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The Role and Impact of Western Medicine in the North-Western Province of Zambia, 1900 - 1963.

By

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M.A

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Date: January, 1992.

DECLARATION

I, Lilian Samundengu, hereby declare that this dissertation represents my own research work and that it has not been previously submitted for a degree at this or any other university.

Signature: ____________

Date: 21/01/92

APPROVAL

This dissertation of Lilian Samundengu is approved as fulfilling part of the requirements for the award of the degree of Master of Arts in History at the University of Zambia.

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DEDICATION

To my late father who gave so much for our education. My mother and the rest of my family for the unlimited support and encouragement.

ABSTRACT

In this study, it has been pointed out that throughout the colonial period, there was a prevalent assumption held by the colonial state, missionaries and indeed Europeans (in general) that Western scientific medicine provided the most appropriate means of coping with human disease. Because of these preconceived ideas, the type of medical services provided by both the missionaries and the colonial Government was oriented towards pursuing this same view. The missionaries openly associated traditional medicine with heathenism and often excommunicated Christians who were alleged to be involved in the practice. The Government through various pieces of legislations sought to undermine traditional healing while it offered support to Western medicine.

The discussion, however, shows that despite the hostile environment traditional medicine was faced with, it still continued to survive due to the fact that Western medical services were still inadequate and inaccessible to the majority of the **peaples of the Northwestern province of Zambia.** Secondly, it was gradually learnt that not all diseases could be cured by Western medicine. So the local people soon realised that there was still something in their traditional medicine which they had relied upon for ages. Despite the continued existence of traditional medicine, it did not remain static but changed to adapt itself to the new diseases introduced into the society as a result of contact with outsiders, colonialism and penetration of mine based capitalism in Zambia.

Through labour migration, the indigenous disease pattern was completely transformed. Yet Western medical services did not grow parallel to the changed epidemiology. Instead the main concern of the colonial state was to ensure that the disease disrupted the colonial economy as little as possible. Owing to this, short term measures were adopted whenever there was an outbreak of an infectious disease. It was therefore not surprising that throughout the colonial period, curative medicine was used as a substitute for public health. The lack of emphasis on preventive medicine led to the continued reoccurences of infectious diseases which could be controlled through innoculation or any other means.

Furthermore, the study will argue that the Western medical work in North-western Province was born out of missionary work. But the missionaries did not develop an elaborate medical system because of lack of finances and trained personnel. Additionally, the medical ministry was only used as a weapon to obtain access to local people whom they sought to convert. Therefore, medical work was done as an ancillary to their evangelistic work and therefore had to be subordinated to it.

Lastly, despite its inadequacy, colonial medicine nevertheless provided a foundation on which post-independence national health service was built.

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Introduction.

The study is an attempt to reconstruct a social history of the introduction of Western medicine in the North-western Province and the impact this had on the existing indigenous African therapeutics. Although at Independence a foundation of medical services was available from the efforts of missionaries and colonial Government, this was quite inadequate considering the vastness of the province and the scattered population. As such, the majority of the population still remained unserved.

In this dissertation, it is argued that right from the beginning of colonial rule, it was quite clear that Government priority was attached elsewhere to projects deemed economically viable. Medical service was never put on the top priority list because it was regarded to be essentially consumption oriented. In addition, the Government did not initially intend to extend health services to the Africans. However, because of the danger of epidemic diseases, medical facilities were then extended to the Africans. This falls in line with Ferguson's argument that in rural areas, the colonial Government's goal was to contain the spread of diseases among the village people so that it did not reach an epidemic level.[1] It has further been argued that the colonial state did not aim at eliminating the social causes of infectious diseases, because this was in line with capitalist policy which aimed at ruling with minimum costs.[2] Because of this it has been pointed out that throughout

the colonial period, curative medicine was used as a substitute for public health.

Moreover, being in a remote part, Northwestern province lacked a settler population that could agitate for development facilities. For this reason the colonial state found it easier to neglect the area in as far as the provision of infrastructure and social services were concerned.

Furthermore, it has been shown that although the area under study is in the remote part of Zambia, it was equally affected by the demands and priorities of both the missionaries and the colonial state. The transition from pre-capitalist to the capitalist mode of production led to the transformation of the indigenous disease pattern. The new conditions increased exposure to a variety of pathogens. Both labour migrants and transport carriers brought their newly acquired inflictions back to their homelands, while interaction with foreigners also enhanced the introduction of new diseases. According to Patterson, 'foreigners who came to Africa brought their own diseases with them /and/ disrupted the existing equilibrium. Through intensifying commercial and military contacts between Africans and foreigners they breached previously isolated disease environments.'[3]

It has also been argued that during the introduction of Western medicine, local people did not remain passive but

responded differently to the various aspects of western medicine bearing in mind that they had their own type of therapeutical system. Through the examination of African reaction to Western medicine, the type of relationship which emerged between the two medical systems especially with regard to the African interpretation of illness will be appreciated.

The attitude of both Missionaries and the Colonial Government towards the existing traditional medical system has been discussed and the impact western medicine had on traditional medical system has been shown. This has helped to test the assertion that, 'in Africa wherever the white man's culture .... touches that of the native, the material traits of the former .... tended rapidly to supersede the indigenous material traits'.[4]

For periodisation, 1900 has been chosen as the starting point because the Missionaries and the Colonial Government established themselves in the area around this date. The colonial Government established an administrative post at Kasempa in 1902, while the first known missionary medical structure was established in 1906 at Kalene Hill. The period from 1900 up to 1963, the close of the Colonial era, is long enough for us to identify different colonial policies governing the provision of social facilities to local people, in relation to the operations of the colonial political economy.

The information used in writing this dissertation was collected in two stages. Firstly, published and unpublished materials were read in the University of Zambia Library and the National Archives of Zambia. The published materials consulted ranged from published books, journals to magazines on the subject. Thereafter two months were spent on collecting oral evidence in the form of personal interviews in Solwezi, Mwinilunga, Kabompo and Zambezi Districts. Different categories of people were interviewed; these included missionaries, local dispensers and nurses. In addition a significant number of traditional healers from various parts of the province were interviewed and these were able to indicate the continuity of their profession since colonialism and problems pertaining to their operations. Apart from informal interviews, formal questionnaires were also available and used especially among medical personnel. On the whole, in this study we have combined the written and oral material and used them for comparative purposes to supplement each other.

Chapter one seeks to reconstruct the pre-colonial disease patterns and attempts made by local people to contain the disease situation. It is shown that most of the diseases of the pre-colonial period were largely influenced by the ecology and reinforced by the existing socio-cultural conditions.

Chapter two traces the introduction of Western medicine

into North-western Province. It is shown that western medicine in the province originated from the efforts of the early missionaries such as Livingstone and Arnot whose objective was personal. Later it was reinforced by missionaries like Fisher, Suckling and Forster who dispensed medicine to the North-westerners as a **means** to achieve their goal which was Christian evangelisation.

Chapters three and four look at the development and expansion of Western medical institutions, tracing the role of the colonial Government in the provision of medical facilities and arguing that Government moved in only when the economy was threatened by infectious diseases. They also discuss the change in the indigenous disease pattern as a result of increased movement of people and the creation of a new disease environment which existing traditional therapy was unable to eradicate.

NOTES:

1. D.E. Ferguson, 'The Political Economy of Health and Medicine in Colonial Tanganyika', in Kaniki, M.H.Y. (ed.), Tanzania under Colonial Rule (London: Longman, 1980), P. 324.

2. Ferguson, 'The Political Economy', P. 324.

3. G.W. Hartwig and D. Patterson (eds.), Disease in Africa: Introductory Survey and Case Studies (Durham: Duke University Press: 1978), P. 7.

4. C.P. Holdredge and K. Young, 'Circumcision Rites Among the Buyok', American Anthropologist, 29, (1927), 661.

CHAPTER ONE:

PRE-COLONIAL DISEASE PATTERNS AND THEIR TREATMENT.

Introduction

The pre-colonial disease pattern of North-western Zambia was largely determined by the cultural and environmental settings. Economic practices also contributed to the outbreak of certain diseases. However the disease pattern was not static but changed over time as it came in contact with outsiders. The African medical system emerged as a response to the prevailing diseases in the area and the therapeutical practices were influenced by Africans' definition of illness. This chapter attempts to establish the relationship between disease pattern and therapeutical practices prevalent in pre-colonial North-western Zambia.

Social Environmental Background

North-western Province has Zaire (former Belgian Congo) on its northern border and on the west (former Portuguese) Angola. It also shares a border with the Copperbelt on the east and Western Province on the south. The area is inhabited by the Kaonde, Lunda, Luvale and related peoples of the Luchazi and Chokwe. For the purpose of this study, however, concentration will be on three ethnic groups namely the Lunda, Luvale and Kaonde. These trace their origin from the Luba-Lunda Kingdoms in Zaire and because of this they possess a similar culture and economic practice which are largely determined by their physical environment.

The Zambezi and Kabompo districts were mainly flat and overlaid with Barotse sands and water-shed grasslands, while the other northern districts were covered by the ferralitic sand which had clay content. Such soils according to Mackel, '... may be used for local crops under good soils management.'[1] Being in a tropical climate, such vegetation favoured mosquito and tsetse fly breeding. For this reason, people preferred to live in other vegetation zones such as the chipya woods.[2]

rainfall

Despite abundant/and relatively lower population in North-western Zambia, settlement in most areas tended to be concentrated in places deemed suitable. Such concentrated settlements created ripe conditions for the spread of diseases qualifying Hartwig's argument that' ... in man's evolution concentrated population created favourable conditions for the spread of acute viral diseases like small-pox, measles and common cold.'[3] The concentrated village settlement increased with constant raids of the Mbundu slave traders. The Lunda of Zambezi for example, tended to stay in large groupings to resist slave traders. Passing through the area, Livingstone noted, '... the Baloanda are a friendly, industrious race and thousands of the Balovale find an asylum among them from the slave dealing propensities of their chiefs.'[4] This slave trade was well noted by every visitor to the area in the period between 1850 and 1900. Owing to the seriousness of slave trading more especially in the Zambezi and Kabompo

area, the equilibrium was disturbed and the spread of diseases was enhanced. Pathogens initially unknown in the area were introduced. Consequently a new epidemiological pattern was now set in motion.

The pattern of population distribution and settlement was also determined by peoples' economic activities. White illustrates this point in his study of the Luvale fishermen:

> ... owing to the porous nature of the sands, [rivers and streams] mostly run from the north to south draining in the Zambezi and Kabompo rivers. ... Highly dispersed villages are impossible and human habitations concentrate ribbon-wise along the major water courses ... a density of 100 persons per square mile in inhabited areas is common; it may rise locally to 300 per square mile.[5]

The economic activities people were engaged in ranged from agriculture, fishing, hunting to food collecting. Subsistence agriculture was widely practised throughout the province. The Lunda and Luvale grew cassava staple food and other crops included maize, sweet potatoes, groundnuts, lentils, pumpkins and many others. The Kaonde in addition to the above listed crops also grew finger millet as their staple food. The local people also enriched their diet by food collecting. They collected roots, leaves, fruits and insects. Writing on the Luvale economic activities, White

noted'.... women play an important part in digging up gerbils (*tatera*) on the plains and some outbreaks of bubonic plague are thought to have been connected with this since gerbils are well-known reservoirs of plague-carrying fleas'.[6] Such an observation helps to illustrate how culture in some way helped to enrich peoples' diet and at the same time was deterimental to their health.

Hunting was an important economic activity more especially among the Lunda and Kaonde. Among the Luvale fishing ranked first and because of the importance attached to it, people tended to settle along the rivers and streams. Lastly, it should be pointed out that economic activities are very important to peoples' health as a lack of a well-balanced diet debilitates people exposing them to increased liability to disease.

Pre-Colonial Disease Pattern

The diseases to be discussed do not represent all the diseases which were prevalent in the province prior to colonialism. Our attention, however, has been focussed on the ones which appear prominent in the sources consulted.

Malaria and other Common Fevers.

Fevers were quite common in this part of Zambia. One would attribute their common occurrence to the climate and physical environment in the area. (Fever here refers to a

medical condition in which the sufferer suddenly develops a very high temperature). As earlier indicated, the province received a high rainfall and this had a direct relationship with the type of vegetation which grew there. The Livunda forest which covered most parts of North-western Zambia had thick and tangled vegetation and the area was quite humid providing an easy breeding area for mosquitoes. Passing through the west part of the province, Livingstone observed the existence of fever among the Luvale, '... my companions all native Zambezians had nearly as much sickness as myself'.[7]

The seriousness of malaria among the earlier explorers and missionaries was shown by taking note of the disease wherever they went. Gelfand's remark illustrates the concern shown by most explorers and missionaries, 'When I think of diseases in Africa, malaria always comes to mind. Malaria and Africa are almost synonymous.'[8] At this time the relation between malaria and mosquitoes was unknown to most missionaries and explorers. According to Gelfand, '... Livingstone held the accepted view that malaria was due to miasmata of the evaporating pools, which loaded the atmosphere with noxious vapour.'[9] The explorers' experience of the disease equally taught them about its dreadfulness.

Although fever was a dreadful illness, it tended to be ecologically controlled or enhanced by man's activities such as settlement patterns as well as culture. Common colds, for example, tended to be rife in cold weather because of the exposure

to cold, more especially if people had no clothes on their bodies. Owing to the nakedness, people would be scorched by the heat during day time and chilled at night. Livingstone wrote, '... though this is the hottest time of the year, the nights are quite cold.'[10] People could therefore control the illness by keeping themselves warm especially from night chills. The Luvale, for example, made clothing out of animal or bark skins.

Pneumonia occurred periodically more especially in the cold and rainy seasons. The disease was long endemic in North-western Zambia because of the cold weather and the heavy rains the area receives. Exposure to cold weather may have contributed to the occurrences of the disease especially among children. Livingstone observed that, 'since the Baloanda wore little or no clothing they were more liable to contract respiratory disorders from variation of temperature.'[11] Although explorers in this part of the country did not take note of pneumonia, it appears it was covered under the umbrella term of either fever or respiratory disorders.

Relapsing fever was a disease transmitted or carried by ticks mainly found on animals like cattle and goats. As Patterson put it, '... domestic animals harboured ... ticks which served as vectors for relapsing fever and some rickettisial disease.'[12] Livingstone took note of the disease at Luanda as early as 1854. He wrote, 'the effects of its bite are a tingling

sensation of mingled pain, itching which gradually ascends the limbs until it reaches the abdomen where it soon causes violent vomiting and purging.'[13] Whereas in North-western Zambia relapsing fever was first reported among the Luvale, its occurrence there was associated with the activities of the Mbunda traders. However, the disease mainly occurred in areas where animals such as cattle and goats were domesticated.

INTESTINAL DISEASES.

Intestinal diseases such as diarrhoea and dysentry tended to be culturally and evironmentally oriented. Dependence on hard foods like meat and cassava which could not be easily digested led to indigestion. The eating of contaminated food and the drinking of unclean or polluted water coupled with hot humid condition often led to diarrhoea. On the same note dysentery, a dangerous and fatal disease, was common in this part of the country. The disease was prevalent in the hot months of September to December. The occurrence and spread of dysentery cannot be divorced from cultural responses, as personal and community cleanliness could lead to either control or enhancement of the disease. Watson noted, '... dysenteries and other diseases are spread by excreta. Flies may feed on it and carry the infection on their feet to food, rain may wash the infection into rivers and water supplies used for drinking.'[14] Thus intestinal diseases could be exacerbated by lack of hygiene in some villages.

