colonial healthcare and public health initiatives in Africa never adequately cared for Africans. For example, in South Africa's Cape Colony, racism became institutionalized within the healthcare system. This led to a difference in medical care between Europeans and indigenous South Africans, the latter receiving much poorer quality of treatment. In rural areas of Cape Colony, where populations consisted mostly of poor African farmers, the town jail functioned as both a hospital and a homeless shelter.[5] For these farmers, this combined space

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[2] Temilola Alanamu, "Indigenous Medical Practices and the Advent of CMS Medical Evangelism in Nineteenth-Century Yorubaland," *Church History and Religious Culture* 93, no. 1 (2013), accessed April 15, 2019, doi:10.1163/18712428-13930102, 26.

[3] Alanamu, *CMS Medical Evangelism*, 24.

[4] Ibid, 24.

[5] Harriet Deacon, "Racism and Medical Science in South Africa's Cape Colony in the Mid- to Late Nineteenth Century," *Osiris* 15 (2000), accessed April 15, 2019, doi:10.1086/649326, 200.

was the only option for any medical assistance because major cities were simply too far away. Conversely, Europeans typically did not have to rely on rural hospitals, often receiving medical care in urban towns, where they were given preferential treatment by doctors. Europeans always prioritized themselves over African patients because of European ideas of race embedded within colonial healthcare services.[6]

European colonizers came to Africa with perceptions of race, based on stereotypes and false information. Racism became ingrained within the medical treatment of African subjects from mental health to tropical disease. In terms of mental health, colonial doctors treated African and European patients very differently. Many doctors believed and theorized that Africans responded to physical treatment better because of their alleged "lower developmental status."[7] In simpler terms, racist pseudoscience of the day framed Africans as unintelligent beings incapable of mental health problems. Leprosy treatment for African was equally ineffective. A popular colonial belief of Africans and African Muslims in Cape Colony was their inherent susceptibility to leprosy. Once identified as a public health problem, leprosy was understood as a societal threat, with African groups identified as carriers of disease. To combat this disease, colonial authorities started to integrate segregation into urban planning as a means of stopping the disease from spreading. Rather than adequately treating afflicted Africans or addressing the socio-economic conditions that caused the disease to spread in the first place, colonial governments used the threat to justify and solidify their power. In the case of Cape Colony, authorities signed the Leprosy Repression Act of 1891 into law. This act gave authorities the power to infringe on the civil rights of Africans by segregation because of the racist medicine identifying them as the

[6] Deacon, *Racism and Medical Science*, 200.
[7] Ibid, 200.

only transmitter of the disease.[8] These policies of racial segregation, rather than preventative care, illustrate the overall inadequacies of European health initiatives in colonial South Africa.

In Zanzibar, a colony in East Africa, island natives also faced similarly ineffective and racist colonial medical programs. When the Europeans first colonized Zanzibar, they faced many hardships from the tropical climate, such as malaria, cholera, and typhoid fever. With the aid of technology and engineering, however, their quality of life improved, eventually surpassing the indigenous population, who were denied access to these advances. For example, Europeans used technologies like draining swamps, quinine to stop fever, and improved sanitary practices, all of which they made no effort to share with the African population.[9] When Europeans noticed the disparity in African and European deaths, they developed a superiority complex attached to hygiene and race.[10] Specifically in Zanzibar, Europeans believed the discrepancy between European and African deaths meant Africans were the cause and primary carriers of tropical diseases, like malaria, yellow fever, and sleeping sickness.[11] These ideas of race started to make their way into urban planning, as European colonial officials disguised segregation as sanitation and public health projects. According to historian William Bissel, sanitation and urban planning in Zanzibar "were never just technical measures or tools for improvement, but instead were strategies of power intimately linked to the essential inequalities of colonial rule."[12] Once again, like with the treatment of natives in Cape Colony, with the natives of Zanzibar considered the main cause for the spread of diseases, colonial authorities segregated them from the main

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[8] Deacon, *Racism and Medical Science*, 204.

[9] William Cunningham Bissell, "Disease, Environment, and Social Engineering: Clearing Out and Cleaning Up the Colonial City," in *Urban Design, Chaos, and Colonial Power in Zanzibar* (Bloomington: Indiana University Press, 2011), 165.

