A HISTORY OF HEALTH SERVICES IN NAIROBI, C. 1899 - 1963

BY

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A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS, HISTORY DEPARTMENT, KENYATTA UNIVERSITY

June, 1990
DECLARATION

This thesis is my own original work and has not been presented for a degree in any other University.

Agnes Adhiambo Odinga

This thesis has been presented for examination with our approval as the appointed University Supervisors.

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DEDICATION

The research process and the eventual writing of this study involved interaction with various people and indeed it would be unfair to attribute its success to a single individual. First of all, my sincere gratitude goes to my two supervisors, Professor Bethwell Alan Ogou and Dr. Kefi-Tseko for their invaluable constructive comments, criticism, encouragement and meticulous supervision which has made this thesis possible.

To my Parents, the late Joseph Odinga and Herenia Odinga

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Many thanks go to all my informants for their personal co-operation, and for sharing with me their many untold practical experiences of the staff of the colonial psychiatric departments. I would like to single out Dr. Wilson who was the first African to work at the European Hospital and the Vega of Mathari Mental Hospital.

I wish to thank my Mother, Mrs. Herenia Odinga, my sisters Josephine, my brothers and sisters for their love.
ACKNOWLEDGEMENTS

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Many thanks go to all my informants for their personal sacrifices, co-operation, and for sharing with me their many years of practical experience as staff of the colonial medical department. I would like to single out Dr. Wilson Aluoch, the first African to work at the European Hospital and Dr. Magu of Mathari Mental Hospital.

I wish to thank my Mother, Mrs. Herenia Odinga, my daughter Josephine, my brothers and sisters for their love,
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Background chapter examines the economic and social history of Nairobi. This is in view of the fact that the socio-economic system under which people live, work and reproduce, determines their health and well being more than does the natural environment. On the basis of this assumption, it is argued that the socio-economic changes that accompanied the colonial government settlement in Nairobi created favourable environmental conditions for the propagation and spread of different illnesses earlier unknown in Nairobi. The politics of the other hand, patterned the production and distribution of health resources in a manner aimed at improving the health status of the population and also at eliminating equitable distribution of the health resources but geared towards optimisation of profit.
ABSTRACT

A HISTORY OF HEALTH SERVICES IN NAIROBI C. 1899 - 1963

The study traces the development of health services in Nairobi from 1899 to 1963. In this broad historical survey and analysis, the study specifically establishes the origin of the qualitative and the quantitative inadequacy of health services that characterised colonial Nairobi and has persisted in independent Kenya. To understand the genesis of the problems, the study analyses the colonial government health policies during the sixty four years of colonial rule.

A background chapter examines the economic and political history of Nairobi. This is in view of the fact that the socio-economic system under which people live, produce and reproduce, determines their health and well being more than does the natural environment. On the basis of this assumption, it is argued that the socio-economic changes that accompanied the colonial government settlement in Nairobi created favourable environmental conditions for the propagation and spread of different diseases earlier unknown in Nairobi. The political machinery on the other hand, patterned the production and the distribution of health resources in a manner aimed at not improving the health status of the population and also not at stimulating equitable distribution of the health resources, but geared towards optimization of profit.
Before 1914 for example, the colonial government health services were limited to the colonial officials, the railway employees and only those Africans who were in government employment. Health services were only extended to the Africans and Asians outside the colonial government employment as emergency measures to check on the spread of epidemics from the African zones to the European zones. Emphasis was put on curative as opposed to preventive medicine; on protecting the health of the male as opposed to the female. As a result of the changes that emanated during World War I, the colonial government realised the necessity of extending the health services to the population that earlier had no access to the services. After the War as a matter of policy therefore, the colonial government revised its health care provision policy. The post-World War I health policy emphasised the provision of health services to everybody and both the preventive and curative medicine were given due recognition. This led to the rise of the dispensaries, child welfare centres and the creation of the sanitation division in medical department. It is, however, argued that, though this was a positive move, the the population hitherto denied the services had become unmanageable in light of the available health resources. It is also shown that the move to extend the services to the population had
economic motives and therefore not aimed at improving the health status of the population in Nairobi.

Due to the imbalance in the provision and distribution of the health services, the intensified Africans and Asians demand for equitable distribution of the services, and the changing global outlook towards the health of the population in general; in the post-World War II era, the colonial government devised new health policies. This led to the rise of the "health centre" system, and for the first time Africans were required to pay a fee for the health resources at their disposal. This further deteriorated the health of the population. Thus, instead of serving the intended purpose, the services were used as a political weapon to increase the Africans' dependence for exploitation.

The study also discusses the colonial government's response to the manpower requirements. It is shown that before 1914, apart from the missionary endeavours in the rural areas, the colonial government was reluctant to train Africans. It was after World War I and in response to the Post-World War I health policy, that the need to train Africans was deemed essential. However, when the colonial government did move to train Africans, it was at very subordinate levels to ensure the European monopoly of the health service market and also to justify the exploitation of the Africans in the medical profession.
The study finally looks at the evolution of the colonial medical researches. It is ostensibly argued that the researches were initiated to improve the health conditions, whereas in actual sense they were meant to check on the diseases that threatened the productivity of the labour force.

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LIST OF ABBREVIATIONS

A.A.D.
Annual Affairs Department
A.M.R.
Annual Medical Report
A.R.R.D.
Annual Report of Reconstruction and Development Authority
C.O.R.
Colonial Office Record
C.P.
Central Province
C.S.M.
Church of Scotland Mission
D.C.
District Commissioner
D.
Doctor
E.A.M.R.
East Africa Mounted Rifles
E.A.S.
East Africa Standard
E.A.U.
East Africa Uganda Rail
Figures
Hospital
I.B.E.A.
Imperial British East Africa
K.A.R.
Kenya African Rifles
K.M.O.H.
Kenya Ministry of Health
K.N.A.
Kenya National Archives
K.U.R.H.
Kenya Uganda Railway Hospital
L.C.
Legislative Council
L.B.E.A.
Leaders of British East Africa
L.C.
Lieutenant Colonel
L.G.
Local Government
Cita
As cited above
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<td>A.R.C.D.</td>
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<td>C.P.</td>
<td>Central Province</td>
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<td>C.S.M.</td>
<td>Church of Scotland Mission</td>
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<td>D.C.</td>
<td>District Commissioner</td>
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<td>DR.</td>
<td>Doctor</td>
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<td>Legco</td>
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M.O.H. Medical Officer of Health
M.O. Medical Officer
NAD Native Affairs Department
NEPD Nairobi Extra Provincial District
O.I. Oral Interviews
P. Page
PAR Provincial Annual Report
P.C. Provincial Commissioner
Pic. Pictures
Tab. Tables
U.N.I.C.E.F. United Nations Children Education Fund
V.D. Venereal Disease
W.H.O. World Health Organization
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CHAPTER 1

1.0 INTRODUCTION

1.1 Statement of the Problem

There has been a rising tide of demand for adequate and equitable distribution of health resources and services throughout the world. In Kenya, various technological advances and strategies have been devised to meet the medical challenges of the perpetually rising population. These endeavours have been resorted to not only to sustain a healthy population, but also to attain the global target of adequate health for all by the year 2000. More important perhaps, it has been an attempt to accomplish the World Health Organization preamble of 1947, which stated that:

.... The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition....

Further acknowledging human rights to medical care, the 1948 United Nations Universal Declaration of Human Rights, quoted in Roemer (1977:233), also noted that:

.... Everyone has a right to a standard of living adequate for health and well-being of himself and his family including medicare ... and the right to security in the event of a sickness.

Despite all the preceding global declarations, a large population of Kenya in general and Nairobi in particular,
have no access to quality and adequate health services. Apparently the current problems Nairobi is facing in the provision of health services are not recent phenomena, they have their origins in the colonial past.

In recent years, particularly since independence, a growing number of scholarly studies on geographical political, economic and other social related issues on Nairobi have been documented. However, no major comprehensive colonial medical history of Nairobi has been carried out. It is because of this limitation that the present study intends to fill the glaring gap in Kenyan historiography and also to harness the available data and facts, to provide the necessary interpretation and a clear picture of the changes that occurred in the development of health services in Nairobi during the colonial era.

The study by Patterson (1981) of health problems and historical development of health services in Accra, indicate that similar studies can be carried out for other cities in Africa.

1.2 Objectives of the study

This study aims at examining how the prevailing socio-economic and political factors during the period under review, influenced the development of health services in Nairobi.
Secondly, the study seeks to establish the historical genesis of the qualitative and quantitative inadequacy of health services that characterised colonial Nairobi.

Third, it also intends to unearth and explicate the colonial government health policies enacted in response to the health needs within different historical epochs.

Lastly, as part of the understanding of the issues involved, the study seeks to explain the extent to which the different colonial health policies were a reflection of the changing levels of capitalist penetration in Kenya.

1.3 Review of Literature

Historians have for a long time neglected the study of the past health conditions as well as the role of health care and medicine in African history (Hartwig and Patterson, 1978:3). The earliest available historical studies on the subject were published in the 1950's (Bayoumi, 1979:1). Whereas the majority of these studies are simply narratives of administrative development¹, a few are autobiographical, spatiodemographic or epidemiological in approach². Most of these studies lack analytical explanations why western medicine was introduced in Africa, why it was inaccessible to those who needed it most and lastly, why the inadequacy and the inequitable distribution of health services persisted throughout the colonial period. In other words, these early medical historians examined health services in a
vacuum – as if the services existed independently of the prevailing socio-economic and political conditions.

Some of the most substantial recent studies on health services in Africa are contributions made by Turshen (1975), Bayoumi (1979) and Patterson (1981; 1982). Unlike the initial studies, these scholars have used the dependency theory to analyse the equity and the rationality of the production and the distribution of health services during the colonial era. Turshen (1975), for example, argues that the German, and later the British health policies in Tanzania, were in harmony with capitalism. Patterson (1981 and 1982) articulate the view that western forms of health services were introduced to Africa to serve the political and economic interests of the Europeans. He further emphasizes that the origins of the inadequacy of health services in Accra was linked to the establishment of capitalist modes of production.

While these studies concentrate on other countries of Africa, the medical history of Kenya and particularly Nairobi has remained the subject of more verbal discussion than serious research. There are only a few fragmentary and incomplete studies on the subject.

The earliest published account of health services in Kenya is an article by Milne (1928) in which he discusses the rise of colonial medical services in Kenya. He contends
that the pre-1914 colonial health policy was limited to a few people. Milne further outlines the organization and the structural set-up of the medical department in the pre-1914 period. Other issues highlighted in the article are the problems encountered by the colonial medical establishment. While this discussion provides the basic facts on medical issues on Kenya, Nairobi has not been given any particular attention. For instance, the author does not show how the pre-1914 colonial medical policy was implemented in Nairobi and how the policy affected the development of health services.

Beck's (1970) book entitled *The history of British Medical Administration in East Africa 1900-1950*, is the first and major historical work written by a historian on medical issues on Kenya. However, the book does not outline the medical history of Kenya alone but embraces the other two East African countries as well. In this book, Professor Beck evaluates the British medical administration in the East African countries. She elucidates the colonial government changing and conflicting political objectives and their effects on medical policy; the role of missionary societies, sociological and cultural influences on policy, communicable disease control and the development of education as measure to alienate Africans from the indigenous medical culture. The work also provides an additional insight into the
political, socio-economic and cultural problems of the three East African countries. The last aspect has been particularly used by the author as a springboard to analyze the development pattern of health services. While this study is characterized by the depth of historical analysis, it is wide in spectrum. Apart from the general approach, the study does not stress the role of the Local Government in the provision of health services or any aspects of epidemiological and medical statistics. Nairobi is occasionally referred to illustrate general phenomena.

In 1974 Professor Beck published an article in a book entitled Health and Disease in Kenya. The article is basically an excerpt from her book published in 1970. In this article she outlines and analyzes the panoramic view of the colonial medical policy in Kenya. However, she does not illuminate the changes that occurred in the development of health services in Nairobi.

Beck's (1981) book entitled Medicine Tradition and Development in Kenya and Tanzania, 1920–1970, discusses medical issues on Kenya and Tanzania. In this study she further delineates the changing colonial economic policies and how these policies were fundamental in shaping the colonial health services particularly after World War II. Like Beck (1970), it is general and does not give health services in Nairobi a thorough focus.
Carman's (1976) book entitled *The Medical History of Kenya* is an autobiography of the author as a medical staff in Nairobi. Apart from writing personal anecdotes, Carman fails to selectively and precisely discuss facts relevant to the development of health services. He simply chronicles various events. However, Carman concurs with Milne (1928) in his arguments on the aims of colonial medical services. Despite this limitation, the work makes a contribution to the present study by pointing out the earliest medical institution in Nairobi, the role of indigenous medicine and the impact of World War I on health services. Despite his contribution, he is silent about sanitation, housing and its relation to the spread of diseases and what happened in the medical scenario prior to 1926.

In the book entitled *A History of Nursing in Kenya* published in 1979, Ndirangu traces the training of Nurses during the pre-colonial, colonial and post colonial period. He discusses the impact of World War I, World War II and the Mau Mau movement on the nurses training programme. This is important to the present study in the sense that Ndirangu identifies the role of Nairobi as a medical training depot. However, the work is narrative and does not provide explanations as to why the training of Africans took so long to stabilize.

Apart from the medical history literature, there are
numerous studies on Kenya and Nairobi which deal with medical related issues. For example, Leys (1924) examines the sanitation problem and gives an overview of the diseases that affected the population in Nairobi during its early years of development. He argues that the roots of the sanitation problem lay in the control of the health resources by the colonial government. The same argument is postulated by Vicar (1968); Zwanenberg (1976); Olumwullah (1986) and Zeleza (1989). These studies however do not analyse the subject in details.

Other studies on Nairobi such as Parker (1948) White, et al., (1948); Foran, (1950); Walmsley (1957); Morgan (1966); Morgan and Shaffer (1967); Ominde (1971); Tiwari (1972) and Werlin (1974) deal with political and economic history of the town and barely discusses health related issues.

As evidenced in the review of the literature, there is need to write the medical history of Nairobi to fill the gap in the available literature on Nairobi.

1.4 Theoretical Framework

There are two major theories that have been used by medical historians to analyse the underdevelopment of the health resources that characterizes the health sector in developing countries. These are the modernization and the dependency theory. Apart from being used in analyzing medical
issues, the theories have also been used as interpretative models to explain the economic underdevelopment of the "Third World" countries.

The modernization theorist from the medical perspective, i.e. (Parson (1960); Hoseliz (1960) and Kahn and Weiner (1967) attest that colonialism through the hospital based technology brought about positive changes in the health status of the population in the developing countries. Paradoxically this has not been the case. Therefore to explain the underdevelopment of the health resources, these scholars argue that the situation is due to the internal and cultural deficiencies within the developing countries.

A further elaboration of this theory is in the "stages of growth" theory popularized by Rostow's Stages of Economic growth. According to Rostow (1962), the underdevelopment of the health sector is due to lack of cultural and technological diffusion; the scarcity of national capital and the existence of dual economies in the underdeveloped countries'.

Despite the great influence the Rostowian theory has on the literature dealing with the distribution of health resources, Frank (1972); Baran (1969) and Griffin (1969) have shown the Rostowian model and its derivatives to be empirically invalid when confronted with reality and theoretically inadequate when called upon to explain the process of development and its concurrent distribution of
resources. This inadequacy explains why this theory is ineffective policywise for promoting development. The critics of the Rostowian theory, point out that contrary to the postulates of the theory, factors identified as the cause of underdevelopment exist in the "Third World" countries. Therefore they cannot be the cause of the underdevelopment of the health sector.

The dependency theory has also been used in explaining the underdevelopment of the health sector in the "Third World" Countries. It has its origins in the findings and stipulation of the Economic Commission for Latin America (Quoted in Aseka, 1989:4 from Presbiach, 1971). The theory attributes the underdevelopment of the "Third World" countries to their incorporation into the world capitalist system. Though used to explain the economic underdevelopment of Latin America, it was first used to analyse the economic underdevelopment of Africa by Amin, Rodney and wallerstein (Zeleza, 1982). It was then taken up and used to analyze economic underdevelopment of specific regions. In Kenya, such macroscopic studies were carried out by Brett, Leys, Zwanenberg, Langdon, Pillips, Kaplinsky and Leo (Aseka 1989:9).

The salient arguments articulated by the dependency scholars are that, from the era of the Atlantic slave trade up to formal colonization and the post colonial period, Africa like latin America had its history characterized by constant
expropriation of its surplus value to the west. Thus, there was constant expropriation of surplus from the periphery to generate economic development in the centre (Frank, 1976). The result of this relationship was the underdevelopment of the periphery and the subsequent development of the centre.

Using the dependency theory, particularly the concepts of unequal exchange and uneven development, Medical historians such as Sankale (1969); Turshen (1975, 1984); Navarro (1976); Nsekela and Nhononi (1976); Lasker (1977); Mburu (1977); Fergurson (1981) and Patterson (1981) have shown that the underdevelopment of the health sector is determined by the same political and economic forces that determined the nature of capitalism. And that, these forces that brought about the general economic underdevelopment also determined the underdevelopment of the health sector. They further argue that, similar to what occurs in the overall economy, the same social groups that determine the patterns of production and consumption in the primary and secondary sectors, also shape patterns of production and consumption in the health sector. These patterns are always aimed at optimizing the benefits of the foreign and national controllers of that capital, and not at stimulating the equitable distribution of resources.

Today there are a whole set of national and international health problems which might be better understood as interrelated problems of exploitation between core
capitalist (industrialized) nations and the peripheral underdeveloped nations. For example, the flight of hazardous and polluting industry to underdeveloped countries; the draining into core countries of scarce medical manpower (the brain drain); the sale of irrelevant high medical technology; the sale and ways of producing and using expensive and often dangerous outmoded drugs; the shift of human experimentation to other countries where informed consent and safety may not even be at issue, to say nothing of being fully assumed; the role of health care and other programmes in controlling the 'have nots' population of the world especially sterilization of women in many African countries and lastly, the historical role of public health and other medical programmes in making the world safe for capitalist imperialism.

Although the dependency theory has widely been used to explain economic and social underdevelopment, it has been found invalid and deficient in explaining certain internal dynamics which caused underdevelopment. However it will be used in the present study as a model to understand the qualitative and the quantitative inadequacy of health services in Nairobi.

1.5 Research Premises

The study is premised on the following propositions:

Though western forms of health services reached Nairobi in 1899, the services did not improve the health status of the
larger part of the population since they were inaccessible to those outside the colonial government employment.

The World War I had devastating effects on sanitation, disease patterns and the provision of health services. The extension of western forms of health services to Africans who served as carrier corps during World War I campaign, was to hasten the success of the ambitions of the colonial government.

Though the colonial government revised its health policy in the inter-war years to encompass the entire population, the services to the Africans and Asians were deficient in quality and quantity.

Training of Africans in the medical profession was initiated not to facilitate adequate provision of health services, but to minimize the costs involved in provision of health services to the "unproductive" population. The African medical personnel were subordinated, overworked and underpaid. They were provided with the inferior medical knowhow to push them to the periphery in the health service market.

Medical researches were initiated not to improve the Africans' health status but to check on ways of improving the health of the labour force in order to increase their productive capacity.

1.6 Justification and Significance of the Study

Medical history has been a neglected aspect of social history in Kenya. A lot of researches have concentrated on
issues such as education, religion and other social institutions. Medicine has not been given any attention despite being a crucial issue in human political economic and social activities. There is particularly little evidence of a thorough diachronic and analytical approach to the study of health services. The role of medicine and disease in shaping Kenyan history have also not been examined. It is therefore because of such limitations that the present study intends to fill the apparently glaring gap in Kenyan history in general and Nairobi in particular.

The choice of Nairobi as the study area was influenced by various reasons.

(i) Nairobi, though not the earliest urban centre in Kenya, developed faster than any other town. This pace and direction of development was also reflected in the expansion and growth of health resources.

(ii) Nairobi unlike any other part of Kenya, had distinct socio-economic structural differentiation during the colonial era which patterned the production and the distribution of health resources.

(iii) Unlike any other part of the country, Nairobi had special health facilities during the colonial era. These institutions are currently used as referral
centres for complicated diseases.

(iv) Having been established for the economic and administrative convenience of Europeans, it has the earliest records on health related issues and therefore has adequate data to rely on.

The period 1899 to 1963 is chosen because, the year 1899 marks the first date a settlement was established on the present site of Nairobi, while 1963 marks the end of colonial rule in Kenya and therefore a significant date in the history of Kenya.

As probably the first attempt on the history of health services in Nairobi, this study should stimulate interest among historians to carry out adequate medical history of the country before much of the available material is lost. More so, it should provide a strategy for carrying out similar studies on other Urban Centres in Kenya and perhaps Africa as a whole.

The study makes a contribution at the theoretical level. This could provide a model on which similar social issues could be examined.

History does not repeat itself, but a critical analysis of past events besides giving important insights into historical problems, may allow the pace of improvement in health standards to be quickened. While this study limits itself to the reconstruction of the history of health services
in Nairobi from 1899 to 1963, there are some past elements which can be utilized in the present and future development of health care facilities in the country and especially in Urban Centres where the problem of meeting the medical needs is more acute due to the steadily rising population as a result of the rural-urban influx.

The study could also help in understanding the roots of problems Nairobi is facing in the provision and distribution of health resources today. It is also imperative for without a knowledge of the past it is impracticable to fully appreciate the present (Foran, 1958:46).

1.7 Research Methodology

A combination of different methodological approaches was requisite for obtaining data necessary for this study.

Primary data was obtained through oral interviews, and detailed question guideline and not a questionnaire was used (see Appendix III). Those interviewed comprised people who had lived in Nairobi during the colonial period. Out of this group specifically interviewed were those who joined the colonial medical services as hospital assistants, medical assistants, laboratory technicians, pharmacists, nurses, dressers, cleaners, cooks or as workers in general. From them information regarding the origins of the Western medical services, accessibility to the health resources, the health problems at the time and how they were dealt with was obtained.

Others interviewed were the indigenous medical practitioners. They provided information on their role in the provision of health
services to the low income group in Nairobi. They also provided information on colonial government attitude towards them. Some informants gave detailed information on how the colonial government instituted varying legal sanctions to check on their activities. Used during the interview sessions were probing and prompting questions. The nature of the subject did not merit any group interviews therefore individual interviews were the most preferred and worked perfectly well.

Interviews were also sought and obtained from the Ministry of Health’s long-serving officials, various hospital representatives, research institutions and Medical training institutions. The criterion for choice of informants was by mention of an individual by documentary sources or mention by other informants.

The researcher intended to interview about eighty people, but due to difficulties of tracing the informants, coupled with the limited time, only about forty people responded positively and provided information that was of much value to this work.

Though oral evidence is useful, it has obvious limitations. This includes poor response from the respondents, prejudice and bias in giving information, lapse of memory and the difficulty of proving the validity of the information provided. However, these problems were minimised by corroborating oral evidence with other sources such as documentary evidence.

A tape recorder was used to record the information from oral interviews. This ensured less interruption of the informants.
However, the venture was both frustrating to the researcher and the informants. The tape recorder was not only expensive to run but also time-consuming especially when transcribing.

Note-taking was also resorted to. Though useful in collecting data, note taking has disadvantages. For instance, the researcher was not in a position to write down everything that was of importance. Also the impression note-taking created in the minds of the informants led the latter to talk with reservation.

The researcher further spent about six months at Kenya National Archives to obtain other primary data. During the same duration, several visits were made to the City Council of Nairobi Archives, the Catholic Secretariat, the Presbyterian Church of East Africa Archives and the Ministry of Health Archives in Afya House. From these places Annual Medical Reports, City Council Reports of the Medical Officer of Health, Political Record Books, Quarterly and Annual Correspondence, the files of the "Natives" Affairs Department (later African Affairs) the Local Government files, the Labour Reports, the Police Reports and Statistical Abstracts were analysed. From these documents information regarding the colonial policy changes, response to various health problems, and the eventual development of health services was obtained. The Political Record Books were particularly useful in providing information regarding the various socio-economic and political factors that influenced the development of health services.

Archival sources though useful, have disadvantages which
include bias and subjectivity. These problems are particularly common with the colonial reports. The problems were however minimized by constant reference to oral evidence and written sources. This helped in ascertaining the validity of the information and therefore a high degree of accuracy was ensured.

Library research was extensively resorted to in obtaining secondary data. Six libraries were consulted in person and help was received from a number of others. The libraries used to a great extent were Jomo Kenyatta Memorial Library at the University of Nairobi, Kenyatta University, Moi Library and the Medical School Library. Data from the published work provided the background information. The researcher was also able to read previous parallel studies. This proved useful in putting the present study in a proper perspective.

Written sources also have their limitations. However, attempts were made to corroborate the information derived from these sources with oral and archival data to minimize inaccuracy and to avoid presenting biased information.

A qualitative approach of data analysis was also resorted to. The approach entailed the use of theory to explain and interpret the colonization phenomenon and the consequence of this process on the health conditions and provision of health services. Further, theory and hypothesis were concurrently examined to appreciate the relationship between socio-economic and political development in the genesis and the development of health services.
Limitations of the study

The problems and the limitations of the present study are few. The major problems experienced during the research process were shortage of time and money. The attitude of some of the informants also proved a hindrance to the researcher's progress. It was particularly difficult for many people to talk about the disease they suffered from. Some informants even demanded tokens of money after providing the information.

The limitation of the present study is lack of extensive discussion on the role of churches in the provision of health services in Nairobi. The work has concentrated on the government contribution in the provision of health services. This approach was determined by the sources the researcher came across. Also note that while initially the researcher intended to examine the role of indigenous health practitioners in the provision of health services in Nairobi, this was not possible particularly for the period studied due to the repressive measures resorted to by the colonial government against the indigenous medical practitioners. It is however important to point out that the two medical systems co-existed and indigenous medicine catered for a large section of the African population in Nairobi throughout the colonial period.
1.8 **The Synopsis**

This study is divided into seven chapters. Chapter one is the introduction to the study and contains, statement of the problem, research objectives, review of related literature, the theoretical framework, the research premises, justification and significance of the study and the research methodology.

