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1. Introduction: looking beyond the state

Anna Greenwood

There is no fresh news in stating that the history of colonial medicine has changed considerably in the last seventy-five years. As academic interests have expanded, attention has moved away from triumphalist accounts of the conquest of disease in former European colonies to a more critical, less ethno-centric and more socially inclusive examination of the complex relationships between colonial states and colonised societies. Yet despite much self-congratulation at achieving a comparatively nuanced understanding of these relationships, glaring gaps remain and there is work still to be done. Although certain colonial institutions and policies have been revisited and reassessed by historians in recent times, others still await the benefits of renewed academic consideration. It is the central rationale of this book that the Colonial Medical Service is one of these institutions, and that the time has come for its history to benefit from new eyes and new perspectives.

When my book, *Practising Colonial Medicine*, on the East African Colonial Medical Service was published in 2007, I was sure that I had captured something of the ethos and experience of the cohort of 424 British government doctors that served in Kenya, Uganda and Tanzania between 1890 and 1939.¹ It soon became apparent, however, that my researches had uncovered only a small slice, barely a sliver, of a much more complicated story. To start with, it quickly became clear that the Colonial Medical Service in Africa was far from the all-white institution that I had portrayed.² Additionally, it was not merely the obedient handmaiden of the British government, but sometimes functioned within its peripheral African locations independently of British command. When colonial officers or governors sought guidance, they were as

likely to do so by consulting the precedents established in other colonial possessions—within and without the African continent—as they were to appeal to the politicians and bureaucrats residing in their mother country. Furthermore, the financially stretched Colonial Medical Service in Africa rarely acted entirely autonomously; in fact, resources and expertise with other locally functioning health agencies were often formally or informally pooled. For sure, there was not always accord and agreement between different groups working under different masters, but facilities and resources were scarce and pragmatism often overcame institutional separatism.

As I scratched beneath the surface all sorts of preconceptions fell away. This was a state institution with centralised policies, and with a certain public face to maintain, but nevertheless its members did not speak with one voice, were not of one colour and were not uniformly obedient. Moreover, Colonial Medical Officers often worked closely with groups whose objectives might be conceived as being in competition with the British government. By talking about officers' shared experiences, backgrounds and attitudes in my 2007 monograph I risked falling into the trap of perpetuating exactly the image of unity that the British colonial state would have had the external world believe, rather than exposing the much more complex, and certainly less coherent, reality.

The present volume should be regarded not as an end point but as a starting point from which to think outside the boxes of state and non-state actors. It offers an academic springboard from which to move away from the compartmentalisations to which colonial historical debate is prone: black and white, elites and non-elites, heroes and villains, each operating in neatly delineated secular or religious fields. It instead makes some tentative steps to describing just one small aspect of the untidy

reality of Empire. The history of an institution such as the Colonial Medical Service, which seems outwardly to represent the pinnacle of an elite government agency, in fact reveals pervasive and persuasive stereotypes (which undoubtedly also represent some aspects of the reality) that are uncomfortably difficult to sustain.

As well as deconstructing the idea of a unified and unidirectional Colonial Service, grouping these eight essays together in one collection also answers recent demands for more comparative studies in the history of medicine, as opposed to the ‘single-site’ case studies that have hitherto dominated the discipline. Although concentrating only upon British territories in Africa (obviously the Colonial Service operated only in British possessions), the volume presents cases from several disparate territories covering Kenya, Malawi, Nigeria, Tanzania, Uganda, and Zanzibar. The final work that has emerged concentrates mostly upon the East African region because of the expertise of the scholars who were available to contribute. This should by no means compromise the revisionist intentions of this volume, which are applicable to all regions of Africa in which the Colonial Medical Service operated. Indeed, I hope that these local studies will spur specialists in other territories to probe deeper into the bureaucratic fictions woven around the British Colonial Services.

The project has synchronic and diachronic objectives, examining tensions *within* the Colonial Medical Service (as demonstrated by my chapter with Harshad Topiwala on Kenya), as well as the relationships forged *externally* with other agencies, for example with local missionary groups (the chapters by Yolana Pringle, Markku Hokkanen and Michael Jennings), private firms (Matthew Heaton), or other (non-medical) research agencies (Shane Doyle). An example is also given of when it was deemed unacceptable to work with a competing local medical charity, as is the case in the chapter I have written on relations between the Colonial Medical Service

and the Indian and Arab dominated Zanzibar Maternity Association. While each case study stands alone in displaying some of the multifaceted dynamics of Colonial Medical Service relationships, it is the intention of this volume to offer these diverse narratives of negotiation as a basis through which to work towards a comparative understanding of the Service's overall reality.