[10] Bissel, *Cleaning Up the Colonial* City, 166.

[11] Ibid, 166.

[12] Ibid, 167.

European population. The colonial strategy left the socioeconomic situations that allowed such stereotypes of race and health to endure completely unexplored and unaddressed. In this way, public health initiatives, such as the sanitation and segregation projects of Zanzibar, did not help to heal or even benefit African colonial subjects, but rather sustained and intensified the material constraints of colonialism on the body.

The effects of racism and colonial power on health were not restricted to East African countries alone. In West Africa, racist pseudoscience permeated anti-mosquito sanitation projects. Sierra Leone started initiatives to expel mosquitos that fared well, but these initiatives were never meant to benefit native Africans. Europeans and Africans shared many of the same hardships together, such as the callous conditions of waste management in Freetown and the mosquitos that carried lethal diseases.[13] In the nineteenth and early twentieth centuries, African mosquitoes were a much more serious threat to life than in present day. Mosquitos are capable of transmitting deadly diseases, such as malaria or yellow fever, very quickly within cities and towns. Although both Europeans and Africans shared a common struggle against the mosquito, the two groups shared no camaraderie.[14] To remedy the mosquito situation, the British first sought to eliminate their breeding grounds, such as streams, puddles, and wells. The Freetown wells, left in an atrocious state of disrepair, remained full of garbage and needed to be addressed first.[15] Expeditions made some considerable improvements, such as the ones made by the Colonial Surgeon of Sierra Leone Dr. Ronald Ross. Ross' gangs, named after mosquito species, made rounds around Freetown to remove garbage from as many as 6,500 houses over the course

[13] Leo Spitzer, "The Mosquito and Segregation in Sierra Leone," *Canadian Journal of African Studies / Revue Canadienne Des Études Africaines* 2, no. 1 (Spring 1968), doi:10.2307/483997, 53.

[14] Spitzer, *The Mosquito and Segregation*, 50.

[15] Ibid, 53.

of two months.[16] Although the anti-mosquito cleaning gangs made some improvements, they could not account for all mosquito infested areas. In reality, the cost of cleaning the massive amounts of garbage was too high for government officials.[17] The high cost gave enough incentive for Europeans to focus on helping themselves, rather than the indigenous population. Unfortunately, this incentive fueled segregation along racial lines.

Officials doubled down on segregation to combat the spread of deadly diseases. The use of segregation to combat mosquitos was not solely based on the wellbeing of colonial subjects. The practice also stopped the economic drain the colonial government faced because of rampant tropical disease.[18] The idea to relocate to higher ground to avoid mosquitos was never for the health of colonial subjects, but rather for British officials to have a place to govern without the fear of mosquito-spread diseases.[19] They built their new neighborhood, called Hill Station, six miles out of Freetown at a higher elevation, designed and certified by European scientists to be out of range of mosquito breeding grounds. Despite the attempt to escape and the scientists' claims, the new settlement failed, as mosquitoes still managed to breed on the hill. The situation became so dire that in 1914, ten out of forty eight government officials contracted malaria and needed treatment.[20] In the end, colonial subjects were never considered in the countermeasures against mosquitoes in Sierra Leone, and Africans faced a great deal of discrimination and racism in the failing settlement of Hill Station. The British failed to remedy the diseases that many Africans faced because of mosquitos. Not only did they fail their subjects, but the British failed

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16 Ronald Ross, *First Progress Report of the Campaign against Mosquitoes in Sierra Leone* (Liverpool: University Press, 1901), 8.

17 Spitzer, *The Mosquito and Segregation*, 53.

18 Ibid, 55.

19 Stephen Frenkel and John Western, "Pretext or Prophylaxis? Racial Segregation and Malarial Mosquitos in a British Tropical Colony: Sierra Leone," *Annals of the Association of American Geographers* 78, no. 2 (June 1988), doi:10.1111/j.1467-8306.1988.tb00203.x 213.

20 Spitzer, *The Mosquito and Segregation*, 60.

themselves by creating a settlement based on the idea that segregation would solve their mosquito problem.

