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Francis Dube
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COLONIALISM, CROSS-BORDER MOVEMENTS, AND EPIDEMIOLOGY: A
HISTORY OF PUBLIC HEALTH IN THE MANICA REGION OF CENTRAL
MOZAMBIQUE AND EASTERN ZIMBABWE AND THE AFRICAN RESPONSE,
1890-1980

by
Francis Dube

An Abstract

Of a thesis submitted in partial fulfillment
of the requirements for the Doctor of
Philosophy degree in History
in the Graduate College of
The University of Iowa

December 2009

Thesis Supervisor: Professor James L. Giblin

ABSTRACT

This dissertation addresses one of the reasons for the lack of confidence in public health in Southern Africa. It examines the impact of intrusive colonial public health measures and colonial attempts to suppress indigenous healing practices in the Manica region. The dissertation asks whether invasive colonial public health interventions had unintended consequences, such as the continued existence of traditional medicine and the reluctance to accept biomedical arguments on the epidemiology of infectious and communicable diseases.

While these intrusive colonial public health measures were constant and pervasive, they were not always effective, partly due to the border that colonialism created. The epidemiology of the Manica region is fundamentally affected by cross-border movements, which not only spread infections, but altered disease ecologies, complicating disease control efforts. Colonial efforts to monitor movements led to the disruption of life and caused much hardship to villagers and townsfolk.

Reflecting the dynamism of African societies, this dissertation argues that while Africans tended to dislike intrusive and discriminatory preventative public health policies, they were willing to experiment with new ideas, particularly treatment services. They were discouraged, however, by the failure of colonial governments to provide adequate treatment-based services for Africans, proving that the provision of health services for Africans was driven by European settler fears of infection and economic imperatives rather than the concern for Africans. However, most of these settler fears stemmed from misunderstandings of epidemiology, and were often grossly exaggerated and racist. Regardless of whether these theories were accurate or not, they still caused hardship.

Although this project looks at the history of public health before the HIV/AIDS pandemic in Southern Africa, the legacy of colonial public health policies affects how

people in Southern Africa comprehend this disease. Through the use of archival materials and oral histories, this dissertation concludes that the current reluctance to embrace biomedicine is connected to social memory and perceptions of the state, and its legitimacy. Had resentment of colonial public health not played a role, biomedicine would have been more readily integrated as an additional option into a repertoire of alternative therapies in Southern Africa.

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To my family and friends

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This dissertation addresses one of the reasons for the lack of confidence in public health in Southern Africa. It examines the impact of intrusive colonial public health measures and colonial attempts to suppress indigenous healing practices in the Manica region. The dissertation asks whether invasive colonial public health interventions had unintended consequences, such as the continued existence of traditional medicine and the reluctance to accept biomedical arguments on the epidemiology of infectious and communicable diseases.

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TABLE OF CONTENTS

LIST OF TABLES	viii
LIST OF FIGURES	ix
CHAPTER I INTRODUCTION.....	1
The Manica region of the eastern Shona	14
The Manica region in pre-colonial times.....	22
The Manica region and the scramble for Africa.....	27
The American Board Mission in the Manica region	28
Anglo-Portuguese relations	31
The border.....	33
Overview.....	36
CHAPTER II MISTAKEN POLITICAL ECOLOGY OF DISEASE: TRYPANOSOMIASIS (SLEEPING SICKNESS)	42
Introduction.....	42
The ecology of trypanosomiasis	48
Tsetse and Trypanosomiasis control before colonial rule	54
Epidemiological consequences of the establishment of colonial rule	59
Prevalence and control of Trypanosomiasis under colonial rule.....	65
African reaction	83
Conclusion	89
CHAPTER III REGIONAL OVERVIEW: POPULATION MOVEMENTS AND THE “NATIVE” AS A RESERVOIR OF INFECTION.....	92
Introduction.....	92
Regional population movements	94
“[T]he whole lot of them are rotten with syphilis”: prevalence of STDs among Africans.....	101
The “native” as reservoir of infection: settler fears and public health	111
The efficacy of medical examinations.....	118
Conclusion	127
CHAPTER IV “NO VACCINATION/NO MEETINGS AND THIS CONTINUES UNTIL YOU COME TO YOUR SENSES”: SMALLPOX AND COLONIALPUBLIC HEALTH ONSLAUGHT ON AFRICAN RELIGIOUS GROUPS AND AFRICAN RESPONSE	129
Introduction.....	129
Outbreaks, diffusion, and vaccination	133
African response: resentment and resistance.....	142
Conclusion	163
CHAPTER V “...AS WE WANT TO HAVE A HEALTHY WHITE POPULATION WE HAVE GOT TO TACKLE INFECTIOUS DISEASES IN THE NATIVE”: PROVISION OF HEALTH SERVICES FOR AFRICANS.....	165

Introduction.....	165
African health services to 1930	170
First Approach: dispensaries in African reserves of Rhodesian Manica	177
Second Approach: provision of medical assistance through missionary societies.....	181
Conclusion	206
CONCLUSION.....	209
BIBLIOGRAPHY.....	213

LIST OF TABLES

Table 1-1 Elevation readings in Portuguese East Africa	19
Table 3-1 STD prevalence in the Mozambique Company territory	108
Table 4-1 Smallpox outbreaks introduced from PEA and Rhodesian areas affected (according to Rhodesian officials)	136

LIST OF FIGURES

Figure 1-1 Map of Southern Rhodesia, 1940s	11
Figure 1-2 Map of the Mozambique Company Territory (Sofala and Manica)	12
Figure 1-3 Map of the Manica region	13
Figure 1-4 Manicaland Districts, Zimbabwe	15
Figure 1-5 Natural Farming Regions in Zimbabwe	17
Figure 2-1 Vegetation of the Save River Valley with main routes of spread of tsetse fly from PEA.....	52
Figure 2-2 Map illustrating the Tsetse Fly Problem in the Rhodesia side of the Manica Region	73
Figure 2-3 Sabi Lundi Area—Tsetse and Trypanosomiasis Distribution, 1958.....	81
Figure 2-4 Cattle inspection centers in the Save River valley, 1952	85
Figure 4-1 Areas from which the Zionist Church attracted “patients”	150

CHAPTER I

INTRODUCTION

Many indicators of public health show that Africa lags behind other continents in spite of all colonial efforts to introduce “modern,” scientific medicine. Nor is there any wholesale confidence in “modern medicine,” partly due to the cost and also due the continuing beliefs in other forms of healing. This dissertation addresses one of the reasons for the lack of confidence in biomedicine. It examines the impact of intrusive public health measures and colonial attempts to suppress indigenous healing practices in the Manica region of central Mozambique and eastern Zimbabwe. It asks whether colonial public health had unintended consequences, such as the continued existence of traditional medicine and the reluctance to accept biomedical arguments on the epidemiology of infectious and communicable diseases. The failure of public health interventions undermined colonial efforts to eradicate African practices which Europeans regarded as superstition by convincing Africans of the efficacy of biomedicine.

Public health can be defined as the “science and art of *preventing* disease, prolonging life and promoting physical health and efficiency through organized *community* efforts...”¹ Such efforts are generally preventive in nature and they include sanitation, control of contagious infections, hygiene education, early diagnosis and preventive treatment, and maintenance of adequate living standards. Public health

¹ Michael H. Merson et al., “Introduction,” in *International Public Health: Diseases, Programs, Systems, and Policies*, ed. Michael H. Merson et al. (Gaithersburg: Aspen Publishers, 2001), xvii-xxx. This dissertation also makes reference to the following terms: *Endemic* means a disease occurs continuously and with predictable regularity in a specific area or population; *Hyper-endemic* refers to a persistently high level of disease occurrence; *Epidemic/Outbreak* refers to occurrence of disease in excess of the expected level for a given time-period; *Sporadic* refers to an irregular pattern of disease occurrence; while *Pandemic* is when an epidemic spreads over several countries. In this thesis, *Epidemiology* refers the sum of the factors controlling the presence or absence of a disease or a pathogen (Medline Plus—online encyclopedia). Please note that I use the names Southern Rhodesia/Rhodesia and Zimbabwe interchangeably in this dissertation. The same applies to Portuguese East Africa and Mozambique. Other countries discussed in this chapter are Nyasaland (Malawi), and Northern Rhodesia (Zambia).

interventions require understanding not only of epidemiology, nutrition, and antiseptic practices but also of social science. However, in the Manica region, one essential component of public health, education, was largely absent. Many Africans only remember being forced to submit to public health measures without any clear explanation on the purposes of such measures. Neither was African understanding of disease or any kind of input considered in colonial public health decisions.

Maryinez Lyons argues that the concept of public health “implies the notion of the state as benefactor and protector of its charges.”² As a result, public health interventions always limit people’s freedoms of movement, association and choices of therapies and medical providers. Often, these involve compulsory quarantine, medical inspections or examinations, surveillance measures, and vaccinations/immunizations. In the Manica region, these also included colonial repression of indigenous healing practices.³ While some scholars claim that the encounter between colonizers and the colonized was a process of annihilation of indigenous knowledge systems by the imposition of western medicine or “epistemicide,” the colonizers were not always successful in their attempts to eradicate traditional healing systems.⁴ These indigenous healing practices survived. Today, when sub-Saharan Africa has the world’s highest

² Maryinez Lyons, “Public Health in Colonial Africa: The Belgian Congo,” in *The History of Public Health and the Modern State*, ed. Dorothy Porter (Amsterdam: Radopi, 1994), 356-381.

³ This dissertation focuses on the following districts in Zimbabwe and Mozambique: Umtali district (Southern Rhodesia) which was adjacent to the Manica district in Portuguese East Africa; Melsetter District (Southern Rhodesia) which was adjacent to two districts in Portuguese East Africa, Moribane district to the north and Mossurize district to the south. After the division of Melsetter district into Melsetter and Chipinga in the 1940s, Moribane then became adjacent to Melsetter (Chimanimani) and Mossurize became adjacent to Chipinga. The locales in this dissertation include Umtali (Mutare), Melsetter/Chipinga (Chipinge), Macequece (Manica), Mt. Selinda (Mt. Silinda), Chikore (Craigmore) Spungabera, and Sussundenga.

⁴ Cristiana Bastos, “Medical Hybridisms and Social Boundaries: Aspects of Portuguese Colonialism in Africa and India in the Nineteenth Century,” *Journal of Southern African Studies* 33, 4 (2007): 767.

HIV/AIDS infection rates in the world, efforts to control HIV/AIDS confront reluctance to accept biomedical arguments on its epidemiology. This reluctance reflects people's prior experience with colonial public health. African resentment of slowed the acceptance of colonial public health (an aspect of health care which is usually difficult to accept because it involves state power, restrictions on freedoms, and does not provide immediate benefits in the form of amelioration of sickness) and also contributed to reinforcing resistance to the most unpopular methods of biomedicine, particularly hospitalization. Had resentment of colonial public health not played a role, biomedicine would have been more readily integrated as an additional option into a repertoire of alternative therapies in the Manica region.

While these intrusive colonial public health measures were constant and pervasive, they were not always effective, partly due to the border that colonialism created. The Manica region constitutes an area whose epidemiology is fundamentally affected by cross-border movements. In a region where the population was highly mobile, public health policies restricted to territorial boundaries encountered enormous difficulties in addressing infectious and communicable diseases, such as smallpox, sleeping sickness, and venereal disease. Movements of people not only spread infections, but altered disease ecologies, complicating disease control efforts. Thus unlike many studies of public health that do not consider the fluidity of borders, this dissertation explores the role of population movements, particularly cross-border movements between Zimbabwe and Mozambique, in the epidemiology of infectious and communicable diseases in the Manica region. Colonial efforts to monitor movements in the region led to the disruption of life and caused much hardship to villagers and townfolk.

Reflecting the dynamism of African societies, this dissertation argues that while Africans tended to dislike intrusive and discriminatory preventative public health policies, they were willing to experiment with new ideas, particularly treatment services. They were discouraged, however, by the failure of colonial governments to provide

adequate treatment-based services for Africans. This attitude of colonial governments towards Africans only served to prove that the provision of health services for Africans was driven by European fears of infection and economic imperatives rather than the concern for Africans. The failure to establish comprehensive and effective treatment services diminished the success of public health programs.

This dissertation contends that settler fears of infection were a major impetus for public health measures. This accounts for the differences in the degree of implementation of public health measures between Portuguese East Africa (hereafter PEA), which did not have a sizeable European settler population, and Rhodesia, which had many European settlers on estates, farms and in towns. The Rhodesian side consequently developed a more rigorous approach to public health due to the pressure from the settler population while PEA lagged behind. As this dissertation demonstrates, however, most of these settler fears stemmed from misunderstandings of epidemiology, and were often grossly exaggerated as well as bluntly racist in nature. This dissertation is not primarily concerned with the accuracy of colonial epidemiological theories. Instead, it is concerned with the policies that emerged from these erroneous and exaggerated theories and their impact on the African population. Regardless of whether these theories were accurate or not, they still caused hardship.

Colonial public health policy was primarily driven by settler fears of infection. Later, settlers became concerned that disease would diminish supplies of African labor. Randall Packard argues that throughout the developing regions of the world from the end of the nineteenth century to the late 1920s, settler societies underwent this evolution of concern about disease. He contends that since their initial movement outward into tropical areas of the world, “Europeans had been concerned with improving health conditions in the tropics,” reflecting preoccupation with the health of Europeans. This attitude began to change in the post-World War I when colonial governments expanded the focus of European health initiatives to include, “in a limited fashion,” the health of

‘native’ populations. “Yet European interest in the ‘health of the natives,’” argues Packard, “like their concern for their own health, was shaped by fairly narrow economic interests. Colonial economies depended on healthy workers....”⁵

Colonial governments concentrated medical services near sites of production and “did little to build rural health services,” argues Packard, adding that for “most rural inhabitants contact with western medical services was limited to occasional medical campaigns.”⁶ Wherever disease was believed to threaten the health of the African labor force, for example in towns, mining centers, and farms, the colonial governments established health services for Africans in the early years of colonial rule. This is true of Manica and Mutare. However, in the remote rural areas, health services came much later in the late 1930s and early 1940s as a result of among other things, economic motives. There is no doubt that financial limitations played a significant part in this lop-sided development of health services, but this should be viewed more in terms of colonial priorities than simply the lack of funds. These priorities that placed emphasis on European health and economic well-being dictated where the available resources were spent, and it was not on African health.

A second characteristic of colonial medical services, according to Packard, was that “they tended to be narrowly technical in their design and implementation.” This led to a “heavy reliance on technology to deal with health problems.” Colonial officials considered broad based efforts to reform social and economic conditions as both “impracticable and unnecessary.”⁷ The final characteristic of colonial medicine, as

⁵ Randall Packard, “Visions of Postwar Health and Development and Their Impact on Public Health Interventions in the Developing World,” in *Internal Development and the Social Sciences: Essays on the History and Politics of Knowledge*, ed. Fredrick Cooper and Randall Packard (Berkeley: University of California Press, 1997), 93-115.

⁶ Ibid.

⁷ Packard, “Visions of Postwar Health and Development ,” 95. See also Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness*, (Stanford: Stanford University Press, 1993), Michael Worboys, “The Emergence of Tropical Medicine,” in *Perspectives on the*

Packard contends, was that “colonial health interventions reflected a view of local populations as inherently incapable of caring for their own health needs,” a tendency which led colonial officials to regard “the native as a reservoir of disease.” Conversely, “great faith was placed in western biomedicine, even when challenged by objective evidence of its limitations.”⁸

David Arnold argues that disease “was a potent factor in the European conceptualisation of indigenous society.”⁹ He asserts that this was especially so at the end of the nineteenth century “when Europeans began to pride themselves on their scientific understanding of disease causation and mocked what they saw as fatalism, superstition and barbarity of indigenous responses to disease.”¹⁰ Ironically, as Europeans began to free themselves of their epidemiological past, they quickly forgot that diseases like cholera, malaria, smallpox and plague, rampant in the tropics, were part of Europe’s own recent experience. Arnold therefore contends that the association of these diseases with the indigenous population “deepened European suspicions of the indigenous population as a whole and of the servants, subordinates and fellow town-dwellers with whom they lived in epidemiologically close proximity.”¹¹ “Ill health among indigenous

Emergence of Scientific Disciplines, ed. Gerald Lemaine, et al. (The Hague: Mouton, 1976), 75-98, Michael Worboys, “The Discovery of Colonial Malnutrition between the Wars,” in *Imperial Medicine and Indigenous Societies*, ed. David Arnold (Manchester: Manchester University Press, 1988), 208-23, John Farley, *Bilharzia: A History of Imperial Tropical Medicine*, (Cambridge: Cambridge University Press, 1991), and L. Doyal, *The Political Economy of Health* (London: Pluto Press, 1979).

⁸ Ibid. See also Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford: Stanford University Press, 1993), and Maryinez Lyons, *The Colonial Disease: A social History of Sleeping Sickness in Northern Zaire, 1900-1940* (Cambridge: Cambridge University Press, 1992).

⁹ David Arnold, “Introduction: disease, medicine and empire,” in *Imperial Medicine and Indigenous Societies*, ed. David Arnold (Manchester: Manchester University Press, 1988), 1-26.

¹⁰ Ibid.

¹¹ Ibid., 8.

peoples,” continues Arnold, “fostered Europeans’ growing sense of their innate racial and physical superiority.”¹²

As a result, some of the measures adopted by colonial powers to deal with disease were discriminatory and based upon compulsion of African people. Administered with no education on the benefits of such measures, they heightened African distrust of western medicine. This was particularly so with the establishment of formal colonial rule. As Cristiana Bastos contends, in parts of Mozambique and Zimbabwe where the Portuguese had been present since the 1400s, there were “mutual borrowings for practical healing purposes” before colonial rule became formalized.¹³ She argues that prior to the establishment of formal colonial rule in 1890, efforts to promote biomedicine had very little impact. However, with establishment of formal colonial rule, Portuguese authorities became less tolerant of African healing practices and attempted to use medicine as a “tool for domination.”¹⁴

Yet, as Bastos argues, by the beginning of the twentieth century, the project of western medicine as a tool for empire was hardly a success. Africans “kept fearing and fleeing European-style hospitals and colonial medical care,” leading some Portuguese doctors to argue in the 1920s that a “viable strategy to reach the natives should adopt some of their customs – or, in other words, hybridise for success.”¹⁵ This African flight demonstrated their fear of or dissatisfaction with biomedicine.

¹² Ibid.

¹³ Cristiana Bastos, “Medical Hybridisms and Social Boundaries,” 767.

¹⁴ Martin Shapiro, “Medicine in the service of colonialism: medical care in Portuguese Africa, 1885-1974” (Ph.D. dissertation, University of California, Los Angeles, 1983). See also Frantz Fanon, “Medicine and Colonialism,” *The Cultural Crisis of Modern Medicine*, ed. John Ehrenreich, New York: Monthly Review Press, 1978, and Spencer H. Brown, “A tool of empire: The British medical establishment in Lagos, 1861-1905.” *International Journal of African Historical Studies* 37, no. 2 (2004): 309-344.

¹⁵ Ibid.

This dissertation demonstrates that Africans resented colonial public health strategies and that resentment is still evident today. One source of resistance to biomedicine was African confidence in pre-colonial public health measures. Public health regulations existed in pre-colonial east-central African societies, and were not therefore, newly introduced by Europeans in the twentieth century.¹⁶ Charles Hughes' definition of public health as all activity that it takes to improve a population's health is broad enough to encompass rain-making, identification of sorcerers, control of infectious diseases, public sanitation works and health education.¹⁷ Thus when epidemics such as smallpox and other catastrophic events occurred, African authorities prohibited people from engaging in certain everyday activities, such as conjugal relationships as well as house-to-house visitations.¹⁸

The understanding of the etiology, diagnosis, and treatment of disease within African societies was wide enough to encompass spirits and witches. Nonetheless, contrary to what is commonly believed in the West, not all illness in Bantu-speaking Africa was associated with spirits and witches. Numerous causes of illness were known, and were treated with an extensive pharmacopoeia derived from barks, leaves, roots, saps, and other natural products.¹⁹ Although most individual health problems were solved in the household, illnesses and other calamities caused by spirits and sorcery required intervention of the ruling elites. Treatment was usually administered by healers and other elderly people in society with a wealth of knowledge about diseases. Thus

¹⁶ Gloria Waite, "Public Health in Pre-colonial East-Central Africa," in *The Social Basis of Health and Healing in Africa*, ed. Steven Feierman and John M. Janzen (Berkeley: University of California Press, 1992), 212-231.

¹⁷ Ibid.

¹⁸ Ibid. The ruling elites may include priests, chiefs and kings, or presidents and ministers of health.

¹⁹ Ibid., 214.

public health systems were in place prior to colonization and did not simply disappear with the introduction of western biomedicine.

Another source of resistance to colonial public health policies stemmed from their attempt to interfere with and usurp the powers of local public health practitioners, such as kings, rainmakers, and healers. For example, in Zimbabwe, where healers, diviners, and spirit mediums were believed by colonial authorities to have posed a threat to colonial conquest during the 1896-7 Chimurenga War, the colonial government jailed many of them on suspicion of inciting resistance to colonial rule.

As colonial powers began to assert their authority, colonial economies and ineffective public health interventions led to the outbreaks of diseases in epidemic form. Human sleeping sickness is a case in point. Little wonder that by the early twentieth century, many Africans understood the increased incidence of disease “as a kind of biological warfare” which accompanied conquest and establishment of colonial rule.²⁰ African means of controlling diseases such as sleeping sickness through environmental modification became difficult to implement after the establishment of colonial rule. The nature of colonial economies therefore led to changes in disease ecologies in many parts of Africa.²¹ Colonialism sought to exploit African land, mineral wealth, and labor. Heavy taxation and labor migration, whether voluntary or forced, greatly increased African mobility as colonial officials pressured Africans to work on mines and farms (especially in South Africa, Rhodesia, and Kenya), to collect natural products, such as

²⁰ Maryinez Lyons, *The Colonial Disease: A social history of sleeping sickness in northern Zaire, 1900-1940* (Cambridge: University of Cambridge Press, 1992), 3.

²¹ Meredith Turshen. *The Political Ecology of Disease in Tanzania* (New Brunswick: Rutgers University Press, 1984); Maryinez Lyons, *The Colonial Disease: A social history of sleeping sickness in northern Zaire, 1900-1940* (Cambridge: Cambridge University Press, 1992); Rita Headrick, ed., *Colonialism, Health and illness in French Equatorial Africa, 1885-1935* (Atlanta: African Studies Association Press, 1994); and James Giblin, “Integrating the history of Land use into Epidemiology: Settler agriculture as the cause of disease in Zimbabwe,” Working Paper No. 176 presented as part of the History of Land Use in Africa project of the African Studies Center, Boston University, and the Forest History Society, 1994.

rubber in the Belgian Congo, to produce cash crops. Colonial officials also alienated African lands, beginning the process of “proletarianization” in settler colonies, such as South Africa, Rhodesia, Kenya and Algeria. Gloria Waite argues that colonial governments intended public health care in east-central Africa to increase African worker productivity.²²

One example of state-administered public health initiatives involved the control of sleeping sickness (trypanosomiasis) in the Belgian Congo. In their efforts to control the disease, colonial officials experimented with various measures, including the imposition of cordon *sanitaires*, forcible isolation, and treatment with drugs, such as atoxyl. However, imposing cordon *sanitaires* curtailed the mobility of the Congolese at a time when colonial demands for rubber forced people to be highly mobile. Thus Belgian colonial officials later resorted to sleeping sickness treatment (medical intervention) rather than prevention by use cordon *sanitaires*. This brings out the clear connection between colonial medical institutions and economic interests. Recent studies have also linked the emergence of tuberculosis in colonial South Africa to extreme racial discrimination, high rates of urbanization, industrialization, and economic growth under colonial rule.²³ British sleeping sickness policies in the Lake Victoria region of East Africa between 1900 and 1950 also provide an important example of the intrusiveness of colonial public health policy. In this region, sleeping sickness control policies involved compulsory massive relocations and intrusive vegetation clearing campaigns which paralleled military campaigns in Europe.²⁴ These intrusive measures often connected to economic interests which marked colonial public health in the Belgian Congo and the

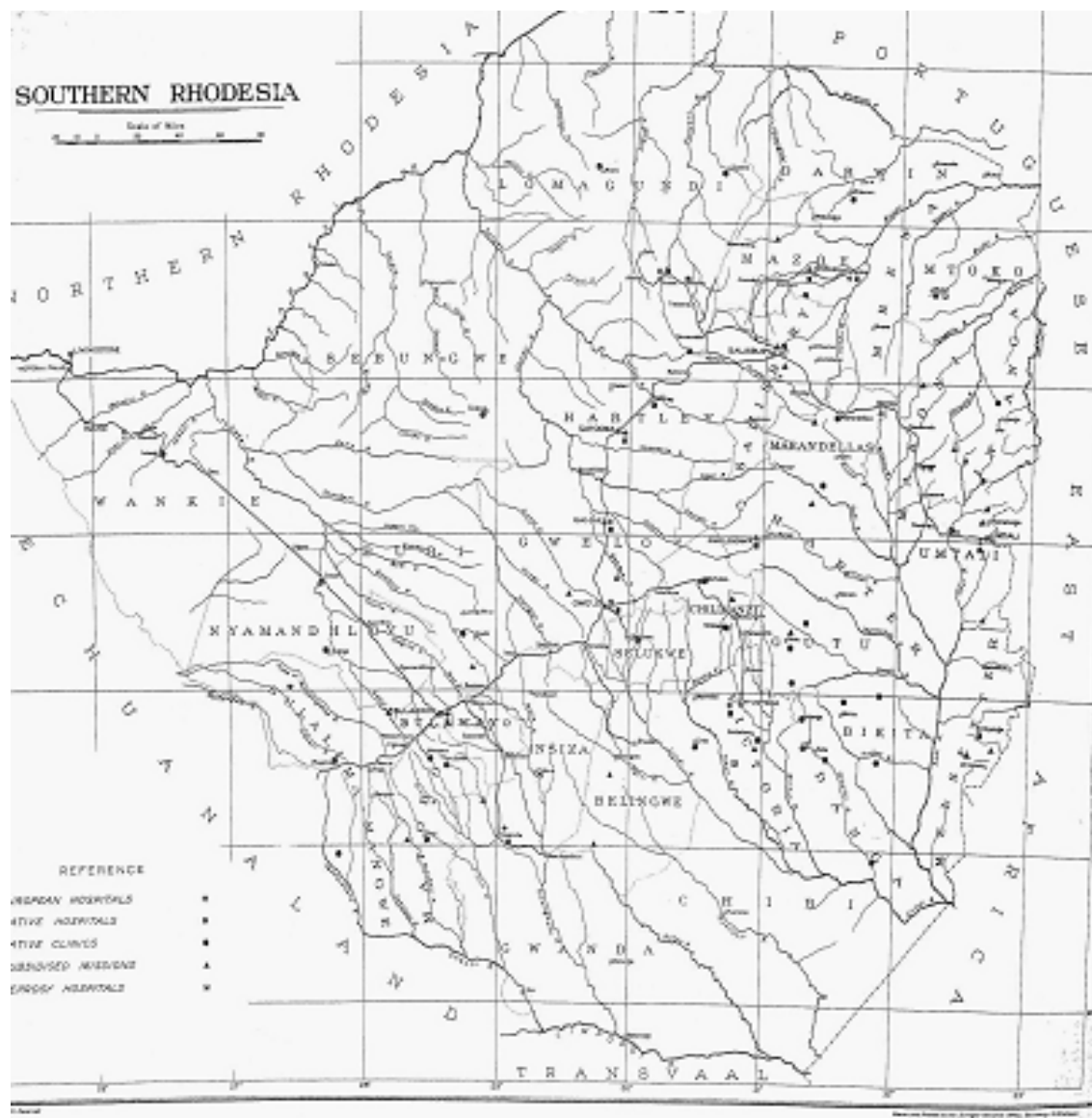
²² Gloria Waite, “Public Health in Pre-colonial East-Central Africa,” 228.

²³ Randall M. Packard, *White plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley: University of California Press, 1989).

²⁴ Kirk Aden Hope, “Lords of the Flies: British Sleeping Sickness Policies as Environmental Engineering in the Lake Victoria Region, 1900-1950,” Working Papers in African Studies, No. 203, African Studies Center, Boston University, 1995.

Lake Victoria region may also be seen in the region studied by this dissertation, the Manica area of Mozambique and Zimbabwe.

Figure 1-1 Map of Southern Rhodesia, 1940s



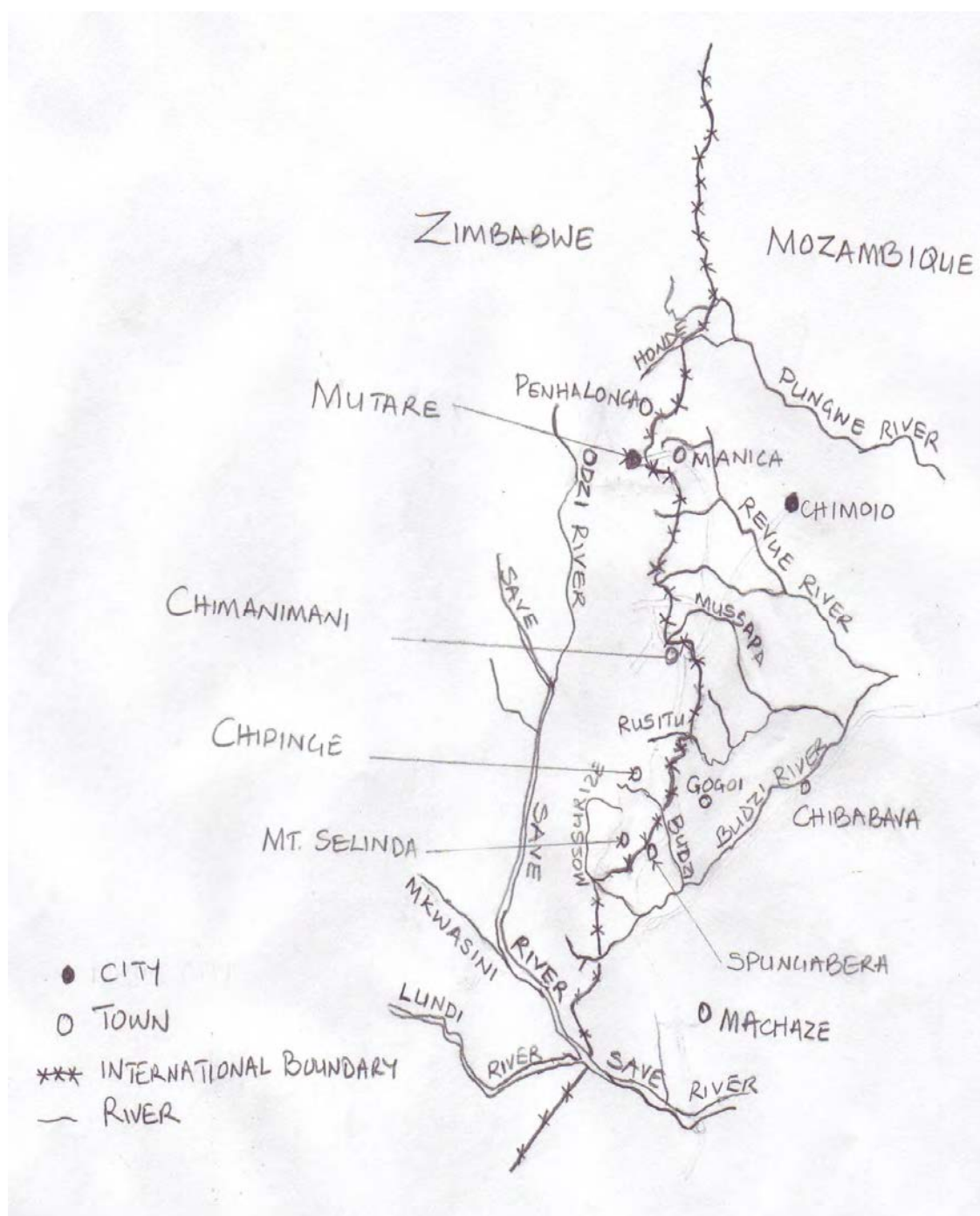
Source: National Archives of Zimbabwe, S2419: Report on Public Health.

Figure 1-2 Map of the Mozambique Company Territory (Sofala and Manica)



Source: Arquivo Histórico de Moçambique (hereafter AHM), Fundo da Companhia de Moçambique (hereafter FCM), Geral-Relatórios, Annual Report for 1912, Repartição de Veterinaria, Caixa 131, Pasta 2702.

Figure 1-3 Map of the Manica region



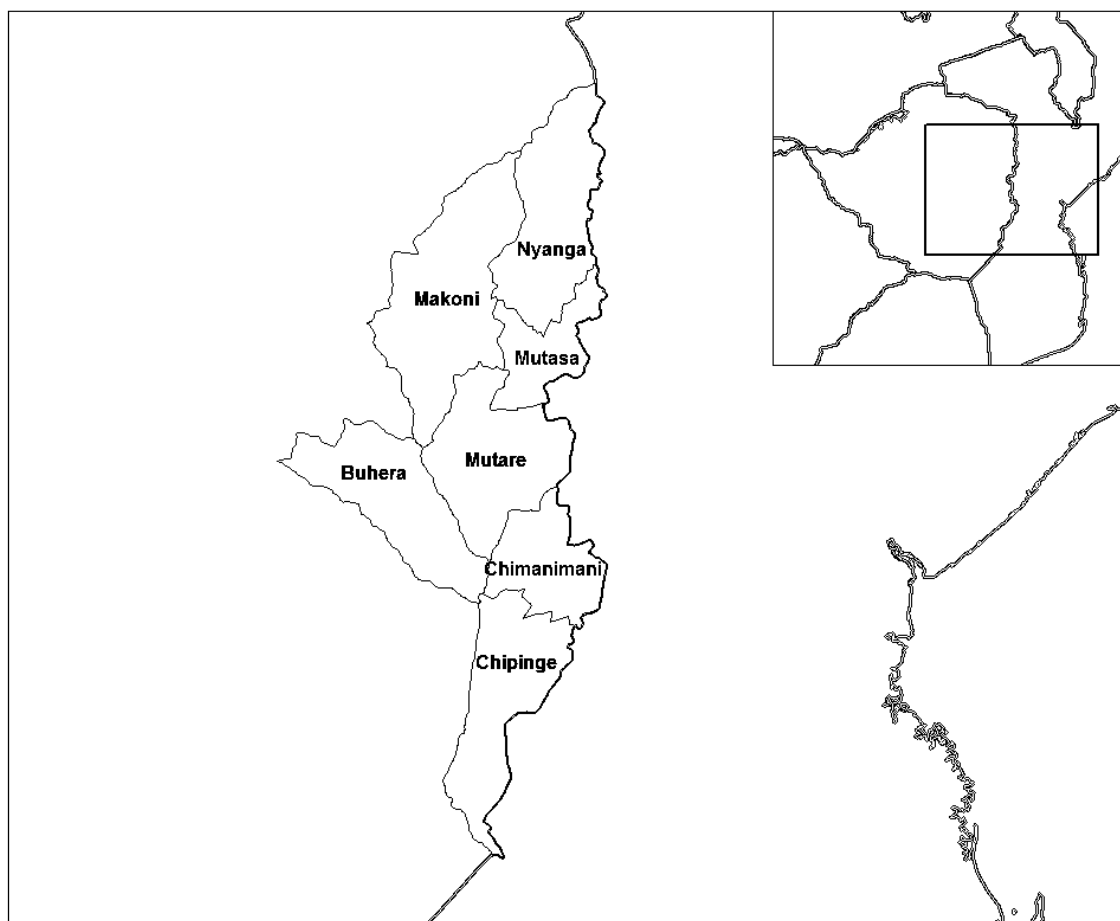
The Manica region of the eastern Shona

This project focuses on area along the Zimbabwe-Mozambique border in the Manicaland Province of Zimbabwe and the Manica Province of Mozambique. For brevity's sake I shall call it the Manica region. The area under focus in Zimbabwe stretches from Pungwe River in the north, down to where the Save River crosses into Mozambique. Its western edge is demarcated by the Odzi and Save Rivers in Zimbabwe and it encloses the Mutare, Chimanimani, and Chipinge districts as shown in Figure 1-4 below. In Mozambique it roughly encompasses the western portions of the Manica, Sussundenga, and Mossurize districts. The Manica region generally falls into areas inhabited by the eastern Shona people, with the Manyika in the north and the Ndau in the south. The major urban centers are Mutare (Umtali), Penhalonga (gold mine), Chipinge (Melsetter/Chipinga), and Chimanimani (originally part of Melsetter district) in Zimbabwe. Major towns on the Mozambican side are Manica (Macequece/Masekesa/Massi-Kessi), Spungabera (Espungabera) in Mossurize district, and Sussundenga.

The Manica region's physical attributes had a profound effect on settlement patterns, livestock-keeping and disease. The region is an area of high elevation, particularly on the Zimbabwean side. In fact, the Zimbabwe-Mozambique international border follows the crest of the Vumba range of mountains to the north and the Chimanimani range of mountains to the south. Known as the Eastern Highlands in Zimbabwe, this region's natural fertility and land as well as water-based routes have influenced its history.²⁵

²⁵ John Keith Rennie, "Christianity, Colonialism and the Origins of Nationalism among the Ndau of Southern Rhodesia, 1890-1935," PhD Thesis, Department of History, Northwestern University, 1973, 37.

Figure 1-4 Manicaland Districts, Zimbabwe



Source: Nationmaster Encyclopedia. This study focuses on the Chipinge, Chimanimani, Mutare and the southern portion of the Mutasa districts.

The fertile soils, mineral resources, vegetation, and livestock-rearing potential attracted both African and European settlement. Land in Zimbabwe has been classified into “natural farming regions” I-V, with region I being the most productive agricultural land with high rainfall and V being an arid environment, with no agricultural potential. The Manica region has the best farmlands ranging from “natural farming regions” I-II as shown in Figure 1-5. These are healthy upland plateaus around Chimanimani and Chipinge at around 1,200-2,400 meters above sea level. The region has deep, reddish

brown sandy loam soils that cover the Eastern Highlands to as far north as Nyanga. These soils have good moisture retention capacity, a characteristic essential for ensuring adequate moisture for growth of plants.

Besides the quality of the soils, other factors crucial for plant growth and animal domestication are rainfall and temperature. The highlands of the Manica region receive annual rainfall of between 45 and 55 inches, which is higher than in any other region in Zimbabwe and very reliable, thanks to light winter rains. The temperatures in the highlands are also comfortable all year round, with the mean daily temperature averaging between 55 and 70 degrees F.

The major rivers associated with the Manica region are the Save (Sabi), Odzi, Pungwe (Pungue), Budzi (Busi), Mossurize (Musirizwi/Umselezwe/Umsilizi/Mossurise), Rusitu (Lucite), Harondi (Chibira/Harom), Mussapa, and Revue. The Pungwe rises in the Inyangani Mountains, whose peaks rise to over 8500 feet, and flows in a south easterly direction to the sea. It is largely “a rapid mountain river” until it enters a flat area towards the sea.²⁶ The Budzi originates in the table-land north of Chief Mapungwana’s area and flows in a south-easterly direction to its confluence with the Mossurize. The Revue also rises in the mountains and follows an easterly direction to the sea.

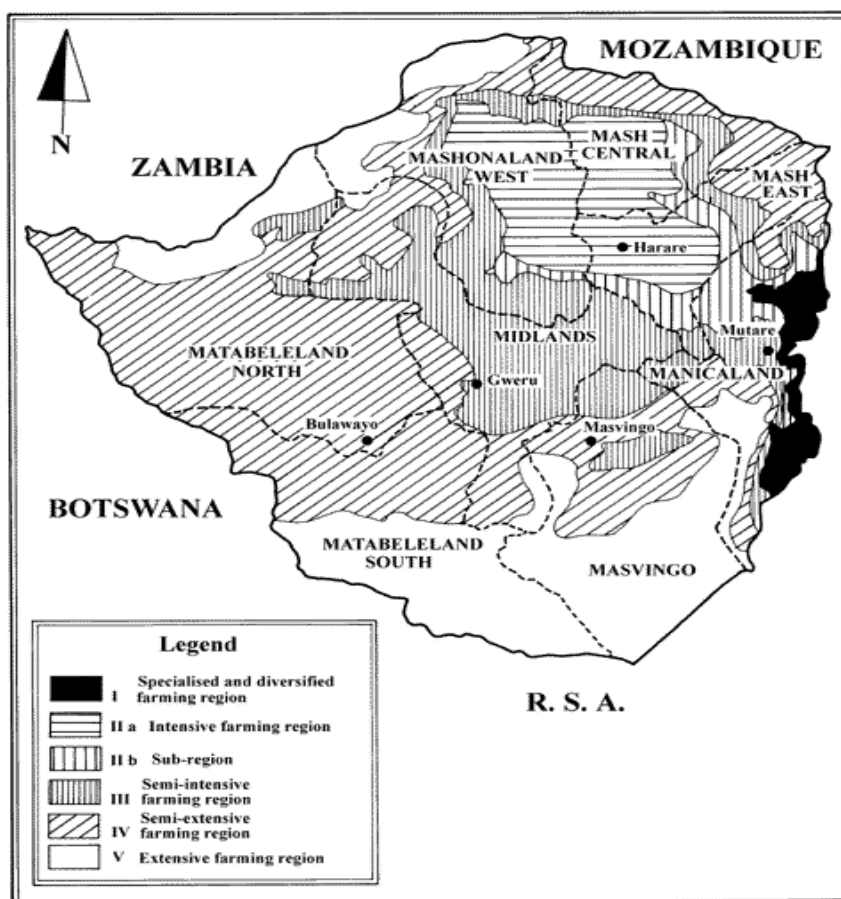
Another river of importance, the Mussapa, originates in an area north of the Chimanimani Mountains and flows in a south-easterly direction to its confluence with the Rusitu. The Rusitu, flowing in a deep valley with mountains on its northern bank, follows an easterly direction towards the sea. J. J. Leveson of the 1892 Anglo-Portuguese Delimitation Commission observed that the right bank of the Rusitu is less mountainous, and is covered with “luxuriant tropical vegetation, in which clearances had been made here and there for the cultivation of mealies [corn] and other kinds of grain.”²⁷ The other

²⁶ J. J. Leveson, “Geographical Results of the Anglo-Portuguese Delimitation Commission,” *The Geographical Journal* 2, no. 6 (1893): 506.

²⁷ *Ibid.*, 509.

important rivers are the Chibira and the Mossurize. While the Chibira River is “a fierce mountain torrent which runs southwards along the foot of the craggy and precipitous western ridge of the Chimanimani Range,” the Mossurize flows through a mountain gorge which widens considerably in some places, affording “room for the native villages and fields of mealies, Kaffir corn, etc., along the river banks.”²⁸

Figure 1-5 Natural Farming Regions in Zimbabwe



Source: United Nations Food and Agriculture Organization (F. A. O.)

²⁸ Ibid., 510.

Although there are no classifications of farming regions on the Mozambican side of the border, the lands adjacent to Zimbabwe's Eastern Highlands are also of high elevation. In the districts of Sussundenga and Mossurize, between the Budzi and Rusitu Rivers, for instance, the Chimanimani Mountains have a peak of over 7,000 feet and there are also massive peaks on the Matibi highlands. The most prominent feature is the straight, high narrow Sitatonga Ridge that "pointing to the magnetic north, cuts at right angles to the two rivers [Budzi and Rusitu] and effectively shuts off the lowland plains east of it from the foot-hill and valley country to its west."²⁹ In general, the elevation ranges from well over 4,000 feet (1,220 meters) on Mount Umtareni and the Sitatonga crests, and 3,700 feet at Spungabera, to 2,000 and 1,000 feet and less in the lower valleys between the Sitatongas and the Zimbabwean border. East of the Sitatongas, the general elevation falls to around 500 to 600 feet above sea level. Table 1-1 below shows elevation readings taken by R. W. Jack of Southern Rhodesia's Entomology Department.

The region's physical and climatic characteristics influenced agricultural patterns. In the northern parts of the Manica region, in what was the Manyika Kingdom, precolonial villagers grew a variety of crops two or three times a year. The relief of the area from the coast to Manica causes the rainy season and mists to last for a long time.³⁰ From the coast, the terrain over 300 km gradually rises until it reaches an altitude of 700 meters and then suddenly rises to elevations varying between 1,500 and 2,000 meters above sea level. Relief rainfall is common in this region as the humid winds from the Indian Ocean condense rapidly to deliver torrential rains. The humid areas close to the coast harbored trypanosomiasis-causing tsetse fly, making cattle-keeping difficult.

²⁹ C.F.M. Swynnerton, "Examination of the tsetse problem in North Mossurize, Portuguese East Africa," *Bulletin of Entomological Research* 11, no. 4 (1921): 318.

³⁰ H. H. K. Bhila, *Trade and Politics in a Shona Kingdom: the Manyika and their African and Portuguese Neighbours, 1575-1902* (Essex: Longman, 1982), 6.

Leverson claimed, “when proceeding up country from the [mouth of the] Pungwe we did not get clear of the tsetse fly till we reached Shimoya’s [Chimoio, east of Manica].”³¹

Table 1-1 Elevation readings in Portuguese East Africa

Location	Feet	Meters
Inyamadzi River, on the British border	2,200	679
Rusitu River, near the British border	1,300	396
Rusitu, near Haroni Junction	1,100	335
Musirizwi River on Spungabera-Masanjena Road	950	290
Gogoyo, Dysart Concession	1,200	366
Mtobe’s Village	1,000	305
Mafuse’s Village	2,200	670
Spungabera	3,700	1,137
Jersey Homestead (in Southern Rhodesia)	2,800	853

Source: C.F.M. Swynnerton, “Examination of the tsetse problem in North Mossurise, Portuguese East Africa,” *Bulletin of Entomological Research* 11, no. 4 (1921): 318. The last measurement, though taken from the Rhodesian side furnishes a general idea of the higher altitudes in the lower part of the Gwenzi area, at around the Chinyika River south of Spungabera.

The highland rivers valleys are fertile and capable of supporting dense populations, but fertility decreases as one moves south towards the Save River valley, an area of low and uncertain rainfall with poor drainage and saline soils. This is because south of the Mossurize River, the land becomes less mountainous, drier, and sandy, forming “a gently undulating district covered with grass and stunted trees....”³² The

³¹ J. J. Leverson, “Geographical Results of the Anglo-Portuguese Delimitation Commission,” 517.

³² J. J. Leverson, “Geographical Results of the Anglo-Portuguese Delimitation Commission,” 510.

same situation applies to the Zimbabwean side of the border as one moves from the Eastern Highlands to the west towards the Save River. To the west of the fertile highlands, in a broad north-south strip parallel to the Save River, the natural farming region classification ranges between III and V. The soils become less and less fertile with low unreliable rainfall totals, often punctuated by periodic droughts. Crop failures are common. The valley floor forms a broad flat sandy plain with elevations of between 1,000 and 2,000 feet. Here the alluvial soils are fertile but rainfall is generally below 24 inches per year and is extremely unreliable and temperatures can rise well to over 100 degrees F. in summer.

The nature of the land and climate influenced vegetation patterns in the region. Around Mutare and Mozambique's Manica district, forests, which influence the distribution of tsetse flies, are of a thin and open character, with a few patches of dense tropical forest. The trees are mostly deciduous with the main product of the forest being rubber from the natural vines, *Landolphia*, which grow over wide areas.³³ The mountains are mostly grass covered. In general, proceeding from the border to the east in Mozambique, the land drops to a heavily forested plateau of about 3000 feet and then to a broad low coastal plain. Rainfall in the highlands ranges from 35 to 70 inches per annum, providing adequate moisture for plant growth.

While surveying the Manica region in 1892, Leveson observed that forests were common, particularly along the mountain slopes exposed to high rainfall, and were covered by the common *brachystegia*, whereas the lowlands were characterized by Mopane bush. "Mount Venga, just to the north of Massi-Kessi, and a few other peaks are covered with trees to their summits," he noted, "but the greater portion of the very high ground is grass land, while the valleys, except that of the Revue, and the plains are nearly

³³ H. H. K. Bhila, *Trade and Politics in a Shona Kingdom*, 7.

everywhere covered with forest.”³⁴ He also observed that the slopes of the mountains enclosing the Rusitu River gorge were for the most part covered with thick forest, while the plains and valleys of the area north of the Save were covered with mopane (acacia) forest.

The Manica region had a variety of wild animals including elephants, antelope, wild pig, buffalo, carnivores and smaller animals, which influenced hunting patterns and the epidemiology of vector-borne disease, including trypanosomiasis. It had large herds of elephants to the extent that the Mutema people, whose capital was traditionally at Ngaone (about 30 miles from the border) in the Eastern Highlands, are remembered as the people who “ruled with ivory.”³⁵ Leveson observed that from Manica in the north to the Save in the south, much of the region’s game existed between the Chimanimani Pass and the Mossurize rivers. This included eland, buffalo, hartebeest, wildebeest, bush-buck, reed-buck, quagga, sable antelope, blue buck, red antelope, and wild boar.³⁶ These similarities and variations in physical feature, vegetation, and wildlife influenced the prevalence and control of diseases, such as trypanosomiasis discussed in chapter two.