This is not a book applauding the old colonial elites. The Colonial Medical Service has generally been perceived historically as an exclusive and privileged institution, but the greater aim of the book is to expose the intricacies within this enduring stereotype rather than to celebrate it. It is clear that in today's historiographical climate it is more fashionable to speak about those who were ruled than their imperial rulers.³ Yet both sides of the story are needed if we are to arrive at a truly balanced and considered metanarrative. Besides which, as this book amply illustrates, the Colonial Medical Service, once placed under the historical microscope, was far from being as distinct, cohesive, or even as elite, as has generally been assumed.⁴ To this end, the over-arching aim of this volume is to emphasise both the Colonial Medical Service's internal diversity and its far-reaching external connections. It raises a number of pertinent questions for further debate: to what extent did colonial doctors collaborate with other non-state orientated organisations? How were both clinical and research agendas mapped and managed? To what extent did informal networks sustain the colonial medical project? What do examples of non-cooperation say about the priorities of the Colonial Medical Service specifically and the colonial state more generally?

The Colonial Service

Belying the uncertain, fluid and complex reality of the British Colonial Services that this collection exposes, the conventional bureaucratic description of the ‘mother’ organisation of all the Services, The Colonial Service, is quite straightforward to describe. The Colonial Service was the personnel section of the Colonial Office, which was the government department in Whitehall, London responsible for administering the British Empire.⁵

The Colonial Service can therefore be rather simply categorised as the ‘people’ side of the organisational bureaucracy, overseeing recruitment of staff for Empire, their terms and conditions of service and acting as the main negotiator for transfers between the colonies themselves. The Colonial Service had been in existence since 1838, but it was really first shaken up and reorganised under the tenure of Joseph Chamberlain (1836–1914), who acted as Secretary of State to the Colonies between 1895 and 1903.⁶ As part of Chamberlain’s vision of ‘Constructive Imperialism’, he prioritised the rationalisation and streamlining of the colonial bureaucracy in Whitehall, which naturally included scrutinising the internal workings of the Colonial Service. Accordingly, Lord Selborne, the then parliamentary Under-Secretary of State was instructed to produce a report detailing the state of the administration. Selborne reported back in 1899 that he found the Colonial Service to be highly deficient and disorganised: not only were their glaring organisational problems inherent to the way business was arranged centrally, but large discrepancies existed between individual colonies in terms of how work was managed, particularly the disparate terms and conditions of employment that were offered.⁷

Progressively, if slowly, the Colonial Service became more centralised. Reforms peaked in the 1930s with the recommendations provided through the findings of the Warren Fisher Committee, and the Colonial Service was formally

organised into vocational branches.⁸ The Colonial Administrative Service was one of the first to be unified in 1932, followed in 1934 by the Colonial Medical Service. By 1949 there were twenty branches of the Colonial Service representing, among other areas, education, law, nursing, policing, research and forestry. Although this marked the point of formal rationalisation, archives and source materials reveal that in official and public understandings there had been regionally based Colonial Medical Services since the second half of the nineteenth century. In fact, certain geographically contiguous African medical services had already been unified by the time of the centralised recommendations. The West African Medical Staff (WAMS) brought together the medical services of Nigeria, Gold Coast, Sierra Leone and Gambia in 1902 and the East African Medical Service (EAMS) formally united the services of Kenya, Uganda and Tanzania in 1921.⁹ The Warren Fisher reforms therefore should be seen as an ultimate action in bringing together regional services each under a single unified vocational umbrella organisation in London that regularised pay scales and terms and conditions of employment.¹⁰

Although these reforms centralised things from the perspective of Whitehall, the workaday reality was still very much as it had been when Chamberlain came into office in 1895. Communication difficulties and financial restraints (once staff were *in situ* each service was meant to be locally financially self-supporting) exacerbated the gulf between the lofty ideals put forward within the corridors of Whitehall and the practical restraints of those working in the African continent. The net result was that practice on the ground continued to play itself out mostly responsively to local demands throughout the colonial period and most colonial officers operated independently of this myth of bureaucratic centralisation. This is not to say that changes did not occur in the way the colonies were managed in the period between

1880 and 1960. There were certainly instances in which the interventionist hand of central government was very much felt, but this claim is rather an acknowledgement of the relative fluidity and autonomy of space in which, for better or for worse, local colonial governments necessarily operated. Indeed, it was precisely this local freedom that allowed many of the interactions with non-government actors that are described in the pages that follow.