Chapter two is a description of the location and the historical origins of Nairobi. The political and the economic history of the town from 1899 to 1963 is also discussed.

Chapter three examines the origins of western forms of health services in Nairobi; the pre 1914 colonial government health policy and how it was reflected in the production and distribution of the health resources to 1914. The genesis of Nairobi's sanitary problem and the remedial measures undertaken by the colonial government are discussed. Finally, the chapter provides an overview of the diseases that affected the population in Nairobi during the period in question.

Chapter four is an extensive discussion on the World War I period i.e. 1914 to 1918. Examined are the events that preceded the outbreak of the World War I, the role of Nairobi during the war, the effects of the war on the health of the population and on the distribution of the health resources. The colonial government's response to the medical needs of the population is also discussed. Lastly, the overall impact of the war on the development of the health services is assessed.
Chapter five covers the development of health services in the Interwar years, i.e. 1919 to 1939. It reviews the post World War I colonial medical policy, factors that led to the change in policy, and how the policy was manifested in the rise of the dispensary system, maternity, child welfare clinics and venereal diseases clinic. The colonial administration's emphasis on providing education, home visiting and health exhibitions has also been discussed. The chapter further discusses the colonial government's efforts in initiating training programmes for African medical personnel and researches on the health problems.

In chapter six, the discussion embraces the impact of the World War II on the health services. This entails a review of the medical services offered to the Africans, Asians and Europeans and the rise of the health centres. The chapter also analyses the impact of the Mau Mau movement on health services. The period under discussion runs from 1939 to 1963.

Chapter seven, is basically the conclusion to the study.
1.9 Notes


4. The term "Third World Countries" has been used to refer to the underdeveloped or the developing countries.
CHAPTER 2

2.0 THE POLITICAL AND ECONOMIC HISTORY OF NAIROBI FROM 1899 TO 1963

2.1 Introduction

This chapter is a description of the location and the historical origins of Nairobi. It also discusses the socio-economic and political history of the town from 1899 to 1963 as a pre-requisite to comprehend the history of health services. This approach is essential in view of the fact that the political hegemony and its ideology, the socio-economic status of a population and the economic policies of a country influence the development of health resources and determine the availability and accessibility of the health resources to the population.

2.2 Location and Historical Origin of Nairobi

Nairobi is located 80 km south of the Equator on the Athi plains (see map on page xv). It stands some 1,650 to 1,800 m above sea level and enjoys a tropical climate. Within the context of Eastern Africa, the City is sited at the eastern end of agricultural heartland of East Africa. In the immediate hinterland, it enjoys access to the heavily populated plateau which extends northwards to include Mount Kenya and Nyambeni hills.

In 1895, Britain was finally committed to the colonization of East Africa. The decision to build a railway linking Uganda with the coast was taken after which construction...
work started in Mombasa in 1896, and by 1899 the railway line had reached 327 miles. Ahead lay steeper slopes of the Rift Valley escarpment presenting great construction problems. It was while the railway officials were deliberating on how to tackle the escarpment that a settlement sprang up at the railhead and subsequently became the nucleus of a new town. This marked the beginning of Nairobi. Thus Nairobi was one of the by-products of the construction of the railway whose beginning was linked with the British desire to exploit East African territories (Smart, 1950:8).

The history of Nairobi therefore dates back to 1899 when it was established some 300 miles from the Indian Ocean as a railway depot - a convenient stopping place en route to Uganda, another 300 miles to the northwest (Werlin, 1974:37). From its original nucleus around the railway premises, roughly between the Nairobi River to the North and at the end of the slope marking the highland edge to the West, the settlement has expanded by a series of boundary changes to a total of 689 square kilometres (268 sq miles) (Werlin, 1974). Before independence, Nairobi City boundary encompassed the urban area only, some 30 square miles extending about 6 miles East to West and 5 miles North to South with only minor additions. The area and land enclosed by this boundary had remained unchanged since 1927 (Dorothy, et. al., 1966). The city's pre-independence expansion spans
a short period of growth between the end of the World War II and 1962.

That Nairobi owes its beginning to the construction of the railway is revealed in vivid description by Colonel Patterson, then District Engineer of the railway (Patterson, 1951:295):

...there was an immense amount of work to be done in converting an absolutely bare three hundred twenty seven miles from the nearest place where even a nail could be purchased into a busy railway centre. Roads and bridges had to be constructed, houses and workshops built, and station quarters erected, a water supply laid on, and a hundred and one other things done which go to the making of railway township. Wonderfully soon, the nucleus of the present town began to take shape....

"The site of the township" according to an early European resident was a favourite spot for animals, and during the wet seasons large herds of game were attracted to the fertile land and grazed along with cattle (Boedecker, 1936:1). There were no inhabitants except the nomadic Maasai who from time to time built their Manyattas on the higher ground. They knew it as "Nairobi", the place of cold water, and sometimes warriors blooded their spears on lions at the edge of the swamp and achieved manhood (Smart, 1950).

The description of the site by Preston (1937:1) reveals the degree of bareness of the place. He observed:

....Nairobi in the month of May 1899, the year in which we moved
to this place may be described as a bleak swamplike stretch of soggy landscape, windswept, devoid of human habitation of any sort, the resort of thousands of wild animals of species. The only evidence of occasional presence of humankind was the old caravan track skirting the big line....

Shortly after the establishment of the site, the railway officials transferred the headquarters of the Uganda railroad to Nairobi (in place of Mombasa) and the administration of Ukamba Province was also shifted from Machakos to Nairobi in 1905 (Rosberg and Nottingham, 1966:23).

The choice of the site as a stop-over was influenced by numerous factors. Walmsley (1957) and Olumwullah (1986) concur in their arguments that the geographical features of the site were at the forefront of the decision. Walmsley (1957), categorically noted that between Mombasa and Nairobi, the railway had to climb 5,400 feet in about 300 miles (an average gradient of 1 to 323) and that to climb over the Kikuyu plateau to the Uplands station seems to have been insurmountable task to engineers. Indeed in the course of surveying the route, it was found that the altitude of the Uplands station was 7,600 feet above sea level, a rise of 2,237 feet which could be accomplished in 35 miles by the railway. This was an average gradient for a railway terrain. Over the Kikuyu plateau, an extra engine was needed. It therefore seemed logical to establish a
locomotive depot just below the first hill. This is how Nairobi came to be chosen by Sir George Whitehouse.

The topographical nature of the site also offered certain advantages. For instance, it had ample level land on the edge of the plain for tracks siding and other impediments of the railway. The climate was cool and this was considered suitable for European settlement.

One other consideration was probably the permanent water supply provided by Nairobi river. Its flow was obviously greater than it is today, but even so, it was only abundant for the needs of a small settlement (Smart, 1950:14). Thus, it was the physical characteristics of the site and its relationship with the surrounding country which combined to make Nairobi an excellent site for the purpose for which it was intended (Morgan, 1967:100).

Once the railway builders had decided on its depot events moved more quickly than anyone had planned. Nairobi was reluctantly accepted as the official capital of the British East Africa Protectorate in 1907 (Carman 1976).

This venture was influenced by a couple of factors. First and foremost, it was the "centre of gravity", that is, it afforded a central place from which the execution of punitive expeditions against the Kenya people during the period of pacification could be organized (Olumwullah, 1986:77). Nairobi was also bound to offer a good market for colonial products because of its centrality. Third, Mombasa, which had been the colonial government's
headquarters, was perceived as a basically an oriental town and like the rejection of laws derived from India in consequent years, was antithetical to colonial settlers' aspirations which envisaged the establishment of a white man's city in a black man's country (Loc.Cit.).

With time Nairobi attracted traders and eventually became a thriving centre for trade. The settlement layout had taken shape and this was later to determine the character of the city for many years. On one side of the track were the European higher income houses and on the other side the houses of other races of lower income. The workers' quarters were laid out in lines on the plain at the foot of the hill on the site of the future city square, where the level black cotton soil was criss-crossed by ditches that were never wholly effective in the rains. An eyewitness suggested that the contrast between the stinking mass of the subordinate railway quarters and the palatial residences of the railway officers had awakened a sense of injustice in the hearts of men (Africans) that no plausible speech could eradicate (Morgan, 1967:100).

A noticeable feature of Nairobi scene at the turn of the century was the physical disparity between the apparatus of the railway administration and those of the government administration. The railway had large funds at its disposal which enabled it to have its own doctors, magistrates and police forces together with highly developed technical administrative staff. Its buildings were numerous and
substantial. In contrast, the government had few staff and were miserably accommodated.

The site on which the town lay presented several difficulties to the railway and the colonial government officials. They had erected bungalows on a swampy place, whilst the original intention was to lay out the official portion of the town on the northeast bank of Nairobi river, but the site was pronounced unhealthy by medical authorities. Consequently, a new town was laid out on the southwest in 1900 (KNA/DC/1/1/1:4).

The other problems which the embryonic town had to face were severe plague attacks and persistent malaria; sprawling and unplanned commercial area; unrestricted development; dusty roads which became quagmires in the wet season; inadequate water supply (despite the proximity of the river from which the city derives its Maasai name); poor sanitation and bad drainage; no conservancy; street lighting, police and above all no money (Morgan, 1967:100).

In May, 1904, Dr. Moffat (P.M.D.) submitted a report in which he made various recommendations with regard to night soil and refuse disposal, water supply and drainage. In October of the same year, Major Pringle, one of the colonial government officials, recommended that the town's new site should be selected three miles from the present one and that a gradual transfer should be made. Lieut. Col. Will, a doctor in the British East Africa Protectorate, on the other
hand proclaimed that it was too late to move the site of the town.

In 1906, a heavy rainfall combined with unrepaired roads, bad drainage, and a rapid growth of traffic made the streets practically impassable. Another epidemic of plague broke out. On this occasion there were 25 cases out of which 21 died (KNA/DC/NRB/1/1/1). This time the campaign for the removal of the town had spent itself and the appointment of Mr. Bransby Williams A.M.I.C.E. from England to advise on the sanitation was a sure indication of the government's intention to make the best of a not satisfactory site. Even the doctors were less convinced that removal would be within the bounds of practical politics. The last words on this episode of Nairobi's early history are contained in Mr. Winston Churchill's book entitled My Africa Journey published in 1908 (quoted in Smart, 1950:24):

.... It is now too late to change and thus lack of foresight and comprehensive view leaves its permanent imprints upon the countenance of a new country (SIC)....

By the end of 1906, medical opinion hitherto most vocal in support of removal had sufficiently come in line to acquiesce in the status quo.

In 1912, the same pattern of events was repeated; a further plague, another commission and a new report by Simpson to improve on the initial report. He firmly advised
on well defined quarters for Europeans, Asians and Africans (Simpson, 1913).

During the World War I, Nairobi as the capital of the colony, played an important role in the campaign against the Germans in Tanganyika, then German East Africa. After the war, Nairobi became increasingly a base for business, government transport (particularly air services), and the headquarters for the government forces.

The next major review of the town's structure and development was made by a Local Government Commission led by Justice Feetham in 1928. It proposed boundary changes which absorbed within the new municipality most of the previously autonomous housing areas and also defined peri-urban areas under separate government administration called Nairobi - Extra Provincial District (NEPD) (Obudho, 1957).

In the interwar years, Nairobi began to assume its urban character as new buildings made from the local stones were put up. During World War II Nairobi assumed imperial importance as the headquarters of the East African troops for the Ethiopian campaign - the Middle East and the Asiatic theatre of war. These events launched Nairobi as a "big city".

In 1947, a master plan for a colonial capital was prepared by a team of South African planners. This did no more than endorse the colonial development of the city. It was developed naturally out of the existing land usage and particularly the existing land-value (Obudho, 1957).
1950, through a charter granted by His Royal Highness, Nairobi became a city, a status it has maintained to date. As more of Nairobi's earlier difficulties were overcome, its virtues came to be more appreciated.

2.3 A Brief Economic History of Nairobi

The Economic history of Nairobi can be traced as far back as the period before the railway officials established camps on the site. Prior to 1899, there was evidence that the site was a meeting place for the Kikuyu and Maasai traders. Between the two communities, there was a flourishing trade in grain, flour, vegetables and fruit from the Kikuyu side, in exchange for sheep, skins and hides from the Maasai (Hake, 1977:20). The Andorobo people also bartered forest products and game trophies in return for stock and hides. Thus, long before the arrival of the railway, the Kikuyu had built up a tradition of trade and commerce, not only with the neighbouring people but also with foreigners and their market places were set up in the area which the City of Nairobi stands today (Hake, 1977:20).

The penetration of the capitalist modes of production in the countryside transformed the aforementioned trade. Nairobi grew as an Urban Centre designed to "service" the rural economy and not as a centre of economic stimulus (Zwanenberg, 1972:9; Zeleza, 1982:12; Olumwullah, 1986:102). As subsidiary centres grew up in the highlands, Nairobi became the centre for supply. When farmers started to
produce goods for export, it was Nairobi which handled the trade (Walmsley, 1957:20). It also acted as the out-post of Mombasa since it was at this point that all the colonial government's trading transactions were undertaken. All the export commodities were collected and graded here, while all imports after their unloading in Mombasa passed through the town to their various destinations. Thus, Nairobi was not only the collecting and the distributing centre for most of the productive parts of Kenya (Walmsley, 1957:20) but also emerged as the capital centre of the European colonial economy (Olumwullah, 1986:110).

The roles assumed by Nairobi during the colonial era were based on the fact that Nairobi was centrally placed, and that between Nairobi and the coast, most of the country was dry and sparsely populated. At the same time between Nairobi and Lake Victoria there was no other alternative centre. Nairobi also assumed the role of a market town for the areas that immediately surrounded it. This stunted the growth of centres such as Limuru, Ruiru and Kiambu.

The economic growth of Nairobi can therefore be comprehensively understood within the parameters of dependent urbanization. This is to acknowledge the fact that its growth was dependent upon the society outside it and its growth in size increased rather than diminished the force of that dependence (Olumwullah, 1986). Nairobi, unlike her Western counterparts was in no way an industrial city. Her urban poverty and wealth was a consequence of
rural economy which in turn was a result of her colonial status (Zwanenberg, 1972, Passim). Its growth was as a whole determined by the Imperial priorities. Thus, Nairobi was basically concerned with administration, the development of transport, the provision of commercial facilities for the white highlands and the provision of amenities for the wealthy minority (Zwanenberg, 1972:9).

With the establishment of the railway camp in Nairobi, traders from the Coast brought their business to town. Casual traders, hangers-on, and prostitutes became part and parcel of the town. At first they supplied only the railway and government employees with goods and services but later the clientele was expanded to include the Africans and Asians.

A certain small amount of manufacturing industry was also initiated by the Europeans and Asians. There were the railway workshop, a laundry, blacksmith, machine shops, a soda water and brewery company, a bakery, the East African Standard Printing Press, Uplands Bacon Factory, the Unga Flour Mill, Timber Mills and Saw Mills. There were also cabinet makers, equipment producers, tailors, outfitters and other small workshops. Throughout the period up to 1939, Nairobi did not develop as a centre of industry but rather to provide services for the inhabitants of the city and for the rest of the colony (Zwanenberg, 1972:9). An analysis of the employment register by the Municipal Affairs Officers in 1939 revealed that there were approximately 2118 Africans in
Nairobi and out of this number, only 210 were described as tailors or cobblers, undertaking productive work. The rest were hawkers, shop assistants or barbers.

In the post-World War II period, investment in industry assumed great importance (Olumwullah, 1986). This contrasted the pre-World War II emphasis on primary processing. During this period most Africans were employed in manufacturing industries. There was on the one hand, the development of secondary import substitution industry which led the town to become a major magnet for International Finance Capital (Olumwullah, 1986:110). Nairobi henceforth became the natural headquarters for business firms of all kinds, which often operated in other territories through branch offices or agencies. It thus became the commercial and financial capital of the whole region.

In a sense therefore, just as Britain functioned as the centre of the economic system in which East Africa was at the periphery, so Nairobi acted as a centre for East African economic system, and other towns and cities in the region functioned in its periphery. Nairobi thus reproduced on a smaller East African scale the international pattern of occurrence of wealth and poverty (Olumwullah, 1986:122).

The economic structure of Nairobi's population varied according to income differential. For instance, the Europeans constituted the largest group of employers and it follows without dispute that they had the highest income, although even amongst them there were differentials in
incomes. Second in the hierarchy were the Asians who formed the largest contingent of the business community (Parker, 1949:10). Therefore, from the point of view of attaining given standards of living, the two racial groups were broadly comparable. Africans, who were numerically superior to the other races, ranked lowest in terms of income. Most of them were employed either as skilled or unskilled labourers. In view of their wages, Africans earned far less money to attain a reasonable standard of living. The amount of monthly wages was set out in the 1939 Report on the Employment and Housing of servants in Nairobi. (See table 2.1):

Table 2.1: Africans' wages in Nairobi by 1939

<table>
<thead>
<tr>
<th>Monthly Wage in shillings</th>
<th>Number of African Employees per group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 10/=</td>
<td>1,786 (which included 1,506 people under 16)</td>
</tr>
<tr>
<td>11 - 20/=</td>
<td>15,661</td>
</tr>
<tr>
<td>21 - 40/=</td>
<td>9,069</td>
</tr>
<tr>
<td>41 - 80/=</td>
<td>1,727</td>
</tr>
<tr>
<td>81 - 120/=</td>
<td>189</td>
</tr>
<tr>
<td>121 - 140/=</td>
<td>64</td>
</tr>
<tr>
<td>200/= - up</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: Davis E.R. (1939) "Some Problems Arising from Conditions of Housing and Employment of Natives" (KNA/9/1707.70.237).
These were the maximum wages earned by Africans. The wages, compared to the general living standards at the time were found to be far much lower, and subsequently had a direct bearing on the various diseases that affected Africans.

The income level also determined the various health services offered and accessible to the various communities. For instance, the Asian and European settlers who were favoured by their economic status occasionally consulted private doctors, whereas the economically disadvantaged Africans relied on indigenous medical practitioners who, due to the influence from the western trained doctors, also began charging their clients exorbitant fees.

2.4 Political and Administrative History of Nairobi

Nairobi assumed its political role as an administrative centre when the colonial government officials moved their office from Mombasa to Nairobi in 1907. From that time it grew partly as a centre for government administration and partly as a centre for commerce. Its administrative functions extended even beyond its economic sphere of influence and covered the whole area of the three mainland territories.

Administratively, dualism of control made intricate the political scenario as early as 1900. This was because the welfare of the town fell between two stools, the railway and the colonial government officials. The work of the railway officials was particularly hampered by the influx of
settlers, which the Railway Department had never planned for. At the same time, the colonial government administrators were clamouring for civil amenities which the railway officials could not provide (Smart, 1950). It was therefore impracticable for the railway authorities to cope unaided with the social consequences of the developments they had initiated in Nairobi (Olumwullah, 1986). These uncertainties led to the search for a formula to make the administration of Nairobi a shared responsibility.

In 1901, the Nairobi township Committee was constituted. At its inception, its membership comprised one protectorate official, two railway officials, two European residents and two Indian traders. In 1905, the official representation of the Committee was reconstituted with the collector as the Chairman, three protectorate officials, three railway officials, four European residents and two Indian traders with the Medical Officer of Health and Town Clerk as ex-officio-members. The Medical Officer and the Town Clerk, later ceased to be members of the Committee (Olumwullah, 1986:84).

In 1906, the imbalance in Municipal racial representation plus the inefficiency of the committee led to a lot of unrest amongst Africans and Asians who demanded a greater say in events, whereas, the Municipal Committee remained adamant of the status quo.

The Committee was supposed to levy rates, make by-laws, maintain public health and ensure social order in Nairobi.
But in so far as these services were concerned, the committee officials were mainly interested in improving their own environments and those of the Africans and Asians were totally neglected. Hence the genesis of the public outcry in the *East African Standard* and the *Leaders of British East Africa* of the appalling conditions in Africans and Asians living environments.

In 1909, an ordinance was passed with the aim of establishing a Municipal Council. By this enactment the Township Committee was to be replaced by a Town Council consisting of not less than eight councillors, to be nominated by the Governor and to hold office for a period not exceeding two years (Olumwullah, 1986:86). The establishment of the Municipal Council took longer than envisaged. By the end of the World War I, even Nairobi Civil Engineers were pressing for greater control in the Municipal Committee. Sir Edward Northey, the successor of Sir Henry Belfied as governor in 1919, granted Nairobi the Municipal Council status on 15th July, 1919 (Parker, 1948). In 1920, the first European Councillor was elected. He bore the title of Mayor.

Worth noting is the fact that from 1919 to 1925, the Asians representatives boycotted the Council because they were offered very subordinate positions. The absence of the representation had a lot of impact on social provision for the Asian community. This was particularly more so when budgetary decisions were being made on the allocation of
funds for hospitals and schools. For a long time the Asian Community had no government sponsored health institution.

Even when commissions sponsored by the Local Government reviewed the representation and the work of the Council, the European Community was accorded the upper hand. In 1928, for instance, the Feetham Commission made proposals to reconstitute the representation of Municipal Council on the basis of the following belief:

.... It is essential that the Europeans should under the present circumstances be entrusted with the larger share of the responsibility for Municipal government in Nairobi ... (Feetham, 1927:52).

Nairobi Municipal Council was then composed of nine elected Councillors, seven Indian elected Councillors, two officials nominated by the government and one administrative officer in Nairobi District to safeguard African interest as by then Africans had no franchise (Parker, 1948). The representation was again varied in 1946 when an aldermanic bench, in accordance with the practice in the United Kingdom, was created in order to ensure continuity of policy. An African appointment came in the post-World War II era, and probably as a result of the political pressure from the Africans that characterized the development of Nairobi during this period.

In 1957, three Africans were nominated to the Council. These were Mr. Musa Amalemba, J.M. Kasyoka and Kairu Ngure.
Charles Rubia, who was later to be the first African Mayor of Nairobi joined the Council much later, replacing Ngure (Parker, 1948).

Shortly before independence, rapid and numerous changes took place in the political arena. On July 3, 1962, the Council elected Charles Rubia as its first African Mayor. Out of twenty-eight Councillors, only four Africans were elected as members. Since then the Council has had African Mayors. Rubia was succeeded by Isaac Lugonzo, then the seat passed to Miss Margaret Kenyatta and Andrew Ngumba respectively. Nathan Kahara was the last elected Mayor before the dissolution of the Council.

Characteristic of the political scenario was the foreign political influence which emanated from other British colonies. In its earliest years, East African Protectorate was virtually a colony of British India and evidence could be found in Nairobi seventy years later (Hake, 1977;25). The influence was reflected in the application of the Indian Penal Code for offenders, the Indian Civil Code, the Indian Evidence Act, the Indian Contract and the Indian Post Office Act. The currency was Indian rupee and to a large extent, the earliest surgeons and the development pattern of health facilities was an imitation of what existed in India. Hake (1977:26) sums up the situation as follows:

.... Kenya may have been ruled from London, but the colonialist association
had just some justification
for the claim that, East
African Protectorate was
governed as if it were a
province of India ....

Thus, for the period up to 1904, in many areas of life when
the new protectorate was searching for a model, Nairobi
looked to Bombay.

A totally new re-orientation in Nairobi's political
scene occurred when Sir Charles Elliot began to encourage
settlers from South Africa to come to Kenya. From 1904
onwards Nairobi looked less to Bombay and more towards South
Africa, whose influence on Nairobi was immense particularly
when the Colonial Government was suggesting legislation,
enactment and implementation of the labour laws. British
East Africa was even affiliated to the British South African
Customs Union.

The Medical field also received a share of the
influence in terms of ideology and policy directives. For
example, the Simpson report of 1913 on residential
segregation, seems to have been a wholesale adoption of the
South African model.1. Secondly, when the proposal to build
the Group Hospital was advanced in the Legislative Council,
experts were sent to South Africa to study health service
system particularly the facility provision.2. To reduce
congestion and subsequently minimize the spread of diseases
from African's zone to European's zone proposal to build
Pumwani, the first African Municipal Council estate, was
advanced and the town planners who embarked on the
undertaking ranging from F.W. Jameson of Kimberley to L.W. Thornton White, L. Silberman and R.P. Anderson in 1946 were almost exclusively drawn from the Union of South Africa, so was Justice Feetham, a former Town Clerk of Johannesburg, who chaired the Local Government Commission of 1926. The draft rating ordinance which he proposed was similar to that of the Transvaal Province (White et al., 1948). The south African influence persisted for a long time. It was in 1950 that Nairobi looked less to South Africa and more to London.

The role of Africans, Europeans and Asians in the politics of Nairobi has been well analysed by (Werlin, 1963, 1973, 1974 and 1981). However, in the present work, it is only imperative to show the position of Africans in Nairobi politics particularly in the light of the formation of political parties as these were the vehicles used by the Africans to voice their dissatisfaction with the prevailing socio-economic and political order. The political arena was characterized by struggles and conflicts between different races or even within the same racial group.

The first important African political group to have an impact on Nairobi was the East African Association. It was founded in 1920, and comprised largely office messengers and domestic servants. It was directed towards Nairobi by-laws associated with the pass system and required Africans to carry kipandes (Werlin, 1974:84). The association was later suppressed.
In 1923, the Native Village Council was formed in Pangani and Pumwani to vocalize African interests. Like its predecessor, it died a natural death. In 1926, the Nairobi African Advisory Council was established. Like the earlier parties it also diminished. The Advisory Council was replaced by the African Ward Council and its successor the Ward Council was not only to discuss matters affecting Africans in Urban areas, but also to exercise influence in the enactment of policy. Yet the constant pleas of Africans in Nairobi for better living and working conditions, better health and educational facilities, the removal of the discriminative by-laws and the promotion of Africans to responsible administrative positions continued to go more or less unheeded (Werlin, 1974:85).