The Manica region is rich in mineral deposits including gold in the north, particularly around the Penhalonga area, north of Mutare in Zimbabwe. This mining potential influenced colonization of the region in the 1890s. The region also possesses coal, iron, and copper deposits. Mining was therefore common in the northern parts of the area, in the Manica district of Mozambique and in areas around Mutare in Zimbabwe.

Communication was by way of the Pungwe River, navigable for about a hundred miles, and also by the Save River, navigable up to the Rhodesian border. There were also

³⁴ J. J. Leveson, “Geographical Results of the Anglo-Portuguese Delimitation Commission, 513.

³⁵ H. H. K. Bhila, *Trade and Politics in a Shona Kingdom*, 2.

³⁶ J. J. Leveson, “Geographical Results of the Anglo-Portuguese Delimitation Commission,” 518.

numerous land routes, some of which followed river valleys all the way to the coast. Hence the Rhodesia-Portuguese border did not enclose natural communication areas, but divided them and bisected the routes to the coast.³⁷ This border and colonial attempts to monitor and restrict movement across the border is a major theme of this dissertation.

The Manica region in pre-colonial times

The ancestors of the Shona people settled on the Zimbabwean plateau in the fifth century CE and practiced mining, agriculture and livestock production. The following centuries witnessed flourishing trade in gold and ivory with Arab trading posts on the east African coast culminating in considerable expansion of Shona culture. The basic social structure of African society in the Manica region comprised extended families and lineage groups clustered in villages. The sizes of these villages varied according to the physical conditions of the area. The most densely populated areas were Zinyumbu, the Mossurize-Budzi basin, and Mafuse (Mafusi) as these were rich agricultural areas with plenty of rainfall.³⁸ Levenson noted the variations in population density of the Manica Region in 1892. "Journeying south from Massi-Kessi it [population] is very sparse as far as the Chimanimani mountains," he claimed, "...Very little is obtainable in the way of food supplies. The Natives have no cattle, and appear to live in the dread of a raid by Gungunyane."³⁹ Levenson observed, however, that there was more cultivation and probably more people in the Mussapa River valley.

Another densely populated area was the land between the Rusitu and Mossurize rivers in the south. Levenson claimed that this was the "most-thickly inhabited and

³⁷ John Keith Rennie, "Christianity, Colonialism and the Origins of Nationalism," 41.

³⁸ H. H. K. Bhila, *Trade and Politics in a Shona Kingdom*, 2.

³⁹ J. J. Levenson, "Geographical Results of the Anglo-Portuguese Delimitation Commission, 515.

prosperous part of the country” he surveyed in 1892. “Here the villages are larger, the huts are much better built, there is more cultivation, and large numbers of fowls are reared; there is altogether an air of well-being and comfort,” asserted Levenson.⁴⁰ John K. Rennie claimed that in the more fertile highlands, population was concentrated in large villages of up to forty huts such that the more scattered populations to the south sometimes referred to the highlanders as *vaguta* (village dwellers).⁴¹ However, south of the Mossurize River the area became less fertile and population diminished again.

The pre-colonial economy of the Manica region included crop and livestock production. When J.J. Levenson visited the Manica region in 1892, he made a note on African crops saying,

The products of the soil cultivated by the natives include bananas, the castor-oil plant...Chili peppers, a very favourite condiment of the natives, tomatoes, sweet potatoes, ground nuts, mealies, Kaffir corn and various kinds of native grain, the most abundant of which is the red oofoo, tobacco, and non-poisonous manioc.⁴²

Apart from agriculture, livestock keeping was also a major activity. Levenson claimed in 1892 that Chief Mapungwana had some cattle which thrived “on the high plateau” where his main “kraal” was situated. He also reported seeing cattle on the high ground in the catchment areas of the Odzi and Mutare streams, where there were no tsetse fly, the vector responsible for spreading trypanosomiasis. Levenson also noted the absence of tsetse in the Revue and Menini River valleys into which Europeans had recently imported cattle.⁴³ However, Levenson reported encounters with the tsetse fly in

⁴⁰ Ibid., 515-516.

⁴¹ John Keith Rennie, “Christianity, Colonialism and the Origins of Nationalism, 54.

⁴² J. J. Levenson, “Geographical Results of the Anglo-Portuguese Delimitation Commission, 515. “Oofoo” is a kind of millet, see Alice Blanke Balfour, *Twelve hundred miles in a wagon* (London: Edward Arnold, 1895), 143.

⁴³ Ibid., 516.

the Save River area. The analysis of marriage practices in the Manica region also shows where cattle were raised. In the fertile and densely populated areas suitable for cattle, such as the highlands, cattle were central in marriage payments. However, in the drier or more mountainous areas less suitable for cattle, such as the northern Melseetter chieftaincies of Hodi, Nyamazha, Gariyadza, and Saungweme, a man did not need cattle to marry. In these chieftaincies a man could obtain a wife by becoming a *mugariri* (son-in-law with labor obligations) to the woman's father.⁴⁴ This practice was also more common among the Danda in the less fertile area between the Save and Budzi rivers than among the Chisanga of the highlands in Chipinge.

The villages sometimes coalesced into empires and chiefdoms. From the Zimbabwean plateau emerged the Mwenemutapa (Mutapa) Empire (c. 1450-1629) that extended to most parts of present-day central Mozambique. At the zenith of its power, the Mwenemutapa Empire controlled vast areas, from the plateau to the east coast, through vassal states like Sedanda (Danda), Quissanga (Chisanga or Sanga), Quiteve, Manica (Manyika), Bárúè (Barwe), and many others.⁴⁵ Thus when the Portuguese explorer Vasco da Gama landed on the east African coast in 1498, Mozambique was the point of contact between two of the most powerful and highly developed civilizations in Africa—the trade-oriented Swahili (Muslim) culture of the east coast and the culture of Zimbabwe, which specialized in metal processing. The coming of the Portuguese into the region hastened the decline of the flourishing Indian Ocean trade and African cultures which experienced a gradual transformation as they interacted with the Portuguese who sought to control the sources of gold in the region. The Portuguese went on to establish their presence in Mozambique through the institution of *prazos* in Tete and Sena, for

⁴⁴ John Keith Rennie, "Christianity, Colonialism and the Origins of Nationalism, 54.

⁴⁵ C. Serra, *História de Moçambique*, volume 1, (Maputo: Livraria Universitária, 2000), 35.

instance, and also by establishing garrisons at Inhambane, Sofala, Villa de Manica, Sena, and Tete.⁴⁶ The Portuguese also attempted to control gold trade. This knowledge of the presence of gold in the Manica region later provided an incentive for the formal colonization of the area.

The Shona people of the Manica region, including the Manyika in the north and the Ndaou in the south, probably formed part of the Mbire state in the eighteenth century. The Mbire was a successor state to the Mwenemutapa Empire. M. D. D. Newitt argues that the Manyika kingdom in the mountainous region, though always small, was of great antiquity.⁴⁷ First ruled by the Chikanga dynasty, this kingdom passed under the Mutasa dynasty in the early nineteenth century before the British and the Portuguese partitioned the entire area between themselves in 1891.⁴⁸

In the southern part of the Manica region, among the Ndaou, a number of polities emerged in the seventeenth century. These included the Dziva chieftaincies of Musikavanhu, Mapungwana, Musikavanhu, Makuyana, Sahodi (Ngorima), Saungweme (Chikume), Mutambara, and Chirimugwenzi (Gwenzi), Mafuse, (Gogoyo) Gogoi and Chisanga (Sanga or Portuguese Quissanga) people whose rulers were known by the dynastic title Mutema.⁴⁹

⁴⁶ *Prazos* were large estates leased to Portuguese colonial settlers and traders. They operated in a semi-feudal fashion and were common in the Zambezi River valley, north of the Manica region. For more on the activities of the Portuguese before formal colonial rule, see M. D. D. Newitt, *Portuguese Settlement on the Zambesi: exploration, land tenure, and colonial rule in East Africa* (New York: African Publishing Company, 1973) and Allen Isaacman, *Mozambique: the Africanization of a European institution; the Zambesi prazos, 1750-1902* (Madison, University of Wisconsin Press, 1972).

⁴⁷ M. D. D. Newitt, *Portuguese Settlement on the Zambesi: exploration, land tenure, and colonial rule in East Africa* (New York: African Publishing Company, 1973), 25.

⁴⁸ *Ibid.*

⁴⁹ John Keith Rennie, "Christianity, Colonialism and the Origins of Nationalism, 65-71.

By the late nineteenth century, however, these polities had effectively disintegrated as kingdoms, except Barwe, although some remnants remained in the chiefdoms of M'cupi in Danda, Manica in Macequece, and Moribane in Quiteve.⁵⁰ Most of Manica region's polities had suffered at the hands of Zwangendaba and Soshangana (Manikusi), Nguni generals who fled from Shaka in Natal during the *mfecane*. The *mfecane* was the dispersal of the Nguni people of Natal which began in the early nineteenth century. Soshangane established the Gaza state with his capital at Bileni, on Delagoa Bay (later called Lorenzo Marques and now the Mozambican capital, Maputo). However, in order to get further away from Natal, Soshangane moved north in 1828 with his army of followers, asserted his authority north of the Save River as far as the Mussapa. He defeated Nxaba and Zwangendaba, (two other Nguni generals who had preceded him), and subdued the surrounding peoples, including Portuguese garrisons at Inhambane, Sofala, Villa de Manica, Sena, and Tete. He then established his empire of Gazaland with its capital in the Mossurize valley and was succeeded by his son, Mzila in 1860. Mzila's reign witnessed the resurgence of Portuguese power and when Mzila died in 1885, his son and successor, Gungunyana unsuccessfully attempted to play off the British and Portuguese against one another.⁵¹ In 1889, Gungunyana evacuated Gazaland and moved his capital to the lower Limpopo, which was his grandfather's old capital at Bileni. However, the Portuguese found a pretext for attacking him between 1895 and 1897. The Portuguese defeated Gungunyana and exiled him to the Canary Islands and effectively dismantled the Gaza Empire, eliminating the remaining obstacle to effective European occupation of the Manica region.

⁵⁰ Barry Neil-Tomlinson, "The Mozambique Chartered Company, 1892 to 1910," PhD Thesis, School of Oriental and African Studies, University of London, 1987, 11.

⁵¹ John Ford, *The Role of the Trypanosomiases in African Ecology: A Study of the Tsetse Fly Problem* (Oxford: Clarendon Press, 1971), 334.

The Manica region and the scramble for Africa

As in the rest of Africa in the 1880s, in the Manica region there was a race among European powers to claim territory. The contest was between the British and the Portuguese. Although the Portuguese had been in east Africa since the fifteenth century, their position in central Mozambique in 1890 was confined to a few posts on the coast and up the Zambezi River, “playing little part in the life of the region’s African population.”⁵² However, the scramble changed everything. With the call by the Berlin Conference in 1885 to make good the claims made on paper by way of “effective occupation,” the Portuguese and the British clashed in their attempts to occupy the Manica region.

British efforts were championed by British South Africa Company (hereafter BSAC) under Cecil John Rhodes, while Portuguese colonialism was led by the *Companhia de Moçambique* (hereafter Mozambique Company). Eric Allina-Pissano argues that whereas Britain was motivated by expansive imperialist ideology and growing financial interests of its private citizens, as well as the need to secure a port for her territories, Portugal drew its impetus “not only from hope for financial gain, but also from a nostalgic, almost manifest destiny-like belief in its ‘right’ - as the (European) ‘discoverer’ of the region – to claim the territory.”⁵³

The bone of contention was the Manica goldfields which the Portuguese had made famous by their writings. Indeed when Rhodes entered present-day Zimbabwe, he was looking for vast goldfields just like those of the Transvaal in South Africa. The Portuguese had known about the Manica gold fields from the time they established

⁵² Barry Neil-Tomlinson, “The Mozambique Chartered Company, 1892 to 1910,” 2.

⁵³ Eric Allina-Pisano, “Negotiating Colonialism: Africans, the State, and the Market in Manica District, Mozambique, 1895-c. 1935” (PhD Dissertation, Yale University, May 2002), 47-48.

themselves in East Africa. However, their attempts to seize them before the scramble failed. They renewed their efforts to control these fields in the 1880s and 1890s. Thus the original Mozambique Company was conceived as a mining enterprise. Nonetheless, the Anglo-Portuguese Treaty of July 1890 effectively excluded much of Manica's mineral resources from the Mozambique Company's territory.⁵⁴ Both companies soon found that the gold deposits were scattered and difficult to extract, unlike those of the Transvaal in South Africa. The companies therefore directed some of their efforts to agriculture and cattle-rearing, with the Mozambique Company, in particular, adopting a policy of granting large sub-concessions to individuals and companies in return for a share of their profits.

The American Board Mission in the Manica region

The analysis of the impact of colonial public health and western medicine would be incomplete without an examination of the contribution of the American Board of Commissioners for Foreign Missions (ABCFM, hereafter American Board Mission) in the southern part of the Manica region. The American Board Mission was the first American Christian foreign mission agency. Established in 1810, its orientation was congregational although it accepted missionaries from various denominations. The mission was involved in many activities, such as Bible translation, education, and medical care. It established its earliest mission stations around the world between 1812 and 1840.⁵⁵ Its work in eastern Zimbabwe and central Mozambique (called the East

⁵⁴ *Ibid.*, 40.

⁵⁵ Charles A. Maxfield, "The Formation and Early History of the American Board of Commissioners for Foreign Missions, 2001. This is an online copy (with minor revisions) of the third chapter of the author's dissertation titled "The 'Reflex Influence' of Missions: The Domestic Operations of the American Board of Commissioners for Foreign Missions, 1810-1850," Union Theological Seminary, Richmond, Virginia, 1995.

Central Africa Mission) was an extension of the work begun among the Zulu in South Africa.⁵⁶ The influence of the American Board Mission is still felt in eastern Zimbabwe today through the United Church of Christ in Zimbabwe (UCCZ) and its various schools and hospitals, including the first school at Mt. Selinda. The American Board Mission was also influential in Mozambique, where it opened stations at Beira on the Indian Ocean coast and another one at Gogoi about thirty five miles east of Mt. Selinda.

As the American Board Mission expanded its work from South Africa, their first port of call was the Inhambane Bay in south-eastern Mozambique where it opened a station in 1880. However, the mission's decision-making body, the Prudential Committee, voted to abandon the Inhambane site after thirteen years of operation because of poor health conditions there and sought to open a new site inland. After three expeditions to Gazaland, one in 1879 to Mzila, another in 1888 to Gungunyana, son and successor of Mzila, and the last one in 1891, the Prudential Committee authorized the "Pioneer Expedition to Gazaland" in May 1892. This expedition consisted of Rev. G. A. Wilder, of the Zulu Mission, Rev. F. R. Bunker and Dr. W. L. Thompson of the East African Mission (Inhambane).⁵⁷

Following several weeks of travels and inquiries, the "Pioneer Expedition to Gazaland" concluded that the most desirable place for the new station was in the territory of Chief Mapungwana, within the limits of the BSAC on the northern slope of Mt. Selinda. This site had an elevation of about 4,000 feet above sea level, "with fertile soil, sweet water, and a goodly native population near at hand."⁵⁸ This was the same site that

⁵⁶ Judson Smith, *A History of the American Board Missions in Africa* (Boston, MA: American Board of Commissioners for Foreign Missions Congregational House, 1905), 28.

⁵⁷ American Board of Commissioners for Foreign Missions (hereafter ABC) 15.6, Box 1, "Report of Sub-Committee accepted and adopted by the Prudential Committee, February 14, 1893.

⁵⁸ Ibid.

Cecil John Rhodes, had recommended to these missionaries in 1891. The American Board Mission received a total of 15,000 morgen (about 37,500 acres) of land from the BSAC of which 6,000 was at Mt. Selinda and the remainder at Chikore (Craigmore) fifteen miles west of Mt. Selinda.⁵⁹

After experiencing the malarial condition of the Inhambane station, the missionaries had to choose a site that met certain criteria. Chief among the factors considered was that the Mt. Selinda site was on high ground, “free from malaria, and undoubtedly more healthful than any other site near Inhambane.” At this time the boundary between Rhodesia and Portuguese East Africa (hereafter PEA) had not been defined. However, when the Boundary Commission completed its work later in 1899, the missionaries found that much of their land had fallen into PEA territory although their main site at Mt. Selinda remained in Rhodesian territory. This prompted efforts to open another station in PEA territory because neither of the two administrations tolerated cross-border movements of Africans. Africans from PEA could not travel at will to attend school and have medical care at Mt. Selinda in Rhodesia. In 1912 the American Board Mission investigated the feasibility of opening a new station in PEA.⁶⁰ They wished to establish a chain of stations linking Mt. Selinda and Beira. By 1917, after protracted correspondence with the Mozambique Company, Dr. W. T. Lawrence, established a station at Gogoi, where he also set up a school and a clinic.⁶¹ Missionary staff frequently moved across the border between the two stations. The American Board Mission also established some outstations in the Sabi Valley and in Rusitu and Mutema in eastern

⁵⁹ ABC 15.4, volume 23, Report of East Central Africa Mission under the American Board of Commissioners for Foreign Missions—submitted by the Congregational Church of the United States and Canada, 1901.

⁶⁰ ABC 15.4, volume 32, Special Meeting of the Rhodesia Branch of American Board Mission in South Africa, Mt Silinda. October, 15-17, 1912.

⁶¹ ABC 15.4, volume 32, “First Annual Report of Gogoyo Mission Station, 1917.

Zimbabwe. The Sabi Valley outstations encompassed areas such as Kondo, Chibuwe, Chisumbanje and Mahenye. Mt. Selinda remained the center of Mission activities and it was the first to have a hospital, followed by Chikore.

Rennie argues that the Mission's strategy regarding Africans was to erode the foundations of traditional society by creating a new class of individualist westernized Christians operating in the market economy.⁶² Mission policy towards traditional medicine and traditional doctors was also influenced by the same strategy, with Mission doctors considering traditional doctors to be institutional rivals and trying to undermine their influence by inculcating biomedical knowledge of disease.

Anglo-Portuguese relations

Throughout the colonial period Rhodesians treated their Portuguese neighbors with contempt. They considered the Portuguese colonial state to be too weak to foster any meaningful development and therefore regarded PEA as a threat to the health of Rhodesia. The border therefore became a problem for colonial public health officials. Rhodesian authorities argued that the Mozambique Company government did not do enough to control diseases. Hence they complained that diseases were spread from the Portuguese side of the border into Rhodesia. However, the Portuguese also alleged that diseases were spreading into their territory from Rhodesia and took preventive measures. These back and forth accusations and fears among colonial officials clearly demonstrate that the border was a major problem in the implementation of public health policy.

Although it was true that the Mozambique Company did not have the same amount of resources that the BSAC (and later the Rhodesian Government) had, it also embarked on coercive public health policies such as smallpox vaccination. The scale of

⁶² John Keith Rennie, "Christianity, Colonialism and the Origins of Nationalism, 65.

these public health initiatives were dictated by the availability of resources and the presence or absence of pressure from European settlers. In order to safeguard their own health, settlers pushed the colonial governments to embark on public health programs that turned out to be intrusive and discriminatory.

While all new settlers faced financial problems, the Rhodesian Government quickly came to the rescue of its settlers by providing loans and other incentives to start commercial farming. However, lacking in funds, the Mozambique Company resorted to granting large sub-concessions to companies and individuals in return for a share of their profits. The financial problems of this company could be traced back to the beginning of its operations in the region, involving its failure to construct a railway from Manica to the coast. This was one of the fundamental requirements in the Mozambique Company's charter. Barry Neil-Tomlinson contends that while this railway was meant to provide communication essential to the development of mining, it was also probably influenced by the realization that Britain would not recognize Portugal's claims in East Africa unless guaranteed a means of ready access to the coast.⁶³ Without any means with which to construct the railway, the Mozambique Company conceded this right to a Dutch businessman, who after failing to raise the capital later conceded this right to the BSAC, which quickly formed the Beira Railway Company and built the railway. Thus despite the "depth of Portugal's anti British feeling throughout the scramble, it was finally the BSAC which built the railway across Portuguese East Africa," because "only the BSAC had both the commitment and the financial weight to build the railway."⁶⁴

It was not long before the missionaries of the American Board joined the Rhodesians in condemning Portuguese colonialism. The missionaries perceived Portuguese colonialism as a threat to their aspirations and the health of the region in

⁶³ Barry Neil-Tomlinson, "The Mozambique Chartered Company, 1892 to 1910," 21.

⁶⁴ Ibid., 30.

general. While they also condemned forced labor on Rhodesian settler farms, the American missionaries had a particularly low opinion of the morality of the Portuguese and considered the Portuguese colonial regime oppressive of Africans and of religious freedom. The American missionaries pushed to have Portugal stripped of her colonial possessions at the 1919 Paris Peace Conference. Their efforts failed, but these deliberations demonstrate the extent of their resentment of the disruption of African society by forced labor, slavery, and other colonial demands. As the following chapter shows, these practices affected the ecology of diseases in the region leading to public health problems and intrusive public health measures.

The border

Although the Zimbabwe-Mozambique border ran along a crest of mountains, which Europeans took to be communication barriers, there were passes and drainage systems that ensured communication and cultural uniformity. In this respect, therefore, the border was drawn arbitrarily, cutting off people of common origin, religion, ethnicity, language, marriage, and blood from each other. D.N. Beach contends that demarcation of the frontier between Mozambique and its Anglophone neighbors was not reflective of long-term historical realities in the region, but was merely a product of the 1891 Anglo-Portuguese treaty. He argues that the treaty “brought a border that cut through larger numbers of African territories on the border areas and across long-term links between the peoples and economies of the Zimbabwean plateau.”⁶⁵ This is what Africanists,

⁶⁵ D. N. Beach quoted in Nedson Popiwa, “The Political and Economic Relations between Mozambique and Zimbabwe, 1890s to the present: A Literature Review,” (Unpublished paper, Department of Economic History, University of Zimbabwe, 2005), 4. One of the border areas I study (area from Chambuta to Zangiwo in north Mosurrize and Sussundenga districts, Mozambique, probably adjacent to Chipinge and Chimanimani district of Zimbabwe, respectively) is really “Zimbabwean” considering the fact that the people there rely heavily on Zimbabwe. The people in this area use Zimbabwean currency and that is all the currency they know. Most of them do not know how the Mozambican currency, the Metical, looks like and

according to David Hughes, constantly term an “artificial border.”⁶⁶ Because of such ties across the border, it is tempting to consider the border to be of little consequence.

Recent work on African borders and borderlands reflects the views of three groups of scholars: those who view boundaries as powerful and progressive-serving to define and advance ideas, activities and outcomes in many domains of social and intellectual life; those who see boundaries as powerful but oppressive, serving to limit and exclude; and a third, recently expanding group who tend to portray boundaries as permeable, contested and not so powerful in shaping the course of events.⁶⁷ Sara Berry argues that fixed territorial boundaries often operate to constrain people’s movements, and restrict people’s access to opportunities and resources:

Title deeds, fences, buffer zones, district and national boundaries all represent (and help to enforce) the right of some individuals or groups to exclude other as well...territorial boundaries can become instruments of oppression and hardship whether imposers are European settlers protected by colonial rule, African herd owners who decide to open range, or governments who harass or expel peaceful and productive residents on the grounds that they are “aliens” from neighboring countries.⁶⁸

Scholars have attempted to apply these three categorizations to the history of the Zimbabwe-Mozambique border. Dismissing the concept of an “artificial border,” David M. Hughes contends that the Zimbabwe-Mozambique border is “hard” and constraining

many do not even have Mozambican identity documents, such that they are harassed, like the now unpopular poor Zimbabweans when they visit urban areas in Mozambique.

⁶⁶ David Hughes, *From Enslavement to Environmentalism: Politics on a Southern African Frontier* (Seattle: University of Washington Press in association with Weaver Press, Harare, 2006), 75.

⁶⁷ S. Berry, “Crossing boundaries, Debating African Studies,” Paper presented at the Fifth Annual Penn African Studies Workshop, October 17, 1997.

⁶⁸ *Ibid.*, p.3. Throughout the colonial period there were colonial officials reported having problems with African cattle herders, who crossed the border, probably to look for greener pastures. This presented a problem for both Veterinarians and Public Health officials concerned about the spread of diseases and often implemented heavy-handed border control policies in response to these movements.

because people “cross it, but emigration strips at least some people of their rights and securities they regularly enjoy at home.”⁶⁹ He argues that this conditional, prejudicial permeability of border characterized much of Southern Africa, just as T.O. Ranger asserts that Britain, Portugal, and France drew Africa’s borders as “sifters of labour rather than as barriers to its movement.”⁷⁰ This dissertation considers the border to be both restrictive and porous at the same time. It was restrictive because colonial officials monitored and limited movements of people across it. This often happened on official ports of entry which were easily accessible, usually by road and on foot. While these official ports of entry regulated movement, there were numerous bush paths that Africans used to cross the border, where nobody could restrict them. This demonstrates that the border was porous. However, these bush paths had restrictions of a different nature. They were not easily accessible. They usually were in areas of difficult and hazardous terrain, such as mountains. Africans therefore had to climb up and down steep mountains, usually with heavy luggage. This is not to mention how many limbs and lives were lost to Mozambicans trying to cross the mine-infested border in the 1970s in search of food after drought and famine struck their lands. Some informants recounted the ordeal in this way,

After independence in Mozambique [1975], there were shortages of basic commodities such as salt, soap and cloth. The only alternative was to cross the border into Rhodesia. But at this time, the war of independence had begun in Rhodesia. People started to go and steal from the settlers in Rhodesia. Then the Rhodesians planted land mines. Many people perished from these mines as they attempted to procure salt and soap. There was a general lack of hygiene due to these shortages and people resorted to using leaves of wild plants and chaff [by-product of pounding maize corn] as soap. These methods were not very effective in removing

⁶⁹ David Hughes, *From Enslavement to Environmentalism*, 76. See also David. M. Hughes, “Frontier dynamics: Struggle for land and clients on the Zimbabwe-Mozambique border,” Ph. D. Thesis, University of California, Berkeley, 1999 and David. M. Hughes, “Cadastral politics: the making of community-based resource management in Zimbabwe and Mozambique, *Development and Change* 32, no. 4 (2001): 741-768.

⁷⁰ T. O. Ranger quoted in David Hughes, *From Enslavement to Environmentalism*, 76-77.

dirt. It was impossible to wash blankets. So people shaved their heads [to get rid of lice] and wore sacks. The only people who wore clothes were those who had husbands working in South Africa, but even for them it was not easy to get these clothes because goods from South Africa now had to come through Maputo, not by the easier route through Rhodesia. Maputo was too far [more than 1,000 kilometers] and most of the bridges along the way had been destroyed or closed. So the closure of the border caused much pain and suffering.⁷¹

Overview

This dissertation argues that settler fears of infection and economic considerations influenced colonial public health policy. It therefore examines infectious and communicable diseases in accordance with their perceived degree of severity and ease of transmission to settlers. Thus Chapter II deals with trypanosomiasis, a parasitic disease of both humans and animals, transmitted by tsetse flies. This disease led to colonial attempts to restrict mobility of African cattle keepers across the border. The border heightened Rhodesian settler fears of infection, particularly from PEA, widely regarded within the settler community as a poorly-governed colony and a hotbed of disease. This chapter also shows that colonial intrusion and establishment of colonial economies led to the disruption of African ways of managing the disease, leading to the worsening of the disease situation under colonial rule. Much of the pressure to implement public health policy came from settlers who wanted protection for their families and their livestock. In the end, it was the Africans who bore the brunt of intrusive colonial trypanosomiasis

⁷¹ Group interview, Chambuta, Mozambique, 22 September, 2006. Many informants in Mozambique who cited the problems they encountered while attempting to cross the border. After the Zimbabwean war of independence (Second Chimurenga) commenced in the 1970s, the colonial government planted landmines along the Zimbabwe-Mozambique border to prevent the movement of Africans to and from training camps in Mozambique (had just gained its independence in 1975). The colonial government closely monitored the official entry points to the extent that Mozambicans who were facing famine could not easily cross to get food from Zimbabwe. They therefore resorted to using the mine-infested bush paths. Many informants indicated that they knew of the dangers but there was no alternative. Many domestic and wild animals were also caught up in these mine-infested areas.

prevention and control, such as the destruction of flora and fauna, creation of buffer zones, and restriction of movements of both humans and their domestic animals which affected transhumance. All this had a significant impact on how Africans perceived western medicine.

Chapter III then considers cross-border movements and their implications on the spread and control of Sexually Transmitted Diseases (STDs). If trypanosomiasis, transmitted by a tsetse fly, led to fears within the settler community, then STDs, spread by sexual contact, was worse. This chapter argues the porosity of the border hampered colonial attempts to control diseases in individual colonies, leading to colonial efforts to regulate African mobility. As usual, settlers employed the colonial notion of the African “Native” as a reservoir of disease, a notion which was driven by their fears of infection and often based on erroneous understanding of disease epidemiology. Claims by settlers that STDs were spread by articles of clothing, by sharing drinking cups, or by simply talking to a sufferer, were unfounded and were convenient ways of evading questions of immorality or promiscuity. Thus while various commentators have argued that medical examinations for venereal disease were part of influx control measures in Rhodesia and that African women’s bodies were regulated for their “potential to infect African [not white] men with venereal disease,”⁷² settler fears for their own health should not be underestimated. These fears of spread of disease were heightened by the scale of African movement, including movement from the supposedly unhealthy Portuguese territory in particular. The border itself invoked the imagination of a distant “other,” the governed and diseased PEA, which, in reality, was not far way.

The colonial response was to severely regulate African mobility and force Africans to undergo shameful medical examinations which involved stripping and

⁷² Lynette A. Jackson, “When in the White Man’s Town”: Zimbabwean Women Remember Chibaura,” in *Women in African Colonial Histories*, ed. Jean Allman et al. (Indianapolis: Indiana University Press, 2002), 191-215.

exposing their genitals for inspection by total strangers. Hence, this chapter demonstrates how colonial public health policies against STDs interfered with African ideas of privacy and masculinity. It shows that the settler notion of the “Native” as a reservoir of disease led to the implementation of invasive public health policies, which hindered the colonial effort to convince Africans to embrace biomedicine.

Chapter IV moves on to what was probably the worst infectious disease, smallpox. Smallpox did not require any medium nor sexual contact, as was the case with trypanosomiasis and STDs. Inhaling the airborne virus through droplets from the nasal or oral cavity of an infected person in a prolonged face-to-face contact could spread the infection. In addition, direct contact with infected bodily fluids or infected objects (fomites), such as clothing and bedding could also result in the transmission of smallpox. Chapter IV demonstrates that the border continued to be an obstacle to the implementation of effective regional public health policy. This chapter shows that in their attempts to control infectious diseases, colonial governments enforced intrusive public health policies, such as depriving Africans of their right to congregate for religious purposes. Africans responded in different ways. While some reluctantly submitted to vaccinations, others put up overt resistance. Because the colonial officials did not explain what they were doing and why they were doing it, some Africans were unwilling to undergo vaccination. It is not surprising therefore that some Africans failed to embrace western medicine because public health policy was mostly driven by settler concerns and fears than the concern for African health.

The settler community’s last line of defense against disease was treating disease in Africans. As the Medical Director for Rhodesia put it, the best way to create a health settler community was to tackle infectious diseases in Africans. This explains why efforts to expand health services for Africans came relatively late in the 1930s and early 1940s and also why they were influenced by the size and political strength of visitors in each colony. As Chapter V examines health service delivery for Africans under colonial rule,

therefore, it also attempts to make comparisons between Rhodesia and PEA, highlighting the differences in regime strategies and attempts at cooperation to control diseases. It argues that while African societies were open to innovation, the discriminatory nature and ineffectiveness of colonial medical services prevented Africans from embracing biomedicine.

In addition, this chapter investigates whether colonial public health measures and their modes of delivery failed because they did not consider African understandings of disease and healing. It argues that colonial governments' insistence on confining Africans in hospitals for treatment under European supervision denied Africans one of their principal approaches to healing. This approach was based on an out-patient treatment procedure which gave Africans a high degree of control over the healing process.

Chapter V also argues that colonial attempts to suppress traditional healing were based on utter disregard for African understandings of disease and healing. Many Africans believed that there were some diseases that could not be treated by western medicine, particularly those caused by spirits, sorcery and witchcraft. That was why Africans resented colonial attempts to suppress traditional healing and pre-colonial public health measures, such as identification and hunting for sorcerers and witches believed to cause certain diseases. For some Africans, the hospital was the last resort after consultations with traditional healers (known as *n'anga* among the Shona) because they believed that it was important to find out whether or not a disease was caused by an evil spirit before using western medicines.

The modern medical establishment failed Africans because colonial governments only paid lip service to treatment-based initiatives that Africans favored, leaving much of the burden to missionary establishments. The final chapter thus focuses on the cross-border operations of the American Board Mission Hospital at Mt. Selinda in Rhodesia and a clinic at Gogoyo in Mozambique. It also explores why Africans preferred missionary medicine to government medicine.

The conclusion links the current lack of confidence in biomedicine and survival of traditional medicine to the legacy of colonial public health. It also considers some findings arising from this research and their implications on the reception of western medicine in the Manica region and the entire region of Southern Africa. Chief among these findings is whether colonial public health failed to convince Africans to embrace biomedicine because it did not consider African understandings of disease, epidemiology, and healing. The conclusion takes up all the issues concerning the discriminatory and intrusive public health policies to account for the failure of colonial public health in the Manica region.

The research for this dissertation began in 2003 in both Mozambique and Zimbabwe as research for a Master's essay. Subsequent research trips in 2004 and 2006 enabled me to collect archival documents, oral histories, and to consult with several government departments in both Mozambique and Zimbabwe. As a result, this project relies heavily on archival documents from the National Archives of Zimbabwe and the documents of the *Companhia de Moçambique* (Mozambique Company) from *Arquivo Histórico de Moçambique*. These documents include reports and correspondence. The Mozambique Company governed central Mozambique for fifty years, from 1892 to 1942, and left much documentation that deals with many aspects of its reign, including health issues. After 1942, the sources on the Mozambican section of the Manica region become rare. Thus this dissertation depends largely on oral histories for this post-1942 period. Sources for Zimbabwe are more readily accessible than those for Mozambique. This accounts for the imbalance of detail evident in some parts of this dissertation.

In addition to the National Archives of Zimbabwe, I also consulted the Department of Agriculture as well as the Natural Resources Department. In Mozambique, I also consulted the Direcção Nacional de Pecuária and the Department of Tsetse Control. The records of the American Board of Commissioners for Foreign Missions also formed the backbone of this research. These are housed in the Houghton Library of Harvard

University in Boston, Massachusetts. The Missionary sources consist mainly of correspondence between missionaries abroad and the directors of the American Board of Commissioners for Foreign Missions in Boston and reports on the medical, evangelistic, and educational activities of the missionaries. These records also include reports on the relations between the mission and colonial governments and minutes of meetings.

Oral histories also play an important role in this dissertation, particularly in determining African perceptions of disease and healing, as well as the impact of colonial public health policy. These were collected between 2006 and 2007, some by the author, and others by research assistants. The interviews were conducted in Shona, a language spoken on both side of the Mozambique-Zimbabwe border. The places visited on the Zimbabwean side include Penhalonga (Tsvingwe Village, Old West Mine Compound, Elim Mission), Zimunya (Chitakatira, Mvududu, Nehwangura, and Nyamakamba villages), Ngaone, and in areas surrounding Mt. Selinda, such as Beacon Hill, Days Hill, Holland Farm, Maengeni Village, and Vheremu. A few more interviews were conducted at Tanganda Halt in the semi-arid part of the Chipinge district and in Harare. On the Mozambican side, interviews were carried out in Chambuta and Zangiuro in the Sussundenga district, and at Spungabera and areas surrounding it, such as Mamuse, Makubvu, Mpanyeya, and Muedzwa in the Mossurize district. I have intentionally left out the names of interviewees because most of the interviews were conducted on the understanding that the names would not be made public due to political considerations.

CHAPTER II
MISTAKEN POLITICAL ECOLOGY OF DISEASE:
TRYPANOSOMIASIS
(SLEEPING SICKNESS)

In any district where the glossina morsitans fly is common there is always a grave possibility of an epidemic of sleeping sickness in the event of an outbreak being started by infective natives.

R. A. Askins, Medical Director, Southern Rhodesia, 1930

Introduction

Many pre-colonial societies, including those of southern Africa, maintained control over trypanosomiasis through environmental modification. Outbreaks of trypanosomiasis depended upon the delicate relationship between vectors, hosts, human populations, and the habitat. With the advent of colonialism, however, Africans lost control over the environment due to land alienation and other colonial demands, such as demands for wage and forced labor. Colonial rule in both Rhodesia and PEA introduced new land use patterns and labor requirements which affected the relationship between villagers and their environment, and in turn, altered their ability to control trypanosomiasis. In addition, abandonment and neglect of land by European settlers and companies due to undercapitalization and for speculative purposes promoted the development of habitats which favored the growth of vector populations, leading to an increase in the incidence of trypanosomiasis outbreaks during the colonial period. This chapter argues colonial states, particularly Rhodesia, implemented invasive trypanosomiasis control measures which contributed to distrust of public health not only because they wanted to control bovine trypanosomiasis, but also due to fear of spread of human trypanosomiasis. Yet, this fear was based on an erroneous epidemiological understanding of trypanosomiasis. This mistaken thinking was influenced by Rhodesian

settlers' imagination of the border through a more diffuse feeling that PEA was a backward, poorly-governed (by Iberians) and unhealthy territory.

Another aim of this chapter is to show that these fears of the spread of trypanosomiasis from PEA led Rhodesians to neglect ecological changes (neglect of and abandonment of land) engendered by colonialism within Rhodesia itself which may have contributed to increase of trypanosomiasis in Rhodesia. These fears of PEA also served in a sense as a cover for the Rhodesians, allowing them to stir up fear of the spread of disease from the outside as a way of diverting attention from the neglect of land in Rhodesian itself. Thus the increase of trypanosomiasis cases in Rhodesia involved two factors, one being the spread from PEA, but the other being changes in land use which made areas of Rhodesia more hospitable for tsetse flies.

Because the border influenced settler imagination, another objective of this chapter is to examine the implications of the environment and cross-border movements in colonial attempts to control trypanosomiasis by focusing on one of the central arguments of this dissertation: that movements of people changed disease ecologies, thereby affecting disease prevalence and control. It thus builds upon the understanding of the historical and physical environment of the Manica region discussed in Chapter I by examining how pre-colonial peoples interacted with their environment and how colonial policy altered these interactions. It therefore explores the epidemiological consequences of the establishment of colonial rule in the Manica region as well as the significance of the international border in disease control efforts. Writing in 1971, John Ford commented that the “existence of a modern international boundary on one side of which no development is taking place [Mozambique] suggests that it [trypanosomiasis] may continue to exist for many years to come.”¹ Hence this chapter looks at control programs

¹ John Ford, *The Role of Africa Trypanosomiases*, 335.

in both Mozambique and Zimbabwe and attempts to make a sense of the colonial border in efforts to control trypanosomiasis.

In their mission to eradicate “ignorance” and institute benefits of “civilization,” the European colonists largely dismissed African knowledge systems as “primitive” and unscientific. They set aside much of the praise that early explorers gave to African agricultural systems in order to make way for colonial “science.” As was the case with other diseases, European settlers blamed Africans for the spread of trypanosomiasis. They perceived Africans as the reservoirs of infection and considered African migrants to be responsible for spreading infection. However, trypanosomiasis was also intimately linked to environmental factors, such as rainfall, temperature, and vegetation. Yet, as this chapter argues, Africans bore the brunt of erroneous and ineffective tsetse and trypanosomiasis control measures. Colonial land alienation pushed Africans to the marginal and tsetse-infested areas where they and their cattle became buffers between tsetse areas and white farms. The border also interfered with African grazing patterns and African mobility. Trypanosomiasis control measures involving cattle and game fences along the border prevented some forms of transhumance which had contributed to protecting cattle from trypanosomiasis in the pre-colonial period.

Trypanosomiasis is a vector-borne parasitic disease caused by *trypanosoma*, which are protozoa transmitted to humans and animals by the tsetse fly (*glossina*). It affects both humans and animals. In Rhodesia and PEA, animal trypanosomiasis occurred wherever tsetse flies were prevalent. These tsetse flies exist widely in Africa and are usually found in vegetation along rivers and lakes, in gallery-forests and in vast expanses of woodland savannah.

Human African trypanosomiasis is also known as sleeping sickness. It is transmitted to humans by bites of tsetse fly which have acquired their infection from human beings or from animals harboring the human pathogenic parasites. Sleeping sickness exists in two forms. One is *trypanosoma brucei gambiense* which occurs in

central and West Africa. This form causes chronic infection, meaning not that it is benign, but that a person can be infected for several months or years without showing any symptoms of the disease. The symptoms emerge when the disease is already at an advanced stage. The second form is *trypanosoma brucei rhodesiense* found in southern and east Africa.² This form causes acute infection that emerges a few weeks after the tsetse fly bite. It tends to be more virulent than the former. As a result, it is detected earlier than the former strain. This strain is conveyed by tsetse fly *Glossina (G) morsitans*, which infested north-western parts of Rhodesia and much of PEA, including the areas on the border with Rhodesia.

The fact that the second strain of disease was spread by *G. morsitans* is crucial because over the course of the colonial period, Rhodesian officials invested much effort in trying to prevent the spread of *G. morsitans* from PEA in order to protect both domestic animals and humans.³ Equally crucial was the belief in early twentieth century Rhodesia in the possibility of the “passage of a human trypanosome through a domestic animal.” Researchers in Rhodesia discovered around 1910 that some trypanosomes which could infect humans existed in both man and animals wherever *G. morsitans* were known to be present, and “since at that time [1910] this fly was known to exist in over ten thousand square miles of [Rhodesian] territory, the situation appeared somewhat alarming.”⁴

² National Archives of Zimbabwe (hereafter NAZ) S1173.266: Public Health Department – Human Trypanosomiasis, Southern Rhodesia, 1934. Rhodesian officials often indicated that that this name was somewhat a misnomer (with the potential to hurt Rhodesian efforts to attract European settlers) as this strain occurred in other colonies, such as Tanganyika, Nyasaland and Portuguese East Africa as well as in Northern and Southern Rhodesia.

³ NAZ, F122/FH/30/1/1: The fight against tsetse fly in the British African Dependencies, undated (probably written in the period after 1955 because it quotes documents written that year).

⁴ NAZ, S246/256: Notes on the Human Trypanosomiasis of Southern Rhodesia, undated (probably written in the period after 1934).

Although there were no epidemics of human trypanosomiasis during the colonial period in the Manica region, officials were concerned about an outbreak of an epidemic. As the Medical Director for Rhodesia put it, “In any district where the *glossina morsitans* fly is common there is always a grave possibility of an epidemic of sleeping sickness in the event of an outbreak being started by infective natives.”⁵ This explains the high level of interest that the Rhodesian Government invested in prevention and control methods in the Chipinge district, bordering portions of PEA that were infested with *G. morsitans*.

Embryonic research and erroneous views at that time also fanned the fears of epidemics. While some researchers thought that the animal trypanosome was “not pathogenic to normal man because of the trypanocidal action of his blood,” others believed that under certain conditions (pathogenic or dietetic), the trypanocidal substance disappeared from the human blood leading to susceptibility to infection with animal trypanosome.⁶ However, the realization that both humans and animals were involved in the transmission of human trypanosomiasis amplified the public health threat posed by, and subsequent colonial efforts to control human and animal (domestic and wild) mobility both within and across territorial boundaries.

This chapter examines how the inter-territorial boundary between Rhodesia and PEA, cross-border movements, and ecological disruption complicated the control of trypanosomiasis. The border was a factor because it divided a region whose environment was conducive to the prevalence of *glossina*. In order to fully grasp the impact of trypanosomiasis control on the African reception of public health, it is necessary to examine the prevalence of trypanosomiasis in domesticated and wild animals partly because fears of the spread of human trypanosomiasis based on erroneous ideas, affected

⁵ NAZ, S1173/336: Preliminary Report on the Medical Treatment of Natives, R.A. Askins, Medical Director, Rhodesia, 8th September, 1930.

⁶ NAZ, S246/256: Notes on the Human Trypanosomiasis of Rhodesia, undated (probably written in the period after 1934).

public health policies, border monitoring, and ultimately, African reception of colonial public health. This chapter therefore uses veterinary records to map animal trypanosomiasis which reinforced of the potential for an epidemic in humans in both Rhodesia and PEA.

An example of erroneous ideas about trypanosomiasis was the claim by E.W. Bevan, who asserted in 1934 that trypanosomiasis could be “transmitted by blood-sucking flies other than the tsetse, [making] the danger [posed by trypanosomiasis] ... immeasurably greater.”⁷ Bevan claimed that trypanosomiasis had been known to occur where the tsetse fly appeared absent. Entomologists were thus inclined to attribute these cases of trypanosomiasis to “mechanical transmission” by flies other than the tsetse. In explaining these scientific views about trypanosomiasis, this chapter is concerned with the policies that emerged from these different epidemiological views and their impact on the African population.

What happened under colonial rule can be classified into three processes: first, the partitioning of land and demands for labor which interfered with pre-colonial tsetse and trypanosomiasis control; second, the attempt by colonial officials to establish sterile zones around settlers’ lands to prevent transmission; third, the implementation of widespread eradication of flora and fauna in addition to border control methods and use of residual insecticides to control the disease. Officials involved in tsetse and trypanosomiasis control efforts were from various departments, such as Veterinary, Public Health, Entomology, Native Affairs, Agriculture, and Tsetse Fly and Trypanosomiasis Control and Reclamation. The Zimbabwean war of independence in the 1970s and the Mozambican civil war (1975-1992) complicated efforts to control trypanosomiasis, leading to an increase in the incidence of the disease. In order to fully grasp the

⁷ NAZ, S246/524-525: Research in Trypanosomiasis, quarterly report by E.W. Bevan, Southern Rhodesia, 10th December, 1934. Bevan was a researcher in trypanosomiasis and his work was funded by the Beit Railway Trustees of London.

significance of environmental modification by pre-colonial societies and the colonial onslaught on flora and fauna, it is important to examine the roles of both vegetation and wildlife in the occurrence of trypanosomiasis and the next section looks at these two factors.

The ecology of trypanosomiasis

Tsetse fly distribution is greatly influenced by environmental factors like density and type of temperature and vegetation. These factors in turn determined tsetse control methods employed by colonial officials. Research on tsetse flies has always shown their restriction to forests, woodlands, and tree savanna as an “adaptation for escaping the ill effects of overheating and desiccation.”⁸ Temperature thus plays a crucial role in the ecology of the tsetse fly, for apart from its effect on the inter-larval and puparial durations (stages in the life cycle of tsetse flies), it also affects the fly’s activity. Tsetse flies become inactive at temperatures below 15°C (59°F). If temperatures go above 35°C (95°F), tsetse flies seek out refuge, in such places as rot-holes in trees, animal burrows, and deep fissures in bark, where they also become inactive.⁹ In 1942, R. W. Jack, former Chief Entomologist in Rhodesia’s Department of Agriculture found through laboratory experiments, that “loss of water is the most serious risk to which tsetse flies are exposed in nature...” and that this was “a serious weakness in the life economy of the tsetse.”¹⁰ Temperature therefore must stay roughly within the 16°C to 35°C range during the day for tsetse flies to remain active and enable them to seek food. Temperature is also closely associated with altitude. In Rhodesia, with a total area of 150,344 square miles, tsetse

⁸ John Ford. *The role of the trypanosomiases*, 288.

⁹ Ibid.

¹⁰ R. W. Jack, “The Life Economy of a Tsetse Fly,” *The Rhodesia Agricultural Journal*, 41 no.1/2 (1944), 28.

flies were not found in areas above 4,000 feet above sea level. This reduced the potential area of infection to 100,000 square miles.¹¹

Researchers believe that tsetse flies need shade, probably to shield them from excessive dehydration. The availability of trees is also important for providing shade for tsetse flies. Grasslands do not support tsetse flies, but all forms of woodland, from savannah to rain forest, usually provide a suitable habitat for some species of tsetse flies. Artificially planted vegetation usually provides a suitable habitat for tsetse flies and so do thickets which develop on abandoned agricultural land, especially those comprising *Lantana camara*.¹² This plant existed in certain areas of the Chipinge district in Rhodesia. In 1955 the Native Commissioner (hereafter NC) for this district reported that *lantana camara*, “a perennial decorative shrub, initially a garden escape, abounds in the Chinyaduma Division where it has ruined much valuable land.”¹³ Hence, one vegetation type may not be suitable for all species of tsetse flies.

Tsetse fly distribution was dependent on the ecology of the fly. In Rhodesia there were three species of tsetse, *G. morsitans*, *G. pallidipes*, and *G. brevipalpis*. *G. morsitans* existed in the rather dry northern part of the Colony, in and adjoining the Zambezi Valley, and was found again just across the south-eastern border of the Colony. The two other species existed mostly in the wetter areas of the Colony along a small part of the south-eastern border of the Colony near Mt. Selinda.¹⁴ These two species were also

¹¹ NAZ, S246/524-525: Research in Trypanosomiasis, quarterly report by E.W. Bevan, Southern Rhodesia, 10th December, 1934.

¹² R. J. Phelps and D. F. Lovemore, “Vectors: Tsetse flies,” in *Infectious Diseases of Livestock, with Special Reference to Southern Africa*. Volume I, ed. J. A. W. Coetzer, et al. (Cape Town: Oxford University Press, 1994), 25-51.