The Colonial Medical Service

In terms of neatly organised institutional narratives, the Colonial Medical Service was the branch of the administration responsible for the health of colonial staff and local populations in each British colony. It was the second biggest personnel branch of the British Empire, with Colonial Medical Service employees making up nearly a third of all Colonial Service staff.¹¹ It was Joseph Chamberlain once again who oversaw the first major changes to the Colonial Medical Service, and notably, one of his first tasks upon becoming Secretary of State for the Colonies was to appoint Patrick Manson (1844–1922)—then regarded as the most eminent tropical medical specialist of the day—to a newly-created position of Consulting Physician to the Colonial Office.¹² This showed the priority assigned to the medical services of Empire. Chamberlain realised that without the tool of medicine, conquest and the maintenance of British supremacy would not be tenable long term, especially in the relatively unknown and climatically hostile environments that Africa presented. In order to address directly an evident need to assure the viability and sustainability of the colonial project by sending qualified doctors out to Empire, Chamberlain and Manson oversaw the founding of the London School of Tropical Medicine; the school opened at the Royal Albert Dock in the East End of London in 1899 as a training facility for new recruits

to the Colonial Service. To strengthen this initiative, they also led an active campaign to promote tropical medical education (and by implication colonial careers) for aspiring medical graduates.¹³

Perhaps surprisingly, medical recruitment was always something of an uphill battle, especially when compared to the large competitive demand for the general civil service jobs of Empire. The Indian Civil Service, which required candidates to pass a competitive examination before being offered a position, was regarded as particularly esteemed and could command the very brightest and best young graduates. The reputation of the Colonial Medical Services of Empire was somewhat different. A hierarchy of prestige can nevertheless be discerned, with the Sudan Medical Service generally thought to represent the most prestigious posting. Not only did this service seem to offer the best terms and conditions of employment, but it held elite associations with its famously exclusive sister service, the Sudan Political Service.¹⁴ The Indian Medical Service, though not a particularly popular destination for medical graduates, especially before 1914, nevertheless held a position in the hierarchy that made it more popular than all the African medical services, except Sudan.¹⁵ Of the African services the WAMS offered a pay supplement to compensate officers for living in the challenging climates of Gold Coast, Nigeria, Sierra Leone or Gambia, where malaria and yellow fever presented a constant threat to life; WAMS was upheld as being something of a model of organisational efficiency. The EAMS, which looked after Kenya, Uganda and, post-1919, Tanganyika (present day Tanzania) was very much lower down the pecking order in terms of prestige, although still preferable to that of the very small medical services of Nyasaland and Northern and Southern Rhodesia.

Of most marked interest for the thematic emphasis of this collection, the story of recruitment to the Colonial Medical Service is revealing of the large gulfs that existed between the face that the British Empire presented to the Western world and the much more diverse reality of the situation in the colonial localities. Readers of some of the first histories of the Colonial Medical Service in Africa could be forgiven for assuming that all of the medical personnel were of European origin, as most of the histories produced in the decade or so after decolonisation focus only upon white experiences. In fact this was far from true. A great diversity of individuals made up the staff of the Colonial Medical Service and most rural Africans would have had no contact with the European Medical Officer, but would have been seen at a dispensary by a member of the large cohort of African staff who worked in subordinate medical roles throughout Empire. But even among the elite class of qualified doctors the situation was far from uniform. As Ryan Johnson has shown, until the turn of the twentieth century, black doctors also served within the WAMS, in one case (Gold Coast Colony) even rising to rank of Chief Medical Officer.¹⁶ Similarly, as Harshad Topiwala and I point out in our chapter within this book, the fact that there were nearly twice as many qualified Indian doctors working for the EAMS as there were white doctors has been perplexingly forgotten in historical accounts.

