

**Robert A. Askins and healthcare reform
in interwar colonial Zimbabwe:
The influence of British and trans-territorial colonial models**

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Abstract

Significant reforms of national healthcare systems took place across African colonies during the interwar period. These reforms were driven by changing notions of colonial governance, public health, and medical science and its various methods and imperatives of care. Although necessitated by local colonial concerns, connections between these schemes and other metropolitan and trans-imperial models are being uncovered, with an increasing number of historians underscoring complex international histories of interweaving models. This article plugs into this burgeoning research niche by unveiling a new case study, colonial Zimbabwe's medical units scheme, a rural district healthcare initiative that was formulated in 1930 by Robert A. Askins, the colonial medical director and former medical officer of health in Bristol. This case study is used to demonstrate the ways in which local colonial healthcare policies evolved in contexts of entanglements and transfer of ideas within and across colonies and empires. That said, individual colonial agents and their departments were responsible for pulling together all the disparate ideas and models into cohesive national colonial policies that simultaneously modernised and subjugated African society.

Keywords: healthcare reform; colonial Zimbabwe; British Empire; imperial models; Askins; medical units.

Opsomming

Beduidende hervormings in die nasionale gesondheidsisteme het gedurende die tussenoorlogse periode regoor kolonies in Afrika plaasgevind. Hierdie hervormings is gedryf deur vinnig-veranderende opvattinge oor koloniale regering, openbare gesondheid en die mediese wetenskap, asook die onderskeie metodes en noodsaaklikhede van versorging. Alhoewel geïnspireer deur plaaslike koloniale sake, word konneksies tussen hierdie skemas en ander metropolitaanse en trans-imperiale

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modelle toenemend ontbloom; met meer en meer historici wat die komplekse internasionale geskiedenis van interverweefde modelle beklemtoon. Hierdie artikel dra by tot hierdie ontwikkelende navorsingsveld deur die onthulling van 'n nuwe gevallestudie, koloniale Zimbabwe se mediese eenheidskemas, 'n landelike distriksgesondheidskema wat in 1930 geformuleer is deur Robert A. Askins, die koloniale gesondheidsdirekteur en voormalige gesondheidsbeampte van Bristol. Hierdie gevallestudie word gebruik om die maniere waarop plaaslike gesondheidsbeleide ontwikkel het in kontekste van verstrengeling en die oordrag van idees binne en oor kolonies en ryke. Nietemin, individuele koloniale agente en hul departemente was verantwoordelik vir die sametrekking van al die verskillende idees en modelle in samehangende nasionale koloniale beleide wat die Afrika samelewing beide gemoderniseer en onderwerp het.

Sleutelwoorde: gesondheidsorghervorming; koloniale Zimbabwe; Britse ryk; imperial modelle; Askins; mediese eenhede.

Introduction

This article examines the form and context of rural healthcare policy reform in interwar colonial Zimbabwe, shedding light on the web of inter-imperial influences and models that the leading reformer, Robert A. Askins, the then medical director, drew from. Of late, increasing numbers of scholars from various disciplines have been grappling with the transnational histories of colonial-era initiatives, tracing the flow of ideas and models within and across empires and colonies, through both official and non-official circuits and conduits.¹ In their edited collection, *Tensions of Empire*, Frederick Cooper and Ann L. Stoler call compellingly for attention to the seminal connections “between metropole and colony” because the two sites co-influenced each other in major ways.² In *Decentring Empire*, Dhruba Ghosh and Dane Kennedy make a case for an even wider panorama that considers these relationships not merely in their bilateral circuits but in the wider webs of transnational networks.³ Case studies have also demonstrated the centrality of transnational, personal and regional connections in the transfer of techno-scientific ideas and models.⁴ Indicative