¹³ NAZ, S2827/2/2/3: Report of the Native Commissioner, Chipinga, for the year ending 31st December, 1955.

¹⁴ NAZ, 483/53/2: Trypanosomiasis and Tsetse fly, 1948-1950—Meeting of the Technical Officers engaged on Tsetse fly control, 15th May 1950, Central African Council.

present in high density on the Portuguese side of the border, as was *G. morsitans* and *G. austeni*. Rhodesian Chief Entomologist, R.W. Jack noted, *morsitans* was an open forest tsetse fly, which avoided the interior of thickets and close forest.¹⁵ It was capable of enduring a comparatively dry, almost semi-arid climate, and unless the temperatures became too high, it was apparently intolerant of very humid conditions. That was why this species of tsetse occurred in the drier and less forested parts of PEA, while generally absent on densely forested and humid side of the border in Rhodesia.

G. pallidipes and *brevipalpis*, by contrast, were dependent on thicket, and both could inhabit dense forest and humid zones, although *pallidipes* was not necessarily confined to such conditions. This explains why these two species occurred in the wetter and densely forested eastern highlands of Chipinge district, whereas *morsitans* was largely confined to the drier and less forested areas. Most southern parts of the Manica region were heavily wooded, with a rain forest at Mt. Selinda extending into the Spugabera area of Mozambique as shown in Figure 2-1. The Budzi River and its tributary, for instance, had “very dense patches of bush with a clearly defined double canopy” and more scattered patches of extensive forest in other areas, which could support *G. brevipalpis* and *G. pallidipes*, respectively, in summer months.¹⁶

In addition, the Rusitu river valley, which was “very densely wooded where untouched” by cultivation, provided habitat for *G. pallidipes* and perhaps *G. morsitans* as well.¹⁷ The situation was the same on the east bank of the Save River (Sabi Division) in

¹⁵ NAZ, R.W. Jack, “The Tsetse fly problem in Southern Rhodesia,” Reprinted from *Rhodesia Agricultural Journal*, Bulletin No. 892, May, 1933, 2.

¹⁶ NAZ, F122/400/7/35/3: Report on visit to the border clearing, by R.J. Phelps, Entomologist, Department of Tsetse & Trypanosomiasis & Reclamation, Southern Rhodesia, 24th April, 1958.

¹⁷ Ibid. The Rusitu River, located north of the border clearing, runs through the Chief Ngorima’s area, the area that used to be called the Ngorima reserve before 1980. One of the dipping tank areas in this reserve, Ndima, recorded a number of trypanosomiasis cases in the 1950s.

the south-western part of Chipinge district, which infested with *G. morsitans*, as were the Honde and Rupembi catchment areas and the Msaswe River. These caused a serious animal trypanosomiasis outbreak in the Musikavanhu reserve in 1954. The Makossa Hill located in this area, with predominant *Brachystegia tamarindoides* vegetation also harbored *G. morsitans*.¹⁸ The NC Chipinga argued in 1958 that the control of the tsetse fly was made “extremely difficult by the dense bush and undergrowth and by the wooded ravines which pocket the Eastern Border,” and felt that control officials were losing the battle against the fly on the Chipinge front.¹⁹

The existence of *G. pallidipes* and *brevipalpis* on the Portuguese side of the border was also due to favorable ecological conditions. C. F. M. Swynnerton observed that there was “primary forest” consisting of “lofty, densely growing trees” that supported many woody lianas and lower tiers of evergreen shrubs with a “carpet and fringe” that could not readily burn.²⁰ He also noted that “primary forest” of the “rainforest” type existed in the highlands, mostly in small patches at Spungabera and in the Rusitu-Sitatonga rubber country. The trees that covered much of these rainforests were *Khaya nyasica* (East African mahogany or *mubaba*), *Chrysophyllum fulvum* (large *muchanja*), and *Piptadenia b Buchananii* (*umfomoti*). The *muchanja* and *umfomoti* trees largely dominated forest in the Rusitu-Sitatonga rubber country, giving it the characteristic of being regularly deciduous. However, the lianas and evergreen shrubs ensured the availability of shade for the forest fly, *brevipalpis*, and conditions conducive to its activities throughout the day.²¹

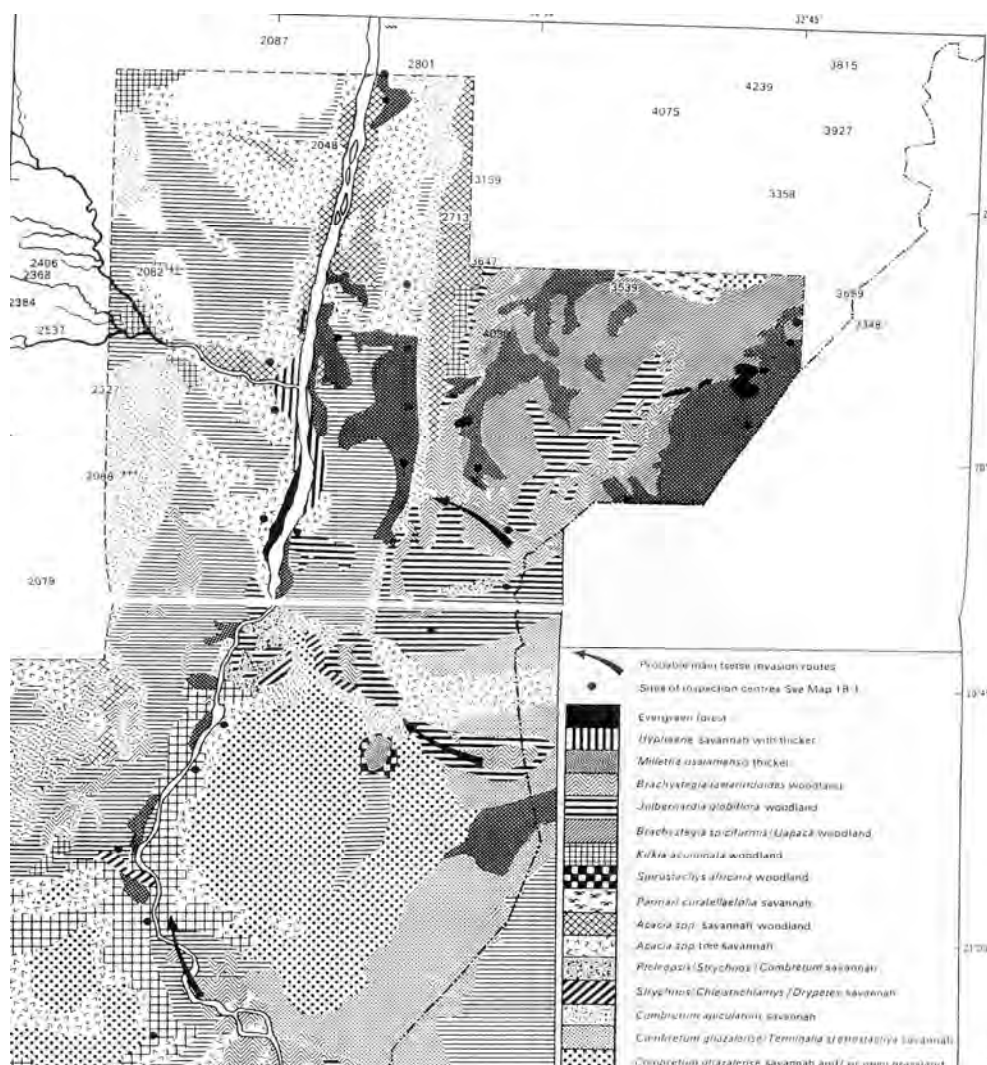
¹⁸ NAZ, FH122/400/7/35/2: Report of the Acting Director of the Department of Tsetse & Trypanosomiasis & Reclamation, Southern Rhodesia, 1956, 8.

¹⁹ NAZ, S2827/2/2/6: Report of the Native Commissioner, Chipinga for the year ending 31st December, 1958.

²⁰ C. F. M. Swynnerton, “Examination of the tsetse problem in North Mossurise, Portuguese East Africa,” 319.

²¹ *Ibid.*, 320-321.

Figure 2-1 Vegetation of the Save River Valley with main routes of spread of tsetse fly from PEA.



Farrell, J.A.K. Maps to illustrate departmental reports on the vegetation of the Sabi river valley. Department of Tsetse and Trypanosomiasis Control and Reclamation, Federation of Rhodesia and Nyasaland, Salisbury, Rhodesia, 1961.

Swynnerton also noted that “secondary forest” included the highly deciduous types (such as *Pterocarpus sericeus*/mubhungu, *Pterocarpus angolensis*/bloodwood or *mubvangazi*) which harbored tsetse fly during the rainy season, lowland bush savanna, *Brachystegia* wooding also known as *tondo* bush or *gusu*, dense secondary forest, and

Bauhinia and *Erythroxylon-Landolphia* thickets. Among these, *Brachstegia* wooding was tsetse bush par excellence.²² The distribution of sub-species of tsetse fly in Mozambique thus reflected the importance of vegetation in the tsetse fly ecology. *G. austeni mossurizensis* was found in *miombo* woodlands with dense undergrowth in the high rainfall, medium to high altitude areas along the Mozambique/Zimbabwe border, while *G. austeni austeni* was usually found in the drier coastal thickets.²³

Apart from climatic factors, wild animals also play a major role in the occurrence of tsetse flies and trypanosomiasis in the Manica region. R. D. Bigalke argues that the many species of game, such as antelopes, African buffalo, warthog, and hippopotamus are capable of surviving in tsetse fly areas.²⁴ These animals, Bigalke contends, “sometimes have high infection rates of various *Trypanosoma* spp. and hence serve as excellent maintenance (reservoir) hosts for nagana [animal trypanosomiasis].”²⁵

The tsetse flies also depend on wild animals for their blood meals, without which they cannot survive. R. J. Phelps and D. F. Lovemore assert that the distribution and abundance of some tsetse fly species, particularly *G. morsitans* and *pallidipes*, which “are often referred to as the game tsetse flies, are closely related to the numbers and habits of certain wild animals.”²⁶ They contend that the tsetse flies prefer certain animals for their blood meals such as the warthog, and bush-pig, as well as some bovidae like the kudu and bush buck. However, tsetse flies also feed on the elephant, black rhinoceros, and

²² Ibid., 321.

²³ Ibid., 37.

²⁴ R. D. Bigalke, “The important role of wildlife in the occurrence of livestock diseases in southern Africa,” in *Infectious Diseases of Livestock, with Special Reference to Southern Africa*. Volume I, ed. J. A. W. Coetzer, et al., (Cape Town: Oxford University Press, 1994). 155-163.

²⁵ R. D. Bigalke, “The important role of wildlife in the occurrence of livestock diseases in southern Africa,” 155.

²⁶ R. J. Phelps and D. F. Lovemore, “Vectors: Tsetse flies,” 29.

African buffalo. The existence of these hosts therefore contributes to the maintenance of a tsetse fly population.

Reflecting the importance of wild animals in the existence of tsetse, the Rinderpest (cattle plague) epidemic which killed many wild animals, such as the buffalo, kudu, eland, bushbuck, bush-pig, and warthog in the last quarter of the nineteenth century, led to the temporary disappearance of the fly.²⁷ The epidemic did not affect the region uniformly, however. In some localities, considerable numbers of wildlife and tsetse flies survived.

Tsetse and Trypanosomiasis control before colonial rule

This section explores pre-colonial tsetse fly and trypanosomiasis control methods and argues that these methods were more effective than subsequent colonial disease-control mechanisms. Studies of trypanosomiasis have shown that pre-colonial African societies successfully co-existed with trypanosomiasis as they achieved protection against the disease by modifying their environment in ways which affected the “sizes of and interaction among the five populations involved in the transmission of trypanosomiasis – humans, their livestock, wild fauna, tsetse flies and the trypanosome parasites.”²⁸ Villagers managed to achieve this not through wholesale eradication of tsetse flies and their habitats, but through ensuring minimum but constant contact with pathogens. They controlled tsetse populations by altering its habitats through burning and clearing for

²⁷ Ibid. Following this pandemic, tsetse flies disappeared from many areas demonstrating that the susceptible animals were their preferred hosts although nobody made this connection during that time. In fact, many observers thought the Rinderpest virus itself was pathogenic to tsetse flies, a theory which recent research has proved incorrect.

²⁸ James Giblin, “Trypanosomiasis control in African history: An Evaded Issue?,” *Journal of African History* 31, no. 1 (1990): 59-80. See also John Ford. *The Role of the Trypanosomiasis in African Ecology: a Study of the Tsetse Fly Problem* (Oxford: Clarendon Press, 1971).

fresh pastures, agriculture, and settlement. As trypanosomiasis researcher E.W. Bevan noted, in protozoal diseases such as trypanosomiasis, immunity tended to die out unless maintained by constant re-infection.²⁹

C. F. M. Swynnerton studied the methods of Mzila (son of the Nguni general, Soshangana) in controlling trypanosomiasis in the southern part of the Manica region (Chipinga and Mossurize districts). When Mzila came back to the Mossurize River valley in 1861 (an area that had been depopulated in 1831 by Zwangendaba during the *mfecane*), he found that this area previously occupied by a cattle-keeping agricultural community before Zwangendaba's invasion in 1831 was now covered with tsetse-infested woodlands.³⁰

Mzila captured cattle among the survivors of the Rozvi Empire and brought them to the mountain grasslands north of Chipinga before attempting to move them to his new capital in the Mossurize River valley in modern-day Mozambique. However, after several attempts to introduce cattle into the Mossurize River valley failed, Mzila ordered an "immense compulsory movement of the population... Everyone of my informants has described graphically the result of this concentration. The bush simply disappeared and the country became bare, except for the numberless native villages and a continuity of native gardens," wrote Swynnerton.³¹ Tsetse flies therefore disappeared from most settled areas because of this modification of the environment, but Mzila left some areas unsettled as wildlife reserves, particularly between the Sitatonga hills and the Budzi River which Swynnerton called the "Oblong." Swynnerton concluded that there was still

²⁹ NAZ, S246/524-525: Research in Trypanosomiasis, quarterly report by E.W. Bevan, Southern Rhodesia, 10th December, 1934.

³⁰ John Ford. *The Role of the Trypanosomiases*, 333. This area is called Mossurize or Mossurisse in Mozambique. In Zimbabwe, it is called Musirizwi or Umsilizwe, all stemming from the Mossurize River.

³¹ C. F. M. Swynnerton, "An examination of the tsetse fly problem in North Mosurise, Portuguese East Africa," 332-333.

plenty of tsetse in the *Brachstegia* wooding and that the fly never disappeared from the “Oblong.” Thus cattle could not be kept in these areas. The same applied to Mtobe’s area and the eastern part of Mafuse’s chiefdom, close to the rubber forest.

In addition, continuing “eastward across the Lusitu of the rubber forests—cattle could never be kept, though Usele and other Zulu settled there and made an attempt.”³² The cattle these Zulu needed for ceremonial purposes had to be brought from safe areas. Cattle could not be kept south of the Budzi either, from the Mwangezi eastwards. These were the areas that were scarcely touched by Mzila’s operations. Swynnerton argued that Mzila’s tsetse operations never fully cleared the areas of chiefs Mtobe and Mafuse. He also observed that the rubber trees spread, offering a suitable habitat for tsetse flies, during the reign of Mzila’s successor, Gungunyana, under encouragement from the Zulu who traded rubber for cloth on the coast. These Zulu then used the cloth to barter for cattle in the Manica region.

However, in the cleared areas cattle-keeping succeeded. These areas included the Zinyumbo’s hills on the Mwangezi, and westward through the Mossurize valley and northward to Spungabera. The same applied to the Gogoyo-Makuyana tract, where cattle were kept right under the Sitatongas, and on the Sabi (Save) in Rhodesia. Swynnerton’s informants said that “Zinyumbo’s area, like Gogoyo’s, was very completely cleared—‘right to the Mwangezi it was gardens only,’ as was Gwenzi’s country, the Mossurise valley and portions of the Sabi.”³³ When the these areas were closely settled, cattle were kept successfully where they had failed before, although herds close to the tsetse areas suffered small and occasional losses.³⁴

³² Ibid., 333.

³³ Ibid., 333.

³⁴ Ibid., 334.

Swynnerton's account shows that villagers, unlike colonial officials, did not embark on wholesale vegetations and wildlife destruction in order to control trypanosomiasis. Trypanosomiasis control was closely connected with land-use patterns which permitted occasional transmission of the disease from wildlife to cattle and maintained the disease in an endemic state with less mortality. Ford concludes that trypanosomiasis in this area was suppressed by settlement, before 1830 by the Rozvi empire (which succeeded the Mutapa state) and again by Mzila after 1861.

As Swynnerton suggested, the waxing and waning of tsetse fly population in the Manica region between 1861 and 1889 resulted from changes in human population densities. The fact that this region was tsetse infested by 1861 can also be explained by the depopulation caused by Zwangendaba's massacres in the 1830s. Many "old people" told Swynnerton's informants that prior to Zwangendaba's massacres, the people of this region successfully kept cattle, even to as far as the Sibatongas, where these "old people" had shown the informants old cattle pits.³⁵ Chiefs Mafuse and Mtobe also told Swynnerton that cattle were kept in all parts of the country where subsequent efforts to keep them had failed. Yet, by the time Mzila arrived in Mossurize, the entire country had reverted to woodland and game had increased. "It was much as it is now;" wrote Swynnerton in 1921, "fly had become plentiful, and the mountains of the present political border were the boundary, then as now, between the fly and such cattle as existed."³⁶

Due to the rinderpest epidemic at the end of the nineteenth century, tsetse disappeared from the previously infested southern part of Rhodesia and almost completely from the northern part, remaining only in a few small isolated "residual foci". From these residual foci tsetse began to spread, re-occupying their former natural

³⁵ Ibid., 332.

³⁶ Ibid.

haunts.³⁷ These residual foci included the heavily forested areas of the Manica region, such as the “Oblong” and the Rusitu rubber plantations, from which the fly began to spread westwards to the border area.

Colonialism only made the trypanosomiasis situation worse than it was in the pre-colonial period, leading to numerous outbreaks. The colonial boundary interfered with longstanding forms of transhumance. These forms of transhumance involved movements of cattle from the low lands on the Mozambican side of the border to the highlands in Zimbabwe during the rainy season when the incidence of trypanosomiasis increased. The rains promoted the growth of lush vegetation and created humid conditions in the lowlands thereby expanding the tsetse habitat. For instance, Mzila, kept his cattle on the grass-covered Chipinge highlands to protect them from trypanosomiasis until he embarked on environmental modification to rid the Mossurize valley of tsetse flies.

The restrictions on cattle movements were a result of the cattle and game fences erected by Tsetse and Trypanosomiasis control officials as a trypanosomiasis control measure. The American Board missionaries at Mt. Selinda noted in 1939, “The Government is requiring the erection of a fence along the International Boundary between Rhodesia and Portuguese East Africa for tsetse fly control.”³⁸ The missionaries indicated that the Rhodesian Government was furnishing the fence, but the cost of construction of this six-mile long fence was to be met by the Mission. In other parts of the Manica region the border fence was much longer. The NC Chipinga, for example, reported in 1955 that although the clearing of bush on the Anglo-Portuguese border continued, it was “to be deplored that considerable sections of the approximate 20 miles

³⁷ NAZ, S483/53/2 Trypanosomiasis and Tsetse fly, 1948-1950: Coleman, Secretary to the Prime Minister, to the Chief Secretary, Central African Council, Salisbury, 14th April, 1950.

³⁸ ABC 15.6, Volumes 8-11, Minutes of Mission Meetings, 1940-44: Semi-Annual Meeting of the East African Mission of the American Board, December, 28th, 1939.

of fencing on the 55 miles stretch from the Rusitu river to international beacon 96” were in “poor repair – possibly due to clandesti[n]e movement of stock and natives.”³⁹ One informant from Mozambique recalled, “the restrictions on the movement of cattle were a heavy blow to us because we were used to moving cattle from one place to another in search of fresh pasture and water.”⁴⁰ While useful in finding fresh pastures, these movements also protected cattle from trypanosomiasis, but the colonial boundary restricted these practices. Hence the analysis now focuses on the changes in the epidemiology of trypanosomiasis brought about by colonialism.

Epidemiological consequences of the establishment of colonial rule

There is evidence that outbreaks of trypanosomiasis occurred as a result of the establishment of colonialism in the Manica region. With the changes in land-use patterns in the colonial period, villagers lost control over the environment, which meant they also lost control over trypanosomiasis. As a result, colonial assault on the environment and wildlife replaced pre-colonial practices as major means of controlling diseases.

Colonial land use patterns made trypanosomiasis control more difficult. As John Ford contends,

In addition to new techniques of land management and pest control, the Rhodesian invasion introduced a quite new factor into the African trypanosomiasis problem. This was private ownership of land. The great estates were marked out, fenced (especially where they adjoined native reserves), and registered with all the legal paraphernalia of a fully developed European society. Associated with this process was, of course, political power;

³⁹ NAZ S2827/2/2/3: Report of the Native Commissioner, Chipinga for the year ending 31st December, 1955.

⁴⁰ Interview, Mpanyeya, Mozambique, 14 December, 2006.

overwhelming on the European side of the fences, negligible on the African.⁴¹

Colonial officials pushed Africans and their cattle to the unproductive and often heavily tsetse-infested area, for example, the Musikanhu and Ngorima reserves, which were prone to invasions of tsetse flies. In this way Africans and their cattle provided a buffer zone between settlers and their cattle provided “an invaluable buffer against spread of infection to European farms.”⁴²

With the establishment of colonialism in the Manica region, Africans lost their rights to land. The British South Africa Company considered land to be a commercial asset, to be sold to European settlers on easy terms.⁴³ Yet, much of the alienated land, like the so-called Crown Land, was not actually under use. Most settlers also did not utilize all their land. The large tracts of land fell into the hands of absentee landlords and land speculators, leading to ecological problems and increased difficulty in controlling the tsetse fly and trypanosomiasis.

On the Zimbabwean side of the Manica region, particularly where the Zulu once settled (Gazaland), colonization was a family business for the Moodie family, who parceled out large tracts of land for their family members with the approval of Cecil John Rhodes.⁴⁴ This effort was led by Dunbar Moodie who pegged huge claims of land for himself, his family, and for South African land and mineral speculators in the last quarter

⁴¹ John Ford, *The Role of the Trypanosomiasis in African Ecology*, 353.

⁴² *Ibid.*, 354.

⁴³ The British South Africa Company led by Cecil John Rhodes acquired a royal charter from the Queen of England to colonize Mashonaland and Matebeleland, areas that form present-day Zimbabwe. The Company exemplifies the British method of establishing colonialism through chartered companies. It ruled until 1923 when white settlers formed the Responsible Government which enjoyed relative independence from Britain.

⁴⁴ S. P. Oliver, *Many Treks made Rhodesia*, reprint edition, (Bulawayo: Books of Rhodesia, 1975). Rhodes was willing to let the Moodie family take up these larger expanses of land in order to counter Portuguese claims to the region.

of the nineteenth century. An idea of the scale of these concessions can be gleaned from the fact that in order to encourage white settlement in this part of Rhodesia, Rhodes was persuaded to give Gazaland settlers double the normal land allocation of 3,000 acres per family.⁴⁵

Contrary to settler claims that they were taking up unoccupied land, the NCs for Melssetter acknowledged the fallacy of such claims. One noted, “The farms in Gazaland are all more or less occupied by Natives.” Another observed that “the very spots on which the Natives were most thickly settled were, to a great extent, selected as farms.”⁴⁶

The claims that the land was unoccupied were based on the belief that this part of Gazaland was completely deserted when Gungunyana moved his capital from the Mossurize valley to Bileni. According to Rhodes, the objective of the Moodies’ Trek (1893-1898) to Gazaland was “to go and occupy round Gungunyana’s old kraals at the headwaters of the Buzi.” “This will suit us as you know it is quite unoccupied land, if we do not occupy it soon,” he warned, “the natives will come and fill it up again.”⁴⁷ Jocelyn Alexander argues that the settler claim of unsettled land “conjures settler fantasies of an empty, unproductive land, ripe for exploitation,” and encompass the “harsh disruption of colonial conquest, eviction and agrarian intervention.”⁴⁸ Gungunyana after all did not take all the people with him down to Bileni and some of those who went with him returned after the Portuguese defeated and exiled him.

⁴⁵ John K. Rennie, “Christianity, Colonialism and the Origins of Nationalism,” 172.

⁴⁶ Ibid., 178.

⁴⁷ Ibid.

⁴⁸ Jocelyn Alexander, *The Unsettled Land: State-making and the Politics of Land in Zimbabwe, 1893-2003*, (Oxford: James Currey, 2006), 1. For more in the politics of land and race in Rhodesia, see Robin Palmer, *Land and Racial Domination in Rhodesia*, (Berkeley: University of California Press, 1977).

Colonial land-use patterns, such as keeping idle large tracts of land encouraged the growth of vegetation which harbored tsetse flies and increased the incidence of trypanosomiasis. In 1915, for instance, the Director of Veterinary Services for the Mozambique Company reported that trypanosomiasis was becoming more prevalent because, as the land was being continually alienated, the presence of tsetse flies was “now being noticed, whilst in the olden days, when these places were not invaded by settlers, flies were neither seen nor heard of.”⁴⁹ The Director of Veterinary Services also noted in 1918,

At the present rate of fighting the “fly” it will take many years “to clean” even those mildly infested parts of Chimoio where the disease exists today, and one reason for it is this – the farms or concessions are too big and it is only relatively a very small proportion of land that is cleared for cultivation purposes, and until larger tracts of land are cleared and the cattle kept in fenced areas and fed therein, the disease is likely to make its periodical appearance.⁵⁰

Colonial labor demands also deprived Africans of the ability to modify the environment. The settlers who took up lands on the Rhodesian side of the Manica region were generally of Boer origin, Afrikaans-speaking, and undercapitalized. They were the ones who had become “poor whites” in the Orange Free State of South Africa, where a depression and constant division of farms produced uneconomic small holdings vulnerable to erosion and loss of soil fertility due to overuse. Because they were undercapitalized, they relied on cheap African labor, interfering with African ability to modify the environment. Through a series of legislation such as the Native

⁴⁹ Arquivo Histórico de Moçambique, Fundo da Companhia de Moçambique (hereafter AHM, FCM), Secretaria Geral— Relatórios, Caixa 131, Pasta 2712: Fourth Annual Report of the Veterinary Department, 1915.

⁵⁰ AHM, FCM, Secretaria Geral— Relatórios, Caixa 132, Pasta 2733: Relatório da Repartição de Veterinária, 1918. Although the Chimoio District was not part of the Manica region, it bordered the Manica District of Mozambique and therefore had the potential of spreading infection to the Manica region.

Passes Ordinance of 1902 and the Private Locations Ordinance of 1908, the colonial government compelled Africans to work for three months every year on settler farms through labor tenancy. Settlers enforced this system by eviction and physical force, for example, using the *chamboko* (hide whip) to beat their African tenants. As late as 1957, NC Chipinge reported that the employment of tenants under labor agreements was still a popular method resorted to by farmers of his district in order to secure a more dependable labor force.⁵¹

The Mozambique Company also attempted to control the land although its financial situation and inability to attract white settlers led to dependence on African labor as the most important asset. The Company forced Africans to work in the public works department, building roads and railways and in the extractive industries, such as mining and rubber collection. This system of forced labor continued well into the 1960s.⁵² As M. D. D. Newitt argues, “In 1928 the new Portuguese labor code abolished forced labor, except for work on government projects, and it was replaced by intensified methods of recruitment and by compulsory crop-growing.”⁵³

Eric Allina-Pisano also contends that although the Mozambique Company compared its Territory to “an unknown country inhabited by a few savages,” when it received its charter, it soon realized that the African population was its “most valuable asset” and “African participation in the colonial economy would come at the barrel of the gun.”⁵⁴ He argues that the Company instituted labor recruitment policies that were akin

⁵¹ NAZ, S2827/2/2/5: Report of the Native Commissioner, Chipinga, for the year ending 31st December, 1957.

⁵² William Minter, *King Solomon's Mines Revisited: Western interests and the burdened history of Southern Africa* (New York: Basic Books, 1986), 30.

⁵³ M. D. D. Newitt, *A history of Mozambique* (Bloomington: Indiana University Press, 1995), 150.

⁵⁴ Eric Allina-Pisano, “Negotiating Colonialism,” 3.

to predatory raids, with police even seizing young boys and elderly men. In order to make up for shortfalls in labor supply, the Company aimed at increasing recruitment within Manica and recruiting Africans from other districts, such as Moribane.

In addition to Moribane, the southern district of Mossurize also became a labor reserve. David M. Hughes argues that after several attempts to colonize Gogoi failed, it became “by default, a labor reserve, in which the Portuguese treated the control of people as far more important than the control of land.”⁵⁵ He contends that the Mozambique Company, just like Portugal herself, lacked the financial resources to move beyond extractive “corporate feudalism”⁵⁶ and as a result, by 1906 the Company had resorted to extracting labor and natural resources. It forced villagers in and around Gogoi to tap indigenous rubber trees and to work on the Company’s projects. Those who refused to work found their way to the prisons, where they underwent physical punishment, such as *palmatória*. One interviewee recalled that *palmatória* involved beating palms and soles of the feet. When bleeding resulted, the officials put salt on the wounds to exacerbate the pain.⁵⁷ As Swynnerton observed, the fact that the Mozambique Company was not willing to sacrifice the Mafusi rubber plantations to control tsetse fly was a testimony to the importance they placed on this extractive industry.⁵⁸

As villagers were forced to work on colonial projects, households lost their ability to modify the environment and keep trypanosomiasis in check. In the African societies of the Manica region, men were usually the ones who cleared land for agriculture by cutting down vegetation and burning it. The women were primarily responsible for planting

⁵⁵ David M. Hughes, *From Enslavement to Environmentalism: Politics on a Southern African Frontier* (Seattle: University of Washington Press, 2006), 21.

⁵⁶ *Ibid.*, 30.

⁵⁷ Interview, Zangiro, Mozambique, September 9th, 2006.

⁵⁸ C.F.M. Swynnerton, “Examination of the tsetse fly problem in North Mossurisse,” 372.

crops and weeding. Writing in 1905 about the division of labor in African societies of this region, W.S. Taberer observed,

The manual labour, i.e., digging up new lands, &c., is invariably done by the men, the stimulus to effort being provided by copious supplies of beer...The household work—grinding corn, cooking food and making beer, is done by the women. The milking and herding of cattle, goats and sheep [is done] by the boys.⁵⁹

Thus women could not readily take over the duties of absent males. This led to the reduction in the size of cultivated land as the women concentrated on lands already cleared, rather than clear new lands. The absence of men also meant less labor on the fields, leading to further reduction in cultivated lands. Thus as the cultivated area shrunk, bush encroached, extending the habitat of the tsetse fly.

Prevalence and control of Trypanosomiasis under colonial rule

As the trypanosomiasis situation worsened, Rhodesian and Portuguese authorities experimented with various control methods, resulting in large-scale destruction of wildlife and vegetation. Tsetse and trypanosomiasis control methods also involved restrictions of movement of across the border, de-flying chambers, and the use of residual insecticides. While these tsetse fly and trypanosomiasis control measures were constant and pervasive, they were ineffective.

The control method employed, whether destruction of game or vegetation clearing, was determined by the species of tsetse fly and its ecology. For *G. morsitans* which was largely dependent on large wild game, officials attempted to control trypanosomiasis by killing wild animals. This was followed by African settlement

⁵⁹ W. S. Taberer, "Mashonaland Natives," *Journal of the Royal African Society* 4, no. 15 (1905): 312.

whenever possible. *G. morsitans* was by far in the most important vector of trypanosomiasis in PEA, covering three quarters of the Colony. However, for the two other species, *G. pallidipes* and *G. brevipalpis*, dependent on certain types of dense forest and/or water, officials used vegetation clearings on the PEA-Rhodesia border. These two species thrived on small game animals. This meant that the method of game destruction could not practically be applied to the control of these two species of tsetse.

Vegetation clearings were implemented in different ways. The first method involved “selective clearing” (of upper and lower vegetation elements), which had proved to be the cheapest methods of tsetse control in some African territories. This form of vegetation control had an added advantage in that it did not cause the decimation or extinction of endemic flora and fauna, nor did it spread the fly. However, Rhodesian officials took no interest in this method and actually dismissed it saying, selective clearing “of one of these elements (upper and lower vegetation elements) might eradicate *G. morsitans*,” but that the matter needed “further study and experimentation before it could be safely adopted as an anti-tsetse measure.”⁶⁰

What became the favorite method of vegetation control in Rhodesia and PEA was the second method which involved barrier clearings along the border to prevent the spread of tsetse flies from PEA. The barrier clearing program, known by the locals along both sides of the border as *Machichimana*, did not have the advantages of the first method. It involved wholesale destruction of indigenous vegetation wherever it was applied, leading to the decimation of endemic flora and fauna.

Outbreaks of trypanosomiasis in PEA worried Rhodesian officials who claimed that trypanosomiasis was endemic in PEA. These officials were concerned about the spread of the disease into Rhodesia. The Mossurize district, for example, experienced

⁶⁰ NAZ, F122/FH/30/1/1: O. J. Sidney, “Tsetse fly control and game eradication,” September, 1959.

severe outbreaks of trypanosomiasis from 1915 which triggered an investigation by C. F. M. Swynnerton in 1918. Swynnerton discovered that although Mzila's measures had driven the fly from a large piece of deciduously wooded country, the fly never abandoned its permanent haunts except on the Save and in the cleared portions of Gogoyo area and the Mwangezi. Thus within eight years after Mzila relaxed the measures in 1889, the fly began re-occupying its old haunts and new areas.⁶¹ This was a result of the increase in the deciduous wooding close to the border and an explosion of wildlife due to a reduction in human population after Gungunyana took some people to Bileni. "Up to a very few years ago cattle were still kept successfully in Mossurise within a few miles of the British border from Puizisi [Pwizizi] to Maruma, and from Spungabera to Inyamgamba," wrote Swynnerton, but these "except the Spungabera cattle, which have suffered, have been largely wiped out by successive attacks of nagana, especially during the last three years."⁶²

Of great concern to Rhodesian officials was that the PEA outbreaks coincided with the isolated cases on the British side of the border. In 1915 the Chief Veterinary Surgeon (hereafter CVS) for Rhodesia investigated outbreaks of animal trypanosomiasis on Tarka, Springvale, East Leigh, and Mt. Selinda farms along the eastern border. He concluded that there had been few deaths and did not detect any tsetse flies on these farms, but hinted "they [tsetse flies] are known to be plentiful a few miles across the border."⁶³ The CVS claimed that buffalo and big game frequently came across to the grazing ground of all the cattle concerned. His visit came after the District Veterinary Surgeon (hereafter DVS) for Melsetter district had reported the presence of

⁶¹ C.F.M. Swynnerton, "Examination of the tsetse fly problem in North Mossurize," 372.

⁶² Ibid.

⁶³ NAZ, V1/10/6: Trypanosomiasis—Melsetter District, letter from the Chief Veterinary Surgeon to the Director of Agriculture, Southern Rhodesia, 28th July, 1915.

trypanosomiasis at Springvale farm. He was not surprised at all that these cattle got fly struck because he thought they had come into contact with cattle which had been moved from the low veldt in Portuguese territory and his evidence for this was the presence of “some very cheap cattle in the district” along the border since 1914.⁶⁴

In order to control the spread of tsetse in this border area, Rhodesian officials began to implement barrier clearings in 1918, although they soon abandoned them because of the influenza pandemic. Rhodesian officials were concerned about the deteriorating situation on PEA, where the director of veterinary services in the Mozambique Company reported trypanosomiasis related deaths in many areas in 1918, including Mossurize, Siluvu Hills, Villa Machado, Muda, and Buzi.⁶⁵

As a result of the perceived potential of tsetse flies to spread to Rhodesia from PEA, in 1920 the CVS assured European farmers that should there be any indication of the movement of game inwards from Portuguese Territory, the Rhodesian Government was prepared to allow shooting of game in a defined belt.⁶⁶ In fact, this fear of invasion of tsetse flies from PEA was deeply embedded in the minds of white people in Rhodesia. Even the American Board missionaries at Mt. Selinda expressed this fear. Dr. Thompson, for instance, claimed, “‘sleeping sickness’ is coming nearer to us every year and maybe upon us before we are ready for it.”⁶⁷ Figure 8 below shows the extent of the tsetse fly

⁶⁴ NAZ, V1/10/6: Trypanosomiasis—Melsetter District, letter from the District Veterinary Surgeon, Melsetter District, to the Government Veterinary Surgeon, 20 July, 1915.

⁶⁵ AHM, FCM, Secretaria Geral, Relatórios Caixa 132, Pasta 2733: Relatório da Repartição de Veterinária, 1918.

⁶⁶ NAZ, V1/10/6: Trypanosomiasis—Melsetter District, letter from the District Veterinary Surgeon, Southern Rhodesia, to the Secretary, Eastern Border Farmers’ Association, Chipinga, 11th February, 1920. The CVS was responding to a request from the Eastern Border Farmers’ Association that certain measures be taken to prevent tsetse flies from getting established in the Melsetter district.

⁶⁷ ABC 15.4 Volume 28: Letter from W.L. Thompson, Mount Selinda, Rhodesia, to James L. Burton, Secretary, ABCFM, Boston, Massachusetts, December 6th, 1907.

problem in Rhodesia which included much of the Save River valley and the lowlands south of Mt. Selinda.

However, there were other explanations for these cases of trypanosomiasis other than laying the blame on movement from PEA. Climatic factors, for instance, were central to the distribution of tsetse and disease. As the CVS noted these cases could have been a result of tsetse fly having extended the usual habitats as a result of the heavy rains in the previous season.⁶⁸ He thought the tsetse fly could have established themselves in small enclaves on some farms, but would recede with a return of normal seasons. The idle land on settler farms in the Manica region contributed to this temporary build-up of tsetse flies. The question of idle land in Rhodesia emerged after 1900 as the colonial administration attempted to reverse the results of reckless land alienation in the 1890s by enforcing “beneficial occupation” as a condition to title and ownership. However, the resident magistrate in Chipinge district defended the Boer farmers arguing that they had demonstrated “beneficial occupation” and that it was the colonial administration’s fault to make grants to people without means.⁶⁹ The idle land, usually wooded, then provided temporary habitats for tsetse fly during the rainy season.

By 1922, Portuguese veterinarians appeared to be giving up all hope for cattle-raising in Mossurise. As the Department of Veterinary Services claimed in 1922, there were only a few African-owned cattle in these districts. Therefore, it was “scarcely worthwhile considering these districts from a cattle point of view because of their distances from possible markets and the impossibility of bringing cattle through the fly-belts in safety.”⁷⁰

⁶⁸ NAZ, V1/10/6: Trypanosomiasis—Melsetter District, letter from the Chief Veterinary Surgeon to the Director of Agriculture, Southern Rhodesia, 28th July, 1915

⁶⁹ John Keith Rennie, “Christianity, Colonialism and the Origins of Nationalism,” 175.

⁷⁰ AHM, FCM, Secretaria Geral, Relatórios Caixa 132, Pasta 2742: Relatório da Repartição de Veterinária, 1922.

Fearing the spread of *G. morsitans* Rhodesian officials commenced “controlled discriminate game destruction” in 1925.⁷¹ By this method, officials argued, the larger game animals on which *G. morsitans* alone could thrive, would be reduced in numbers enough to kill the tsetse flies by starvation in a belt (usually about twenty miles wide) along the boundary of infestation.⁷²

However, these trypanosomiasis control efforts targeting wild animals were not proving successful. In 1929, the Rhodesian Director of Veterinary Research lamented, for “several years large sums of money have been spent in the endeavour to eliminate the ‘fly’ by eradicating the game upon which it is thought to be dependent, but these operations have not proved entirely successful.” He revealed the discriminatory nature of veterinary services in saying; “In the meantime, efforts have been made by my Department to deal with the problem from another angle, namely, by endeavouring to save the lives of animals belonging to settlers who have ventured into fly-infested areas.”⁷³

Confronted with a worsening trypanosomiasis situation, Rhodesian officials renewed efforts to use barrier clearings in 1932, with the clearing of a forty mile front of the border in the Chipinge district.⁷⁴ The width of this clearing was between one and three miles. It was maintained by slashing back re-growth and by the “judicious use of fire.”

⁷¹ NAZ, S483/53/2 Trypanosomiasis and Tsetse fly, 1948-1950: Coleman, Secretary to the Prime Minister, to the Chief Secretary, Central African Council, Salisbury, 14th April, 1950.

⁷² Ibid.

⁷³ Southern Rhodesia: Report of the Director of Veterinary Research for the Year 1928, presented to the Legislative Assembly in 1929, 5.

⁷⁴ NAZ, F122/FH/30/1/1: O. J. Sidney, “Tsetse fly control and game eradication,” September, 1959.

In fact, a Rhodesian Committee of Inquiry reported that the “judicious use of fire” was “a valuable secondary weapon in the hands of the tsetse reclamation officer.”⁷⁵ Veterinary officers therefore extensively used fire in Chipinge district to compliment barrier clearing. Without vegetation clearing, the use of fire would have been less effective as the Rhodesian Chief Entomologist noted that the tsetse fly areas in Rhodesia consisted largely of either *mopane* forest (where grass was usually thin and scanty, or sometimes completely absent), or poorly grassed mufuti (*Brachystegia woodiana*) forest.⁷⁶ The total area cleared was approximately 60,000 acres, and was replaced by grass.

Although Rhodesian officials argued that these tsetse flies seldom, if ever crossed the barrier clearing, tsetse crossed the clearing during periods of heavy rainfall. As a result, *G. morsitans* covered the entire eastern bank of the Save River by 1933 as shown in Figure 2-2. In the areas around Mt Selinda and Chipinge, officials claimed that *G. pallidipes* and *G. brevipalpis* were encroaching from their haunts in PEA. Thus in 1934 trypanosomiasis control officials extended the border clearing southward from the Chiredza valley past Mt. Selinda to the southernmost beacon of Jersey. This was an attempt to protect Gungunyana, Mt. Selinda, Jersey, and other farms along this border area.⁷⁷ Officials attributed the occurrence of a few cases behind the clearing to either the ineffectiveness of the clearing itself, or to a few flies having been present in Rhodesia and then cut off by the clearing.

⁷⁵ Committee of Inquiry on Tsetse and Trypanosomiasis in Southern Rhodesia, Federation of Rhodesia and Nyasaland, (Salisbury: Government Printer, 1954), 8.

⁷⁶ R.W. Jack, “The Tsetse fly problem in Southern Rhodesia,” Reprinted from *Rhodesia Agricultural Journal*, Bulletin No. 892, May, 1933, 14.

⁷⁷ Report of the Secretary, Department of Agriculture and Lands for the year 1934, Southern Rhodesia, 19. Gungunyana was an area named after the grandson of Soshangane.

Border clearing continued through 1937, with the NC Chipinge reporting that “a gang of Natives was employed under European supervision in clearing trees and bush from a strip of country along the Eastern border ... with the object of checking the advance of Tsetse fly.”⁷⁸ Yet, even this aggressive effort at vegetation clearing did not succeed in checking the advance of the fly. In 1939, following the heavy rains of 1938, Rhodesian veterinarians claimed that tsetse flies had “encroached from Portuguese East Africa into the Chipinga sub-district (Chimanimani),” causing “the farmers much loss and concern.”⁷⁹

The problem of tsetse flies on the Portuguese side worsened to the extent that in September 1941, officials from Rhodesia and the South Africa requested permission (which was granted) to enter PEA to study the “spread of Morsitans.”⁸⁰ These officials were Dr. P.J. du Toit, the Director of Veterinary Services in South Africa, with his two associates, and two officials from the Government of Rhodesia, Mr. B.A. Mayhill, the Chief Veterinary Surgeon, Mr. K.W. Jack, and Mr. Chorley.

Portuguese authorities cooperated with Rhodesian authorities in the control of trypanosomiasis, as the Rhodesian authorities noted,

The Portuguese Government, in response to overtures made by the Government of Southern Rhodesia, has generously declared a large area in Portuguese East Africa along the border, east of Melsetter district, an open area for the destruction of all classes of game. It is very doubtful whether much relief will be obtained along that portion of the border infested with the tsetses *G. brevipalpis* and *G. pallidipes*, that is, the section running from the Puizeze river, south, to the Umselezwe [Mossourize] river, but as *G. morsitans*

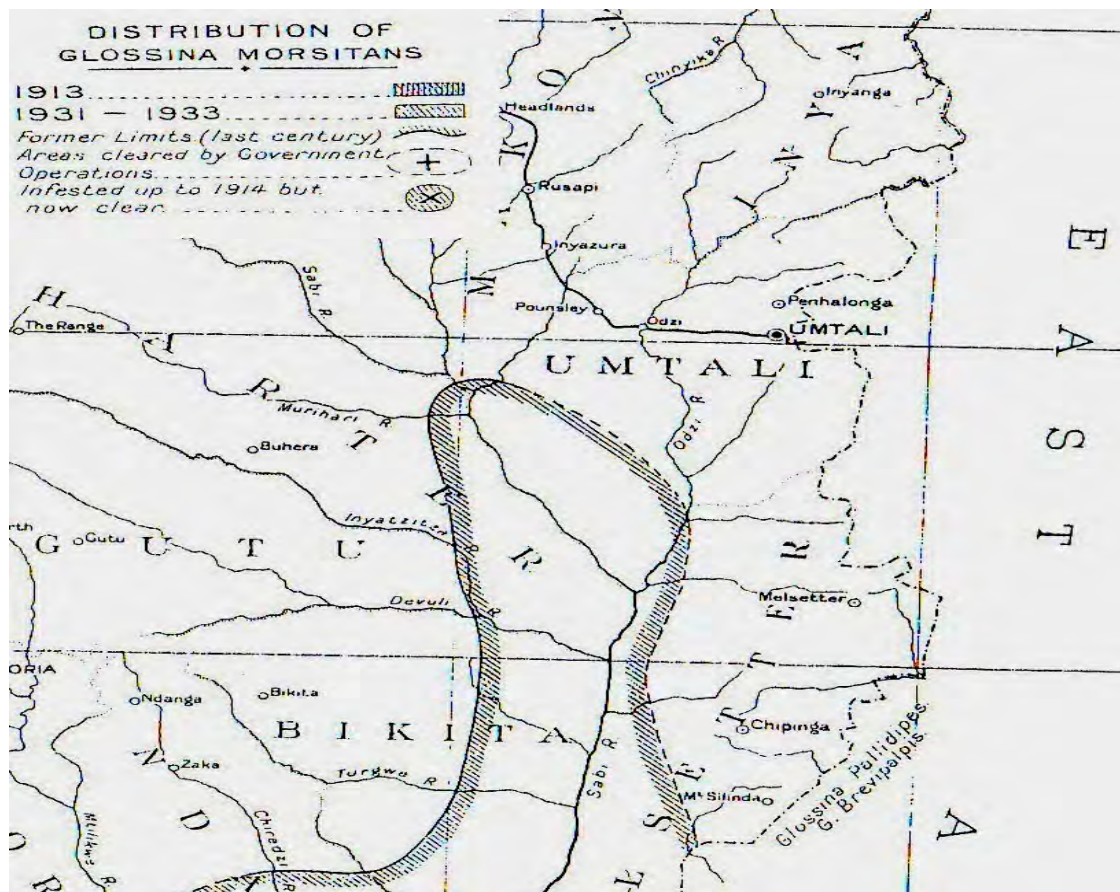
⁷⁸ NAZ, S1563: Report of the Native Commissioner, Chipinge, for the year ending 31st December, 1937.

⁷⁹ Report of the Secretary, Department of Agriculture and Lands for the year 1939, Southern Rhodesia, 5. These cases occurred in the Rusitu valley, leading to a number of deaths among African-owned cattle in the Ngorima reserve and adjoining Native Purchase Area, see NAZ, S235/517: Report of the Assistant Native Commissioner, Melsetter, for the year ended 31st December, 1939.

⁸⁰ Ibid.

occurs on the Busi river in this area the harassing of the big game close to the border may help.... Further representations have been made to the Portuguese Government on this matter.⁸¹

Figure 2-2 Map illustrating the Tsetse Fly Problem in the Rhodesia side of the Manica Region



NAZ S482/61/39: R. W. Jack, "The Tsetse fly problem in Southern Rhodesia," (reprinted from the *Rhodesia Agricultural Journal*), *Sleeping Sickness Bulletin* no. 892, May 1933.

⁸¹ J. K. Chorely, "Tsetse Fly Operations: Short Survey of the Operations by Districts for the Year ending December, 1943," *The Rhodesia Agricultural Journal* 41, no.1 (1944): 413.