The selective retelling of the history of the Colonial Medical Service to the exclusion of non-white faces reflects the preoccupations of the time in which many of these early Medical Service histories were written. This was a time before the rise of Social History and the critical changes within colonial historiography brought about by the analytical reorientations of the Subaltern Studies School.¹⁷ Moreover, this was precisely the story that the Colonial Office told to itself and to its public. All recruitment to the African services in London was white recruitment and the other

doctors and medical personnel that were recruited for jobs were appointed locally, somewhat quietly, away from the official centralised record keeping. The Colonial Service was very strict in its policy of employing only doctors of European parentage to work in Africa; it would not have done to publicise that in the colonies themselves, doctors were also regularly recruited from Goa or Bombay by local agents.¹⁸

From the London perspective the Colonial Medical Service was not a particularly desirable career. Initially, this was heavily to do with the way the ponderous machinery of the Colonial Office worked. Up until the First World War (and tacitly afterwards) most appointments were gained through the 'right' social networks. For doctors, many of whom came from solidly middle-class backgrounds, this was a formidable initial hurdle. It was recognised early on, however, by the first Director of Recruitment between 1910 and 1948, Ralph Furse (1887–1973) that a more meritocratic system needed to be introduced. Officially at least, Colonial Service recruitment became decided through introducing the regularised process of asking interested candidates to submit an official application form and then, if deemed suitable, to attend an interview.

Despite this reorientation the system remained a highly subjective and not entirely transparent process with individual applicants being turned down for their colour, their lack of sporting prowess or apparent signs of mental weakness.¹⁹ Furse, for all his public commitment to stamping out nepotism and regularising application procedures, was a conservative through and through and had firm ideas about the sort of person that it was desirable to recruit. Doctors from all echelons of society could apply, but the archetypal qualities perceived as being associated with the British public school system were routinely put forward as the most desirable skillset for the job.²⁰ Suitable recruits were to be athletic, young, adventurous, resilient, independent

and patriotic. Furse himself admitted that 'public school training is of more importance than university training in producing the personality and character capable of handling the natives well.'²¹ A certain type was chosen for colonial appointments and that meant not necessarily recruiting the cream of the medical schools:

I do not think that we need to attract the very best men.

Such men are more useful at home. In the colonies we want a good all-round general practitioner with a good physique and a sporting temperament. Higher attainments are not required, and an unfit man for appointment in so far as there is probably no less satisfactory officer than a man who is too good for his job.²²

This lack of emphasis upon academic standards was made all the more obvious through the absence of an entrance exam to gain access to the African branches of the Colonial Medical Service.

The unattractiveness of a colonial career for most British medical graduates was compounded by the widespread perception that the pay was not competitive. Pay scales remained surprising static throughout the colonial period. For example, in East Africa a new Medical Officer could expect to be appointed on a basic salary of £400 per annum, a figure that eventually rose after much campaigning by the British Medical Association to £600 in 1939.²³ In terms of take-home salary, then, officers could easily make much more back home in private or local government practice.²⁴ Conditions in the colonies were known to be harsh, with meagre facilities, and the chance of integrating wives and families limited. Add to this the ever-present

possibility of serious disease (or even death) and it is hardly surprising that the Colonial Medical Service was never an especially popular career choice and faced intermittent recruitment problems throughout its existence.

On the other hand the career could, for the right sort of person at least, be an attractive and rewarding one. Life was not for the faint hearted, but even within this difficult environment there were some palpable advantages to be had. Pay was low, but so was the cost of living. Medical Officers could command a large amount of professional independence, often looking after entire regions and thereby enjoying a local status that they could not have hoped to achieve back home.²⁵ Communications were slow and while this might be a cause for frustration, it meant that individuals could operate independently of the watchful eye of the Colonial Office and come up with their own innovative schemes and models of collaboration. Medical officers had to work with Asians and Africans in innovative ways that would not have been possible at home—an exposure that arguably influenced as many individuals to become socially and culturally open as it reinforced in others a deeper commitment to the dominant racist attitudes. While fully recognising the many racist assumptions that ran throughout government policies, it must nevertheless be acknowledged that the officers of Empire were an eclectic bunch, many of whom devoted much time to learning local African languages and invested huge amounts of personal and professional effort into improving clinical care and levels of public health. Furthermore, individuals with an active interest in tropical medicine could not conceive of being in a better place in which to experience first-hand exciting aspects of medical practice that would have been impossible back in the UK. Suitably motivated individuals could, and sometimes did, contribute to making important advances in the emergent field of tropical medicine.

A picture emerges of a colonial bureaucracy that, although not popular, was clearly keen to present an organised and unified face to the British public. One of its central problems was, however, that it was largely impotent to control the day-to-day character of life in the colonial outposts. However smooth and centralised the organisation seemed to be in London, the logistical difficulties of ruling somewhere as infrastructurally undeveloped as Africa were hard to overcome. Memos and edicts took days, or even weeks, to arrive and the daily demands of running busy dispensaries alongside the immediate practicalities of controlling epidemic and endemic diseases were so urgent that even when instructions did arrive, they were often out of date and impossible to implement. In practice the head of each territory's medical department (a role variously called Principal Medical Officer, Director of Medical Services or Director of Medical and Sanitary Services) ran his department as best he could in accord with the exigencies of the immediate situation. While this could create a sense of regional fiefdoms with different priorities and little coordinated practice, it also allowed individual medical services to have relatively free reign as to how they conducted their business. Even if an order came through from Whitehall, there was considerable leeway for freedom of interpretation in the field.