Thus, throughout the colonial period, though Africans formed political parties to voice their opposition to the existing social order, the situation remained unchanged. The marginalization of Africans and Asians in the political circles ensured that when decisions were made in regard to various facilities they received minimal share.

2.5 Conclusion

It is apparent that Nairobi has a long history dating far back as 1899. Its origin was closely associated with the colonial government's desire to exploit the natural resources in the countryside. It was hoped that the railway would facilitate the penetration and appropriation of these
resources. Throughout the sixty four years of colonial rule the political arena was characterized by the Africans operating at the periphery and the Europeans at the centre. This justified why major decisions on production and distribution of the health resources were mainly undertaken by the colonial masters. More often the decisions were in conformity with the colonial government's interests.
2.6 Notes


CHAPTER 3

3.0 HEALTH SERVICES IN NAIROBI BEFORE 1914

3.1 Introduction

This chapter discusses the origins of Western forms of health services in Nairobi. The pre-1914 colonial government health policy and how it was reflected in the overall growth and development of health services during the period under review is also examined. The roots of the sanitation problem and the remedial measures resorted to by the colonial administration are also elucidated. Finally, an overview of the diseases that affected the population of Nairobi is provided.

3.2 The Origin and Administration of Health Services in Nairobi

Before a comprehensive analysis of the origin of Western forms of health services in Nairobi, it is imperative to give a brief historical background of the origin of these services in Kenya.

Western forms of health services were first introduced to Kenya through doctors who accompanied various expeditions, explorers, missionaries and later the colonial government (Malone, 1980:3). Each of the groups cited above had an obligation to accomplish. The missionaries had a task directed towards their church. The explorers like Krapf and Rebmann were thirsty for discoveries, while the colonialists were out to subjugate and exploit the local
people. Apart from their evangelical work, the missionaries also provided medicine to the population they came into contact with as a prerequisite to effective evangelization. This was because medicine had proved to be an indispensable means of drawing the population under the influence of the Christian church. Dr. J.W. Arthur of the Church of Scotland Mission had the following to say about medical work in 1912:

"...The missionary should gain the confidence of the patient through his medical work and in this way prepare him for acceptance of the Christian message. (quoted in Foster, 1970:51)."

Thus, medicine at the mission stations was primarily to serve the missionaries and colonialists. The medical facilities were to achieve the ideological goal and the availability of medical services in many areas came to depend upon people's attitude towards the church.

The colonial government was aware of the importance of ideological influence in their enterprises. They expected the missionaries to oppose any measures which threatened to undermine the government's authority. In this way the missionaries played a direct part in supporting the entrenchment of colonial production.
In response to the medical needs the churches developed dispensaries, health posts and eventually hospitals with resident doctors and trained nurses. The Protestant churches were the pioneers in medical work in Kenya. They established hospitals in a few centres at a time when the government medical services were in a rudimentary stage. The first doctors recruited by the Church Missionary Society and the Church of Scotland Mission commenced medical work in Mombasa in 1888. Other hospitals were opened at Kikuyu in 1902, Kaimosi in 1903, Kaloleni in 1904, Maseno in 1905, Thogoto in 1907, Tumutumu in 1910 and at Buxton High School in 1914. Organized medical work by the Catholic Church commenced later - the first Catholic hospital being opened in Nyeri (the Mathari Hospital) by the Consolata Fathers in 1940, although there were some dispensaries in operation as far back as 1908 (Malone, 1980:4) and (Sindiga, 1990:133).

Whereas it is evident that the rural parts of Kenya received a large share of medical attention from the Missionaries, Nairobi had a different story and throughout the colonial period the missionary medical influence was very minimal. The colonial government embarked on extensive provision of health services as a matter of policy in the 1920(s) and a considerable regional variation existed in the provision of the services depending on the degree to which different parts of the country were integrated into the capitalist money economy. For example, the northern part of
Kenya which had little to offer to the colonialists was simply ignored in regard to the provision of hospitals, roads and schools (Rodney, 1972:227).

Western forms of health services reached Nairobi in 1899 when the railway officials established a settlement on the site. What later came to be the Railway Medical Department had been started a year after the Imperial British East Africa Company (herein after referred to as IBEA) was granted a charter to further her economic pursuits in East Africa. The work of the doctors employed by IBEA Company was somehow different to that carried out by the Missionary doctors. They limited their medical treatment to the personnel of the Company and did not make any attempt to reach Africans (Beck, 1974:91). The earliest doctors appointed to the Company in their chronological order were doctors A. Mackinon, I.S. MacPherson, W.H.B. MacDonald and Dr. R.B. Moffat (Carman, 1976:5).

After the collapse of the IBEA Company in 1895, the British Foreign Office took over the administration of the Protectorate. Among other things the British establishment also inherited the Railway Medical Department which was eventually amalgamated with the scanty colonial government health services to form Nairobi Medical Department (Beck 1970). The establishment of a Medical Department in Nairobi coincided with the establishment of British East Africa Protectorate Medical Department in 1901. This was the first step towards Colonial Medical Organizaiton supported and
controlled by the State (Beck, 1974:92). In 1901 the Commissioner of Kenya, Sir Charles Elliot, listed the medical department of British East Africa Protectorate (as Kenya was then known) as consisting of seven doctors, three nurses and seven hospital assistants (Elliot, 1905:206). In the same year the Municipal Committee was constituted by the Nairobi Municipal regulation of 1st December, 1901 (No. 20 of 1901) (KNA/DC/NRB/1/1/1 - 1899). The administration of the town was partially handed over and the Municipal committee was to undertake the prevention and control of infectious diseases; the protection and regulation of public water supplies; disposal of waste; construction and cleaning of the latrines; control of burial grounds and the registration of births, marriages and deaths (E.A.U.M., 1901:4). By 1907, Nairobi had two bodies entrusted with the provision of health services; that is, the Municipal Committee was supposedly in charge of preventive, promotive and rehabilitative health measures while the colonial government concerned itself with curative services.

From 1903 to 1908, the colonial medical services of Uganda and Kenya were amalgamated (Vogel, 1971:2). Doctor Moffat became the first Principal Medical Officer of the combined medical units. The factors that led to the amalgamation were inadequate finance, staff and facilities. It was hoped that the venture would call for sharing of doctors and facilities.
The duration when the two medical departments were under a single administrative machinery, very little attention was given to the general health of the population in Kenya and Uganda. In Nairobi for example, the work of the medical department was almost brought to a standstill due to lack of efficient co-ordinating machinery. Sometimes, all the doctors were in Uganda with none to take care of the casualities in Nairobi.

In 1908, Dr. Captain James Will succeeded Dr. Moffat as the Principal Medical Officer. He immediately realised the ineffectiveness of administering medical department for a vast area. He consequently split the medical department, and Dr. Milne became the first Principal Medical Officer of Kenya. His office was based in Nairobi (Carman, 1976:5).

3.3 Colonial Government Health Policy before 1914

The pre-1914 colonial government health policy was clearly spelt out in the objectives of health services, as follows:

.... Health services were meant to care for the Europeans and especially those who were in government employment. After they had been taken care of, the government concerned itself with the health of the Asians and Africans in colonial employment ... (Carman, 1976:8).

In view of the policy, Africans who due to the changing capitalist relations in the countryside moved to Nairobi to seek wage labour were subjected to enormous health risks as
they were denied the services. The denial of the benefits of western forms of health services to the Africans and Asians by the colonial administration was done alongside the total disruption of their way of life. This had interfered with the health practices which the Africans had developed in response to the prevailing health problems. Land alienation in various parts of the country and its subsequent mechanization also interfered with the sources of the African medicine. Thus, European medicine moved beyond that of the Africans. This was as a result of the different economic contexts in which the medical traditions were practised. European doctors for example, were practising at the centre of the world capitalist system. Africans who were denied access to western forms of health services secretly consulted the indigenous healers for medication (Kamau, M. O.I; 28.10.1988; Singh, R., O.I. 29.11.1988).

The colonial administration was keen on protecting the Europeans who were viewed as the custodians of development. The Europeans argued that Africans were supposed to fend for themselves and that by the virtue of their temporary residence in the town there was no need to provide for their social needs (Parker, 1948:200).

In line with the policy of catering for only a few people, the colonial establishment emphasised curative medicine as opposed to preventive. Emphasis on cure of the sick rather than prevention of diseases was brought to the town from the metropolitan country (Ferguson, 1981).
were two main factors that intimidated the metropolitan countries to emphasize the curative branch of medicine. First, under monopoly capitalism, health care became a commodity with a substantial exchange value resulting from the length and complexity of the doctor's experience who then sold his services. That is, he realized the exchange value by serving the individual patients who purchased the doctor's care. Secondly, preventive services were viewed as costly, bearing in mind that they had to be paid for out the profits from industry (Leys, 1924:30). As things were at the time it was absolutely "impossible" out of the "meagre" profits to provide services to the Africans who were not involved in profit making enterprises. Thus, it can be argued that emphasis on cure and not prevention was in harmony with capitalism (Turshen, 1975).

The preventive services were extremely limited and were carried out ostensibly to protect the European and to check on the spread of the diseases (Zeleza, 1989:64). The goal of this narrow conception of preventive medicine was to contain the spread of diseases but not to eliminate the social cause(s) of diseases.

The curative policy was manifested through the opening of the "Native" Civil Hospital in 1901, the European Hospital in 1907, the Lunatic Assylum in 1910 and the infectious Disease Hospital in 1914 (Carman, 1976:6). The dual hospital system was reflected in the existence of unequal and separate facilities for different races. The
"Native" Civil Hospital served the medical needs of Africans who were partially in government employment. The European Hospital catered for the Europeans, particularly those who were in government service, while the Lunatic Assylum and the Infectious Disease Hospital served all races in the categories cited above with each race having separate facilities to cater for their needs (Ochieng', O.I., 2/4/1988).

The bed ratio in the various hospitals for different races reflected a clear discrepancy. The doctor-patient ratio adhered to the same pattern. Expensive adequately staffed, well equipped hospitals were the norm for the European ruling class. Inexpensive, understaffed, poorly equipped hospitals or clinics were the norm for the Asians and Africans who served the colonial economy. The description of the "Native" Civil Hospital by the Simpson report of 1913 clearly illustrates the difference:

.... The ward in which I was informed plague patients had been admitted is only thinly partitioned from the receiving room. The rain water from roof and the effluent from the latrine, is conveyed by a cement channel to a point at the back where it discharges into the open about 30 yards from the irrigation channel which runs parallel to Government Road. To this channel the drainage finally soaks. The postmortem room has no drainage of any kind ... (Simpson Report, 1913:23).
In contrast to the condition described above, the European hospital was located on a hill well drained and neatly maintained (Carman, 1976).

Imbalance was also inherent in the distribution of specialists. For example, gynaecology, pediatrics and public health were given very minimal regard while surgery represented the top speciality in terms of physicians' percentages. Nairobi, for example, had no maternal and child-care welfare clinics until 1926 when the scheme was initiated by Lady Grigg, the wife of the then Governor of Kenya. Before this period, the mother and the child were cared for only by private nursing homes. The Europeans went to MacNulty Maternity Home which admitted only up to six mothers at a time. Others went to the Kenya Nursing Home, while the rest were catered for by the nursing sisters in their own homes (E.A.S., 22/2/1950). A few Asians and majority of the Africans resorted to traditional birth attendants for any gynaecological complications. Asians of good economic standing consulted the private nursing homes (Magu, 0.I, 12/3/1989).

To understand why the colonial government gave very little regard to the mother and the child, it is important to review the place of women in capitalist economy particularly during this period. In capitalist states, of which Kenya was no exception, women's economic activities were classified as uneconomic domestic activity.
According to Wolpe (1972), Meillasoux (1975) and Murray (1981), when women's economic activities were not regarded as productive, the policy-makers made no attempts to ensure their survival just as they did with the non-waged males. Besides, women were not considered an integral part of urban life. They were supposed to remain in the rural areas to feed the male workers or in some places to provide export crops without significant investment in them. This was in part a consequence of the total pattern of paying for the social costs at the work place while the population reproduced itself in the rural areas (Feierman, 1986).

The Colonial government's indifference to the health needs of the town was further reflected in the Annual protectorate budget. Sir Charles Elliot gave the military and the economic endeavours high regard. For example, in 1899, 1900 and 1901, the government spent £3,892, £4,010 and £4,712 on the medical needs of the Protectorate respectively. During the same period, the military spent £32,663, £50,513 and £38,005 respectively (Beck, 1970:15). The figures provided were in reference to the entire Protectorate. What happened in Nairobi could only be deduced from the fact that the little that was allocated to the Protectorate's medical department had to be shared between the various provinces in the Protectorate. This implied that each province had very minimal share. Beck (1970) sums up the whole arrangement by saying that Elliot and his officials underestimated the importance of health
services. This could also partly explain why the recommendations by William Bransby Commission of 1906 and Simpsons Sanitary Commission of 1913— all geared towards the improvement of the general sanitary state of the town, were never implemented as proposed but were kept in abeyance.

The work of the medical department was not, however, smooth sailing. Apart from financial constraints, harsh environments, lack of proper legislation also impeded the development of health services (Beck, 1974:93). The implementation of the few scattered ordinances was also very lax. Mr. William Bransby had the following to say about them:

.... These various ordinances contain useful regulations. Many are vague and difficult to follow. Their greatest defect is that they contain no instructions with regard to legal proceedings and in practice they appear to be almost dead letters ... (Bransby, 1906:11).

Despite the difficulties experienced by the medical departments, Dr. Milne, the Principal Medical Officer, made attempts to ensure that basic hygienic standards were adhered to. Between 1911 and 1915, he worked hard to get legislation for the public health act. He also established the sanitation branch of the medical department and by 1914, the department had appointed Mr. Gillespie to head the new sanitary division. At the same time, Dr. Ross P.H. a bacteriologist, was also appointed to the department, while
Dr. Boedeck assisted in the dispensing work at the "Native" Civil Hospital (L.B.E.A., 1914).

It is therefore important to note that the organisation and distribution of health services in Nairobi during the period under review followed an inverse pattern to the need for them. The imbalance by the type of care, race and social class and by the type of financing that characterised the provision of health services, was determined by the same parameters that defined the evident social and economic underdevelopment (Navarro, 1976:20).

3.4 The Origin of the Sanitation Problem in Nairobi, 1899 - 1914:

The genesis of the sanitary problems that prevailed in Nairobi were linked to the general socio-economic and political changes in Kenya in the 19th Century. Zeleza (1989) has argued that the imposition of colonial rule in Kenya entailed the penetration of capitalist economies and the integration of African economies into the capitalist system. This was characterized by massive land alienation mainly in Central and Rift Valley Provinces of Kenya. Land alienation was followed by cash crop production which in turn necessitated the need for labour. Various mechanisms such as taxation, force and monetary incentives were introduced to hasten the provision of labour. With no land to subsist on Africans were forced to search for survival
alternatives. The only immediate alternative was to sell their labour. This process of proletarization led to migrations either to the reserves or towns. Migration to towns was preferred because wages were higher compared to those in the rural areas (Zwanenberg, 1972:173). But despite the comparatively attractive wages in urban centres, they were paradoxically low in relation to the cost of living (Zwanenberg, 1972:180).

The railway industry also represented a wave of future development and the little settlement at Nairobi was a place where opportunities would be found for getting, first, the pickings of the operation and later perhaps, a place within its ranks (Hake, 1977:24). Thus rural-urban influx, particularly to urban areas, was basically occasioned by capitalist penetration and transformation in the countryside (Olumwullah, 1986:178). The movement was therefore a reflection of the changing nature of capitalist production in the countryside.²

How then were these changes related to the emergence of the sanitary problem? The sanitary problem in Nairobi was linked to urban poverty, a measure inherent in any capitalist state. During the colonial period, Africans were subjected to massive exploitation through overwork and very minimal wages. At the same time no provision in terms of urban living was made for the Africans. This was in accord with the general behaviour of capitalist working with unlimited labour supply. The result of the colonial
government's negligence and exploitation was the emergence of "Uncontrolled" African settlements in the town. These settlements were Mombasa, Masikini (poor), Pangani and Kileleshwa. Some Africans also lived in the Indian Bazaar (White, et. al., 1948; Smart, 1950; Hake, 1977; Olumwullah, 1986 and Zeleza, 1989).

The African houses in the above mentioned settlements were built of mud, stones, and tins with no measure of drainage taken into consideration. There were no latrines and children and adults eased themselves in the surrounding environment. Water supply was not given the outlay it merited.

Commenting on the situation, Leys (1924), said that the urban proletariat could not exist decently and healthly on wages from £6 to £15 a year on a land worth 200 to 500 acres. Mugo (1970) expressed the same sentiment when he noted that the poor living conditions among the Africans and Asians were as a result of the disparity in the rates of pay. This meant that Africans were unable to buy their own houses or improve the ones they had built. As if that was not enough, Africans whether employed or not had to pay poll tax and were liable to arrest and imprisonment if found looking for jobs without which they could not pay the tax. The result was overcrowding in the insanitary huts.

Many of the Asians occupied the Indian Bazaar (today Biashara Street). The description accorded to the Bazaar by
Dr. Radford, the Medical Officer of the town was equally appalling:

.... the Bazaar, he noted, was a collection of tin huts used indiscriminately as dwelling houses, stores, bakeries, brothels, butcheries and shops. Life in the Bazaar was filthy to the extreme ... (KNA/MOHI/2:3).

An equally amazing description of the Bazaar was by Dr. Spurrier who observed the following:

.... damp, dark, unventilated overcrowded dwellings on filth soaked and rubbish bestrewn ground housed hundreds of people of most unclean habits who loved to have things so and were so let .... (KNA/MOH2/3:4).

The Medical Officer of health in his confidential despatch to the foreign office pointed out that:

.... It was impossible for anyone familiar or acquainted with the sanitary rudiments to allow the Bazaar to persist in the centre of the township.... (KNA/MOH, 1909).

The problem of the Indian Bazaar was similar to that of the African environments described in the preceding paragraphs. The problem was presented by a community denied full civil rights, forbidden by law to own or rent land for building outside the town at all and restricted inside it to certain areas (Leys, 1924:287). The Asiatic community of
6,689 souls occupied 300 acres. The size of building plots in the Bazaar was as small as 50 feet by 75 feet or roughly 12 feet to the acre. When Nairobi was originally planned and built Indians were allowed to build houses consisting of both shops and living premises, at a rate of twelve to the acre. That was the minimum area admissible in English cities (Loc. Cit.).

Thus, urban areas represented just another section of the colony where land was allocated on racial basis. Instead of land use being determined by the needs of the population, its distribution was made along racial lines. Limited space, low remuneration, the colonial government's indifference to the social needs of the Asians and the Africans, led to appalling living conditions. This was clearly illustrated in the words of administrator H.R. Tate in 1913 Nairobi Sanitary Commission report where he observed the following:

.... For months past, those up-country "natives" who are provided within the compounds of their employees have been forced to rent miserable quarters in insanitary localities of the town and at excessive rates. An enormous number of employees of the government and of hotels and of private firms are absolutely without quarters of their own ... An inspection of some of the quarters rented by "native" employees of Europeans reveals the conditions under
which they live. Most of
the rooms visited measured
8' x 10' and were occupied
by 4 to 6 boys. The stench
from some of those places
was very bad ... In many
of them the roofs could
be touched by the hand when
standing in the centre of
the room (KNA/PRO.co 533-209
29.7.1914).

The discriminatory practice of providing adequate and
inadequate sanitation facilities to different zones was
apparent in the service of waste disposal. The government
built sewers in the European zones and neglected the African
and Asian zones. Faecal disposal in the African settlement
was the most inefficient. Before the introduction of the
bucket latrines, the Africans eased themselves in the nearby
bush. Even after the introduction of the bucket latrine,
the population requirement often exceeded its capacity.

Disposal of household and other refuse was done by
municipal carts (see Appendix 1b). The carts frequently
collected refuse from European zones. The "uncontrolled"
African settlement and the Indian Bazaar were often
neglected. The collection of rubbish was not always
frequent owing to the inadequacy and inefficiency of the
carts.

The drainage system was the most defective. Writing to
the Municipal Committee B.W. Cheret, the Medical Officer of
Health, stated the following:

... The whole place is in a shocking
sanitary condition, in fact it has a
huge evil smelling swamp, due to escape of liquid refuse from the houses, drains and overflowing slumps. The cause of trouble is that there is no drain in River Road or sanitary lanes, except one of earth which we have recently constructed. Houses have been built and are being built all over the estate and not the slightest provision of drainage has been attempted on the part of the authorities.

Most of the houses have slumps, but no slump made could deal with the tremendous amount of escaping soil water.

I recommend that the necessary drainage be built. (Sigd)
B.W. Cheret, Medical Officer of Health. (quoted in White et. al., 1948:30).

The colonial government also discriminated in the supply of water to different zones. Piped water and private wells were the norms in the European zones. Africans depended on water from Nairobi river which was grossly contaminated. The first known mention of the quality of water supplied to the town was in 1909 when probably the water consumption was over 150,000 gallons per day. This quantity was adversely inadequate for the needs of the population of Nairobi. Dr. Radford recognized the importance and the urgency by which improved water supply was needed in the town. Similar sentiments were expressed by Mr. Williams in 1907:

.... The mains in 1907 supplied only 130,000 gallons a day or some 9 gallons per person instead of the Customary English Standard
of 12-15 gallons. This contrasts badly with the 18 gallons which is what a person in the tropics should expect ... (Bransby, 1907:21).

The consequence of poverty, inadequate water supply and lack of housing was the outbreak of different diseases with plague having a tremendous impact on the population of Nairobi. Historians have given the plague issue in Nairobi some extensive coverage. (For details see McGregor (1968), Mugo (1970), Carman (1976), Beck (1974) and Zeleza (1989).

3.4.1 The Colonial Government's Response to the Sanitation Problem between 1899 and 1914

If fate ever warned a population of the effect of age-old sanitary sins, such a warning came to Nairobi administration authorities as early as 1900, when plague struck in the earliest Indian Bazaar (KNA/DC/NRB/1/1/1899). Realizing the importance of public health, in 1901 the colonial government published the Municipal Council regulations to provide guidelines for the administration of the town and to check on matters related to environmental health (Smart, 1950:17). In December of the same year, the sub-commissioner presented his first budget for the township. The proposed expenditure for 1901 included salaries of eight Indians, six policemen, two sweepers, the cost of oil, uniforms which totaled to 7,161 rupees. The budget also included an additional levy of two months a
payment for the construction of a new police office, latrines and sweeper carts (Smart, 1950:17).

In March 1902, the Committee entered into an agreement with a Budder Din. The agreement made between the Budder Din contractor and the Secretary of the Municipal Committee read as follows:

(i) ...That the said Budder Din sweep and keep clean of all paper and rubbish whatsoever, all roads in the Bazaar, and the roads in front and behind the houses known to belong to the township of Nairobi.

(ii) That the said Budder Din keeps all ditches which lie in the districts known to belong to the township of Nairobi clean of all rubbish whatsoever...

(iii) That the said Budder Din agrees to supply oil for thirteen street lamps in the bazaar and for six lamps in station street and to keep the lamps clean in order to take care of the fact that the lamps are burning properly every night from 8 p.m. until 6 a.m.

(iv) That the said Budder Din receives rupees one hundred and fifty (150) at the end of every month so long as he attends to the work in such a way that no objections can be raised in paragraphs Nos. 1, 2 and 3 come into consideration.

(v) That the said Budder Din has to give one month's notice in case he wants to terminate this contract and that he agrees to pay the penalty of Rupees one hundred and fifty (150) in case he terminates without giving previous notice.

This contract was one of the earliest indications of the Municipal Committee's attempts to improve and ensure that a clean environment was maintained. The endeavour was however shortlived due to inadequate finance.

In 1902, the second outbreak of plague in the Indian Bazaar stimulated further interest in improving the sanitary conditions in the town. In response to the situation, Charles Elliot appointed five medical men to report on the sanitary state of the Bazaar. The group unanimously condemned the site and advocated for its removal.

In 1903, Dr. Moffat, the Principal Medical Officer of the then combined medical services formulated guidelines with regard to the disposal of refuse and excrement. This move followed the institution of the vagrancy ordinance in 1902 which prohibited Africans and Asians from moving from one place to the other.

In 1904, another plague epidemic struck the town. This impelled the colonial government to seriously consider the problem. Consequently, in 1906, the colonial office sent Mr. William Bransby, Civil Engineer to the British East Africa Protectorate, to make an official report on conditions and solutions on the sanitary state of the town. He spent over two months in Nairobi and his recommendations are printed in a lengthy paper dated 28th January, 1907, (a copy is at the Kenya National Archives). His main proposals were as follows:
(i) Re-arrangement of the town (including Inter-alia, the removal of the Indian Bazaar to a new site near the railway landhies).

(ii) Improvement of drainage in the central portion of the Municipal area and of the western valley.

(iii) Increased water supply.

(iv) New "native" location to the southwest of the boundary of township area.

(v) New Dhobi quarters.

(vi) Fresh public health legislation (KNA/NRB/DC/1/1/1 - 1899:4).

The total estimated cost of the work proposed by Mr. Williams amounted to £116,000 which he suggested should be spread over three years (KNA/DC/NRB/1/1/1 1899:5). Mr. A.C. Tanbull, a valuer and member of the Committee, estimated that it would cost £83,000 to remove the Bazaar to a new area (Smart, 1950:32). The cost of other improvements was £23,000; this amount was considered a rather large sum for a little township with an annual income of £9,100. These figures were high enough to justify a further shelving of the problem (White, et. al., 1948:15).