Rhodesian officials doubted the efficacy of game destruction to control *G. brevipalpis* and *G. pallidipes*, because these species of tsetse were more dependent on the presence of vegetation and small game than the big game (buffaloes and elephants) that Portuguese officials were targeting. *G. brevipalpis* and *G. pallidipes* were not “game tsetse fly.” The destruction of wild animals in this area followed consultations made in 1939, when Dr. Carlos Ramos, the Director on Veterinary Services in the Province of Manica and Sofala, PEA, asked for rifles and ammunition to use for hunting wild animals along the border. In response to this request, J.K. Chorley, the Chief Entomologist of Rhodesia indicated that Rhodesia agreed to loan PEA twenty Martini Henry rifles, and to sell three thousand rounds of ammunition. This consignment was sent to the Veterinary Department of PEA at Macequece.⁸²

In their control efforts, the Portuguese authorities employed twenty licensed African hunters to kill wild animals along the border. They hunted along the valleys of the Rusitu, Buzi, Mossurize, and Save Rivers. The preferred animals were buffaloes and elephants despite Swynnerton’s findings. “I conclude ... that any attempt in north-west Mossurise to destroy the fly by starving it in its permanent haunts is doomed to failure,” warned Swynnerton in 1921, “if the bush-pigs, and perhaps the baboons also, are not destroyed; and the destruction of the pigs in this type of country is not easy.”⁸³ Yet, in January 1942, the *Chefe* of the district of Mossurize indicated that he had deployed twenty hunters to hunt the buffaloes and elephants.⁸⁴

⁸² AHM, FCM, Negócios Indigenas Processos—Assistencia Social, Culturas Indigenas, 1931-42, Caixa 7, pasta 34.

⁸³ C.F.M. Swynnerton, “Examination of the tsetse problem in North Mossurise,” 337.

⁸⁴ AHM, FCM, Negócios Indigenas Processos, 1931-42, Caixa 7, pasta 34: “Caça ás espécies selvagens,” *Chefe* of Mossurise District, to the Governor of the Territory of Manica and Sofala, 2 January, 1942.

As proof of the ineffectiveness of colonial trypanosomiasis control programs, Rhodesian veterinarians reported in 1942,

Unhappily, the long threatened extension of tsetse fly from Portuguese East Africa into the southern portion of the Melsetter district has now assumed very serious dimensions. It is evident that border clearings of forest and bush, as a greater protection against the incursion of *G. pallidipes* and *G. brevipalpis* must immediately be widened and extended southwards, whilst other measures must be adopted to combat the approach of *G. morsitans*, now located in considerable density within six miles of the international boundary. The threat to stock farming in the South Melsetter district is grave and should [the] fly become permanently established there in numbers, the risk of its spread to our south-eastern ranching areas cannot be ignored.⁸⁵

Nineteen forty-two was also the when the Mozambique Company ended its operations in PEA. The transition from Company administration to the colonial administration and the Second World War demands contributed to the relaxation of tsetse and trypanosomiasis control measures, which included border supervision. In 1945 the area below Chikore (Craigmore) recorded heavy losses all along the border on a front of about 60 miles.⁸⁶ A year later, the NC Chipinge reported that a strip along the Anglo-Portuguese border south of beacon 104 was infested with tsetse fly. He said that African hunters were employed there on the destruction of game, but their efforts were not of use as the flies had encroached further into the Colony in the area where they were operating.⁸⁷

However, even with these dismal assessments of game destruction, Rhodesian officials still enforced game destruction as the principal control measure against *G.*

⁸⁵ Report of the Secretary, Department of Agriculture and Lands for the year 1942, Southern Rhodesia, 10.

⁸⁶ Report of the Secretary, Department of Agriculture and Lands for the year 1945, Southern Rhodesia, 65.

⁸⁷ NAZ, S1051: Report of the NC Chipinge, for the year ended 31st December, 1946.

morsitans, leading to widespread decimation of wildlife.⁸⁸ Tsetse and trypanosomiasis control led to the killing of 24,351 wild animals in 1946, 16,802 in 1947, and 22,160 in 1948, nationally.⁸⁹ By 1952, trypanosomiasis control measures had resulted in the killing of 486,206 wild animals and this number rose to 666,009 by January 31st, 1959.⁹⁰ An authority on Rhodesian wildlife policy, Roben Mutwira, argues that these animals were “mercilessly slaughtered in order to create buffer zones between [trypanosomiasis] resistant game and European owned land or farms.”⁹¹ He also contends that much of the pressure to eliminate game came from white farmers and missionaries “on the fringes of the tsetse fly belt” who “asked for a clear policy on their protection from an epidemic similar to that in the lake region of Uganda between 1898 and 1905 when one-quarter of the whole population perished from sleeping sickness.”⁹²

On the Portuguese side the *Missão de Combate às Tripanossomias* (Mission to Combat Trypanosomias) was also involved in game destruction in combination with other measures. Between 1947 and 1956, the *Missão de Combate às Tripanossomias* killed as many as 71,475 wild animals.⁹³ Although officials claimed that the number of

⁸⁸ The animals killed included the elephant, hippopotamus, rhinoceros, zebra, giraffe, buffalo, wildebeest, eland, roan & sable, kudu, hartebeest, sassaby, waterbuck, nyala, bushbuck, impala, oribi, steinbok, duikerbok, duiker, suni, sundry small antelopes, warthog, bush pig, baboon, monkey, lion, leopard, hyena, jackal and other carnivores, small rodents and other mammals, gemsbok, reedbuck, klipspringer, cheetah, wild cat, lynx, antbear, and some unclassified animals.

⁸⁹ J. A. Wheelan, “A Review of the Tsetse fly situation in S. Rhodesia, 1948,” *Rhodesia Agricultural Journal* 46, no. 4 (1949): 319.

⁹⁰ NAZ, F122/FH/30/1/1: O. J. Sidney, “Tsetse fly control and game eradication,” September, 1959.

⁹¹ Roben Mutwira, “Southern Rhodesian Wildlife Policy (1890-1953): A Question of Condoning Game Slaughter?” *Journal of Southern African Studies* 15, no. 2 (1989): 250.

⁹² *Ibid.*, 257.

⁹³ NAZ, F122/FH/30/1/1: O. J. Sidney, “Tsetse fly control and game eradication,” September, 1959.

mammals destroyed each year was only a small proportion of the existing game, there was no way of knowing how many game animals were present in any given area.⁹⁴

As a result of this “merciless slaughter” of fauna, by the 1950s, only small herds of elephants, mostly calves could be seen emerging from the forest of Mossurize “near the frontier, in search of scrub and other plants that grow in the saltish lands of the littoral.”⁹⁵ This was part of the seasonal migration of elephants in the region.

Yet, even with this wholesale destruction of these elephants, there was no relief to the trypanosomiasis situation. The NC Chipinge reported in 1955 that trypanosomiasis spread from Muumbe, Mwangazi, Gwenzi, Ndima, and Chisumbanje dipping tank areas to six new dipping areas of Chibunji, Chibuwe, Gumira, Dakate, Emerald, and Kondo, resulting in heavy mortality.⁹⁶ He also said that the clearing of bush on the Anglo-Portuguese border continued throughout the year, but considerable sections of the approximate 20 miles of fencing on the 55 mile stretch from the Rusitu River to the international beacon 96 were in poor repair, “possibly due to clandestine movement of stock and natives.”⁹⁷ The problem with the border was that it cut across common grazing grounds, disrupting seasonal movements of cattle, particularly in years of drought, and 1954 had witnessed a drought that reduced pastures for domestic animals. It also limited the mobility of Africans, who had to carry passes and seek permission whenever they wanted to travel outside the areas designated for them. The missionary, Dr. Thompson,

⁹⁴ Ibid.

⁹⁵ Mozambique, Comissão de Caça, *Hunting in Mozambique*, A monograph presented by the Mozambique Hunting Committee on the Occasion of the African Tourism 4th Congress held in September 1952 at Lorenzo Marques, 42-43.

⁹⁶ NAZ, S2817/2/2/3: Report of the Native Commissioner, Chipinga, for the year ending 31st December, 1955. All in all about 1425 cattle were lost to trypanosomiasis. The first five dipping tank areas had been infected since 1952.

⁹⁷ NAZ, S2827/2/2/3: Report of the Native Commissioner, Chipinga, for the year ending 31st December, 1955.

for instance, was perturbed by the Portuguese directive that Africans make a three-day trip to Spungabera to secure permission to visit a relative who might live just across the border.⁹⁸

Due to the worsening trypanosimiasis situation, Rhodesian officials commenced selective clearing of the southern-most portion of the Sabi Division, (area east of the confluence of the Mkwadini and Save) by clearing along the Anglo-Portuguese border through the Mossurize valley with the cooperation of Portuguese authorities. These efforts, geared towards tsetse control, were complemented by game destruction. For instance, in 1956 the NC Chipinge reported that an entomologist had, for six months been involved in destruction of game in the Sabi (Save) Tsetse-fly control area. These hunters received 22/6d per year after the colonial government banned the sale of meat and hides as a form of payment.⁹⁹ In addition, Rhodesian officials made representations to the Portuguese Commandant at Spungabera to stop all donkey traffic across the border, but in spite of these precautions and the construction of an eight mile 8-strand barbed wire fence, tsetse flies continued to be a problem.¹⁰⁰

⁹⁸ John Keith Rennie, "Christianity, Colonialism and the Origins of Nationalism," 320.

⁹⁹ NAZ, S282/2/2/4: Report of the NC Chipinge, for the year ended 31st December, 1956.

¹⁰⁰ NAZ, S2827/2/2/5: Report of the Native Commissioner, Chipinga, for the year ending 31st December, 1957. Commandants were Portuguese officials responsible for the administration and governance of districts and sub-districts of the Mozambique Company' territory of Manica and Sofala. They served under the governor of the territory At Beira and their duties involved the exercise of minor judicial powers, the collection of "native" and other taxes, issuing licenses, opening and maintaining roads, and conducting the annual census. According to R. C. F. Maugham, the Commandant "is judge, magistrate, conveyancing barrister, chief of public works, receiver of taxes, supervisor and collector of revenues, chief of police, postmaster, and keeper of Government stores; he is the advisor of all, the friend of the native, the father of his district." For more on this, see R. C. F. Maugham, *Portuguese East Africa: The History, Scenery, and Great Game of Manica and Sofala* (London: John Murray, 1906), 31-35. Maugham was the H. B. M. Consul for the Districts of Mozambique and Zambezia, and for the Territory of Manica and Sofala.

As wholesale vegetation clearing decimated endemic flora, Rhodesian officials replaced it with fast-growing exotic species such as eucalyptus, wattle and pine trees for commercial purposes. The Forest Commission led these reforestation efforts that included planting blocks of eucalyptus on the Zona Tea Estate (originally part of Mt. Selinda Farm).¹⁰¹

Although these officials argued that exotic plantations could not provide permanent tsetse fly habitats,¹⁰² these plantations contributed to the existence of temporary foci of infection, particularly during the wet season, worsening the tsetse fly situation in the Manica region. The director of Tsetse and Trypanosomiasis Control and Reclamations reported in 1958 that “A complicating factor in the maintenance of the border defence scheme [was] the increase in tree plantations among tea estates.”¹⁰³ These exotic species were also detrimental to the environment because they siphoned all the nutrients from the soil leading to loss of fertility. Fertile fields became barren after eucalyptus trees were planted.

However, despite sacrificing endemic flora, trypanosomiasis problems continued. In his report for 1958, J. Ford, now the Rhodesian Director of Tsetse and Trypanosomiasis Control and Reclamation, indicated just how serious the trypanosomiasis situation had become. He said that the task of re-organizing his Department to adopt techniques of tsetse control other than game destruction was hampered by a general deterioration of the trypanosomiasis situation in the eastern and south-eastern parts of Rhodesia.¹⁰⁴ He noted that during the summer months the

¹⁰¹ NAZ, F122/400/7/35/3: Minutes of a meeting of the Tsetse and Trypanosomiasis Control Committee, 6th March, 1958.

¹⁰² Ibid.

¹⁰³ NAZ, F122/FH/30/1/1: Report of the Director of Tsetse and Trypanosomiasis Control and Reclamation for the year ended 30th September, 1958.

¹⁰⁴ NAZ, F122/FH/30/1/1: Report of the Director of Tsetse and Trypanosomiasis Control and Reclamation for the Year Ended 30th September, 1958.

infection rate among cattle on the eastern border farms increased to a peak higher than in any year since 1943 when officials diagnosed 270 infections. When tsetse control officials surveyed the area south of the Lundi River after the rains ceased, they concluded that extensive advances of tsetse fly (both *G. morsitans* and *G. pilladipes*) had occurred since 1956 in a southerly and westerly direction.

Officials attributed this increase in trypanosomiasis incidence to heavy rainfall during the mid-1950s. "It appears that during the wet season," Entomologist, R. J. Phelps indicated in 1958, "tsetse invaded Southern Rhodesia via the Nyamadzi and Busi river systems."¹⁰⁵ However, these cases also demonstrated the ineffectiveness of control methods as officials asserted that these tsetse flies crossed the clearing which was at least one mile wide. Phelps therefore suggested treating a narrow strip of forest across the full width of these river valleys, both on the eastern and western edge of the clearing with a residual insecticide to prevent future invasions of tsetse. Ford later realized that the tsetse problem was an ecological one which impinged upon many fields of rural activity.¹⁰⁶ Ford therefore set up a system of "local Trypanosomiasis Committees" consisting of a Native Commissioner, as Chairman, together with a Government Veterinary Officer and a Tsetse Entomologist. The main purpose of these committees was to co-ordinate tsetse and trypanosomiasis control. According to Ford,

The tsetse programme and the prophylactic and therapeutic measures carried out by the Veterinary Department can be outlined and explained to representatives of other departments as well as the local farming community and the need for collaboration in such matters as control of cattle movement, grass fires, etc., explained. On the other hand, developmental schemes of various kinds, e.g. native settlement schemes, road building, labour recruitment, etc., which may influence or be influenced by anti-tsetse operations, may be discussed.¹⁰⁷

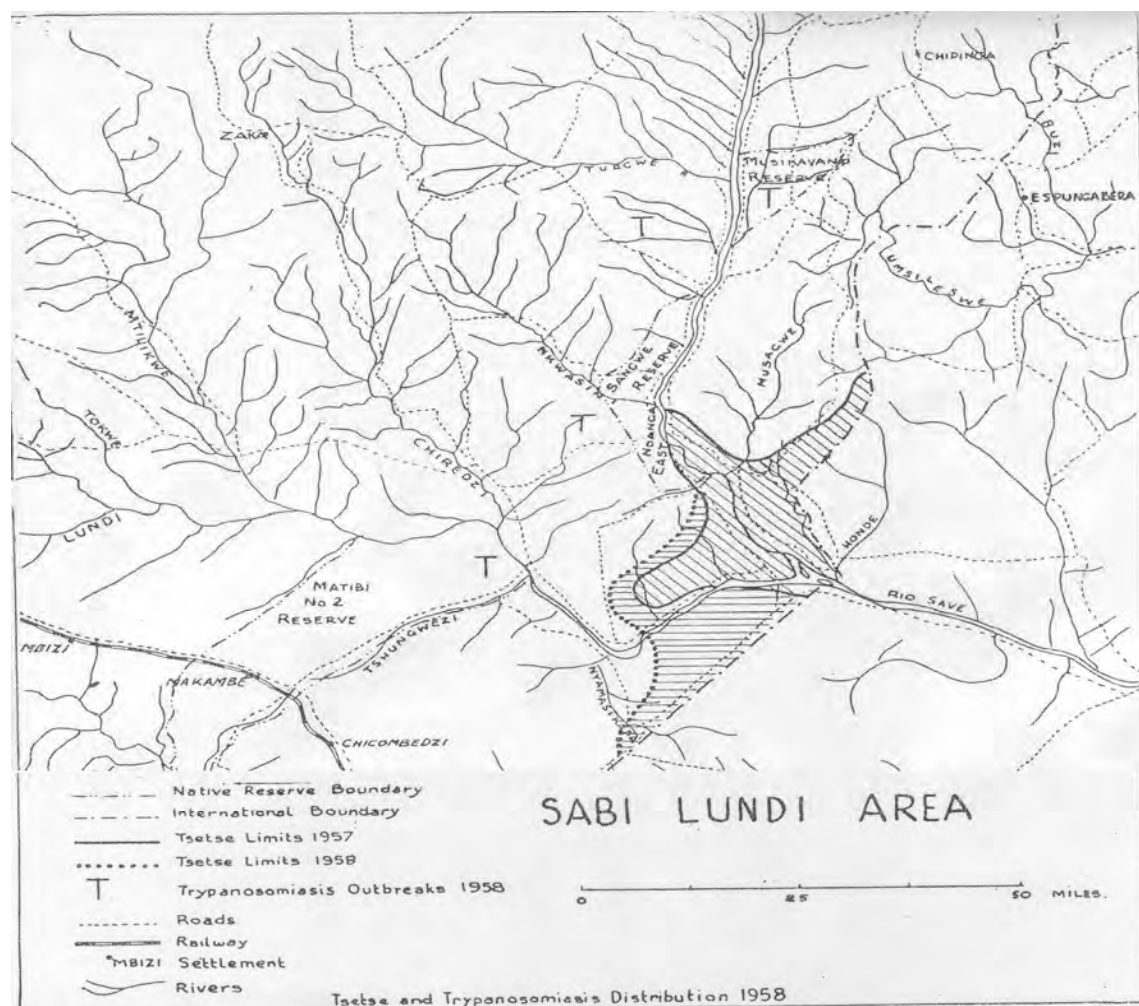
¹⁰⁵ NAZ, F122/400/7/35/3: Report on Visit to the Border clearing, 24th April, 1958.

¹⁰⁶ NAZ, F122/FH/30/1/1: Report of the Director of Tsetse and Trypanosomiasis Control and Reclamation for the Year Ended 30th September, 1958.

¹⁰⁷ Ibid.

Ford's suggestion also implies that colonial rule interfered with pre-colonial trypanosomiasis control methods and casts doubt on the theory of spread of infection from PEA.

Figure 2-3 Sabi Lundi Area—Tsetse and Trypanosomiasis Distribution, 1958



Source: NAZ F122/FH/30/1/1: Report of the Director of Tsetse and Trypanosomiasis Control and Reclamation for the year ended 30th September, 1958.

Ford realized that a new approach was needed to solve the trypanosomiasis problem which reached crisis proportions in 1958. At that time, the NC Chipinge claimed that tsetse fly had invaded areas up the Save valley and threatened the Musikavanhu Reserve. He extended the tsetse fly area to include the entire Musikavanhu Reserve, the entire Sabi Division (as shown in Figure 2-3 above), the Ndima Reserve, and all other Native Purchase Areas, leaving only the Mutema Reserve free.

Other tsetse fly and trypanosomiasis control measures involved the restrictions of movement and monitoring of entry points and aerial spraying of chemicals, such as DDT. Under the Rhodesia Tsetse Fly Act (1929), for instance, the Governor had powers to control the movement of stock, motor vehicles, cyclists and pedestrians from or into proclaimed Tsetse Fly Areas.¹⁰⁸ The Governor could declare any defined area to be a tsetse fly area and make regulations for prohibiting the movement of persons, domestic animals and vehicles to, from or within fly areas, restricting such movement to certain defined routes, and to fixed periods of the day or night. The Act also made provisions for the inspection of domestic animals and vehicles. These inspections were geared toward the detection and removal of tsetse from people, animals or vehicles. Contravention of these regulations was an offence punishable by a fine not exceeding \$10 or, in the case of default of payment, to imprisonment not exceeding one month.¹⁰⁹

Because tsetse control officials argued that tsetse flies, particularly *G. morsitans*, *G. swinnertoni*, and *G. pallidipes* could be carried for long distances on vehicles and shorter distances on cyclists and pedestrians, Rhodesian officials established gates on the eastern border to inspect cars, cyclists, and pedestrians. The NC Chipinge, for instance, claimed that motor transport was responsible for spreading the fly in certain cases and

¹⁰⁸ Committee of Inquiry on Tsetse and Trypanosomiasis, 9.

¹⁰⁹ Maria-Theresa Tarutira, "A Review of Tsetse and Trypanosomiasis in Southern Rhodesia: Economic significance up to 1955," M. A. Thesis, Department of History, University of Zimbabwe, March 1988, 40.

that “natives travelling on foot through fly belts introduce[d] them among cattle...”¹¹⁰ The inspections involved the use of de-flying chambers which served two purposes—to prevent the transportation of tsetse into fly-free areas and to provide an index of the density of tsetse fly in the areas through which traffic had traveled. Officials at the Mt. Selinda border gate often caught tsetse flies in cars from Mozambique.¹¹¹ While this shows that there was some spread of tsetse flies between the colonies, it also affirms degree of harassment that pedestrians endured on the border. In the mid-1970s, officials began spraying DDT on a barrier strip along the eastern border.

African reaction

Colonial officials feared that movement across the border would pose serious threats to their efforts to control diseases and so sought to restrict the mobility of cattle keepers. In 1917, a PEA veterinarian argued that the Manica district was “always liable to an invasion of the disease [East Coast Fever] on account of its proximity to Rhodesian farms and secret smuggling of cattle from Rhodesia by natives.”¹¹² The Portuguese later deployed fifteen African police to Manica and five African police in Moribane and Mossurize in 1927 to monitor cattle movements.¹¹³ This supervision of the border was sanctioned by the cattle regulations that prohibited the importation of cattle into, and the

¹¹⁰ NAZ, S1051: Report of the Native Commissioner, Chipinga, for the year ended 31st December, 1946.

¹¹¹ NAZ, S3107/1/6: Mount Selinda—Tsetse fly Border Gate: Traffic Control – Eastern Districts, Chipinga – Mount Selinda Border Gate.

¹¹² AHM, FCM, Secretaia Geral, Relatórios Caixa 132, Pasta 2729: Relatório da Repartição de Veterinária, 1917. East Coast Fever was a disease of domestic animals and it ravaged parts of Rhodesia leading to measures by the Portuguese to prevent its spread into their territory.

¹¹³ AHM, FCM, Secretaia Geral, Relatórios Caixa 130, Pasta 2684: Projecto de reorganização e Orcamento da Direcção de Veterinária, 1927.

movement of cattle within PEA without prior approval from the authorities.¹¹⁴ Eight years later, authorities reported that some cattle suspected of disease had clandestinely entered Moribane from Rhodesia, and that various villagers in Rhodesia wanted to move into PEA with their cattle.¹¹⁵ While they emphasized the importance of supervising the border, not much thought was given to seasonal movements of cattle. The border affected cattle-keepers and it was not surprising that cattle keepers sometimes broke border cattle and game fences.

Resistance to trypanosomiasis control measures took many forms. In PEA authorities reported in 1941 that in the district of Mossurize, African-owned cattle suffered heavy casualties because the cattle-keepers, Africans, being “naturally superstitious and rebellious,” concealed the major portions of their herds from the authorities.¹¹⁶ As a result, these cattle perished in large numbers because they were not treated for trypanosomiasis. In 1955 Rhodesian officials claimed, “... local natives will not hunt where directed.”¹¹⁷ Rhodesian officials were concerned because their surveys that same year revealed a heavy build up of *G. morsitans* in PEA from the Ndanga River north of Makoho to the Sabi-Lundi junction in Rhodesia as shown in Figure 2-4. These seemingly irrational behaviors of Africans were prompted by their distrust of colonial trypanosomiasis control methods and the evidence that the measures were ineffective.

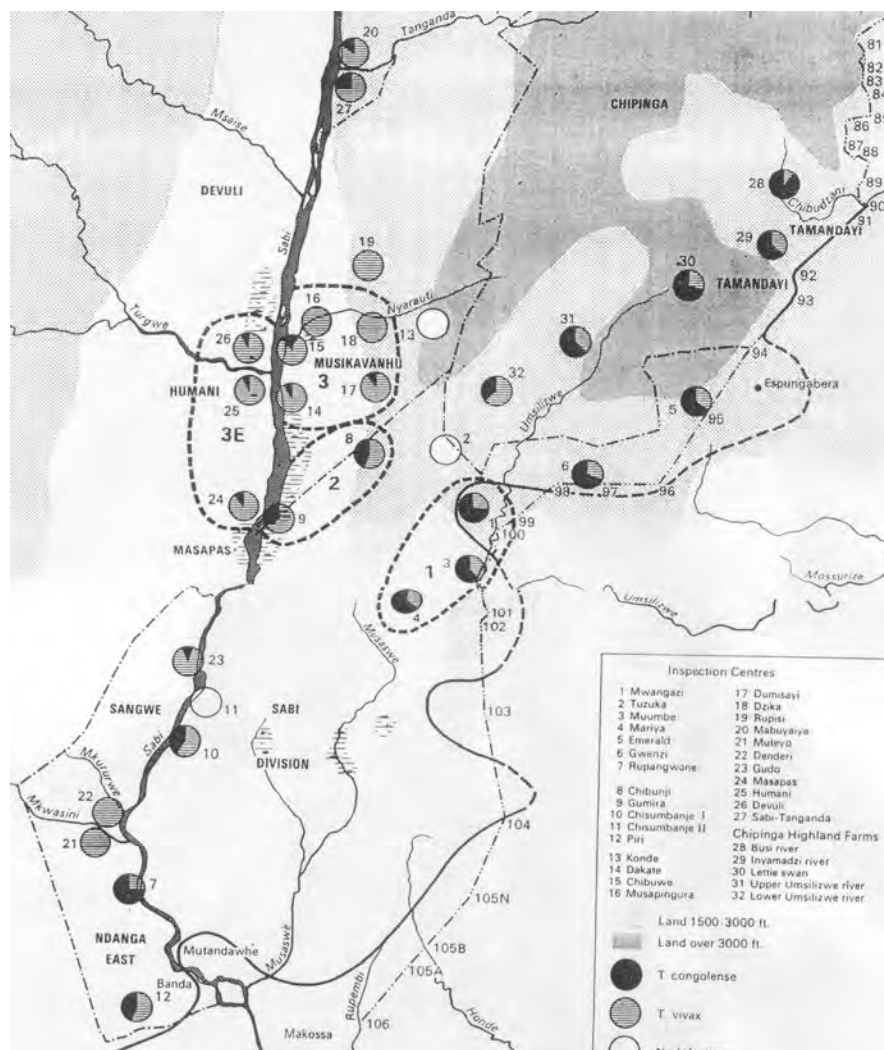
¹¹⁴ AHM, FCM, Secretaria Geral, Relatórios Caixa 130, Pasta 2684: Regulamento de Sanidade Pecuária do Território da Companhia de Moçambique, 20 December 1912 , amended 3 October, 1924.

¹¹⁵ AHM, FCM, Secretaria Geral, Processos 1892-1942 Caixa 548, Pasta 1894: Sanidade Pecuária-Fiscalização de Gado na Fronteira, 1935.

¹¹⁶ AHM, FCM, Secretaria Geral, Relatórios Caixa 130, Pasta 2695: Relatório da Repartição de Veterinária, 1941.

¹¹⁷ NAZ, F122/FH/30/1/1: Annual Report of the Director of Tsetse and Trypanosomiasis Control and Reclamation for the Year Ended 30th September, 1955.

Figure 2-4 Cattle inspection centers in the Save River valley, 1952



Source: John Ford, *The Role of African Trypanosomiasis*, 304-305.

African hunters resented game laws imposed by the colonial government, which took away African rights to wildlife. These hunters could not hunt at will when they needed food, but had to hunt animals they could not eat to comply with colonial demands. To make the best of the need to comply with such demands, Africans resorted to selling game meat and hides, but it was not long before colonial officials clamped down on this activity. In 1956, for example, the Director of Tsetse and Trypanosomiasis

Control and Reclamation indicated that the reduction in the area of operations, the concentration of hunters between fences, and the prohibition on the sale of meat and hides would lead to greater control over the activities of hunters, and would drastically curtail African traffic into and from the tsetse area and with it the transportation of fly.¹¹⁸

Interviews with residents of the border areas show that people still recall trypanosomiasis measures, such as clearings. One interviewee from Mozambique recalled that the greater proportion of border clearings was on the Zimbabwean side of the border to prevent tsetse flies from infecting cattle. He said that Africans knew tsetse bites could cause disease, but argued that it was primarily the sucking of blood by the flies that would result in a shortage of blood in the person or animal affected, causing the disease.¹¹⁹ He thought that the way Europeans treated the disease in hospitals was to add more blood (blood transfusion) while administering some drugs. This understanding of disease causation and healing might have also contributed to African mistrust of hospitals in the early decades of colonial rule. Africans feared that their blood would be taken in the hospital, that they would be killed, or that another person's blood would be put into their blood stream. Blood was sacred and the mixing of blood was detestable to them.

This interpretation of disease causation demonstrates that trypanosomiasis control policies were poorly received by Africans because they did not include African understandings of disease causation and healing. As a result, Europeans did not gain greater compliance on disease control from Africans.

Another interviewee recalled that those forced to slash vegetation to create these clearings were bandits (prisoners), or people “who had been captured.”¹²⁰ In

¹¹⁸ NAZ, F122/400/7/35/2: Annual Report of the Acting Director of Tsetse and Trypanosomiasis Control and Reclamation for the Year Ended 30th September, 1956.

¹¹⁹ Interview, Zangiro, Mozambique, September 9th, 2006.

¹²⁰ Interview, Zangiro, Mozambique, September 9th, 2006.

Mozambique, this could mean anybody who resisted colonial authority, particularly those who resisted forced labor. Another recalled that villagers were forced by colonial officials to clear the border by cutting tress and clearing the grass so as to control tsetse fly, which they believed to be the major cause of death in animals and human beings, and that “these tsetse control measures included the destruction of many wild animals at a certain place.”¹²¹

There were, however, differing opinions on the purpose of these clearings. Rhodesian veterinarians reported in 1958 that the “clearing was being maintained [probably by both settlers and Africans] more for pasture improvement [than tsetse control] which was not the function of the Tsetse Control Department.”¹²² Some informants from the area around Spungabera also remembered, “the *Machichimana* program involved people cutting down trees along the border to prevent people from crossing with their herds unnoticed,” adding, “it was also said to be a control measure for tsetse fly but since many people avoided crossing the border with their cattle, for fear that they would be confiscated, the clearing of the border was then to prevent people from crossing unnoticed.”¹²³ Another interviewee from Makubvu Mozambique argued that *Machichimana* was not primarily for controlling tsetse fly, but to prevent Africans from crossing the border unnoticed.¹²⁴

Africans residing on the Zimbabwean side of the border also had their own interpretations of colonial veterinary and public health policy. One informant said that border clearing was geared towards checking the movement of animals, such as cattle, as

¹²¹ Interview, Mpanyeya, Mozambique, 14 December, 2006.

¹²² NAZ, F122/400/7/35/3: Meeting of the Tsetse and Trypanosomiasis Control Committee, Department of Tsetse & Trypanosomiasis & Reclamation, Southern Rhodesia, 9th January, 1958.

¹²³ Interview, Mamuse, Mozambique, 23 February, 2007.

¹²⁴ Interview, Makubvu, Mozambique, 6 January, 2007.

well as checking the movement of certain contaminated products, such as fruits.¹²⁵ However, despite fencing and shooting operations, seasonal game movement was responsible for spreading tsetse.¹²⁶ This contributed to breaches of cattle and game fences by wild animals, cattle, and cattle keepers who disliked measures that prevented long established patterns of transhumance.¹²⁷

In 1961 the NC Chipinge reported on African resistance to tsetse fly and trypanosomiasis control measures by cattle owners at Kondo and Chibuwe who refused to make available their cattle for smearing (to diagnose trypanosomiasis). He claimed that the prosecution of 192 owners eventually broke the resistance.¹²⁸ Although these African cattle owners later cooperated with the colonial authorities by having their cattle inoculated, this incident shows that some villagers disliked government-imposed control measures. In other cases, colonial officials prevented Africans from owning cattle due to fear of trypanosomiasis. The same NC Chipinge reported in 1961 that villagers living in Tamandayi N. P. A. [Native Purchase Area] had “been pressing for [permission to own cattle] for some time.”¹²⁹

In the 1970s the civil war in Mozambique and the war of independence in Zimbabwe interfered with tsetse and trypanosomiasis efforts. The general insecurity in the countryside complicated control efforts. As a result, the incidence of trypanosomiasis increased. One informant claimed that they might have been some outbreaks of human

¹²⁵ Interview, Maengeni Village, Chipinge, Zimbabwe, 14 January, 2007.

¹²⁶ NAZ, F122/400/7/35/3: Minutes of a meeting of the Tsetse and Trypanosomiasis Control Committee, 7th August, 1958.

¹²⁷ NAZ, S3708/5/1-2: Monthly reports, Department of Tsetse and Trypanosomiasis control, Southern Rhodesia, 1975-6.

¹²⁸ NAZ, S2827/2/2/8: Report of the Native Commissioner, Chipinga, for the year ended 31st December, 1961. Advocate Hebert Chitepo was the first African lawyer in Southern Rhodesia.

¹²⁹ Ibid. Tamandayi is on the eastern border with Mozambique.

trypanosomiasis and that some of the people who contracted the disease became insane.¹³⁰

Conclusion

This chapter has demonstrated how the imposition of colonial rule led to the disruption tsetse fly ecology and made control of trypanosomiasis difficult. It has also shown how fears of infection, based on erroneous epidemiology of trypanosomiasis contributed to efforts to restrict human and animal mobility within and across territorial boundaries. Although some African societies had developed some mechanisms of keeping the tsetse flies and trypanosomiasis in check, the nature of colonial rule did not make way for African knowledge systems. These were often dismissed to make way for European science. In any case, the labor demands of the colonial economy would not have allowed for Africans to keep their ability to modify the environment and ensure limited but constant contact with tsetse flies necessary to provide immunity.

Colonial economies demanded that Africans be dispossessed of their lands, be pushed to the marginal areas, and provide labor for colonial projects. In both Mozambique and Zimbabwe, forced labor was common at the beginning of colonial rule. Although there was more land alienation in Zimbabwe than in Mozambique, Portuguese labor policies were equally disruptive to the environment. Through much of Mozambique's colonial period, Portuguese officials forced Africans to provide labor for farmers, miners, and for building roads and bridges and other colonial projects. In other parts of Mozambique, such as Gogoyo, Africans were forced into the forest to tap wild rubber, and to work for settlers in the northern parts of the Manica region. Thus while there was no large-scale land alienation in the Mozambican portion of the Manica region,

¹³⁰ Interview, Chitakatira Village, Mutare South, August 1, 2006.

colonial labor conscription and other demands reduced the time Africans devoted to cultivation. All these demands meant that Africans no longer had the ability to modify their environments and control trypanosomiasis.

The imposition of colonial rule therefore had deleterious consequences on the epidemiology of African trypanosomiasis. The large tracts of land that settlers seized from the Africans, kept idle by absentee landlordism, or partially cultivated due to lack of resources, soon became overgrown with vegetation, which became havens for tsetse flies. Thus while there could have been some movement of tsetse from PEA into Rhodesia, the existence of these large expanses of idle land, the introduction of exotic tree species in cleared areas, and African inability to modify the environment created some local foci of infection within Rhodesia itself.

In addition, the border prevented the continuation of the forms of transhumance which had contributed to protecting cattle from trypanosimiasis. The uplands of Zimbabwe had always served as safe areas to move cattle during the wet season when trypanosomiasis incidence increased in the lowlands of Mozambique. Yet, as this chapter has demonstrated, border game and cattle fences prevented the movements of cattle in these micro-environments. Tsetse fly and trypanosomiasis control measures therefore led to the disruption of the African way of life. They caused hardship to many Africans. As Africans and their cattle became buffers to protect Europeans and their cattle from trypanosomiasis, they suffered the most from the effects of changing tsetse ecologies at a time when it was impossible to practice local forms of transhumance that protected cattle from trypanosomiasis and provided fresh pastures. These public health and veterinary measures ultimately led to African distrust of western medicine.

Confronted by a worsening trypanosomiasis situation, colonial officials resorted to wanton destruction of wildlife and vegetation. Even when there were signs that game eradication was not effective, officials still hailed this method, mercilessly slaughtering wild animals and leading the reduction in wildlife populations in order to protect mostly

settler cattle and settlers themselves from disease. Although there were no recorded cases of human trypanosomiasis in the Manica region, its existence in other parts of the two colonies, coupled with erroneous ideas about the epidemiology of the disease, led to the implementation of stringent control measures by colonial officials. Thus as long as *G. morsitans* existed, officials for a long time believed that they could trigger an epidemic in humans as shown by the statement from the Medical Director for Rhodesia in 1930. In addition, early studies that mistakenly demonstrated the ability of an animal trypanosome to infect humans only worsened the fears colonial officials had and led to more public health measures. These early studies also led to the belief that trypanosomes could be transmitted by flies other than the tsetse fly, which caused alarm in public health circles.

Public health policies failed to convince Africans of the efficacy of western medicine because they did not respond to what Africans understood to be the cause of disease. The next chapter takes this analysis of erroneous theories of disease causation by settlers and colonial officials to another level, arguing that settler fears of the spread of STDs led to the implementation of intrusive and discriminatory public health policies as well as pervasive border monitoring.

CHAPTER III
REGIONAL OVERVIEW: POPULATION MOVEMENTS
AND THE “NATIVE” AS A RESERVOIR
OF INFECTION

Introduction

If trypanosomiasis, spread through the medium of the tsetse fly was of much concern to settlers and colonial officials, then Sexually Transmitted Diseases/Infections or venereal disease (hereafter STDs or STIs), spread without any medium was a perceived greater threat to their health. This chapter links the failure of colonial public health policy to colonial attempts to monitor African mobility in order to control STDs, particularly syphilis, known among the Shona as *siki*.¹ It examines regional population movements to bring out the extent of cross-border mobility between PEA and Rhodesia and to demonstrate how the border hindered the implementation of effective regional public health policy in the Manica region, where cross-border movements were extensive. Labor migrants and other travelers, unlike cattle keepers whose mobility was curtailed by the border game and cattle fences, regularly slipped across the border. The chapter explores the factors responsible for these movements and shows that the creation of territorial borders made the public health task difficult in both PEA and Rhodesia. Mozambicans living in proximity to the border were more likely to go to Rhodesia than elsewhere, and therefore were likely to encounter Rhodesian public health measures, such as medical examinations for STDs. The border, including the portion in the Manica region was a site of public health inspections, contributing to the resentment of public health monitoring and reluctance to embrace western medicine.

¹ To this day, when some Africans are not feeling well, they prefer to say they are “ill,” rather than “sick,” because “sick” can be interpreted as suffering from an STD, particularly syphilis (*siki*).

This chapter also examines settler epidemiological misunderstandings and fears of STDs as one of the major forces behind public health policy as evidenced by the colonial notion of the “native” as a reservoir of infection. Settlers thought that they could contract STDs through articles of clothing, through sharing kitchen utensils, or by merely talking to a sufferer. Settler fears were therefore based on erroneous understanding of STDs. Consequently, African lack of confidence in colonial public health was based in part on that recognition that European understandings of disease were not necessarily sound as well as on the ineffectiveness of colonial public health policy towards STDs. Africans knew very well that syphilis was sexually transmitted. That was why many African boys thought contracting syphilis symbolized sexual potency and transition to manhood.

Regardless of whether settler fears were grounded in truth or not, these perceptions informed and directed public health intervention and often led to the implementation of discriminatory public health policy. Enquires into the prevalence of venereal disease among Africans revealed that the infection rates were lower than what lay settlers claimed. Yet, Africans still suffered from the consequences of epidemiological misunderstandings and settler fears based on exaggerated and unfounded STD prevalence rates. Colonial officials compelled African migrants, both local and alien, male and female, to undergo humiliating medical examinations, which interfered with African ideas of privacy and masculinity.

This chapter argues that much division and debate among whites in Rhodesia and that medical professionals were under pressure from the white public to adopt views and policies which they did not think were correct. While Rhodesian senior medical authorities held different views based on empirical research and observation, they could not dismiss pressure from the settler population, who in Rhodesia had the right to vote and control their own destiny. This suggests that whereas in African societies healers enjoyed much status and influence, in the settler community the more progressive medical professionals advocated views which provoked considerable opposition.

Regional population movements

As early as the 1890s, Eric Allina-Pisano contends, some villagers in the Manica district of PEA devised a tax evasion strategy of fleeing to Rhodesia, semi-permanently or permanently. Communities in the Manica district were mobile. After all, these borderland people shared many cultural attributes with their Rhodesian counterparts and were now being arbitrarily separated from friends and relatives by European-imposed borders. Allina-Pisano argues,

For those nearest the border the risks and drawbacks of flight were reduced, and people took advantage of the border's porosity. They often had lived on or farmed land that now fell in British territory. Many "Portuguese" Africans had "British" relatives nearby. They quickly learned that a move across the new boundary gave them relief from the demands of the [Mozambique] company administration. Moreover, these short-distance moves were less disruptive to people's sense of their intellectual community. With a move of short distance, they may have well remained within the zone they retained the spiritual protection of their ancestors.²

Allina-Pisano asserts that by 1907, economic growth in the Manica district strained the relationship between the Mozambique Company administration and the African population because competition for African labor among rural African households, white employers (primarily farmers and miners), and the local administration "far outstripped the available supply."³ He added that the "established practice of commandeering African labor through predatory recruitment sweeps (though often with the assistance or intervention of local chiefs) *was not effective in Manica due to the porosity of the border with Southern Rhodesia.*"⁴

² Eric Allina-Pisano, "Negotiating Colonialism, 76.

³ Ibid., 123.

⁴ Ibid. Emphasis added.

In their attempts to control cross-border movements, PEA officials required that Africans seek passes before crossing into Rhodesia. The data generated from these officials shows that small numbers of Africans sought passes to Rhodesia. Africans from the Manica district usually visited border areas in Rhodesia, such as Melsetter, Umtali, and Penhalonga. They went to trade, visit relatives and friends, to buy household goods, and to seek medical attention. The most frequently visited places were Umtali, followed by Penhalonga, and then Melsetter. The areas in Rhodesia visited by Africans from the Mossurize district were numerous, including Melsetter, Chipinga, Mt. Selinda, Jersey, Chikore, Mutema, Sabi (Save), Mahenye, Muzite, Dondo, and Mapungwana. However, the majority of Africans never bothered to seek permission to visit Rhodesia as there were many clandestine entry points dotted all along the border. This pass system was therefore ineffective, to say the least. Even present-day trends show more clandestine than authorized movement across the border from both Zimbabwe and Mozambique.

However, in some instances, NCs in Rhodesia were able to detect huge influxes in PEA migrants. When the population of Melsetter district increased from 33,360 in 1922 to 36,568, the Chef Native Commissioner asked the NC for that district to verify his figures and the NC “replied to the effect that they [figures] were in order and that what appeared to be an abnormal increase was chiefly due to the influx of natives from Portuguese territory.”⁵ In 1924 the NC Umtali estimated the “alien floating population” at 4,200 compared to 4,150 in 1923.⁶ He added that most of these aliens were resident in Umtali Township, on mines and railway compounds. Although that number of aliens included Africans from other territories, such as Nyasaland and Northern Rhodesia, those from PEA constituted the greatest percentage, given the proximity of Umtali to PEA.

⁵ NAZ, S235/501 District Reports: Native Commissioners, Review of Reports of Native Commissioners Division III for the Year ended 31st December, 1923.

⁶ NAZ, S235/502 District Reports: Native Commissioners, Report of the Native Commissioner, Umtali District, for the Year ended 31st December, 1924.

As a testimony to the existence of cross-border movements, in 1924 the Mozambique Company launched an inquiry on the clandestine migration of Africans to South Africa and Rhodesia and various *Chefes de Circunscrições* (District Heads) provided estimates and the reasons for the migration. The *Chefe* of the *circunscrição* of Manica district estimated that about a hundred annually and that these primarily went to Rhodesia. The *Chefe* of the *circunscrição* of Moribane, south of Manica claimed that approximately 400 Africans migrated to South Africa and 200 to Rhodesia yearly. Further south, the *Chefe* of the *circunscrição* of Mossurize estimated that about 1,500 Africans migrated to Rhodesia and South Africa annually.⁷ These officials charged with border control gave low estimates which were wildly and deliberately inaccurate. They wanted to show that they were doing a good job of monitoring the border.

The reasons for this emigration were many and varied. The *Chefe* for Manica indicated the primary reason as the wish for better salaries which allowed them to quickly procure the bride price. For the *Chefe* of Moribane, the main reason was “to obtain better salaries and good treatment,” while the *Chefe* for Mossurize indicated that emigration was a “racial tradition,” and added other reasons such as “better salaries, good treatment, and to get money for marriage (£25).”⁸ This assessment was similar to that of the Administrator of the Mozambique Company who claimed in 1934,

The native of Mossurize, from boyhood, has only one ambition in life, which is to work for the Rand, and, as soon as he reaches the age of paying tax, he goes out in the path towards “John” [Johannesburg or Joni], as they say, given that he who does not work in the mines is not considered a man.⁹

⁷ AHM, FCM, Repartição do Gabinete-Processos, 1903-1942, Inquérito sobre a emigração clandestine para o Transval e Rodésia, 1924, Caixa 76, I-35. For an extensive discussion of the labor migration to Rhodesia, see Joel das Neves, *O trabalho Migratório de Moçambique para a Rodésia do Sul, 1913-1958/60* (Maputo: Universidade Pedagógica, 1990).

⁸ Ibid.

⁹ David M. Hughes, *From Enslavement to Environmentalism*, 36.

In South Africa, PEA migrants usually worked on the Rand gold mines while in Rhodesia, they labored in the agricultural as well as mining sectors. Working on the Rand mines went beyond the pragmatic consideration of wages to include issues of gender and masculinity in African society. In fact, one interviewee recalled how young men who had gone to Johannesburg (*Joni* in Shona) came back to take all the girls as they had money and were well respected.¹⁰ It became difficult for men who stayed behind to compete for brides with labor migrants returning from South Africa.

Just how “better” were these salaries from Rhodesia and Transvaal? The *Chefe* for Moribane indicated that Africans who migrated to Rhodesia were paid £1 and those who went to the Transvaal obtained up to £5 per month. John Rennie argues that the average wage of African labor migrants in South Africa was £3 per month, substantially more than the average African wage in either PEA or Rhodesia.¹¹ Work in the mines and plantations of South Africa and Rhodesia paid wages that were more than double those offered by local Portuguese settlers. As Allen Isaacman argues, similar disparities drove a considerable number of northern Mozambicans to the cotton and tea estates of Nyasaland and the sisal plantations of Tanganyika.¹²

While the numbers cited above appear to be insignificant, there was extensive movement from PEA into Rhodesia. The registered numbers were small because border monitoring was ineffective, at least in these early years of colonial rule, up to the 1920s. This weak control of the border could be one reason why the Rhodesian settler community feared mobile Africans as sources of disease. These fears were heightened by the view among most settlers and Rhodesian officials that PEA was a hotbed of disease

¹⁰ Interview, Harare, Zimbabwe, 10 July, 2006.

¹¹ *Ibid.*, 198.

¹² Allen Isaacman, “Coercion, paternalism and the labour process: The Mozambican cotton regime 1938-1961,” *Journal of Southern African Studies* 18, no. 3 (1992): 486-526.

and that Portuguese officials were not doing enough to combat disease. The settlers therefore knew that the number of migrants was considerable, but they also knew that their government exerted little control over African movement.

As a result, cross-border movements continued. In 1925 the NC Umtali reported that 637 Africans from the Portuguese territory had acquired domicile in the district, while that for Mesletter sub-district reported that a few Africans from Portuguese Territory had “settled on the Crown lands and farms in the eastern part of the sub-district and also in the Ngorima reserve.”¹³ In 1926 the NC Melsetter reported that 168 African men, some of them with families, came to live in the district from adjoining Portuguese Territory whereas the NC Melsetter sub-district reported that a number of Africans went to live in Portuguese Territory, returning “whence they came a few years ago” and that number of Portuguese Africans who settled in the district was very small.¹⁴ This suggests that there may have been enough movement across borders to have altered the disease environment in the region. Officials not charged with the responsibility for border controls gave better estimates of migration from PEA.

That cross-border movements were common was shown by the increase in applications from PEA for permission to reside in Rhodesia, some of which were rejected. The NC Umtali reported in 1929 that Africans from the neighboring districts of Portuguese Territory frequently applied for permission to become domiciled in Rhodesia. This permission was granted only “after careful investigation” of whether land was available for them and of their previous history.¹⁵

¹³ NAZ, S235/502 District Reports: Native Commissioners, Report of the Native Commissioner, Umtali District and Melsetter sub-District, for the Year ended 31st December, 1925. “Crown Land” was land not yet apportioned, thus considered to belong to the Queen.

¹⁴ NAZ, S235/504 District Reports: Native Commissioners, Report of the Native Commissioner, Melsetter District and Melsetter sub-District, for the Year ended 31st December, 1926.

¹⁵ NAZ, S235/507 District Reports: Native Commissioners, Report of the Native Commissioner, Umtali District, for the Year ended 31st December, 1929.

Nevertheless, this movement was not always one way. Africans in Rhodesia also frequently crossed the border into the Portuguese territory for various reasons. In 1929, for instance, nine adult Africans moved to the Portuguese Territory.¹⁶ Similarly, when drought struck in Rhodesia in 1933, the NC Melsetter reported that, driven by famine, which was general throughout the district south of Chipinga, “large numbers of Natives have wandered away into adjoining Portuguese Territory in search of food so that at time certain areas have seemed to be almost depopulated.”¹⁷

Moreover, while the *Chefe* of Mossurize reported that approximately 403 Africans were working in Rhodesia and the Transvaal in 1937,¹⁸ the NC Chipinga reported in 1938 that the failure of crops due to drought made it difficult for Africans to procure sufficient food “to tide them over until the next season and many of them travelled miles into the adjoining Portuguese Territory to barter grain from their more fortunate neighbours.”¹⁹

Apart from these border crossings at times of crises, Africans from both sides of the border always mingled for a variety of reasons. In Rhodesia, applications to domicile there continued to come from PEA for various reasons. Some applicants were discontented with the conditions of life in Portuguese Territory, while others stated that all their surviving relations were in Rhodesia and another group comprised those who had lived in Rhodesia for many years and had married indigenous wives. However, the NC Umtali claimed that owing to the “extremely limited space available,” in the Umtali

¹⁶ Ibid.