This book will highlight the various and colourful ways this organisational self-determination was played out within different British African colonies. In so doing it destabilises the notion of London as the stable heart of the colonial administration. The chapters in this book reveal numerous cases of adaptive working, especially in terms of the way the Colonial Medical Service could be seen to collaborate with groups deemed to be operating beyond the formal boundaries of the state. The time for such a study is ripe, as there has been no study bringing together

the varied experiences of the different regionally based Colonial Medical Services in British Africa, and only a handful of specific regional studies.²⁶ Tellingly, these studies were mostly written shortly after decolonisation and are characterised by the celebratory tones in which they describe the introduction and dissemination of western medicine as one of the highpoints of the British colonial encounter. Only a few recent works offer more balanced perspectives.²⁷

One of the key insights provided by the chapters in this book is that, in practice, the Colonial Medical Services were extremely adaptive —Janus-faced even—looking simultaneously towards the very different requirements of London and Africa.

Colonial Service histories, of course, make up only a very small part of the rich historiography of colonial Africa. This terrain is well known, but the present volume fits extremely well within this wider historical perspective by providing an additional dimension to the ever-expanding scope of colonial historical enquiry that has emerged since the 1980s, deconstructing the old grand narratives of progress in favour of more critically engaged assessments of the social and political encounters of British imperialism.²⁸

By common consent Daniel Headrick started the ball rolling in 1981 with a book that famously shifted interests away from hagiographic accounts of hero doctors dispensing philanthropy, instead critically describing colonial medicine as a political and social ‘tool’ ultimately used as an aid to imperial domination.²⁹ This opened the sluice gates of academic reappraisal of the topic, with other highly critical accounts following, including some which have now become extremely well known in the field

such as the works of Sanjoy Bhattacharya, John Farley, Mark Harrison, Maryinez Lyons, Randall Packard and Megan Vaughan among others.³⁰

This profound change in ways of evaluating the colonial medical encounter went alongside a renewed interest in trying to locate the voices of the colonised peoples. Immediate source material was scarce, but it was possible to map the way in which united actions of resistance and even, sometimes, outright rebellion, very much mediated the way colonial medical policies were enacted.³¹ Such studies set the scene for a closer analysis of sectors of society that had traditionally been neglected by historians.³² In the context of colonial Africa, this meant studying the roles of native intermediaries, subordinates and clerks who had long existed in the shadows of history and were not thought significant enough to warrant attention in their own right.³³

Increasingly colonial medicine was no longer academically discussed solely in terms of an elite western practice foisted willingly or unwillingly on indigenous peoples. Medicine began to be seen something that was frequently adapted and appropriated by local people who were often seen to pragmatically amalgamate new cultural traditions with their old ones and embrace pluralism.³⁴ Other studies stressed the multiple international links within the colonial encounter.³⁵ Particularly, the usefulness of undertaking broader comparative histories began to be more regularly explored. Examination of the interconnectivities of the different British territories replaced the narrow focus on separate territories of Empire, which was newly recognised as a series of highly complicated networks, with people, ideas and practices all regularly exchanged between its different parts.³⁶

These fresh insights had the effect of moving scholars away from studying official government medicine when describing the colonial medical encounter. Missionary medicine came under detailed historical analysis;³⁷ the link between

colonial notions of development and the subsequent channels through which modern international health services operated started to be investigated.³⁸ Success stories that had been unambiguously applauded for decades were reassessed, such as Sanjoy Bhattacharya's recent reassessment of the WHO smallpox eradication campaign.³⁹ The scene had been set for exciting new areas of enquiry, a number of which form the basis of this present book.