In 1911, a severe plague visited the town. This aroused stormy meetings and militant solutions were demanded by the officials and the Asians alike. This was the signal to set up the first local commission and in 1913, Professor W.J. Simpson, C.M.G., M.D.F.R.C.P., was sent out to East Africa to advise on sanitary matters.
Professor Simpson recommended the complete removal of the Bazaar to the North of Nairobi River where Ainsworth, the father of Nairobi had once before established a shopping area. The report also recommended racial segregation and zoning which was expressed in the following words:

.... It has been recognized that the standard and mode of life of the Asians except of those in highest class, does not conform with those of the Europeans and that on the other hand, many European habits are not acceptable to Asians and Africans unfamiliar with and not adopted to the new conditions of town life will not blend in with either. In the interest of each community and the healthiness of the locality and country, it is essential that town planning should provide well-defined and separate quarters for Europeans, Asians and Africans .... (Simpson, 1913:74).

This report embodied nothing more than the justification of racial segregation which ensured that best land and better health and sanitary facilities were reserved for the privileged race and that the Africans and Asians could be controlled and kept as far as possible to avoid the spread of contagious diseases from their zones to the European zones. These sentiments are expressed in the works of four Nairobi historians: Parker (1948), Vicar (1968) Zwanenberg (1972) and Olumwullah, (1986).
3.5 Diseases in Nairobi between 1899 and 1914

The history of diseases that ravaged Nairobi during the colonial period were in part as a result of the incorporation of Kenya and hence Nairobi into the colonial capitalist system. The colonial government economic demands created conditions and accentuated the spread of diseases in the town. Poverty, a major social cause of diseases was a product of the capitalist development. Improvements in the means of communication further encouraged the movement of the disease pathogens from one place to another. The patterns of diseases were also dependent on the production of health resources, which at the time emphasized curative medicine and personal health services as opposed to preventive and environmental health services.


<table>
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<tr>
<th>Year:</th>
<th>1902</th>
<th>1905</th>
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<td>67</td>
<td>-</td>
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Source: Political Record Book: Nairobi District KNA/DC/NRB/1/1/1, 1899, P.7.

* The figures stand for the cases affected
* Though plague occurred in Nairobi as early as 1899 there were no recorded cases for 1899, 1900, 1901, 1903, 1904, 1912, 1913 and 1914.
As evidenced in Table 3.1 as early as 1900 various diseases presented varying health problems to the population that lived in Nairobi and particularly Africans. The leading cause(s) of mortality were pneumonia, followed by respiratory disease, malaria, dysentery, plague, smallpox, tuberculosis, typhoid, enteric fever and sleeping sickness respectively. Cases of malnutrition were also numerous, though not recorded.

Plague, for example, was introduced to Nairobi through the cotton waste brought by the rail from India. The first outbreak occurred in 1900 at the Indian Bazaar where conditions for its spread had been paved way for. The colonial government officials could not understand why plague had visited Nairobi which was located on a plain with free access to wind and sun (Beck, 1970:26). After serious thoughts, debates and consideration, Sir Charles Elliot advanced a hypothesis that plague must have been imported from Karachi India with the cotton waste delivered from the Uganda railway (Elliot, 1901:155).

Professor Beck, in her book A History of British Medical Administration of East Africa 1900-1950, attributed the cause and spread of plague to the disruption of African social structure:

.... At the beginning "Native" huts were not overcrowded since according to their customs only one adult human being occupied one hut .... After the introduction of a hut tax of five rupees, it
became common for more than one person to occupy a hut to avoid payment of more taxes .... (1970:26).

Thus, capitalism with its varying mechanism of exploitation created favourable conditions for the spread of disease.

In 1902 there was a second outbreak of plague epidemic. This was curbed by burning and subsequent removal of those affected from the Bazaar to a quarantine camp. In 1906, another outbreak of the disease occurred. This time Drs. Robertson, Haran, Radford, Falker and the Senior Medical Officer of the Railway carried out systematic fumigation, disinfection of the infected houses and the extermination of the infected rats (KNA/MOH/5749:1). In addition a plague patients' hospital was opened close to the railway quarters. Later a plague hospital No. 2 was opened to meet the growing demands. Other outbreaks of the disease occurred in 1911, 1912, 1913 and the last major outbreak occurred in 1940. Beck (1974) attributed the failure of the colonial government to stamp out the disease to lack of commitment.

Many vector-borne diseases flourished in Kenya, malaria being one of them. The disease occurred in endemic form. Its major cause was lack of proper drainage. The highest death rate was recorded in 1910 and 1911. The colonial government's efforts to eradicate the disease included clearing of the mosquito breeding areas, passing of
Pneumonia also occurred in various forms. It was also among the leading cause(s) of death. The highest death rate was recorded in 1910 with a total of 126 cases (see table 3.1). Majority of the victims were Africans and Asians. This was attributable to the poor living conditions and lack of adequate housing. Therapy for the disease was not successful until the advent of sulphur drugs after 1918. Dysentery was also a menace to health of the population. The highest mortality occurred in 1907 with a total of 36 cases. The disease occurred as a result of drinking contaminated water from river Nairobi, which was as a result of the colonial government's reluctance to provide chlorinated water to the Africans and Asians. Tuberculosis had equally devastating health impact on the Africans. Its spread was exacerbated by overcrowding which occurred due to lack of proper housing policy for the Africans before 1919. Therapy for the disease was not effective until 1950's. Before this time the only cure was proper nursing care.

Nairobi's experience with smallpox was somewhat different from what happened in other parts of the country. The town with its dense population and insanitary conditions had frequent large outbreaks. The disease first struck on a significant scale in 1909 with a total of 67 casualties (KNA/MOH/182/44). Other outbreaks occurred in 1913 and 1914 (KNA/PC/CP/4/2/1, 1909 - 1910). Its occurrence was usually
several months long (MacDawson, 1979:24). The fast development of Nairobi as an urban centre had a lot of impact on the epidemiology of the disease (Simpson's Report, 1913:9). For instance, the large and dense population of the town and being a business and transport centre had a constant attraction for wage labour. This provided a suitable environment for the spread of the disease. As a commercial and transportation centre, Nairobi acted as a focal point for the dissemination of the disease to the countryside. Between 1900 and 1914, medical reports referred to smallpox occurrences as sporadic and appearing in mild forms.

Malnutrition became rampant in Nairobi among Africans under colonialism. There were a number of reasons for this development. First there was the uprooting of the formerly self-sufficient food producers who became of necessity cash crop producer or wage labourers. If engaged in cash crop production, subsistence food production was often neglected. In both the case of the cash crop producer and wage worker, the income received for their labour was seldom adequate to purchase the requisite food for good health.

3.6 Conclusion

It is apparent that the colonial government limited the provision of health services to those who were important to the colonial economy. In practical terms that meant that those outside the colonial wage labour were minimally cared
for. Emphasis was on certain aspects of health services and not others. This was done in the hope of minimizing costs. Health services, especially the preventive branch, was geared towards the well being of the Europeans (Rodney, 1972). The Pre-1918 health policies determined the organization and production of health services. These policies were the foundation of the problems of inadequacy of health services in Nairobi.
3.7 Notes


CHAPTER 4

THE IMPACT OF WORLD WAR I ON HEALTH SERVICES
IN NAIROBI, 1914 TO 1918

4.1 Introduction

The first World War formed a major landmark in the history of health services in Nairobi. Many unprecedented changes occurred in the general health of the population, African attitude towards colonial medicine, the colonial government perception of Africans' health, sanitation and diseases patterns. This chapter therefore endeavours to discuss briefly the events that preceded the World War I, the role of Nairobi in the war process and the changes that emanated in the provision of health services as a result of the war. The colonial government's response to the medical needs of the population is also discussed. Finally, the overall impact of the war on the development of health services is assessed.

4.2 The Role of Nairobi in the World War I

When the war was declared on 4.8.1914, the Germans and the British were to face each other at various battle fronts. Prior to this date, prospects of war had been kept alive in Europe; particularly throughout the first half of 1914. It was clear to every mind that Europe would go to
war. However, it was not expected that the European's crisis would spread to East Africa (Igham, 1962:285). Many people in Europe and Africa believed it unthinkable that Africa, especially its population, would be involved in the quarrels of European powers (Savage, et al., 1966:314). Besides, the British and the Germans were encountering varied problems in consolidating their power in East Africa. It was therefore unlikely that both powers would engage in any war in East Africa. In addition to the above, articles X to XII of the Berlin Act of 1885 had bound the signatories to the principle of neutrality (Ochieng', 1985:112). This gave an added sense of security. It was therefore likely that both the British and the Germans would abstain from staging a display of legalized slaughter of whites by whites on the East African soil. (Huxley, 1935:13). These speculations were later dispelled when the British cruisers, the Astrae and the Pegasus bombarded Dar-es-Salaam on 8.8.1914. East Africa henceforth became one of the theatres of war outside Europe.

When it was at last ascertained that the Germans and the British in East Africa were at war, British East Africa, as Kenya was then known, went into panic. Meanwhile Nairobi assumed the role of a military base and centre of every operation (E.A.S., 31/10/1914). It also became a centre of speculation and rumours. The following description by Davis, in his book entitled Kenya Chronicle (1928:97) gives a glimpse of the situation in Nairobi at the time:
... Nairobi house, the only stone building in town, somehow became the fulcrum of enquiries concentration, conversation and military gravity. Around the house, a seething mob of people boiled and bubbled. This mob was armed to the teeth. Some of it carried rifles, shot guns, and revolvers. Others were armed with long bamboo canes upon the end of which was affixed knives. It was a patriotic mob. It demanded that it should be permitted to fight. Britain the motherland was at war and as a matter of course, British East Africa, the youngest child of the mother felt impelled to take up a family quarrel ... 

The only regular military force available in the Protectorate at the time was Kings African Rifles stationed in Nairobi (Smart, 1950:37). Volunteers from India, South Africa and England also came to Nairobi to offer their services to the British. They organized themselves into units as Broweries Horse, Ross coles and Wessell's Scouts (Smart, 1950). These irregular units, for want of better rewards, crowded into the capital and were finally combined after much indecision into East African Mounted Rifles (E.A.M.R.).

African's involvement in the campaign as Carrier Corps was of prime necessity. The recruitment plans seemed to have been devised in great haste after the outbreak of the war. Waggins, an official in the Protectorate, sums up the process in the following words:

... On 13th of August, 1914
Messrs J.M. Rearson of
the Civil Service was selected for this duty and instituted what was to become the extensive and indispensable organization known as Carrier Corps ... (quoted in Savage, et al., 1966:316).

Various methods ranging from persuasion, the use of incentive to coercion were used in the accomplishment of the task. The recruitment exercise mostly affected the Kamba, Luo and Kikuyu areas. From the various districts the recruits were sent to the carrier corps depots for medical examinations to determine their physical capability. One such depot was in Nairobi. For the first time since the establishment of the medical department, a complete medical record of Africans serving as carriers was obtained (Beck, 1970:65). This was essentially a turning point in the medical history of not only Nairobi, but also the whole of Kenya as prior to this period no records on health conditions of the Africans had been obtained.

In 1915, the "Native" followers ordinance was enacted. This further gave the government more powers to conscript Africans for carrier corps duties. The term "followers" was used to allow those conscripted to be used for other duties as well as porterage (Savage, et al., 1966:314). The clause "followers" was of great significance to the development of health services. It was on the basis of this clause that Africans were used as stretcher bearers and nursing orderlies - a contribution which in the post-World War I era influenced the government institutionalised
training of Africans into the medical profession. The European and the African soldiers' influx to Nairobi had a drastic impact on the population increase. In 1914 the population estimate was 20,900 persons (Ann Med. Rep. 1915). By 1918, the population had risen to 21,565 persons (Ann. Med. Rep., 1919). The sudden rise in the population had far reaching consequences on the health of the population in and outside Nairobi. Overcrowding which characterized the town during this period aggravated the spread of infectious diseases that had prior been a menace to the health of the population. Soldiers from various parts of the world brought with them foreign diseases such as enteric fever, smallpox and venereal diseases (Kamande, O.I., 4/5/1989; Wafula, O.I., 6/4/1989). They too fell prey to the diseases that were prevalent in Nairobi such as plague (Blunt, O.I., 8/2/1989). Africans who moved from Nairobi to their rural homes took their acquired afflictions to the villages (Akoko, O.I., 9/1/1989). Thus, apart from being the administrative and military base, Nairobi also acted as a focus for the massive dissemination of various diseases (MacDawson, 1979).

4.3 The Colonial Government's Response to the Medical Needs of the Town

The sudden outbreak of the war found the British Colonial Government quite unprepared (KNA/PC/CP4/2/1 - 1915). The medical department, for instance, had made no
arrangements to deal with a large population. The department was still at its formative stages and the available health facilities were only meant to cater for a small portion of the population, namely, the Europeans, Indians and Africans in government employment. The minimal vote allocated to the medical department had made it even more difficult for the department to acquire a large staff and adequate facilities from the beginning. How the department was going to deal with the large soldier population, and the extra civilian population, remained a mystery to the colonial officials in Kenya and abroad.

According to the colonial office list, there were twenty nine senior medical officers in charge of the British East Africa Protectorate by 1914. Out of the twenty nine, twelve were stationed in Nairobi, but in relation to the population the ratio was relatively small. These medical staff were Milne (P.M.O.), his deputy Haran, Gilks, J.H; Thomson, J. M; Mackinon, Ross, H., the Medical officer in charge of the medical laboratory, his assistant J.H.H. Pierie, the Chief Sanitary Officer, D.J. Radford, Dental Surgeon, V.G.L. Von Someren and the Medical Officer of Nairobi Dr. B.W. Cherret. There were only five hospitals in Nairobi at the time, namely, the European Hospital, the "Native" Civil Hospital, Mathari Mental Hospital, the Infectious Disease Hospital, and the Railway Hospital which mainly catered for the railway employees.
Given that these facilities and staff were barely enough to meet the needs of the population in Nairobi, the British Colonial government had to do something to save the lives of the large soldier population that had converged in Nairobi.

The first step in this direction involved mobilization and training of Africans who had acquired some elementary education. They were instructed on how to nurse wounds, read thermometers and how to keep proper records of patients. Part of the group was under the jurisdiction of Dan Wilson, the Medical Officer in charge of the East Africa Mounted Rifles. It was later combined with Major Keane's Uganda Africa Medical Corps to form the East African "Native" Medical Corps.

The second group comprised twenty African dressers under the command of Dr. J.W. Arthur of the Church of Scotland Mission Hospital in Kikuyu. One of the most outstanding dressers during the campaign was Mr. Samson Njoroge Thomson. He was most efficient in his duties and played a major role in instructing other African dressers (Ndirangu, 1979:29).

While medically the soldiers were catered for, the medical needs of the civilian population continued to be neglected. Majority of the doctors in Nairobi were seconded to the World War I campaign. The few who remained in Nairobi continued to care for the officials. Thus, the colonial
government patterned the provision of health services to conform with their priorities.

The imbalance and inequality in the distribution of the health resources were further reflected in the buildings put up in town to cater for the wounded soldiers. In some cases, the arrangements involved renovating or converting buildings initially used for other purposes into temporary wards. In this connection the Principal Medical Officer noted the following in a letter to the Director of Public Works:

.... I have the honour to request that a few alterations to the existing hospitals be made as soon as possible to meet the requirements of the increased dispensing, and that the occupant of the house plot No. 20 be ordered to vacate the premises as the building is intended for reception of the sick and the wounded (KNA/MOH/2236).

Other attempts made by the colonial administration to meet the medical needs of Nairobi included the allocation of 20,730 to the Medical Department (E.A.S., 25/10/1914). In reference to the vote, the Medical Officer in charge of the town explained the following:

.... Extra staff is required and provision has been made for the following: three medical officers, one dispenser, one nurse, six sister surgeons, five sub-assistant surgeons, two sanitary inspectors, one pathological and assistant bacteriologist, and a certain
addition to the clerical staff. Considerable increase in the number of "Native" attendants and guards for the Infectious Diseases Hospital and quarantine stations, additional provision for the upkeep of European Hospital, furniture and some epidemics disinfectants and ambulance service ... (E.A.S., 25/10/1914).

Consequently, new temporary hospitals were put up in the town to cater for the medical needs of the soldiers and the porters. These were the Kings African Rifles (K.A.R.) Military Hospital sited along Ngong Road, the South African Troops Hospital found south of Muthaiga, the British Military Hospital in Kabete (L.B.E.A., 4/3/1915), and the Indian Troops Hospital.

Despite all these attempts, the racial discrimination in the provision of medical care facilities continued and enhanced the unequal distribution of facilities and medical care during the war. The Kings African Rifles Hospital meant for the wounded African soldiers was grossly understaffed. It had one medical officer who did most of the surgical work. The officer was assisted by Junior Medical Officers, an English Matron, and a Ward Sister (Carman, 1926). The other three hospitals were in most cases adequately staffed with doctors of better qualification and different specialities.

The provision of housing to accommodate the extra soldier population posed problems to the colonial government. As indicated in Chapter Three, before the war,
the colonial government was indifferent to housing requirements of the Africans who they argued were not an integral part of the town, and that being in their own country they were supposed to provide shelter for themselves. This in essence meant that something had to be done to house the extra African soldiers and foreign troops, who were supposed to fight for the interests of the metropolitan country. Here, the colonial policies and priorities were contradictory. Whereas the colonial government needed the services of African soldiers, they were not ready to adequately provide for their welfare needs, particularly medical and housing, to sustain a healthy soldier. The only attempt by the colonial government was the provision of makeshift emergency houses made of wood, mud and corrugated iron sheets (E.A.S, 15/6/1914). Camps were also established at Racecourse Road, Grogan Road, Nairobi House, Quarantine camp and the 29th Punjab's Camp (E.A.S, 15/6/1914), (KNA/PC/CP4/2/1 - 1915).

The sanitary state of the camps was generally appalling and hazardous to health. This was especially so, given that most of the buildings were put up in haste with no proper attention given to sewage, drainage, refuse and faecal disposal. The water supply was poor and deficient in quantity and quality. The insanitary situation was further aggravated by the large population with different cultural habits. Most of the camps proved to be the breeding grounds for various disease vectors. Diseases such as
diarrhoea, bacillary dysentery, tuberculosis, enteric fever, syphilis and gonorrhea were on the rampage. KNA/PC/CP4/2/1-1914). Table 4.1 indicates that from 1914 to 1918 pneumonia, cerebrospinal menengitis, dysentery, plague and tuberculosis were the leading cause(s) of death.

Table 4.1  Principle Diseases Between 1912 and 1917 in Nairobi

<table>
<thead>
<tr>
<th>Year</th>
<th>Pneumonia</th>
<th>Cerebrospinal Menengitis</th>
<th>Dysentery</th>
<th>Malaria</th>
<th>Enteric fever</th>
<th>Tuberculosis</th>
<th>Plague</th>
</tr>
</thead>
<tbody>
<tr>
<td>1912</td>
<td>98</td>
<td>-</td>
<td>48</td>
<td>30</td>
<td>3</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>1913</td>
<td>98</td>
<td>121</td>
<td>24</td>
<td>54</td>
<td>54</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>1914</td>
<td>154</td>
<td>44</td>
<td>39</td>
<td>16</td>
<td>8</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>1915</td>
<td>121</td>
<td>40</td>
<td>74</td>
<td>68</td>
<td>14</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>1916</td>
<td>152</td>
<td>29</td>
<td>103</td>
<td>53</td>
<td>6</td>
<td>15</td>
<td>119</td>
</tr>
<tr>
<td>1917</td>
<td>138</td>
<td>236</td>
<td>48</td>
<td>45</td>
<td>1</td>
<td>16</td>
<td>152</td>
</tr>
</tbody>
</table>

Source: Ukamba Province Annual Report - 1915

Although the official view attributed the causes of the insanitary conditions of the town to lack of funds, lack of municipal authority, absence of adequate building regulations, lack of town planning and insufficient municipal supervision, the Crown had itself to blame for these misfortunes (E.A.S., 21/2/1914). The defective drainage was attributed to the inefficiency of administrative officials who being in the position of
appropriating building estates, alienated large portions of the estates without first fulfilling the obligations in respect to drainage. Lack of co-operation in the past between the Government and the Municipal Committee was also spoken of.

From the sanitary conditions that prevailed in Nairobi, it is possible to attest that the high death rate of the soldiers in the campaign could have been partly due to the insanitary conditions at the camps in Nairobi. The soldiers contracted various diseases which were exacerbated by encounter with the new environments and coupled with lack of proper medical attention, overwork and malnutrition, it is no wonder that the death rate among Africans in the East African Campaign was high. On this note, Dr. C.J. Wilson, a British Medical Officer in Kenya, noted the following:

... The appalling mortality among the African porters who accompanied the fighting troops and maintained the lines of communication was a feature of the campaign outstanding in its grim tragedy. An early and unforgivable mistake was made when it was proposed to maintain the corps in the field on a ratio of nothing but a mealie meal. In spite of the most vigorous protest by those who realised the inhumanity of following such a proposal... (quoted in Clyde, 1962:58).

The carriers were essential for victory. In East Africa they were required to do extremely difficult work of
transporting supplies which was often done by vehicles in other theatres of the war, and the men had to do this while suffering from malnutrition (Ferguson, 1918).

.... Undernourished porters had to move heavy equipment over a terrain that lacked roads. The porters marched an average of 15 miles per day with an average load of forty pounds ... (Beck, 1970:64).

The colonial government's attempt to improve on sanitation was through the enactment of by-laws. This venture was however not much of a success. To the majority of Africans, the by-laws were sheer forms of colonial decoration.

Dr. Radford, the Chief Sanitary Inspector of the town, lamented over the scarcity of the inspectorate staff (E.A.S. 4/2/1915). There was also acute shortage of sanitary carts. Most of the available carts had been commandeered for use in the military camps. Giving evidence before the Municipal Committee, Dr. Radford attributed the situation to lack of government involvement in ensuring that the drainage and the sewage disposal in the town were up-to-date (L.B.E.A., 13/10/1917). The Committee's failure to check on the deplorable sanitary conditions subjected it to a lot of criticism during the war. In a discussion tabled at the Legislative Council Annual Meeting, the government called for the dissolution of the committee and the subsequent creation of a Municipal Council.
While the preceding discussion portrays the colonial government's indifference and failure to improve the health of the Africans and Asians, there were, some, government officials who made positive contribution towards the welfare of the Africans during the war. Prior to the appointment of Ainsworth as the Military Commissioner of the British East Africa, the Civil authorities had done little in the way of caring for porters discharged from the carrier corps. Despite the difficulties caused by shortage of medical officers and personnel, the colonial army had tried to take care of the sick and the wounded in their own camps. Once the men were discharged from the carrier corps, little was done for them and many already weakened by their tasks under appalling conditions fell sick and died either on the way or once they reached their destinations (Savage, et al., 1966:338).

In 1915, Ainsworth initiated a War Relief Fund. This called upon each and every district in the Protectorate to collect and hand in some money to the war office in Nairobi. Cards amounting to 25 cents each were sold to the African population (E.A.S., 1915). The money collected was to assist African soldiers, senior police, carriers and stretcher bearers, who while in the campaign became incapacitated by wounds or diseases. It was also to provide extra medical comfort to wounded African soldiers and porters during their convalescence period and to supplement, when necessary, the bonus granted by the Government as wound
By the end of December 1917 the East African War Relief Fund had amounted to £66,457 out of which £17,568 had been spent on articles of food, clothing, tobacco and fruit for the sick and wounded carrier corps, and as monetary assistance to those who were repatriated (L.B.E.A., 28/5/1918). Few African soldiers received the money. At the end of war the money that remained from the War Relief Fund was used to supplement the construction of the "Native" training medical depot in Nairobi (E.A.S., 4/8/1915).

Ainsworth drew up another comprehensive plan for the welfare of the returning carriers. He established convalescent camps whereby the soldiers who fell ill on the return journey could rest and be cared for. The camps were supervised and supplied with essential medical facilities by the Principal Medical Officer. But alas, in the first nine months of the implementation of the scheme about two thousand and one hundred men died at one of the carrier corps camps in Nairobi (L.B.E.A., 3/10/1917), as Savage, et al., (1966:340) observed:

.... It was fortunate that the camps were set up because conditions in the field had been particularly bad for the carriers in 1917. From January to November of 1917, 16,550 men died as compared with the total of 4,208 men who had died up to 31st December, 1916. The number of men left sick and weakened by the campaign of 1917 must have been particularly greater had
Ainsworth’s convalescent and rest camps not been in operation. Many of these men might never have reached home ...

As a result of that incident, Ainsworth appealed for help from missionaries and volunteers to maintain the health of the soldiers in the camps. To some extent he succeeded when some missionaries volunteered to give assistance. In Nairobi, Reverend Hamilton of the Church of Scotland, took charge of one of the camps (KNA/ a letter from Ainsworth to the Principal Medical Officer, 16.7.1917).

4.4 The Overall Impact of the World War I on the Development of Health Services

By 1918 the war had reached its verge of diminishing and its impact was widely felt. It led to far reaching medical changes in the Protectorate and Nairobi in particular than could have been anticipated prior to 1914. It left behind a trail of grief, sickness, poverty and famine.

Quite a number of historians have attempted to analyze the general impact of the war on African socio-economic and political institutions. Such scholars include Leys (1924); Huxley (1935); Ingham (1962); McGregor (1968); Oliver and Mathew (1968); Ogot (1974); Ochieng’ and Beck (1970); (1974); and Beck (1981) among others. Despite the general analysis they have accorded to the impact of war, these scholars explicitly argue that the war had adverse effects on the
health conditions of the Africans. Their evidence includes the figures on the death rate which vary depending on ones source. One message is however clear, that is, poor and inadequate medical attention, inadequate diet, overwork, exposure to different environmental conditions and of course gunning left many Africans dead or incapacitated. In this connection Norman Leys, a Medical Officer in the Protectorate during the campaign, noted the following:

.... that it is so sad to read in the earlier reports how a great boon we bestowed by stopping inter-tribal wars. Our own war has destroyed more life than a generation of Inter-tribal wars ....