¹⁷ NAZ, S235/511 Volume III: Native Commissioners-Reports, Report of the Native Commissioner for the Melsetter District for the Year ended 31st December, 1933.

¹⁸ AHM, FCM, Negocios Indigenas-Processos, Caixa 26, Pasta 166-Trabalho Indigena-Diversos Assuntos, O Chefe de Mossurize para Exmo. Senhor, Diretor dos Negocios Indigenas, Beira, 15 April 1937.

¹⁹ NAZ, S235/516 District Reports: Native Commissioners, Report of the Native Commissioner, Chipinga, for the Year ended 31st December, 1938.

district for African settlement, these applications were only “granted in exceptional circumstances.”²⁰ The 1930s and 1940s also witnessed sharp increases in the number of PEA Africans entering and residing in Umtali district. For instance, the number of PEA Africans as a proportion of the Rhodesian labor force in the Umtali district increased from 21.1 percent in 1931 to 25.4 percent in 1936, and from 43.0 percent in 1941 to 51.1 percent in 1946.²¹

Movements across the border continued. In 1947 the Clerk in charge of the Native Department at Penhalonga reported that 449 Africans from PEA migrated to the district and that he had issued 115 passes to Africans from PEA to leave the Colony.²² These are only a few documented cases of cross-border movements. There was a lot more clandestine movement across the border. The NC Melsetter claimed that because the “majority of natives employed” on farms along the border areas were from PEA, they were “liable to disappear over the border when they tire of work.”²³ This demonstrates that the border between PEA and Rhodesia was porous and that border crossings always posed the threat of disease transmission from one colony to another. These cross-border movements and the perceived high STD prevalence rates among Africans fueled settler fears of infection.

²⁰ NAZ, S235/516 District Reports: Native Commissioners, Report of the Native Commissioner, Umtali, for the Year ended 31st December, 1938. While claims of insufficient land were reasonable, the strong demand for migrant Portuguese African labor contributed to denials of permission to settle in Rhodesia. Rhodesian officials feared that if Portuguese migrants settled in the Colony, they soon would shun the farms and mines just like the local villagers and result in labor shortages.

²¹ Richard Hodder-Williams, *White Farmers in Rhodesia, 1890-1965: A history of the Marandellas District* (London: Macmillan, 1983), 166.

²² NAZ, S1051 Native Commissioners Reports: Report of the Clerk in charge, Native Department, Penhalonga, for the quarter ended 31st December, 1947.

²³ NAZ, S2827/2/2/3 Native Commissioners Reports: Annual Report for the Year ended 31st December, 1955. Native Commissioner, Melsetter.

“[T]he whole lot of them are rotten with syphilis”:
prevalence of STDs among Africans

The lay sections of the white settler community cited baseless and exaggerated rates of infection among Africans in order to foster their perception of Africans as reservoirs of disease. As early as 1898, the NC Umtali, T. B. Hulley commented on what Europeans viewed as the reasons for what the settler community considered high prevalence of STDs among Africans. Writing on African customs, particularly the practice of polygamy, Hulley claimed that Africans practiced polygamy, with women having “absolutely no say in their own disposal, many being sold before they were born or even before their mothers were grown up.”²⁴ According to Hulley, marriage amongst Africans was “a lottery and that the course of true love has but a poor chance of running smoothly.” He claimed that as a result, “adultery and immorality” was rife among Africans as “a woman’s virtue goes no further than her market value.” Yet, Hulley was surprised that with the circumstances prevailing at that time, when an influx of white men who were “away from responsibility, and home ties and self respect [were] forgotten for that time, that the [African] women [had] not become prostitutes to the whites.”²⁵ He also did not, at this time, report any STD cases.

On the Portuguese side, *Chefe* of the Manica district expressed his astonishment as early as October 1904, at the “high number” of STIs which resulted in a police hunt for black prostitutes and their examination in the Macequece hospital for two days.²⁶ Other European observers in PEA also cited high rates of STDs in the Manica region. Writing

²⁴ NAZ N9/1/1-4: Native Commissioners - Reports, Annual Report for Umtali, 1 April, 1898.

²⁵ Ibid.

²⁶ AHM, FCM, Secretaria Geral-Relatórios, Caixa 126, Pasta 2638, Circumscricção de Manica-Secção de Saúde, Relatório do Mez de Outubro de 1904.

in 1907, Guillaume Vasse claimed that syphilis prevalence rates were high among the Africans of Manica (which included Macequece, Moribane, and Mossurize, among other districts).²⁷ As a result of these “high rates” of STDs among Africans, in 1917, the *Chefe* of Manica district called for a weekly inspection of “prostitutes.”²⁸

After the First World War, officials in Rhodesia began to report apparent increases in the incidence of STDs among Africans. Reporting on Rhodesian towns, the Medical Director, A. M. Fleming wrote, “the prevalence venereal diseases amongst natives, both in employment and casuals, is yearly becoming more serious”²⁹ He therefore urged the government to adopt measures for the detection, segregation and treatment of these cases, claiming that there was no system of any kind whatsoever for the isolation and treatment of these cases in any of the towns, “regardless of the fact that many of these affected natives may be in domestic service and expose innocent persons to considerable risk.”³⁰ According to Fleming, one of the reasons for the delay in erecting special wards for treating STDs stemmed from the failure to agree as to whether the cost should be borne by the central government or the Municipalities concerned.

Various commentators argued that single African women were responsible for spreading STDs. The Rhodesian Medical Director wrote in 1919 that the continuous spread of STDs was “undoubtedly partly due to a certain class of native women, mostly aliens from the north, who travel from mine to mine,” and “between town locations, and who live on the proceeds of prostitution, or attach themselves to one native for a time as

²⁷ Guillaume Vasse, “The Mozambique Company’s Territory II,” *Journal of the Royal African Society* 6, no. 24 (1907): 385.

²⁸ AHM, FCM, Secretaria Geral-Relatórios, Caixa 126, Pasta 2649, Circumscrição de Manica-Relatório anual dos service de Saúde do hospital de Macequece, 1917.

²⁹ NAZ, A3/12/6/1: Correspondence from A. M. Fleming, Medical Director, to the Secretary, Department of the Administrator, Southern Rhodesia, 17th June, 1919.

³⁰ Ibid.

his temporary wife....”³¹ Fleming therefore considered it logical to attack the what he regarded the “root of the mischief and institute a system of examination and control of these women,” but he acknowledged that this would probably entail special legislation.

These calls for special legislation to impose medical examinations on Africans were driven by what settler believed to be a high prevalence of STDs among Africans, including those from PEA. In 1920 the NCs Umtali and Melsetter reported one death in each district resulting from STDs, but the NC Melsetter made the remark that his district was free from syphilis with the majority of the cases being contracted by Africans working outside the district.³² Three years later, the NC Umtali claimed that after “extensive enquiries,” it “appeared” that 600 Africans were suffering from STDs in the district, with about 450 of them suffering from syphilis and the rest, gonorrhoea.³³ He complained that there were no laws allowing compulsory examination and treatment of “any one section of the community,” and urged the government to take steps to provide hospital accommodation for Africans suffering from STDs. The NC asserted that provision of separate hospital accommodation was important because STDs patients who were “being excluded from ordinary hospitals and unable to help themselves,” were a “serious menace to public health, to say nothing of the suffering of the patients themselves.”³⁴

In that same year, the NC Melsetter reported two deaths from syphilis and noted that although there were no alarming figures, STDs had firmly established themselves in

³¹ NAZ, A3/12/6/1: Correspondence from A. M. Fleming, Medical Director, to the Secretary, Department of the Administrator, Southern Rhodesia, 17th June, 1919.

³² NAZ, S2076: Native Commissioners-Reports, Report of the Native Commissioner, Melsetter District, for the year ended 31st December, 1920.

³³ NAZ, S235/501: District Reports-Native Commissioners, Report of the Native Commissioner, Umtali District, for the year ended 31st December, 1923.

³⁴ Ibid.

the population.³⁵ The NC also urged the Government to take steps to eradicate these diseases. Thus views about rampant widespread of STDs among Africans began to make their way into the settler public as were the calls for compulsory medical examination of Africans.

The year 1923 is also crucial for Rhodesia because that was the year Company rule ended and whites settler assumed Responsible Government, with the power to elect the prime minister and members of the Legislative Council, as well as enjoying some degree of independence from Britain. Hence the following year, 1925, witnessed the passage of the Public Health Act with provisions for isolation, compulsory medical examination, and STDs. With all these powers in their hands, it is not surprising that white settlers heightened their criticism of the government, calling for pervasive public health measures for Africans.

In 1924 the NC Umtali was concerned about the increase in STDs cases although he did not cite any statistics. He claimed that syphilis was on the increase and that “loose women were the source of evil.”³⁶ The NC was grateful for the Public Health Act, which, according to him, would enable “the compulsory examination of women who frequent towns and mining camps.” Umtali was said to be particularly vulnerable because apart from being a major eastern town, it was also close to Penhalonga, a mining town, as well as PEA, long considered a hotbed of disease by Rhodesians. In that same year, the NC Melsetter sub-district, with a town smaller than Umtali, reported “there does not appear to be any increase of venereal disease.”³⁷ Yet reports from Government medical

³⁵ NAZ, S235/501: District Reports-Native Commissioners, Report of the Native Commissioner, Melsetter District, for the year ended 31st December, 1923.

³⁶ NAZ, S235/502: District Reports-Native Commissioners, Report of the Native Commissioner, Umtali District, for the year ended 31st December, 1924.

³⁷ NAZ, S235/502: District Reports-Native Commissioners, Report of the Native Commissioner, Melsetter sub-District, for the year ended 31st December, 1924.

officers, other NCs, and missionaries from various districts continued to show the prevalence of STDs in Africans. Public health officials acknowledged that they did not have sufficiently reliable statistics which might indicate whether or not the disease was increasing amongst the African population.³⁸ However, many settlers believed that the disease was rampant and needed urgent attention.

The NC Melsetter raised similar concerns in 1926. Considering that American missionaries had been working in the district continuously for thirty years, he felt disappointed at what he considered “the small progress made by Natives as a whole” in the district.³⁹ The NC argued that, with the exception of the comparatively small communities that clustered around the European-controlled stations of Mt. Selinda and Chikore, there was nowhere among the adult generation “any recognition of the need for improvement...” and that polygamy, which perhaps was “the strongest of all inhibitions against change,” was the general practice. He claimed that even the chiefs were all “of the old school” and were never progressive. On the contrary, the NC said these chiefs were backward, “so to speak, to the contents of the beer-pots” and the drinking of beer often continued “till far into the night with intermittent dancing while sexual irregularities” were “winked at by the older people,” who themselves had become unfit to enforce restraint.⁴⁰ These were the practices that settlers considered an impetus to the spread of STDs.

While settlers thought that all Africans were infected with STDs, surveys of the prevalence of these diseases among showed that settler fears were exaggerated. In 1928 the Medical Director for Rhodesia, Dr. A. M. Fleming chided settlers, saying,

³⁸ NAZ, S2419: Report on the Public Health for the Year 1924, Southern Rhodesia.

³⁹ NAZ S235/504 Native Commissioners-Reports, Report of the Native Commissioner for Melsetter District, for the Year ending 31st December, 1926.

⁴⁰ Ibid.

On this subject, a good deal of nonsense has been talked, and one is constantly confronted with loose statements on the prevalence of venereal disease among the native races; in fact, it is not uncommon thus to hear a responsible person, who should know better, give it as their considered opinion that up to 80 per cent or 90 per cent of the native population are syphilitic, or to hear the more careless expression “*the whole lot of them are rotten with syphilis.*”⁴¹

It was alarming that even “responsible person[s],” presumably physicians, also discarded known facts and joined in the chorus of unfounded claims of STD incidence that prevailed within the settler population. Fleming argued that STD prevalence rates among Africans were much lower than commonly assumed. For example, in 1928 Fleming noted that of the 110,000 African male adults examined for STDs, the incidence of syphilis (in clinical form) among them was approximately two to three percent or to 20 to 30 per thousand, “not an excessive or alarming figure and indeed one which compares favourably with similar returns from our own [British] army and navy.”⁴²

However, despite these assurances from the medical community, settlers continued to claim that STDs were rampant among Africans and blamed African customs and lifestyle for the prevalence. In 1929, Mary W. Waters, the Organizing Instructress in the Native Education Department urged settlers to act on what she considered “vices” among Africans, arguing, “Are we to leave them [Africans] with these vices. Are we to shut our eyes to people who live in a state of terror, darkness, poverty and filth; *with the most degraded sexual practices, and consequently with disease and suffering rife among*

⁴¹ NAZ S1173/220: Venereal Disease: Notes of a Conference held in the Committee Room, Municipal Offices, Bulawayo, on Saturday, October 6th, 1928. Emphasis added.

⁴² NAZ, S1173/220: Venereal Disease: Notes of a Conference held in the Committee Room, Municipal Offices, Bulawayo, on Saturday, October 6th, 1928. This total of 110,000 included Africans residing in urban areas, African prisoners in goals, members of the Native Police Force, African patients under treatment in Government Hospitals, and Africans who were looking for work on mines and railways. All these were under direct European control and subject to medical examination and treatment when sick. Fleming was referring to the British Army and Navy, noting that the incidence of venereal disease in the navy for the year 1926 was seven percent. This meant that of the total naval population of about 90,000 men, 6,453 of them were suffering from venereal disease.

them.”⁴³ Little wonder European settlers perceived Africans as reservoir of disease.

Some sections of the European community, particularly settlers considered *all* Africans to be syphilitic owing to their way of life. Much of this denigration of African customs came from misunderstanding and lack of will to learn African ways.

It was the same story in Mozambique involving the condemnation of African cultural practices as major contributors to the prevalence of STDs. A 1929 health services report asserted that alcoholism and STDs among Africans posed a grave threat to the public. The report claimed the Africans lacked notions of hygiene and that because Africans lived in communities where prostitution abounded, they were often fatal victims of STDs.⁴⁴ The report recommended the development of measures to prevent the spread of STDs. Included among these measures were attempts to repress prostitution.⁴⁵

Perceptions of Africans as reservoirs of disease persisted with exaggerated STD prevalence rates culminating in the assumption that “the whole lot of them are rotten with syphilis.” In Rhodesia, the American Board Mission Hospital at Mt. Selinda reported having treated 89 cases of syphilis and yaws in 1930 and 208 cases in 1931, with STDs being the second “great offender” among Africans after malaria.⁴⁶ Most of these claims of high rates of infection in rural areas were estimates which, according to Fleming, were difficult to make because STDs, particularly syphilis had symptoms similar to those of leprosy and framboesia, both of which were “common” among Africans. Thus according to Fleming, a certain proportion of cases reported by various treatment centers

⁴³ NAZ, S1173/337-338: Address on the work amongst Native women and girls in Southern Rhodesia given to the Members of the Welfare Society and others in Bulawayo, March 13th, 1929 by Mary W. Waters, Organizing Instructress, Native Education Department, Rhodesia.

⁴⁴ AHM, FCM, Secretaria Geral-Relatórios, Caixa 128, Pasta 2678, Relatório da Direção dos Serviços de Saúde-Assistência Sanitaria ao Indigena, 1929, 3.

⁴⁵ Ibid.

⁴⁶ NAZ, S2014/6/2: American Board Mission, 1925-1947, Report of Medical work—Mount Selinda Mission, 1931 and 1932.

countrywide as STDs, were actually framboesia or yaws. He argued that framboesia (yaws) was a disease of African villages which was exceedingly prevalent in tropical and sub-tropical parts of Africa such as Kenya, Tanganyika (Tanzania), the Belgian Congo (Democratic Republic of Congo and Congo-Brazzaville), and in certain areas of Rhodesia. Distinguishing between framboesia and syphilis was difficult because both diseases had similar primary, secondary, and tertiary stages.⁴⁷ Hence it was difficult for social workers and public health authorities to give correct estimates as regards the incidence of STDs, particularly among Africans in rural areas.

Similar associations of Africans with STDs were also made in PEA as hospitals recorded numerous cases of STDs among Africans. PEA hospital records suggest that syphilis was the most prevalent of all STDs, as shown in Table 3-1.

Table 3-1 STD prevalence in the Mozambique Company territory

Year	Total cases	African contribution
1936	285	263
1937	351	329
1938	273	261

Sources: AHM, Fundo da Companhia de Moçambique: Secretaria Geral-Relatórios, Caixa 119, Pasta 2294, Direcção dos Serviços de Saúde, 1936, 1937, 1938, 1939, and 1940. VD stands for venereal diseases.

The numbers above are for the entire territory of the Mozambique Company, encompassing all the sixteen *circunscrições* of Beira, Buzi, Chemba, Cheringoma, Chimoio, Gorongosa, Govuro, Manica, Marromeu, Mocoque, Mossurize, Neves Ferreira,

⁴⁷ Ibid. Framboesia is an infectious tropical disease resembling syphilis in its early stages. Its symptoms include red skin eruptions and ulcerating lesions.

Sena, Sofala, Chingune, and Gafaria. It is therefore difficult to detect STD prevalence in the specific districts under study. However, there are a few records for these specific districts. Manica district registered 17 cases of syphilis in 1917, 5 cases in 1935, 33 cases in 1939, and 47 cases in 1940, whereas Mossurize district registered 2 cases in 1939 and 10 cases in 1940. As for other STDs, Manica district registered 20 cases in 1935, 21 cases in 1939, and 22 cases in 1940 while Mossurize district registered 3 cases in 1939 and one case in 1940.⁴⁸ Since Manica district had larger urban centers than Mossurize, it was bound to have more STD cases. Overall, the data generated by public health officials did not substantiate the notion of widespread incidence of venereal disease among Africans.

The figures in Table 3-1 above suggest that the incidence of STDs was small. These were totals for all the sixteen districts of the Mozambique Company. Even when considering these annual infection rates against the total population under the Mozambique Company government in 1909, which was 237,941, one finds that the infection rates were negligible.⁴⁹ These infection rates did not warrant alarm even when considering the population of one district alone. For instance, the total African population of Mossurize district was estimated at 25,305 in 1935, 35,037 in 1936, 36,712 in 1937, and 38,222 by 1938.⁵⁰

Furthermore, European settlers alleged that the source of STDs was “primarily in the native districts, and spreading from there to the centres of European occupation and was becoming a menace to the white population.”⁵¹ Yet inquiries made by public health

⁴⁸ AHM, FCM, Secretaria Geral-Relatórios, Caixa 119, Pasta 2294, Direcção dos Serviços de Saúde, 1936, 1937, 1938, 1939, and 1940.

⁴⁹ AHM, FCM, Secretaria Geral-Relatórios, Recenseamento da População da Europa, e Indígena, Território de Manica e Sofala, 24th March 1909, Box no. 193, File no. 636.

⁵⁰ AHM, FCM, Secretaria Geral-Relatórios, Report of the District of Mossurize for the Year 1935, 1936, 1937 and 1938, box no. 266.

⁵¹ NAZ, S1173/220: Venereal Disease: Notes of a Conference held in the Committee Room, Municipal Offices, Bulawayo, on Saturday, October 6th, 1928.

officials to determine the prevalence of syphilis continuously demonstrated that STDs were spreading *from* the towns and centers of European settlement towards and not from African districts because urban areas had a higher percentage of STD incidence than the rural areas.⁵² Fleming argued that the incidence of STDs among Africans in towns and mining centers was not so much influenced by contact with Europeans as by working and living conditions in towns. According to him, most of the unskilled labor was undertaken by male adult Africans who, whilst in employment, were divorced from family life and amongst whom cohabitation and promiscuity with African women was accordingly common.⁵³ He noted that in 1926 there were 110,041 African males employed in urban and mining areas while only 2,908 African females resided in these same areas. The problem was that the largest number of these employed males came from neighboring colonies as temporary immigrants seeking work, without their wives and families.⁵⁴ Fleming added that of these “3,000 African females distributed among 110,000 male Africans” in urban and mining centers, the majority of them were prostitutes and this accounted for the increasing incidence of STDs in Rhodesia.

As Fleming noted, the STD issue was primarily a social and economic problem which could have been addressed by ameliorating the social conditions of migrant African workers in urban and mining centers through the provision of decent family units and “family wages,” not “bachelor wages.” It was not entirely a medical problem. However, the settlers clamored for medical examinations only without addressing the root-cause of the problem.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ Ibid.

The “native” as reservoir of infection: settler fears and
public health

In the 1920s Rhodesian officials remarked that the spread of STDs among Africans in both “Native Reserves” and on mines had been the subject of constant discussion on the part of the Native Department officials, missionaries, and the Legislative Council. However, before the passage of the Public Health Act in 1925, neither the Government nor local authorities had sufficient powers to deal with what public health officials considered a “pressing and outstanding menace to the public health and the future child life of the native population.”⁵⁵ Hence, Chapter III of the Public Health Act dealt entirely with STDs, which according to officials, was “a public health question of primary importance in Southern Rhodesia to-day, more especially as it affect[ed] the native population....”⁵⁶

The decades that followed the proclamation of the Public Health Act witnessed the adoption of vigorous, sometimes racist measures to arrest the “menace” of STDs. These measures included medical examinations of African men and women in towns and mining centers. African men, including those from neighboring colonies, such as PEA, Northern Rhodesia, and Nyasaland were examined for STDs before they could be employed in urban and mining centers. African women increasingly came to be viewed by colonial officials as the source of evil as they assumed that independent African women were prostitutes, spreading gonorrhea and syphilis in towns and mines. As a result, colonial officials examined women entering urban and mining areas for STDs.

⁵⁵ NAZ, A3/12/25 Health and Medical Services: Public Health Act, September 17, 1920-February 18, 1925.

⁵⁶ Ibid.

These inspections were also dictated by the interests of capital, for they ascertained a man's suitability for labor. Industry wanted to keep to an absolute minimum the cost of maintaining health among its workers. "Inspections" had to fulfill this duty of keeping reservoirs of infection from reaching mining compounds. Thus in addition to STD examinations, African men seeking employment also had to undergo medical examinations for tuberculosis, scabies, leprosy, and ring worm. As Randall Packard argued, in the inter-war years, colonial governments were largely concerned about the health of Europeans and that of African laborers. The shift to provide health services for entire populations only came after the Second World War because of technological advancement and the re-conceptualization of "development."⁵⁷

In 1933 the Medical Officer for Umtali, Oswald E. Jackson pressed for compulsory medical examinations, citing the "proximity of the Portuguese Border" in relation to Mutare, "as a large number of P.E.A. [Portuguese East Africa] natives obtain work here [Umtali]."⁵⁸ He added that "it is not likely that these people can obtain medical help across the border as easily as in S. Rhodesia." Jackson's claim suggests that the fear of reservoirs of disease was heightened by proximity to the PEA border and how the border affected settler imagination by stirring up fear of an unfamiliar "other" territory, which in this case was not far away.

Although Jackson argued, the "danger of a native servant infecting a member of the household is remote," he stressed, there "is a very decided fear of infection in the public mind...."⁵⁹ This fear led to calls for compulsory examination of Africans. A system to force *all employed* Africans in urban areas to undergo medical examination for

⁵⁷ Randall Packard, "Visions of Postwar Health and Development," 96.

⁵⁸ NAZ S246/343: Umtali, Natives-Medical Examination, 1937-48, Correspondence from Umtali Medical Director, Oswald E. Jackson to the Secretary, Department of the Colonial Secretary, Southern Rhodesia, 5th May, 1933.

⁵⁹ Ibid.

STDs was already in place by 1933, but the Umtali Town Council wanted this system to be extended to all Africans *seeking work*. One settler, Mr. Malcom, told then the Rhodesian Medical Director, R. A. Askins that the Umtali people feared “that natives seeking work will infect the European population with venereal disease.”⁶⁰ However, Askins argued, “It is not stated upon what grounds these fears are based, but it may be stated that venereal disease is not spread from one person to another in this manner,” adding that “the [Umtali]Town Council have exaggerated the idea of the danger of infection.”⁶¹

Another example of this fear of infections was shown by the Rhodesian settler, Colonel H. A. Stewart, who castigated the government neglect of STDs. Stewart’s African employee had been diagnosed with STDs. He wrote, angrily,

I ... feel most strongly that the Government Medical Authorities of Southern Rhodesia are guilty of culpable negligence in allowing a system to exist in this country whereby the white population, and more especially the women and children are exposed to the risk of infection from this terrible disease.... Therefor[e] it stands to reason some means should exist whereby a native suffering from venereal [disease] was compelled by law to state the fact or to produce some document showing the disease he was suffering from and this should not necessarily be confined to venereal [disease] as there are other diseases such as tuberculosis which though not so horrible may be even more deadly.⁶²

To emphasize his point, Stewart wrote about his experience in the British Army where, he claimed, a Medical History Sheet “is kept for every Regular Soldier under Commissioned rank.” He argued, “it is a crime, under the Army Act, for ANY soldier, however exalted or humble his rank may be, to conceal the fact that he is suffering from

⁶⁰ NAZ S246/343: Umtali, Natives-Medical Examination, 1937-48, Correspondence from the Medical Director, Southern Rhodesia to The Secretary, Department of the Colonial Secretary, Southern Rhodesia, 5th May, 1933.

⁶¹ Ibid.

⁶² NAZ, S482/534/39: Natives-Medical Examination, 1937-48, Correspondence from Colonel H. A. Stewart to the Minister of Native Affairs for Southern Rhodesia, 11th April 1938.

venereal disease.” Yet, a system which was “devised for the health and general wellbeing of the British Regular Army,” continued Stewart, “*composed as it is of well educated, cultured white men is apparently considered by the Government Officials of Southern Rhodesia as degrading to a black African native who less than a century ago was in the most literal sense a savage and today is very little, if any, better.*”⁶³

Such racist language was commonly used in comments on non-whites. While investigating the sources of STDs in 1947, one of the Public Health Department committee members, Lt. Col. Appleby claimed, “Coloured females particularly are responsible for a good proportion of V.D. [venereal disease] of Europeans and therefore a number of the names reported to local health authorities would be of persons of these races.”⁶⁴ Colored people were those of mixed races, particularly between white and black.

Every effort therefore had to be devoted to stopping infection from reaching Europeans. Colonel Stewart went on to state,

I understand from the press that this Government [Rhodesia] is about to bring in legislation to encourage and financially assist the immigration of a good class of white settler. May I ask, Sir, with every respect whether these immigrants are going to be warned that its Government takes no steps whatsoever to safeguard them against the greatest scourge known to man. Under existing regulations all immigrants have, apparently, to satisfy the Immigration Officers that they are free from tuberculosis yet with amazing inconsistency the Medical Authorities of Southern Rhodesia not only permit, but by their passive, non-committal attitude actually encourage a far worse and more horrible disease to stalk unchecked through the land. And this at a time when all great nations of the world are doing their utmost to improve the standard of health of their peoples and particularly of the young generation.⁶⁵

⁶³ Ibid. Emphasis added.

⁶⁴ NAZ, S2014/3/10: Plague, 1937 February 5th—1947 April 30th, Notes of a meeting to discuss the tracing and investigation of infection of venereal disease held in the Public Health Department on 5th November 1947.

⁶⁵ NAZ, S482/534/39: Natives-Medical Examination, 1937-48, Correspondence from Colonel H. A. Stewart to the Minister of Native Affairs for Southern Rhodesia, 11th April 1938.

Attracting a “good class of white settler” was of paramount importance in Rhodesia, which faced stiff competition from South Africa, Kenya, and some British dominions, such as Australia, New Zealand and Canada. For Rhodesia, populating the colony with white settlers was the basis of survival given that the African population always far outnumbered the white population. Many white settlers believed that there was a need for more white settlers to occupy the land, “develop” it, and defend it from the more numerous Africans. Under such conditions, it is not surprising that the Government of Rhodesia was compelled by settler arguments to implement tough public health laws. In any case, with the advent of Responsible Government in Rhodesia in 1923, power lay in the white settlers, the only ones who had the right to vote for government officials. Protection of white settler privilege and health was central to colonial governments. A Colonel Stewart of Rhodesia lamented, “The present state of affairs in regard to *venereal disease among the native population and the terrible danger of its infection to the white people is a disgrace to this Government and their Medical Authorities.*”⁶⁶

Stewart vigorously advocated compulsory medical examination of Africans for STDs. The Rhodesian Medical Director, Andrew Paton Martin responded by saying that Stewart’s complaint reflected “the old story of compulsion, but always compulsion for somebody else...but as you know, compulsion has been abandoned long ago by most public health departments who ever attempted to deal with this condition.”⁶⁷ Martin wondered “what Colonel Stewart would have to say if he were asked to carry about a medical history sheet and submit himself to medical examination whenever somebody else thought he ought to do so.” Stewart’s premise, however, was that Africans were “savages” and thus could be compelled to undergo invasive public health measures

⁶⁶ Ibid. Emphasis added.

⁶⁷ NAZ S482/534/39: Natives-Medical Examination, 1937-48, Letter from Andrew Paton Martin, Medical Director, to the Prime Minister, Southern Rhodesia, 23rd April, 1938.

because they were not at par with “well educated, cultured white” people. Martin did not succeed in reducing racist influence in public health. If anything, the lobbying of the settler community that led to the formulation of public health policy, just as any nation responds to the pleas of its citizens.

Most of the settlers expressed a lack of understanding of the epidemiology of STDs. Public health officials always had to correct misunderstandings of these diseases among the lay white populace. Then the Medical Director of Rhodesia, R. A. Askins lamented, the “lay people have an exaggerated dread of venereal disease,” adding that “many think that all natives have it and that you can become infected by simply talking to a sufferer.”⁶⁸ However, this expression of ignorance might have been a convenient way through which these lay people tried to absolve themselves of immoral activities, such as prostitution. Fears of infection and the need to find scapegoats therefore led European settlers to blame Africans for STDs as Askins indicated in 1939,

The Public’s attitude towards this examination [for STDs] is ... an ill-informed one, but is based on the very genuine fear that exists against exposure to infection and the contraction of these diseases. But this fear is not well-founded and the dangers of the risk of infection are grossly exaggerated. All these awful tales of the contraction of infection from closet-seats, towels, drinking cups, are just so much moonshine and for the most part are the inventions of persons who are driven to all sorts of expedients to explain the origin of the venereal disease from which they are suffering. These stories are the common currency of the doctor’s consulting room and medical men have long learned to maintain discreet silence in the face of these voluble explanations.⁶⁹

⁶⁸ NAZ S1173/332-334, Letter from the Medical Director, Southern Rhodesia, R. A. Askins to The Secretary, Department of Internal Affairs, Southern Rhodesia, 31st October, 1933.

⁶⁹ NAZ S482/534/39: Natives-Medical Examination, 1937-48, Letter from the Medical Director, Southern Rhodesia, to the Minister of Internal Affairs, Southern Rhodesia, 11th January, 1939.

In the same vein, the Rhodesian Secretary for Health, M. H. Webster deplored these erroneous settler views of STDs, which some professionals also embraced. He noted,

There was always then, as always, a curious pre-occupation with venereal disease. This was reflected in the prominence given to venereal diseases and the control thereof in the Public Health Act which was introduced in 1924 and promulgated in 1925. The superstitious awe with which the general public views venereal disease is possibly understandable in view of the scandalous connotations of these conditions, but it is hard to see why a learned profession should consistently exaggerate the public health importance of syphilis and gonorrhoea....⁷⁰

Thus while the layman's misunderstanding of the transmission of STDs might have been genuine, that of learned professionals was inexcusable. Africans became convenient scapegoats of settler misunderstanding of the epidemiology of STDs. Yet, these Africans knew that syphilis was a sexually transmitted disease and thought of it as having a primarily moral cause, often associated with prostitution and having extra-marital affairs, as some think now about HIV/AIDS. Africans also knew that syphilis, for instance, was a disease of cities and compounds on farms and mines. The name *siki* itself, a derivation from English (syphilis), suggests that this disease was associated more broadly with colonialism and the intrusion of Europeans than with pre-colonial society. Thus while colonial officials argued that prostitution was responsible for the spread of STDs, what they considered "prostitution" was then a new kind of sexual relationship which was associated with urban and compound life on settler farms and mines. This "prostitution" was associated colonial labor demands and wage employment which contributed to extensive migration.⁷¹

⁷⁰M. H. Webster, "A Review of the Development of the Health Services of Rhodesia from 1923 to the Present Day, Part I, the 1920s." *The Central African Journal of Medicine* 18, no. 12 (December, 1972): 246.

⁷¹ For more on prostitution and STDs on Rhodesian mine compounds see Charles Van Onselen, *Chibaro: African mine labour in Southern Rhodesia, 1900-1933* (London: Pluto Press, 1976).

The efficacy of medical examinations

In Rhodesia, after the promulgation of the Public Health Act in 1925, the government secured all the powers needed to enforce medical examinations for STDs among Africans as a public health measure. This Act represented an extension of a system of medical exams which had started on the mines. Hence, women entering mining and urban centers and men seeking employment were examined for STDs. But what was the purpose and impact of these racially-motivated medical exams? This is a crucial question because settlers thought they would be protected from the so-called infective Africans by implementing compulsory medical examinations.

In order to finance these medical examinations, municipalities and local authorities demanded half of the Town Pass Tax so they could place more Africans under medical examination. However, the Medical Director argued that in making this proposal, both Central and Local governments appeared to have attributed more significance to the public health merits of a medical exam than “present methods seem to warrant.” The main reason for his doubts was that this so-called “medical” examination was carried out by laymen, usually sanitary inspectors, and consisted merely of cursory inspection of Africans under circumstances not conducive to any more detailed examination even if this were desired.⁷² He argued that this type of medical examination was ineffective because the visible and “grosser” signs of infection were ephemeral in duration and disappeared long before the end of the infectious stage. For this reason, a small percentage of people suffering from STDs in a communicable form were detected by the medical exam. As a result, a large number of people who did not show external signs of the disease but who were nevertheless highly infected and frequently highly infectious,

⁷² NAZ, S482/534/39: Natives-Medical Examination, 1937-48, Letter from the Medical Director, Southern Rhodesia, to the Minister of Internal Affairs, Southern Rhodesia, 11th January, 1939.

were not detected at all.⁷³ The Public Health Department was aware of the limitations of this method of examination, but held on to the belief that a small gain in the fight against STDs was better than none at all.

Furthermore, public health officials argued that another flaw of this type of examination and “other more trustworthy methods” was that the results obtained were only true for the actual time of examination. Thus a person who was reasonably and justly certified to be free of STDs at the time of examination, could an hour or two afterwards contract the disease and become capable of transmitting. Yet, the public (mainly Europeans), despite all these warnings, continued to cling to the idea that medical examinations alone had some protective value which extended over indefinite periods of months. They believed that a recently examined person found to be uninfected could not possibly be suffering from the disease. These were, according to public health authorities, dangerous beliefs which led to an unjustifiable sense of security.⁷⁴

The Medical Director concluded that the “cursory” medical examination of Africans was, at best, of extremely limited value. He argued that this method was only useful in detecting a very small percentage of cases which without examination went undetected, but that “it has no value whatsoever as a crucial test enabling us [public health officials] to distinguish the infected from the non-infected and the infectious from the non-infectious.”⁷⁵ The Medical Director suggested methods that were more effective than the one above and these included the adoption of (a) a tactile examination, that is, a thorough examination by the fingers of the examining officer, and (b) a series of highly technical laboratory tests such as the Wasserman Reaction (blood and cerebro-spinal fluid tests) or microscopic examinations of smears and swabs. According to him, these

⁷³ Ibid.

⁷⁴ Ibid.

⁷⁵ Ibid.

methods often resulted in a reliable and accurate diagnosis in at least 90 per cent of the cases.

However, these methods, though effective, were extremely difficult to apply when dealing with large numbers of people. They took a considerable amount of time. The collection of specimens for laboratory tests was slow and tedious so that the number of examinations that could be carried out by an examiner in an hour could be six at most. As a result, this method required employing many “medical men” to conduct the examinations at a high cost. In addition, the laboratory tests were complicated and time consuming. With only two laboratories in Rhodesia in 1939, one in Salisbury (Harare) and another one in Bulawayo, it was clear that this would require more spending and personnel.⁷⁶

The lack of funds had also led to mere treatment of symptoms of STDs without any attempt to cure them. Even treatment itself was costly. Each individual case cost approximately £1. Thus the medical authorities could only focus on a method of treatment which relieved the patient of symptoms and rendering that patient non-infectious to others and this was achieved by administering a course of six injections given at the rate of one per week. Medical officials admitted that this treatment was largely a palliative one although it had the advantage of preventing the spread of infection.

What militated against the adoption of effective methods of medical examination was largely the lack of funding. However, the Medical Officer had more concerns about the application of these measures apart from the question of finance. First, he was “quite sure that the introduction of a tactile examination would give rise to great resentment particularly amongst native females.”⁷⁷ He warned that these Africans were not coming

⁷⁶ Ibid.

⁷⁷ Ibid.

to public health officials as sufferers seeking relief from pain and sickness, and for that reason, willing to undergo a certain amount of physical discomfort and embarrassment. On the contrary, these Africans were “being forced by the compulsion of law to submit themselves to an examination of an intimate character which for the most part they must consider totally unwarranted.”⁷⁸ Second, the Medical Director doubted whether any Government had the “moral right to compel one section of the community to undergo a physical examination which was repulsive to all its ideas” and one “*which was imposed merely for some dubious benefit which might or might not accrue to another section of the same community.*”⁷⁹ However, because the settler community was so powerful, the Rhodesian Government eventually implemented this detestable method. Thus public health authorities instituted this system of examination as a result of public pressure, although they themselves understood that the exams were ineffective. This clearly demonstrates what was wrong with public health in a colonial, undemocratic setting.

These European understandings of STDs in Rhodesia resembled those in South Africa and this was important because Rhodesia relied on South African laws as the basis for her own public health regulations. However, public health authorities in South Africa had already discredited these methods and were developing new ways of controlling STDs. In 1936 South African public health officials argued that although public interest in STDs continued, it was unfortunate that “this interest only too often expresses itself in demands and resolutions of an impracticable and ignorant nature.”⁸⁰ The European community there had advocated wholesale compulsory examination and treatment, urging the government to introduce class and race discriminatory measures on non-European female servants. However, according to the public health officials, such views

⁷⁸ Ibid.

⁷⁹ Ibid. Emphasis added.

⁸⁰ Ibid.

revealed “the distorted attitude to venereal diseases of the large sections of the public.” They suggested that wise education of the lay person as to the nature and extent of the problems of syphilis and gonorrhoea could help in fostering an appreciation of the difficulties faced in controlling these diseases.

South African public health officials emphasized that compulsory examination and treatment of any section of the community, “except in very special circumstances,” accomplished little. “The definite diagnosis of many phases, even highly infectious phases,” they argued, “may be extremely difficult and involve complicated laboratory technique. Further a single examination is useless as a guarantee of freedom from infection for any length of time.” Hence it was futile to attempt compulsory or ‘police’ methods of handling the problem.

Instead, the officials in South Africa argued that the usual basis of successful programs of combating syphilis and gonorrhoea was the provision of “attractive, convenient treatment, administered with sympathetic consideration for the patient.” In addition, they contended that because STDs in many stages were not superficially obvious, securing the trust and co-operation of the patient would stem out “the evil results of concealment.” It was on this principle that the STD policy in South Africa was largely based. The South African Public Health Department therefore embarked upon securing free, convenient treatment in all areas through generous refunds on STD schemes instituted by local authorities, “through the free provision of certain drugs and through the services given in rural areas and in urban areas lacking local departmental services by the district surgeoncy system.”⁸¹

This South African report reveals a diversity of views within the European community. While the lay sections of the European community believed in the efficacy of compulsory medical examination of non-Europeans, the medical community in both

⁸¹ Ibid.

South African and Rhodesia argued that compulsory medical examinations were ineffective. This ineffectiveness of public health policy towards STDs was another reason why Africans lacked trust in colonial public health.

However, despite of all these concerns, the Government of Rhodesia adopted the tactile system of medical examination, a system which some women later referred to as *chibeura*, literally meaning being forced to open their legs for “inspection.” An authority on this subject, Lynette A. Jackson, argues that these compulsory STD examinations imposed on single African women who traveled to urban and industrial spaces in colonial Zimbabwe were “an example of how gender violence and violation were formalized as an official state policy.”⁸²

Jackson also adds that unattached and mobile African women in towns were inscribed into colonial space as “stray women,” who, according to the Rhodesia’s Medical Director, were responsible for “spreading disease all over the country.”⁸³ Thus such compulsory STD examinations were a part of colonial regulations intended to control the mobility of Africans. These “inspections” were first introduced on the compounds of large mining concerns in the early 1920s. Although there were fears of spreading STDs to Europeans, Jackson argues that, in essence, African women’s bodies were regulated for their “potential to infect African men with venereal disease and, to a lesser extent, for their potential to infect European men...when Europeans began hiring African women as nursemaids...”⁸⁴ Jackson also links these medical examinations to influx controls in Rhodesia, designed to limit the number of Africans entering European urban and mining spaces. However, there is danger of losing sight of the fact that these

⁸² Lynette A. Jackson, “When in the White Man’s Town”: Zimbabwean Women Remember Chibeura,” 191-215.

⁸³ Ibid.

⁸⁴ Ibid.

medical examinations were primarily public health initiatives aimed at preventing the spread of disease. Thus medical examinations of Africans in general arose out of European fears of infection. Their premise was mistaken and racist and this was the impetus of colonial public health policy.

As to how intrusive and shameful these medical examinations were, Jackson cites one woman from PEA who underwent medical examination on the border during the Second World War. She recalled,

I got into the room and I was asked to take off my skirt. These days we did not wear any panties at all. So I was asked to lie on the bed and open my legs. Then, wonder of all wonders, this white man began touching and poking at my private parts [genitals]. It was the worst experience that had ever happened to me. Even my husband had never looked at my private parts like that. The black nurse was just standing there mum. You see, I was still in that age where women gave birth to their children at home with traditional midwives attending, not a foreign male doctor like what you have in hospitals right now [1990s]. So you can imagine how I felt when this white man was looking at me naked.⁸⁵

Africans resented medical examinations because they considered issues of sexual health to be private matters and in the past healers would have respected patients' preference not to expose bodies. Exposing bodies, particularly genitals would have been done only in the presence of the healer, unlike a hospital where STD sufferers were exposed to nurses, attendants, and other patients. One informant said that to Africans STDs and menstrual problems were private matters. Going to the hospital with these diseases was a shameful act.⁸⁶ African men who had syphilis said that it showed manliness and perhaps a graduation into manhood. One informant from Penhalonga recalled, "Syphilis was common amongst the young men during our time and you could

⁸⁵ Ibid., 204.

⁸⁶ Interview, Makubvu, Mozambique, 6 January, 2007.

boast of it but if you did not cure it, you could face serious consequences of paralysis or death if it got worse.”⁸⁷ Asked if he was ever diagnosed of it, he responded,

Oh yes it was my graduation into manhood. I was about twenty-something years old just started working at Old West and I had taken a woman from Nyaronga bar. I remember very well that it was her who caused it. I boasted to my friends but I could not be treated at the clinic I felt shy so I was treated by an old man we called him *Amankwala* (Chewa for medicine man).⁸⁸

Africans preferred to visit traditional doctors instead of violating their habits of discretion in relation to sexual relationships by going to hospitals and clinics. One informant noted,

Venereal diseases were common but most young men did not report these because it meant a certain achievement to be sick of a minor and treatable venereal disease (they called it *siki*, referring to syphilis). I remember my friend who kept silent about this disease because his brother’s wife worked at the mine clinic so she would get to hear of his problem if he sought treatment there. So he avoided the clinic until he could no longer walk properly and it was soon clear to everyone that he had a problem. Eventually, he was treated at the mine clinic.⁸⁹

Thus problems of STDs in African society went into the social realm of relations between youths and elders. While older people did not necessarily disapprove of sexual activity by young people, they expected young people to conduct their affairs with strict discretion so that these older people would not hear about them.

Another problem associated with medical examinations and treatment in hospitals and clinics was that government officials questioned the patients about how they contracted the disease. Officials forced patients to name every person they had sex with in order to track them down and treat them too. African patients therefore felt that

⁸⁷ Interview, Penhalonga, Zimbabwe, 29 August, 2006.

⁸⁸ Ibid.

⁸⁹ Interview, Tsvingwe Township, Penhalonga, Zimbabwe, 28 August, 2006.

colonial public health abused their habits of discretion in relation to sexual relationships. Yet, traditional healers never questioned these patients about how they contracted STDs. As the same interviewee above indicated,

[The doctors and nurses] at the clinic spoke the language that despised our understanding of health care. The nurses gave us a hard time. It was always our fault for getting sick even if it was a result of hard underground [mine] work. You see, that is why we went to *Amankwala* because he did not make a fuss about where we got syphilis, or to bring the person who gave it to us—such an embarrassing thing to do.⁹⁰

While colonial officials blamed independent African women for the spread of STDs, Africans in Mozambique thought that soldiers, police and other government officials were the ones responsible for its spread. One recalled,

This *siki* [syphilis] was mainly spread by colonial soldiers who forced any woman, particularly girls to have unprotected sex with them. They left their victims with unwanted pregnancies and fatherless children. Locals tried to help girls by hiding them in caves, but it was of no use because the soldiers' movements were unpredictable.⁹¹

This concurs with the observations of the American Board missionaries who reported that Portuguese colonial officials (*Commandants*) and their African policemen (*cipaes*) forcibly took concubines.⁹² The missionaries claimed although the *Commandant* at Spungabera was not involved in this practice, his two secretaries frequently developed sexual relationships with local African women in places where they worked. It was also the practice of these secretaries, “when out among the people collecting taxes, or in traveling thru the country, to demand native girls at night.” Villagers therefore thought that all white men were the same. Thus when the missionaries were out touring, they had

⁹⁰ Ibid.

⁹¹ Interview, Makubvu, Mozambique, 6 January, 2007.

⁹² ABC 15.4, volume 33: Letter from J.R. Dysart, Gogoyo, P.E.A., to Dr. James L. Burton, Boston, MA, November 19, 1919.

to make it clear to villagers that they did not want to stay overnight and did not want girls. African communities had become so traumatized that all young unmarried girls fled upon hearing that some white men were coming. In addition, the missionaries asserted that African “police boys,” after the fashion of their white masters, also demanded girls whenever they liked and if a father denied the “police boy’s” demand, the police boy soon found “something for which to accuse him before the Commandant as for instance to lie about his not having paid his tax or some other delinquency which cans a fine or being sent away for work.”⁹³

Conclusion

This chapter has explored the broad issues that affected public health in the region. Although cross-border movements had implications for the epidemiology of STDs, European attitudes towards Africans affected the formulation and implementation of public health polices in the region by exaggerating the risk to whites of STDs introduced from PEA and other neighboring territories. Erroneous views on the epidemiology of STDs by the settler community resulted in the adoption of discriminatory public health practices that affected the way Africans perceived western medicine. The colonial governments singled out Africans for intrusive medical examination as a result of highly exaggerated settler fears and economic considerations.

Public health policy based on racial ideology and political economy led to distrust and dislike of colonial medicine and biomedicine in general. As shown in this chapter, these medical examinations, done in some cases by laymen without any medical background, were not effective. Yet, regardless of whether these examinations were effective, they still robbed Africans of their privacy and mobility. Africans considered

⁹³ Ibid. Offenders could be sent to Beira to serve a long sentence with hard manual labor.

issues of sexual health a private matter. They preferred to deal with these issues in private, not by being forced to strip before total strangers or to name every person they had sexual intercourse with. Medical examinations therefore violated African norms of bodily modesty and discretion with regard to sexual relationships.

The porosity of the border meant that public health policies in Rhodesia failed to stop diffusion of disease from PEA, widely regarded by officials in Rhodesia as a poorly-governed reservoir of infection. Erroneous understandings of the epidemiology of STDs by lay Europeans and the intrusiveness and ineffectiveness of compulsory medical examinations contributed to African lack of confidence in colonial public health. This chapter also shows how public pressure in a colonial and profoundly undemocratic setting led to the institution of bogus public health measures, contributing to African dislike of western biomedicine.

CHAPTER IV

“NO VACCINATION/NO MEETINGS AND THIS CONTINUES UNTIL YOU COME TO YOUR SENSES”: SMALLPOX AND COLONIAL PUBLIC HEALTH ONSLAUGHT ON AFRICAN RELIGIOUS GROUPS AND AFRICAN RESPONSE

Introduction

Trypanosomiasis and venereal disease aside, smallpox was probably the most feared disease within colonial society because it is a highly contagious disease. It led to implementation of stringent measures on African mobility and intrusion into African society, such as denying Africans freedom to gather for religious purposes. This chapter explores colonial public health policy and its effects on Africans by looking at one of the worst epidemic diseases, smallpox. It explores new ways of understanding resistance against colonial rule in Southern Africa by looking religious opposition to colonial public health, thereby broadening the analysis that has in the past been confined to nationalism. The chapter argues that although smallpox existed in endemic form before the imposition of colonial rule, epidemics of smallpox resulted from colonial intrusion and the labor demands of the colonial economy that encouraged extensive migration. It also argues that Africans had developed their own public health systems to deal with smallpox. Their resistance to colonial public health measures (vaccination and disease surveillance) must therefore be viewed as a rejection of the legitimacy of colonial authority. Colonial officials therefore resorted to intrusive vaccination campaigns which led to African distrust of biomedicine.