Another common intestinal disease was hookworm. The disease is caused by a parasitic worm which penetrates the bare skin of the host. Infected persons release the parasites through bodily waste such as urine and faeces. The lack of latrines and contaminated water supplies provide an ideal place for parastic breeding and proliferation of the disease. Although endemic in the pre-colonial period the disease was reported to have been on the increase during the colonial period. According to Fisher, he found that the patients he treated had this disease in addition to any other medical complaint.

A dreadful alimentary disease locally known as kapokota was quite common in the province. The local people easily identified the illness from its multi-symptoms which ranged from headache, fever, constipation, vomiting and was crowned by the destruction of anal tissue. Transmission of the parasitic worm was through drinking of contaminated water and food. Turner's work shows that the disease which perforated the intestine originated from Northern Rhodesia Copperbelt. However, Fisher's earlier records show that the disease was noted as early as 1906 when migration among the North-westerners was oriented towards Katanga.[15]

Opthalmic Complaints.

In this part of the country, opthalmic complaints were quite common. These ranged from sore-eyes, eye-lid inflammation,

conjunctivitis to cataracts. Sore eyes were caused by poor sanitation in villages in addition to heat. Similarly eye-lid inflammation was caused by dirty fingers, dust, flies and the disease enhanced by contact by social mingling more especially in concentrated villages. Thus the spread of eye diseases helps to illustrate the role of culture in epidemiology. Although cases of blindness as a result of conjunctivitis or trachoma were not common, cataracts in most cases resulted into blindness especially if not ealier treated. Fisher (for example) treated a number of patients whose blindness was due to cataracts.[16]

Venereal and other Syphilitic Diseases

Venereal diseases were reported in the Upper Zambezi as early as 1875. A colonial official reported, 'so long ago as 1875 Serpa Pinto described it [syphilis] as one of the plagues of Barotseland ascribing its introduction to the slave caravan from the West Coast.' [17] Mbunda slave raiders who had contacts with foreigners on the coastal areas are said to have spread the disease to the Upper Zambezi. Syphilis is therefore one of those diseases brought in from the outside which disrupted the existing equilibrium. Through contact with slave traders from Angola, the disease spread to Kasempa.

Another syphilitic related disease endemic in Kaondeland

was yaws. F.S. Arnot recorded the existence of the disease under its local name of monono in 1887.[18] Predisposing causes include warm climates, personal uncleanliness, overcrowding, insanitary surrounding, scanty clothing and bedding. The nature of its transmission helps to illustrate how both culture and environment can either control or enhance the spread of the disease. Although yaws was long endemic in Kaondeland it only reached an epidemic level in the 1920s when increased contact through social mingling exacerbated the spread of the disease.

Other Diseases.

Sleeping sickness which was due to blood parasites known as trypanosomes transmitted by tsetse fly bites was prevalent in some parts of Kasempa, Mwinilunga and Kabompo. The existence of thick forests and wild animals in which the disease incubated meant that the disease was environmentally based and could be controlled. Although it had become endemic in the districts, local people had developed effective controls of trypanosomiasis through isolating most dangerous trypanosomiasis grenzwi drasser, as people avoided contact with tsetse flies living in the forests. Selective settlement was the effective control measure which accounted for less human suffering from trypanosomiasis rather than Arnot's assertion that human beings and wild animals did not suffer from the disease.[19] As a result of their settlement patterns, human sleeping sickness though endemic in the area did not reach an epidemic level until during the colonial period when

social-environmental changes occurred.

Tuberculosis was a disease common in some parts of North-western Province. The disease is transmitted through inhalation of the bacilli contained in air or sputum and could also be transmitted by eating contaminated food or drinking dirty milk. Prior to trade contacts, the disease was either not endemic or non-existent; this is evident from Livingstone's observation on the Lunda '... they are an imperishable race but it ought to be born in mind that though fever prevails there are few other diseases. There is no consumption [an old name for tuberculosis] scrofula ... or mental diseases.'[20]

The existence of tuberculosis in Chavuma area in Zambezi is associated with the trading activities of the Portuguese or their trading partners, the Mbunda. Its spread was facilitated by overcrowding in houses as the area population increased due to migration from Angola and development of markets in labour recruitment centres. Studies of the colonial period showed that tuberculosis was found in concentrated areas like Chavuma. This was an area of reasonably good soil, densely populated and extensively cultivated. In this area it was discovered that '... the spread of the disease was found to be concentrated in small villages and family groups especially among those in close house contact.'[21]

Lastly, there were other diseases which were widespread but were found in isolated areas. Although some of them were

not reported by the explorers, it is important to take note of them. Jigger for example was quite common in Kaondeland. The presence of jigger disease seemed to have been enhanced by the keeping of pigs.[22]

Epilepsy was also reported among local people, although it was not a common disease. According to Fisher, people were very much afraid of epileptics as they thought they were possessed by evil spirits.[23] Epilepsy was characterised by sudden attacks of uncontrolled violent movement and loss of consciousness and this was why local people associated it with infliction by evil spirit.

Smallpox was another disease which increasingly became more common during the war time than before. Arnot reported the occurrence of smallpox in Msidi and among the Luvale in 1891.[24] Fisher also recorded its occurrence at Kazombo in Angola in 1895. The strangeness of the disease led Chief Sakawamba to demand that the children be thrown into the Zambezi river which was the usual treatment for anyone with a contagious disease.[25] Apart from this, there were no other prominent cases of smallpox in the area prior to 1912 when the first smallpox epidemic was reported in North-western Province.

It should also be mentioned that diseases related to culture were equally common. Amongst the North-westerners, medicines were given to pregnant women in order to activate

movement of the uterus and easy childbirth. In some cases such medicines resulted into miscarriages as the uterus ruptured due to overdose. An examination of the colonial period showed that infections were quite common due to lack of proper treatment. In some women this often caused perpetual miscarriages.[26]

Furthermore, amongst the Luvale, sharpening of the incisior teeth and the need to remove them was apparent from the dentists' comment in the colonial period, 'one of the great troubles in this area is still with the four upper incisor teeth - many boys and girls are still having these cut into points. The teeth soon decay and abscess form making it necessary to remove the teeth.'[27] Since the sharpening of teeth was associated with beauty, the Luvale whose teeth were removed desired to have the gap filled with a denture.

Finally, it is important to note that diseases cannot be completely separated from cultural and environmental setting. Secondly, that the indigenous disease pattern was not static but changed as a result of contact with the outsiders through trading activities and labour migration.

Traditional Therapeutics.

African socities developed their own medical health delivery system to deal with the scourge of diseases in their midst. The therapeutics ranged from home herbal remedies to

specialist doctor. Thus when a person was confronted with an illness, attempts with home remedies were carried out before advice from a specialist doctor was sought.

The traditional medicineman played a very important role in the society. His ability to treat diseases gave him an influential and outstanding role in the society. According to Swan, (though exaggerated) '... medicinemen have great respect from both chief and people; they are men of influence.'[28] A medicineman was therefore a person who had recognised practice in his community to deal with health and illness issues. Twumasi rightly referred to a medicineman as 'a person who is recognised by the community in which he lives as competent to provide health care by use of vegetables, animals and substance and certain other methods based on the social, cultural and religious background as well as knowledge, attitude and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability.'[29] Because of his ability to deal with health and illness issues, a medicineman was quite influential in the society.

There were three categories of medicinemen identified with pre-colonial North-western Zambia. These included herbalists who used herbs, animal and mineral matter in the treatment of physical and symptomatic illness. Secondly, were traditional midwives who acted as gynaecologists, **paediastriacians**

as well as general practitioners in the villages. The third group consisted of diviners who were specialists in diagnosing the patients' illness and explaining the source of distress within the community. The common household remedies were known to women who would administer them before specialist treatment was sought.

Although the medicineman was a respected member of the community he was an ordinary human being and when not engaged in healing, he led the ordinary life as other members in the village. In spite of the importance attached to the skill of healing, initiation was not determined by one's social status. Instead, it was open to anyone who wanted to serve the society and knowledge would be acquired through association with medicinemen. Other specialists started by being patients themselves. Turner illustrates this point, '... it is no surprise to find that many doctors became so because they began as patients but learnt the medicine and curative procedure for a particular disease in the course of receiving treatment.'[30] Some medicinemen also acquired the knowledge after a dream or vision or a severe illness alleged to have been inflicted by the spirits of the dead. In this case, the skill of medicineman lasted only as long as his supernatural guidance remained with him. If his healing spirit became offended with him, it would withdraw its aid and the skill disappeared.

Despite the differences in the acquisition of knowledge, the degree of respect which the <u>chimbuki</u> or <u>ng'anga</u> received

from the society depended largely on his professional skill and success in the treatment of various diseases. Thus, although almost each and every village had a specialist healer, the choice of where to seek medical advice largely depended on the healer's previous performance and area of specialisation. The traditional healers also charged fees in accordance with the type of treatment administered. Generally, herbalists charged fees when the patient recovered but if there was no cure, no pay was charged. While for traditional midwives, a chicken and some meal would be presented after successful delivery as a token of appreciation as deliveries had social effects for cementing family relations. But for divining a fee was placed on the ground before divining commenced.

The role of diviners in the societies was important because of people's view concerning disease causation. The Lunda for example, tended to perceive disease as being controlled by those above them. Turner explains this by saying, 'the Ndembu theory of affliction decrees that when conscious voluntary beings decide to afflict human beings with illness, they rarely do so alone in their own right but usually with the help of another conscious being or through intermediary being or power.'[31] It was in such circumstances that local people sought divination.

Divination/Kuhona/Kuponga.

Divination was an important element of Lunda, Luvale and

Kaonde therapy. It was conducted through the medium of bones, claws and many other items.[32] The juxtaposition of these various objects in the basket determined the course of divination. Among the Luvale and Lunda, in addition to the popular 'throwing of bones', they also divined by using an axe handle or pounding stick. This was mainly used in divining the name of a new born-child.

The 'throwing of bones' was however widely practised in the province and formed an important cornerstone of their healing system. It was used to determine the cause of somebody's illness or death (as death among the North-westerners was associated with superstition). In case of illness for example, divining helped to identify the cause as well as to determine a type of treatment system to be followed. This was in line with people's beliefs that effective healing would be achieved if the cause of the illness was identified.

Apart from blame-fixing, divination was also used in witch-finding. On this Dillone-Malone wrote, 'in particular diviners uncover the presence and activity of witches who are perceived as the very epitome of evil and human perversity in the society.'[33] Owing to this important role, chiefs would invite diviners to clean their villages. In most cases, the diviners were called upon in cases of frequent occurrences of unexplainable diseases or deaths in the community. The

diviners also acted as foretellers, through them people learnt the nature of the calamities about to befall them. The local people also sought the advice of a diviner before embarking on a hunting expedition. Due to the different activities the diviner was engaged in, he received great respect and admiration. Dillon-Malone's observation supports this view, 'diviners are inspired and guided in their crucial work by the spirit world, they are perceived as religious specialists whose role is central to the preservation and maintenance of the health and well-being of the spirit.'[34] In a nutshell, divination among North-westerners was very much tied to their therapeutical practices.

Symptomatic Therapies.

Symptomatic medicines were widely used in the whole society. The cure of various diseases depended so much on the treatment of different symptoms. Medicinemen identified purgatives, emetics and enemas which they used in the treatment of intestinal/enteric diseases such as diarrhoea, dysentery, typhoid fever and indigestion. Herbs were drunk in order to induce the continuous emptying of the bowels which ensured the removal of the disease. Purgatives were commonly administered in cases of indigestion, venereal diseases and infertility.[35] Emetics were either drunk or eaten to cause a person bring up food from the stomach through the mouth. This type of medicine was widely used in cases of poison or the common mwavi tests

which aimed at eliminating the witches in the society.[36] Enemas were also used in cases of kapokota, dysentry and prolonged labour. It formed the basis of household remedies as this type of medicine helped to relieve pain.

Symptomatic medicine also included a lot of steaming remedies. In such cases, leaves were collected and put in a pot with water and heated to boiling point, then the patient covered his head and inhaled the steam. The vapour was also commonly used in the treatment of colds, fevers and other related diseases. This treatment was based on the belief that disease comes out with induced perspiration. Another kind of inhalation commonly applied involved the burning of medicinal herbs so that the patient inhaled the pungent smell. It is said to have been commonly used in coughs as well as nose bleeding.[37]

Cupping was also commonly used in cases of severe headache and opthalmic complaints. It entailed the sucking of blood from the inflicted part using a horn. Livingstone observed that 'cupping is performed with a horn of a goat or antelope.'[38] Cupping in most cases was done hand in hand with exorcism. This involved the casting out of demons (evil spirits) from a patient. This was commonly used in complaints where the ng'anga felt the patient was inflicted or possessed by evil spirits (chihamba) and the patient felt healed psychologically as the supposedly cause of the illness was removed. Incisions were quite common too. This included the incisions being rubbed

with powdered medicine. It was used in the treatment of rheumatic, abdominal pains, backache and headache.

In addition to the actual treatment of diseases, local therapeutics also involved the quarantine of people suffering from infectious diseases. The medicineman identified a sick bush where patients considered to be a menace to public health were kept and when the illness had run its course the house was burnt.[39]

Protective/Specialist Medicine

Medicine among the North-westerners was not only used for curative purposes but also for protection against future misfortune. The wide use of protective medicines led Arnot to write, 'Africans believe largely in preventive measures and their fetish charms are of that order.'[40] Protective medicines were used to avoid harm of the witches thus, 'before starting a journey a man will spend perhaps a fortnight in preparing charms to overcome evils by the way and enable him to destroy his enemies.'[41] These medicines were sewn into belts and hung in little horns round the neck. It was therefore common around that time to see people with medicine hanging around their necks, wrists and waists '... in passing through a country (Arnot observed) where leopards and lions were found they carefully provide themselves with the claws, teeth, lips and whiskers of animals and hang them round their necks to secure themselves against attacks.'[42]

Charms were also placed in gardens to deter thieves from stealing crops. Livingstone noted, 'a piece of medicine is tied round the trunk of the tree and proves sufficient protection against thieves.'[43] Similar medicines were also used to protect the entire village from a misfortune of any kind. This caught the attention of Livingstone who wrote, 'passing through one large village [Luvale] I saw a tall pole in the centre with a pot of medicine on the top and bark ropes connecting it with each house in the village, looking for all the world like an old English "maypole". This I was told was in order to protect the hut from lightening.'[44] Such medicines differed from one ng'anga to another, they either were for drinking, chewing, wearing or incisions or put in oil for smearing the body.

Specialist medicines were equally important among the North-westerners, This included love potions and hunting charms. Love potion was also used for attraction and enticement. The medicine could be drunk, eaten, smoked or smeared - oil or tatoos. Women widely used love 'potions' to maintain their husband's love. Keller's post colonial study **revealed** that 'women have a general belief that no marriage is necessarily permanent and this gives added weight to their reliance upon medicine as a routine precaution.'[45] Through the use of medicines, women felt secure in their marriages.