Mr. G.L. American Representative at the Paris Conference, stated that: We recruited over 350,000 unarmed porters in the campaign against the Germans in East Africa, of whom 150,000 were raised in Kenya. About 14,000 "Natives" of Kenya were included in the armed forces (Leys, 1924:300). (See table 4.2).
Table 4.2: Number of Porters killed in the East African Campaign

<table>
<thead>
<tr>
<th></th>
<th>Killed</th>
<th>Died out of Disease</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armed</td>
<td>1,377</td>
<td>2,923</td>
<td>4,300</td>
</tr>
<tr>
<td>Unarmed</td>
<td>366</td>
<td>41,952</td>
<td>42,318</td>
</tr>
<tr>
<td></td>
<td>1,743</td>
<td>44,875</td>
<td>46,618</td>
</tr>
</tbody>
</table>


Various troops, for instance, the Indian and the British troops under the command of General Jan C. Smuts, suffered attacks from malaria. Enteric fever was equally menacing as described by C.J. Wilson, the Medical Officer who commanded the East African Mounted Rifles. Malnutrition rendered many soldiers weak, hence making them susceptible to disease attack.

The change in the disease pattern was a feature of the aftermath of the war. Movement of troops to and from Nairobi encouraged and accentuated the spread of contagious diseases. Diseases such as smallpox became rampant among civilian population. Cerebrospinal menengitis equally caused havoc. The result was overcrowding to capacity in most hospitals. A final legacy of the war was the 1918-1919 influenza epidemic which originated in Europe and spread rapidly to the colonial world (Ferguson, 1981).

Mental disorders also increased tremendously (Magu, 0.I., 4./1/1989). This was attributed to a lot of stress
related to the war conditions. For those at war this was caused by anxiety of winning the war, uncertainty, lack of assurance and comfort in the desert. Equally, those who were left behind were subjected to a lot of mental torture about the security of their relatives who were taken away to fight a war which they did not understand (Ndirangu, 1979).

This was reflected in the attendance records of Mathari Mental Hospital. The sister in charge of one of the African wards at Mathari Hospital observed that a cubicle meant for two people accommodated about eight women (KNA/MOH/2239, 1916).

Interaction with alien disease environment accentuated the movement of diseases from one environment to another. Military units, supported by long columns of porters, crisscrossed the countryside carrying with them respiratory and intestinal diseases associated with camp life. Social diseases such as gonorrhoea and syphilis were common features in the camps. The only mode of treatment was injection using penicillin. Antibiotics became much in use during the Second World War (Aluoch, O.I., 23.4.1939).

The First World War played its part in hastening the pace of social change among Africans. During the campaign, Africans were cut off from contacts with the indigenous healer. The absence of the healer and the long contact with the European doctor during the campaign enhanced Africa dependence on western forms of health services during the war through enforced camp hygiene. The African's experiences
encouraged the realization that they were part and parcel of the larger social system, and that they were no longer under their own control (Rosberg and Nottingham, 1966:26). To fit into the colonial set up, Africans had to adopt western social system, and institutions, such as colonial medicine. On this account, the Principal Medical Officer, Dr. A.D. Milne recorded the following in his 1918 Annual Report (Ann. Med. Rep., 1918:24):

"... the eruption of war into the centuries of old manners and customs of Africans had its impact on the colonising ideas of peaceful permeation of Western civilization, and are bound to have far-reaching results. What this may be one cannot as yet foresee ...."

During the campaign, tribal contact was not the only new experience (Rosberg and Nottingham, 1966:26). Those who worked in the campaign as stretcher bearers and nursing orderlies acquired diversified knowledge on surgical treatment, basic hygienic requirements and the importance of good sanitation. When the campaign ended, the nursing orderlies and the stretcher bearers not only brought back the surgical knowledge, but also helped in the implementation of hygienic remedial measures. The five years of interaction therefore certainly enhanced the positive change of attitude towards colonial medicine in the later years. It is therefore possible to argue that mass
acceptance of colonial medicine in the late 1930's in Nairobi dates back to this period.

The activities of the African Medical Corps during the campaign also deserves mention. Their activities during the campaign brought a complete reversal in the European attitude towards the intelligence and level of Africans. Before the war, the imperialists held a theory that the Africans' cranial capacity was small and was only suitable for manual work. While at war, the African Medical Corps displayed a wealth of intelligence by mastering the medical instructions given within a very short time. In addition to the medical corps achievement in real medical emergency, was the example the corps set. It clearly dispelled doubts held by many administrators that African youth could not be trained for independent and advanced work (Beck, 1974).

Consequently, after the war, the colonial government urged for an immediate action to train Africans to supplement in the provision of health services. Immediately the colonial administration began to revise their views on the education of Africans. The dependence of health on education was not unknown theoretically. It had been proven by practical experience (Beck, 1970:71).

The mythology among imperialist scholars that African were immune to tropical diseases was completely dispelled following the observation that the death rate among Africans due to disease out numbered the gunned and wounded.
Thereafter, the British colonial government approached the problem of human disease with commendable thoroughness and enthusiasm. From the point of view of humanity, there was need to extend health services to Africans and Asians.

The war led the colonial government to examine ways in which Africans dealt with various health problems before the introduction of western forms of health services. Consequently the officials embarked on the analysis of "traditional" medicinal plants. When an active chemical agent was discovered, it was synthesised in the metropolitan country and sold on the world market or back to the people of Kenya by a British pharmaceutical firm. This practice of tapping traditional medical knowledge was used by the Europeans to accumulate their wealth of pharmaceutical knowledge.

4.5 Conclusion

World War I was characterised by orientation of the medical resources to satisfy the interest of the metropolitan country. For instance, the available medical resources were diverted to care for the soldiers while the health of the civilian population in Nairobi was completely neglected.

The war brought a myriad of factors to the limelight. For example, that Africans were not immune to tropical diseases as evidenced in the death rate and as such, it was vital to extend health services to them. Thus, the limited
post-World War I task where the colonial Government was mainly concerned with the health of a few was bound to change in the years after 1918.

The war led the colonial government medical officials to acknowledge the importance of preventive health services - something that was not given much attention in the pre-1914 epoch. The post-World War I colonial Government emphasis on preventive health services stemmed from the fact that, most of the diseases that killed many Africans during the war occurred due to neglect of environmental hygiene at the camps.

The war led to the change in the disease patterns and therefore forced the colonial medical officials to embark on researches.

Finally, the war brought many Africans into contact with "Western medicine." This slowly led to Africans' dependence on Western forms of health care. At the same time the colonial government never at any one time adequately met the medical needs of the Africans and Asians.

Thus, the First World War was significant in setting the pace and direction in the development of health services in Nairobi in the years that followed.
4.6 Notes

1. See KNA/PC/CP4/2/1 - 1918

Annual Report for number of patients who attended Mathari Mental Hospital.
CHAPTER 5
HEALTH SERVICES IN THE INTER-WAR YEARS, 1919 TO 1938

5.1 Introduction

This chapter examines the political and socio-economic developments in Nairobi in the post-World War I era. It discusses the post-World War I Medical Policy, factors that were instrumental in the change of policy and how the policy was implemented. This embraces a discussion on the role of the Central Government and private agencies in the provision of health services. The colonial government’s effort in initiating training programmes for African medical personnel and research programmes in a bid to meet the medical requirements of the town is also discussed. Other issues highlighted are the impact of the new medical changes on the health of the population and the factors that inhibited effective implementation of the new medical policy.

5.2 A Brief Overview of the Socio-Economic and Political Changes in Nairobi and Post-World War I Health Policy

When the war came to an end and the aftermath had receded, Nairobi entered a new phase of rapid expansion (Carman, 1976:8). The town was filled with men of all races seeking for an economic advancement opportunity. Settlers were anxious to invest their war gratuities and hundreds of African askaris and carrier corps looked towards
Nairobi for settlement. The result of the influx was a drastic increase in the population of Nairobi (See Appendix II) and all the races were competing to have access to the few social facilities in the town. Africans who had acquired a wealth of knowledge with regard to sanitary measures as a result of the World War I campaign, were at the forefront in urging for improvement in the sanitary measures and in the provision of health facilities. The Africans' political parties formed in the 1920s were also forceful in expressing the same sentiments. The colonial government response to these outcries was often repressive in nature.

The Asian community was also mounting pressure on colonial government for proper representation commensurate with their numbers in the Municipal Council as this was the only way they could effect changes in health facilities and other social amenities provision. In return the colonial establishment responded to the Asian request by according them very subordinate positions in the Council. The Asians in turn boycotted participating in the Municipal Council and withheld the payment of rates on the grounds that the social services were unequally allocated. Between 1919 and 1925, the Asian's representatives were absent from the Municipal Council.

Partly as a result of the intense pressure from the African and the Asian communities for equitable provision of social amenities, and partly as a result of other factors
that shall be discussed later in this work, the colonial administration was forced to change the pre-1914 health policy which catered for only those who were directly part and parcel of the colonial economy.

In 1922, Dr. J. Gilks, the new Principal Medical Officer of Kenya, in recognition of the fact wrote the following:

.... The Medical Department as a whole was no longer considered merely as an organization maintained by the government to facilitate administration by maintaining the health of the executive personnel, but as a government department responsible for carrying out the most important function for which the government itself is established - namely the maintenance of the health of the general population of the country and the improvement of the condition under which that population lives ...


Prior to this period, the department had stressed clinical work and the maintenance of sanitary conditions of small administrative stations serving a population of half a dozen Europeans and perhaps fifty or a hundred African troops or police (KNA/A.M.R., 1921). Now the new policy embodied the provision of both preventive and curative health services to Africans even if they were not directly employed on European plantations or government camps. In 1922, when the general
debate on colonial development barely began to take shape, Dr. Gilks, the medical administrator in Kenya had come independently to the conclusion that promotion of better living conditions for the entire population of Kenya was essential. It was also a result of the development of the

What was the fundamental basis of this change (Beck, 1981:15)? This change was attributed to several factors. From the war experiences it had become more fully realised by the government and the European section of the community that the establishment and provision of health facilities, in addition to the control of epidemic diseases among the African population, was a matter to be undertaken at the earliest opportunity (KNA/A.M.R., 1921:18). An article in the East African Standard (3/11/1928:3) in recognition of the urgency reported the following:

.... In the matter of the public health ... the well-being of every section of the community is of paramount importance not only to the colony as a whole, but also to each other section in particular. No section can be neglected either in a settled area or in an African reserve without some section being prejudicially affected.

Thus, the realization of the inter-dependence of the health of all sections of the communities was partly a driving force in steering the change in policy.

Emphasis on curative medicine during this period was undoubtedly undertaken partly due to an appreciation of the
fact that the economic welfare and progress of the country was at the bottom dependent on a numerous and healthy population. The realization of the importance of the conditions of labour had occurred during the East Africa campaign. It was also a result of the realization of the actual needs of the Africans and the debt that was due to them not only in consideration of taxation, but also for the services they rendered during the war (KNA/A.M.R/1921).

In addition to being prompted by the desire to control labour, the change in policy was part of a general drive to curb the rising tide of discontent which had manifested itself in the "Thuku" affair, the activities of the Young Kavirondo Association and Kikuyu Association. Secondly, the change was steered by the desire to safeguard the health of the European community by paying attention to the chief focus of disease. The change was also connected with an increased emphasis on the position of African women in towns because of venereal diseases and prostitution or what Leys (1924:306) called temporary wives. In addition, there was the realization that a diseased and discontented workman is a poor workman (Parker, 1948:110).

Another motivating force was the recognition that the health service system itself is an industry - the social service-based industry with virtually endless potential for swelling the gross national product. There was therefore the need to promote the use of this industry to enable it maintain its rapid growth rate and to create greater and
greater dependence to enable the industry to grow from strength to strength.

The Post-World War I stagnation also forced Britain to concentrate her energies on new economic and social policies. Two sets of objectives were proposed. One was upgrading of the European economic sector in Africa hence Kenya and the other was the social improvement of the African population.

There was also growing appreciation among the British Colonial government officials that economic progress could only be achieved by extending the health services to the Africans. The exploitation of the natural resources of the country inevitably focused attention on the necessity of providing the means to be taken to conserve the labour supply and to ensure its efficiency. Thus, the economic development of the country had brought home to the policy makers the immense importance of the provision of health facilities (East African Commission, 1925:53).

Reporting on the relationship of the proposed policy to production, the Chief Native Commissioner noted the following:

... It is a vital matter that an immediate increase in these Services should take place. Recent research shows that the "Native" of Africa is unfit to a degree that he is holding development. Experiences show that once made fit he proceeds forthwith to undertake his share in development ... (Maxwell, 1925:27).
Several colonial officials also expressed the importance and urgency of the matter, for example, during the 1928 budget session, the Financial Secretary expressed the view that the scope of preventive or social medicine should largely be taken into consideration (Martin, 1921:1).

Thus, during the transition from war to peace, a new medical and social philosophy was embraced. The formulators of the policy may not have been aware of the implications, but their new goals were not compatible with the role of "Colonial stewardship of dependent people".

To facilitate the implementation of the new outlook towards the health of the population, the public health ordinance of 1921 was enacted. It was an imitation of the public health act of the Union of South Africa No. 36 of 1919. It gave the Kenya Medical Department much broader powers under which the Central Board of Health with the Principal Medical Officer as the Chairman was established. The function of the Board was to advise the Governor on any matters affecting the public. Hence, the ordinance was the most important milestone in the development of Public Health administration in the colony in general and Nairobi in particular (KNA, A.M.R., 1936:2). It testified to the government the Legislature's appreciation of the importance of the public health. The Medical Department consequently, became statutory and for the first time the functions of the department were defined. It was on the basis of this ordinance that new health policies were embraced and
enormous expansion of health services embarked on (Beck, 1970).

5.3 Policy Implementation

5.3.1 Curative Branch: The Role of the Central Government

With a new broader policy to pursue in the provision of health services, the Central Government was bound to play a major role as hospitalization and other medical services were in government hands (Parker, 1948:111). The first step towards the implementation of the new policy was the recommendation by the government to build a new "Native" Hospital in Nairobi (KNA/A.M.R., 1923). This was not only to improve health conditions in Nairobi, but also to provide a training centre for African dressers to enhance the extension of health services to a wider population.

A few years prior to 1925, the Government had been making attempts to deal with the welfare of mothers and children. It had established welfare centres at the Health Office in Nairobi, the Pumwani African Location, and at Kabete. In 1926 it proposed to open others at Pangani and at the railway area (KNA/A.M.R., 1925:66).

The colonial government also wished each section of the community to provide for itself to minimize the government expenditure on these services. Yielding to popular demand and political pressure, the colonial administration agreed to extend the services through dispensary system financed
out of the local subscription. The dispensary also seemed
to be the answer to the problem of insufficient manpower and
the general trend of liberalizing colonial government
services (Beck, 1981). It was staffed with African medical
personnel trained in technical work.

The General Dispensary, then located at the southmost
end of Moi Avenue where the Central Police Station stands
today, was consequently opened (Orwa, O.I., 2/4/89). It was
to act as a filter unit for the "Native" Civil Hospital.
Apart from the reasons given above, the spread of venereal
diseases as a result of the war, and also partly as a result of
the male/female demographic imbalance influenced the
decision to open up the dispensary. It was hoped that it would
make adequate provision for the male venereal diseases
victims. In the 1940s, the General Dispensary was closed
down because of its distance from the African precincts and
also because it could not help in the enforcement of the
segregationalist policy.

The colonial government responded to the closure of the
General Dispensary by opening dispensary services in African
locations in the hope of avoiding the necessity of Africans
frequenting the European areas. Apart from the official
arguments of taking the services closer to the people, as
mentioned in Chapter Three the move was to facilitate and
enhance the unequal distribution of facilities and services.
This venture was practically in agreement with the official
segregationist policy as set forth in earlier colonial
government reports and in the 1933 Carter Commission Report:

"... Having regard to the widely different standards
of living observed by "natives" in Nairobi as compared with other races,
we are convinced that due to considerations of health, social amenities should

Consequently, three dispensaries were opened at
Pumwani, Kariokor and the Railway headquarters respectively.
Apart from the above mentioned, the Loco Dispensary, Police
Prisons and the Nairobi District Health Office Dispensary
were also set in operation (KNA/A.M.R, 1933). Until 1930,
the dispensaries seemed to thrive without much effort.
Simple wattle and daub huts with one, two or three rooms
were set up and maintained by local authorities. The medical department's role was purely advisory. Selected youths were trained for three months and the government administration was responsible for matters of discipline and administration (Beck, 1981:17).

The years 1926-1929 were golden years of the long awaited improvements and expansion on almost every front. There were discussions of a Group Hospital for all races, and an earmarked improvement was achieved in the new "Native" Civil Hospital where the prevailing conditions were
later described by the Principal Medical Officer as a little better, if at all better, than those which prevailed during the Crimean War.\(^2\)

The Group Hospital was to embrace facilities for all races in the same area, yet not necessarily under the same roof (E.A.S., 2/7/1927). The advantages to be gained by concentrating medical facilities for all races in the same place were so obvious that the scheme found favour at once with the laymen equally with the professional men (E.A.S., 25/6/1927). Having a Group Hospital meant that attendances would be more efficient, experimental apparatus would not be duplicated and that the laboratories and other clinical sections would be in closest possible connection with the hospital. It was also hoped that an African medical training corps consisting of three hundred men would be attached to the hospital.

In the years thereafter, the locational site of the Group Hospital inspired a very controversial debate.\(^3\) Various sites were proposed for instance, the Kiambu Road, because of its centrality and accessibility to all races. However, this site was protested by the Asian community as it had been demarcated for an Indian school. Next the Racecourse Road was suggested, but the European community opposed the idea since the site was close to the African precincts whose surrounding was considered unhealthy. At a Legislative Council budget session in 1928, a decision to abandon the combined hospital scheme was reached (Orr,
1928:17). This had far reaching repercussions on the training of African personnel. Training programmes could not proceed until buildings had been put up. Yet, one of the urgent needs of the department and the town at the time was properly trained and disciplined hospital attendants - men whose capabilities were known and who could be entrusted to carry out the work required of them under supervision in the hospitals or in independent charge of dispensaries in the estates. In the 1931 Annual Medical Report, Dr. Gilks lamented that it was unfortunate that political consideration rendered the construction of the Group Hospital impossible.

The upswing of 1937-1939 saw the revival of the idea of a Group Hospital. However, no progress was made because of the outbreak of the World War II. The "Native" Civil Hospital, always a cinderella, was expanded to 216 beds by 1936, and a further 40 beds were added in the following year (Hake, 1977). Mathari Mental hospital, which had provisions for about 130 patients in 1929, could take 250 in 1936 in vastly improved conditions (Loc. Cit.). Partly because of these changes, African infant mortality rate (estimated at 400 per 1,000 live births in the 1920's was reckoned to have dropped to about 215 by 1939) (KNA/A.M.R of M.O.H, 1939) (see Fig. 5.1 on the next page.
Figure 5.1: Infant Mortality Rate in Nairobi Between 1934 and 1939

Source: Annual Medical Report of the M.O.H., 1939.

5.3.2 Private Initiatives

There was a certain amount of voluntary effort in the Provision of medical facilities, especially with regard to
maternity and child welfare clinics. The first such effort in Nairobi was initiated in 1919, when the Lady Northey Home was founded in Parklands. However, it was for Europeans, the aim being to provide for motherless and orphan European children and those whose mothers were ill or at work, thus eliminating any necessity for European children being left under the care of African ayahs (E.A.S., 10.7/1926).

In 1926, there was a campaign in Nairobi and Mombasa amongst the officials for the extension of the work of the Lady Northey to the other races. The challenge was taken up by Lady Grigg who formed a child welfare league which eventually led to the opening of Voluntary African Child Welfare Centre and Maternity Home in Mombasa in the same year (KNA/A.M.R., 1926:53). In Nairobi, Lady Grigg held a fete in the grounds of Government House to establish:

(a) a maternity home for Europeans
(b) a welfare centre for Indian women and children, and
(c) a model infant welfare centre for "natives" (E.A.S., 32/1/1926).

What prompted the change towards the provision of health services to the mother and the child? Parker (1948) has argued that the Europeans pressed their claims for such services. There was a general movement among the Europeans for greater hospital provision for themselves, and the need for provision of special amenities to other races was also
felt. Discontent among the Africans which had culminated in the "Thuku" affair and later the Mombasa strike called attention to the deficiencies. There was also fear that the African population was decreasing. Asians too were pressing their claims largely as a result of difficulties encountered in maternity cases. There was also the need for some control of the children who were flocking the town as they were considered as potential criminals (E.A.S., 17/7/1926). The officials argued that cleanliness inculcated in mothers and children would reap rewards later. Hence the first suggestion for Africans was a model infant welfare centre rather than a maternity home (Parker, 1948:112). Through the infant welfare centre influence would be secured over children at an early age, and better cooking, housewifery, care of children and diet could be taught to the mothers to eliminate malnutrition (Loc. Cit.).

The success of Lady Grigg's project in Nairobi was realised in October 1926 when she laid the foundation stone of the maternity and child welfare home for Africans in Pumwani which was subsequently opened in 1927. Three years later, an Indian welfare and a maternity centre were also opened. The two maternity hospitals were referred to as Lady Grigg Pumwani Maternity and Lady Grigg's Indian Maternity Hospital respectively.

Reviewing the work of Lady Grigg's welfare league, Dr. Gilks, the Principal Medical officer had the following to say:
The extra ordinary progress which has been made by the league in the three years of its life is evident in each section. In the Indian section an Indian maternity hospital and a training centre now stands on its own ground in Nairobi. In Pumwani "Native" village of Nairobi, there is the African Maternity and child welfare hospital and training centre which contrary to the expectation when it was founded was receiving the whole hearted support of the "natives" of the district... (E.A.S., 4/9/89).

The Lady Grigg maternity hospitals and their services were regarded as augmenting the effort of the government which became the largest subscriber.

The second private initiative in the provision of health services was specifically in regard to the Asian community. Up to this period, the Asians had no hospital financed by the government as was the case with the Africans and Europeans. The only hospital provision for Asians at the time was a single ward in the "Native" Civil Hospital. Dr. Karve tells the story of the conditions in the following sentimental words:

.... There was no maternity ward for the Asians in the "Native" Civil Hospital, and all maternity cases had perforce to be treated in their own homes. There were no trained Indian Nurses. untrained midwives (Dais) attended all cases sometimes
It was because of such limitation that Dr. Karve started a Nursing Home for the Asian community. His efforts were however shortlived because of financial limitations.

5.3.3 **Role of the Local Government**

The origin of the Local Government can be traced far back as 1835 when the Municipal Council Act established local authorities in Britain. The sole function of the Municipal Council was the prevention of nuisance, the protection of public water supplies, the removal of town waste, housing and the control of communicable diseases (Woodley, 1945:32). In Kenya, the notion of Local Authority was first established in 1901 when a Municipal Committee was constituted in Nairobi. Its functions were similar to those defined by the Municipal Council Act of 1835.

A brief history of the Local Authority in Nairobi indicates that from 1901 to 1918, the Municipal Committee was the sole Local Authority entrusted with administrative duties and the maintenance of environmental health. Its activities were, however, hampered by a lot of prejudice, corruption, inefficiency and insufficiency. Consequently, in 1916, a discussion on the activities of the Committee was tabled in the Legislative Council. In 1919, Nairobi was subsequently granted the Municipal Council status. It
inherited all the duties that were initially performed by the Municipal Committee.

The Kenya Public Health Ordinance of 1921 re-emphasized the role of the Local Government in the provision of preventive health services. However, in 1928, the Local Government Ordinance further extended the curative responsibilities to the Council. It was to control the Child Welfare Centres, venereal diseases clinics, ante-natal clinics and Maternity hospitals. Consequently, in 1935, the Medical Department officially transferred the administration of the aforementioned centres to the Council. In addition, the Council officially began to regulate the activities of Pangani, Pumwani and the Kenya Uganda Railway Dispensaries opened in 1928, 1929 and 1930 respectively (KNA/A.M.R. of M.O.H. 1931:39).

It is significant to point out that the decentralization of health services was a positive measure towards the effective realization of the post-World War I Medical policy. However, the modalities, especially the financing of these institutions, was ostensibly transferred to the Africans. Through taxation and other contributions to the Local Government, Africans were able to facilitate the running and the maintenance of these institutions. It was true that the Central Government continued to subsidize the maintenance of these institutions, but more often the subsidy kept decreasing. The result of financial limitation
was that most of the institutions never acquired adequate facilities and staff.

The sanitary conditions in Nairobi in the inter-war years remained deplorable. In 1926, the Annual Medical Report described them as far from satisfactory - not due to deliberate negligence but to ignorance of what sanitary conditions were and to a belief that conditions which Europeans or even animals cannot be expected to stand, could be borne with impunity by Africans. Refuse and human excreta disposal remained inefficient and ineffective. These conditions were ideal for the propagation and the frequent outbreak of dysentery, hook-worm and enteric diseases.

The Colonial government was aware of these conditions but they chose to take a low profile in improving them. Only when the conditions threatened labour output did they intervene. Ollumwullah (1986) has argued that this was a reflection of the 20th Century capitalist formation in Kenya, whereby the colonial state was not ready to voluntarily pay for the reproduction of labour which according to them was "natural" among non-whites.

The constant pleas from various races, and particularly the Africans and Asians and of course a few Europeans, necessitated some course of action. The colonial government in liaison with the Nairobi Municipal Council established a framework within which sanitary improvement in the town would be achieved. The first step in this direction was the
creation of a sanitation division in the Medical Department and a Chief Sanitation Officer was subsequently appointed to manage the affairs of the division. Secondly, decentralization of the sanitary services was embarked on. Lastly, improvement of housing conditions for Africans to lessen congestion and therefore minimize the spread of diseases; formulation of new malaria and other diseases control policies and the introduction of Africans to sanitary measures through educational campaign (propaganda), health exhibitions and home visiting was resorted to.

Decentralization of sanitary services was realised in 1936, when the city cleansing services were transferred to the City Engineer. However, the activities of the engineer in a bid to accomplish his objectives were hampered by inadequate finance and lack of co-operation from the Municipal Council authorities.