The individual chapters that follow add considerably to our understanding of the multiple, sometimes contradictory ways, medicine was enacted in the colonial localities. Yolana Pringle deals first with relations between government and missionary medical services covering some of the active collaborations that existed between the Church Missionary Society and the Uganda Colonial Medical Service before 1940. Working with the missions was a pragmatic means of filling a gap in state provision, while serving the purposes of the missionaries themselves, as it provided an opportunity to extend their evangelising messages and for individuals to extend their professional range and boost their personal incomes. By taking a broadly chronological approach, and using Mengo Hospital as a case study, Pringle maps the way that relations between the state and missionary medical services subtly changed and evolved. She identifies a shift from short-termist and *ad hoc* responses to slightly more formalised, strategic relationships (particularly with regards to the payment for the services of missionary personnel) but ultimately argues for the persistence of an enduring, if fluid, relationship between state and non-state medical provision. Furthermore, although the contributions of the missions shaped the character of colonial state medicine in Uganda, in practice, Pringle notes, patients would have

been unaware of any formal delineation between state and non-state medical provision.

Leading on from this discussion, Markku Hokkanen, moves the focus of attention to Nyasaland (Malawi) and the relations that existed there between medical service employees and local missions. In contrast to Pringle's story about Uganda, Hokkanen depicts the Malawian context as containing examples of conflict between the missions and the government medical service, as well as those of cooperation. Although numerous examples can be found of the way that the two groups shared materials, equipment, personnel and services, Hokkanen argues that they were deeply divided in their attitudinal stances towards their respective organisations. However, although tensions, professional rivalries and conflicts were regularly expressed, in general it was felt better for these to be kept muted.

It is this desire to present a harmonious and united front that also forms the central point of the chapter by Harshad Topiwala and myself. Here, we take a fresh look at the Colonial Medical Service of Kenya and show that, contrary to popular conceptions of this service, there were almost twice as many Indian doctors working for the Colonial Medical Service as Europeans before 1923. To be sure, these doctors were not appointed, nor paid, at the same rank as Medical Officers, and were rather designated Assistant or Sub-Assistant Surgeons, but nevertheless they would have regarded themselves as fully qualified doctors (having attended medical schools in India) and performed clinical and administrative duties largely identical to their European counterparts. The chapter explores not only why historians of colonial medicine have previously missed this fact, but also why this state of affairs suddenly stopped in the early 1920s. It is, Topiwala and I conclude, necessarily a complex series of reasons, ones that all nevertheless point towards a strong urge within the

Colonial Office to present an image of unity and strength. When the Colonial Service was to be opened up, it was felt more in line with ideas of trusteeship to give Africans precedence. Indians somehow fell between the cracks of British government policy—they were neither deemed a suitable official face for the imperial services of Kenya, nor were they regarded as the needy recipients of more official attention, as black Africans became from the mid-1920s.

The next chapter continues this theme of saving colonial faces by providing the book's one case study of non-cooperation. Here I take the example of the Zanzibar Maternity Association (ZMA), which was a local philanthropic organisation for the care of expectant mothers, started in 1918 and largely funded from charitable donations from Arab and Indian coffers. Actually the ZMA had originally been a British idea, and filled a conspicuous gap in the healthcare provision for women and children that the local Zanzibari Colonial Medical Service could not provide (they had no female medical officer), but the case study shows that the British were quick to distance themselves from the ZMA—even actively disparaging it—when their proposition to run it as an adjunct part of the colonial medical department was rejected by the local funders. This seems to be an example of the British rejecting cooperation when it was not precisely on the terms that they wanted. By revealing the limits to cooperation in this way, I expose some of the dominating preoccupations of the British Empire in the region: namely the desire to be seen to be fully in control.

Matthew Heaton's next chapter moves the scene to the interaction between the Colonial Medical Service in Nigeria and the private shipping company, Elder Dempster, providing a rare example of the way the colonial authorities cooperated with private business as a means of repatriating back to colonial Nigeria persons deemed to be lunatics. Although the Colonial Office in London undertook much of

the organisation of these repatriations, the local colonial medical departments had to confirm or deny each individual's homecoming. Furthermore, they created the preconditions for a patient's return by ensuring the mental health infrastructure was in place for their care. This highlights the intricate tripartite negotiations that had to occur, both within and beyond the state, to facilitate the repatriation of those regarded as being insane. This three-way dialogue simultaneously reinforced fundamentally racist ideas of the periphery of Empire (i.e. the colonies) as the desired dumping ground for unfit African immigrants, rather than looking after them in European mental health institutions.