Throughout the discussion, it has been shown that medicine

in the African context was not only looked upon as an organised system of ideas and practices concerning illness but that it entailed the whole welfare of the society. It was this applicability of medicines which brought the North-westerners into conflict with the Europeans. To the local people medicines treated a lot of conditions ranging from symptomatic (physical signs - sufferer), spiritual and mental illness, bad luck, misfortune and unfaithfulness of spouses to bodily dysfunction (disease). Thus it embodied the material and spiritual afflictions while the practice of medicine among the Europeans meant the science of prevention and cure of disease.

CONCLUSION

The Chapter has argued that the pre-colonial disease pattern was largely determined by the cultural and environmental setting. It has also shown that the indigenous disease pattern did not remain static but changed as a result of contact with the outsiders through trading activities and later labour migration. Moreover, it has also been pointed out that the African medical system emerged as a response to the prevailing diseases in the area and that it was largely influenced by people's definition of illness and rooted in their social-cultural setting. Traditional medicine provided the only type of medical treatment among the North-westerners. It was with this view that local people's efforts aimed at eliminating and controlling the disease situation in the area.

NOTES:

1. R. Mackel, 'Soils' D.H. Davies (ed.) *Zambia in Maps* (London: Hodder and Stoughton, 1971), P. 26.

2. *Chipya Woodlands* consisted of mixed tree growth and small trees.

3. G.W. Hartwig and D.K. Patterson (eds.) *Disease in Africa: An Introductory Survey and Case Studies* (Durham: Duke University Press, 1978), P, 5.

4. D. Livingstone, *Missionary Travels and Researchs in South Africa* (London: John Murray, 1857), P. 54.

5. C.M.N. White, 'A Preliminary Survey of Luvale Rural Economy:' *Rhodes-Livingstone Papers*, 29 (1959), 2.

6. White, 'Luvale Rural Economy', 6.

7. I. Schapera (ed.) *Livingstone Missionary Correspondence, 1841-56* (London: Chatto & Windus, 1961), P. 629.

8. M. Gelfand, *Rivers of Death in Africa* (London: Oxford University, 1963), P. 3.

9. M. Gelfand, *Livingstone the Doctor* (Oxford: Basil Blackwell, 1957), P. 98.

10. Livingstone, *Missionary Travels*, P. 72.

11. M. Gelfand, *Livingstone*, P. 92.

12. Patterson, *Disease in Africa*, P. 98.

13. Gelfand, *Livingstone*, P. 92.

14. E. Watson, *African Highway* (London: John Murray, 1983), P. 16

15. E. Burr, *Kalene Memories* (London: Pickering and Inglis, 1956), P. 28.

16. Within Mwinilunga, Fisher first operated on chieftainess Nyakaseya (1907) whose eye was blind because it had a cataract.

    NAZ, HM8, F12/3/3 Dr. Walter and Anna Fisher Papers, P. 29.

17. NAZ, SEC2/7, Barotseland Annual Report, Balovale, P. 26.

18. J.A. Acheson, 'Framboesia Tropica or Yaws with Special Reference to its occurfence in the Kasempa District of Northern Rhodesia', M.D. (Trinity College, Dublin, 1964), 4.

19. E. Baker, *The life and Explorations of Frederick Stanley Arnot* (London: Seeley, Service & Co. Ltd., 1971) Pp. 306-7.

20. Gelfand, *Livingstone*, P. 98.

21. G.F. Grave and M.K. Ililonga, 'The Problems of Tuberculosis in Balovale and Kabompo District' *Central African', Journal of Medicine* (8, 6, 1962), 221.

22. Interview, J. Mukaza, 3 March, 1989, Lusaka.

    The jigger insects locally known as *tutobera* would burrow under one's toes and there deposit eggs which hatched in a few days if not removed. Soon after the feet got eaten into holes by these insects.

23. S. Fisher and J. Hoyte, *Ndotolu: The Life Stories of Walter and Anna Fisher of Central Africa*, Mwinilunga: Lunda - Ndembu Publications, 1987), P. 72.

24. Arnot Missionary Travels, P. 113.

25. Fisher, Ndotolu, P. 100.

Kazambo was about 30 miles from Kalene Hill, there is therefore a possibility that smallpox cases could have been present in the Northern part of Mwinilunga District, although there is no information to that effect prior to 1912.

26. See A. Spring, 'Epidemiology of Spirit possession among the Luvale of Zambezi', J. Hoch-Smith and A Spring (eds.) Women in Ritual and Symbolic Roles (New York: Plenum Press, 1973).

27. NAZ, NR7/189, Christian Mission in Many Lands Chitokoloki, 1949-51.

28. A.J. Swann, Fighting the Slave Hunters (London: Seeley 2 Co. Lt. 1910), P. 127.

29. P.A. Twumasi, Professionalisation of Tradiational Medicine (Lusaka: Institute for African Studies, 1983), P. 14.

30. V.W. Turner, 'Lunda Rite and Ceremonies', Rhodes-Livingstone Museum occassional Papers (10, 1953), 71.

31. V.W. Turner, 'Lunda Medicine and the Treatment of Disease', Rhodes-Livingstone Museum occasional Papers (15, 1963), 693.

32. Arnot, Missionary Travels, P. 27.

33. C. Dillon-Malone, 'Indigenous Medico-Religious mevements in Zambia, A Study of Nchimi and Mutemwa Churches', African Social Research (36, 1983), 456.

34. Dillon-Malone, 'Medico-Religious Movements', 456.

35. This view was expressed by Lupezyi Kapyololo who admitted that she greatly used a lot of herbs which had purgative power in the treatment of venereal diseased patients and infertility. Through purging she explained that the stomach would be greatly cleaned. Interview, Lupeyi Kapyololo, 13 February, 1989 Mize - Zambezi.

36. In the Mwavi test, the person's innocence or guilt was ensured in the first by vomiting the poison while in the second, no vomiting was experienced and death ensued.

37. Interview, Yowanu Mapulanga, 21 February, 1989, Mwinilunga.

38. Livingstone, Missionary Travels, P. 129.

39. In 1900 for example durimg the outbreak of smallpox at Kazombo Fisher got into conflict with Chief Sakuwamba as he broke the regulation that any smallpox patient had to be thrown into the Zambezi river. See Fisher, Ndotolu, P. 100.

40. Arnot, Missionary Travels, P. 88.

41. Arnot, Missionary Travels, P. 43.

42. F.S. Arnot, Garanganze or Seven Years Pioneer Mission Work in Central Africa, (London: James Hawkins, 1889), P. 237.

43. Livingstone, Missionary Travels, P. 285.

44. Livingstone, Missionary Travels, P. 145.

45. B. Keller, 'Marriages and Medicine: Women's Search for love and luck', African Social Research (26, 1978), 491.

CHAPTER TWO:

THE DEVELOPMENT OF WESTERN MEDICINE, 1900 - 1924.

Africans have accepted Western medicine enthusiastically from the time of advent of Europeans on the continent.[1]

The period from 1900 to 1924 marked the formal establishment not only of colonial rule but also of Western medicine in North-western Province. Prior to 1900 pioneer missionaries such as D. Livingstone and F. Arnot introduced Western medicine to the area. The contact with western society also introduced new diseases to the region which the company and missionaries struggled with. The chapter will also attempt to see whether the Africans of North-western Zambia accepted Western medicine enthusiastically, as indicated by the quotation above.

The Origin of Western Medicine.

The origin of Western medicine goes back to earlier missionaries like David Livingstone and Frederick Arnot who passed through this area. The medical boxes the missionaries and explorers possessed were initially meant for their own personal use as they considered the continent a "white man's" grave. In the course of their exploration they extended the medical services to the Africans. To them spiritual healing and instruction was not all, they had to be combined with all that medical science and practice could provide for the body. Livingstone wrote, "English medicines" were eagerly asked for

and accepted by all and we always found medical knowledge an important aid in convincing the people that we were really anxious for their welfare.'[2] Similarly Arnot also realised that he had to contend with the disease-ridden environment besides spreading Christianity. Through the use of medicine, access was obtained to chiefs and other people in authority.

Western Medicine and Early Christian Missions.

Arnot was the first missionary to enter North-western part of Zambia in 1882. He therefore played a major role in determining the nature and direction of missionaries in the area. In 1906 a second branch of the Plymouth Brethren (to which Arnot was pioneer father) transfered itself from Kalunda (Angola) to the country of the Lunda and Luvale. The branch which later was known as Christian Mission in Many Lands (hereafter CMML) led by a prominent medical missionary Dr. Walter Fisher and his wife Anna started medical work at Kalene Hill in Mwinilunga in 1906.[3] S. Fisher wrote, '... while the evangelistic and educational missionary have necessarily to mark time until a certain degree of proficiency in language study has been attained, the nurse begins her Christ-like ministry on the day she reaches the field.'[4]

A school was also started where E. Darling, another missionary devoted her time. The missionaries at the station believed that 'no church can be strong in spiritual life unless

most of its members can read God's words for themselves in their own tongue.'[5] A year later in 1907, Mr. Sawyer, a missionary carpenter, arrived at the station. He was mostly involved in the construction at the mission station. More missionaries continued to come to the station to reinforce educational and medical activities almost every year.

In 1913, George Suckling and Lambert Rogers who had already spent two years at Kalene hill left with F. Arnot to open another CMML station at Chitokoloki. Arnot's aim was to implement Livingstone's motives, '... I would pronounce the country about the junction of the Zambezi and Kabompo as a most desirable centre-point for the spread of civilization and Christianity.'[6] A mission station was opened in 1914 at Chitokoloki forty kilometers further up the Zambezi. Here medical and educational work was started. However due to chronic shortage of staff, the medical and educational work did not develop seriously until the 1930s.

The CMML missionaries received no salary but were supported by friends and relatives at home or through the operation of trading stores.[7] They consisted of loosely organised groups of conservative evangelists who ensured co-operation amongst themselves as their main concern was to heal people spiritually. According to Wilkin, this lack of competition hindered the development of social services as competition not only seemed to bring in more money and staff from overseas but also induced

'... missions to use their resources vigorously in providing education, medicine and direct evangelism.'[8] Owing to the Brethren policy, stations started in other parts of Mwinilunga, Zambezi and Kabompo operated independent of each other although occasionally Kalene was used as referal point.

While missionaries elsewhere in the country competed for spheres of influence, Arnot feared the entry of the Catholics in Kaondeland which was still open. On his visit to South Africa in 1909, Arnot whose resources and those of his brethren were overstretched extended his invitation to South Africa General Mission (hereafter SAGM). In 1910 he personally guided A. Bailey to a site near the Kansanshi Copper mine. In 1912 with the arrival of missionary reinforcement (Mr. Harris and his wife) at Chisalala - Solwezi, Bailey set off to Kasempa where a mission station was opened. Their work was mainly evangelical as their policy was to 'preach where Christ is not named thus the occupation of new fields where there was no evangelical body at work.'[9] Such kind of policy prevented the development of elaborate educational and medical work, because each and every time they sought to break new grounds where the gospel had not reached. In 1917 however, with the arrival of Reverend Charles Forster, SAGM worked towards opening a central site. In 1926, Mukinge hill in Kasempa was chosen as a suitable site and the slender resources were concentrated there to ensure the development of both educational and medical work.

Despite the differences in organisation, both CMML and

SAGM had the same doctrine and one spiritual father, Arnot. They remained the only missions in this remote corner of the country until the 1950s when Catholic missions, the Capuchin and Franciscan fathers started stations at Zambezi and Mwinilunga respectively.[10] It was through these mission stations that western culture was exposed to the North-westeners through Christianity, elementary education and Western medicine.

Initially it was not missionaries' intention to heal the sick. Their medical chests were mainly intended for personal use. At each and every station, some crude medical services were begun owing to the fact that often the missionaries worked in isolation from all medical aid. At Kalene the purpose of erecting a sanatorium was to provide medical services to missionaries from less healthy localities such as Angola, Zaire and within Zambia.[11] Gradually, the medical services were extended to the Africans on humanitarian grounds as well as to achieve their objective which was spiritual healing. One missionary wrote, 'through medical services an exceptional opportunity was afforded to deal with the souls of the patients while manifesting the true spirit of Christianity.'[12] With regard to healing, the missionaries claimed they were demonstrating the love of God about which they preached.

Dr. Fisher believed medical work would largely contribute to the progress of the gospel in heathen lands. He observed that

> In the other villages right from the first, they seem entirely callous to our message and treat us as if

> they would rather we did not come, apparently thinking we had some other object in view than only telling out to them the love of God, in some of these, opportunities have occurred for showing kindness in curing some of their sick people. This has softened them and they made us feel more welcome in their midst.[13]

It is in this context that missionaries demonstrated their skill to the African chiefs and others in authority.

The strategy of using western medicine to win converts to Christianity proved to be effective in North-western Province in the colonial period. Through their medical skills, the missionaries obtained access to chiefs and their people. The nurturing of friendship with chiefs led to missionary success in their evangelical work. The eye operation administered on chieftainess Nyakaseya in 1907 encouraged her to become a believer through-out her life time fearing that if she backslided she would lose her sight. Because of her influential position in the society, her people were also encouraged to join the church.

Whenever missionaries went preaching, they carried a bible in one hand and a medical box in another. People at each gathering were preached to first before receiving treatment. Because of this strategy the missionaries adopted, the local people came to associate preaching of the gospel with healing of the sick. At Kalene hill out-patients gradually gathered in the waiting room at 9. a.m, a short service was held with them there before they were seen by the doctor.[14] In addition, Elsie Burr a helper to Fisher

testified that, 'each day while massaging Samakonga's leg, we would talk together about the word of God.'[15] In Kaondeland during the anti-yaws campaign, a woman was told that she would not get medicine because it was finished, promptly she asked, 'if I believe will you give me an injection?'[16] Most people living near mission stations had only one choice to take the medicine or education along with constant preaching.

Moreover, the missionaries in North-western Zambia like elsewhere used medical services as a weapon for converting Africans as well as keeping believers faithful. In Uganda for example, a missionary once remarked, 'I regard the medical work from its missionary aspect ...I consider how far it is likely to aid our work not how much suffering will be relieved.'[17] In addition through the provision of medicines missionaries also aimed at undermining the effort of the <u>chimbuki</u> or <u>ng'anga</u> (traditional healer). One missionary thought he could wean Africans from superstition and the worship of ancestors and bring about lasting conversion by a demonstration of the power of the white man's medicine.'[18] The missionaries hoped the use of western medicine would prevent the Africans from the use of 'fetish' remedies and other 'sinful' practices which according to them was a hindrance to their testimony for God.

Traditional healing was associated with evil. The use of words such as 'witch doctor' to refer to African medical expert is indicative of this view. The 'doctors' were identified

with paganism and witchcraft and the congregation was exhorted to avoid them. A man in 1923 asked George Suckling if he could have a dance to appease the ancestor of a woman who was sick. To this he answered, 'we said we did not object to the dancing on our own account but because we know that in so doing they were not putting their trust in one who could help them and spurning the real Lord and giver of life.'[19] Since the missionaries' objective was to spread Christianity, they condemned the African therapeutical and traditional customs which they felt blocked evangelism.