Housing development to reduce overcrowding and consequently improve on the sanitary state of the town was much underway as early as 1906 when the report of the Land Commission for East African Protectorate recommended separate location for all races. However, the issue was kept in abeyance until 1919 when it was tabled for discussion. The result of the discussion was the demolition of the African villages of Masikini, Pangani and Mombasa. The occupants of these villages were moved to Pumwani, located on the poorest soil in town. In 1928, the Kariokor Housing Estate was opened. It was more of a labour
cantonment than a housing estate. In 1938, Pangani was demolished and subsequently replaced by Shauri Moyo village (New Pumwani). The new estate was put up at a cost 46,555 to accommodate Africans who had been living in Pangani. The name "Shauri Moyo" was best translated as "Hobson's Choice" reflecting the Africans attitude towards the estate.

While it is apparent that the colonial government made efforts to improve housing for African's, a survey by the Superintendent of "Native" locations revealed that houses permitted to be occupied by 171 persons was found accommodating 503 persons on a certain night of 1938. This condition catalysed the urge by various bodies on the improvements of the conditions. The leading educational authorities and missions in Nairobi had the following to say:

.... It desires to place on record its view that the provision of educational facilities in the area cannot prove of any great value until a wide scheme of social welfare, embracing programmes for housing, health and recreation has been planned and funds have been provided to put it in operation ...
(quoted in Davies, 1939:4).

Evident is the fact that instead of minimizing the intensity of the problem, it persisted. It is also worth noting that the racial segregation in the residential areas
continued to be emphasised as a means of minimizing the spread of diseases from the African location's to the European zones and as a measure aimed at improving the sanitary conditions.

Through the war experiences, the colonial government and the Local Authorities were more convinced that in order to win the confidence of Africans into accepting colonial medicine and the sanitary measures especially where African customs interfered with progress in that direction, education and persuasion were to go hand in hand. Education, it was hoped, would gradually change the attitude of Africans towards accommodating European medicine. Persuasion, on the other hand, involved the use of incentives at various health institutions to encourage the Africans to visit the clinics and dispensaries.

In the 1929 Annual Medical Report, Dr. Gilks stated that education was the desire of times and that before this period the aims of Education were not well defined. It had no links to life, but only aimed at producing clerks and this in turn encouraged the rural-urban influx to Nairobi. In the more recent years Gilks remarked:

.... Some systematic education on broader links has been provided and partly as a result of many other factors which have been educational in their effects. There are many Africans who are endeavouring to develop their land. There is no solution to
the problem of diseases in Africa except in the culture of the land and good agriculture. Good social conditions will not remain a possibility unless education is carried out to the point at which the desire for high standard of living will be met sufficiently to counteract the tendency to bad health habits...
(KNA/A.M.R. 1929:17).

Education was thus to be used as an instrument to enhance the African's awareness on environmental health hazards and to facilitate the African's dependence on Western forms of health services to boost the gross national product of colonial health service industry. The whole venture entailed the opening of a public health museum in Nairobi which contained exhibitions illustrating the spread and prevention of diseases such as plague, malaria, smallpox and diarrhoea. Samples of various sanitary vessels, sanitary systems and the statistical charts indicating the general level of the African health were also displayed (E.A.S., 5/8/1925). In 1930, another exhibition based on the slogan "How to Make Africa Healthy" was held with basically the same motive (E.A.S., 11/1/1930).

The introduction of Education as a measure towards improving environmental health had an immediate impact on Africans attendance at various hospitals. Its emphasis also coincided with the African demand for better education.
Marxwell, the Chief "African" Commissioner, reported the change in the following words:

... Africans who some years back were being forced to heed to colonial medicine were now asking for it... (Marxwell, 1927:28).

Beck (1970) echoed the same sentiments when she wrote that previously the government had tried to make the Africans seek treatment. After the war it was the African who requested for the medical services. They demanded more than the government could provide. Each person wanted individual treatment and personal concern for his health problems. However, the government could not extend curative and preventive services to individuals, but to the community as a whole (Loc. Cit.: 13).

The outcome of the changes was reflected in the attendance at the child welfare centres, ante-natal clinics, venereal diseases clinics and the dispensaries (see table 5.1) next page.
Table 5.1: Attendance at Clinics and Home Visiting

<table>
<thead>
<tr>
<th></th>
<th>(a) 1938</th>
<th>(a) 1939</th>
<th>(b) 1940</th>
<th>(b) 1941</th>
<th>(c) 1946</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ante-Natal</td>
<td>1,759</td>
<td>1,945</td>
<td>1,906</td>
<td>1,982</td>
<td>3,560</td>
</tr>
<tr>
<td>Child Welfare</td>
<td>4,109</td>
<td>4,880</td>
<td>4,966</td>
<td>4,269</td>
<td>7,661</td>
</tr>
<tr>
<td>Dispensaries</td>
<td>7,021</td>
<td>5,086</td>
<td>3,591</td>
<td>1,510</td>
<td>1,546</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12,889</strong></td>
<td><strong>11,911</strong></td>
<td><strong>10,463</strong></td>
<td><strong>7,761</strong></td>
<td><strong>12,867</strong></td>
</tr>
<tr>
<td>Home visits</td>
<td>2,149</td>
<td>3,353</td>
<td>4,480</td>
<td>4,755</td>
<td>8,290</td>
</tr>
</tbody>
</table>

(b) " " " 1941 p.52
(c) " " " 1946 p.65

Reporting on the situation, Dr. Tilling, the Medical Officer of Nairobi noted the following:

".... It is felt that the confidence of the "Native" mother has been won and she responds by bringing not only her sick children for treatment at the dispensaries, but by regular week attendances at the Child Welfare Clinics where the healthy children are examined and weighed and the earliest symptoms of illness are detected and treated ...." (KNA/A.M.R. 1933:23).
On a similar note, Montgomery, successor of Marxwell as the Chief "Africans Commissioner, apprehended the situation in the following words:

.... For whereas only a few years ago women could only with difficulty be persuaded to enter hospitals and centres for ante-natal and maternal care, the difficulty is how to find accommodation for them... (Montgomery, 1937:103)

Dr. Patterson, the successor of Dr. Gilks, expressed the same views in the following phrase:

.... Whereas ten years ago it was difficult to get Africans to come to the hospitals and exceedingly difficult to get them to submit to surgical treatment, now hospitals are occupied largely by heavy cases of minor order of urgency and severity. Today our beds are occupied by heavy cases of surgical treatment for difficult gynaecological conditions such as vesicular vaginal fistula which is popular to a degree and sought after to the point at which most of our large hospitals at least have waiting list ... (KNA/A.M.R., 1934:2)

.... The Africans bring up the matter at all meetings and have contributed quite large sums for hospitals and dispensaries. The old prejudice against European medicine was gradually being overcome... (Marxwell, 1926:45)
The impact of the African demand for western forms of health services were pronounced. In the 1937 Annual Medical Report, Patterson lamented that the volume of work in hospitals and dispensaries had increased tremendously. Overcrowding in the hospitals had become a common feature. Patterson expressed the conditions prevailing in the following words:

.... The continued increasing demand for admission to hospitals and out-patient treatment at dispensaries, placed severe strain on almost all government institutions. For instance, the volume of surgical work increased to a degree that it became impossible for one surgeon to bear the burden and extra Medical officers had to be recruited as Assistant Surgeons...(KNA/A.M.R., 1935:1)

Why had the change towards colonial medicine occurred that suddenly? Was it because of the impact of the war, the educational campaign or because of Africans willingness to change? It may be argued that it was as a result of the interplay of all these factors. The availability and accessibility of the health services to all races had also a part to play.

Other measures advanced by the colonial government in co-operation with Nairobi Municipal Council to check on the spread of diseases entailed formulation of new policies in
an effort to minimize the outbreak of diseases. More attention was particularly given to the control of malaria. Malaria may be defined as an acute systematic disease sometimes severe, and often chronic—characterized by shaking and chill, rapidly rising temperature and a palpable spleen (Roberts, 1974:305). The history of malaria in Nairobi goes as far back as 1902 when the first malaria epidemic occurred (Symes, 1940:17). Malaria outbreaks were often sudden accompanied by acute infection. Treatment was by prophylactic use of quinine and the elimination of anopheles breeding places. When the malaria problem intensified in the years thereafter, the colonial government initiated a Research Programme on the mosquito parasite and its cycles before a concerted effort to contain the disease was realized.

No general colony wide anti-malaria policy was defined prior to 1925 because, until that year, the only major problem of malaria was in the reserves (KNA/A.M.R., 1928:17). In 1926, a malaria epidemic which affected Nairobi and the surrounding country broke out. This intimidated the colonial officials to formulate a policy aiming at the ultimate elimination of the dangerous anopheles mosquitoes from the Municipality. In 1928, Dr. Gilks noted that malaria was gradually being recognized as a "social disease" and occurred mostly where there was a low standard of living. The general success of anti-malaria policy was largely governed by the standard of sanitation
and freedom from possible breeding grounds from the African's area (KNA/A.M.R. 1928:7). Consequently provision was made for specific as well as general measures to check the spread of the disease (Beck, 1970:106).

Large numbers of pamphlets dealing with malaria, the housing of African employees and the treatment of intestinal worms were issued. Systematic oiling, filling and ditching were also carried out. The anti-malarial work was facilitated by the census data that had been collected by the entomologist and his staff. On the basis of the data, other comprehensive measures to control malaria were embarked on. Substantial financial provision amounting to £40,000 was made with a view to improving conditions in Nairobi. Arrangements were also made for a specialist in malariology to visit Nairobi.

Towards the end of 1929, Colonel James, adviser on tropical diseases to the Ministry of Health in England, arrived in Nairobi (KNA/A.M.R., 1929:28). He gave public lectures at various venues on the methods and measures to be adopted to minimize the malaria problem. He advocated the handcatching method. Africans were subsequently asked to catch mosquitoes, put them in tins and then deliver them to the Municipal Council office after which one would be exempted from paying tax. Nevertheless, progress in anti-malaria measures were held up from the first instance, because neither the council nor the government was prepared to take the necessary measures to deal with the European lands which
were known focal for mosquito parasite breeding (Parker, 1948:100).

From the discussion on malaria problems and control in Nairobi in the inter-war years, it is evident that the conditions that hastened the spread of the disease were created by the colonial government in the name of developing the town. African houses provided breeding grounds for the mosquito parasites. Nairobi River, along which the town developed was a major mosquito breeding area. Thus, one can argue that, the economy of the colonial government and the enclave pattern of development contributed to the seriousness of the problem. The colonial government's attempt to eradicate mosquito menace in Nairobi was therefore an attempt to solve the problem that they had helped to create. The control of the malaria problem reflects the general trend in the development of health services. For instance, at the beginning of malaria eradication process, emphasis was placed on the clinical treatment using quinine. As malaria problem intensified, preventive measures were resorted to. Then followed the enactment of policies dealing with the problem. By 1938, the Medical Department was no longer merely satisfied with checking malaria epidemics; they also aimed at the economic and cultural improvement of the people. (pictures on malaria control measures Appendix II).
Training of African Medical Personnel in the Inter-War Years, 1919-1938

The training of Africans as medical helpers started as an emergency measure during the war, when the East African Medical Corps was formed. The Corps acted as stretcher bearers, nursing orderlies and as medical clerks. During the period of adjustment to Post-War I life, both the missions and the government officials urged for an immediate action to start the technical training of qualified Africans. This was further re-emphasised by the Phelps-Stokes Commission of 1924 that was sent to Kenya to review the kind of education essential for the Africans.

The colonial government Post-World War I emphasis on training of African medical personnel was also partly as a result of the efficiency and competence displayed by the East African Medical Corps. During the campaign, the Corps dispelled the mythology among the imperialist that Africans were not capable of any constructive work. The other reason and perhaps the most substantive, was that the colonial government hoped that African involvement would offset the expenses that were likely to be incurred by the Medical Department, if it was to effectively implement the post-war emphasis of the provision of health services for all races. Besides, it was apparent that the endeavour was compatible with the capitalist tenets of maximizing profit, exploitation, dependence and hence underdevelopment. In other official circles, it was argued that for total
permeation of the western medical culture, Africans had to be participants. There was also the necessity to conserve the labour supply through the improvements of their living environments and the provision of other essential medical supplies to facilitate production. These could only be achieved with a reasonable number of staff. This move to train Africans as medical personnel was therefore influenced by an interplay of several factors, but the colonial government's exploitation of both human and natural resources ranked highest.

It is significant to note that prior to this period some rudimentary training of Africans was undertaken by the missionaries in the rural areas. The government involvement was very minimal. For example, Dr. Arthur of the C.M.S. hospital at Kikuyu, had amassed a number of Africans whom he instructed on how to nurse and dress wounds. Dr. Phillip of Tumutumu also undertook a similar venture. These were just few and scattered to meet the medical needs.

Immediately after the war, when the colonial government moved to train African staff it was at the lowest level. The first government initiative in the training of the African staff was undertaken at the government medical training depot attached to the "Native" Civil Hospital. By 1924, the Principal Medical Officer reported that he was entirely dissatisfied with the progress of the training programme for African dressers (Beck, 1970:83). He
described the dressers as undisciplined and pointed out that this was the major hindrance to the training progress.

Consequently, the Principal Medical Officer called for a re-examination of the training programme. After serious deliberations and consultations, in 1925 the Medical Officer submitted a scheme to the government advocating the creation of an enlisted African Medical Corps on a basis somewhat similar to the police (KNA/A.M.R, 1925:3). This move to instil discipline in the Africans was meant to subordinate and marginalize their participation in the medical field. The training programme involved drills, running and generally behaving and dressing in a manner similar to the police (see Picture 5.1).

Pic. 5.1: African Medical Trainees

Every morning the African Medical staff were paraded and inspected as if they were a guard of honour (Ochieng', O.I 20/4/89).

Discipline and cleanliness were virtues to be adhered to. Failure to comply with the orders meant severe punishment or suspension (Awithi 0.I, 24/4/1989). Africans resented being subjected to this kind of harassment and especially when it was done by European female nurses (Mugo, 0.I, 30/12/1988). In 1922, Gacheru Mugo, a trainee at the medical training school, joined Harry Thuku and voiced the trainees grievances and particularly the racial injustices they were subjected to through the Kikuyu Central Association.5

By the end of 1926, the reorganized training programme had achieved less, and Dr. Gilks noted:

.... Technical education was easily acquired by the Africans, but a sense of responsibility, pertinacity honesty, and general trustworthiness were woefully lacking... (KNA/A.M.R., 1926:6).

The programme was eventually abandoned. A year later, the Principal Medical Officer proposed that instead of African Police Medical Corps, a system of apprenticeship found in the workshops of the Kenya and Uganda railway be adopted in training the African Medical Staff (KNA/A.M.R., 1927:1).

The new programme entailed familiarization with subjects such as carpentry, masonry and plumbing, plus a few subjects
of relevance to the medical profession. The colonial government's objective in providing the inferior kind of medical know-how to the Africans was influenced by the European desire to monopolize the health service market and to find a justification for exploiting the African medical staff. For a long time, the British excluded African medical staff from the normal ranks of the medical service and apparently discouraged the practice of sending Africans for training as Medical Doctors. The inherent fear among the British was based on the fact that Africans might excel in the profession and challenge the prevailing deficiencies in the provision of health services, for example, the health consequences of labour recruitment and urban segregation.

Systematic training of Africans began in 1930. Africans were trained at the level of Hospital Assistants (Clinical Officers), Laboratory Assistants, Compounders (Pharmacists) and Dressers. The Hospital Assistant course took four years. The trainees were expected to master the anatomy and physiology, medical surgery and public health (Awithi, 0.I; 21/4/1989). The Laboratory Assistants were expected to learn the chemical composition of various specimen and how to analyze them. The compounders mainly learnt the dispensing work, while the dressers concentrated on the basics of nursing. After completion of the courses, the African medical staff were posted to various health institutions in or outside Nairobi where they were not only
overworked but also underpaid. For example, they were paid sixty shillings per month, although by the standards of the time the money was paradoxically a lot.

To facilitate the effective implementation of the preventive and environmental health policy, a decision was taken to train health inspectors at Kabete. The training programme commenced in 1933 and three years after its inception, it was abandoned on the grounds that the cost involved was enormous.

The decision to train African women in the medical cadre was first reached in 1923 by the East African Women league. The training of women officially began in 1938, and apart from taking courses in hospital assistantships, they also specialised in midwifery at the Lady Grigg Maternity Hospital and the Municipal Council Child Welfare and maternity clinics where the women were subjected to the same kind of treatment as their male counterparts. Women joined the medical profession at a later date partly due to the colonial government's attempts to marginalize their participation in all sectors of the economy and partly due to the societal cultural inhibitions.

By 1937, steady progress in training African medical personnel had been achieved. This was made possible by the completion of part of the Group Hospital. Medical instructors from outside the country were also forthcoming, the lack of which had hindered progress for along time. At
the outbreak of the Second World War, the medical department had acquired a reasonable number of African medical staff.

In an attempt to analyze the African medical training programme, Beck (1970) asked why it had such a slow start. This is the question that tortured the minds of several people in and outside Nairobi. From an analysis of what was going on at the time, it was apparent that the colonial medical officials were faced with various problems which inhibited training progress. Financial constraints played a major role. For example, the 1922 and 1924 financial curtailment and the 1929 to 1930 world wide Economic Depression had constraining influence. The political atmosphere was also uncompromising in the sense that various views on the training programme emanated from different directions. The result was lack of co-ordination. The indecisiveness reflected in the co-ordination of the programme is enough evidence to conclude that the colonial government had no plans to develop and provide health services to the bulk of the Asian and African population that flocked to Nairobi. It was by accident and not design that the colonial government embarked on a mass scheme to provide medical facilities to the Africans which they even paid for either directly or indirectly.

5.5 Medical Research in the Inter-War Years

Medical Research is a prerequisite for intervention in medical fields to alleviate suffering inflicted on man
diseases. A brief history of the phenomenon in Kenya in general and Nairobi in particular, reflects the general pattern of the development of health services. Prior to 1914, the necessity of medical research was recognized but despite this manifestation of concern for research, no major organizational effort was made until 1920 (Beck, 1970:195). There were various reasons that accounted for this passiveness for instance, lack of personnel and the general attitude of the colonial government towards the venture. One essential element towards the realization of medical research objectives is the systematic compilation of data. However, statistics were not available before 1918. The only statistics that were available were those that contained the birth and death rates of the Europeans.

In 1919, the issue was brought to the limelight. But even though this was the case, emphasis was on livestock and agricultural researches to boost their production. Dr. Kavuntze argues in the Bacteriologist Laboratory Annual Report that, to the Europeans in the protectorate, the death rate of a cow was apparently of greater significance than the health of the Africans. When the committee appointed to consider the position of medical services submitted their recommendations, in regard to medical research it noted:

.... There is no better investment for the money of any colony than
scientific research, both medical and economic... (quoted in Beck 1920:178).

In 1933, the organization of medical research began. Dr. Patterson, Director of Medical Services, identified the problems that inhibited effective implementation of the research policy. In his Annual Report of 1934, he described the difficulties as lack on clarity on how a great service might be rendered not only to the industrial development of the people of Kenya, but also to the development of medicine as a whole, if adequate medical research was undertaken.

Between 1935 and 1939 various conferences were held to look into the possibilities of proper organizational effort, but progress was hampered by first the 1933 government curtailment on expenditure and the outbreak of World War II.

5.6 Conclusion

During the period under review, it is apparent that several changes occurred in the organization and the provision of health services which culminated in the declaration of a new health policy that had provision for all races and all aspects of medicine. Noted is the principal progress in health care. However, this progress was not due to a humanitarian outlook on the part of those who controlled industry; rather, it arose from their economic interest. The attitude of the capitalist towards the health of the worker is, in other words a consequence of the conditions under which capitalism operates. At this
time there was need for adequate labour supply and thus a pressing need on the ruling class to eliminate contagious diseases in the increasingly unhealthy town. The colonial priorities and needs at the time played a significant part in shaping the pattern of production and distribution of health resources and services. On the other hand, Africans were not passive spectators in their own environment. After being introduced to the western forms of health services through various means, they began to demand for better services.
5.7 Notes


4. See Annual Medical Report of the M.O.H. (1926-1930), Government Printer, Nairobi, for the population figures. Also see Appendix II for the population of Nairobi.

CHAPTER 6

6.0 HEALTH SERVICES DURING THE SECOND WORLD WAR AND THE PERIOD THEREAFTER UP TO 1963

6.1 Introduction

Kenya witnessed another political upheaval when World War II broke out in 1939, during which Nairobi maintained its role as the military base and the headquarters of the East African Medical Services. The war had devastating effects on the embryonic Medical Department. However, when the atrocities of the war had receded, the department entered a phase of reorganization, consolidation, and expansion of health services to meet the growing demand for them. This chapter therefore examines the colonial government post-World War II expansion policies and the strategies embraced to realize the intended objectives. It also discusses the impact of Mau Mau movement on the development of health services, the colonial government's attempts to train Africans at higher levels in the medical profession and the emphasis on intensive medical research.

6.2 Health Services During World War II, 1939 - 1945

At the outbreak of World War II, Nairobi was endowed with exiguous health facilities which though rudimentary in nature, were much better compared to the situation during the World War I campaign. Arrangements had been made to cope with the war casualties during World War II
as it had been anticipated. In 1939, for example, part of the completed section of the Group Hospital was taken over by the government for military use and an additional one hundred beds were provided to meet the demands of the soldiers. The transfer of the hospital from civil to military use was done at the expense of the medical needs of the population. At the same time a rehabilitation centre was opened at the "Native" Civil Hospital. Kariokor Dispensary was transferred from civil use to a first aid camp for war casualties. At the European Hospital, Infectious Diseases Hospital and Mathari Hospital, enormous expansion to accommodate war casualties was also embarked on.

Despite all the arrangements to meet the challenges of the time, the war thrusted a severe strain on the health facilities. In 1941 for example, Patterson noted that the problems faced by the department were three-fold. First, how to meet the emerging demands for indoor and outdoor medical relief, especially with regard to the treatment of serious surgical cases; second, how to obtain adequate and timely medical relief with regard to unspectacular diseases such as malaria, tuberculosis and venereal diseases; and lastly, how to arrange for the training of Africans especially women to play a much larger and more responsible part in the medical department (KNA.A.M.R., 1940:9). Initially women had been pushed to the periphery and were trained only as midwives.
In 1942, Dr. Patterson echoed similar sentiments when he wondered how the department was going to meet the accommodation of the ever-increasing number of patients. The problems of the department were now even more defined. It became clear that it was difficult to meet the increasing needs without adequate staff. Secondly, provision for indoor hospital treatment had to be enlarged. And third, there was an emergency need to guard against the outbreak of yellow fever, which had occurred in Sudan and the likelihood of it spreading to Nairobi was so obvious. Apparently solutions to the problems were not forthcoming as the department had inadequate finance to make any break through.

By 1945, the war had left the department in a pathetic situation. The medical stores were completely depleted. The situation was worse to an extent that operation was done without surgical gloves. At the same time, attendances at the hospitals, dispensaries and the welfare centres increased tremendously. But more often the military medical needs overrode that of the civilian population.

6.3 Post-World War II Health Policies

When peaceful conditions returned, the medical department embarked on a programme of re-organization and consolidation of the available health facilities. Health services were expanded and particular emphasis was laid on the provision of the services to women and children. The anticipated improvements appear, however, to have stemmed
less from pressures exerted by doctors than from basic changes in labour policy. For example, changes in the British economic policy led to changes in the distribution of the social costs. The British wanted to expand exports of primary products and to substitute African products for imports. Their decision therefore was to stabilize labour, and to expand the payment of social costs. The labour advisor to the Secretary of State in reference noted the following:

... This will of course entail heavier loss on industry for the social services at present are lacking at a superfluous level. The increase in efficiency should counterbalance this expense and eliminate any increase in the cost of production which might handicap competition with trade rivals in other countries ... (Orde, 1946:58).

The social services in this case included health, housing and education.

Several administrative and organizational changes were devised henceforth to meet the rising need for health services while at the same time minimizing costs. First, the development Act of 1929 was replaced by the Development and welfare Acts of 1940 and 1945. The change in title emphasised a change in thinking. Development and welfare funds were to be earmarked in future for the development of colonial reproductive resources as well as improvement of human well-being (Beck, 1980:9). The Development and the
Reconstruction authority established in Kenya was to facilitate the post-World War II planning and to coordinate the projects envisaged in the next ten years (Ingham, 1965:378).

A Development and Reconstruction Fund was created in which funds were set aside for capital development. From the funds some progress was however achieved in Nairobi. Six operating theatres and surgical ward blocks of three hundred beds were added to the African Hospital (Beck, 1970:155). They were officially opened by Countess Mountbatten of Burma who announced at the opening ceremony that his Majesty King George VI had graciously consented that the hospital should be named after him. From this achievement it can be argued that the 1945 ten year colonial Development plans pointed to a new direction by emphasising the long term commitment of funds and expressly including social issues for consideration even though they were not sufficiently funded.

Secondly, in 1946, a Committee was set to examine the anomalies existing in the provision of health services to various races (Potter, 1946). The committee’s report observed that the Africans hospitals were inadequately staffed and the bed ratio was abnormally wide. See Tables 6.1 and 6.2 respectively.
Number of Beds and Staff in Various Government Hospitals in 1945.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Europeans</th>
<th>Asians</th>
<th>Africans</th>
<th>Medical Officers</th>
<th>Europeans Nursing Sisters</th>
<th>Technicians</th>
<th>Africans Ungraded</th>
<th>Africans Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil</td>
<td>-</td>
<td>41</td>
<td>423</td>
<td>9(1)</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>120</td>
</tr>
<tr>
<td>Hosp.</td>
<td>15</td>
<td>16</td>
<td>294</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Hosp.</td>
<td>45</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>14</td>
<td>-</td>
<td>-</td>
<td>52</td>
</tr>
<tr>
<td>Hospital</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Union</td>
<td>-</td>
<td>-</td>
<td>59</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20</td>
</tr>
<tr>
<td>Hosp.</td>
<td>-</td>
<td>-</td>
<td>87</td>
<td>-</td>
<td>1</td>
<td>3</td>
<td>-</td>
<td>34</td>
</tr>
<tr>
<td>Hosp.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Hosp.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dept Dis.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Research</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>9(3)</td>
<td>-</td>
<td>-</td>
<td>40</td>
</tr>
<tr>
<td>Training</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>8</td>
<td>171</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Includes Senior Surgical Specialists, Ophthalmic Specialists and Anaesthetist who work at the European Hospital and Dispensary, and Medical Officer i/c of medical Training depot.