Shane Doyle, adds another subtle strand to the analysis by arguing for the influence of non-medical research as a core determinant in the shaping of Colonial Medical Service policies and practice. Some of this research came from colonial departments outside the Colonial Medical Service while others came from research organisations affiliated to, but not run by, the British state (such as the East African Institute for Social Research). Furthermore, to justify certain stances and interventions, Doyle shows how the medical department of Tanzania regularly sought a broad variety of academic opinions, particularly from expert anthropologists, psychologists and ethnographers, to underpin its decisions and practices. By looking at the cases of the campaigns against sexually transmitted diseases in Buhaya, Tanzania and malnutrition in Buganda, Uganda, Doyle is able to show how the Tanzanian and Ugandan Colonial Medical Departments regularly looked outside their own immediate remit to bolster and secure their own socio-medical interventions.

Finally, in the last chapter we return to the relationship between the government medical service and the missions, this time with a specific eye to analysing the passage to post-colonial ideas of development. Mike Jennings uses

Tanzania as his case study and rounds off the volume by making the valuable and original point that colonial medicine was a progressively formalised joint endeavour between state and missionary healthcare providers. This, he points out, directly impacted the subsequent development of the post-colonial voluntary sector in Tanzania after independence. Jennings looks particularly at the role of the Tanganyika Mission Council (est. 1934) and the Medical Missionary Committee (est. 1936) as formal representative bodies of the mission sector in Tanzania, arguing that their establishment created the preconditions to make them a formal part of the Tanzanian health sector. In an academic climate that always seems hungry to measure the ‘impact’ of studying history on the understanding of modern issues, Jennings’ final conclusions are especially welcome. He persuasively argues that the modern ‘encroachment of NGOs into the public space from the 1980s was, then, not something new, but a recasting of older forms of the delivery of public goods’. Missions should be seen, according to Jennings, as the originators of the voluntary sector and should be, along with state actors, part of our new histories of welfare and development.

The reach of the Colonial Medical Service went far beyond the state, with a significant number of members of the service collaborating, formally and informally, with a range of non-governmental groups, such as missionaries or those with commercial ties to Africa. Of course there were local differences, differences that sometimes existed within a single territory. Relations within the same government department with distinctive groups of non-state actors were likely to be differently adaptive to the particular circumstances of each engagement. For each example this book shows of government Medical Officers working with non-government ones, a

contrary example can no doubt be found elsewhere which does not convey such an easy harmony. It is not our intention to push an idealised image of a misunderstood Colonial Medical Service always keen to work with everyone and with the health of the indigenous people as its only philanthropic intent. Far from it. Indeed, it is vital to grasp how cases of collaboration were nearly always ultimately coloured by colonial self-interest. At the end of the day the Colonial Medical Service had to uphold government values, and when dissenters raised their voices too loudly they were likely to be kicked out.⁴⁰ Similarly, irrespective of the fact that black and brown people also worked diligently within the medical department's framework, they were only exceptionally allowed to hold full ranking Medical Officer positions, even if their experience and medical qualifications were identical to, or even superior to, those held by their European colleagues. Yet, for all of its internal diversity, a strong sense of professional unity predominantly—if tenaciously—bound government officers together under the umbrella of their work for the British government. Yet while cautioning against over egging the pudding of a happy-go-lucky image of the comparatively free nature of colonial life, the myth of unity that I wrote about in 2007 was clearly too simplistic.

It might be useful to think of the Colonial Medical Service as one of the victims of the tyranny of the discipline of history itself. Certain parts of its history, because they were not palatable at the time, were simply not regularly spoken about at and were recorded only indirectly (if at all) in the archive. National pressures—above all the importance of Empire building, and later justifying it—subtly came to influence the way history has been written. Just as controversies were not good for the public face of Empire, neither were examples of collaboration. They somehow diluted the might of the imperial workforce and perhaps suggested that it was not as self-

sufficient and dominant as the British government would have liked to present it as being.

Slowly we are getting to the heart of these understated, but nevertheless quite powerful, public relations exercises of the British colonial government. Recent scandals, such as the discovery of the thousands of hidden Colonial Office and Foreign Office files should make us sit up and pay attention to the fact that colonial historians have only ever been fed a rather partial diet of historical facts.⁴¹ The UK state archives are mostly open and accessible, but there are clearly still many things that historians do not know about, precisely because the Colonial Office and subsequent governments did not want us to know about them.⁴² We are not exposing any great scandals within the pages that follow, but even gentle reassessments help us to reorientate our former understandings of past historical events. They remind us once again, that history is always on the move. We will never to capture the full story, but each baby step brings us a little closer to understanding it a little better.

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⁴ Indeed the social background and academic qualifications of many Colonial Medical Service employees were often modest compared to those of their contemporaries in

the Colonial Administrative Service. See Crozier, *Practising Colonial Medicine*, p.106

⁵ The Foreign Office managed the African colonies until the early 1900s, at which point most African territories (except Sudan and Egypt) moved under the Colonial Office. The India Office managed the area now covered by the modern territories of India, Pakistan, Myanmar and Bangladesh.