By so doing the missionaries aimed at supplanting African medicine. However, this was impossible as Western medicine did not treat all diseases.[20] Moreover, all the missionaries who settled in North-western Zambia except for Fisher (a medical doctor) only possessed rudimentary knowledge of medicine which they acquired either by experience or as a result of a short course in a seminary.[21] The missionaries bandaged wounds, set bones, drained sores, passed out pills and gave injections. At most of the mission stations there was a perpetual short supply of drugs. Owing to such shortcomings, the majority of Africans still confidently held on to traditional medicine. Fisher observed that there were a lot of relapses (among patients he was treating); he attributed this to the patients' continued use of herbs/treatment suggested by a 'witch doctor'. Eventually he enforced a ruling that once a patient was under his care he

must be allowed entire charge of the case.[22] Whether this ruling was practically possible is highly questionable as at that time (1909) only a dispensary had been constructed at Kalene hill and there was no permanent accommodation for the patients. They lived and were nursed in small huts built by their relatives who acted as nurses.[23] At most mission stations in the province, the lack of specialised personnel hindered the development of institutionalised medical services so the majority of people still remained under the care of their local doctors.

The medical ministry was therefore important to missionaries in several ways. Firstly, the medicines were of great help to them in their bid to treat tropical diseases strange to them. Secondly, through medical services access was obtained to local people. Recalling his missionary work, Chapman wrote, 'the ministry of healing is a very special preparation to that other ministry, the preaching of the word. A man whose confidence and esteem you have gained by this means will be favourably disposed towards the gospel you preach.....'[24] Thus the use of medicine as an avenue to evangelism was very important to the missionaries.

The Role of B.S.A. Co. in the Provision of Medical Services 1900 - 1924.

Although Northern Rhodesia fell under British Protection and British South African Company administration as from 1890,

an administrative post in the Northwest was only established at Kasempa in 1902. Thereafter another post was started at Kansanshi an area of strategic importance to the B.S.A. Company because of small- scale mining which started there as early as 1899. The desire to extend British rule along with the quest for mineral wealth in the Zambezi-Congo watershed led to the establishment of another administrative post at Mwinilunga in 1905.[25]

The most outstanding feature during the imperialist penetration was the rapid development of mineral resources. This was accompanied by an extension of rail-line from Cape Town to the Belgian Congo (Zaire). The mineral deposits determined the construction and extension of the rail-line north of Zambezi through North-western Zambia to Katanga mines. This penetration of mining capital into Zambia and Zaire had an effect on the way of life of the North-westerners. The existing disease pattern was transformed as a result of increased movement of people induced by labour migration. In Kasempa district, the Tanganyika Concessions Ltd., which was the mining company based in Katanga recruited carriers from there.[25] Another group, named Robert Williams Company took up the responsibility of supplying the necessary labour to the Katanga mines. R. W. Yule was placed in charge of labour recruitment in the Kasempa districts.[27]

Within Mwinilunga district, labour recuitment was

facilitated by missionary effort. At Kalene hospital, individual Europeans approached Fisher to help them in the recuitment of labour. He wrote, one Britisher ... came one day to the doctor in despair 'can you possibly help me out with some workmen ...'[28] In addition, Robert Williams Company also asked Fisher to examine medically all the recruits who passed through Kalene on their way home from Angola to the Katanga copper mines. For such services rendered, missionaries were paid and this was one way in which they raised money to facilitate their medical work.

Labour from North-western province was recruited for Katanga mines and South African based mines. Within Zambezi district a WENELA recruitment centre was established. Immigrants from Portuguese Angola, and the Luvale from within the district were recruited to work on the gold mines in South Africa. The 1938 Pim report observed that although WENELA drew some of its labour from Zambezi, the number was quite minimal as most of its labour was drawn from Western province (Barotseland).[29] However, as from 1930, the native labour association was formed to avoid competition in the recruiting areas by various Zambian mining companies. This labour company still maintained Zambezi district as a recruitment centre.

The discovery of copper as a feasible industry led to the disruption of the disease pattern in North-western Zambia. Labour migration left the local people prone to a number of diseases. At the end of their contracts many of the diseases

afflicting migrant workers posed threats to their families. The increased movement of people from one place to another meant that the once isolated disease environments were now vulnerable to diseases. Further more, the diseases once unknown to the province now became endemic. These included respiratory tract disorders and other communicable diseases. It should be mentioned that, although the B.S.A. Co. established administrative posts in the different districts, no social services were provided. Instead the welfare of the Africans was left in the hands of the missionaries as the company did not regard the health services of the general public as its responsibility. The first company dispensary in North-western Zambia was opened at Kansanshi to serve the mine employees based there.

However, as from 1910, there was a change in the company's medical policy, this was a result of different circumstances and forces. In 1909, the board of directors of the B.S.A. Co. in London requested that something be done for Africans.[30] Furthermore, a number of diseases had caused great concern amongst the Europeans and administrators in the region. Among these were epidemic diseases like small-pox, influenza, yaws and venereal diseases reported to have been rampant among mine employees. In North-western Zambia, the 1913-14 outbreak of smallpox was said to have been import ed from the Belgium Congo. Similarly the outbreak of tropical ulcers and influenza in the years 1916-17 was associated with the return of war carriers.[31]

What followed the outbreak of epidemic diseases was the promulgation of the March 1914 public health rules, a step in safeguarding the health of the public. According to this promulgation, 'it was an offence for the head of a family or an employee of labour to fail to notify any infectious diseases in his house or among his employees.'[32] Similarly, a person suffering from any infectious disease was forbidden to appear in a public place. The list of infectious diseases included small-pox, diptheria, whooping cough, meningitis, typhoid fever, sleeping sickness, cerebro-spinal fever and plague.[33] To effect this promulgation, dispensaries were started throughout the country. In North-western Zambia these were at Solwezi, Kasempa, Zambezi and Mwinilunga. The one at Solwezi consisted of a small burnt brick surgery and a medical officer was in charge.

In Mwinilunga and Kasempa, the district officer was in charge of the dispensaries. He delegated the medical work to untrained African employees who were expected to undertake the health measures to control the spread of disease amongst the African population. These dispensaries merely existed in name. They lacked qualified medical personnel and basic drugs. Yet these were supposed to serve as screening centres where suspected cases of more serious diseases could be referred to hospital for diagnosis.

Furthermore, the meagre company efforts to contain

epidemics were greatly supplemented by missionaries' medical work in the area. Missionaries took advantage of famines and epidemics to spread their ideological influence. During the outbreak of smallpox in Mwinilunga, the missionaries devoted most of their time and money treating the sick. To them an avenue was found where the gospel would be easily spread. They procured their medicines, money from friends and relatives as well as through Government grants. In 1919 for example, a sum of £100 was granted to Fisher for his services in the smallpox epidemic. An additional £200 was given to him the following year to facilitate his work.[34] Inspite of the costs involved in the treatment of various diseases, most missionaries were pleased to just pass a pill while they preached the gospel.

The above discussion has illustrated that the medical services provided during Company rule (1902 - 1924) were both inadequate and unable to withstand challenges which were gradually emerging as a result of the rapid transformation of the epidemiological environment. Although it was a well known fact that western medical services provided were inadequate, witchcraft laws were instituted which aimed at undermining African medicine. The colonial administrators applied the term 'witchcraft' to include most of the traditional practitioners.[35] Because of the new piece of legislation, African medicinemen near mission stations and administrative centres were not free to practise. As a result, they migrated to far away places as the colonial official reported,

> I now learn that 'doctors' frightened to follow their 'profession' have migrated either to Congolese or Portuguese territories where the Lunda and Ndembu go to consult them ... it will be readily seen that until our neighbours make some effort to administer their respective territories the official in charge of this division will have an uphill fight to stamp out this particular crime.[36]

Thus through the 1914 Witchcraft Act the colonial officials aimed at eliminating traditional healing which had been in existence for centuries.

African Response to Western Medicine 1900 - 1924.

The African response to western medicine was a mixed one and has been explained variously. In some areas, missionary medical work was received enthusiastically. The response of chiefs for instance demonstrated a zeal to try the white man's medicine especially when it concerned diseases which their own therapeutical systems were unable to cure. Furthermore, people generally attributed high esteem to foreign healers largely because their weaknesses were unknown to a distant society. From Mushingeh's point of view, 'a foreign doctor was often seen as possessing different and more effective remedies than the local healers.'[38] Similarly, White observed that during colonial rule, local people in Zambezi freely crossed into Angola and Zaire seeking medical attention from traditional healers who had a high reputation.[39]

Another point advanced by Janzen is that Africans readily accepted western medicine because of the similarities in the two healing systems. Both therapeutic systems at that time were based on the administration of herbal remedies accompanied by limited surgical knowledge.[40] A similar view was expressed by S. Fisher when he wrote about medical work at Kalene,

> ...paradoxical though it may sound the primitive conditions of the early medical work were in some ways an advantage. Had the Lunda people at that time found at Kalene hill a huge modern hospital with large airy wards and much complicated apparatus they would have been scared and distrustful. As it was, the small grass huts and the little dispensary rooms appealed to them as something familiar and therefore safe.[41]

In addition, Africans were also attracted to western medicine because of the anticipated difference in the effectiveness of both therapeutical systems. Through the use of injection, Fisher gained a considerable reputation. According to Burr, it was quite common to hear people saying, 'I want a needle,'[42] The injection influence seemed to have been widespread in Africa. In Kenya for example, the impact of the injection increased in the 1920s during anti-yaws campaign and because of this influence '... patients whatever their complaint ... so long as they had a past history of ulcers or sores demanded for <u>sindano</u> (swahili: needle) and were bitterly disappointed if for any reason this was denied them. Infact one or two had to be pushed out by force when told they would

get other treatment.'[43] Because of the influence of the injection some local people responded favourably to western medicine.

Furthermore, minor operations like the skill of removing cataracts carried out by Fisher also spread far and wide. Initially most Africans shunned away at the mention of an operation. A woman who was blind due to cataract which was removable by operation was only convinced to have it removed af persuasion.[44] However, because of repeated successes in minor operations, many people demanded to be opened up at once as they felt confident that if only that was done then the evil spirit within would be able to get out and the cure would be instantaneous. To the local people, it was more of a miracle for one to be opened up and sutured having had the cause of the illness removed. A combination of the different factors, therefore, made Africans respond favourably to western medicine.

It should however be argued that although people responded well to white man's medicine, the response was not uniform. In some, foreign interference was resisted. These included gynaecology and midwifery where doctors such as Fisher and others encountered difficulties. To the local people it was a taboo for men to treat women suffering from gynaecological diseases or attend to women in confinement. This was an area left to female traditional healers.[45] In most villages, women in confinement were taken to a modern doctor only after attempts by traditional midwives had failed.

An increase in the number of maternity cases that were referred to the mission for professional assistance were first recorded in the early 1920s.[46] Even this did not imply a majority, because the medical facilities available were inadequate and many women still had confidence in home deliveries which they had depended on for ages.

Circumcision too was an area in which missionaries encountered different reactions. Although in the early 1920s some Lunda and Luvale Christians (believers) allowed missionaries to perform circumcision in hospitals, this was still resisted by most people in the Lunda and Luvale land.[47] The so called 'non-believers' still continued with the traditional mukanda ceremonies as this constituted the main path for tribal acceptance and the initiation of boys into manhood. Gradually, through the use of anaesthesia and anti-septic treatment to prevent the infection of wounds, hospital circumcision gained popularity. However, the existing medical institutions were unable to perform circumcision to most willing people because of lack of personnel and drugs.

From the above evidence, one can argue that medical services provided by both the missionaries and colonial Government gave the Africans an alternative medical system. Secondly, the African consumers used both therapeutical systems at will. Lastly, the African response to various aspects of

western medicine was not uniform.

Conclusion

In the period under discussion, the pioneer missionaries' role in the provision of Western medicine in North-western Zambia was minimal and had a limited impact on the local people. This was because of their shortlived stay in the area. Patients were in most cases treated while the missionaries were in transit to Angola. Medical work by missionaries was only a means to the spreading of the gospel. Their efforts were hindered by the lack of funds and poor medical training.

The Chartered company confined itself to providing medical services to white areas and only extended its activities to remote areas when threatened by epidemics. The outbreak of epidemics provided opportunities for collaboration between the company and missionaries. Despite the availability of western medicine the African consumers consulted both medical systems without any sense of contradiction.

NOTES:

1. Health Data Publications, Federation of Rhodesia and Nyasaland (Washington: Walter Read Army Medical Centre, 14, 1962), 10.

2. R.I. Rotberg, 'Plymouth Brethren and the occupation of Katanga, 1886 - 1907', Journal of African History, 5 (1964), 296.

3. S. Fisher and J. Hoyte, Africa Looks Ahead: The Life stories of Walter and Anna Fisher of Central Africa (London: Pickering and Inglis, 1948), P. 131.

4. S. Fisher and J. Hoyte, Ndotolu: The Life Stories of Walter and Anna Fisher of Central Africa (2nd ed.) Mwinilunga: Lunda-Ndembu Publications, 1987), P. 66.

5. Dr. Walter Fisher took advantage of this opportunity to visit and treat the chief. Each time he spoke to him about God and prayed for his conversion.

5. Fisher and Hoyte, Africa Looks Ahead, P. 135.

6. P.D. Snelson, Educational Development in Northern Rhodesia 1885 - 1945 (Lusaka: NEDCOZ, 1974), P. 74.

7. Interview, Charlie Geddes, 6 February, 1989, Loloma, Kabompo.

8. P.D. Wilkin, 'To the Bottom of the Heap: Educational Deprivation and its social implications in the North-western Province of Zambia, 1906 - 1945', Ph.D. thesis (Syracuse University, 1983), 43.

9. Snelson, Educational Development, P. iii.

10. R. Henkel, 'Mission Stations in Zambia: Their Location and Diffusion Patterns,' Zambia Geographical Journal, 35 (1985), 18.

11. E. Burr, Kalene Memories (London: Pickering and Inglis, 1956), P. 28.

12. NAZ, HM8, F12/3/3, Dr. Walter and Anna Fisher Papers, P. 10.

13. NAZ, Fisher Papers, P. 10.

14. Burr, Kalene memories, P. 30.

15. Burr, Kalene memories, P. 32.

16. Wilkin, 'To the Bottom of the Heap',

17. D.E. Ferguson, 'The Political Economy of Health and Medicine in Colonial Tanganyika', in Kaniki M.H.Y. (ed.) Tanzania under Colonial Rule (London: Longman, 1980), P. 319.

    These remarks were passed by Archdeacon Walker (C.M.S.) who was based at Mengo in Uganda.

18. W. Fisher as quoted by R. Rotberg, Christian Missionaries and the Creation of Northern Rhodesia 1880 - 1924 (Princeton: University Press, 1965), P. 93.

19. These words were said by G. Suckling quoted by Rotberg from Echoes Sept., 1923. Rotberg, Christian missionaries P. 132.

20. Illnesses like mental disorders (for instance insanity), reproduction problems (infertility and virility), epilepsy and Kapokota - acute constipation and destruction of tissue in the region of the anus - were some diseases which

Western medicine failed to cure satisfactorily. This view was expressed by Yowanu Mapulanga during an interview with him on 2 February, 1989, Mwinilunga.

21. Snelson, Educational Development, P. 79.

22. NAZ, Fisher Papers, :P.5.

23. Fisher and Hoyte, Ndotolu, P. 148.

24. W. Chapman, A Pathfinder in South, Central Africa (London: W.A. Hammond, 1909), P. 300.

25. B.C. Kakoma, 'The Establishment of Colonial Rule Among the Lunda of Mwinilunga District of Zambia, 1909 - 1913', Paper presented to the History Department, University of Zambia (12 May, 1970), 13.