Includes three Entomologists.

### Table 6.2. Government Health Institutions in Nairobi 1945.

<table>
<thead>
<tr>
<th>CURATIVE SERVICES</th>
<th>PREVENTIVE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALL RACES</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Government</strong></td>
<td><strong>Government</strong></td>
</tr>
<tr>
<td><strong>Municipal</strong></td>
<td><strong>Municipal</strong></td>
</tr>
<tr>
<td><strong>Private</strong></td>
<td><strong>Government</strong></td>
</tr>
<tr>
<td><em>(sometimes with</em></td>
<td><em>)/Or Municipal aid)</em></td>
</tr>
<tr>
<td><strong>AFRICAN</strong>*</td>
<td><strong>AFRICAN</strong>*</td>
</tr>
<tr>
<td><strong>Group Hospital</strong></td>
<td><strong>Airport Inspection</strong></td>
</tr>
<tr>
<td><strong>- St. John &amp; Red Cross Societies</strong></td>
<td><strong>- Incineration.</strong></td>
</tr>
<tr>
<td><strong>AFRO-ASIAN</strong>*</td>
<td><strong>AFRO-ASIAN</strong>*</td>
</tr>
<tr>
<td><strong>European</strong></td>
<td><strong>Medical Officer of Health.</strong></td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td><strong>Hygiene Instruction in Schools.</strong></td>
</tr>
<tr>
<td><strong>- Maia Carberry Nursing Home</strong></td>
<td><strong>- Full soil removal.</strong></td>
</tr>
<tr>
<td><strong>- Eskotene Nursing Home</strong></td>
<td><strong>- Slum clearance.</strong></td>
</tr>
<tr>
<td><strong>ASIAN</strong>*</td>
<td><strong>- Inoculation and vaccination.</strong></td>
</tr>
<tr>
<td><strong>Asian Maternity Home</strong></td>
<td><strong>- Food inspection and examination of hawkers.</strong></td>
</tr>
<tr>
<td><strong>- Indian Maternity Home</strong></td>
<td><strong>- Inspection of premises.</strong></td>
</tr>
<tr>
<td><strong>- Social Service League Dispensary</strong></td>
<td><strong>- Cordon Sanitaire.</strong></td>
</tr>
<tr>
<td><strong>E.U.R. &amp; H. AFRICAN</strong>*</td>
<td><strong>- Maintenance of Abattoir.</strong></td>
</tr>
<tr>
<td><strong>African Maternity Clinic</strong></td>
<td><strong>- Medical Officer of Health.</strong></td>
</tr>
<tr>
<td><strong>- V.D. Clinic</strong></td>
<td><strong>- Department and training of staff.</strong></td>
</tr>
<tr>
<td><strong>- Shauri Moyo Dispensary</strong></td>
<td><strong>- Talks to Schools, etc.</strong></td>
</tr>
</tbody>
</table>
| **Source:** White Thornton et al. (1948), Nairobi Master Plan for a Colonial Capital, His Majesty's Stationery Office Press, London, P.33.
In a bid to rectify the imbalance, the Committee identified the major priorities of the department. Among the agenda for action in the post-World War II era, was the establishment of health services throughout the colony, the construction of a new much larger Medical Training School and the completion of the new Group Hospital to cater for the training of nurses and auxiliaries staff and also to provide a specialist centre for the colony (KNA/A.M.R., 1946). By 1949, one of the objectives had been realised by the partial completion of the Group Hospital which had additional beds which place the bed number at 650 for Africans and 42 for Asians.

The realization of the other plans was impeded by inadequate finance and help was not forthcoming from the colonial office in Britain. Consequently, the government had to devise ways of funding the health services. It was proposed that each race make some contribution towards the hospital expenses.

In 1946 therefore, another Committee was set up to examine the practicability of Africans paying a proportion of the cost of personal medical services provided by the Government and the Local Native Councils at various hospitals and dispensaries. If found practicable, the Committee was to make recommendations as to the procedure to be adopted to provide adequate safeguards against any loss of Government or Local Council revenue and also to make recommendation as to the scale of fees to be charged. After considerable deliberations, the officials found it impracticable to implement the policy as it entailed the denial of hospital facilities to those Africans who could not afford the fee. The difficulties of collecting the
money were also anticipated. The services therefore continued to be financed by the employer's subscription to the department and also out of the taxes paid by Africans.

In the same year, a third Committee was set up to examine how the cost of the individual patient in the Government European Hospital could be reduced and how such a scheme could be made to apply to non-governmental hospitals and nursing homes. The Committee was further to establish how the cost of maternity cases could be reduced. When the report was presented to the Legislative Council, it advocated for a compulsory hospital insurance scheme for all Europeans.

Asians were also pressing their claims for an improvement in the health services offered to them. They urged for the hospital insurance scheme instead of racial taxation as it could enable sick persons to receive better and cheaper treatment. In retaliation the colonial government set up a committee to examine the possibility of implementing such a scheme for the Asians.

Following these developments and contrary to the Asians expectations, on 14th January 1950, an Asian Hospital Authority Fund was established. Thus a racial hospital tax was now a fact and the Indian congress resolution and policy statements against it were completely ignored. It was not long before this state of affairs was obliterated when hospital contribution became a non-racial tax and hospital services became available to all persons on the same terms.
In regard to the hospital facilities to the Asians, the Committee endorsed that a construction programme for building a new hospital and the increase of beds for the Asian Community would be a timely move. In 1949, the Asian Community agreed to build a 123-bed hospital in the vicinity of the Group Hospital. A sum of £600,000 from the Ismail Rahimtulla Valji Hirji bequest was used. The hospital formed in the later years, the nucleus of the projected training for Asian nurses and midwives under the aegis of the Nurses and Midwives Council of Kenya. Plans for another new Asian hospital in Nairobi were completed in the same year and the construction commenced in 1951.

Progress in the department was however slowed down by the outbreak of the Mau Mau struggles and the accompanied declaration of the State of Emergency in 1952.

6.4 The Impact of the Emergency on Health Services

The declaration of the State of Emergency affected every part of Kenya and particularly those areas where Mau Mau movement was active. It was in part the climax of the struggle between the colonial government and the Africans over land alienation, taxation and generally the social injustices that the Africans were subjected to during colonial rule. In the present study, the event is examined as a manifestation of the impact of capitalist penetration
in the countryside, but which affected Nairobi in varying ways especially in terms of the spread of diseases, distribution and in the provision of health services.

The Mau Mau movement crystallized in the 1950s. The followers of the movement overtly expressed their dissatisfaction with the prevailing economic and political order. This culminated in the declaration of the State of Emergency in 1952.

The movement had a direct impact on the Medical Department which by 1950 had achieved a lot. For example, Muthurwa, Kariokor, Pumwani, Kaloleni and Bahati dispensaries in Nairobi were closed down. The European and Asian clinics were minimally affected by the disturbance. This was due to the fact that the holders of power patterned the distribution of the health resources such that Africans who were the majority and who urgently needed medical attention were the most affected. The situation was further aggravated by the re-orientation of the health resources to other areas which had been severely affected by the Emergency. Nairobi was therefore left with a limited number of staff. (KNA/A.M.R., of the M.O.H., 1950).

The most adverse and serious result of the Emergency was the impact it had on the recruitment of doctors which hitherto had been achieving steady progress in 1950. This was unfortunate because it happened at a time when
commitment to health services had greatly increased. The financial stringency resulting from the Emergency slowed down the longterm development programmes envisaged.

Murder in the African location became a daily event. The climax to these calamities reached when a European officer was assasinated in Ziwani. The incident sparked off debates as to whether it was possible to continue the African Maternity and Child Welfare Services in the African locations. After some deliberations, it was found possible to do so by cutting out health visits and reducing the number of clinics in the African location. One service that was considerably disrupted was that of the African child Welfare Clinics.

During the Emergency, the Kikuyu, Embu and Meru communities employed in the Medical department or by the City Council became quite unco-operative and unwilling to work (Wanjohi O.I., 27/3/89). The City Council Cleansing Services were severely handicapped by shortage of staff as the night soil sweepers and refuse removal staff who were Ndia from Embu District were found to be the most contaminated with Mau Mau ideology (N.A.D., 1953:7). Similarly, the conservancy staff became so depleted that refuse and night soil in the African locations could only be carried out twice or three times a week.

In 1954, "Operation Anvil" led large numbers of
Kikuyus in Nairobi to the detention camps at Langata and Embakasi. Highly trained auxiliary staff from Kikuyu Community found their way to the camps. The Medical trainees from the other two nationalities were no exemption. In total about thirteen learners were detained (KNA/A.M.R., 1954:7).

At the detention camps, overcrowding and poor sanitation were a common feature. This led to the outbreak and spread of varying diseases. In April 1954, for example there occurred an outbreak of typhoid in the detention camps. This was preceded by a severe outbreak of tuberculosis, dysentery and pellagra. Other diseases such as poliomyelitis and ariboflavionosis proved to be equally menacing at Embakasi camp. Childhood diseases such as gastroenteritis were also on the rampage. However, the spread of the diseases was arrested by a mass inoculation campaign.

The enormous increase in the establishment of the police and the drafting of civil population into the security forces compelled the Medical Department to examine the recruits. Consequently, Medical facilities had to be provided for the greatly increased number of police post both for the treatment of casualties and the day to day medical needs of a greatly expanded force (KNA/A.M.R. of the M.O.H., 1953:60).
There also occurred an increase in medical legal work. A number of Medical Officers were constantly called to appear in courts, thus spending a lot of time doing work outside their normal hospital duties. Reporting on the impact of the Emergency on King George VI Hospital, the Medical Officer of Health had the following to say:

.... One of the major incidents of the Emergency was the Lari massacre... Victims included women and children who were treated at King George VI Hospital ... this increased a lot of responsibility on the Hospital staff ... (KNA/A.M.R., of the M.O.H., 1953:14).

Emergency regulations greatly affected ordinary Africans as patients. The regulations required Kikuyu, Embu and Meru communities to have passes to appear in Nairobi. This caused a lot of difficulties for out-patients attending refill clinics at the hospitals in Nairobi.

The medical staff from time to time suffered considerable intimidation from the Mau Mau guerrilla fighters and a few African members of staff had to be transferred from Nairobi to other areas for security reasons (Mwangi, O.I., 18/12/1988). To combat this state of unrest, the African staff quarters were surrounded with security barbed wire fence. At the same time, a homeguard on voluntary basis was organized by the medical staff.

A positive impact of the Emergency on public health was the re-organization of African housing on community basis and the repatriation of 24,000 Kikuyu, Embu and Meru
communities (KNA/LG13/3191). This endeavour encouraged various communities to maintain a clean environment. To control violence barbed wire fencing was used. But at the same time it was resorted to as an aid to apportion sanitary responsibility to dwellers in each village.

As Mau Mau continued to affect the activities of the Medical Department in varying dimensions, there were sections where some noticeable progress was attained. In 1953, for example, a new clinic was opened at Bahati (see picture in Appendix Id). At Mathari, an occupational therapy department under the control of a qualified therapist was opened. This filled the gap that existed in therapeutetic armamentorium. Patients at Mathari were to engage in occupational undertakings depending on their prior knowledge and experience (Magu, O.I., 4/5/1989).

At King George VI Hospital, the following specialist fields were established: senior surgical specialist, surgical specialist (General), surgical specialist (Ear, Nose, Throat), surgical specialist Anesthetist, Medical Officer (Gynaecology). There were also other Medical specialists and one Medical Officer (Paediatrics). The need of the time, especially as witnessed at the Lari Massacre had led the colonial government to give surgical field special attention (KNA/A.M.R. of M.O.H., 1954:5).

To improve public health during the Emergency, education propaganda was of great significance. This was hoped would instil in the Africans and Asians the self-help and self-protection ideology. In 1952, the Colonial Government set up a graphic museum near the Medical Training Centre in Nairobi. Its objective was to emulate the well-equipped and remarkable institute attached to the Medical
Training School in Khartoum. The museum was to provide a permanent health demonstration centre (KNA/A.M.R., of M.O.H. 1956:68).

6.5 Post-Mau Mau Movement Development in the Medical Department

When the state of Emergency ended, more settled conditions returned and the department embarked on further expansion and consolidation of health facilities. The movement hastened the pace of change by directing the colonial government to the anomalies. The department consequently enacted new policies in an effort to meet the ever growing demand for health resources. The "Health Centre" system was at the moment deemed to be the immediate solution to the problem of inadequate health resources. The centres were designed to fulfil the responsibility which had hitherto been carried out by the Dispensaries.

The health centre was first enunciated in Kenya in 1946, when in a report by the Development Committee of the colony and protectorate of Kenya it was noted:

"... We accept the view of the National Health Service Commission of South Africa that the foundation of personal health service is the health centre. The health centre will be the basic unit and it will be here that the actual personal services will be rendered. ... (A.R.C. & Development, 1946).

Although the principle was propounded as early as 1946, it was not until 1953 that proposals for financing the health centres were outlined. The purpose of the health centre was
to correct the inherent inadequacy of health facilities. Fendall (1955), writing of his experience and translating policy into practice, said:

.... It is essential that the health centre be integrated with existing medical and health services; or rather and more logically, the existing services should be integrated with the health centre concept and organization ....

Thus, the concept "Health Centre" was consciously substituted for "Dispensary", the idea being that not only would the sick be treated, but also an opportunity would be taken to inculcate ideas of prevention and avoidance of sickness into the minds of those attending the centres (KNA. A.M.R., M.O.H., 1954:13).

The health centres were also to serve as out-patient departments for King George VI Hospital. They were to provide basic medical services for lower waged Africans with good diagnostic services and the necessary forms of therapy. Specialist treatment and other complicated investigations were to be referred to King George VI Hospital or appropriate government medical sections (KNA/A.M.R., M.O.H., 1954:6). More important, however, the Health centres were to be in integrated with preventive and promotive services through the help of an African team of health assistant, a health visitor and a midwife. Their task was to help
educate people in public health matters and sanitation. Above all, the efforts of the colonial government in initiating the Health Centre project, was hoped, would have marked effect on reducing absenteeism of sickness amongst the Africans employed in commerce and industry in the city. However, it was stressed that such services were purely ancillary which presumably meant that the weight of medical services rested with the other established medical institutions (Beck, 1981:22).

Translating policy into practice, four Health Centres were opened at Bahati, Kaloleni, Pumwani and at Rhodes Avenue in the city centre. When the services became operational, the City Council together with the Central Government agreed to institute a charge of two shillings for a week's treatment for adults and one shilling for children. In 1959, the fee was raised to three shillings per adult and one shilling and fifty cents per child. This marked the end of free medical treatment for Africans and the beginning of cost sharing in health services. Mr. Earnest Vasey, Minister for Finance, explained that the contribution was of necessity because of the rising cost of health resources.

An assessment of the Health centre a few years after its inception revealed that the design was principally good. However, until Kenya's independence in 1963, financial difficulties, poor constructions, the administrations'
inability to train sufficient number of medical staff and a multitude of other problems that confronted the Health Centres, rendered their activities ineffective. Once again, the indecisiveness reflected in the training programme of Africans was reflected in the choice of health resource suitable for the needs of the time. Before the World War I, hospitals were the only health resource available. This was found inadequate and after the World War I, the dispensary system was initiated. Later health centres which had already shown signs of diminishing came into being.

In the post-Mau Mau re-organization, plans were advanced to transfer the administration of the dispensary from the Central Government to the City Council. This was not immediately possible because of the problems cited above. However, in 1958, the City Council became responsible for the dispensary services in the City. This superceded the transfer of the City Cleaning Services from the City Council to the City Engineer. The City Council later opened dispensaries at Mbotela, Ofafa and Karen.

In the same year, the H.H. Aga Khan Hospital was opened. Patients who visited the hospital, were required to pay sixty-five to seventy-five shillings a day to cover both medical and surgical treatment. The charges were relatively high at the time and therefore only a small proportion of the population had access to the hospital services.
By 1958 health services in Nairobi had become completely commercialised. The patient fee at the government hospitals had gone up. At the state Hospital that is, King George VI patients were required to pay fifteen shillings. At the European Hospital, all members of the European Community who sought treatment were required to pay a special Hospital charge at a fixed rate of fifty-five shillings per day. The Asian Community had a similar form of payment towards their hospital dues. The insurance policy pursued by the European and the Asian communities was considered the most appropriate undertaking towards paying for health services in developing countries where funds were very limited.

In 1959, the government established the Ministry of Health and Welfare as a self-contained portfolio (Akim, 1959:5). Honourable W.B. Havelock, M.L.C., was appointed the Minister in charge of the office. At the same time, the posts of Permanent Secretary, the Chief Medical Officer, the Assistant Director of Health and an Under-Secretary - Finance were established and filled. These arrangements and re-organization were aimed at facilitating the development of health services and more so in anticipation of Africans' control of the health services.

In 1960, the Lancaster House Conference with its proposed changes to the Constitution resulted in a certain
amount of unsettlement of staff (Fendall, 1962:8). In anticipation of the country's independence, many of the European staff were preparing to leave. Nairobi was the most affected by the endeavour since it had many European doctors. This situation was met by an intensification of training programme for Africans to fill the eminent vacant posts (Magu, O.I., 6/5/1989).

Meanwhile the new socio-economic and political trends impelled the Principal Medical Officer to recognize the role of health services. He noted that it was the responsibility of the Department to improve the health of the population to enhance the development of the economic resources (KNA/A.M.R., 1962:12). These views were similarly appreciated by the international Bank for Reconstruction when it stated:

.... Expenditure on health that improves the productive capacity of the population like those on Education, may be viewed as investments, although the returns are not easy to calculate or to realize .... (Fendall, 1962:14).

The report further pointed out that this could only be realised when emphasis was placed on preventive rather than curative medical services.

In 1962, the Catholic Church spearheaded the missionary participation in the provision of health services in Nairobi when Mater Misericordiae Hospital was opened. The hospital had been planned several years earlier to act as a low-cost amenity Hospital for middle-income groups. However, because of financial constrains and differing opinions between the Church and the
State, the construction of the hospital delayed. Unlike in the medical field, missionaries contributed greatly in the provision of education in Nairobi.

Kenya attained independence in 1963 and the late Dr. J.C. Likimani was appointed the first African Chief Medical Officer. It was hoped that he would succeed Dr. Fendall as the Principal Medical Officer. At the same time, Dr. J. Kabiru became the Medical Officer of Nairobi, a post which had been held by Europeans throughout the colonial period. Thereafter, there was enormous Africanization of posts in the department. The Group Hospital, the name of which was changed in 1951 to King George VI Hospital, experienced yet another change of name in 1964. The announcement was made by Dr. J. Mungai, the then Minister for Health that the hospital was to be known as Kenyatta National Hospital in honour of Mzee Jomo Kenyatta and up to date (1990) the hospital still serves as a teaching and a referral hospital for the whole country.

Another historic action by the government that had a bearing on the development and improvement of health services was the decision after independence that all out-patient care in government hospital would be given free of charge. This decision later placed a lot of strain on the available resources.

Other changes entailed the abolition of racial segregation in various hospitals. Africans and other races alike could avail themselves for treatment at the European or Asian hospitals.
Further, the use of hospitals was made easier by the introduction of the National Hospital Insurance Fund instituted in 1966. A compulsory contribution system to National Hospital Insurance Fund was established and all those who were earning a minimum of 600 per annum and above were required to submit their contribution every month. The late President Mzee Jomo Kenyatta further abolished payment of fee for out-patient treatment in government hospitals. This move subjected the department to a lot of financial difficulties especially in the period of readjustment and reorganization to an African controlled health service.

Thus, in the sixty four years of the development of health services in Nairobi, they developed against a background of limited financial resources. Shortage of personnel and the continued requirement for expansion of the services caused by the steady growth of the population and the ever increasing demand for better quality service also thrusted a severe strain on the medical department.

6.6 Training of Africans in the Post-World II to 1963

When World War II broke out in 1939, emergency medical supplies and medical personnel were required to cope with casualties that is always found in wars. Before the outbreak of the World War II, the medical department had achieved very little progress in training Africans in the medical cadre. This was as
result of the conflicting theories and ideas as to what should constitute a suitable curriculum for African Hospital Assistants.

During this period, most of the Hospital Assistants were recruited into the army to serve as nursing orderlies. Others were stationed at various strategic points to control emergency health problems. The number left in Nairobi to care for the civilian population was so small. The result was severe deterioration of Africans' health conditions in Nairobi. Apart from increasing responsibilities on the Medical Department, the war also had an impact on the training of Africans. One positive break through in this direction was the commencement of the training of African Masseurs at newly established rehabilitation centre (KNA/A.M.R., 1943:35). In addition an orthopaedic section was established to cope with the deformities. An X-ray service was also initiated.

Changes in the general level of education in the country also influenced the level of training in the medical profession. It is apparent that by the time of the outbreak of World War II, there were quite a number of Africans who had attained secondary level of education. They were therefore sent for higher level training at Makerere. A review of the training programme by Mr. Hasking, the Chief African Officer, revealed that at least six Africans who had been trained at Makerere University college were employed as "Assistant Medical Officers". It is worth noting that the title "Medical Assistant" was used inappropriately for the Africans who had undergone the higher level training and were supposed to be addressed as doctors. This was an attempt by the
colonial medical officials to subordinate and therefore underpay the African Medical Staff. It is because of these injustices that Gacheru Mugo rose in protest. He narrates the exploitation in the following sentimental words:

.... There were six Senior African Laboratory technicians at the Medical Research Laboratory who joined the services fifteen or twenty years ago. These people acted as instructors to the recruits in the department. They even taught the Asians and some Europeans, but the Asian and European trainees were always paid more than African instructors...

(Mugo, 1970:79).

He further observed:

... the African uniform was also different from that won by Asians and Europeans. The latter had white overalls and the Africans wore khaki. The African overalls had M.R.L. (Medical Research Laboratory) marked in red across the chest. The overalls won by the Europeans and Asians were plain. (Loc. Cit.).

To meet the challenges of the times, the government devised a plan for expanding the existing training facilities. In 1952, the government embarked on rebuilding the Medical Training Centre. The admission capacity of the department was also expanded. In that year, eight Hospital Assistants qualified. In 1953, the number had risen to twenty six. At the same time, the training of African girls as nurses was expanded on a larger
In 1953, King George VI Hospital was recognized and approved by most of the medical schools in the United Kingdom for the purpose of the one year post-graduate internship which was required under the Medical Act of the United Kingdom. In 1955, the name of Medical Training School was changed to Medical Training Centre. At the same time, a new category of trainees, that is, Medical Assistants was introduced. It was anticipated that the Medical Assistants would be trained at a higher grade than the Hospital Assistants. Unlike their counterparts, they were trained in nursing procedures. The aim of initiating the Medical Assistant Course was to train personnel who would be capable of taking charge of rural health centre or small subsidiary hospitals. The post was also to bridge the gap between the demand and supply of doctors qualifying from the East African School of medicine. By the end of 1955, there were three hundred students at the Medical Training Centre undergoing the Medical Assistant Course as dispensers, entomological assistants, radiographers, and Kenya registered nurses.

In 1957, Miss Houghton, Education Officer of the general Nursing Council of England and Wales, visited East Africa with a view of assessing the quality of training in nursing in all the territories and to make recommendations to the Council on the practicality of recognising those schools which could provide the
requisite standards of practical training. Nurses graduating from the institution were eligible for registration as state registered nurses with the General Nursing Council without the need for further training or examination. The General Medical Council of Britain also recognized and accepted the diploma of licentiate in Medicine and Surgery of the Makerere University College as a registrable qualification (KNA/A.M.R., 1962:27). This was to enable doctors qualifying from Makerere to have a solid foundation in the provision of health services.

Reporting on the achievements of the department in regard to training, the medical officer noted:

.... Training has been maintained for all grades and the Nurses training school has had its period of provisional recognition by the General Nursing Council of England .... (KNA/A.M.R., 1962:29).

By the end of 1958, the number of students at the Medical Training Centre was 349, divided between the various courses listed below:

- Kenya Registered Nurses - 24
- Medical Assistants - 153
- Assistant Radiographers - 5
- Darkroom Technicians - 6
- Dispensers - 27
- Laboratory Assistants - 25
- Assistant Physiotherapists - 2
The number of dressers training at King George VI Hospital was reduced. This was because of the decision to give instructions at Provincial and District centres in order to allow more girls to be admitted for training in Nairobi.

In April 1962, The Aga Khan Hospital Nairobi became a training school for Kenya Registered Nurses. In September of the same year, Mathari Mental Hospital Nairobi was granted provisional recognition as a training school for Assistant Mental Nurses (Ogoji, O.I., 5/4/89). In the same year again, Dr. J.H. Middermiss, Professor of radiology, at the University of Bristol, visited King George VI Hospital. Following his visit, it was proposed that training of radiologists would in future be undertaken at the hospital.

In anticipation of independence the training of Africans was intensified. Many Medical Assistants were sent to Europe to acquire the basics of administering an African-controlled health services. It was hoped that these people would replace the expatriates.

When Kenya attained independence, the curriculum structure and the administrative procedures followed by the colonial government, the problems of finance and imbalance in the distribution of health services were also inherited.
With time, the major problem of the discrepancy between the demand and supply persisted. To solve the problem, the Kenya Government, like the rest of the African countries, considered integrating traditional medical practitioners with western forms of health services to complement the provision of health services. This integration was realised with the establishment of the Kenya Traditional Medicine and Drug Research Institute in 1979.