Smallpox is an acute contagious disease caused by the Variola virus. It is called *varíola* in Portuguese and is commonly referred to as *nhomba* among the Shona of the Manica region. Smallpox was one of the world's most feared diseases until a

collaborative global vaccination program led by the World Health Organization (hereafter WHO) eradicated the disease in 1979. According to the WHO, the last known natural case of smallpox occurred in Somalia in 1977.¹ After this outbreak, the only known cases resulted from a laboratory accident in 1978 in Birmingham, England, which killed one person and caused a limited epidemic.² While smallpox was endemic in Rhodesia and PEA, it often occurred in devastating epidemic cycles during the colonial period. Smallpox has now been eradicated worldwide, but it is important to point that this took a concerted effort from the WHO and international cooperation, which was difficult to achieve between Rhodesia and PEA. It was not until 1977 that the WHO's International Commission for Smallpox Eradication (A Comissão Internacional para a Erradicação da Variola) certified smallpox eradication in Mozambique, together with Tanzania, Zambia, and Malawi.³ Smallpox outbreaks in the Manica region continued well into the 1970s.⁴ It is by no coincidence, however, that in both Mozambique and Zimbabwe, the last recorded cases of smallpox occurred in the late 1970s.⁵

Arbitrary colonial boundaries which divided people of common origins and culture meant that control and eradication of smallpox was a difficult exercise due to occasional diffusion of this disease through cross-border movements as infectious

¹ World Health Organization: Smallpox Fact Sheet.

² Ibid.

³ AHM, Saúde, Boletim a Saúde em Moçambique, Caixa no. 22, 1978, 12.

⁴ F. Chasokela, "A History of Smallpox in Southern Rhodesia, 1890-1970," B. A. Honors Dissertation (Department of History, University of Zimbabwe, 1985), 17, O. Ransford, *Bid the Sickness Cease: Disease in the History of Black Africa* (London: John Murray Publishers, 1983), 211. See also Clever Muyambo, "Medical History of Mutare: A case study of the City's Health Services, 1960-1992," Master of Arts in African Economic History Thesis, (Department of Economic History, University of Zimbabwe, 1995), 32.

⁵ NAZ, RG-P/FOR 35 Health Services and Mortality Statistics in Rhodesia and other African Countries, Fact Paper 4/77, AHM, Saúde, Boletim a Saúde em Moçambique, Caixa no. 104, Pasta no. 36, 1979, 10, and Clever Muyambo, "Medical History of Mutare: A case study of the City's Health Services, 1960-1992, 32.

diseases respect no boundaries. Thus colonial authorities dealt with outbreaks they believed were brought in by immigrants from other territories as well as outbreaks from local foci of infections, particularly amongst the members of the Apostolic and Zionist Church, who, for religious reasons, refused to be vaccinated.

Due to the problems posed by the border in smallpox control programs, the Rhodesian government implemented a policy of vaccinating all labor recruits at ports of entry, although a some migrants still managed to enter Rhodesia using undesignated ports of entry dotted along the lengthy border between PEA and Rhodesia (820 km). This pervasive monitoring of the border and mandatory vaccination at entry points increased illegal immigration, potentially spreading smallpox. In addition, the African religious sects mentioned above also presented enormous challenges to the public health system because their gatherings generally drew African from other colonies, particularly PEA and Nyasaland.

As this chapter demonstrates, Rhodesian authorities enforced laws to prevent the so-called “alien natives” from entering the reserves to attend religious gatherings. This chapter therefore contends that cross-border movements are a factor to be considered in analyses of public health and that public health programs that ignored these movements were bound to fail. It examines the implementation of public health policy, its impact on the African people, as well as the African response and how these policies helped to shape African attitudes toward western medicine.

In Rhodesia, officials argued that smallpox diffusion posed a potential danger to the white population, which the colonial government aimed at protecting.⁶ In addition,

⁶ F. Chasokela, “A History of Smallpox in Southern Rhodesia, 1890-1970,” 16. As for Mozambique, Gerhard Liesegang has also looked at how smallpox, among other factors, such as, famines, plagues, and long periods of warfare affected relations of production and distribution in his paper, “Famines, Epidemics, Plagues and Long Periods of Warfare: their effects in Mozambique, 1700-1975, Paper presented at the Conference on Zimbabwean History: Progress and Development, University of Zimbabwe, 23-27 August 1982.

because of its tendency to deplete populations, smallpox was destructive economically by depriving the colonial government of the much needed labor force. Hence, the colonial government needed to widen the net on health issues to include Africans.

It is imperative to note that Africans practiced variolation and quarantine to control smallpox.⁷ For example, in 1893 Lobengula (leader of the Ndebele people in western Zimbabwe) ordered the *impi* (regiment) which he sent to the Zambezi not to proceed further than Inyoka because it had contracted smallpox. Lobengula summoned the *impi* to send him their captured cattle but otherwise to stay away.⁸ After Lobengula ordered that “[t]hese ill people should not proceed here they should remain in the bush,” word came out that “[i]f anyone has a relation who has the disease, he should take the pus from him and make an incision on himself then smear that pus on himself. Then you would fall ill... That was the treatment.”⁹ This was smallpox inoculation, a procedure

⁷ Variolation is a method of inoculation involving deliberate introduction of smallpox (variola) to a sufferer in a controlled manner in order to minimize the severity of infection and to induce immunity. Many people from other parts of the world also practiced this form of inoculation, for example in India. This was different from vaccination in that whereas variolation involved infection by the lethal smallpox virus, vaccination transmitted non-lethal cowpox virus to achieve the same objective. Edward Jenner, a British physician developed the smallpox vaccine from cowpox after observing that the milk maids in Britain never contracted smallpox. It was later discovered that they got their immunity against smallpox from their exposure to the less virulent cowpox, which occurs in cattle. The British then took smallpox vaccination to other parts of the globe using the “arm-to-arm” technique to transfer infection from one child to another until they reached the intended recipients. There was no other way of transporting the live virus for long distances before the advent of refrigeration. This procedure thus involved the use of orphans, who were forced onto ships to travel over long distances, transferring the pathogens from one child to another.

⁸ NAZ, AOH-59 Oral History: Smallpox, Interview with Mrs. Maore Raridza Mudzongai-Ngomambi (Born 1896) at Mumugwi, Bindura District, on 8 August 1979, Interviewer: Dawson Munjeri. For further details see: AOH/58 Interview with Ngomambi and S. Glass, *Matebele War*, (London, Longmans, 1968).

⁹ NAZ, AOH/58 Oral History: Smallpox, Interview held with Mr. Mbangwa Ngomambi (born c. 1877 d. 1983) on 14 July 1979 at Mumugwi, Bindura District, Interviewer: Dawson Munjeri.

involving the application of pus from the pustules of a sufferer onto the scarified skin of a non-sufferer, which provided a lifelong protection against smallpox.¹⁰

Although Lobengula's area falls outside the Manica region, both the Ndebele and the Soshangane's people who settled in the Manica region had the same origins among the Ngoni people of Natal, South Africa. Some informants in the Manica region recalled that people who suffered from smallpox lived in secluded places near the bush, where their family and relatives brought them food until they recovered from the disease. Resistance to colonial vaccination campaigns which arose in some sections of the African population occurred because many Africans practiced their own "public health" and were aware of the benefits of these interventions.

Outbreaks, diffusion, and vaccination

Smallpox was endemic in the Manica region. However, many Africans believed that epidemics of smallpox increased during the colonial period.¹¹ The first recorded outbreak in Rhodesia was the 1893 epidemic, which was followed by another one in 1898. These outbreaks occurred at a time Rhodesia lacked a comprehensive program for the vaccination of the African population. All the pre-1924 smallpox outbreaks were dealt with using the Cape Colony Public Health Act of 1886 (South Africa), involving medical supervision (surveillance) of the affected area, isolation of patients, and the systematic vaccination of the local population by the Native Department.

The promulgation of the Public Health Act in 1925 enhanced the powers of Rhodesian officials in public health matters. Some of the major aims of this Act were "to prevent and guard against the introduction of diseases from outside;" and "to promote the

¹⁰ F. Chasokela, "A History of Smallpox in Southern Rhodesia, 1890-1970," 1.

¹¹ Interview, Vheremu, Zimbabwe, 24 December, 2006.

public health, and the prevention, limitation or suppression of infectious and contagious diseases within the Colony.”¹² For the purposes of this Act, the term “infectious disease” referred to the following diseases: smallpox (and any diseases resembling smallpox); chicken pox; typhus fever; plague; Asiatic cholera; leprosy; anthrax; rabies; trypanosomiasis (sleeping sickness); and all forms of tuberculosis. That smallpox topped the list of these infectious diseases was not a mistake. This emphasizes the extent of the mortality that smallpox epidemics caused and the fear it generated among European settlers. Smallpox deaths could exceed 30 percent “if the community is not at least partly immunized,” as demonstrated by the 1670-72 and 1707 smallpox epidemics which occurred on Iceland, with the 1707 outbreak taking a toll of about a third of the population.¹³

In PEA comprehensive public health legislation came with the promulgation of the *Regulamento dos Serviços Sanitários do Território* (Regulations for Sanitary Services of the Territory, hereafter *Regulamento*) in 1918. Article 1 of this *Regulamento* stated that the services of public hygiene and sanitary police were to monitor and study the hygiene and physical life of the population in the interest of public health. The other goals included, among other things, the promotion the public health, guarding against the invasion of diseases the prevention, control of infectious diseases, promoting the health of public places and habitations, and any other applications of public hygiene relating to the physical well-being of the population.¹⁴

However, the Portuguese were vaccinating Africans even before the promulgation of the 1918 *Regulamento*. In 1901 Mozambique Company officials requested tubes of

¹² NAZ, S1173/225-227: Infectious Diseases-Public Health Act, 3-4.

¹³ Gerhard J. Liesegang, “Famines, Epidemics, Plagues and Long Periods of Warfare, 4.

¹⁴ AHM, FCM, Secretaria Geral: Processos, 1892-1942, Serviços Sanitários, 1897-1941. Caixa 478, Pasta 1786. Governo do Território de Manica e Sofala: Regulamento dos Serviços Sanitários do Território, 1918.

vaccine lymph in order to contain an epidemic in Manica and Chimoio.¹⁵ In his annual report for the year ending 1906, the Company's Health Services director wrote, "we continued the vaccination service with the regularity of the previous years. We do not have any epidemic to combat. It is only for prophylaxis that we vaccinated all the natives who passed through these centers of service—Beira, Macequece and Sena."¹⁶ Portuguese officials enforced compulsory vaccination of Africans in an affected district. In its report on sanitary assistance to Africans, the Company stated that as far as smallpox prophylaxis was concerned, there was need for obligatory vaccination and the only way to achieve this was to perform a mass vaccination of the whole population, taking advantage of census records.¹⁷

A point worth noting is that first among the main aims of Rhodesian and Portuguese public health regulations was preventing the introduction of infections from outside the colony. Rhodesian officials often blamed smallpox outbreaks on Mozambican migrants because these officials believed the Mozambican public health system was poorly developed. This reflected general Anglophone prejudice on Lusophone colonies. Rhodesian officials exaggerated the extent of diffusion of disease from neighboring Mozambique to conceal the ineffectiveness of their own public health system. There were, for instance, many local foci of disease because of African resistance to smallpox vaccination.

The history of smallpox in Rhodesia shows that the border posed enormous challenges to the adoption of regional smallpox control programs. The lack of a

¹⁵AHM, FCM, Secretaria Geral: Processos, 1892-1942, Varíola e Influenza, 1903-1938, Caixa 130, Pasta 478.

¹⁶ AHM, FCM, Secretaria Geral: Relatórios, Caixa 127, Pasta 2594, Relatório anual dos Serviços de Saúde da Companhia de Moçambique, 1906.

¹⁷ AHM, FCM, Secretaria Geral: Relatórios, Caixa 128, Pasta 2678, Relatório da Direcção dos Serviços de Saúde, 1929: Assistência Sanitaria ao Indígena, 9-10.

comprehensive cross-border vaccination program, cross-border movements, and resistance from some sections of the African population ensured that smallpox remained a major problem in the region, even in Rhodesia, where colonial officials prided themselves on more effective and comprehensive control programs.

Thus when Rhodesian officials learned of the existence of smallpox at Beira, PEA, in August 1919, they issued an order prohibiting the entry of PEA Africans by train through the Umtali border post, unless the Africans were in possession of a certificate showing they had not been in contact with a case of smallpox for twenty-one days.¹⁸ However, on 9th September, Rhodesian officials discovered that a PEA African who had traveled by train from Umtali to Gwelo was suffering from smallpox. They claimed that he “was one of a gang which had evaded the railway restrictions by walking from Portuguese Territory through Penhalonga to Umtali where they entrained.”¹⁹ Thus attempts to monitor the border contributed to an increase in clandestine crossings which complicated smallpox control efforts.

Table 4-1 Smallpox outbreaks introduced from PEA and Rhodesian areas affected (according to Rhodesian officials)

Year	Affected areas on the Rhodesian portion of the Manica region
1918-22	Umtali
1936	Chipinga, Eastern Border districts
1937	Umtali, Cashel
1948	Umtali
1971	Umtali

Source: Southern Rhodesia Public Health Reports

¹⁸ NAZ, A3/12/29: Smallpox, 1910-1922, Letter from the Secretary, Department of Administrator, to the Town Clerk, Salisbury, Rhodesia, 16th January, 1920.

¹⁹ Ibid.

However, smallpox outbreaks continued as shown in Table 4-1 above, which colonial health officials and Native Commissioners blamed on Africans from PEA

Before assessing the African response to smallpox vaccination, it is useful to consider how the colonial officials performed vaccinations as this demonstrates the disparity between theory and reality and why there was opposition to vaccination. The Mozambique Company stated that in order to execute the vaccination, one indigenous auxiliary nurse had to accompany an official in charge of the procedure to list the names of individuals vaccinated at each point of visit. This was to be carried out until all the people met had been vaccinated or revaccinated.²⁰

The Government of Rhodesia also provided clear rules on vaccinations. The Colonial Secretary invoked sections 66 and 81 of the Public Health Act 1924 to declare a lay vaccinator as any official of the Native Department, police or other person whose selection for this service had received approval of the Minister. Every vaccinator received the following products, which he took with him when proceeding on vaccinating duty. These were: a vaccinating needle or lancet, a spirit lamp and a supply of fresh spirit; a supply of fresh tested calf lymph in a thermos flask. These articles were supplied as required by the Public Health Department, Salisbury.

In carrying out vaccination the vaccinator was required to follow the following procedure: the vaccinator had to first thoroughly cleanse his hands with warm water, soap and nail brush; thoroughly cleanse the outer side of the upper arm of the person to be vaccinated with soap and water and wipe dry, without using disinfectants; thoroughly sterilize a lancet or vaccinating needle by passing it through the flame of a spirit lamp, or dipping into boiling water, and then allowing it to cool, and holding the arm of the person

²⁰ Ibid., 10.

to be vaccinated so that the skin of the outer side of the upper arm was kept on the stretch, gently scarify the skin with a number of scratches in three or four separate places. It was important for the vaccinator to warn the person or the parent or guardian in the case of a child to avoid washing off the lymph and that the vaccinated area must be kept clean and protected from injury or dirt until the scabs have fallen off. The government ordered the vaccinator to exercise every precaution to ensure scrupulous cleanliness in vaccinating. The vaccinator was also required to sterilize the lancet or needle after vaccinating each person as well as making sure that no lymph was used beyond the date specified on the container.

In addition, the government required every vaccinator to record the names and particulars of every person vaccinated. Also, a record had to be kept of the name and other particulars of every person, and in the case of a child of the parent or guardian, declining to be vaccinated and the reason if any, and the same had to be transmitted to a magistrate. Moreover, if it came to the knowledge of the vaccinator that any person was suffering from ill effects attributed to vaccination, the vaccinator was required to furnish full particulars including the name and address of the person suffering, and of his informant, to a magistrate.²¹

Most of the vaccinations performed on Africans were done by the lay vaccinators under the supervision of a European. The instructions above were just theoretical guidelines. In practice, the procedure seemed to be a haphazard one. Noel Allison Hunt, who performed vaccinations on Africans in Rhodesia during the 1920s, explained how he performed these vaccinations,

... You must remember that the African—this is two generations ago—the African population was very much smaller. Our lunatic policy of free medical treatment and inoculation and so forth hadn't yet begun to show the results which produces the enormous

²¹ NAZ, 1173/357: Public Health Act, 1924-1932, The Government of Southern Rhodesia, Regulations for the performance of vaccination.

sea of second rate human beings that now pollute all over Zimbabwe...Once a year we used to go down and have what we called a vaccination campaign. You rounded up all the tribes-people who hadn't been vaccinated. You had a cork with needles in it and one got paid a penny a head (I'd forgotten this, it was a valuable source of income). So one rounded them up (with the help of the ["Native"] messengers, of course) and had them in lines of 25 and they all stood there with their left hand on their left hip. First of all a messenger went down with a swab of methylated spirits on cotton wool, cleaned their arms and one then went along and scratched it, [using] the thing with a needle just to get the under skin exposed, the white underskin exposed. Then you went along with the messenger next to you with a handful of these tubes of lymph which you broke and blew on to the sore. *You then told them not to wash it off—which they immediately did, of course.* And off you went. And I can still remember the smell of a Karanga woman's armpit at 2 o'clock on a hot Saturday afternoon, believe me. And when I think that due to idiots like myself there are thousands and thousands of them alive who would otherwise have died of the ravages of smallpox...Yeah, well...Anyway, for this one got a penny a head. Put in a voucher and claimed it and eventually it came and one was able to buy a new shirt or whatever.²²

Phrases, such as “rounded them up,” testify to the intrusive nature of such vaccination campaigns on Africans. There exists no data to suggest that the colonial officials requested the consent of Africans, or at least, educated them on why these vaccinations were performed. Neither is there any indication that the vaccination teams singled out the unvaccinated Africans for vaccination in such a military-style vaccination procedure. Many Africans were vaccinated more than once during the colonial period on suspicion of an unsuccessful vaccination, whenever there was a smallpox epidemic in their village.

Also standing out clearly from the interview above is the fact that Africans resented such vaccinations as they quickly washed the vaccine from the wounds. This raises questions about the effectiveness of these vaccinations. Some Mozambican interviewees said this vaccination exercise was a very unhygienic procedure since the vaccinators used the same cotton swab and needle on everybody without sterilizing the

²² NAZ, ORAL 240: Oral History, Smallpox Vaccination, Interview held with Noel Allison Hunt in England on 27th November, 1983; Interviewer- I. J. Johnstone. Emphasis added.

needle. One interviewee from Mozambique said that colonial officials forced Africans to submit to vaccination while other Africans fled.²³

The account quoted above shows that some members of the vaccination staff regarded the exercise as a money-making venture. As such, compulsory vaccinations served two purposes. One was to conform to the requirements of health officials, and the other one was to earn some money (the more the people, the more the money). The idea was therefore to force as many people as possible to be vaccinated and this led to mixed reactions from the African population. Some resisted, others did not.

Also worth noting are some racist connotations in the account quoted above. Other European officials expressed such racist attitudes, claiming, “The vaccination of natives is a filthy, smelly job which European members of staff object most strongly to performing.”²⁴ High-ranking officials often sympathized with the European staff involved in vaccinating Africans and suggested that the actual application of vaccine be done by African clerks.

In PEA the vaccination process involved summoning the chiefs to gather people before the vaccination. According to an informant, speaking in a group interview,

The Portuguese went to the chiefs and summoned them to gather their people in one area for the vaccination. They demanded that entire families gather there to be recorded [tying of knots] and vaccinated. The vaccination process could last for a whole week. The Portuguese would go from one headman to another vaccinating people. People had to cook and stay there until the process was completed.²⁵

²³ Interview, Muedzwa, Mozambique, December 20, 2006.

²⁴ F. Chasokela, “A History of Smallpox in Southern Rhodesia, 1890-1970,” 14.

²⁵ Group interview, Ngaone, Chipinge District, 19 September, 2006. Officials recorded the number of children per household. Tying knots was a way of keeping track of the ages of children, with each knot representing a year. This was done chiefly to determine when a child was old enough to be involved in *zheti* (forced labor). Each adult man had to work for several months on government projects without pay and this was tantamount to slavery.

Whenever there was a smallpox outbreak, colonial governments took stern public health measures, such as compulsory vaccination as well as surveillance measures to control the disease and prevent it from spreading to other areas. For instance, when an outbreak of smallpox occurred at the end of 1919 in the Umtali District, “the vaccination of *all* natives in the district was undertaken and was completed at the end of March [1920].”²⁶ There were several outbreaks that year, the first at St. Augustine’s Mission in February, and the second at Nyamana’s “kraal” which culminated in nineteen deaths in March. In addition to these two, there were four more outbreaks later that year, one in May at “Park” farm, another one in June at Battery Spruit, and the two more in August at Toronto Mine and on the Umtali Commonage. The NC claimed that in “almost all cases except that of St. Augustine’s Mission the sufferers were natives who had recently arrived from Portuguese East Africa.”²⁷

Twenty-eight years later, in 1948, the NC Umtali repeated his claim that cases of smallpox occurred occasionally, but these “appeared practically solely amongst alien immigrants from P.E.A. and [had] been reported from the Migrant Labour Depot at Mutasa North Reserve and in Umtali.”²⁸ This reinforced the Rhodesian authorities’ view of diffusion of disease from their Lusophone neighbor and prompted accusations that the Portuguese were not doing enough to prevent the spread of diseases. However, it also shows the porosity of the border and the ineffectiveness of public health policies designed to work along territorial lines in a highly mobile region.

In 1963 after discovering twenty five cases of smallpox in the Dora, Zimunya, Chitora, and Penhalonga communal areas, the Umtali City Health Department took some

²⁶ NAZ, S2076: Report of the Native Commissioner, Umtali District for the year ended 31st December 1920. Emphasis added.

²⁷ Ibid.

²⁸ NAZ, S1051: Report of the Native Commissioner, Umtali for the year ended 31st December, 1948.

measures to prevent the disease from spreading into the city. These measures consisted of a vaccination campaign from 3rd to 5th December, which culminated in the vaccination of 816 people. The campaign appeared to bring the disease under control.²⁹ This outbreak was followed by another one in August 1965, which the City of Umtali Health Department claimed was brought into the city by five Mozambicans from Beira.³⁰ City officials immediately vaccinated these Mozambicans, but two of them died and a campaign launched during the same month resulted in the vaccination of 4 673 Africans. In yet another smallpox epidemic, a more serious one in September, 1971 in Umtali, the city's Health Department launched an extensive house-to-house vaccination campaign in Sakubva and Dangamvura Townships from 1st November, 1971 to the end of January, 1972, culminating in the inoculation of over 90 percent of the population.³¹

African response: resentment and resistance

While some African villagers and town dwellers submitted to vaccination, others resisted. Resistance to vaccination took many forms, including concealing a smallpox outbreak to avoid vaccination, hiding in the bush to avoid vaccination teams, or even outright refusal to be vaccinated. Commenting on the 1910 smallpox epidemic in PEA, the *Chefe* of Macequece expressed disappointment on the way Africans in the district responded to smallpox control programs. Although the auxiliary nurse of that district, Joaquim Pedro Fernandes, had inspected the district and recorded morbidity and mortality statistics, the *Chefe* still maintained that,

²⁹ Clever Muyambo, "Medical History of Mutare: A case study of the City's Health Services, 1960-1992, 32.

³⁰ Ibid.

³¹ Ibid.

In my opinion, I judge that the numbers of deaths due to smallpox are more than those obtained by auxiliary Fernandes. It is, however, very difficult, otherwise impossible, to know all the truth due to the fact that these natives, for fear, hid in the bush and never told the truth.³²

Interviews carried out in the nearby district of Mossurize confirm such reactions to smallpox control efforts in PEA. In fact, some of the informants said that smallpox vaccinations left a permanent scar on the arm. During these years, different colonies chose different areas of the arm for vaccination. As a result, a person from PEA was easily identified by this vaccination mark or scar. Since it was the practice of many Africans from Mozambique to go and work in Rhodesia and particularly to South Africa on the Rand gold mines, vaccination scars easily exposed them to officials who then deported them if they were illegal immigrants. One informant remembered,

On smallpox, yes, the Portuguese health officials used to visit villages and vaccinate people against it. The bad thing was that when one went to *Joni* (Johannesburg, South Africa), South African officials would see the vaccination scar and know that you came from Mozambique. They would then deport you. This vaccination might have been good for disease prevention, but it was bad for work in *Joni*.³³

Upon their return to their villages in PEA, these men discouraged their children from being vaccinated against smallpox, telling them that vaccination scars would jeopardize their chances of getting jobs outside PEA.

Africans also disliked the vaccination process itself. It was often painful and scary because of the prominent wound that developed on the vaccination spot. According to some informants,

The Portuguese came to perform smallpox vaccinations and after the vaccination a huge wound developed. So people [Africans]

³²AHM, FCM, Secretaria Geral: Processos, 1892-1942, Epidemias: Variola e Influenza, Circunscrição de Chimoio. Caixa 131, Pasta 478, Chefe da Circunscrição de Manica-Macequece, para Delegado de Saúde, 17 de Setembro de 1910.

³³ Interview, Zangiro, Mozambique, 23 September, 2006.

were scared to death that they would die. They could not understand why such a huge wound developed if this was meant to prevent disease. They thus fled. As soon as the announcement went out that Portuguese officials were coming to vaccinate, Africans fled, stayed and slept in the bush. Others who did not flee but tried to resist were arrested by the police and forcibly vaccinated.³⁴

Africans thus could not understand why this process of vaccination resulted in wounds that could endanger their health.

Even in areas outside the Manica region, colonial officials implemented invasive public health measures. In Rhodesia, all chiefs were required to report smallpox outbreaks. The fate of those who failed to do so was typified by the experience of Chief Nyashanu of Buhera, who failed to report the prevalence of smallpox in his area in 1914 “as all chiefs had been instructed to do, in terms of Section 31, Subsection 2 of the Southern Rhodesia Native Regulations Proclamation of 1910.”³⁵ Upon being asked why he did not report this epidemic, he expressed ignorance of the prevalence of this disease, but public health officials claimed that the disease had been prevalent for six months and among the victims was his own son. To punish the Chief for failing to obey smallpox surveillance measures, the Government withheld the Chief’s subsidy for twelve months.

Nor was resistance against vaccination confined to the Manica region. In 1928 the Native Superintendent who went to supervise smallpox control efforts in Hyde Park encountered acts of resistance. In order to suppress smallpox outbreaks, Rhodesian public health officials resorted to the burning of African houses, which heightened the sense of grievance inspired by such public health measures. This destruction of houses was in accordance with Part III, Section 41 (m) of the Public Health Act of 1924, which stated that the Minister may make regulations as to,

the evacuation, closing, alteration or the demolition or destruction of any premises the occupation of which was considered likely to

³⁴ Group Interview, Tanganda Halt, Chipinge District, Zimbabwe, 24 September, 2006.

³⁵ F. Chasokela, “A History of Smallpox in Southern Rhodesia, 1890-1970,” 4.

favor the spread or render more difficult the eradication of disease, and the definition of the circumstances under which compensation may be paid in respect of any premises so demolished or destroyed and the manner of fixing such compensation.³⁶

Yet, colonial officials refused to pay any compensation for the houses destroyed in public health operations. In fact, A. M. Fleming, then the Medical Director for Rhodesia said that the Government would not compensate for the destruction of property due to smallpox suppression efforts, arguing that the infection had occurred due to personal neglect of ordinary precautions and claimed that Africans themselves usually burnt down their houses in three-year intervals for sanitary and other reasons.³⁷ However, Africans generally destroyed dwellings only when moving considerable distances. No wonder such control measures were unpopular with Africans.

In addition, during the smallpox outbreak of 1929 which officials claimed originated in Northern Rhodesia, Nyasaland, and PEA and spread slowly southwards “along the native routes...reaching the native districts of Mtoko and Mrewa,” villagers attempted to hide its presence till more than a couple of cases had occurred.³⁸ After this outbreak was ascertained, the Public Health officials isolated the sick and established cordons of special police. These measures, asserted officials, together with the general vaccination of the African population in the affected areas and in the neighboring reserves, “resulted in an early suppression of the epidemic, though some limited outbreaks and sporadic cases continued to occur in other parts of the Colony for some time afterwards.”³⁹

³⁶ NAZ, S1173/225-227: Infectious Diseases-Public Health Act, 16.

³⁷ F. Chasokela, “A History of Smallpox in Southern Rhodesia, 1890-1970,” 6.

³⁸ NAZ, S2419: Reports on Public Health, 1923-1945, Report on the Public Health for the Year 1929, 12.

³⁹ Ibid., 12-13.

Furthermore, officials also monitored the South African border in order to control smallpox. When a smallpox epidemic thought to have originated from the South Africa occurred in Gwanda, Fort Tuli, and Beitbridge areas in 1937, Rhodesian public health authorities implemented “exceedingly vigorous measures” after an inspection of the Beitbridge cases revealed that this was an extensive outbreak of virulent smallpox. These measures included the prohibition of the entry of potentially infected persons into the Colony through Beitbridge until an extensive vaccination barrier had been formed in the area south of the line of Bulawayo-Fort Victoria-Umtali.”⁴⁰ However, an inspection of the station along this barrier revealed the existence of a focus of infection in some inaccessible areas at the confluence of the Sabi and Lundi Rivers. Medical officials noted resistance on the part of Africans in this area, claiming that the “omission to notify the disease on the part of the natives was in large part said to be due to the fear that repressive measures similar to those which had been enforced during the recent outbreak of foot and mouth disease, would be instituted.”⁴¹

In addition, during the 1948-1952 outbreaks, the vaccination teams encountered enormous difficulties in implementing the vaccination program among the Tonga people of Binga (in Matebeleland, west of the Manica region) because the Tonga “usually fled at the appearance of vaccination teams.”⁴² While these cases occurred outside the Manica region, they help to demonstrate how invasive smallpox control policies were and why they contributed to the failure of public health.

Within the Manica region itself, there were numerous cases of resistance to smallpox control measures. In September 1953, headmen Manjeya, Jairos Mundadi, Sidi,

⁴⁰ NAZ, S2419: Reports on Public Health, 1923-1945, Report on the Public Health for the Year 1937, 11.

⁴¹ Ibid.

⁴² F. Chasokela, “A History of Smallpox in Southern Rhodesia, 1890-1970,” 10.

Willie and Luke of Umtali district, whose duty it was to inform people about vaccination dates and venues, refused, together with their families, to report for vaccination.⁴³ However, the climax of these cases of resistance came from Independent African Churches in Manica region during the 1940s and 1950s. These churches were the Zionist/Apostolic sects, which resisted smallpox vaccinations and treatment of diseases on religious grounds. These sects considered vaccination as unnatural. In fact, these sects present fertile field for exploring trans-boundary issues. The trans-border nature of these sects is demonstrated by the fact that they commanded a following from both Rhodesia and PEA. Hence, there was much cross-border movement to attend church gatherings, worsening officials' fears of smallpox diffusion.

An authority on independent African churches, Bengt Sundkler, contends that Zionists are Independent church organizations which call themselves by some of the words "Zion," "Apostolic," "Pentecostal," and "Faith."⁴⁴ They are also referred to as "Spirit" churches. Sundkler argues that historically, they originated from Zion City in Illinois, United States of America.⁴⁵ "Ideologically they claim to emanate from the Mount Zion in Jerusalem," contends Sundkler, but theologically the Zionists "are now a syncretic Bantu movement with healing, speaking with tongues, purification rites, and taboos as the main expressions of their faith."⁴⁶ These churches are opposed to any kind of medical intervention because they believe in faith healing. For this reason, they should

⁴³ Ibid.

⁴⁴ Bengt Sundkler, *Bantu Prophets in South Africa* (Oxford: Oxford University Press, 1961), 55.

⁴⁵ In the early 1900s Zionist missionaries travelled to South Africa and established churches there, with an emphasis on divine healing, abstention from pork, and the wearing of white robes. These were later followed by Pentecostal missionaries who stressed spiritual gifts and baptism in the Holy Spirit, with speaking in tongues being the initial evidence of their teaching.

⁴⁶ Ibid., 54-55.

not be confused with some Pentecostal churches in the Manica region which encourage the use of biomedicine.

The importance and nature role healing in Zionist churches helps to explain why they were against vaccination. Jean Comaroff's study of the Tshidi of South Africa offers invaluable insights on this subject. Comaroff argues that the mushrooming of distinct movement, collectively known as "Zionist" or "Spirit" churches, "centered on a range of inspired leaders who were conceived of as healers rather than ministers in the Protestant mold."⁴⁷ The centrality of faith-healing contributed to the resistance to colonial public health initiatives. This healing was not only for physical ailments, but also involved holistic healing, which brought "complete health to the individual and to society."⁴⁸ Comaroff observed that while these churches varied in socio-cultural form, "most were multipurpose associations, each organized around a focal ritual place and a holistic ideological scheme," full of energy and creativity and "centered explicitly upon the ritual reconstruction of the body—on rites of healing, dietary taboos, and carefully prescribed uniforms."⁴⁹ Healing was so central to these churches to the extent that they have been referred to as "medico-religious social movements."⁵⁰ Figure 4-1 below shows the churches' catchment area, which extended well into the Manica region.

Any attempt by colonial health officials to enforce public health measures would have threatened the very basis of the existence of such churches and would have threatened to usurp the position of the church leader as the chief healer. One informant

⁴⁷ Jean Comaroff, *Body of Power, Spirit of Resistance: The Culture and History of a South African People* (Chicago: University of Chicago Press, 1985), 166.

⁴⁸ Ezra Chitando, "Spirit-Type Churches as Holistic Healing Movements: A Study of the Johane Masowe WeChishanu Church," B.A. Honors Dissertation, Department of Religious Studies, Classics and Philosophy, University of Zimbabwe, 1991, 6.

⁴⁹ Jean Comaroff, *Body of Power, Spirit of Resistance*, 167.

⁵⁰ Harold W. Turner, *African Independent Church, Volume II: The life and faith of the Church of the Lord (Aladura)* (Oxford: Clarendon Press, 1967), 108.

recalled, “Colonial officials prohibited Apostolic gatherings because they thought these gatherings would spread smallpox, but the Apostolics argued that nothing could happen at these gathering because they had prophesied about it.”⁵¹ Church members refused medicine saying Jesus Christ did not move around with medicines.⁵² Another informant said that the Apostolics even refused purified or treated water because they believed that there were chemicals in that water, which they took to be medicine.⁵³ Instead, the Apostolics blessed and drank their own water (holy water), which they believed could heal the sick. This demonstrates that the Apostolics placed more faith in their prophecies than in public health arguments. Accepting smallpox vaccinations was thus tantamount to doubting the validity of their prophecies and their faith.

In addition, Apostolic beliefs accorded better with older ideas about the causation of disease, including smallpox, than did European vaccination campaigns. These older ideas attributed some diseases to evil spirits and misfortune, which to the Apostolics, needed divine intervention. The Apostolics believed in witchcraft and “treated” patients who they thought had been bewitched while encouraging Shona traditional beliefs in ancestral spirits and practices, such as polygamy. Consulting western medical practitioners was a breach of fundamental church doctrine and resulted in excommunication from the church. Hence, the punishment for visiting clinics and hospitals often involved the church’s refusal to bury church members who died at clinics or hospitals. However, those who used western medicine could be forgiven if they confessed their sin. The church could welcome them back to the fellowship.⁵⁴

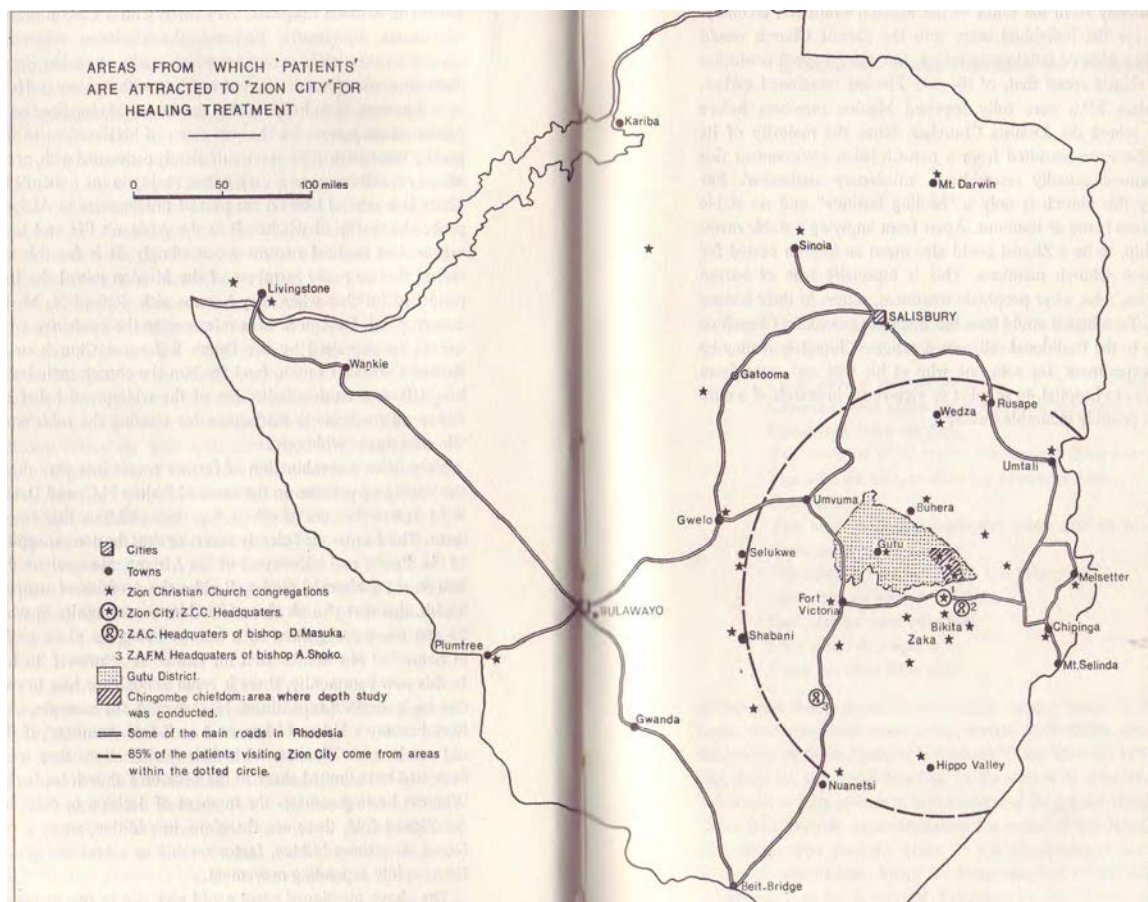
⁵¹ Interview, Nyamakamba Village, Zimunya District, Mutare South, Zimbabwe, 31 July, 2006.

⁵² Interview, Mvududu Village, Mutare South, Zimbabwe, 1 August, 2006.

⁵³ Interview, Chitakatira Village, Mutare South, Zimbabwe, 31 July, 2006.

⁵⁴ Interview, Zangiro, Mozambique, 23 September, 2006.

Figure 4-1 Areas from which the Zionist Church attracted “patients”



Source: M. L. Daneel, *Zionism and Faith-Healing in Rhodesia: Aspects of African Independent Churches* (The Hague: Mouton & Co, 1970), 24-25.

Some scholars have theorized that the publication of Christian scriptures in indigenous languages contributed to the rise of independent African churches.⁵⁵ As Africans began to discern the scriptures, they noted discrepancies between missionary teaching and biblical teaching in areas, such as family, land, fertility and significance of women, and thought the Bible endorsed polygamy and respect for ancestors.⁵⁶ Thus as M.

⁵⁵ David B. Barrett, *Schism and Renewal in Africa: An Analysis of Six Thousand Contemporary Religious Movements* (Nairobi: Oxford University Press, 1968), 268.

⁵⁶ Ibid.

L. Daneel argues, “lack of understanding and sometimes austere rules of the missionaries in cases of polygamy, the use of beer and ancestor worship, were ... responsible [for the way] that the members of the Mission Churches broke away [from Mission churches] and joined up with the Independent Churches.”⁵⁷

Furthermore, for these independent churches, opposition to public health became the main method of resisting colonial rule. Bengt Sundkler contends that these sects sprang out from African interactions with the Western church and that the apparent ease with which Africans internalized the principles of the Western church masked an often trenchant resistance to the culture of colonial domination.⁵⁸ In Rhodesia, the comparatively late emergence of the Independent movements among the Shona was a result of many factors, such as the strict control on movements of sectarian preachers by the Rhodesian government.⁵⁹ In PEA, Allen and Barbara Isaacman argue that, as in other parts of Southern and Central Africa, the independent churches in Mozambique offered an opportunity for laborers and peasants to vent their hostility against the new social order and the hypocrisy of the established Christian churches. They cite a 1957 report prepared by the Portuguese secret police which concluded that the popularity of the separatist churches was due “both to the racial discrimination within the larger society and the insensitivity of the European missionaries with regard to the natives.”⁶⁰ Thus colonial officials considered activities of these sects as acts of insubordination to colonial authority.

⁵⁷ M. L. Daneel, *Zionism and Faith-Healing in Rhodesia: Aspects of African Independent Churches* (The Hague: Mouton & Co, 1970), 11.

⁵⁸ *Ibid.*, 19.

⁵⁹ T.O. Ranger, “The Early history of Independency in Rhodesia,” in *Religion in Africa: proceedings of a seminar held in the Centre of African Studies*, University of Edinburgh, 10th-12th April, 1964.

⁶⁰ Allen Isaacman and Barbara Isaacman, *Mozambique*, 72.

Evidence shows that migrant workers from Rhodesia imported these sects from South Africa. M. L. Daneel contends that Zionism spread to Rhodesia only after the First World War when two Ndebele labor migrants, Mabhena and Petrus Ndebele, who had joined that Christian Apostolic Church in Zion in South Africa, returned to Matebeleland and began propagating the new faith in the Insiza district.⁶¹ However, their influence beyond Matebeleland was limited. Hence the rise of the Zionist movement among the Shona of the Manica region can be traced to the 1920s when Mtisi, a Ndaou migrant worker from Melsetter introduced the religion from South Africa. Mtisi was among the first of the Shona leaders to join the South African Zionists in 1921.⁶² He was also the first of the Zionist evangelists to return to Rhodesia and upon his return, he started preaching in the Melsetter district from his homestead called “Zion City.”

From their very inception, these Zionist/Apostolic sects attracted the attention of colonial authorities, particularly NCs. In 1932, for instance, the NC Melsetter, wrote in his annual report, under the section for “Political Situation” that,

Of political activity in the customary sense of that word there has been little or nothing, nothing at least that has been sufficiently public to reach my ears...Nevertheless, there has of late been a feeling in the air, so to speak, of what one might, perhaps, best call insubordination, emanating undoubtedly from scattered numbers of local Natives who had some schooling here before they made their traditional journeys to the Johannesburg mines. It is a feeling never openly expressed but often obliquely voiced in the course of prayers and local preachings by way of metaphor and parable...The discontented Natives tend to look heavenwards for the change they desire from their earthly condition which they have come to believe has been unjustly imposed upon them by the whites. At first, therefore, we hear only whisperings and prayers, later we may see open defiance and attempts at direct hostility.⁶³

⁶¹ M. L. Daneel, *Old and New in the Southern Shona Independent Churches, Volume I: Background and Rise of the Major Movements* (The Hague: Mouton & Co., 1971), 286.

⁶² *Ibid.*, 288.

⁶³ NAZ, S235/510 Native Commissioners Reports: Report of the Native Commissioner for the Melsetter District, for the Year ended 31st December, 1932.

On the Mozambican side, Allen and Barbara Isaacman note, “Virtually all independent churches traced their origin to the separatist church movements (Zionist and Ethiopian) in neighboring South Africa and Rhodesia.⁶⁴ They contend that these Mozambican migrant laborers found refuge in these churches while in South Africa and Rhodesia, and when they returned home, “they either organized branches or formed autonomous sects modeled after their South African and Southern Rhodesian counterparts.” This in itself is evidence to the transnational nature of these churches, drawing a following from various colonies and posing threats to public health as these churches resisted vaccination or any intervention of western or traditional medicine.

In 1932, the NC Melsetter wrote that towards the end of that year, reports reached him “of certain ebulliences in the form of continuous night-dancing of both sexes conducted by the local leader [of an Apostolic sect], one Jeremiah. He called for a meeting in the Mutema Reserve at which he “enjoined the reputed members of this sect to discontinue entirely those objectionable practices.”⁶⁵ In fact, the NC spoke with a prophetic voice when he hinted that “later we may see open defiance and attempts at direct hostility” because the 1940s and 1950s witnessed such open defiance against smallpox vaccinations. In 1948, for instance, the Nyanyadzi clinic treated a young smallpox patient, whose parents, being members of the Apostolic Church in Marange or Maranke Communal Land, refused to have their children vaccinated. This Apostolic sect was the most prominent in the Manica region, led by Johane Marange from the Marange Communal Land in the Umtali district.

⁶⁴ Allen Isaacman and Barbara Isaacman, *Mozambique: From Colonialism to Revolution, 1900-1982* (Boulder: Westview Press, 1983), 72.

⁶⁵ NAZ, S235/510 Native Commissioners Reports: Report of the Native Commissioner for the Melsetter District, for the Year ended 31st December, 1932. Mutema, Nyanyadzi, and in fact, the entire are under the Melsetter District were inside the Manica region.

In addition, the NC Umtali reported in 1952 that vaccination in “Native Reserves [Jenya, Marange, Zimunya, and Mutasa] continued throughout the year despite some opposition from ‘VAPOSTORI.’⁶⁶ The NC added that some of the ‘VAPOSTORI’ or Apostolics “were prosecuted and eventually the others fell into line.” In 1956 the NC Chipinge, south of Umtali, reported that due to continuous routine vaccination, with 9,843 people having been vaccinated that year, there were no cases of smallpox, but three villagers “were prosecuted for refusing, because of alleged religious scruples, to submit to vaccination.”⁶⁷

In what appeared to be a classic case of concealing smallpox cases, in February 1959, soon after the notification of a smallpox case at the Birchenough Bridge clinic, the Government Health Inspector (hereafter GHI) for Chipinge proceeded to Headman Zvenyika’s area, with three Native Lay Vaccinators (hereafter NLVs), ready to vaccinate villagers in the Magetsi area where they thought the outbreak originated. However, right from the beginning they encountered strong opposition, mostly in the form of passive resistance, as “No one, including the Headman, knew where Magetsi kraal was. No one ever heard of the patient’s father, Nyamasana.” The villagers claimed “They had never heard of any smallpox or any disease remotely resembling smallpox” and that “there had been no deaths for many months”⁶⁸ However, the GHI heard the direct opposite of the above from storekeepers and teachers, who told them that there were several deaths, but

⁶⁶ NAZ S2403/268: Annual Report of the Native Commissioner, Umtali for the year ended 31st December, 1952.

⁶⁷ NAZ, S2827/2/2/4: Report of the Native Commissioner, Chipinga, for the year ending 31st December, 1956.

⁶⁸ NAZ, F122/400/7/31: Smallpox, 1955-1961, The Government Health Inspector, Chipinga, to The Provincial Medical Officer of Health (Eastern), Umtali, 23rd February, 1959. The Birchenough Bridge area covers both the eastern (in Chipinge District) and western banks of the Save River. The eastern bank falls into the Manica Region, but the Birchenough Bridge clinic (now hospital) was located on the western bank of the Save. This clinic served Africans from both banks of the Save.

could not give definite information. In fact, there were many smallpox cases in the villages of at least four Headmen, Makumbo, Zvenyika, Matudzi, and Muzirikayi. In order to get to these cases, the GHI reported,

We then got hold (literally) of the Headman Matudsi (sic) and gently persuaded him to show us some smallpox cases. He took us for a distance of about seven miles over the worst possible terrain to three chicken pox cases, laughing up his sleeve as he very well knew that they were not smallpox. By this time the sun had set and it was late when we returned to Matudsi's (sic) kraal. The following morning we accidentally discovered that the N. C. Buhera, was nearby at a place called Msasa... I explained our difficulty to him, [the A. N. C., Mr Reed] that I get no co-operation from the people, presumably because they are almost a 100% Zionists and Apostoles, including the Chief, Ny[a]shanu and his Headmen, also that I noted very few vaccination marks on the arms of children that should have been vaccinated.⁶⁹

This was another clear case of resistance from Zionist/Apostolic sects. However, the GHI and his team eventually managed to examine 295 children who should have been vaccinated, only to find that 203 (that is, 68.8 percent!) had no vaccination marks. Two NLVs then remained in the area to vaccinate these children as the GHI left for Chipinge.

Due to these acts of resistance emanating from Zionist/Apostolic churches, Medical officials there came to regard the members of these sects as reservoirs of smallpox and began mulling over some legislation to prohibit church meetings if the members did not submit to vaccination. In fact, this thinking reflected the tendency within colonial circles to blame Africans for the introduction of epidemics into European enclaves. For instance, the Rhodesian Minister of Internal Affairs claimed that almost every year there come from the Reserves "epidemics of small-pox, chicken-pox, whooping cough and mumps, some of which affect the children of Europeans, interfere with their educational progress, and tax the capacity of the Health Department of the country to suppress."⁷⁰

⁶⁹ Ibid.

⁷⁰ NAZ, S2419: Report on the Public Health for the Year 1938, 8.