    At this time (1909) Dr. Walter Fisher had already set up a mission station at Kalene Hill.

26. Kasempa District included Solwezi, Mwinilunga and Kasempa Districts.

27. Pim Report, (London: His Majesty's Stationery Office,1938), P. 30.

28. Fisher and Hoyte, Ndotolu, Pp. 190-1.

29. Pim Report, P. 33.

30. M. Gelfand, Northern Rhodesia in the Days of the Charter: A Medical and Social Study 1878 - 1924 (Oxford: Basil, Blackwell, 1961), P. 17.

31. NAZ, KSE6/1/2, Mwinilunga Annual Report (1911/12-1915/16), P. 11.

32. Pim Report, P. 290.

33. Pim Report, P. 290.

34. Fisher and Hoyte, Ndotolu, P. 192.

35. Interview, Yowanu Mapulanga, 2 February, 1989, Mwinilunga.

36. NAZ, KSE6/1/3 Mwinilunga Annual Reports (1914/15-1919/20) P. 9.

This observation was noted by Bruce Miller who was the Native Commissioner then.

38. A.C.S. Mushingeh, 'A History of Disease and Medicine in Botswana 1820 - 1945', Ph.D. Thesis (Cambridge University, 1984), 116.

39. C.M.N. White, 'Elements in Luvale Beliefs', Rhodes-Livingstone Papers, 32 (1961) 67.

40. J.M. Janzen, The Quest for Therapy in Lower Zaire (California: University Press, 1978) P. 33.

41. Fisher and Hoyte, Ndotolu, P. 149.

42. Burr, Kalene memories, P. 28.

43. M.H. Dawson, 'The Social History of Africa in Future, Medical Related issues', African Studies Review, 30, 2 (1987), 8.

44. Fisher and Hoyte, Ndotolu, P. 50.

45. An example of resistance in the field of midwifery can be observed from Fisher's experience in Burr, Kalene memories, P. 32.

46. NAZ, KSE6/1/3/192/1922, Mwinilunga Annual Reports, P. 5.

47. Rotberg, Christian Missionaries, Pp. 94-95.

It was not a Kaonde tradition to send boys for circumcision.

CHAPTER THREE:

WESTERN MEDICINE UNDER COLONIAL RULE, 1925-1945.

INTRODUCTION

The medical services provided by the colonial state did not develop parallel to the changing disease pattern. The colonial demands and repressive laws of taxation, labour migration and to a certain extent, land alienation contributed greatly to the change in the indigenous epidemiology. When the British took over administration of Zambia in 1924, the medical facilities provided by the chartered company formed a foundation of the colonial medical structure. Northwestern Zambia being in the periphery was mainly served by the missionaries who due to constraints did not develop an elaborate medical programme.

The main concern of the colonial state was to ensure that disease disrupted the colonial economy as little as possible. Despite the repressive laws passed by the colonial state which forced traditional healers to practise underground or flee to neighbouring countries, it was not possible to undermine traditional medicine because their resources and facilities were inadequate. As a result, the majority of the local people relied upon traditional medicine for survival. Faced with a changing disease pattern, colonialism, and Christianty, traditional medicine did not remain static, but changed to

adapt to the new environment.

Colonial State Medical Services 1924-1945.

In 1924 when the colonial state took over administration of Northern Rhodesia, the same medical services started by the B.S.A. Company were continued by the imperial Government. During the Chartered company's term of office, the medical services had as their earliest mission the protection of the health of the whites, therefore services provided were concentrated in places where whites lived and these were mainly along the line of rail.

However, because of high mortality and sickness rate amongst mine labourers, the company extended medical services to the Africans, starting with the employees of the mining sector which formed the backbone of the economy. The principal reason for the provision of the medical services to the African employees was as a result of the material interests embedded in their work.[1] International capital did not perceive health as developmental but rather as consumption oriented and not growth as the case was with industry. The colonial state invested in health only when their interests which were profit oriented were threatened.

As from 1917, rudimentary health services were extended

by missionaries to a few Africans in remote areas. This although a humanitarian move, was necessitated by the danger of epidemic diseases like smallpox, influenza, pneumonia, venereal diseases and many others spreading to the European community as well as crippling the labour force the mining capital so much depended on. This view was commonly held in other colonies as well. In Southern Rhodesia, Dr. Askins remarked, '... as we want to have a healthy white nation we have got to tackle infectious diseases in the native ...'[2] For an African was looked upon as a reservoir of the infections. In view of this, the outbreak of epidemics especially from 1900-1930s led to the extension of Government dispensaries into remote parts of Zambia. According to Baylies, the period between 1890-1930 was regarded to have been the unhealthiest in Africa's history. The same view was echoed by Patterson.[3]

The dispensaries established at administrative centres in Northwestern province were used as places where local people obtained medical treatment. The dispensaries lacked equipment, drugs and qualified personnel. They were entrusted into the hands of untrained Africans and yet these were supposed to serve as screening centres where suspected cases of more serious diseases could be referred to hospital for diagnosis. The observation by Gelfand that '... by 1924 every important station, post or district had its own Government doctor in all the larger towns, European sisters were placed in the hospitals

which were able to provide adequate and efficient care for the patient',[4] is open to contention considering the level of development in the territory. What is clear though is that whatever medica facilities available were positioned in strategic places so as to benefit the white settlers and the colonial Government. For a remote area like Northwestern Zambia where a few whites settled owing to distance from the rail line and a few prospects for profitable venture and without a settler population that could agitate for development facilities, the colonial state found it easier to neglect the area in as far as the provision of infrastructure and social services were concerned. This helps to explain why the initial stage of the introduction of Western medicine was mainly characterised by the medical facilities of the missionaries rather than the colonial Government.

It is also important to argue that as from 1924 to 1937, there was no notable change in the type of medical services provided by the colonial state. This is explained by a number of factors. Firstly, there was negligible effort on the part of the colonial officials. As earlier stated, the state's interest was to yield huge profits and rule cheaply. Due to this attitude, priority was attached to profitable ventures such as the mining industry while releasing little funds for the provision of social services such as medical facilities in areas which were regarded to be non-viable economically. This view is evident from the Director of Health's remark:

> When I arrived in Northern Rhodesia in 1935 and took charge of the health department, the acting director who handed over to me said, 'about African work,

> Haslam, leave it to the missionaries; they have and Government has not the missionary spirit.'[5]

By deciding to rule cheaply as was characteristic of capitalist tendencies, the Government mainly concentrated on the maintenance of law and order and on other services which they regarded to be economically viable. The question of lack of funds was constantly raised as a hindering factor in the development of medical facilities. In 1932 for instance, the health department reported, 'the Africans resident in native areas are under the care of the medical officers stationed at the more important administrative centres but up to the present it has not been found possible to begin extensive medical work in these areas. It is hoped that progress will he made when the finances of the country improve.'[6]

The financial difficulties the colony was facing at that time was evident from the retrenchment of some health officials during the period of depression (1931-1933). The Pim report described the activities of the health department prior to 1937 as amounting to very little.[7]

The Colonial State's Role in Containing Diseases.

Although the colonial state failed to provide adequate medical facilities for the Africans, it played a major role in

the transformation of African disease pattern in this period. The colonial Government measures of promoting labour migration and the introduction of coercive measures such as hunting restrictions and payment of tax entailed a number of changes on the indigenous society. With the colonial demands of labour and tax payment, young able-bodied men were forced out of their local societies to mining areas. Additionall due to the proximity of the province to both Zaire and Angola, local people easily crossed into the two countries either seeking employment or avoiding Government repressive laws. The increase in human movement facilitated the spread of diseases in the area.

With the penetration of mine based capitalism into Zambia a number of diseases were introduced into the society altering the pre-colonial disease pattern. Upon arrival on the mine, migrants were exposed to poor conditions of living designed by the capitalist company which was mainly interested in yielding huge profits. The poor conditions on the mines left African employees more vulnerable to disease. This is noted by Ferguson:

> Labour migration whether a voluntary reaction to economic opportunity or a necessary response to ... poverty and taxation had major implications for health. The migrants, generally poor, ragged and badly nourished often walked or rode hundreds of miles bringing their own disease with them. At their destinations, they encountered a hostile local disease environment and faced additional hazards inherent in their marginality and in

> the new occupation. Migrants to urban areas frequently had to live in crowded squalor where they were vulnerable to a variety of respiratory and enteric diseases.[8]

At the end of their contracts, many miners became highly susceptible to parasitic and communicable diseases because of the generally debilitated state they were in. Most of the diseases afflicting migrant workers posed threats to their families upon returning home. However, these afflictions were not responsible for the bulk of morbidity and mortality in the area but it enhanced the rate.

Although the colonial state played a significant role in the transformation of the disease pattern in Northwestern Zambia no significant measures were taken to arrest the situation. The state's main interest was on the mining area where the company provided medical facilities for its workers. Even these were quite inadequate when one considers the poor conditions on the mines which left miners susceptible to diseases. But what happened to the workers at the end of their contracts was not the company or the colonial Government's concern. Instead workers had to fend for themselves. It was not therefore surprising that labour recruiting companies later became choosy on the type of workers to recruit. In 1933 for instance, the District Commissioner in Mwinilunga reported, 'the mines decline to employ the Lunda and Ndembu because of their poor physique....'[9] However, to come up with a fair assessment of colonial medical service, it is necessary

to examine the role the state played in containing the outbreak of some parasitic and communicable diseases. Through this examination measures taken by the state will be clearly shown.

Pneumonia was a disease which occurred periodically in the area especially in the cold and rainy season. However, during the colonial period it became perennial both in North-western Zambia and mining areas. In 1930, a colonial official observed that, 'though the death rate from pneumonia may seem high, it must be remembered that the disease heads the list of causes of death in ordinary life.'[10]

Influenza was another disease characteristic of the colonial period. Its occurrence was first reported in the province in the first World War period. Thereafter it became endemic in the area and cases were recorded during the cold months In 1935 influenza was recorded to have affected one-third of the population.[11] The spread of the disease was enhanced by increased human movement as a result of labour migration and social mingling.

Another respiratory disease whose occurrence was rife in the province was tuberculosis. The disease had a long history in Chavuma area (Zambezi) where its origin was associated with immigrants from Angola. Its spread however, was facilitated by increased social mingling and overcrowding especially in areas like Chavuma which were suitable for agriculture. The state took no elaborate measures to eliminate the social cause of the disease which was rooted in poverty and impoverishment.

According to Grave poor diet made tissues unfit to withstand the spread of the tubercular bacilli.[12] Although drugs were dispensed at mission stations and Government dispensary no preventive measures were undertaken to contain the spread of the disease.

Another disease which attracted the attention of the colonial state was small-pox. Its appearance was recorded as early as 1912 and thereafter recurrences were recorded in consecutive years.[13] Owing to its virulence and adverse effects, the Government reacted promptly. Boma messengers conducted vaccination campaigns while mission stations were supplied with vaccines and financial assistance.[14] In June 1925, smallpox out-break was reported in Ntambu (Mwinilunga) alleged to have been brought by returning labourers from Lubumbashi. To contain the situation, the provincial medical officer was reported to have sent supplies of vaccine to Kalene hill and Kamapanda where missionaries conducted vaccination campaigns.[15] These campaigns were only undertaken in cordoned areas. Moreover, in most remote parts of the province, quarantine was not strictly adhered to as the colonial state lacked qualified personnel to effect such measures. Despite the attention small-pox received countrywide, the disease was not easily eliminated. Its survival was perpetuated by poor sanitation, uncontrolled human movements and lack of long term programmes.

The prevalence of venereal diseases such as Syphilis and Gonorrhoea was reported in the 1920s. The District Commissioner

(Zambezi) reported that serious diseases like Syphilis and Gonorrhoea were quite difficult to contain due to an influx of Angolans who were identified as furnishing constant channels of fresh infection.[16] The increased human movement perpetuated the continuation of the disease such that by 1937 syphilis (specifically) had become one of the most difficult diseases for the colonial medical services to combat. In 1939, the Government attempted to control the illness through venereal disease campaigns. These were started in Namwala and Eastern Province and yet Zambezi where the disease was quite rife was left out. By 1940, it was reported that nearly 60% of the inhabitants of the district were suffering from one disease or another. The District Commissioner noted that as an experiment, 'my predeccessor sent forty immigrants who had come to the office to be written on and the medical officer found that thirty of them were infected with venereal disease.'[17]

The increased morbidity of syphilis was blamed on the failure by the Portuguese Government to provide facilities for treatment in Angola. Yet the Government took no specific measures to restrict the immigration of Angolans into Zambia. Moreover, the spread of venereal diseases were enhanced by the growing infidelity and promiscuity more especially Balovale which was used as a WENELA recruitment centre. The district became a focal place where immigrants from Angola and Zaire converged. Along the migration routes, settlements emerged which attracted

an influx of people. Additionally, there was an increase in syphilitic cases during the second world war period as African porters returned home with fresh infection of the disease. This state of affair was unfortunately not matched by an increase in medical and health facilities.

In Kaondeland, the endemic syphilitic related disease of yaws reached an epidemic level in 1925, 1929 and 1939.[18] Although transmission was by direct non-sexual contact, its enhancement during the colonial period was as a result of poverty, overcrowding and personal uncleaniliness. Despite the anti-yaws campaign started by missionaries and the colonial state, relapses were always observed. Missionaries blamed this state of affair on the Africans' reluctance to finish off treatment. In most of these cases, the Africans had to travel long distances to get an injection and distance was in a way a hindering factor on the anti-yaws campaign.

Other skin diseases were equally prevalent in the area. These although endemic were a clear indication of poverty and impoverishment. The most common skin disease was scabies. It was widespread among both adults and children and according to the District Commissioner, the spread of scabies was facilitated by insanitary surroundings, uncleaniliness and bad diet in villages.[19] The public health duties were delegated to local authorities who were inadequately equipped both financiallly and in terms of experience to challenge the rapidly changing

disease environment.

Tropical ulcers, another skin disease which caused concern among missionaries in Mwinilunga. **Recurrences** of the disease were recorded in 1925 and 1926. Moreover, relapses were quite common and these were partly due to failure by both the missionaries and the colonial state to eliminate the socio-economic causes which included poorly balanced and vitamin-deficient diet, lack of clothing and increased social mingling. In most cases, the Government ignored the fact that '... the social economic system under which a people live, produce and reproduce is more determinate of people's ill-health or well-being than is the natural environment.'[20] Until such socio-economic causes were eliminated, the Government could not claim to provide effective medical services.

The boma dispensaries also dealt with common ailments such as colds, fevers, malaria, digestive and malnutritional diseases. No elaborate measures were taken to contain the prevalence of malaria among the Africans. Measures were however, taken to prevent the occurrence of the disease amongst Europeans. This can be deduced from the 1930 annual report, 'though, malaria incidence during the year has increased, provided the usual precautions are taken against infection by mosquitoes, the use of mosquito net, mosquito boots e.t.c. and a daily dose of quinine is taken, there is no part of Northern Rhodesia in which this disease need alarm the intending settler or his family.'[21]

To justify its position the colonial state argued that Africans had lived in malaria infested areas for a long time and had developed natural resistance to the disease. The colonial state failed to recognise the fact that Africans' pattern of settlement in a way helped to lessen the occurrence of the disease. However with the state legislations and demands, conditions for further spread of the disease were created.