6.7 Medical Research in the Period 1939-1963

During World War II, discussions on Medical research intensified. Various conference were held in Nairobi, Dar-es-salaam and Kampala to discuss the possibility of establishing a central board to organize and control researches in the three East African countries. It had become clearer and apparent that any significant improvement on the health conditions could only be attained if research was undertaken.

In 1942 for example, Patterson noted the urgency of undertaking research. He asserted vehemently that there had to be greatly increased facilities for research into many problems of medicine and health. This could only be achieved by collection and analysis of all statistics having a bearing on health and social problems such as consumption and production.

In 1945, Dr. N.M. MacLennan, Patterson’s successor, continued along the same lines. He noted that more research was needed on a wider range of social services like better housing,
better water supplies, more sanitation and more prevention strategies.

After a protracted consultation between the colonial officials in London and those in East Africa, a unanimous decision was reached to establish East Africa Bureau of Research in Medicine and Hygiene. This decision was effected in 1949 and Dr. K. Martin, a retiring Deputy Director of Medical Services in Kenya, assumed its directorship. The objectives of the bureau, together with the Medical Research Committee in London, was to carry out large scale medical and sanitary surveys in selected areas, follow them through by application of required measures, extend the application of measures to larger areas, maintain established conditions and review them from time to time.

The activities of the bureau were hastened by the Statistics Act of 1949 which put the activities statistics department on a broader scale and made it possible for the personnel to broaden its activities. In addition to its main office in Nairobi, it established branch offices in Entebbe and Dar-es-Salaam.

These two historical changes in the medical research history facilitated research into various health conditions in Kenya and Nairobi in particular. In the late 1950's for example, it was realised that tuberculosis, typhoid and poliomyelitis caused devastating havoc. Consequently in 1958, the government, in conjunction with the World Health Organization and the City

At the beginning of the campaign, it was viewed with grave suspicion by the African population. Rumours had gone around that X-rays would render people sterile and that the whole campaign was a scheme to control African influx to the city. Considerable efforts by the information service and the City Council dispelled these doubts after which people began to respond positively to the changes (KNA/A.M.R, M.O.H., 1958:2).

The World Health Organization and the United Nations Children Education Fund (U.N.I.C.E.F.) jointly opened a tuberculosis headquarter at Rhodes Avenue. Attached to it was the Chest Clinic which catered for varying chest problems. The success of the venture was a result of inter-national aid, hence Kenya's dependency on foreign aid to improve the health of her population instead of tapping the existing health resources. The opening of the Chest Clinic was a definite milestone in the history of public health in the City.

Development outside Kenya also facilitated the development of health researches in the City. The development of inoculation against poliomyelitis in America and the United Kingdom, indicated to the authorities in Kenya that it was already time a similar scheme was embarked on in Nairobi where the disease had caused formidable deaths.

Two other important research projects undertaken in the
Nairobi as a result of the establishment of the bureau in 50's, was the survey on the needs of children. The survey was carried out by the Child Welfare Society with a view to prevent and alleviate malnutrition which caused death among children. Earlier the Throughton Report had devoted a Special Section on Nutrition and recognized that grave malnutrition existed among African children. It recommended the creation of a Nutrition Board and a Nutrition Survey. It was against this background that the National Advisory Council was formed and the Nutritional Survey undertaken.

Other developments in research included the advancement in the collection and, interpretation of basic statistical, information on agriculture and labour enumeration. Surveys were conducted on patterns of income, expenditure and patterns of unskilled labour. The information was used to devise alternative ways of improving the health conditions.

In 1952, the East African Standing Advisory Committee for Medical Research was established. It met once a year to advise on policies for the Bureau and co-operation between the Medical Department in the field of research. Its name was later changed to the East African Medical Research Scientific Advisory Committee. In 1961, the East African Medical Research Council took over the administration of the Advisory Committee.

One may question the logic of the broader discussion on the history of Medical research in the three East African countries
while in essence the discussion ought to have embraced the developments in Nairobi alone. As pointed out elsewhere in this study, developments in Nairobi could not be studied in isolation from the general historical trends that characterized the development of health services in Kenya, for by so doing we would be reducing historical processes to single entities and we would be subjected to elimination of very important facts. What the historian does, therefore, is to extrapolate the facts from the general to explain the specific.

An analysis of the history of organized medical research in Nairobi reflects the general pattern of the development of health services. As early as 1902, the importance of research was recognized. However, no major attempt was made towards the organization of research until 1920.

In the Inter-war years, efforts were made towards research policy formulation. These efforts were however, slow because of indecisiveness, lack of direction and basically lack of enthusiasm on the part of the colonial government. Efforts in this direction were only made when a particular health problem threatened the life of Europeans and were bound to affect the labour output. In the post-World War II era organized medical research began to take shape.

6.8 Conclusion

The period under review was characterized by attempts to
reorganize, consolidate and expand the health facilities. Amid a myriad problems, the colonial government had to look for alternative ways of extending health services to the constantly rising population. Various solutions were forthcoming, for example, the institution of payment of fee for the health services rendered and insurance schemes for the Europeans and Asians. The period was also characterized by rapid expansion of the African Medical Training programmes and intensive research undertakings. In the last decade of colonial rule, the activities of the department that had been progressing steadily were disrupted by the activities of the Mau Mau movement. Thus, the changing political and socio-economic conditions had diverse effects the development of health services in Nairobi and in the colony at large.
6.9 Notes

1. See Kenya Colony and Protectorate, (1947) "A Committee to Consider the Possibility of Africans Financing Health Services." His Majesty's Stationery Office, London. A copy is found at the K.N.A.

2. For more details on the proposals of health insurance scheme for the Europeans, see the E.A.S., 5/7/1947 "Hospital Schemes for Europeans in the Protectorate."


CHAPTER 7

7.0 CONCLUSION

The present study endeavoured to trace the historical development of health services in Nairobi from 1899 to 1963. The data gathered revealed that the socio-economic and political forces that prevailed in Nairobi for the sixty-four years of its development shaped the pattern of growth, production and distribution of health services.

The study sought to investigate the origins of the qualitative and quantitative inadequacy of health services in Nairobi. Through the perusal of the dearth of historical documents at the Kenyan National Archives and the use of the historical tools of analysis, it is evident that the problem emanated from the changes that occurred in Kenya as a result of colonialism and introduction of western capitalist economy.

The problem further originated in the pre-1914 health policy which emphasized the maintenance of the health of the executive personnel to facilitate the administration of the colony and to ensure that diseases did not become a threat to the economic priorities of the government. Any form of health care extended to the Africans was unprecedented. Arguments advanced both within and outside the official circles were that, Africans were not part and parcel of the urban world. By virtue of their temporary residence in Nairobi, there was no need to provide for their social needs. Whereas the policy emphasized the care of the
minority, the disruption of the African traditional medical culture was also taking place through the missionary effort, and the institution of legal sanctions (i.e. the 1910 witchcraft ordinance which prohibited the African Medical practitioners from engaging in any form of Medical Care activity). The indigenous medical practitioners were pushed to the periphery. This was achieved by using various instruments of cultural alienation, such as education, religion and the legal system.

The changing pattern of life and attitudes in the countryside forced Africans to move to urban areas where they could sell their labour to subsist. Nairobi was attractive to many; however, jobs were scarce, but the number continued increasing (see appendix II) such that when the colonial government decided to extend health services to the Africans in the 1920's, the population had reached unmanageable level. It is arguable therefore that the under-utilization of the available health resources (i.e. the indigenous medical culture) and the changes that occurred in the countryside also contributed to the emergence of inadequate health facilities.

The colonial government was concerned mainly with the health of the labour force in order to sustain high productivity. But since Nairobi had a surplus labour force, which could be hired cheaply, there was little concern with the health of the general population. The conjecture that the introduction of western forms of health services
had a tremendous impact in terms of improving African health in Nairobi. The services were never adequately accessible to a large part of the population. Contrary to the view that introduction of western forms of health services improved the health of the population in Nairobi, Kucyznski (1949) has shown that the highest death rates in Nairobi occurred during the early colonial era.

It is significant to note that emphasis was put on certain aspects of health services within a given period. For example, before World War I, emphasis was on curative as opposed to preventive and promotive health services. In the period after World War I, emphasis was more on preventive and not curative medicine. Characteristic of the limitation was the emphasis put on protecting the men as opposed to mothers and children because the latter were deemed to be unimportant to the colonial economy. However, when the colonial government realised that the death rate among the male population was becoming high and therefore posed a threat to the number of the labour force, the mothers and children began to be protected as well.

The study has shown how the World War I had significant impact in the overall colonial health policy. The changes emanated from the war experiences, and above all, from the African demand for the provision of better social services. Apart from influencing the change in the colonial health policy, the war also led to changes in the disease patterns. This was as a result of the increased
movements to and from Nairobi. Thus, apart from its administration role, Nairobi also became the central focus of disease dissemination.

The inter-war years (1919-1938) witnessed the rise of the "Dispensary" System in Nairobi. This move was aimed at extending health services to the Africans while at the same time minimizing the costs from government revenue by engaging the African personnel. This partly influenced the beginning of training Africans in the medical cadre. For a long time, the colonial government searched for an appropriate medical curriculum for the Africans. What was eventually initiated was a curriculum that produced inferior African medical personnel, who apart from being underpaid, were grossly overworked.

Racial segregation was part of the development of health services. This was first emphasized by the Bransby Commission of 1906, then the Simpson Report of 1913 and later the Carter Commission of 1933. Apart from checking on the spread of diseases from the Africans locations to the European zones, it also enhanced the unequal distribution of health facilities.

The years after the Second World War saw the rise of the health centre system and various committees being set up to examine health facilities offered to the various races in Nairobi as a measure to correct the imbalance that characterized the dispensary system. The committees recommended the payment of a fee for health services offered either in
government hospitals or local government dispensaries.

Health Centres were initiated by the colonial government as an attempt to facilitate not only the curative health needs, but also to help in inculcating the preventive aspect of medicine among Africans. However in the later 1950's the health centres were faced with a myriad problems.

Progress in the Medical Department was further inhibited by the outbreak of Mau-Mau struggles which had far reaching repercussions on the provision of health services, training of the African medical personnel, sanitation and the spread of diseases.

The sanitation problem like many diseases that affected the population of Nairobi and particularly Asians and Africans, was as a result of many social and economic changes brought by the colonial government. The sanitation problems were closely linked to urban poverty which was a result of the colonial government's desire to exploit the Africans. Leys (1924) sums the cause of sanitary problems as not only a matter of engineering but also of economic nature. The penalty for its neglect was the rapid wastage of manpower desired by the economy.

The diseases that ravaged Nairobi emanated from the economic priorities of the colonial government. For example, plague was introduced to Nairobi through the cotton waste from Karachi and as early as 1901, plague had devastated the Africans and Indians, particularly those who
lived in the overcrowded bazaar. Other diseases included smallpox, syphilis, yaws and rinderpest (Sindinga, 1990).

The socio-economic changes facilitated the spread of diseases such as tuberculosis, smallpox and meningitis. The male-female demographic imbalance in the town enhanced the spread of venereal diseases. For a long time for example, men were not allowed to bring their legally married wives to towns. The result of this social pattern was competition for the few women who came from Kiambu, Limuru and Ruiru, to look for jobs as Ayahs in Nairobi. Dysentery was also rampant among Africans because of the inadequate provision of clean water. Africans relied on River Nairobi which was grossly contaminated. Malnutrition which was particularly common among Africans was attributed to massive land alienation in the countryside, emphasis on cash crop production, changes in the household labour patterns, the colonial government's interference with the ecology and above all low wages.

Training of Africans in the medical profession was slow to start. For instance, until 1914, the colonial government was reluctant to engage Africans in the medical profession. The reluctance arose from the colonial medical Professional desire to monopolize the medical service industry. The initiative to train Africans was a result of the ensuing demand by Africans for better social services. This in turn encompassed the extension of health facilities to the Africans who had been initially left out by the pre-1914
health policy. Therefore, from an analytical point of view, Africans training was to minimize the cost involved in extending health services to what was considered "unproductive" labour force. For a long time Africans were trained in very subordinate positions to push them at the periphery in the art and to subject them to exploitation.

The study also expresses the view that the economic structure of Nairobi during the colonial period, which was entirely based on racial class composition, manifested itself in the health sector, and that the different degrees of political and economic power, had an impact on the means of production, reproduction, the composition, value and function of the health sector during the colonial period.

The inadequacy of health services persisted throughout the colonial era due to the constant population growth rate (see appendix II) the underutilization of the existing African indigenous health practitioners, the desire of the colonial government to maximize profit, the emergence of different diseases and above all due to forces that determined the overall underdevelopment of other social, economic and political sectors. At independence the problems were inherited and continued to threaten the life of many people who lived in Nairobi. To minimize the problem the independent government has sought various alternatives. First, there has been the attempt to integrate western forms of health services with traditional medicine. This has been realised in the establishment of the Kenya Traditional Medicine and Drug Research Institute (KEMRI).
Drug Research Centre (KEMRI). Secondly, there has been emphasis on primary health care programmes. Lastly, the President Daniel Arap Moi has established Nyayo wards in various parts of the country. Despite all these efforts, the problem has persisted. If the problem has to be eradicated and an equilibrium established, it is recommended that an improvement in the socio-economic status of the majority of urban dwellers should be improved in order to minimize environmental health problems.
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(3.6.1911): "The Plague Remedy Removal of Indian Bazaar."

(4.9.1912): "The Plague case."

(2.11.1912): "Nairobi sanitation."

(3.4.1914): "Municipal committee. the Drainage System."


(14.4.1914): "Medical Profession."

(28.2.1914): "Municipal committee".

Kalemba, P., "A City in the Making". Daily Nation 29.1.90, Fact File No. 41
## ORAL INTERVIEWS

### LIST OF INFORMANTS

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<td>Achieng, R.</td>
<td>1914</td>
<td>20/12/1988</td>
<td>Joined the Medical Department in 1936 as a Laboratory Assistant.</td>
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<td>Aluoch, W.</td>
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<td>Recruited to the Medical Department in 1914 to work at Kings Riftes Hospital. He was also the first African to work in the European Hospital Nairobi.</td>
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<td>Akoko, W.O.</td>
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<td>Worked in the Medical department as a compounder (pharmacist).</td>
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<td>Antony, O.</td>
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<td>Sister Gualberta.</td>
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<td>A nursing sister at Precious Blood.</td>
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<td>Sister Lucigi.</td>
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<td>Sister Umberta.</td>
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<td>Wanga Paul</td>
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<td>20/2/1989</td>
<td>A Psychiatrist at Mathari Hospital.</td>
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APPENDIX I
Pictures and Illustrations

Appendix 1 a

(a) Old Hospital, Nairobi 1926.
(b) Its replacement 1946

Source: City Council of Nairobi (1953); Annual Report of the Medical Officer of Health, Government Printer, Nairobi, P.5.
Source: City Council of Nairobi (1950); Annual Report of the Medical Officer of Health. Government Printer, Nairobi, P. 30
APPENDIX 1 c

Source: City Council of Nairobi (1950); Annual Report of the Medical Officer of Health. Government Printer, Nairobi, P. 30
The New Bahati Clinic

Source: City Council of Nairobi (1953); Annual Report of the Medical Officer of Health, Government Printer, Nairobi, P.5
Source: City Council of Nairobi (1953); Annual Report of the Medical Officer of Health, Government Printer, Nairobi, P. 5.
APPENDIX 1 f

Source: City Council of Nairobi; (1952) Annual Report of the Medical Officer of Health, Government Printer, Nairobi
EASTLEIGH CLINIC OPENED JULY 11TH 1952

Source: City Council of Nairobi; (1952); Annual Report of the Medical Officer of Health, Government Printer, Nairobi, 1
APPENDIX 1

Source: City Council of Nairobi, (1950); Annual Report of the Medical Officer of Health. Government Printer, Nairobi, P.30
APPENDIX 1 k

SOME PLAGUE CONTROL MEASURE

(a) Bait laying on grassland.

(b) Catching rats by hand in a Warehouse

Source: City Council of Nairobi, (1953); Annual Report for the Medical Officer of health. Government Printer, Nairobi, P.8
(c) A nest of young Rats exposed during handcatching operation.
(d) Hand catching operation

Source: City Council of Nairobi (1953) Annual Report for the Medical Officer of health. Government Printer, Nairobi, P.8
APPENDIX I

MALARIA CONTROL MEASURES

THE TODD INSECTICIDAL FOG APPLICATOR

(a) Anti-Fly measures at the Municipal Tip

(b) Residual Spraying in African Housing

## APPENDIX 2

### NAIROBI: GROWTH OF POPULATION

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<tr>
<th>Year</th>
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APPENDIX 3
SAMPLE GUIDING QUESTIONS

3.1 QUESTIONS TO THOSE WHO WORKED IN THE MEDICAL DEPARTMENT

1. During your office tenure, which were the main health problems in Nairobi?

2. What was their cause(s)?

3. What curative, preventive or promotive measures were taken to ensure that the health problems cited above did not occur?

4. What was the impact of the public health legislation act issued between 1911 and 1915 here on the health conditions in Nairobi?

5. Which were the major changes in the hospital facility provision that occurred during the inter-war years (1918-1938)?

6. What were the effects of the post-war inflation on health services?

7. Which contribution did the Africans nationalitic movements make towards the provision of health facilities?
8. How did the declaration of the state of emergency during the Mau Mau unrest affect the provision of health services in Nairobi?

9. Which were the major health problems during and after World War II?

10. Who pioneered the introduction of the Western forms of medical services in Nairobi?

11. What were their aims in the provision of medical services?

12. What kind of medical services were offered, i.e., curative or preventive?

13. What was the colonial policy towards the provision of health services?

14. Which were the first hospitals to be built in Nairobi?

15. Who were the first medical doctors to be based in Nairobi?

16. How was sanitation at the time?
17. What was structural set up of the medical department in Nairobi?

18. Between 1903 and 1908 the medical services of Kenya and Uganda were unified; how did this affect the development of health services in Nairobi?

19. Which were the main health hazards that were a threat to the Europeans, Indians and African population living in Nairobi, i.e., between 1899 and 1914.

20. What were the methods used in controlling various diseases?

21. Which were the major changes in government policy towards the provision of health services? that is, between

1899 - 1914
1919 - 1920
1921 - 1938
1939 - 1946
1947 - 1951
1947 - 1951
1952 - 1963
22. Which were the major problems experienced by the medical Department in Nairobi? How did the problems vary?

23. How did the existing social structure among Africans affect the development of health services?

24. How did the prevailing political trends, changing concepts of welfare in modern society and new ideas on Education in tropical countries influences the development of medical services in Nairobi?

25. What direction was given to the medical services by the abrupt social transformation of an agrarian and tribal society into a technologically oriented contemporary structure?

26. Major Kean's training programme of 1919 in preparation for a native medical corps had a lot of impact of training on the medical personnel. How did this affect training of the medical personnel in Nairobi?

27. How did the co-operation between the Medical Department and other social agencies set up in 1955 spearhead the improvement of medical services in Nairobi?
28. How did the African's demands for better living conditions in 1920 affect the development of health services in Nairobi?

29. What was the impact of World War I:
   i) on the provision of medical services to the general population living in Nairobi?
   ii) to the carrier corps?
   iii) on the general health of the population in Nairobi?
   iv) on the disease patterns?

30. What were the major changes in terms of
   i) budgets?
   ii) personnel?
   iii) disease pattern?
   iv) and the general policy of the colonial government that occurred during World War I?

31. When did the child welfare clinics begin in Nairobi?

32. When did the training of African personnel begin?
   What kind of courses were offered?
   Where was the first training institutes established, etc.?
33. Upto to 1963, which were the main health clinics or dispensaries built by the colonial government. List them in chronological order and possibly indicate year of establishment.

34. Apart from the colonial government, which other bodies offered health services during the colonial era?

3.2 QUESTIONS TO THOSE WHO LIVED IN NAIROBI BETWEEN 1899-1963

1. When did you come to Nairobi? (Year)
2. Why did you come to Nairobi?
3. Where you engaged in paid employment? If yes, what kind of job did you do and how much were you paid? If no, what did you do?
4. In which part of town did you live?
5. How was the general cleanliness of the surroundings? If pathetic, what measures were taken by either you or the colonial government to improve on the prevailing conditions?
6. Did you bring your family to Nairobi?
7. What kind of diseases did you suffer from while in Nairobi?

8. Did you visit any hospital? If yes, which hospital? and if no, what measures did you resort to curb the diseases?

9. Did you go to any of the world wars? If yes, what kind of work did you do?

10. While at war, did you fall sick? Which were the new diseases that you encountered?

11. How was the diagnosis process and what explanations did the doctor give to be the cause(s) of the disease?

12. Were there any African doctors? If yes, were you allowed by the colonial masters to seek treatment from them?

13. Were you treated at the same place with the other races that lived in Nairobi?

14. According to your own assessment at that time, what was the attitude of the Africans towards hospitalised health services or the measures introduced by the colonial government to prevent the spread of diseases?
15. Was there any time that the colonial masters reduced your wages? If yes, did this affect you in terms of change of residence, or in buying certain dietary requirements?

16. What kind of diseases did you suffer from thereafter?

17. Were you in Nairobi when the Mau Mau war was in process? If yes, how did it affect your life in terms of residence, access to the health institutions and above all in terms of diseases that affected you?

18. Did you take part in Kenya's struggle for independence? If yes, among your grievances to the colonial government, was demand for better medical services included? What was the basis of the demand?

19. What was the relationship between crime and health and how did this relationship vary over the years?

20. For all the time you lived in Nairobi, and visited the hospitals/ dispensaries/health centres, were you required to pay some fee for any services offered? How much was the fee?
3:3 QUESTIONS TO TRAINING INSTITUTIONS
1. Name of the institution-----------------------------
2. Year when training of the medical or para-medical staff was started --------------------------
3. What factors led to the emergence of the institution?
4. What are the major socio-economic and political factors that have affected the institution's activities?
5. What levels of training does the institution offer and how has this varied over the years?
6. What major changes have occurred in the numbers enrolled in the institution since it started its activities?
7. What has been the role of Christian Churches in training?
8. What major courses are offered at each level cited above?
3:4 QUESTIONS TO MEDICAL RESEARCH INSTITUTIONS

1. Name of the institution.................................

2. Year when the institution started conducting medical research .....................................................

3. What factors lay behind the founding of the institution?

4. Which are the main areas of research specialization and what have been the findings of the institution on the areas of specialization outlined above? How have these findings varied over the years?

5. What socio-economic and political factors affected the institution's activity positively or negatively? What attempts have been made to overcome the problems outlined above?

6. How did World Wars I and II affect the activities of the institution?

7. How did the Mau Mau struggle affect the activities of the institution?
3.5 QUESTIONS TO VARIOUS AGENCIES OFFERING HEALTH SERVICES IN NAIROBI

1. a) What is the nature of the health service (tick)
   i. Governmental
   ii. Missionary
   iii. Herbal practitioner/Faith healer
   iv. Private or voluntary agency

   b) If it's hospitalised health service, indicate the name of the hospital
      .................................................................

   c) If African herbal practitioner, indicate name
      .................................................................

2. When did the institution or the agency begin offering health services? (Year) .........................

3. What factors motivated the emergence of the institution or the work?

4. What kind of health services has the institution been offering and how have they varied over time?

5. What are the main health problems the agency has been concerned with and how have these varied over the years?
6. If it's hospitalized health services, does the hospital rely purely on "Western" forms of medical services or there are attempts to integrate "Western" and "indigenous" medicine to cure certain diseases? If yes, give examples and if no, state the reasons why.

7. And if it's African herbal practitioner are there occasions when you have used Western medicine and indigenous medicine to cure certain disease? Cite examples.

8. Since the institution emerged, what are the main socio-economic and political problems experienced?

9. What attempts have been made to solve the problems listed above?

10. Does the institution offer any training of the medical staff? If yes, when did it begin and how far has the institution gone in training? If no, why and from where does the institution get its personnel?

11. According to the medical reports available, which have been the main health problems dealt with by the institution?
12. What gender mainly gets treatment from the agency?

13. How did the two World Wars (1st and 2nd) affect the services of the institution or agency?

14. How did the economic depression of 1935 in Kenya affect the agency?

15. At independence, what major changes occurred in terms of the nature of the diseases treated, hospital attendance, and even training of manpower?

16. So far, in assessing the contribution of the agency in offering health-services, is it progressing or deteriorating in its services?

17. How did the 1980's inflation affect the agency's services?

18. What major steps were taken to solve the problems?

19. What are the reasons behind the government's efforts towards integrating "western" and "indigenous" medicine?

20. So far, in what areas have "we" (government) plus the agencies concerned succeeded?
21. Are there problems experienced in incorporating the two? If there are, give examples.

22. What do you think should be done?

23. In assessing the current trend of health services, is it going to be possible to attain health for all by the year 2000 as it is hoped? If yes, give reasons why and if no, also give reasons why.

24. What do you think should be done to meet the goal?

APPENDIX 4

GLOSSARY

Health Services

- Health Services is rather a vague concept - it covers three rather different sorts of activity.

(a) Personal Medical Services. (These are often termed "Curative Services").
(b) Preventive Medical Services - those which are aimed at promoting health (as opposed to treating illness) through measures having a direct impact on individuals, e.g. mass vaccinations, attempts to improve family nutrition etc.

(c) Environmental health service - health promoting measures are aimed at the environmental rather than individuals, e.g. sanitation, food inspection, malaria spraying etc.

Dispensary

These ones for practical purpose serve as health centres except that they do not have maternity wings and therefore normal formalities cannot be conducted in them.

Health Centre

The health centre is the backbone of health services in Kenya - They were designed to serve the following basic health services:-

(i) Maternal and child health communicable disease control, environmental sanitation, maintenance of records for statistical purposes, health education of the public health nursing.