The NC Umtali reported that an extensive outbreak of smallpox in August and September of 1958 was “traced back to a large meeting of the Apostolic Sect in the Maranke Reserve.”⁷¹ The nature of this outbreak was “fortunately mild, but the disease was carried to a number of other districts before control was effected by the Department of Health.” As a result of a meeting between Health Authorities and leading members of the Apostolic and Zionist sects in the Manica region, “it was agreed that while the latter would not positively commit their members to vaccination, any proposal to hold meetings of any size would be notified in advance so that protective measures could be undertaken where considered necessary.”⁷²

Thus on 31st October 1958, D. A. W. Rittey, Director of Medical Services, wrote to the Secretary for Health, saying, “as you are aware, we have had considerable difficulty all over the territory in vaccinating the religious sects Apostolic/Zionist owing to their religious objections,” and that as a result, “we have had outbreaks of smallpox directly traceable to gatherings of this sect, particularly in the Maranke Reserve.”⁷³ Rittey suggested that Section 41 of the Public Health Act of 1924 should be invoked to prohibit Zionist/Apostolic church meetings in the Manica region on the grounds of public health.⁷⁴

In order to solve this Zionist/Apostolic sect problem, Rittey presented suggestions from various officials. These included vaccinating all people attending apostolic rallies, which Rittey himself did not favor. Such methods, he believed, would lead to “forcible

⁷¹ NAZ, S2827/2/2/6: Annual Report of the Native Commissioner, Umtali, for the Year ended 31st December, 1958.

⁷² Ibid.

⁷³ NAZ, F122/400/7/31: Smallpox, 1955-1961, D. A. W. Rittey, The Director of Medical Services (Southern Rhodesia), to D. M. Blair, Secretary for Health, 31st October, 1958.

⁷⁴ NAZ, F122/FH/30/15: Smallpox, 1955-1959, D.A.W. Rittey, Director of Medical Services, to the Secretary for Health, 19th November, 1958.

vaccination, and since these gatherings often number several thousands” there was a serious risk of provoking public disturbance, resulting in failure to vaccinate. The other suggestion was to ensure that all persons attending these rallies were vaccinated before the gathering took place. This meant the colonial officials would deny permission for religious gatherings unless all the attendees were vaccinated.⁷⁵ Rittey indicated that there was the possibility that the organizers of the rallies might refuse to accept these conditions and therefore suggested that these measures could be enforced by the Public Health Act under Section 41, (a) (c) and (d). This section of the Public Health Act gave the Minister of Health powers to make regulations, in the case of the occurrence or threatened outbreak of any formidable epidemic disease, to restrict activities, such as gatherings or meetings for the purpose of public worship.⁷⁶ This meant that the Minister of Health had extraordinary powers under the Public Health Act to interfere with African religious observance.

On 6th November 1958, D. M. Blair, then the Rhodesian Secretary for Health, in support of Rittey, claimed that “any large meetings of persons who are not vaccinated against smallpox constitute a danger to public health.” He asserted that there was “ample evidence in Southern Rhodesia that religious rallies of such nature have often been followed by widespread outbreaks of smallpox by unvaccinated incubating cases of the disease *travelling far and wide*.”⁷⁷ It was true that these gatherings drew followers from many parts of the Manica region, including PEA. One interviewee said that the Apostolics refused to cancel their gatherings because they “had invited people from

⁷⁵ Ibid.

⁷⁶ Ibid.

⁷⁷ NAZ, F122/400/7/31: Smallpox, 1955-1961, D. M. Blair, Secretary for Health, to The Director of Medical Services (Southern Rhodesia), 6th November, 1958. Emphasis added.

distant places.”⁷⁸ The Apostolics could not thus “not just tell their followers to go back.” They continued with their plans and the “police would come to watch over.”

However, this practice of police just coming to “watch over” was about to end as colonial officials mooted ways of forcing the Apostolics to undergo smallpox vaccination. Blair favored the solution of the Secretary for Native Affairs (enforcing vaccination or cancelling the gathering in case of non-compliance), and did not see any reason why action could not be taken as an emergency measure in terms of section 76 of the Public Health Act (Paper 140 of Southern Rhodesia), if the organizers of the meeting did not cooperate. Blair added that under the Public Health Act, the Provincial Medical Officer of Health could seek a Ministerial instruction to enforce disease control measures.⁷⁹

All these suggestions demonstrate that there was much debate among Government officials about Zionist/Apostolic sects. Responding to the suggestions above, T.G. Osler, Provincial Medical Officer of Health, Eastern, said that he did not wish to vaccinate *all* people attending these apostolic rallies “*as the Apostolics have in the past caused*

⁷⁸ Interview, Nyamakamba Village, Zimunya, Mutare South, Zimbabwe, 31 July, 2006.

⁷⁹ NAZ, F122/400/7/31: Smallpox, 1955-1961, D. M. Blair, Secretary for Health, to The Director of Medical Services (Southern Rhodesia), 6th November, 1958. Section 76 of the Public Health Act, 1924 (Emergency vaccination of population in areas threatened with small-pox) stated that in the event of the occurrence or threatened occurrence outbreak of smallpox in any area-(a) the local authority or its medical officer of health or the Government medical officer may require any person to be forthwith vaccinated or re-vaccinated who has or is suspected to have been in any way recently exposed to small-pox infection, or may require the parent or guardian of any child who has or is suspected to have been so exposed to have such child vaccinated or re-vaccinated forthwith. Any person failing to comply with such requirement shall be guilty of an offence; (b) the local authority may, or when instructed by the Minister so to do shall, require all persons or specified classes of persons within an area defined to attend at centers according to instructions issued and to undergo inspection, vaccination or re-vaccination as circumstances may require. Such instructions may be issued by notice in the Press or by notices posted in public places or otherwise as may be deemed sufficient by the local authority. Non-attendance shall be deemed to be an offence; (c) any Government medical officer, public vaccinator or medical practitioner duly authorized by the Minister or the local authority may require any person in such are to furnish satisfactory proof (including the exhibition of vaccination scars) that he has been successfully vaccinated within five years immediately preceding the date of such requirement. Any person who fails to furnish such proof as regards himself or as regards any child of which he is the parent or guardian, and refuses to allow himself or such child to be vaccinated, shall be guilty of an offence.

disturbances and threatened assaults to the Vaccinators, who would then have to run away, leaving the Apostolics masters of the situation.”⁸⁰ Rittey ended the debate by ordering “no vaccination/no meetings and this continues until you [Zionists/Apostolics] come to your senses.”⁸¹

The years following 1958 witnessed the application of Rittey’s order. The organizers of such church gatherings had to first apply for permission, indicating the number of people expected, where these people would come from, and the duration of the gatherings. They were also required by law to agree to have their church members inspected by public health officials as well as agreeing to the vaccination of the unvaccinated. Public health officials turned down some of these applications on grounds of public health. In May 1959, for instance, T. G. Osler informed Rittey regarding a proposed African Apostolic gathering scheduled for 8-18 July 1959 in Marange, to which persons were expected from all parts of Rhodesia. The organizer of this gathering, Johane, expected approximately eight hundred to one thousand attendees. Osler prohibited the proposed meeting, saying that “there was threat of spread of smallpox from Buhera, Bikita, Zaka;” that “with such a large number of persons spread about the area for 10 days” the public health officials were not sure that they “could inspect all persons and vaccinate those requiring it;” and that public health officials could not “visit all cases of illness suspected to be smallpox.”⁸²

Johane then asked for a local gathering in Marange in July, with fewer people attending, but Osler reiterated that the case “would be considered on its merits; if the

⁸⁰ NAZ, F122/400/7/31: Smallpox, 1955-1961, T. G. Osler, Provincial Medical Officer of Health, Eastern, to D. A. W. Rittey, Director of Medical Services, 14th November, 1958. Emphasis added.

⁸¹ NAZ, F122/400/7/31: Smallpox, 1955-1961, D. A. W. Rittey, Director of Medical Services, to the Secretary for Health, 19th November, 1958.

⁸² NAZ, F122/400/7/31: Smallpox, 1955-1961, T. G. Osler, Provincial Medical Officer of Health, Eastern, to D. A. W. Rittey, Director of Medical Services, 6th May, 1959.

gathering were of such a nature that we could carry out the necessary duties refusal would not be given.” Osler said that public health officials would require the meeting not to last longer than two to three days, that the people to attend the meeting should be local to Marange, that the number of persons attending “should not be excessive” from their point of view, and that the organizer “would have to require of all persons attending that they comply with [public] health precautions.”⁸³ Thus smallpox control efforts interfered with the regular church activities of the Zionist sects.

What also worried colonial officials was that these religious gatherings generally drew people and allegiance from PEA. The Rhodesian Criminal Investigation Report of 1946 indicated that one of the Apostolic church preachers, Takawira, had gone to Johannesburg to preach “accompanied by an unknown native stated to be the representative of the sect in Portuguese East Africa.”⁸⁴ Later that year, the NC Umtali reported that an Apostolic meeting that took place in his district inside the Manica region was probably about 1,000 strong, men, women, and children, “drawn from the Salisbury, Darwin, Hartley, Gwanda, Mazoe, Buhera, Melsetter, Makoni, Marandellas and Umtali districts plus a few from Portuguese Territory and a few other aliens.”⁸⁵ One informant indicated that members of this religious sect often crossed the border into Mozambique, travelling over sixty miles to as far as Machaze in the Manica region for their gatherings.⁸⁶

These religious gatherings continued to command a following from across the southern and eastern borders of Rhodesia. For instance, in 1954, while proceeding to the

⁸³ Ibid.

⁸⁴ NAZ, S2810/2337: Criminal Investigation Department, Rhodesia—Mapostles, and Apostoles “Johanne,” 24th July 1946.

⁸⁵ NAZ, S2810/2337: Mapostles, and Apostoles “Johanne,” Letter from the Provincial Native Commissioner, Umtali, to the Chief Native Commissioner, Salisbury, 14th August, 1946.

⁸⁶ Interview, Harare, Zimbabwe, 24 July, 2006.

southern section of the Marange Reserve for a vaccination campaign which had been arranged in conjunction with the Native Department, the Regional Health Inspector was informed by one of the Lay Vaccinators of a gathering of members of the Apostolic church in the Reserve. The Lay Vaccinator indicated that the Apostolics had gathered there for two weeks and that “representatives from as far afield as Salisbury, Gwelo [Gweru], Bulawayo, and Johannesburg were attending and were ‘too many’ in number.”⁸⁷ By the time the Health Inspector arrived at the camping site, the meeting had ended and vehicles were already transporting the attendees from the site. The Inspector estimated that only about 750 people were still at the site. He then asked the African Chief to vaccinate the people and the Chief agreed with that if it was a government order. While the Chief appeared to be understanding, the Inspector claimed that the same could not be said of the other adherents because as the reason for his visit became known, “people started running to the four corners of the compass” in an act of resistance to vaccination.

As the Inspector recalled, when “an attempt was made to form the usual vaccination lines other people in apparent paroxysms of grief jostled the line and continually broke it up.” He claimed, “Within about 15 minutes, some 400-500 crazy, head wagging, half-demented, singing and screaming lunatics were raging up and down, surrounding the lorry and generally impeding the course of an efficient vaccination campaign.”⁸⁸ It was at this point that the Inspector felt it “politic to retire, if not in confusion with dishonour.” His Native Lay Vaccinators informed him that if he had not been present, “some damage would have been done to their persons.”

⁸⁷ NAZ, S2810/2337: Vaccination Campaign—Maranke Reserve, Letter from the Regional Health Inspector, Eastern, Umtali, to the Native Commissioner, Umtali and the Director of Preventative Services, 23rd July, 1952.

⁸⁸ Ibid.

In an attempt to stop cross-border attendance to such religious gatherings in African reserves, Rhodesian officials invoked sub-section 1 of section 42 of the Rhodesian constitution, which stated that the Native Reserves were set apart for the sole and exclusive use and occupation of the indigenous African inhabitants of the Colony. Colonial officials also relied on the Settlement of Colonial Natives in Native Kraals Prohibition Act, which prohibited the settlement of “colonial natives” in “native kraals” in Rhodesia.⁸⁹ In addition, section 3 of the Prevention of Trespass (Native Reserves) Act prohibited the entry of non-indigenous Africans into African reserves. Hence, colonial officials declared, “Alien natives will not be invited to enter the Reserves for the purpose of attending these [religious] meetings.”⁹⁰ Rhodesian officials claimed that the presence of large numbers of Africans from other colonies in the reserves spread infection and increased acts of insubordination as these foreigners were not bound by Rhodesian laws. There were several African reserves in the Manica region, set aside for the sole occupation by indigenous Africans. These included the Musikavanhu, Mutema, Ngorima, Muusha, Ndowoyo, Zimunya, Marange, Zimunya, Mutasa, and Jenya. The Rhodesian government later renamed them Tribal Trust Lands in the 1960s.

Another method employed by colonial public health officials to prevent spread of smallpox involved the setting up of road blocks on the major routes leading to a gathering place. Here officials ordered all pedestrians to disembark and submit to inspection and smallpox vaccination for those not vaccinated. One informant who used to be a bus driver remembered,

At one time, there was a Mapostori [Apostolic] gathering in Buhera [on the west bank of the Save, outside the Manica Region]. The police established road block on all roads leading to this

⁸⁹ NAZ, S2810/2337: Native Affairs Act (Chapter 72): Section 51” “Lawful of Reasonable Order,” 1952. “Colonial natives” were probably Africans from other British colonies, such as, Nyasaland and Northern Rhodesia.

⁹⁰ Ibid.

gathering, including on the road crossing the Save River. I was transporting Mapostori to the Buhera, across the Save [from the Manica region]. When we reached the roadblock, the police forced the Mapostori to be vaccinated. Women and children bowed to the pressure, but the men refused and fled. They later used bush paths in order to get to the meeting place in Buhera.⁹¹

Colonial officials had many reasons to monitor or even prohibit such meetings. The members of these religious groups often gathered for weeks, reported officials, without any suitable sanitary provisions, no proper toilets nor safe drinking water, and they often resorted to cutting down trees for firewood and to construct temporary shelters. Colonial officials felt the need to intervene and interfered with activities of these religious groups. Eventually, some bowed to colonial pressures. The Provincial Health Inspector in charge of a “kraal to kraal vaccination of the whole of Maranke Reserve” in 1959 said that he had received “a great deal of co-operation” from the all villagers, “including members of the African Apostolic Faith.”⁹² The NC Umtali then argued, “it would seem that even the most unenlightened Africans now appreciate the benefit of protection against smallpox.”⁹³ However, others refused to surrender completely. To this day, some members of these sects still refuse vaccinations and treatment in hospitals, or the use of any medicine, whether traditional or western medicine.

Conclusion

By focusing on smallpox epidemics in the Manica region, this chapter has demonstrated that cross-border movements, whether transnational or internal, are a factor to be considered in the epidemiology of diseases. Colonial officials claimed that these

⁹¹ Interview, Chitakatira Village, Mutare South, 31 July, 2006.

⁹² NAZ, S2827/2/2/7: Annual Report of the Native Commissioner, Umtali, for the Year ended 31st December, 1959.

⁹³ Ibid.

movements contributed greatly to the difficulties in eradicating smallpox in the region. The border itself became an obstacle to the control and eradication of smallpox. However, diffusion of disease from other colonies was not the only reason for smallpox outbreaks. The British in Rhodesia exaggerated diffusion from PEA due to their prejudice against the Portuguese and to mask the ineffectiveness of their own interventions.

This chapter has also argued that due to their intrusive nature, public health policies implemented against smallpox triggered mixed reactions from Africans, including accommodation but most importantly, resistance, which manifested itself in many forms. For some Africans, opposition to vaccination became the main way of confronting colonialism. Discriminatory implementation of public health policies during the colonial period led to the failure of the colonial public health. The continued existence of traditional medicine and refusals to accept biomedical theories and prevention mechanisms of diseases, such as HIV/AIDS demonstrate African lack of confidence in colonial public health. Resistance to vaccination in these colonies ensured that local foci of infection remained resulting on occasional outbreaks of smallpox.

Settler fears of spread of infection contributed to intrusive public health policies. That smallpox was a contagious disease, amplified these fears, leading to prohibition of worship and restrictions on African mobility. Colonial public health campaigns threatened the basis of some African beliefs and it is not surprising that there was so much resistance to them. African resistance to colonial public health was also a way of questioning the legitimacy of colonial rule. The next chapter looks at the settlers' last line of defense, the establishment of health services for Africans. That is, if immunizations, vaccinations, and medical examinations failed to prevent outbreaks of disease, the only preventative measure left was to treat infection in Africans and curb its spread to the European population.

CHAPTER V

“...AS WE WANT TO HAVE A HEALTHY WHITE POPULATION
WE HAVE GOT TO TACKLE INFECTIOUS DISEASES IN THE
NATIVE”: PROVISION OF HEALTH SERVICES FOR
AFRICANS

Colonialism was hardly good for the health of the Third World. The good that western medicine did was marginal and incidental. It formed, however, an integral part of the ideological baggage of empire. With colonialism equated with civilization, a prominent place was claimed for medicine among the benefits the West could bestow. White man's medicine excluded others, and Christianity's 'healing' doctrine was a challenge to the rival power of local 'witchdoctors'. The imperialism latent in western medicine was obvious in its attitudes towards indigenous healing: it aimed to establish rights over the bodies of the colonized. The vigorous denunciation of the 'witchdoctors' of Africa and other indigenous healing specialists was supported by claims that their practices were grounded in dangerous superstition.

Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity*

Introduction

This chapter examines the delivery of health services for Africans. Although some colonial officials argued that the creation of hospitals and clinics was driven by genuine concern for the health of Africans, the history of rural health services for Mozambique and Zimbabwe suggests that this was probably the last line of defense for the colonial society against disease. In Zimbabwe, the decision to create a rural health infrastructure was a culmination of settler fears of “infectious natives” discussed in preceding chapters. In Mozambique, by contrast, the lack of a rural health service reflected weaker settler influence on government.

Government services reflected the conventional thinking of western medical professionals at the time that hospital confinement was the best form of treatment.¹ This

¹ Even in the west, confinement and observation was emphasized in treating infections. Michel Foucault has emphasized these aspects, see Michel Foucault, *Discipline and punish: the birth of the prison* (New York: Vintage Books, 1995).

approach caused problems of two kinds. First, insistence on hospitalization contradicted African views of the best ways of treating many afflictions. As a result, just as public health measures caused hardship, harassment, prosecution and imprisonment, the delivery of government health services caused resentment because it failed accommodate African preferences and concepts of illness. Second, the expense of this approach meant that the coverage of rural African communities by government health services remained limited. In the absence of government services, therefore, in many rural areas western medicine was left to missionaries. In the Manica region, it was the American Board Mission at Mt. Selinda (Mt. Silinda) and Gogoi which provided rural medical services. The missionaries were more flexible in accommodating African preferences because their primary goal was to win converts. They were less insistent on hospitalization and more willing to make visits to patient's homes. However, the border obstructed their work and consequently became an obstacle to their work.

An examination of rural health care shows that, as we have seen in previous chapters, although Africans often rejected public health measures, they responded quite differently to the provision of treatment services. African societies were innovative, open to new ways of healing, and willing to test alternatives methods. Curiosity and dissatisfaction with established healing methods led to willingness to try alternatives. Yet, although Africans were willing to try out curative services, they disliked confinement in hospitals, where they lost control over the healing process. Their dislike of hospitalization stemmed from one of the principal pre-colonial views of healing which granted patients and their families a high degree of control over healing. Precolonial healing was often best done in a local context, where patients had access to multiple therapeutic alternatives and advice from kin, and where practitioners could get very detailed knowledge of the social relationships which might affect a patient's health. Yet, healing was not strictly confined to a patient's immediate surroundings, because sometimes, particularly in cases involving spirits or physical ailments, patients left their

homes to visit specialists. The same trend occurred among Independent African Churches after their introduction to Rhodesia in the 1920s.

In stark contrast to the versatile repertoire of methods and close attention to social conditions practiced in precolonial healing, colonial health services were rigid and neglected social circumstances. Because Africans were not educated, colonial officials believed, the only effective way of treating them was through confinement and close supervision by European physicians in hospitals. This chapter therefore argues that the modes of delivery of government treatment services did not respond to African preferences and this accounts for the failure of these programs in persuading Africans to embrace western medicine. Even the establishment of dispensaries (out-patient treatment centers) by colonial governments in the late 1930s was a result of financial considerations, not African preferences.

African understandings of illness and healing help to explain why Africans favored missionary medicine. Missionaries not only visited the sick in their homes, but also provided out-patient services to those who visited their hospitals and clinics. These practices meant that Africans often used western medicines without European supervision. As a result, medical missionaries and government officials complained that Africans misused western medicines, particularly by combining them with indigenous pharmacopeia. Yet, this, too, reflected the enduring strength of tradition of experimentation with alternative therapies, as did African insistence of sharing their understandings of disease and healing with missionaries.

In the southern part of the Manica region, the center of missionary medical services was the station established by the American Board Mission at Mt. Selinda in 1893. Because at that time supervision of the border barely existed, the American Board missionaries assumed that it could extend health care throughout a catchment area that included territory in both Rhodesia and Mozambique. When the border was officially demarcated in 1899, however, they faced new difficulties. Much of their catchment area

fell into the Portuguese side while the mission station fell onto the Rhodesian side. Yet it was vital for them to cover the entire area, because, given that their primary goal was evangelization, they had a strong incentive to accommodate African preferences by extending their medical practice into local communities. They felt that providing medical services in ways which accommodated African understandings of illness and healing would be the best way to lure Africans to Christianity. Their need to accommodate African preferences led them to ignore government restrictions on border crossings and government insistence on confining African patients in hospitals.

By contrast, as colonial governments became concerned with the “public health threats” posed by “infective natives,” they demonized African healing practices while asserting their own theories of disease and healing. Even Portuguese officials who had formerly tolerated hybridization of healing practices shifted to outright rejection and repression of indigenous healing practices at the end of the nineteenth century.²

However, when “empire” became the organizing principle at the end of the nineteenth century, with medicine adopted “as a major tool of influence and control over the local population, hybridising practices were discouraged or repressed.” Among the Portuguese in Mozambique there emerged a clear distinction between what Europeans considered proper (European) and improper (indigenous) medical practices. The Portuguese castigated indigenous healing practices as “savage, primitive, superstitious and ignorant, rude, vile, and dirty.”

Inspired by these views, in both Mozambique and Zimbabwe, colonial governments interfered with pre-colonial healing and public health practices, such as rain-making and identification of sorcerers. For example, the 1899 Witchcraft Suppression Act in Zimbabwe, did much, thought American Board missionaries, to break

² Cristiana Bastos, *Medical Hybridisms and Social Boundaries*,” 768.

down a “powerful impediment in the upward progress of the nation.”³ When famine struck in Gogoyo, Mozambique, in 1916, another American Board missionary reported that a rain doctor complained that he could not practice because of government interference.⁴

During the early years of colonial rule therefore, the rural areas where the majority of Africans lived, found both that their own public health systems had been weakened, and that they had only limited access to hospitals and clinics. However, in the 1920s the growing political influence of settlers led to the extension of health services to Africans. The Rhodesian Government established a network of dispensaries in the rural areas to provide treatment services to Africans. In Mozambique, however, where settler influence was weaker, the Portuguese established a much less effective health infrastructure which relied heavily on provision of medical services through schools.

Nevertheless, the dominant narrative by colonial officials in both territories was that colonialism greatly improved the lot of colonized Africans. These officials argued that western medicine reduced sickness in African populations, causing a sharp decline in mortality. Thus colonial officials often touted the “Proud Record” or “Tropical Victory,” particularly in their assessment of the impact of western medicine on Southern Rhodesia, Northern Rhodesia, and Nyasaland.⁵ Yet, prior to 1918, colonial governments “did little to build rural health services.”⁶ While financial constraints played a huge role in the lop-

³ Judson Smith, *A History of the American Board Missions in Africa*, 41. The Witchcraft Suppression Act made it a crime to accuse someone of being a witch.

⁴ ABC 15.4, volume 32: Letter from Dr. W. T. Lawrence, Mt. Silinda, Melsetter, Rhodesia, South Africa, May 13th, 1916.

⁵ Michael Gelfand, *Proud Record in Health Services in Rhodesia and Nyasaland* (Salisbury, Southern Rhodesia, 1959).

⁶ Randall Packard, “Visions of Postwar Health and Development and Their Impact on Public Health Interventions in the Developing World,” 94.

sided development of health services, the primary factor was colonial priorities. Emphasis on European health and economic well-being dictated where resources were spent, and it was not on African health. What most rural inhabitants encountered were the coercive public health programs, such as smallpox campaigns, not the curative services that they—particularly those who had been “enlightened” by western education—were willing to try. This chapter therefore argues that African societies were open to innovation, but that the nature of colonial health services discouraged the adoption of biomedicine. Hence the eradication of African “superstition” and the application of “science” and “reason” to the colonized were colonial goals which never materialized.

African health services to 1930

African health services in both PEA and Southern Rhodesia suffered neglect up to the 1930s. While officials at the top of the colonial government preferred hospitals, those on the ground complained about complete lack of health services. This preference for hospitals impeded the creation of a less-expensive system of treatment delivery. In PEA, in August 1904 the *Chefe* of the *circunscrição* of Mossurize remarked upon the need for medical services at Spungabera, a concern he had raised earlier in 1902.⁷ As a clear indication of preference for treatment of Africans in hospitals, the director of medical services for the Mozambique Company urged the government to construct new wards in African hospitals.”⁸

In Rhodesia, as late as 1924, the colonial government did not have a scheme for the treatment of Africans, a testimony to the fact that medical services were originally for

⁷ AHM, FCM, Secretaria Geral—Relatórios: Relatório mensal da circunscrição de Mossurize, Agosto, 1904, Caixa 259.

⁸ AHM, FCM, Secretaria Geral—Relatórios: Relatório da Direcção dos Serviços de Saúde, 1928, Caixa 116, Pasta 2283.

European settlers only. There were some facilities in urban areas and only a few medical units under the control of Mission stations operating in rural areas. These facilities “were, however, totally inadequate and in actual fact, very little was being done to meet the essential medical needs of Natives.”⁹ In 1924, Reverend G. Hardaker of the Southern Rhodesia Missionary Conference pleaded for medical assistance of Africans to the Medical Director,

In our journeys on the Reserves all Missionaries see cases of unnecessary suffering. We do what we can, in our simple way, to help, but we feel that the Government might also do something more than it is doing at present. Dispensaries within reach of every Reserve (whether under Govt. or Missionary control) would be a means of great help. At a recent meeting of native teachers a pathetic plea was brought forward for help, and the remark was made by a native that the Govt. provided medicine for all their (the natives’) cattle (alluding to Dips) but not for the people.¹⁰

It is important to note that this “pathetic plea” from African teachers was a request to the Government to distribute medicines on an out-patient basis, just as the missionaries did. This plea also came from African teachers who had received a western education and therefore more likely to appreciate western ways. That the colonial government provided treatment for cattle (dip tanks), while not doing enough to alleviate the suffering of the people was not surprising at all. One of the goals of colonialism was to exploit the colonies for the benefit of the metropolises. Cattle production was, together with tobacco farming, and maize production, the most productive sectors of the Rhodesian economy. The only Africans who got modest medical care were those employed on farms, plantations or by companies because the employers wished to maintain a stable and healthy workforce and also wished to prevent the spread of diseases to Europeans from

⁹ NAZ, S2803/FNWS/63: Internal Affairs-Health, 1941 August 5-1948 February 3, Memorandum-Federation of Native Welfare Societies in Southern Rhodesia: National Health Services for Africans, 6th September, 1942.

¹⁰ NAZ, S1173/301-304: Medical Missions, 1924-1932, Rev. G. Hardaker, Southern Rhodesia Missionary Conference, to the Medical Director, Southern Rhodesia, 21st June 1924.

Africans who they regarded as the “reservoir of infection.” In addition to the importance of cattle to the economy, ideas of bovine diseases paralleled those of human diseases in that Europeans made dipping of African cattle mandatory not so much because they wanted to preserve African wealth, but because they feared the spread of disease to their own herds.

Prior to 1925, the Public Health Department confronted four difficulties, which according to Percy Ibbotson of the Federation of Native Welfare Societies in Southern Rhodesia, were the “totally inadequate existing medical facilities,” lack of “training for Native orderlies,” the “scattered Native population,” and “traditional Native opposition to what has been described as ‘European medicine.’”¹¹ However, although Africans generally resented preventative public health programs, they were willing to try curative forms which gave them some form of control on the treatment. In the Manica Region the NC Umtali reported in 1924, “Natives seem to have overcome their apathy to hospital treatment and during the year numbers [sought] treatment, so much so that some had to be turned away for lack of accommodation.”¹² In the same year, the NC Melsetter also reported, “Natives sometimes *request* to be sent to the Government Medical Officer for treatment...”¹³

In 1926 the NC Melsetter went further to state that the women who resided within the reach of the doctor at Mt. Selinda or the nurse in charge at Chikore Mission Station could no longer be “contented with the superstitious mouthings of the old crones who attend as midwives but clamour for the help which they have learnt to appreciate and for

¹¹ NAZ, S2803/FNWS/63: Internal Affairs-Health, 1941 August 5-1948 February 3, Memorandum-Federation of Native Welfare Societies in Southern Rhodesia: National Health Services for Africans, 6th September, 1942.

¹² NAZ, S235/502: Report of the Native Commissioner, Umtali District, for the Year ended 31st December, 1924.

¹³ NAZ, S235/502: Report of the Native Commissioner, Melsetter District, for the Year ended 31st December, 1924. Italics reflect my emphasis.

which they appear to be really grateful.”¹⁴ Although his comment reflected a disdainful attitude of colonial officials towards African practices, it also demonstrates African willingness to experiment with western medicine.

However, government health services for Africans in rural areas were still non-existent. By the 1920s there was only one government hospital in Umtali and several missionary hospitals in Mutambara, Rusitu, Chikore, and Mt. Selinda. In 1929 several chiefs petitioned for the establishment of native dispensaries in the Native Reserves.¹⁵ A report of the NC Umtali commented on the circumstances which led to this petition:

During my patrols I noted several diseases such as Ophthalmia which should be treated locally. Not only does the education of the children suffer but the labour supply of the country is seriously diminished through insufficient medical attention.¹⁶

The breakthrough in the extension of health services to Africans in Rhodesian rural areas came with the shift to settler (Responsible) government after 1923. British South Africa Company rule ended in 1923 and Rhodesian settlers chose “Responsible Government.” This arrangement gave settlers considerable autonomy. Settlers now had the means to implement legislative changes to their own benefit. The settler community feared that Africans, whom it considered to be reservoirs of infection, would turn an “extraordinarily healthy country for white people to live in,” into an inhospitable environment. The settler community realized that the best way to safeguard their own health and have a healthy African labor force was through treating infectious diseases in Africans.

¹⁴ NAZ, S235/502: Report of the Native Commissioner, Melsetter District, for the Year ended 31st December, 1926. This was a reference to the medical services of the American Board Mission which established hospitals at Mt. Selinda and Chikore.

¹⁵ NAZ, S235/507: Report of the Native Commissioner, Umtali District for the year ended the 31st December, 1929.

¹⁶ Ibid. Ophthalmia is inflammation of the eye.

While members of the settler community and missionaries pressed for reform, government physicians took the lead in justifying the need the extension of health services to Africans. Their primary concern was the health of European settlers. One of these physicians, Dr. Askins, argued, “Here we have an extraordinarily healthy country for white people to live in, but on the whole our death rate is not as low as it ought to be considering the young constitution of the population, *and as we want to have a healthy white population we have got to tackle infectious diseases in the native.*”¹⁷ He went on to argue that the “native is the reservoir of these infectious diseases,” adding, “Take malaria. No amount of nets and screens will prevent it in a country like this unless measures are taken to deal with it in the native. Take dysentery. Most of our dysentery comes from native carriers.”¹⁸ Thus treating African infections was not an end in itself but a means to an end, the end being the health of European settlers! Referring to a speech by a government Minister who had used “the economic aphorism that the best way to increase your own wealth is to increase the wealth of those around you,” Dr. Askins argued in similar terms that the “best way to increase your own health is to increase the health of those around you.”¹⁹

The fear of spread of diseases from the African population to the Europeans was enough to guarantee swift action. Medical officials further emphasized the urgency of such a move, noting that beyond a small amount of hospital treatment and a few cases brought forward by the Native Commissioners, very little was “being done at present for the medical needs of the 950,000 natives in Southern Rhodesia.”²⁰ Askins clearly

¹⁷ NAZ, S1173/336: Scheme for Medical Treatment of Natives, by Dr. Askins, Medical Director, Southern Rhodesia, 1930. My emphasis in italics.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ Ibid.

articulated this fear when he reported that most of the diseases that occurred in endemic or epidemic form among Africans of Southern Rhodesia were liable to spread to Europeans. Askins tried to heighten the impression of danger by highlighting the high rates of infant mortality which prevailed among Africans. He cited a “highly experienced NC in the Southern Rhodesia Service” who told him that more than half of the African babies born in Southern Rhodesia died within one year.²¹ Askins used such indications of the prevalence of childhood diseases to argue that as long as these diseases existed, they could spread to the European community.

Advancing his case for medical treatment of Africans, Akins reiterated the concerns of many settlers that diseases supposedly prevalent among Africans could spread into the European community. He argued that throughout the African population of Rhodesia, there were “to be found many extreme examples of Africans in the late stages of such diseases as leprosy, yaws etc.” He argued that infection “may be conveyed to European households by natives who have had the disease and are carrying the infection, though to all outward appearances perfectly well.”²² Other infections which Askins cited as potential dangers were malaria, dysentery, internal worms (bilharzia and hookworm), venereal disease, cerebro spinal meningitis, smallpox, and sleeping sickness.

The high incidence of some of these infections in the European population encouraged the belief that they originated from the African population. Malaria, for example, was the chief preventable cause of death amongst European babies or children of school age in Rhodesia.²³ Medical officials asserted that strains of amoebic and

²¹ NAZ, S1173/336: Preliminary Report on the Medical Treatment of Natives, R.A. Askins, Medical Director, Southern Rhodesia, 8th September, 1930. The fact that the Medical Director relied on anecdotal evidence from an NC demonstrated government failure to collect reliable statistics. Indeed, the government only recorded vital statistics for Europeans in its public health reports. The only data on the African population came from crude estimates of NCs.

²² Ibid.

²³ Ibid.

bacillary dysentery were “spread to the European population frequently by [African] carriers and [were] responsible for much suffering.” Cerebro Spinal Meningitis occurred “fairly commonly amongst the natives” and was “usually borne to European households by apparently healthy [native] carriers.”²⁴

Erroneous views about the epidemiology of diseases heightened fears of infections. For example, in the case of venereal diseases, the common assumption was that all Africans were infected. Even professionals such as physicians sometimes succumbed to settler fears and distortion of established facts. For instance, Rhodesian medical officials were concerned that although syphilis “is infectious almost entirely through the medium of sexual intercourse it is undesirable from an aesthetic point of view that there should be the risk of native boys being employed in European houses whilst they are suffering from this disease.” They asserted that “Infection through other means than sexual intercourse, though exceedingly rare,” was “nevertheless possible.”²⁵

Europeans also held erroneous ideas about human trypanosomiasis which supposedly threatened the health of Europeans. “[Currently], many authorities doubt the importance of big game as a factor in the maintenance of human trypanosomiasis in tsetse areas,” Akins wrote, “it is possible that infected natives are the cause of the disease remaining endemic in certain of such districts.”²⁶ He claimed that in any district where the *glossina morsitans* fly was common there was “always a grave possibility of an epidemic of sleeping sickness in the event of an outbreak being started by infective natives.” Provision of medical services to Africans was therefore driven by a number of erroneous understandings of epidemiology.

²⁴ Ibid.

²⁵ Ibid.

²⁶ Ibid.

At the insistence of physicians, missionaries, Native Commissioners and the settler community, the colonial government began to look deeper into African health issues. Their thinking was shaped by a tendency to dismiss African understandings of illness and healing, and to insist upon European supervision of medical treatment. A. M. Fleming, the Medical Director of Rhodesia, stated his preference for the treatment of Africans in hospitals under European supervision by saying that as far as the needs for sick Africans were concerned, ample provision was made in hospitals.²⁷ In response to the requests to provide medical aid to Africans in rural areas, the colonial government took a two-pronged approach. One of the approaches involved a scheme of dispensaries or “collection centers” managed by the colonial government. The seriously sick would be “collected” at these centers for transfer to hospitals. The other approach involved placing the responsibility of African medical care on the missionaries. This was in effect a continuation of the previous strategy, the only difference being that the colonial government now had to provide grants to missionary societies providing medical attention for Africans in reserves. These approaches resembled schemes undertaken in other British territories such as Kenya, Uganda and Tanzania after 1920.²⁸

First Approach: dispensaries in African reserves of
Rhodesian Manica

Under this approach, the Rhodesian government built dispensaries in “native” reserves under the aegis of the Native Department. The major feature of this scheme involved plotting out the colony into districts, with each district having its own central

²⁷ NAZ, S1173/328-329: A. M. Fleming, Medical Director, Southern Rhodesia, to the Colonial Secretary, 25th June, 1924.

²⁸ David Baronov, *The African Transformation of Western Medicine and the Dynamics of Global Cultural Exchange* (Philadelphia: Temple University Press, 2008), 115-119.

hospital surrounded by a ring of dispensaries not exceeding six in number and not more distant than fifty miles on “motorable roads.”²⁹ Each dispensary had to treat Africans from a radius of approximately seventy-five miles or a diameter of one hundred and fifty miles.

Staffed by an African orderly as caretaker and dresser, these centers gathered sick Africans “at fixed points in the reserves where they could be visited periodically by the local Government Medical Officer.”³⁰ Medical officials indicated that the seriously ill could be transferred from such a scheme of local dispensaries to the nearest Government Hospital for “special care and treatment.”

Colonial officials continued to refine the scheme for the medical treatment of Africans over the years. In October 1930 they proposed to establish a number of stations where there would be a Government Medical Officer, a “native hospital,” and outpatient department, and a small nursing staff, in addition to creating a ring of “native dispensaries” around each station.³¹ In order to staff these centers, the colonial Government had to train male African orderlies and possibly female African nurses in larger African hospitals. The Government Maternity Training School (which was yet to be established) would be responsible for training female African midwives.

However, as late as 1952, there was little improvement in health services over the situation that had existed in the 1930s. In the Melsetter sub-District (Chimanimani), for instance, the NC reported, in 1952 that there were only “two modern” clinics in the sub-

²⁹ NAZ, S1173/336: Scheme for the Medical Treatment of Natives”, R.A. Askins, Medical Director, to the Chief Native Commissioner, Southern Rhodesia, 24th December, 1930.

³⁰ NAZ, S1173/328-329: Medical Assistance to Indigenous Natives in Reserves, Medical Director, Southern Rhodesia, to The Secretary, Department of the Colonial Secretary, Southern Rhodesia, 9th June, 1927.

³¹ NAZ, S1173/336: Treatment of Natives, R.A. Askins, Medical Director, to the Secretary, Department of the Colonial Secretary, Southern Rhodesia, 31st October, 1930.

district....”³² In addition, the Rusitu and Mutambara Missions had their own clinics. Nevertheless, some Africans therefore had to travel distances of more than 25 miles in order to get to the nearest treatment center. These few treatment centers served an African population of 23.960 in 1952.

Another indication that government health services for Africans were inadequate was evident in the report of the NC Melsetter sub-district, who reported that only “those living in the immediate vicinity of Clinics take the trouble to seek hospitalisation for the simple reason that transport facilities virtually do not exist.”³³ If clinic services today are any indication of the clinic services in the 1950s, “hospitalization” probably meant out-patient services because clinics do not have the capacity to treat patients under confinement. In the south the NC of Chipinga district (with about 51,213 Africans) reported that Chipinga Native Clinic was inadequate to meet the growing demands for health care. He said,

The Chipinga Native Clinic has worked at full pressure during the year. Although urgent minor repairs have been done the clinic is still in a bad state of repair. A Native Hospital should be built, as Chipinga serves as a base for all the outside clinics and all serious surgical and medical cases are sent in. Accommodation is limited. If a fully equipped native hospital could be erected the European nursing and secretarial staff could assist in the administration.³⁴

The Sabi Valley was served by only two clinics, Birchenough and Nyanyadzi.³⁵ The NC added that as the majority of the African population “live South of this area, a large proportion of the native population in the worst malarial area are not served by a clinic.”

³² NAZ, S2827/2/2/2 Annual Report of the Assistant Native Commissioner, Melsetter, for the Year ended 31st December, 1952.

³³ Ibid.

³⁴ NAZ, S2403/2681: Native Commissioners’ Reports, 1952, Report of the Native Commissioner, Chipinga, for the year ended 31st December, 1952.

³⁵ Ibid.

In the northern part of the Manica region, the clinics at St. Augustine's Mission, Old Umtali Mission, in the Maranke Reserve, Odzi Village, and Tsonzo Division were inadequate for an African population of 86,506 in 1959 in rural Umtali district as these clinics were "invariably overcrowded."³⁶ Reflecting the African preference for outpatient treatment, "innumerable outpatient treatments" were "given at the various hospitals and clinics, and at the Government dispensary on the Melsetter road" near Umtali. "It would certainly appear that additional curative institutions would be warranted in this district," commented the NC Umtali, "especially in the Muromo Special Native Area and the Mutasa North Reserve where the medical facilities provided by the Ziwe Zano Society at the Honde Clinic continue to be inadequate and unsatisfactory."³⁷

Reflecting the enduring reliance of government on the medical services of religious institutions, in 1961 the Roman Catholic Mission opened a clinic at Chisumbanje, south of Chipinge. This clinic was staffed "by European nurses, one an American and one a Canadian."³⁸ It improved what, according to the NC Chipinga, "was a desperate position for the local population," but was still "small and inadequate." Aside from this clinic, the only other option for sick African residents of southern Chipinge district was a small, informal clinic run out of her house by the wife of the Land Development Officer at Chibuwe. In addition, the American Board Mission ran an outpatient center at Zamuchiya, some 28 miles south of Chikore Mission.

³⁶ NAZ, S2827/2/2/7: Annual Report of the Native Commissioner, Umtali, for the Year ended 31st December, 1959.

³⁷ Ibid. The Ziwe Zano Society was an African Society.

³⁸ NAZ, S2827/2/2/8: Annual Report of the Native Commissioner, Chipinga, for the Year ended 31st December, 1961. Note that instead of being referred to as "white," Americans and Canadians were considered "European" in this case.

Second Approach: provision of medical assistance through
missionary societies

Apart from government health services, colonial governments sought to extend health services to African through religious institutions. The American Board Mission played a vital role in the health delivery systems of both colonies. Its main station at Mt. Selinda was established in 1893. Although the missionary physician, Dr. Thompson reported in 1894 that the medical work of the mission station was still small, “probably not more than two cases daily, including white patients,” he was confident that this work would increase with time.³⁹

The medical missionaries dealt with a wide range of diseases and conditions among both Africans and white settlers. The most common disease was malaria. Other diseases included syphilis, intestinal worms, skin infections, eye and ear infections, diarrhea, dysentery, enteritis, respiratory infections and gynecological infections. The missionaries reported that they had attended 590 cases in 1894.⁴⁰ Of these cases, 268 were African while 94 were among white settlers.

With little government medical infrastructure available, colonial governments depended on the American Board Mission to provide health services to Africans as well as to white settlers in this southern portion of the Manica region where the American Board Mission station was located. This was shown by the willingness of colonial governments, particularly that of Rhodesia, to fund medical missionaries. Because they were providing medical services to European settlers, the American Board requested

³⁹ ABC 15.4 volume 19: Letter from W. L. Thompson, Mt Selinda to Judson Smith, Boston, MA, April 6, 1894.

⁴⁰ ABC 15.4 volume 20: Letter from W. L. Thompson, Mt Selinda to E. E. Strong, Boston, MA, February 18, 1895.

medical aid from the Rhodesian Government as early as 1896.⁴¹ In 1908, the missionaries received “the gift of a horse from the Government for the use of the Medical Department.”⁴² The horse helped missionary physicians visit white patients who could not be brought to the Mission for treatment. Thus the concern of the colonial government during this early period remained exclusively on providing health care for Europeans.

During these early years, much of the assistance missionaries received from the Rhodesian Government for the provision of African health care was in the form of free medicines. In 1911 the Government supplied free remedies for the treatment of syphilis and had thus assisted the missionaries in coping with what they thought was a “grave malady... so prevalent among the natives.”⁴³ However, two years later, the Medical Director of Rhodesia recommended that six missionary physicians “be appointed and paid by the Government to take care of the health of natives in Southern Rhodesia” and the American Board Mission applied for one of these appointments, which the Government eventually approved.⁴⁴ Although these efforts to extend medical services to Africans were significant, they still were largely inadequate for the region.

⁴¹ ABC 15.4, volume 20: Letter from H.J. Gilson, Secretary, East Central Africa Mission, to Judson Smith, Secretary, ABCFM., Boston, MA., September 24th, 1896. The “unsettled state of affairs” probably involved Zimbabwe’s rebellion against colonial rule, often referred to as the “First Chimurenga.”

⁴² ABC 15.4, volume 23: Report of the Medical Department, Rhodesian Branch, A.B.M. in S.A., June 31, 1907 to June 31, 1908. The granting of the horse was a result of a request made by white farmers and the missionaries so that Dr. Thompson could “more easily meet the [medical] needs of the district.” However, the horse died in April 1913 due to horse sickness, making long trip to patients difficult to accomplish.

⁴³ ABC 15.4, volume 32: Annual Report, Rhodesian Branch American Board Mission in South Africa for the year ended May, 31st 1911. It was Rhodesian policy to offer treatment for venereal diseases such as syphilis free of charge to Africans. The missionaries reported later in the 1914 annual report that the Government had continued to supply medicine for syphilis but the promise of 22 pounds of quinine for routine prophylactic administration “to our school children [had] not been kept, though the Medical Director expressed much interest in the experiment as already tried on a small scale.”

⁴⁴ ABC 15.4, volume 32: Annual Report, Rhodesian Branch American Board Mission in South Africa for the year ended May, 31st 1913.

Reflecting their principal goal of making converts, the missionaries were willing to provide medical services to the entire region and often traveled long distances to visit patients in both Rhodesia and PEA. After the death of the Melsetter District Surgeon in 1902, Dr W. T. Lawrence, a missionary physician was the “only medical man in the [Melsetter] district” embarking on “long journeys to attend English, Dutch, Portuguese or native patients.”⁴⁵ As Lawrence reported in 1911, the nearest Government District Surgeon in Rhodesia was sixty-five miles north of Mt. Selinda. Contrary to Langson Mahoso’s assertion that “everyone who was sick had to come to the mission station” for treatment, the medical missionaries traveled long distances to attend to cases in both Rhodesia and PEA.⁴⁶ In 1911, for example, a missionary physician traveled from Mt. Selinda, Rhodesia to Spungabera, PEA to treat an African chief who had a “bad heart” and advanced tuberculosis on both lungs.⁴⁷

The willingness of the American Board Mission to extend its services to PEA was also evidenced by missionary responses to the influenza epidemic. When Spanish influenza hit the colonies in 1918, the missionaries engaged in cross-border work of inoculating Africans. One of the missionaries, A. J. Orner, indicated that the disease had been raging for six or seven months in Rhodesia and that the mortality had been heavy on the mines, particularly amongst Africans.⁴⁸ Although the Rhodesian Government took “all possible steps to try and hold it in check,” Orner claimed that it was “a very difficult

⁴⁵ ABC 15.4, volume 25: Letter from H. J. Gilson, Melsetter, Rhodesia to The Prudential Committee of the ABCFM, Boston, MA., December 29th, 1902.

⁴⁶ Langson Takawira Mahoso, “The Social Impact of Christian Missions in Zimbabwe 1900-1930: A case Study of American Board Mission, Brethren in Christ Mission and the Seventh Day Adventist Mission,” M.A. Thesis (Temple University, 1979), 31.

⁴⁷ ABC 15.4, volume 32: Report Letter No. 20 from the Mt. Silinda Station, American Board Mission in South Africa, Rhodesian Branch, April 12, 1911.

⁴⁸ ABC 15.4, volume 34: Letter from A.J. Orner, Mt. Selinda, Rhodesia to Rev. James L. Barton, Boston, MA., November 28, 1918.

task in a country like this to prevent the natives from going about and spreading it wholesale.” He also claimed that more than one thousand Africans had deserted from one of the big Rhodesian mines “when things were at worst, going to their homes and so spreading the sickness broadcast.”⁴⁹

Realizing the fluidity of the border and the potential for the diffusion of influenza, the missionaries adopted a regional approach of disease control by inoculating in Portuguese territory. By January 1919, Orner had walked over a distance of three hundred miles, inoculating about 1,700 Africans.⁵⁰ He also reported that Africans in the entire region around Mt. Selinda had been inoculated, about 3,000 at Gogoi, as well as about 500 inoculated at Chikore. Orner could only observe a few isolated mild cases in the Melsetter District, where the epidemic was practically coming to an end by January, 1919. However, on the Portuguese side, the epidemic was still spreading to the east and south of Mt. Selinda where no inoculation had been carried out, “in spite of very strenuous efforts on the part of the Portuguese Government to prevent the natives from moving about the country at the present time.”⁵¹ However, Africans in some areas had been inoculated, thanks to the willingness of the American Board Missionaries to work in Mozambique.