Digestive diseases were also culturally or environmentally oriented. Insanitary surrounding created excellent conditions for the survival of hookworm, diarrhoea and dysentery. At Kalene hospital the doctor reported that '....practically every patient is found to be suffering from hookworm in addition to any other disease for which they might have come for treatment. The difficulty of course is that even after treatment natives get reinfected on return to their villages.'[22] The lack of community cleaniliness led to the recurrences of the disease. In most cases the intestinal diseases were spread by excreta. Due to lack of pit latrines people squatted in open areas littering them with faecal deposits which were either washed into rivers or (infection) carried by flies. In 1932 Amoebic dysentry reached an epidemic level in the vicinity of Kalene area.[23]

A digestive disease locally referred to as kapokota was quite endemic in the area. Since the disease was unfamiliar to Europeans, their drugs failed to cure it and in most cases it resulted into untimely deaths as the district officer once reported.[24] Government measures to control diseases of alimentary

canal entailed the popularisation of pit latrines which were unwanted by the local people. Moreover, within the colonial health department, sanitation was only given an official recognition in 1937. Prior to that it was not considered important.

Lastly, the importance of food supply to health warrants the examination of dietary deficiency diseases which prior to colonialism were limited in scope and season. Malnutrition was historically endemic in the area subject to weather as food supplies varied from year to year. However, with the colonial Government measures of promotion of labour migration and introduction of other coercive measures such as hut tax, hunting restrictions, agricultural productivity and viability were undermined and this created a rife environment of malnutritional diseases making them perennial as opposed to seasonal as the case was in the pre-colonial period.

Malnutrition in the colonial period was as a result of natural conditions (climatic) and man-made factors. In most cases malnutrition led to the diminution of physical strength and energy exposing one to increased liability to disease. As can be seen from the colonial officer's observation, '... Malnutrition consequent upon the serious food shortages undoubtedly diminished natural resistance towards disease and this fact is attributable to the high incidence and mortality rate.'[25] According to Baylies, 'lack of nutrition debilitated people in the most basic sense severely affecting the quality of their lives ... it makes nonsense of the concept of able-bodied

youth and it makes its victims susceptible to disease agents, many of which are endemic in the environment....'[26] Dietary dificiencies therefore exposed the local people to different diseases which remained endemic.

From the foregoing discussion it can be observed that the limited medical service provided by the colonial state was mainly curative in nature. No elaborate measures were undertaken to control disease occurrences. To the colonial state, curative services were in harmony with capitalism which aimed at ruling with minimum costs. While preventive medicines dealt with alleviation of human suffering and the eventual elimination of the social causes of infections, this entailed an elaborate and expensive medical service which the colonial state was reluctant to offer.

Missionary Medical Work.

Although the demands of the colonial state contributed to African epidemiological change, no stringent measures were taken to control the disease situation. The medical care of the majority of Africans in rural areas was left in the hands of missionaries. The only time the colonial state showed concern was when the capitalist economy was threatened by the outbreak of epidemic diseases.

In Northwestern Zambia CMML and SAGM remained the only missions until the 1950s when the Catholics moved into the area. Both SAGM and CMML mission stations organised their work

autonomously. The Brethren eschewed any type of hierarchy in the church and internal conflicts amongst themselves were precisely avoided by building of new stations. This was evident at Kabulamema in 1940 when Miss Falconer and Mr. Lorah avoided an internal conflict developing at Chitokoloki mission by breaking off and establishing a new site at Kabulamema.[27] The wrangle between Chitokoloki and Kabulamema became more pronounced in the late 1940s when the Government provided financial assistance and drug supply to the latter.

The intra-denomination conflict in a way facilitated the development of medical services in the area concerned. Had this type of competition prevailed widely in the province, better medical facilities would have been provided. It is therefore with this view that it can be argued that the lack of inter-mission competition hampered the development of social services in the province. Wilkin pointed out that '... competition not only seemed to bring in more money and staff from overseas but also induced the missions to use their resources more vigorously in providing education, medicine and direct evangelism.'[28] In Eastern Province for example, the Dutch Reformed Church and White Fathers attempted to out maneuver each other. Due to the fear of losing converts, social services were provided to induce African followers.[29] The absence of inter mission competition in Northwestern Zambia caused laxity on the missionaries in the area. In most cases missionaries lived in scattered isolated places making inter-church competition almost impossible.

Although, initially, missionaries were reluctant to provide institutionalised medical facilities, gradually faced with a rapidly changing disease environment, missionaries at most stations were compelled to provide medical structures where their African patients would be cared for. In Mwinilunga in addition to Kalene hospital and Kamapanda another dispensary was started at Mujimbeji in 1933. In Zambezi a dispensary was opened at Dipalata in 1937 and another at Kabulamema in 1940. SAGM also opened medical facilities at Mukinge in 1926 and Mutanda in 1937, in Kasempa and Solwezi respectively.

At the medical stations, missionaries attended to the local people's health and also played a significant role in containing the spread of infectious disease. Like the colonial state, the missionaries also dealt with diseases at superficial level in that they treated physical illnesses without eliminating the socio-economic causes. Additionally, financial constraints and shortages of skilled medical personnel hampered the development of an elaborate medical system in an area where Government medicial facilities were inadequate. A colonial official wrote, '... no Government rural dispensaries existed in the outlying districts. Such dispensaries if they did exist would serve very great service in those thickly populated areas which are not served by mission dispensaries.'[30]

Owing to the shortage of medical personnel, the missionarie realised the importance of training local personnel who would help in the dissemination of health culture. Hitherto in the 1920s,

Fisher began training a few local people to assist him in hospita work. The District Commissioner '... suggested to Dr. Fisher that he should continue to concentrate in the excellent medical work done by him rather than embarking on literacy education particularly in regard to the training of natives as dispensers and sanitary officers ....'[31] The suggestion was intended to encourage the growth of medical services in the area which so much needed trained medical personnel.

Furthermore, the shortage of drugs was another hindering factor on the development of missionary medical work. Initially drugs were purchased through individual effort; as from 1924 however, the Government started giving out grants to missionaries. Accessibility to Government grants was on the basis of the mission station's medical work and its role in containing the outbreak of epidemics.[32]

The financial constraints necessitated some mission stations to request for permission to charge medical fees. In 1935, the medical doctor at Kelene hospital wrote to the director requesting for permission to start charging fees. Although the plea was referred to the mission conference for discussion, some missionaries were already charging fees for specific medical cases. Dr. Fisher for example started charging fees on syphilitic patients as early as 1924. He claimed an increase in the number of syphilitic cases entailed expensive treatment.[33] However being a missionary, Fisher associated

syphilis with immorality among the Africans, he thought therefore that through fee paying Christian morals would be observed.

Circumcision was another area where missionaries instituted payment. A payment of 1/- per head was instituted in 1944 in Mwinilunga and Zambezi districts.[34] Through hospital circumcision, the missionaries aimed at eliminating the African rituals. The actual operation was not condemned as it was in line with biblical teaching. Although payment was instituted, the local people also took some gifts to the missionaries as a token of appreciation. Such gifts were also brought to the mission stations by mothers who had successfully delivered in the medical institutions. At some mission stations, able-bodied patients did some work in return for food.[35]

Although the missionaries were doing a commendable job in the provision of medical services, the health of the local people still remained poor. With limited support to missions from the main administrative apparatus of the colonial state, the mission medical facilities did not grow parallel to the disease pattern. Moreover the missionaries' attitude towards the provision of medical services to the Africans was quite apathetic. Medicine was used as a weapon for winning African souls to a different cultural system. It was therefore not surprising that the missionaries chose when to treat and which diseases to concentrate on. When the Government advised them on which diseases to concentrate on, the reaction in most cases was unbecoming. The Director of Medical Services complained of

such an attitude.

> Missionaries and missions who conduct medical work seem far from unanimous either as individuals or as an organisation as to the underlying purpose of that work. For example some missions and individual missionaries say their medical work is only ancillary to their evangelistic work and must always be subordinated thereto.[36]

In a nutshell, both the colonial Government and the missionaries provided medical services only in an attempt to pursue their interests.

Impact of Western Medicine on Traditional Healing.

Although the imposition of colonial rule and the loss of political autonomy had an effect on the indigenous doctors' role in medical service, it did not completely wipe them out. The failure by both the missionaries and the colonial state to provide adequate medical system to contain diseases meant a continued reliance on indigenous therapeutical system.

Additionally, the inability of western medicine to cure all diseases implied the continued practice of an alternative therapeutic system. Diseases such as epilepsy, mental disorders and many others were referred to local doctors. Similarly, through labour migration, diseases such as smallpox, tuberculosis and other respiratory tract diseases were introduced into the

African societies. Such diseases were often referred for treatment at the modern hospital as they were classified as European diseases.

Gradually, traditional African system of healing changed in response to the new colonial society, disease pattern and western medicine. Both the Government and the missionaries sought to undermine traditional healing through various legislations and Christianity. The 1914 Witchcraft Act was so broad in that it prohibited the practice of almost any kind of traditiona medical pracitce. It read '....Soliciting any person to advise any matter by non-natural means is an offence.'[37] Such an Act implied the elimination of divination on which African therapeutics relied. Amongst the Northwesterners, traditional healing was noted in determining the cause of the disease before any effective therapy would be administered.

With the element of divination removed, people preferred crossing into Zaire and Angola. In addition, indigenous doctors also pursued their profession in Zaire and Angola where such regulations did not exist. The Native Commissioner reported, 'it will be readily seen that until our neighbours make some effort to stamp out this particular crime then it will be fruitless for Northern Rhodesia to clamp down this practice.'[38] Similarly the missionaries preached on the wickedness of traditional healers. They saw in the medicinman only his opposition to all efforts of evangelisation. The colonial state also aimed at stamping down

traditional healers as they regarded them to be influential in decision making in the society.

Moreover, by providing Western medicine both missionaries and colonial officials assumed that its development required the neglect as well as abandonment of traditional medicine. They (for instance) realised that the training of local medical personnel would help to undermine traditional medical practice. This was apparent from the Native Commissioner's suggestion, 'if a number of men were taught the value of the more common drugs to diagnose the more prevalent disease then sent back to their villages with a small supply, I feel convinced they would do more to break the power of the 'witchdoctor' than anything I have ever suggested.'[39] Thus to both the missionaries and the colonial state medical service was also used as a means of undermining the African therapeutical system.

Throughout this period (1925-1945) a hostile relationship between traditional healing, western medicine, Christianity and colonial rule was pursued. While traditional doctors accepted western medicine as a supplement this was not the case with modern doctors. As already shown the penetration of international capital through mining paved the way for the infiltration of both new diseases as well as other therapeutic system. Some elements of western culture were adopted in the African healing system. These included the use of razor blades in cupping and tatoos as well as the use of mirrors in divining.[40] While

western medicine aimed at eliminating traditional medicine, the latter made adjustment to its healing system and accommodated the former.

Despite the conflict which existed between the two therapeutical systems, the consumer saw no contradictions in using both methods. The choice of which therapeutical system to follow depended on how the people perceived disease and their beliefs about disease causation. Lastly, while western medicine greatly depended on Christian and Government legislation for survival traditional medicine relied upon the initiative of the practitioners for its continued survival.

Conclusion

In the chapter it has been argued that the colonial demands and repressive laws largely changed the indigenous epidemiology. But both the missionaries and colonial state were unable to provide elaborate medical measures to contain the rapidly changing disease pattern. In addition, their medical service under-emphasized preventive medicine to minimise costs. Lastly, while western medicine largely depended on Christianity and Government legislation for survival, traditional medicine survived on practitioner's own initiative. It did not remain static but changed as a result of imposition of colonial rule and changing epidemiology. Western medicine remained inadequate throughout this period and was therefore unable to supplement traditional medicine.

NOTES:

1. D.E. Ferguson, 'The Political Economy of Health and Medicine in Colonial Tanganyika', in Kaniki, M.H.Y. (ed.) Tanzania Under Colonial Rule (London: Longman, 1980), P. 313.

2. Dr. Askins as quoted by J. Gilmurray, R. Riddell & D. Saunders, The Struggle for Health (London: Catholic Institute for International Relations (1979), P. 24.

3. C. Baylies, 'The Meaning of Health in Africa', Review of African Political Economy, 36 (1986), 67.

   Also see D. Patterson in G.W. Hartwig and D. Patterson (eds.) Disease in Africa AN Introductory Survey and case studies (Durham: Duke University Press, 1978), P. 5.

4. M. Gelfand, Northern Rhodesia in the Days of the Charter: A Medical and Social Study 1878-1924 (Oxford: Basil Blackwell 1961), P. 175.

5. African Health Department Annual Report (1942), P. 9.

6. Annual Report on the Social and Economic Progress of the People of Northern Rhodesia (1932), P. 10.

7. Pim Report, (1938), P. 289.

8. Ferguson, 'Political Economy of Health', P. 313.

9. NAZ, SEC2/952, Mwinilunga Tour Reports (1930-1933), P. 25.

10. Northern Rhodesia Annual Report (1930), P. 40.

11. NAZ, SEC2/133 Mwinilunga Annual Report (1935) P. 1. Influenza epidemics were reported in 1936, 1937 and 1938 in both Zambezi and Kabompo Districts.

12. G.F. Grave and M.K. Ililonga, 'The Problems of Tuberculosis in Balovale and Kabompa Districts', Central African Journal of Medicine 8, 6 (1962), 221.

13. Small-pox outbreaks were reported in 1912, 1914, 1916 and 1924 at different places within Mwinilunga. See NAZ, KSE4/1 Mwinilunga District Notebook (1906-1964), P. 2.

14. S.W. Fisher and J. Hoyte, Ndotolu: The Life Stories of Walter and Anna Fisher of Central Africa (Ikelenge: Lunda-Ndembu Publications, 1987), P. 192.

15. NAZ, KSE4/1 Mwinilunga District Notebook (1906-1964), P. 166.

16. NAZ, SEC2/71/1935, Barotse Annual Report, P. 112.

17. NAZ, SEC2/74/1938, Barotse Annual Report, Chapter, 7.

18. See J.A. Acheson, 'Framboesia Tropica or Yaws with special reference to its occurrence in the Kasempa district of Northern Rhodesia', M.D. Thesis (Trinity College Dublin, 1969) 4.

19. NAZ, SEC7/47, Balovale Tour Report (1942), P. 112.

20. Ferguson, 'Political Economy of Health,' P. 323.

21. Northern Rhodesia Annual Report (1930), P. 39.

22. NAZ, KSE3/153, Mwinilunga Annual Report on Native Affairs (1935-1937), P. 5.

23. NAZ, KSE2/132, Mwinilunga Annual Report (1932), P. 15.

24. NAZ, KSE4/1, Mwinilunga District Notebook (1906-1964), P. 167. For the meaning of Kapokota see Chapter I.

25. NAZ, SEC2/71, Northwestern Province Annual Report for Native Affairs (1937), P. 935.

26. Baylies, 'Meaning of Health in Africa', 62.

27. NAZ, KTVI, Kabompo District Notebook (1948-1964), P. 5.

28. P.D. Wilkin, 'To the Bottom of the Heap: 'Education Deprivation and its social implications in the North-western Province of Zambia; 1906-1945', Ph.D. Thesis (Syracuse University, 1983), 143.