Transportation challenges and funding issues also hindered the delivery of adequate health care services to Africans during the colonial period. The Kenya-Uganda railway, built in 1901 by the British Empire, transported building materials to the Kenyan highlands. This allowed European settlers and Africans easy access to the railroad, but travel to a proper medical professional in town still took a day or more.[21] In terms of funding, it was very expensive to have a doctor come out of town into these communities. Many farmers in Kenya and Southern Rhodesia faced these transportation issues. One farmer in Southern Rhodesia, Hylda Richards, wrote in her memoir that doctors were too expensive to consult, and in the rainy season, a flooded river cut off her farm from telephone communication.[22] With limited options, Africans living in these remote regions were forced to turn to undertrained, white female doctors for medical services. Amateur medicine became so common in non-urban centers that handbooks for living in Africa mention the necessity of amateur practice. These handbooks portrayed the African subjects as primitive people with no understanding of healing, while framing the amateur practitioners who treated them as humanitarians.[23] Many of the tasks performed by amateur practitioners consisted of cleaning and dressing wounds, burns, and ulcers. Many white and African settlers often faced the same issues and diseases, but when it came to detailing them, Europeans often spared the gory details about European sickness, instead focusing on the horror stories from African patients in order to preserve the illusion of European strength.[24] In the end,

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[21] Julia Wells, "“I Was Doctor”: White Settler Women’s Amateur Medical Practice in East and South-Central African Communities, 1890–1939," *Bulletin of the History of Medicine*92, no. 3 (Fall 2018), doi:10.1353/bhm.2018.0054.

[22] Wells, *Amateur Medical Practice*, 416.

[23] Ibid, 414.

[24] Ibid, 422.

any health care initiative from colonial officials failed to reach these white, rural communities, leaving medical responsibilities to the European settlers. Therefore, any African who needed medical assistance had to rely on an amateur practitioner, rather than a trained medical professional. Many of these medical amateurs would go on in their memoirs to portray themselves as benevolent, only taking note of successful operations and not mentioning the negative effects their practices had on the indigenous population.[25] The Colonial Empire had the responsibility to heal and treat people in medical need, but they failed to perform this duty by allowing amateurs to practice medicine which brought more harm than good.

Not only was colonial healthcare inadequate across Africa, but these medical services were used to commit mass atrocities against African colonial subjects. Medical experimentation in Africa originated from the quest to map out disease in the environment, or "bioprospecting." To bioprospect, many travelers and government officials would travel around Africa and take blood samples of local Africans.[26] By World War I, many vampire stories started to spread across the continent because the bioprospectors resembled vampires from African folklore.[27] Once the Europeans had an idea of what diseases were affecting their respective regions, they started to make efforts in defeating those diseases through human experimentation. Usually, human experimentation across the world had been done within the confines of a developed medical system and was non-therapeutic. For example, in developed countries such as the United States, medical experiments under a developed medical system were typically much safer for the volunteer. On the African continent, however, developed medical systems were severely lacking.

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[25] Wells, *Amateur Medical Practice*, 421.

[26] Helen Tilley, "Conclusion: Experimentation in Colonial East Africa and Beyond," *International Journal of African Historical Studies* 47, no. 3 (2014):, 497.

[27] Luise White, "'They Could Make Their Victims Dull': Genders and Genres, Fantasies and Cures in Colonial Southern Uganda," *The American Historical Review* 100, no. 5 (1995): 1380, doi:10.1086/ahr/100.5, 1380

Colonial officials were aware of the deficient medical systems and took advantage of the situation. Some colonial scientists depended on this advantage, believing their ability to apply therapeutic treatment through trial and error a real boon.[28] Africa, for these scientists and officials, became one continent-sized laboratory with a native population that had no say in what methods of practice these doctors could use.

The degree of experimentation that medical scholars and colonial officials took was irresponsible and dangerous to the Africans they experimented on. In Colonial Africa sleeping sickness, a parasitic disease, rampantly infected African natives. While many suffered, the fatality rate of the disease was relatively low, but could have been avoided altogether. For example, in a German East African border district, out of thirty three cases of sleeping sickness, only twenty eight survived.[29] Many European countries were researching the disease in the early twentieth century, but scientists in German East Africa took a more ill-advised approach in treating the disease. Robert Koch, a German scientist known for his work in microbiology, took on the challenge of finding a cure for sleeping sickness. He made an expedition to the British East African Sese Islands, where a large portion of the local African population suffered from sleeping sickness.[30] Koch and his team started to treat patients with arsenical Atoxyl, however, as noted by Koch's assistant, he was administering Atoxyl in unorthodox ways, giving patients much larger doses than traditionally recommended. [31] At points throughout the treatment, there were dosages as large as one gram, double the recommended dosage. Generally, doctors give dosages this size over the course of a month, but Koch administered these dosages in as little as a

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[28] Tilley, *Experimentation in Colonial East Africa*, 500.