The cross-border inoculation done by missionaries helped to reduce the extent of the diffusion of influenza in this southern portion of the Manica region. By February 1919 Orner was able to report that the Spanish influenza epidemic had come to “a distinct halt” about eighty miles north of Mt. Selinda allowing time for a good deal of inoculation

⁴⁹ Ibid.

⁵⁰ ABC 15.4, volume 34: Letter from A.J. Orner, Mt. Selinda, Rhodesia to Rev. James L. Barton, Boston, MA., January 14, 1919.

⁵¹ Ibid. The Portuguese Government concentrated most of its efforts on restricting movements of Africans rather than inoculating them.

as a preventative measure.⁵² Orner also reported that Dr. Lawrence had done considerable inoculating at Gogoi, where the epidemic appeared “to be stopped about ... ten miles from the station.” This probably meant that the spread of the disease was checked ten miles from the station due to the prophylactic efforts of missionaries.

The missionaries provided a service which colonial officials, constrained by frontier, could not provide. Orner claimed that it was through the “great generosity of the British Government” that Dr Lawrence was able to “inoculate several thousand natives in a radius of some ten or fifteen miles from Gogoyo [Gogoi] with the result that the influenza” had been “very mild in all that region” and there had been no deaths while just outside the area covered by the inoculation it had been very severe with many deaths.⁵³ As Orner argued, the vaccine for use in Gogoi, Portuguese East Africa, “was furnished on our [missionaries’] suggestion as a protection to the Melssetter District on the east and thanks to that protection and the large amount of inoculating that has been done in the district we have had no epidemic here at all and only a few isolated cases.”⁵⁴ Although the Rhodesian medical assistance to the missionaries was intended for use on the Rhodesian side of the Manica region, the approval of influenza vaccine use on the PEA side was an exception. This was approved after the missionaries had successfully argued that it was necessary to “protect” their station at Mt. Selinda.

While missionary medical services for Africans were constrained by the availability of resources up to the 1920s, the Rhodesian government finally became aware of the need to extend health services to rural Africans. This coincided with many requests for more church involvement in African health. In 1924, Rev. Dr. Gurney “urged

⁵² ABC 15.4, volume 34: Letter from A.J. Orner, Mt. Selinda, Rhodesia to Rev. Enoch F. Bell, Secretary ABCFM, Boston, MA., February 7, 1919.

⁵³ ABC 15.4, volume 34: Letter from A.J. Orner, Mt. Selinda, Rhodesia to Rev. Enoch F. Bell, Secretary ABCFM, Boston, MA., March 9, 1919.

⁵⁴ Ibid. Emphasis added.

the unity of the two phases of mission work, preaching and medicine,” arguing that the “command to the Apostles was to preach the Kingdom of God and heal the sick.”⁵⁵ He also said that Jesus Christ was “a medical missionary.” Three years later, the government encouraged missionary societies to engage more extensively in medical mission work by the payment of “definite and fixed Government grants towards the salaries of qualified medical missionaries and nurses especially engaged for this purpose, and toward the maintenance of mission hospitals, and dispensaries.”⁵⁶

As the government sought to rely more on missionaries for the provision of medical services to Africans in rural areas, some health officials were concerned about how, in their view, missionaries, easily accommodated African preference for out-patient treatment instead of confining Africans in hospitals. For instance, the Medical Director complaint about “how undesirable it [was] for the Government to pander in any way to the constantly reiterated request from missionaries...for ‘free drugs’ at Government expense for the treatment of natives, irrespective of whether the persons concerned have the requisite knowledge to diagnose disease, or to dispense the remedies....” He added,

In this respect many missionaries exhibit an attitude of mind which is not in the best interest of the patient concerned, and without labouring the point I would merely draw the attention to the fact that instances could be multiplied to any extent of where native sick are encouraged ... to go long distances to the Missionaries for relief, often at great risk to themselves, rather than to properly staffed and well appointed hospitals which are provided for them. In extenuation it is argued that the native dislikes a hospital, but so does a child, and I am afraid I have seen no tendency on the part of Missionaries to combat this prejudice, even if they do not foster it.⁵⁷

⁵⁵ NAZ, S1173/301-304: “Health and the Native,” Rhodesia Herald, 5th June, 1924.

⁵⁶ NAZ, S1173/328-329: Medical Assistance to Indigenous Natives in Reserves, Medical Director, Southern Rhodesia, to The Secretary, Department of the Colonial Secretary, Southern Rhodesia, 9th June, 1927.

⁵⁷ NAZ, S1173/328-329: Medical Assistance to Indigenous Natives in Reserves, Medical Director, Southern Rhodesia, to The Secretary, Department of the Colonial Secretary, Southern Rhodesia, 9th June, 1927.

He therefore recommended that missionary societies accepting government grants should consent to government inspection and the right to call for any reports and returns in order to “keep a modicum of control in the hands of the Government.”

Missionaries were more likely to accommodate African preferences, for example, out-patient treatment, which gave Africans some control on the treatment process because they thought western medicine could greatly aid them in their efforts to make converts. Dr. W. T. Lawrence argued that one of the most difficult and most important tasks which confronted the missionary was “that of gaining the natives’ confidence.”⁵⁸ He claimed, having “won a native’s love you have gained a powerful influence over him which you can use in attempting to win him to Christ.” To him, it was the medical missionary work which accomplished this goal “in less time and more effectually” than it could “be accomplished in any other way.”⁵⁹ According to Lawrence, “The native comes to be treated, or you are called to treat him at a time when he and his family are most susceptible to the presentation of the truth. He is at least ready to listen to what you have to say.”

Missionaries were willing to provide medicine to Africans as long as this served their higher purpose, which was to make converts. Thus when Lawrence visited Gogoyo in 1916, he reported that there were great opportunities for a physician there because he had encountered “many people who were in a very serious condition.” He claimed that malarial fever, skin diseases, and digestive disturbances were “very common” and had distributed medicines, hoping that the Africans would use them as directed. “In this way,”

⁵⁸ ABC 15.4, volume 23: “Medical Mission Work in S. Africa,” 1906.

⁵⁹ Ibid.

argued Lawrence, “some good can be done and in any case this is an important means of breaking down prejudice.”⁶⁰

The missionaries believed that it was necessary to provide medicines to Africans to show concern about their welfare before attempting to convert them. They argued that the “native is naturally suspicious, he thinks you are seeking your own rather than his good.” According to the missionaries, Africans thought the colonial governments were not genuinely concerned about their welfare as Dr. Lawrence argued,

The white man has deprived him [the African] of his land, he is breaking down his native customs, and making him pay what seems to him to be heavy taxes. He is getting from the native and not giving to him—so it seems to the native.⁶¹

This probably accounts for why Africans thought going to the hospital was another form of submission to colonial authority. One informant said that most Africans, particularly the elders, did not visit hospitals when sick because they thought that avoiding the hospital was a way of resisting the colonial governments and their westernizing influence.⁶²

However, merely distributing medicines to African villagers was sometimes not enough to convert them. Villagers were not easily swayed by western medicine because they had great confidence in their own medicine. The missionaries complained, “so great is the confidence they [Africans] feel in the native witch doctor, that they are liable to go to him rather than to the physician, or else to use the treatment of both at the same

⁶⁰ ABC 15.4, volume 32: Letter from Dr. W. T. Lawrence, Mt. Silinda, Melsetter, Rhodesia, South Africa, May 13th, 1916.

⁶¹ Ibid.

⁶² Interview, Mpanyeya, Mozambique, 14 December, 2006. Although this interviewee links African resistance to hospitalization with colonialism, most elderly people probably thought they would just die in hospitals.

time.”⁶³ One of the physicians noted that the Africans wanted “quick results” and that they sometimes got them from African healers.⁶⁴ One informant remembered, “my own father did not appreciate clinics of the white men. He discouraged us saying their methods were inferior to ours. He was knowledgeable of indigenous methods of healing so he did not want us to use other methods.”⁶⁵ Africans thought western medicine was inferior because those treated in hospitals took much time to recover. For Africans who wanted quick results, western medicines proved ineffective and unnecessary.⁶⁶

In addition, some Africans thought going to the hospital would kill them. Dr Lawrence argued that it was only fair to say that there was a great fear on the part of the Africans of being treated a hospital. “Boys at work in the mines and towns,” he claimed, “frequently run away when ill or maimed rather than subject themselves to hospital treatment. They say that if a sick native does not get well soon, the attendants give him poison to put him to sleep and he never awakens! this because they do not want to be bothered with the care of him any longer!”⁶⁷ Lawrence also made reference to his own experiences saying, “almost invariably, when a native in our care seems to be nearing death, even though to us his chances of recovery are good, his people want to take him away home.” One such case occurred in June 1916 with the result that the girl in question was still “an invalid” at her home by October of that same year. Lawrence had “no doubt” that the Africans thought this was “a case of the triumph of native medicine.”⁶⁸

⁶³ ABC 15.4, volume 32: “General Letter in regard to the Work of the Rhodesia Branch of the American Board Mission in South Africa,” May 1910.

⁶⁴ Ibid.

⁶⁵ Interview, Penhalonga, Zimbabwe, 29 August, 2006.

⁶⁶ Interview, Maengeni Village, Zimbabwe, 14 January, 2007.

⁶⁷ ABC 15.4 volume 33: Letter from Dr. W.T. Lawrence, Mt Selinda, to Rev. J. E Burton, Secretary ABCFM, Boston, MA., October 6th 1916.

⁶⁸ Ibid.

Many informants confirmed the complaints of missionary physicians that Africans thought they would be “finished off” or killed if they sought treatment in hospitals. One recalled, “My uncle died in the hospital after his daughter forced him to go there. So after his death, the whole clan did not entertain the idea of going to hospitals because they thought that hospital personnel killed patients they did not like.”⁶⁹ Another recalled that there were rumors that the white people had brought drugs to inject and kill children. Thus when Portuguese authorities announced they would “inject children in schools to prevent some diseases, many parents stopped sending their children to school.”⁷⁰

Rumors of killings in hospitals resulted from mortality in hospitals and perceived ineffectiveness of western medicine. In most cases Africans tried traditional healers first before consulting western doctors. They then took the patient to the hospital as a last resort when he or she was critically ill. When that patient died in the hospital, Africans then thought the hospital personnel had “finished off” that patient. One informant said that “even today, those who have knowledge of traditional medicines would try to help themselves first, before going to the hospital.”⁷¹

Missionaries felt the need of not only converting Africans, but of keeping them in the Christian faith as well through provision of medical care. J. R. Dysart argued,

I must pass on the need for a physician [for Gogoyo]. We are teaching these young Christians that they must stop going to the witchdoctor and come to us for help in time of sickness. If no medical help is here what will they do? They will go back to the witchdoctors and to heathenism simply because we will not be able to help them.⁷²

⁶⁹ Interview, Beacon Hill, Chipinge District, Zimbabwe, 29 December, 2006.

⁷⁰ Interview, Zangiro, Mozambique, 23 September, 2006.

⁷¹ Interview, Zimunya District, Mutare South Zimbabwe, 31 July, 2006.

⁷² ABC 15.4, volume 33: Letter from J.R. Dysart, Gogoyo, P.E.A. to Mr. Bell, Boston, MA, August 12th, 1919.

In the same vein, Dr. Lawrence contented, “If we [missionaries] do not bring aid in times of illness then the pupils and their parents as well are sure to continue to report to the witchdoctor—to whom else could they go?”⁷³ For missionaries therefore, the main concern was to bring into and retain converts in Christianity even if that meant yielding to African preferences which colonial officials resented.

Apart from their apparent lack of confidence in western medicine, Africans wanted an active role in the healing process. They were drawing upon some aspects of the pre-colonial healing which granted patients and their families or “therapy managers” a high degree of control over healing. One medical missionary, Dr. Thompson, claimed that his African patients had “very decided views of their own about disease” and were “usually quite ready to inform” the missionary physicians as to what the trouble was and even made suggestions to the treatment.⁷⁴ Thus according to him, in the case of internal pains, Africans usually had “not the slightest doubt that a worm or a snake” was the cause of the trouble. Anything else for which a “natural cause” was “not plainly apparent to them,” Thompson argued, the Africans “ascribed to witchcraft.”⁷⁵

Steven Feierman and John Janzen, who have examined precolonial healing, contend that therapy managers, “drawn from among the patient’s relatives, neighbors, and friends, are at the heart of African healing.”⁷⁶ These scholars argue that therapy managers “are defined solely through their relationship to the patient and the patient’s particular illness.” It was also the responsibility of therapy managers to help choose

⁷³ ABC 15.4, volume 35: W.T. Lawrence, “The Future of the work of the Medical Department, the East Africa Mission, June 1929.”

⁷⁴ ABC 15.4 volume 19: Letter from W. L. Thompson, Mt Selinda to Judson Smith, Boston, MA, April 6, 1894.

⁷⁵ Ibid.

⁷⁶ Steven Feierman and John M. Janzen, introduction to *The Social Basis of Health and Healing in Africa* (Berkeley: University of California Press, 1992), 18.

among healers and pay for health care in some cases. Therapy management, according to Feierman and Janzen, served two functions. The first was “authoritative diagnosis and control over treatment,” which fell into “the hands of the one person (or limited group) who has juridical authority over the patient.”⁷⁷ This one person could be the father or the husband of the patient. However, adult men and independent women could make therapy decisions for themselves. The second function of therapy management involved supportive care, which was distributed widely among neighbors, old friends, passers-by, and distant relatives. All these could “suggest possible diagnoses and treatments,” but could only share in the final decisions if they were invited to do so by the authority bearers.⁷⁸

The process of diagnosing and treating an illness in precolonial society sometimes required many players because it was complex. Ideas of disease causation and diagnosis often involved differentiating between “misfortunes or afflictions stemming from ‘natural’ or God-given causes from those stemming from human involvement.”⁷⁹ Both the living and the dead (ancestors) were believed to cause disease or misfortune. Thus in the Kongo society of central Africa, for instance, John Janzen argues that “affliction was driven by a compelling worldview issue, namely, the question of whether or not the affliction [was] merely matter of fact, or whether ‘there [was] something else going on,’ that is, other persons, spirits, ancestors, or the social setting itself, in the causation of the case.”⁸⁰ He contends that ancestors represent an extension of the human community as a major cause of misfortune and cure in African society. In eastern Bantu cultures,

⁷⁷ Ibid.

⁷⁸ Ibid.

⁷⁹ John M. Janzen, *Ngoma: Discourses of Healing in Central and Southern Africa* (Berkeley: University of California Press, 1992), 65.

⁸⁰ Ibid., 86.

including those of the Manica region, ancestors or spirits of the dead are known by the common term, *dimu* (which is probably proto-Bantu) and as *mudzimu* (singular) and *vadzimu* (plural) among the Shona of the Manica region. Among the Shona are the Ndaus in the southern portion of the region. Janzen argues that the “Ndaus, or Vandaus, are considered the original ancestors of the Kalanga (a South Shona or Thonga group) and the most powerful spirit group, with a direct interest in the affairs of the living.”⁸¹

For many Africans, diagnosis of disease thus involved questions of who caused the disease, not only had what caused it. The local social context was therefore central in diagnosis and treatment of disease. While the *n'anga* provided answers to both questions, western medicine could not say who caused the disease. According to one informant,

When the sick visited a *n'anga*, the *n'anga* would determine the cause of sickness, where the disease came from, and who bewitched the sick person. So we, as Africans, trusted that very much, to know where the infection came from and what would happen next [the prognosis]. The *n'anga* would give all that information in addition to the treatments. So people favored the *n'anga* because they got much information about the illness.⁸²

Understanding the traditional African approach to health and healing also helps in analyzing the role of independent churches such as the Zionists discussed in the preceding chapter. The concept of illness in African society was wide, encompassing ancestors, witches, and sorcerers. According to M. V. Bührmann, illness was “ascribed to a disturbance of the balance between man and spiritual or mystical forces, and the aim of health [was] to restore the equilibrium.”⁸³ Restoration of this balance was achieved by communication and communion with the ancestors by performing rites, rituals, and ceremonies.

⁸¹ Ibid., 95.

⁸² Interview, Mvududu Village, Mutare South, Zimbabwe, 3 August, 2006.

⁸³ M. V. Bührmann, “Religion and Healing: The African Experience,” in *Afro-Christian Religion and Healing in Southern Africa*, ed. G. C. Oosthuizen et al., (Lewiston: The Edwin Mellen Press, 1988), 26-34.

The spread of Christianity led to the incorporation of these religious beliefs and practices, particularly in the independent African churches. In some of these churches, there are strong beliefs in the traditional system. “Some people are believed to have an inherent quality that allows them to change shape, go about invisible, and cause death or misfortune, either by themselves or by means of familiars,” contented W. D. Hammond-Tooke, while others “may use special powers to kill at a distance.”⁸⁴ These two groups, witches and sorcerers respectively, were thought to possess malevolent powers over others that caused evil. According to Hammond-Tooke, this evil could be classified as “evil incarnate (the witch) or evil inherent in matter (sorcery)” and was “explicitly associated with negative emotions of envy, jealousy and anger.” Thus evil “refers to the essentially antisocial attitudes and actions that threaten the very basis of social life.”⁸⁵

Some Independent African churches have adopted some of the traditional beliefs. G. C. Oosthuizen argues that in African Independent Churches “especially the Zionists, the real adversary is the sorcerer, who is an antagonistic human being.”⁸⁶ Oosthuizen contends that the role of the prophet is of crucial importance in most African Independent Churches “where the office of prophet/prayer healer is a substitute for the office of diviner in the traditional society.” He also claims that as “in the case of diviners, most of the prophets are assisted by ancestral spirits in the diagnosis and treatment of illness,” and that these churches “acknowledge that bewitching, sorcery, spirit possession are realities....”⁸⁷ This is true for some Apostolic churches in the Manica region where

⁸⁴ W. D. Hammond-Tooke, “The Aetiology of Spirit in Southern Africa,” in *Afro-Christian Religion and Healing in Southern Africa*, ed. G. C. Oosthuizen et al., (Lewiston: The Edwin Mellen Press, 1988), 44-65.

⁸⁵ Ibid., 53.

⁸⁶ G. C. Oosthuizen, “Indigenous healing within the context of the African Independent Churches,” in *Afro-Christian Religion and Healing in Southern Africa*, ed. G. C. Oosthuizen et al., (Lewiston: The Edwin Mellen Press, 1988), 71-90.

⁸⁷ Ibid.

causes such as evil spirits and witchcraft are recognized as being legitimate explanations of illness or misfortune. Like the *n'anga*, prophets in these churches could, according to some informants, point to who caused an illness or anomaly in a patient. One woman who could not conceive noted,

I have once been to the Vapostori [Apostles]. I could not conceive and they helped me much. I had been to hospitals also but it did not work for me...Maybe they [western doctors] should even allow us to catch witches because I was told the person who was blocking my tubes and I believe it is her. I was shown so many things I did not know about healing by these African prophets, only that they mix Christianity with traditional African ways which can be confusing.⁸⁸

An authority on Zionist churches, Bengt Sundkler, contends that in South Africa Zulu Zionists “combat the use of the *inyanga*’s [traditional healer’s] medicines and they fight against the diviner’s demons of possession.”⁸⁹ Yet, as Sundkler claims, “the weapons with which they [Zionists] fight the struggle belong to an arsenal of old Zulu religion.” He asserted a “strong section of the Zionists is deliberately nativistic, and Churches of this kind in the end become the bridge over which Africans are brought back to the old heathenism from whence they once came.”⁹⁰

However, some groups discourage or disassociate themselves from the use of traditional medicine and worship of ancestors. For instance, when South African faith healers (prophets) were asked to compare themselves with the traditional healers (diviners), they said the “main differences between prophets and diviners were that

⁸⁸ Interview, Old West Mine Compound, Penhalonga, 28 August 2006.

⁸⁹ Bengt Sundkler, *Bantu Prophets in South Africa* (Oxford: Oxford University Press, 1961), 55.

⁹⁰ *Ibid.*

prophets go to church, pray and use only holy water, whereas diviners use herbs, bones and killing medicine.”⁹¹

In contrast with the willingness of Zionist churches to work with concepts of disease and healing, the reluctance of western medical practitioners to learn about and understand African ideas of causation and healing partly explain their failure to convince Africans to embrace biomedicine. According to one interviewee, the greatest weakness of western medicine was that it could not diagnose an illness caused by witchcraft because western doctors did not understand it: “because of their mentality, they could not accept it.”⁹² Accordingly, the clinics could not diagnose and treat diseases “caused by one’s enemies, the witches.” The informant warned, “You see these diseases have their own origins and we need to be careful when we seek treatment from western doctors because we can waste lots of money on what the *n’anga* can easily see.” Another interviewee argued, “Sometimes you want to hear many views especially those that are easy to understand not those long confusing words of doctors which are hard to understand. I do not like them.”⁹³

When asked if Africans still go the traditional healers because there are some diseases western medicine cannot treat, one informant responded, “Yes, some disease caused by some evil spirits and sorcery cannot be treated in hospitals.”⁹⁴ That explains why some Africans consulted traditional healers first, before going to the hospital. According to one informant, “when Africans got sick they always wondered if they had spirits. So they would say, let me go to the *n’anga* first, to get rid of the spirits before

⁹¹ W. H. Wessels, “Healing practices in the African Independent Churches,” in *Afro-Christian Religion and Healing in Southern Africa*, ed. G. C. Oosthuizen et al., (Lewiston: The Edwin Mellen Press, 1988), 91-108.

⁹² Interview, Tsvingwe Village, Penhalonga, Zimbabwe, 28 August, 2006.

⁹³ Interview, Elim Mission, Penhalonga, Zimbabwe, 29 August, 2006.

⁹⁴ Interview, Zimunya District, Mutare South Zimbabwe, 31 July, 2006.

going to the hospital.”⁹⁵ Even African nurses encouraged Africans to consult traditional healers to determine if there was no sorcery or evil spirits involved in one’s illness. These nurses claimed that the patients could be treated easily at the hospital only after these evil spirits had been removed.⁹⁶ Studies in some central African societies have also revealed that although the signs and symptoms accompanying the sick “may be identified and even treated with biomedical methods and medicine, the salient point that brings these sufferers to diagnostic entry into the ritual therapies is not so much the sickness but the identification of the spirit force behind the sickness.”⁹⁷

Prophylactic measures against sorcery and witchcraft involved methods which western medical practitioners dismissed as mere superstition. According to one informant, government and medical missionaries did not tolerate the African practice of “immunizing babies by tying *madumwa* and *mazango* [charms used to protect children from sorcery and disease]. They did not see that as useful. Treatment for them probably meant an injection not a necklace [charm] tied around the waist of a baby.”⁹⁸

Included in this realm of illnesses caused or worsened by sorcery and witchcraft is HIV/AIDS. Some interviewees associate HIV/AIDS with spirits or witchcraft and are reluctant to accept biomedical explanations because, if biomedicine worked, “people would not be dying in huge numbers.”⁹⁹ One interviewee argued, “some people just say so what shall we do, we need to get married, others are married but are still engaging in risky behavior. So we think it is an evil spirit driving people into this risky behavior, a

⁹⁵ Interview, Nehwangura Village, Mutare South, Zimbabwe, 2 August, 2006.

⁹⁶ Interview, Ngaone, Chipinge, Zimbabwe, 20 October, 2006.

⁹⁷ John M. Janzen, *Ngoma*, 92-93.

⁹⁸ Interview, Elim Mission, Penhalonga, Zimbabwe, 29 August, 2006.

⁹⁹ Interview, Zimunya, Mutare South, Zimbabwe, 31 July, 2006.

kind of wish to die.” Given that biomedicine cannot appease spirits, it is only logical for some people to resort to traditional doctors.

In the same vein, changes in the stigmatization of HIV/AIDS have in some cases reflected African dependence on traditional beliefs, not biomedical explanations. One informant recalled, “People used to stigmatize AIDS patients by wearing gloves and burning their clothes at the beginning, but now do not do that because they are afraid of *pfukwa* [revenge from the spirit of a dead person for the ill-treatment].”¹⁰⁰ While it is true that people all over the world have changed their attitudes toward AIDS sufferers, changes in attitudes among some Africans in the Manica region did not result from the discoveries of western medicine that mere contact with infected people or their clothes could not spread infection, but from the continuing allegiance to traditional beliefs. This African reluctance to embrace biomedicine shows that colonial health initiatives failed to convince Africans of the efficacy of western medicine. Hence, some Africans still practice traditional medicine and still believe in traditional explanations of disease causation and misfortune.

Due to the complexity of ideas of causation and healing in precolonial society, the nature of illness determined approaches to diagnosis and healing. In the case of illnesses caused by malevolent powers of others (which western practitioners did not acknowledge), it was important that healing be done in local contexts, where patients had access to multiple therapeutic alternatives, advice from kin, and where practitioners could get detailed knowledge of the local social context. This was because, unlike the ancestors, who according to Hammond-Tooke, “can follow one wherever one goes (even to town), the effective range of witchcraft is limited to the little community,” where the witches “are the enemy within the gates.”¹⁰¹ These illnesses sometimes entailed the intervention

¹⁰⁰ Interview, Zangiro, Sussundenga, Mozambique, 23 September, 2006.

¹⁰¹ W. D. Hammond-Tooke, “The Aetiology of Spirit in Southern Africa,” 53-54.

of travelling specialists called in from afar, just as the medical missionaries did outcalls. Thus according to D. Dube who studied the Zionists of South Africa, besides “restoring physical well-being and a sense of and a feeling of oneness with the supernatural,” a further dimension of healing was realized when the whole Zionist congregation visits the homestead of the patient. “The healer plays a leading role on rendering the homestead safe for habitation either by removing the cause of illness or by making the other inmates of the homestead and the homestead itself strong against any further mystical attacks” he argued.¹⁰² This explains why some African patients who were taken out of their local social context to confinement in a distant hospital would not expect to get better.

However, in other cases, particularly those that involved spirit possession, some physical ailments, and misfortune, patients themselves travelled to specialists. Many spirit-type or independent churches replicated this pattern even though it often required clandestine trans-frontier movements which colonial governments wanted to suppress. Colonial health practitioners and Christian missionaries in the Manica region commented on this pattern of health delivery, which sometimes rivaled theirs. In 1934 Gertrude Merrill of the American Board Mission at Gogoi reported, “Mention should be made of a rival in the healing art who appeared a few months ago, who claimed to be the agent of Mary Mother of God in distributing her benefits by means of a medicine called ‘muchapi.’”¹⁰³ Merrill claimed that people came from long distances with tins and containers, which the “doctor” put in a secret place, where “Maria” would fill them with the precious fluid (“muchapi”) while all were asleep during the night. She added that this fluid was supposed to “preserve” a person’s purchases and family from harm or even death. “Several imbibers of ‘muchapi’ were treated at Gogoi for upset stomach,” she

¹⁰² D. Dube, “A Search for Abundant Life: Health, Healing and Wholeness in the Zionist Churches,” in *Afro-Christian Religion and Healing in Southern Africa*, ed. G. C. Oosthuizen et al., (Lewiston: The Edwin Mellen Press, 1988), 109-136.

¹⁰³ ABC 15.4, volume 43: Gogoi Medical Report, June, 1933 – June, 1934.

asserted, adding, the “[Portuguese] Government treated with disfavor this enterprise, and I no longer hear much about it; tho[ugh] doubtless it is still carried on, being financially much more profitable to the agent than mine to the Mission.”¹⁰⁴

Audrey Richards argues that although the origins of *muchapi* or *mucapi* remain elusive, this was an anti-witchcraft movement which swept through Nyasaland, Northern Rhodesia and other neighboring territories during the 1930s.¹⁰⁵ According to Karen Fields the essence of the *Mucapi* Movement was to “organize the surrender of medicines and medical objects during large communal rituals,” where “witches would confess, and all would drink the *mucapi* medicine together, so that they would henceforth be invulnerable to witchcraft.”¹⁰⁶ Hence Timothy Scarnecchia refers to the practitioners of *mucapi* as “cleansers.”¹⁰⁷

On the Rhodesian side of the Manica region the NC Umtali reported that the “self-styled faith healer,” Mai (Mother) Chaza, established herself in the Zimunya Native Reserve in 1956.¹⁰⁸ He claimed that “in a matter of weeks a pole and dagga town of nearly 1,000 huts sprang up.” This “town” later became “Guta RaJehovha,” Shona for “City of God.” Before starting her own church, Mai Chaza, a mother of six children, was

¹⁰⁴ Ibid.

¹⁰⁵ Audrey I. Richards, “A Modern Movement of Witch-Finders,” *Africa: Journal of the International African Institute* 8, no. 4 (1935): 448. For an extensive discussion of *mucapi*, see Max Marwick, *Sorcery in its social setting: a study of the Northern Rhodesia Ceŵa* (Manchester: Manchester University Press, 1965) and W. M. J. van Binsbergen, *Religious Change in Zambia: exploratory studies* (London: Kegan Paul International, 1981).

¹⁰⁶ Karen E. Fields, “Christian missionaries as anticolonial militants,” *Theory and Society* 11, no. 1 (1982): 104. See also, Karen E. Fields, *Revival and Rebellion in Colonial Central Africa* (Princeton: Princeton University Press, 1985).

¹⁰⁷ Timothy Scarnecchia, “Mai Chaza’s Guta re Jehova (City of God): healing, reproduction, and urban identity in an African Independent Church” *Journal of Southern African Studies* 23, no. 1 (1997): 97.

¹⁰⁸ NAZ S2827/2/2/4: Annual Report of the Native Commissioner, Umtali, for the year ended 31st December, 1956.

a member of the Wesleyan Methodist Church. She became ill with a chronic infection, was divorced and “died” (went into a comma), but later “resurrected.” After her “resurrection, she claimed that she met Jesus Christ and became a healer and preacher, drawing upon traditional religion and history. However, Barbabra A. Moss claims that after Mai Chaza was revived, she became a *n’anga*, earning her living by divination and spiritual healing.¹⁰⁹ She founded her church in 1955 and she died in 1960. Kathleen Sheldon argues that her church was “especially popular with women because it accentuated motherhood and fertility.”¹¹⁰

A church with this name or simply G. R. J. still operates in the Manica region to this day. The NC wondered how this woman was attracting patients of all backgrounds, including Europeans and Indians in addition to local and alien Africans when he reported,

It is difficult to understand how this woman, surrounded as she is by small time racketeers, and relying for the most part on tricks which are reminiscent of pseudo-spiritualists of the past – spirit voices singing on the hilltop, ceremonies in a darkened room – retains the confidence of the hundreds who still flock to her. No specific examples of “miracle cures” are known. Women who have been declared pregnant by Mayi Chaza are still pregnant 18 months later! The child will be born when Mayi Chaza wills it! It is reported that her cure for barrenness is not very original. Women who take the cure are installed in the village and admonished not to resist “spirits” which may visit them during the night. Locally these “spirits” are dubbed “the bulls of Mayi”! An interesting fact is that she is known to [a] number [of] Europeans and Indians among her patients. A European woman suffering from cancer is

¹⁰⁹ Barbara Moss, “Holding Body and Soul Together: Women, Autonomy and Christianity in Colonial Zimbabwe,” (PhD Thesis, Indiana University, 1991), 165.

¹¹⁰ Kathleen E. Sheldon, *Historical Dictionary of women in Sub-Saharan Africa* (Lanham: Scarecrow Press, 2005), 137. See also, Mary-Louise Martin, “The Mai Chaza Church in Rhodesia,” in *African Initiatives in Religion*, ed. David B. Barret (Nairobi, East African Publishing House, 1971), 109-121; Allan Anderson, *African reformation: African initiated Christianity in the 20th century* (Trenton: Africa World Press, 2001), 119; Rosalind I. J. Hackett, “Women and New Religious Movements in Africa,” in *Religion and Gender*, ed. Ursula King (Oxford: Blackwell Publishers, 1995), 257-290; and Timothy Scarnecchia, “Mai Chaza’s Guta re Jehova (City of God): healing, reproduction, and urban identity in an African Independent Church” *Journal of Southern African Studies* 23, no. 1 (1997): 87-105.

said to have deserted her regular doctor and now receives treatment at the Guta re Jehovah [sic].¹¹¹

Although the same NC reported in 1958 that Mai Chaza's sect, which had continued to function in the Zimunya Reserve and "on occasions...attracted large crowds of visitors seeking relief from physical ills," was "non-political" and caused "no harm," the government still wanted to suppress it.¹¹² Officials wanted to suppress the sect because it attracted "non-indigenous patients," probably Mozambicans from across the eastern border. Thus in 1959 the NC Umtali reported,

The "Guta ra Jehova" is quite clean and orderly, though measures had to be adopted to enforce the prohibition against non-indigenous patients contained in the agreement permitting this healing centre...All sorts of accusations have been levelled with a view to having the centre closed, but the latest, that Native foreigners *continue* to visit the "Guta" secretly appears on investigation to be completely false and neither Chief Zimunya nor his Council are prepared to recommend Mai Chaza's removal.¹¹³

In stark contrast to these multifaceted ways of delivering treatment in African society, colonial governments insisted on confining Africans in hospitals, which denied Africans one of their main approaches to diagnosis and treatment. For colonial officials, therefore, the main issue regarding African health services was whether Africans were to be treated under confinement in hospitals or treated on an out-patient basis. The Rhodesian Medical Director clearly favored the former, asserting,

The benefits of medical treatment in acute and dangerous illness are based on constant and not periodic medication, and though it may sound humanitarian and progressive policy to establish these local dispensaries and occasional visits from a doctor, the actual results from a medical point of view are not likely to be very great. The native who is to reap the benefits of this system, is still too

¹¹¹ Ibid.

¹¹² NAZ S2827/2/2/6: Annual Report of the Native Commissioner, Umtali, for the year ended 31st December, 1958.

¹¹³ NAZ S2827/2/2/7: Annual Report of the Native Commissioner, Umtali, for the year ended 31st December, 1959. Emphasis added.

primitive to take advantage of it: You cannot tell an ignorant native mother whose child is suffering from an acute and dangerous disease, that she is to give it a dose of the prescribed remedy every hour, for she does not know what an hour is, and cannot calculate the dose. I think it may be generally accepted that the maladies of indigenous and uneducated natives cannot satisfactorily be treated by European methods except under supervision, and preferably in hospitals.¹¹⁴

Unlike colonial governments, missionaries, in addition to treating Africans in their hospitals, also treated them in their local contexts. Missionaries realized that public health management should not be confined by the border as shown by their request to the Rhodesian government for vaccine to inoculate Mozambicans against influenza in 1918. They were willing to treat Africans in their local contexts by engaging in extensive cross-border work between in the Manica region. This also accounts for why missionaries were popular and effective in the region. Even when there was negligible government aid, as was the case in PEA, missionaries still engaged in cross-border work, treating Africans in local contexts. The American Board missionaries argued that in PEA, the need for government support was greater than in Rhodesia “because the natives [were] even poorer, [and] because of the additional expense of supplies due to costly transport and the heavy Portuguese customs super-imposed upon the Rhodesian ones.”¹¹⁵ However, they got very little assistance. The missionaries claimed that the only help they received from the Portuguese Government was the lymph used to administer about 150 vaccinations for small pox between 1933 and 1934, which the Mozambique Company agreed to pay for.¹¹⁶

¹¹⁴ NAZ, S1173/328-329: Medical Assistance to Indigenous Natives in Reserves, Medical Director, Southern Rhodesia, to The Secretary, Department of the Colonial Secretary, Southern Rhodesia, 9th June, 1927.

¹¹⁵ ABC 15.6, volume 2: Reports, 1930-1939—Medical Report, Gogoi, June 1930.

¹¹⁶ ABC 15.6, volume 2: Reports, 1930-1939—Gogoi Medical Report, June 1933—June 1934. Dr. W.T. Lawrence resigned from the American Board Mission in May, 1946. Mission secretary D.U. Marsh wrote to the Registrar of the medical Council of Southern Rhodesia in March 1946 informing him of the retirement of Dr. Lawrence. The Mission was unable to secure a doctor to replace him and this left its “native medical work of 50 years standing in a difficult

Yet, PEA still relied on missionaries in providing health services to rural Africans. The *Chefe* of the Mossurize district reported in 1933 that some Africans utilized the American Board Mission Hospital at Mount Selinda, “where they have a good American doctor and two or three nurses of the same nationality.”¹¹⁷ He also asserted that at the American Board satellite dispensary at the Bela Vista School in Gogoi, an American nurse gave good medical services.¹¹⁸ In addition, in 1935, the *Chefe* reported that medical assistance to indigenous people was provided by local Post Administrators who used ambulances to transport some African patients to the Mt. Selinda hospital.¹¹⁹ The American nurse probably encouraged patients to consult with her colleagues at Mt. Selinda, whereas the *Chefe* of the district disliked movement across the border. The missionaries at Mt. Selinda claimed that patients came from all directions and often traveled fifty or even a hundred miles in order to reach the hospital. A particular case was that of a young man who came from a village in Portuguese territory, fifty miles away from Mt. Selinda, suffering from a broken back and complete paralysis, the result of an accident in a mine shaft in Johannesburg, South Africa.¹²⁰

position.” Reference: National Archives of Zimbabwe File no. S2014/6/3: The American Board Mission, 1925-1947—Letter from D.U. Marsh, Secretary of the American Board Mission, Mount Selinda, to the Registrar of the Medical Council of Southern Rhodesia, March 30th, 1946.

¹¹⁷ AHM, FCM, Secretaria Geral—Relatórios: Report of the District of Mossurize—Health Services, 1933, box no. 265, file no. 5821.

¹¹⁸ Ibid.

¹¹⁹ AHM, FCM, Secretaria Geral—Relatórios: Report of the District of Mossurize for the Year 1935. Box no. 266.

¹²⁰ ABC 15.6, volume 9: Institutions—Mt Selinda Hospital, Annual Report, 1944. It was common for young men from P.E.A. to go to work in the South African mines, but this also shows the neglect that migrant miners faced from mining companies in South Africa. These mining companies simply sent the sick and injured back to their villages and recruit new healthy workers. This was particularly the case with those workers who contracted tuberculosis on the mines. See Packard, Randall M. *White plague, Black labour: Tuberculosis and the Political Economy of Health and Disease in South Africa*. Berkeley: University of California Press, 1989 and Susan Parnell, “Creating Racial Privilege: The Origins of South African Public Health and Town Planning Legislation,” *Journal of Southern African Studies*, 19 (1993) 471-488.

In the PEA therefore, just as in Rhodesia, rural health services were left to missionaries and these services were inadequate. The ideal solution, according the *Chefe*, was constructing a small ward for the indigenous people of Upper Mossurize in order to reduce the dependence on Mt. Selinda.¹²¹ The Mozambique Company finally established a clinic at Spungabera around 1940, two years before the Company ceased governing central Mozambique.

By the 1950s, there was only one hospital at Macequece.¹²² It catered mostly for the European population and Africans employed in public works. To the south, in the Mossurize district (with an estimated population of 38,183 Africans in 1938)¹²³, there was only one clinic at Spungabera and another at Chibabava. Some of the medical facilities were in the Mozambique Company's schools, serving as posts to distribute medicines.

As far as hospital treatment was concerned, interviews with Africans in the Manica region show that they preferred missionary hospitals. Many interviewees in Chipinge district said that if they ever had to visit a hospital, they preferred missionary to government hospitals because "hospitals like the Mt. Selinda Mission hospital had better conditions, particularly the way the nurses and white doctors treated Africans, as well as the provision of adequate food, clothing, and attention."¹²⁴ By contrast, according to some informants, the nurses and doctors in colonial hospitals "looked down upon Africans, particularly the poor and the old people."¹²⁵ These informants also asserted

¹²¹ AHM, FCM, Secretaria Geral—Relatórios: Report of the District of Mossurize for the Year 1935. Box no. 266.

¹²² AHM, FCM, Secretaria Geral—Relatórios, Macequece, August, 1904, Caixa 126, Pasta 26636.

¹²³ AHM, FCM, Secretaria Geral—Relatórios: Relatório da circunscrição de Mossurize referente ao Ano de 1938, Caixa 266.

¹²⁴ Interview, Days Hill, Chipinge District, Zimbabwe, December 13, 2006.

¹²⁵ Interview, Maengeni Village, Chipinge District, Zimbabwe, 14 January, 2007.

that hospital personnel used harsh language to Africans and in some cases, beat old people. This is supported by the Council of the Federation of Native Welfare Societies in Rhodesia which recommended in 1943 “that more sympathetic consideration be given to African patients by the staff employed in the [government] hospitals,” and “that general conditions existing in Native hospitals should be improved in order to ensure greater comfort and convenience for African patients.”¹²⁶ Standard medical practices were the same in both European and African wards, but African wards were poorly equipped to the extent that the whites, Indians and Coloreds (bi-racial people) did not want to be treated in African wards. Even the mission hospital at Mt. Selinda had separate wards for whites and Africans, but many informants said they received better care in mission than in government hospitals.

Conclusion

While the analysis of the provision of health services for Africans in Southern African has focused on economic imperatives such as the need for a healthy African labor force, this chapter has demonstrated that settler fears of disease also played a central role. This is true of the Manica region and it can also be applied to the entire Southern African region. The extension of colonial health services to Africans was thus informed by European settler fears and economic imperatives rather than the concern to improve African health as an end in itself. Because settlers perceived Africans as reservoirs of infection, they argued that the only way to safeguard their own health from the “infectious natives” was to treat disease in the Africans. The extension of health services in to Africans in the 1930s can thus be seen as the last line of defense against spread of

¹²⁶ NAZ S2803/FNWS/61 Internal Affairs-Hospitals, 22nd March 1943-22nd June 1950, Secretary for Native Affairs, to the Medical Director, Southern Rhodesia, 22nd March 1943.

disease to the settler community and the need for healthy African labor. As a result, public health policy and its modes of delivery failed to respond to African preferences.

While most Africans were hostile to intrusive public health campaigns, they were willing to experiment with the curative aspects of biomedicine, particularly out-patient treatment, which gave them a high degree of control over the healing process. Africans generally disliked confinement in hospitals which took away their ability to control the treatment process. However, colonial governments' insistence on hospitalization denied Africans one of their principal approaches to diagnosis and healing. Hence, some African patients taken out of their local social contexts to confinement in a distant hospital did not expect to get better. Practitioners on the ground, such as medical missionaries realized that public health management should extend beyond the border to reach out to Africans in their local contexts. This partially explains why they were popular among Africans.

African societies were thus open to innovation but the discriminatory nature and ineffectiveness of colonial medical services discouraged the adoption of biomedicine. Discrimination against Africans by medical personnel in government hospitals contributed to African distrust of biomedicine. The hospitals were highly segregated and Africans received second grade care while confined in these colonial hospitals. It is not surprising therefore, that Africans preferred treatment from medical missionaries, who usually distributed medicines and instructions on their use, leaving the whole treatment process in African hands. This preference of out-patient treatment still exists in both Mozambique and Zimbabwe, where the demand for antibiotics is high on the black market. Yet, physicians discourage this illicit trade in antibiotics, arguing that unsupervised of them would lead to resistance.

Finally, there were no efforts on the part of colonial governments to learn about African understandings of disease causation and healing. They simply dismissed African knowledge systems as dangerous superstition. As a result, colonial health programs interfered with African public health initiatives, such as rain-making and witch hunting.

The failure of these health initiatives to persuade Africans to embrace western medicine has to be seen in the light of all these interventions under colonial rule. African understandings of health and illness are still at play in the Manica region and indeed in the rest of Southern Africa, where some people are reluctant to accept biomedical explanations of HIV/AIDS.

CONCLUSION

One of the goals of colonialism was to “civilize” the colonized population of Africa and other continents. This also involved, among other things, the eradication of indigenous healing practices which colonial officials branded dangerous superstition. The aim was to replace local practices with Europe’s emerging biomedicine whose origins lay in the germ theory of disease. “Civilizing” Africans meant that Africans had to relinquish “superstitious healing practices” and embrace biomedicine which conformed with the Western civilization which Europeans brought to Southern Africa. Colonial regimes therefore embarked on campaigns to repress and eradicate indigenous healing practices through legislation and public health policies. Missionaries also perceived traditional medicine as a hindrance to their efforts to spread Christianity. They too denounced it as superstition.

However, after ninety years of colonial rule in Zimbabwe and eighty-five years of colonial rule in Mozambique, Africans of the Manica region still consult traditional healers. They never embraced western biomedicine. Even some Christians who were supposed to have castigated traditional medicine, which is tied to ancestral worship, still consult traditional healers when they think nobody is watching. James L. Cox argues that although over half over of Zimbabwe’s population adheres to some form of Christianity, “religious allegiances are flexible.”¹ He asserts many “who call themselves Christians join mainline Christian denominations but continue to consult traditional religious practitioners, participate in rituals prescribed by the practitioners,” and if necessary, “seek the mediation of prophets in African Initiated (Independent) Churches.”²

¹ James L. Cox, “Characteristics of African indigenous religions in contemporary Zimbabwe,” in *Indigenous Religions: A companion*, ed. Graham Harvey (London: Cassell, 2000), 230-242.

² Ibid.

Colonial public health programs and their modes of delivery failed to convince Africans of the efficacy of biomedicine. This dissertation investigated what went wrong with the colonial health initiative by examining this failure through the lens of public health policy. It has raised the question of whether colonial public health programs and their modes of delivery failed because they did not respond to African preferences.

Several reasons contributed to this failure of colonial public health to persuade Africans to embrace biomedicine. The border, which itself was created by colonial powers, became a major obstacle to the implementation of comprehensive regional public health programs. Although the border was drawn along the crest of the Vumba and Chimanimani mountains, it still arbitrarily divided a region which shares similar environmental and epidemiological characteristics. It also divided people of common origins. Thus cross-border movements had implications on the epidemiology of infectious and communicable diseases.

In the case of diseases such as trypanosomiasis, the border prevented the continuation of the forms of transhumance which had contributed to protecting cattle. In Mozambique, where Portuguese officials subjected Africans to forced labor, the border also served to increase dependence on migrant labor to South Africa, because Africans could not freely seek employment or trading opportunities in Zimbabwe. Tsetse fly and trypanosomiasis control measures therefore disrupted the African way of life. These public health and veterinary measures ultimately led to African distrust of western biomedicine.

Similarly, European attitudes towards Africans affected the formulation and implementation of public health policies in the region. Erroneous views on the epidemiology of STDs by the settler community resulted in the adoption of discriminatory public health practices that affected the way Africans perceived western medicine. The colonial governments singled out Africans for intrusive medical examination as a result of unfounded and highly exaggerated settler fears and economic

considerations. This is an important theme that runs through this dissertation. These white settler fears often based on erroneous epidemiology led to the implementation of invasive and discriminatory public health measures. Though ineffective, these policies caused hardship among Africans, from villagers, cattle keepers, town dwellers, to local and foreign labor migrants. Public pressure from white settler, particularly in Rhodesia, compelled public health officials to enforce intrusive public health policies, which contributed to African distrust of western biomedicine. Settler fears of infection in Rhodesia were amplified by the imagination of the border, which engendered fear of an unfamiliar “other territory” (PEA), which in reality was not far away.

While there are many other factors that discourage Africans from western medicine, such as its high cost, invasive and discriminatory colonial public health policies are at the center of this reluctance in some circles of the African society. This is particularly so for the illiterate and less educated country folks. For many of these people, their first encounter with western medicine was through these compulsory and intrusive public health campaigns, such as smallpox vaccinations. What made the experience worse was that colonial officials did little to teach or explain what they were doing to Africans. The colonial mentality dictated that these colonial officials just tell Africans they had to submit to public health measures because they were good for them. It is not surprising therefore, that when Africans think of colonial public health, they often link it to oppression. Thus resistance to colonial public health policy and its modes of delivery became part of the general resistance to colonial domination.

Hence this dissertation has broad ramifications for the understanding of resistance to colonial rule, not only in the Manica region, but in the entire Southern African region. It goes beyond a narrow explanation of resistance against colonialism as one confined to political issues because for some Africans, particularly the *Mapostori* (Apostolics), public health policies and intrusion of health and healing became the most important grievances against colonial rule and the most important source of resistance. This is an aspect of

decolonization that has been obscured by nationalism, which sought to cast anti-colonialism as purely a political matter. Nationalism, in turn, served powerfully to legitimize post-colonial states, and to further legitimize their continued intrusion into matters of disease, health, and healing.

Through the examination of public health policy on STDs, this dissertation also shows the ineffectiveness and impact of public health in a colonial, undemocratic setting. It suggests that public pressure in a colonial and profoundly undemocratic setting could lead to the institution of bogus public health measures, which ultimately contributed to African dislike of western biomedicine.

The social memory of colonial public health measures still shapes attitudes to western biomedicine today. While public health measures are bound to incite resistance wherever they are implemented, the Manica region was unusual because of colonial rule and racial discrimination that accompanied it. Although some colonial officials argued that public health measures were implemented to benefit Africans, this dissertation demonstrates that the primary motive behind public health policy was settler health, not African health. If colonial officials were concerned with the health of Africans, they would have invested some time to learn about African understandings of disease and health.

When some of these Africans look back, they feel that their traditional medicines were effective in dealing with number of disease present before colonial rule. They may not have invented the germ-theory of disease, but certainly knew how to control the disease of the colonial period. Thus attempts to suppress traditional medicine, instead to promoting allegiance to western medicine, had the opposite effect. These attempts created a longing for the ways of old that some people still think worked well. In the face of the incurable HIV/AIDS pandemic today, these longings and desperate efforts to find cures serve to further alienate some people from western biomedicine.

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