29. See P.D. Snelson, Educational Development in Northern Rhodesia 1883-1945 (Lusaka: NEDCOZ, 1974).

30. Northern Rhodesia Health Annual Report (1926), P. 3.

31. NAZ, KSE4/1, Mwinilunga District Notebook (1906-1964), P. 341.

32. NAZ, RC/347, M.D. 4505/B SAGM Kasempa Grants to mission for medical work (1926), 277.

33. NAZ, KSE 6/1/4, Mwinilunga Annual Report (1925), P. 5.

34. NAZ, KTWI, Balovale District Nortebook (1906-1964), P. 285.

35. NAZ, SEC2/133, Mwinilunga Annual Report (1935-37), P. 28.

36. Northern Rhodesia Annual Health Report (1942), P. 22.

37. NAZ, SEC2/427, 31/1945, Memorandum witchcraft ordinance, P. 13.

38. NAZ, KSE 6/1/3, Mwinilunga Annual Report (1928), P. 9.

39. NAZ, KSE 6/1/4, Mwinilunga Annual Report (1929),P. 1.

40. This view was expressed by Lupezi Kapyololo, traditional healer, interviewed on 13 February, 1989, Mize - Zambezi.

CHAPTER FOUR:

CONSOLIDATION OF WESTERN MEDICINE AND ITS IMPACT IN THE POST-WAR PERIOD.

In this chapter, it will be shown that the post-war period was marked by increased Government measures towards the social welfare of the Africans which included the extension of medical services to them. This was so, because dependency on a healthy labour force helped the mining capital to achieve its major goal of profit maximisation. Besides during this period, the copper industry formed the backbone of the Zambian economy. This explains why the measures were mainly concentrated in areas which the colonial state deemed viable in as far as the recruitment and employment of labour force was concerned.

It also seeks to argue that, although during the post-war period Government measures towards the control of prevalent diseases were intensified, they were far from containing the disease situation which had already reached an alarming rate. Government measures were oriented towards curative medicine which dealt with symptoms instead of the root causes of many diseases. For this reason, diseases which could be prevented by vaccination or otherwise ended up forming a vicious circle which both the missionaries and the Government medical services found almost impossible to break during this period.

Lastly, the chapter will argue that during this period, the Government interest was still oriented towards the promotion of western medicine while undermining traditional medicine.

But traditional medicine continued to survive because of its efficacy on certain diseases and the limitation of western medicine.

Colonial Period 1946-1953.

The post second war period was marked by increased Government support towards the welfare of Africans. According to Doyal, the increased contribution towards the well-being of the colonised should be understood in the context of the economic and political developments within Britain during the inter-war period. Here the situation was characterised by widespread unemployment and one way in which the British Government thought they would resuscitate the situation was to exploit the economic potential of the colonies in as far as the supply of raw materials for British manufacturers was concerned. Secondly, there was need to expand colonial demand for British manufactured goods and in order to effect the measure, 'financial support was therefore given to schemes which would provide immediate and substantial orders for British goods. In addition, some funds were also made available for health-related projects because of the consequent improvement .... in the productive capacity of the populations affected resulting in increased purchasing power.'[1]

All over the world, the war period enhanced the demand for copper which was needed in both war and electrical industries. Owing to the strategic importance copper had acquired, mining capital in Northern Rhodesia wanted to maximise profit from the industry. To do this, it needed to improve social welfare

of the labour force as dependency on a healthy labour force helped the mining capital to achieve its objective which was mainly oriented towards profit maximisation. Although the provision of medical services to the labour force was a positive stance, it largely benefitted mining capital which had realised that if capitalist production had to continue there had to be a renewal of the means of production of these, the most important being the forces of production thus the ability of men and women to work. It was mainly because of the need to pursue their interests that the mining industry extended medical services to their workers who were mainly concentrated on the Copperbelt, the main copper mining area in present day Zambia.

In North-western Zambia, however, there was no significant economic development which could have attracted the colonial Government's interest in the area. What then made its role significant was the expansion of copper industry on the Copperbelt which in turn led to an increase in the demand for the working population. Already, North-western Province was used as a labour reservoir; both the state and mining capital was looking at the generation of labour because urban areas had not expanded to the extent where they could be relied upon for the recruitment of cheap labour. Remote areas like North-western Zambia were therefore relied upon to provide a constant flow of labour to mining areas.[2] In the mining areas labour migrants were catered for medically, and yet this was not the case at the end of their contracts. Then African miners returned to their tribal homeland

and relied on the help of their kinsmen and missionaries who provided the services the state was supposed to render.

However, as from 1946, there was a slight change in the Government medical policy. Efforts were made which aimed at providing services in areas where labour for the mines was obtained. During the period before world war II, the only existing Government hospital in the province was at Balovale. However, this hospital had been meant for the regeneration of labour in an area largely used as a labour recruitment centre. Though the medical services and facilities available indicated that it was not worthy the term 'hospital'. According to a colonial official, 'the hospital at Balovale .... perhaps deserves preservation as a museum specimen of bush hospitals belonging to Livingstone's days otherwise their early destruction and replacement is a clamant need.'[3]

During the colonial period, Government medical facilities did not expand qualitatively. What was characteristic of the post-war period was increased Government support to mission-run medical institutions. Some mission stations not initially subsidized by the Government were now given regular grants. Among these were Kabulamema, Loloma, Chavuma, Dipalata, Kamapanda in addition to Kalene, Chitokoloki and Mukinge which were receiving grants. The grants were mainly based on the average daily number of in-patients accommodated in a given medical institution in addition to the amount of work done at a given institution. This explains why the

District Commissioner for Zambezi opposed Government grants to Chavuma. He reported, '.... this mission deserves no help whatsoever from the Government because it is not carrying out adequate medical work ....'[4] The Government financial support to mission medical work still remained inadequate. To overcome the shortfall, the missionaries made arrangement to obtain drugs from their friends and relatives back home. Drug consignments were usually sent through missionaries who had gone on furlough and new arrivals sent to reinforce mission work in the area.[5] Through such means new technology and drugs reached this remote part of the country.

Throughout the post-war period, the colonial officials continued to work in collaboration with the missionaries to contain the disease situation in the area. Between 1946-1953 the diseases prevalent in North-western Zambia comprised communicable, parasitic, infectious and nutritional diseases as well as other diseases such as small-pox, tuberculosis, leprosy, syphilis, sleeping sickness, malaria and many others. The continued recurrences of diseases which could be prevented by innoculation and public health service is indicative of the extent of the basic social services which were available in the area. The continued recurrences of small-pox (for example) a disease which could have been prevented through innoculation was an indication that no elaborate measures were taken to eliminate the disease.

Tuberculosis was another disease common in the western part of the province. As a result of development of roads and markets which emerged in response to labour migration, tuberculosis became endemic in the area. Incidences of death were quite high where living conditions were at their worst as predisposing causes included overcrowding, poor diet and increased social mingling. Although the colonial Government was concerned with high incidences of tuberculosis in the Chavuma area, no long term measures were started to contain the disease situation. In Zambezi where a large number of cases existed, there was no X-ray plant and medical examinations were based on clinical symptoms. Thus although BCG campaigns were introduced, results were quite futile most times as only a few people would be vaccinated.[6]

The prevalence of venereal diseases in this part of the country also caused concern among the colonial officials. In 1952, a medical officer indicated that syphilis continued to be a scourge in the province. He wrote '.... certainly the Lovale that I saw as emigrants in Barotseland were heavily infected.'[7] In addition, another medical official also noted the increase in the number of syphilitic cases treated at Chizera. He wrote, 'this is due to Chizera dispensary being situated on a much used labour route from Angola to the Copperbelt, most of the patients being Chokwe immigrants from Portuguese West Africa.'[8] The continued immigration of people from Angola

always brought in fresh infection of the disease but the colonial state measures undertaken did not entail restrictions on immigration as this would have curtailed the number of labour migrants, the economy so much depended on. Instead what the colonial state decided to do was to introduce voluntary clinics where venereal disease patients were treated. Being a labour recruitment centre, Zambezi was one area where such a clinic was situated. All those wishing to migrate were first of all examined and venereal disease patients put on penicillin treatment before they were allowed to migrate.[9] This measure proved futile because fresh infections continued to be introduced in the area. After second world war, African porters returned home with fresh infection of the disease. In addition, the lack of restriction on Angolan immigrants who were identified as furnishing constant channels of fresh infection and the lack of preventive measures led to the continued prevalence of the disease in the area.

Leprosy was another common disease in the western part of the province. In 1950, a survey carried out by Dr. Ross Inness revealed '.... the increase in the incidence of leprosy in the river and riparine and marsh and lake population as opposed to the higher and drier plateau country.'[10] The survey also revealed that family leprosy was common and this was the major reason for the persistence of leprosy amongst African tribes, although high incidences of leprosy was as a result of high atmospheric humidities and communal and domiciliary over-

crowding. However, with the establishment of leper settlements and the introduction of a new leprosy drug (sulphone) the occurrence of the disease was reduced. Initially, some lepers resisted being resettled in Leprosarium and insisted that they move with their family members. While others who had been resettled realised after they had been discharged that they had nowhere to go. In Zambezi Nyamona rehabilitation village was founded for discharged patients.[11]

Other common diseases which were long endemic in the area were also not easily eliminated. For malaria (for example) the precautions taken such as house spraying were only put into practice in areas where whites lived. In 1946, the surveying team in Solwezi suggested that European houses should be away from African compounds and regularly sprayed to prevent an outbreak of malaria.[12] These measures were widespread throughout the country as malaria was regarded to be a principal menace to European life and health while it was argued that Africans had lived in malaria infested areas for a long time and hitherto had developed a natural resistance to the disease. In a nutshell the preventive policies adopted against malaria seemed doomed to fail in the absence of more foundamental public health provision.

Digestive diseases such as diarrhoea and dysentry were quite common too. As from 1937 the health department gave recognition to sanitation department and popularised the use of pit latrines. On urban areas, the colonial state assisted

by contributing a portion towards the costs incurred. Also personnel were provided where they were needed. While in rural areas hygiene was taught in schools and to the local authorities in the hope that these would play a significant role in bringing about social change in the society as they prepared the Africans to understand and appreciate the importance of sanitation and personal hygiene to good health. In Zambezi, the district medical officer gave classes to teachers in hygiene and first aid, while in mission medical institutions, African orderlies and school pupils were given classes in hygiene. These were valued as being instrumental in bringing about change in African attitudes and culture.[13] Such measures were not widespread and inadequate as predisposing causes were still prevalent in the society.

Despite the increase in the contribution of aid towards western medical facilities, the rural dispensaries remained largely the only source of Government medical attention. In most cases, these were grossly inadequate since they were still locally funded by impoverished native authorities. As a colonial official observed, 'The problem presented by the creation of local Government authorities and the assignment to them of important powers and duties in connection with health at a stage when these authorities are financially unable to discharge their responsibilities is no new one'.[14] To justify this policy, the colonial state claimed that 'Northern Rhodesia policy aimed at providing more liberal health service for Africans and through

his native authority the African was given more say in the whole question of health services ....'[15] From the Colonial office assistance was supposed to be in the form of visits by experts, participation in conferences and recruitment of medical personnel.

The standard of work done at the dispensaries therefore, varied a good deal. Many were still staffed by Africans who had very little training. A District commissioner once reported, '.... until the Government is able to provide a medical officer who can devote his whole time to supervising the medical work .... it cannot pretend to be seriously tackling the health problem.'[16] In Mwinilunga the mission medical doctor stationed at Kalene was given the responsibility of supervising the Government dispensaries. This was almost impossible to run apart from the mission hospital. Additionally, missionaries did not give medical work top priority as they argued that it was ancillary to their evangelistic work and therefore had to be subordinated to it.

Lastly, it ought to be mentioned that although the post-second world war period was marked by a slight change in the colonial state's attitude towards the health of Africans, no long term measures were started to contain the rapidly growing disease pattern. Instead they established working mechanisms against most communicable and parasitic diseases but these measures were doomed to fail in the absence of more fundamental public health services. Throughout this period, less attention was directed towards preventive medicines and yet this dealt

with the alleviation of human suffering and eventual elimination of the social causes of infection. To the colonial state, this implied the provision of an elaborate and expensive medical service which they were not ready to offer despite the improvement in the state finances.[17] Yet this would have implied dealing with the root cause of many diseases instead of merely treating the symptoms. The absence of preventive medicine created a vicious circle of diseases which both the Government and mission medical services were unable to break.

Federal Period 1953-1963.

Zambia entered the Central African Federation with inadequate medical facilities for the majority of its population settled in the remote parts of the country. As already noted, the Northern Rhodesia medical policy prior to federation had left the responsibility of the Africans in rural areas in the hands of the provincial administrators and the native authorities.

In Northwestern Zambia, the native authorities throughout the federal period continued putting up more medical infrastructure and contributing towards the maintenance of the existing ones. A leper settlement at Mukinge received a small grant from the two authorities in Kasempa and Solwezi.[18] Although

these grants may not have been adequate to sustain the smooth operations of the settlement which also received government grants it was nevertheless an indication that local people had begun to appreciate the existence of such medical institutions. In Chavuma for instance before the new health centre was opened '.... local Africans raised a levy of 4/- per head of resident male population as their share towards the health centre.'[19] Although the local people were quite vigorous in matters concerni the construction of facilities in most cases they were let down by the Government which failed to provide the dispensary with the necessary equipment, drugs and personnel.

In 1955, the training of local personnel was born out of missionary effort in the province. The training of African nurses was started at Mukinge mission hospital in Kasempa. While at Kalene, training of medical personnel was started in 1956, but was not recognised by the Government until 1969. Owing to the lack of training facilities the province was faced with a constant shortage of medical personnel. During this period, a medical officer based in Zambezi was supposed to constantly supervise the work at the dispensaries. Owing to the vastness of the area, transport was still a serious problem. In other parts of the province, the work was left in the hands of the mission medical officers.

Although the opening of the Zambezi hospital coincided with the administration of the Federal Government, the actual construction of the hospital was done during the colonial days.

During the Federal period the only medical institution opened was Chinyama Litapi in 1956. It was opened after constant demands by the chief of the area. The Director of medical services reported, 'the building of this dispensary would be an excellent advertisement for the federal ministry of health in this very backward area ....'[21] Thus the dispensary was mainly constructed as an advertisement for the federation so that it was seen to be doing something for the Africans especially at a time when there was a growing African nationalism throughout the country.

However, the Government continued to subsidize mission run hospitals and dispensaries. At Chitokoloki for example, the hospital received a quarterly maintenance grant of £850-£955 which was for the staff, while the general hospital grant was fixed at £960 per annum.[22] These grants were however, inadequate considering the change in the disease pattern. Chitokoloki Leprosarium for example did not cater for the local people only but patients came from different parts of the country and outside. Zambezi Medical Officer complained, '... to some extent this settlement has become a dumping ground for unwanted people from other districts.'[24] Other mission institutions such as Kalene, Kamapanda, Kabulamema, and Dipalata also continued to receive Government grants.

Throughout the period the missionaries and the Government worked together in the bid to reinforce western medical

practice among the local people and to eliminate communicable, parasitic and infectious diseases prevalent in the area. Smallpox occurrences were recorded in Zambezi district in 1954. The territorial Government adopted working measures which entailed mass vaccinations. Over 2,500 people were reported to have been vaccinated. Surprisingly, two years later smallpox was reported to have broken out again within Zambezi district.[25] Additionaly, in 1960, a health official reported, '... 94 cases of smallpox resulting in 12 deaths and the disease has spread in the North-western province where there were 51 cases and 6 deaths.'[26] The continued **recurrences** of a disease which could easily be prevented by vaccination is indicative of the weakness inherent in the health services available in the area.