[29] Wolfgang U. Eckart, "The Colony as Laboratory: German Sleeping Sickness Campaigns in German East Africa and in Togo, 1900-1914," *History & Philosophy of the Life Sciences* 24, no. 1 (November 22-23, 1996): doi:10.1080/03919710210001714323, 71.

[30] Eckart, *The Colony as Laboratory*, 72.

[31] Ibid, 73.

week. This led to many medical complications ranging from vertigo, sickness, and in some cases, blindness.[32] Overall, Koch's experiments and efforts were a reckless endeavor that offered no solution to the epidemic.

The practice of negligent and dangerous experimentation was not limited to British East Africa, however. In colonial Tanganyika, medical experimentation was defined by a careless system that gave no value to African lives. There, the head of the Tinde Laboratory, J. F. Corson, deliberately infected healthy Africans with the sleeping sickness parasite so that he could monitor the symptoms and "complications" of the drug Bayer 205.[33] Corson was so insidious in his experiments that he infected himself and a few assistants.[34] Even though Bayer 205 successfully treated the disease in early stages, Corson's disregard for medical safety would prove fatal in one case, and detrimental to the health of many others. After his experiments ended, he returned to check on the health of his human subjects. One man had died three months after the experiments, while thirteen of the original forty three faced symptoms such as body pain, diarrhea, and fever. In his later years, Corson acknowledged his role in actively placing many Africans at risk during his human experimentation.[35] European biomedical research, meant to treat tropical diseases, was imprudent and unregulated because racist colonial medicine had no value for African life. These Africans victims were treated improperly, left with a host of "complications," and became victims of an unregulated biomedical industry.

European colonial healthcare services failed to heal or even help African colonial subjects. Many Africans had to rely on white amateur practitioners for many simple ailments, like cuts and burns. Africans who lived in rural towns and villages faced poor socioeconomic

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[32] Eckart, *The Colony as Laboratory*, 73.
[33] Tilley, *Experimentation in Colonial East Africa*, 502.
[34] Ibid, 503.
[35] Ibid, 504.

conditions that healthcare failed to address. Africans who were lucky enough to reside in larger towns and cities had to face the racist colonial medical institutions that would choose white European settlers over African lives. When Europe scrambled for Africa in the late nineteenth century, many European colonizers couched their expansionism in savior rhetoric and a paternalistic quest to liberate a "barbaric" continent. However, in terms of medical care, they failed horribly, and Africans faced medical blunders that would not only harm natives, but the Europeans themselves. This harm was apparent in medical solutions, such as the idea to segregate living communities in Sierra Leone to allow Europeans respite from malaria-carrying mosquitos at the expense of indigenous populations. The new settlement, Hill Station, instituted racist color lines and ultimately failed to keep the mosquitos away from Europeans. Even with racial segregation meant to combat the spread of disease, treatment of these diseases in hospitals was poor. Biomedical scientists in colonial Africa, such as Koch and Corson, abused the unregulated biomedical industry to test risky therapeutic methods on African natives. Many of the patients and volunteers they treated would face harsh medical complications later in their lives. Koch's overdosage of arsenical Atoxyl caused incurable blindness in his patients, and Corson's patients faced hardships such as fever and, in one case, death. These therapeutic experiments were so unregulated that medical professionals would purposefully infect their volunteers with sleeping sickness and treat them so that they could see the results of their experiments. In the end, colonialism in Africa was a complete failure for Europeans and especially Africans. Healthcare was just one cog of the European imperial machine that ravaged Africa of its resources. It is important that we study the way Africans were treated by Europeans because their voices matter and is an important chapter in African history that needs to be told. The legacy of European racism can still be seen today, long after imperial powers have left the

continent. Africa today still faces crushing epidemics such as the Ebola virus and the AIDS epidemic, calling into question the continuing failure to care.

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