⁶ For a full history see: Cosmo Parkinson, *The Colonial Office from Within, 1909-1945*, London, Faber and Faber Ltd., 1947; Charles Jeffries, *Partners for Progress: The Men and Women of the Colonial Service*, London, 1949; Anthony Kirk-Greene, *On Crown Service: A History of HM Colonial and Overseas Civil Services, 1837-1997*, London, I.B. Tauris, 1999; John Smith (ed.), *Administering Empire: The British Colonial Service in Retrospect*, University of London Press, 1999; Anthony Kirk-Greene, *Britain's Imperial Administrators, 1858-1966*, London, Macmillan, 2000

⁷ Kirk-Greene, *On Crown Service*, p.11

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¹⁰ Anthony Kirk-Greene, *A Biographical Dictionary of the British Colonial Service, 1939-1966*, London, H. Zell, 1991, pp.v-vi

¹¹ Kirk-Greene, *On Crown Service*, p.16

¹² Although the position was not formally ratified as being Chief Medical Advisor to the Colonial Office until 1926, Manson held the position *de facto* from 1897.

¹³ H.J.O.D. Burke-Gaffney, 'The History of Medicine in the African Countries', *Medical History*, 12, 1968, pp.31-41, pp.33-4; Anon, 'Instruction in Tropical Diseases', *British Medical Journal*, i, 1895, p.771

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¹⁵ Mark Harrison, *Public Health in British India: Anglo-Indian Preventative Medicine 1859-1914*, Cambridge, 1994, pp.27-35

¹⁶ This is the 1893 case of West African John Farrell Easmon. Although once the WAMS was amalgamated in 1902 an explicitly racist entry policy was instituted. Ryan Johnson, "'An All-White Institution": Defending Private Practice and the Formation of the West African Medical Staff', *Medical History*, 54, 2010, pp.237-54, p.238

¹⁷ Ranajit Guha, 'The Small Voices of History' in Shahid Amin and Dipesh Chakrabarty (eds.), *Subaltern Studies: Writings on South Asian History and Society*, Vol. IX, Oxford University Press, 1988

¹⁸ Greenwood and Topiwala, *The Forgotten History*

¹⁹ Crozier, *Practising Colonial Medicine*, pp.19-31

²⁰ For a detailed explanation of this see James Anthony Mangan, 'Benefits Bestowed'? *Education and British Imperialism*, Manchester University Press, 1988

²¹ NA [National Archives]/CO/877/1/37811 Ralph Furse, 'Proposal for Holding the Tropical African Services Course at Oxford and Cambridge', 1 April 1920

²² RHL[Rhodes House Library, Oxford]/Mss.Brit.Emp.s.415 Furse Papers,

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²⁴ Crozier, *Practising Colonial Medicine*, p.50

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²⁶ Colin Baker, ‘The Government Medical Service in Malawi: an Administrative History, 1891-1974’, *Medical History*, 20, 1976, pp.450-65; A. Bayoumi, *The History of the Sudan Health Services*, Nairobi, Kenya Literature Bureau, 1979; Ann Beck, *A History of the British Medical Administration of East Africa: 1900-1950*, Cambridge Massachusetts, Harvard University Press, 1970; Mary Bull, *The Medical Services of Uganda 1954-5*, Report 20, Oxford Development Records Project, Rhodes House Library, Oxford, [n.d. c.198?]; Mary Bull, *The Medical Services of Tanganyika 1955*, Report 21, Oxford Development Records Project, Rhodes House Library, Oxford, [n.d. c.198?]; David F. Clyde, *History of the Medical Services of Tanganyika*, Dar Es Salaam, Government Press, 1962; W.D. Foster, ‘Robert Moffat and the Beginnings of the Government Medical Service in Uganda’, *Medical History*, 13, 1969, pp.237-50; W.D. Foster, *The Early History of Scientific Medicine in Uganda*, Nairobi, East Africa Literature Bureau, 1970; Michael Gelfand, *A Service to the Sick: A History of the Health Services for Africans in Southern Rhodesia, 1890-1953*, Gweru, Mambo Press, 1976; Judith N. Lasker, ‘The Role of Health Services in Colonial Rule: the Case of the Ivory Coast’, *Culture, Medicine and Psychiatry*, 1, 1977, pp.277-97;

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