Furthermore, incidences of tuberculosis were reported throughout the federation period. In 1953, the medical officer reported, 'tuberculosis remains public health problem **number one** . admission to the hospital which is now named Queen Elizabeth /Zambezi/ have been on the upgrade ....'[27] Despite BCG campaigns, it was still impossible to break the vicious cycle the disease had formed. The Government officials ignored the fact that the major factor in the prevention of tuberculosis is better housing and good diet. According to Watson, 'in dealing with tuberculosis an infectious disease, the mere provision of curative medical services, necessary though they are without preventing people from becoming diseased is a waste of money. Logically and economically, prevention is the goal at which to aim and to which the efforts of all the various agencies, official and

voluntary should be geared.'[28] As far as the Government was concerned, provision of preventive medicine was too costly.

Working measures were adopted to control the occurrences of diseases such as malaria, dysentery, sleeping sickness, bilharzia and veneral diseases but these were mainly a continuation of the colonial Government measures. Emphasis on good sanitation and house spraying was placed in areas where the majority of the white population settled. The health facilities in the area still remained poorly equipped. In most parts of the province, medical work was still largely in the hands of the missionaries who battled it out during the outbreak of various infectious diseases. The concept of preventative medicine was not given much importance by the missionaries who were mainly concerned with curative medicine. As Shulpen pointed out, '... it is only the concept of healing that carries religious potency so that the notion of prevention has always been distinctly unappealing to missionaries.'

The federal period was therefore characterised by the adoption of health measures for the Africans in rural areas, which were largely ineffective. The territorial Government still remained responsible for the health of the local people, while the missionaries were the major source for medical services to Africans in this remote part of the country. But both the Governme and the missionaries battled it out to eliminate communicable and parasitic diseases which had rapidly grown making it difficult for their inadequate medical services to contain the diseases.

Western Medicine and its Impact.

Right from the advent of colonialism both the missionaries and the colonial state believed and preached that scientific medicine provided the only viable means for mediating between people and disease. It was with this view that they sought to undermine traditional healing which Africans had relied on for ages and a lot of lives were saved through it. The repressive witchcraft laws passed in 1914 implied that some traditional healers could not practise freely. In 1954 a colonial official observed, 'professional diviners are active in the Balovale district but fear of prosecution has resulted in their going across the border to hold their witch finding ceremonies outside British jurisdiction.'[30] However, due to the vastness of the province, it was not possible for the administrative officials based at the district centres to identify people associated with the practice of "witchcraft" in the area.

In some areas, traditional rulers were not forthcoming in reporting cases associated with witchcraft. In Chief Kanonegesha' area (Mwinilunga) the District Commissioner reported '.... the cas would have been suppressed if a district messenger had not by chance been in the area at that time.'[31] In some areas, native authorities punished local people for failing to respond positivel to western medicine. In Zambezi, it was reported that the 'Manyin Native Authority have sentenced to one month imprisonment with

hard labour one headman because his village refused to be examined by the medical officer on Tour.'[32] Moreover, to try and undermine traditional healing, the missionaries took stern measures on Christians allegedly involved in the heathen practices such as traditional healing. According to Samakaka, Christians continued to be excommunicated if found to be involved in the practice of traditional healing or seeking traditional treatment.[33] Inference from present day Christian attitude towards traditional medicine is that they condemn it openly while they practise it in secrecy.

Despite the hostile environment which prevailed, traditional medicine had continued to survive. The inadequacy of the alternative medical therapy provided by both the missionaries and colonial Government implied the continued practise of traditional medicine. Throughout the colonial period, it has been shown that although medical services were extended to rural areas like Northwestern province, these still remained inaccessible to the majority of the people. Secondly, western medicine was unable to cure all diseases. Impotence and mental illnesses were considered to be treated by African medicine. According to Bishop Milingo,

> ... not all problems have been solved through the Christian beliefs. That is why we are still having the Zambia spiritual consultors, medicinemen and women, prophets and prophetesses ... in many ways the Christianity we have adhered to leaves a lot to be desired. It promised paradise which often does not give a few foretastes of that forthcoming paradise ... while our traditional beliefs do actually solve the problems.[34]

Although traditional medicine survived throughout the colonial period, it did not remain static but underwent a process of change, continuity and adaptation. The practice of healing changed in response to the new colonial society, disease pattern and western medicine. The introduction of the witchcraft legislations meant that some aspects of traditional healing such as divination which was the basis of traditional healing was eliminated.[35]

Moreover, through the penetration of international capital, new diseases previously unknown in this part of the country were now introduced. In addition, through labour migration other types of medicines previously unknown to the society were introduced.[36] Furthermore, the elements of western culture such as the use of razor blades, mirrors in healing and divining respectively were adopted. These were trinkets unknown to the Northwesterners but through the process of introduction of western culture, such objects were introduced into the society.

The introduction of money into the societies led to the transformation of the healing process. Firstly, healers started demanding for cash instead of the payment in Goods as the case was in traditional African society. A study by Turner in 1955 showed that 'doctors and herbalists [in Mwinilunga] are paid in cash instead of in good.'[37] Thus the money economy had penetrated into areas of social life. The cash economy also led to change in the process of healing. Prior to that healers

had areas of specialisation, gynaecologists, paediatricians, diviners and many others. However, with the introduction of cash economy most healers became general practitioners. This in some cases led to the emergence of fake traditional healers and this reinforced the argument that traditional healers were lacking in expertise. It also led to the emergence of healers who preserved medicine for sale.[38] Thus while western medicine created a hostile environment, traditional medicine made adjustments to adapt to the new environment.

As far as traditional doctors and local people were concerned, western medicine offered a therapeutical alternative. If the disease was considered European, the healer would refer it to the hospital. Illnesses such as leprosy, tuberculosis, smallpox and cancer were referred to the hospital. While impotence and mental illnesses were considered African. The traditional healer as well as the consumers accepted western medicine as a supplement. As a colonial official once reported, 'on the whole it can be stated that the Africans in this area are health-minded and do not feel shy of modern medicine even if they gave their own remedies a try first ....'[39] Thus the people used what was best in traditional healing and modern medicine. Their belief about disease causation in a way helped to determine which therapeutical system to follow.

In 1956, Mwinilunga District Commissioner reported, 'so far from showing resistance to modern medicine, these people have a boundless appetite for it, which is not to say, that they do not

have regular recourse to their own forms of treatment.'[40] A similar observation was made by a missionary who indicated that it was quite difficult to eliminate circumcision rituals which most times were transfered into wards. While parents preferred hospital circumcision because of its use of anaesthesia and antiseptic, they still clung to traditional circumcision rituals to ensure physical endurance and inculcate a high sense of obedience in the initiates (tundanji).

Lastly, it is important to point out that the establishment of Western medical institutions acted as a magnet as they attracted large African settlements. The place became a focal point in that in most cases a school was built and a market emerged. So although the institution became instrumental in containing the disease situation, it also played a part in the spread of diseases. Concentrated village settlements led to increased social mingling which facilitated the spread of infectious and communicable diseases.

Conclusion.

The missionaries and the colonialists preached that the adoption of Western medicine required the total rejection of traditional forms of healing. Due to this attitude, both the missionaries and the colonial state undertook measures which aimed at eliminating traditional medicine. However, the inadequacy of Western medicine as well as the efficacy of

NOTES:

1. L. Doyal, The Political Economy of Health (Boston: South End Press, 1981), P. 253.

2. See Appendix I.

3. Northern Rhodesia Health Report (1946), P. 16.

4. NAZ, NR7/154, Balovale Medical Report (1952), P. 16.

5. Interview, Dr. Swain, 27 January, 1989, Kalene hospital, Mwinilunga. At the time of the interview, Dr. Swain was the medical doctor in charge of Kalene hospital. She first came to serve at the hospital in 1959.

6. See G.F. Grave and M.K. Ililonga,'The Problems of Tuberculos in Balovale and Kabompo District', Central African Journal of Medicine 8, 6 (1962).

7. NAZ, NR7/86, Balovale Medical Report (1952), 21/G/52.

8. NAZ, NR7/53, Annual Report Provincial Medical Officer - Western.

9. *Northern Rhodesia Colonial Report*, Pp. 10-11.

10. Northern Rhodesia Health Annual Report (1950), P. 3.

11. NAZ, NR7/186, Christian Mission in Many Lands (1951-56).

12. Northern Rhodesia Health Annual Report (1946), P. 64. Leper colonies were estabilished at Chitokoloki, Kabulamema and Mukinge hospital.

13. NAZ, SEC2/155, Provincial and District Organisation Balovale, P. 1.

14. Northern Rhodesia Colonial Report (1936), P. 4.

15. NAZ, NR7/249, Federation Health Services (1952-1953), P. 39.

16. NAZ, SEC2/133, Mwinilunga Report (1953), P. 1.

17. Prior to the second war period, when copper was not fetching much on the World Market, the colonial officials always complained that the lack of funds retarded the development of an elaborate medical system. Despite the improvement in copper sales after 1945, still no significant medical policies had been adopted.

18. NAZ, NR7/186, Balovale Annual Report (1951-56), letter from the District Commissioner, Balovale to the District Commissioner Chingola dated 10/12/54.

19. NAZ, SEC2/137, Northwestern Provincial Annual Report for African Affairs (1954-56).

20. Interview, Dr. Swain, Mwinilunga.

21. NAZ, NR7/265, Balovale District Dispensary (1947-57) letter from Director of Medical Services to Secretary of Health Federal Ministry dated 1/1/56.

22. NAZ, NR7/186, Christian Mission in Many Lands (1951-56).

23. See Appendix II.

24. NR7/188, Chitokoloki Leper Settlement, P. 2.

25. NAZ, NR7/157, Balovale Medical Report, P. 224.

26. Northern Rhodesia Health Annual Report, (1960).

27. NAZ, NR7/154, Balovale Medical Official Annual Report (1952-56) P. 3.

28. E. Watson, African Highway (London, John Muray, 1953), P. 169.

29. Schulpen as quoted by Doyal, Political Economy, P. 252.

30. NAZ, SEC2/137, Northerwestern Province Annual Report on African Affairs.

31. NAZ, SEC2/133, Mwinilunga District Annual Report, 1948.

32. Interview, Mutombu Samakaka, 29 January, 1989, Mwinilunga.

33. E. Milingo, Are Zambians Superstitious? Address to the Conference for Zambian Christian Students' Movement Munali, 19th August, 1975, Pp. 9-10.

34. Interview, Enock S. Sameta, 2 February, 1989, Mwinilunga.

35. Interview, Bedford Sawulombu, 28 January, 1989, Mwinilunga.

36. V.W. Turner and E.L.B. Turner, 'Money Economy among the Mwinilunga Ndembu, A Study of Some individual cash budgets', Rhodes-Livingstone Journal (1955), 18, 19.

37. Interview, Nyamusole Kapyololo, 13 February, 1989, Mize, Zambezi.

38. NAZ, SEC2/136, Northwestern Province Annual Report (1953).

39. NAZ, SEC2/71, Barotseland Protectorate Annual Report on African Affairs.

40. Interview, Dr. Swain, Mwinilunga.

APPENDIX I

Proportion of Labour by Area of Origin in each Mine, March, 1951.

Men Per 1,000 TotallStrength

	R.A.C.M.	NKANA	MUFULIRA	NCHANGA	TOTAL
tal strength	12,445	14,051	11,171	8,653	46,3240
reas of origin					
rotse Province	12.1	16.7	14.9	15.0	14.7
entral Province	144.4	66.6	65.6	21.6	78.9
stern Province	111.9	60.7	69.4	42.5	73.1
rthern Province	295.1	276.4	286.4	238.2	276.6
uthern Province	3.8	7.8	4.1	4.2	5.2
estern area[a]	42.7	87.8	82.3	188.6	93.2
apula area[b]	82.5	162.7	248.3	206.2	169.9
eri-Copperbelt[c]	54.3	20.6	22.6	40.9	33.9
ongo	13.7	16.0	29.2	26.6	20.6
asaland	95.9	49.9	58.7	48.3	64.1
ozambique	14.9	4.4	6.2	1.1	7.1
gola	34.9	40.5	41.4	91.4	48.7
anganyika	93.5	187.6	67.9	71.4	111.7
sewhere	0.2	2.3	3.0	4.0	2.3
otal	1,000.0	1,000.0	1,000.0	1,000.0	1,000.0.

. Solwezi, Kasempa, Mwinilunga, Kabompo and Balovale districts.

. Fort Rosebery & Kawambwa districts.

. The Urban districts but including Ndola rural districts.

By far most labour comes from the Northern Province followed by the uapula Valley, Tanganyika, the Western areas, Central province, the astern province and Nyasaland.'

ource: Mitchell J. Clyde, 'The Distribution of African labour by area of origin on the copper mines of Northern Rhodesia', Rhodes-Livingstone Journal XIV, 1955, P. 30.

APPENDIX II

Leprosy Patients - Chitokoloki - 1951.

Place of Origin		No. of Patients	Place of Origin		No. of Patien
Balovale	-	105	Kasempa	-	9
Mongu	-	25	Ndola	-	12
Congo	-	13	Kalabo	-	13
Kabompo	-	15	Senanga	-	3
Mankoya	-	17	Mwinilunga	-	1
Solwezi	-	24	Mazabuka	-	4

Source: NAZ, NR7/188, Christian Mission in Many Lands, Leper Settlement Annual Report, (1949-51), P. 2.

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NAME	DATE	PLACE
Chikomu, K.G.,	9, February, 1989,	Kashinakaji, Kabompo
Geddes, C.,	6, February, 1989,	Loloma, Kabompo.
Gould, M.,	9, February, 1989,	Loloma, Kabompo.
Ewart, V.,	15, February, 1989,	Chitokoloki, Zambezi
Fwalanga, M.L.,	16, February, 1989,	Zambezi.
Kamalata, T.J.,	27, January, 1989,	Kalene Hill, Mwinilu
Kapyololo, L.,	13, February, 1989,	Mize, Zambezi.
Kaumba, M.,	8, February, 1989,	Loloma, Kabompo.
Kashimwanta, A.,	2, February, 1989,	Mwinilunga.
Mapulanga, X.,	2, February, 1989,	Mwinilunga.
Maseka, M.,	1, February, 1989,	Mwinilunga.
Mbinda, T.,	26, January, 1989,	Kalene Hill, Mwinilu
Mujatulanga, L.,	18, January, 1989,	Solwezi.
Mukaza, J.,	3, March, 1989,	Lusaka.
Mutembu, S.,	4, February, 1989,	Mwinilunga.
Samakaka, M.	29, January, 1989,	Mwinilunga.
Sameta, B.,	26, January,	Kalene Hill, Mwinilu
Sameta, E.S.,	29, January,	Mwinilunga.
Sameta, K.,	29, January,	Kalene Hill, Mwinil
Sameta, S.,	25, January,	Kalene Hill, Mwinil
Samulozela, M.,	1, January, 1989,	Mwinilunga.
Sanjombi, A.K.,	14, February, 1989,	Zambezi.
Dr. Swain,	27, January, 1989,	Kalene Hill, Mwinil
Sawulombu, B.,	28, January, 1989,	Ikelenge, Mwinilung

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