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1. A.L. Stoler and F. Cooper, “Between Metropole and Colony: Rethinking a Research Agenda”, in F. Cooper and A.L. Stoler (eds), *Tensions of Empire: Colonial Cultures in a Bourgeois World* (University of California Press, Berkeley and Los Angeles, 1997); D. Ghosh and D. Kennedy, “Introduction”, in D. Ghosh and D. Kennedy (eds), *Decentring Empire: Britain, India and the Transcolonial World* (Orient Longman, New Delhi, 2006); K. Trumpener, *Bardic Nationalism: The Romantic Novel and the British Empire* (Princeton University Press, Princeton: NJ, 1997).
 2. Stoler and Cooper, “Between Metropole and Colony”, p 15.
 3. Ghosh and Kennedy, *Decentring Empire*, p 2.
 4. M. Aso, “The Scientist, the Governor and the Planter: The Political Economy of Agricultural Knowledge in Indochina during the Creation of a ‘Science of Rubber’”, *East Asian Science, Technology and Society*, 3, 2/3 (2009), pp 231–256.

of a broader shift in scholarship, these works have contributed to revamping our understanding of imperial-colonial connections by foregrounding the non-formal, but extremely important conduits and circuits which fostered the transfer, replication and adaptation of ideas and techniques across imperial networks.

While it is correct to ascribe colonial healthcare reforms to local considerations, historians of colonial healthcare systems have also started giving prominent attention to the transnational and entangled nature of healthcare reforms. Although it is true that colonial reforms were contemplated as responses to volatile local epidemiological conditions that undermined artificial racial divides severely, affected labour productivity negatively and threatened the colonial project,⁵ it is also true that the reforms proposed to counter this menace bore broader influences. Prominent historians of interwar healthcare reform in both imperial Europe and colonial Africa have begun to show that the ostensibly country-specific models actually benefited from trans-national exchanges and borrowed ideas.⁶ Indeed, as Ilana Lowy reminds us, “investigations limited to developments in a single country may fail to cover all the ways medicine is embedded in a larger social context”.⁷ Seeing that the reforms in question took place almost simultaneously across the various European colonies in Africa, solely local-bound explanations give an incomplete picture of colonial healthcare reform.

This article plugs into this burgeoning research seam by unveiling a new case study, colonial Zimbabwe’s medical units scheme, a rural district healthcare initiative that was formulated in 1930 by Askins, the colonial Medical Director (1930–1935) of

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5. Examples include, D. Arnold, “Medicine and Colonialism”, in W.F. Bynum and R. Porter (eds), *Companion Encyclopaedia of the History of Medicine* (Routledge, London and New York, 1993); J. Iliffe, *East African Doctors: A History of the Profession* (Cambridge University Press, Cambridge 1998); S. Doyle, “Population Decline and Delayed Recovery in Bunyoro”, *Journal of African History*, 41, 3 (2000), pp 429–58; M. Gelfand, *A Service to the Sick: A History of the Health Services for Africans in Southern Rhodesia, 1890–1953* (Mambo Press, Gwelo, 1976); W.M. Macmillan, *Africa Emergent: A Survey of Social, Economic and Political Trends in British Africa* (Harmondsworth, Penguin, 1949); O. Olumwullah, *Disease in the Colonial State: Medicine, Society and Change among the AbaNyole of Western Kenya* (Greenwood Press, Westpoint, 2002); G.O. Ndege, *Health, State and Society in Kenya* (University of Rochester Press, New York, 2001).
 6. See for example, S. Marks, “Common Sense or Utopian Dream?, Part I, South Africa’s Practice of Social Medicine, 1940–1955 in Transnational Perspective”, Paper presented at History of Health in Africa Conference, Basel, 12–14 September 2011; A. Digby, “Vision and Vested Interests: National Health Service Reform in South Africa and Britain in the 1940s and beyond”, *Social History of Medicine*, 21, 3 (2008), pp 485–502; P. Weindling, “Health and Medicine in Interwar Europe”, in R. Cooter and J. Pickstone (eds), *Companion Encyclopaedia to Medicine in the Twentieth Century* (Routledge, London and New York, 2003).
 7. I. Lowy, “The Social History of Medicine: Beyond the Local”, *Social History of Medicine*, 20, 3 (2007), p 466.

the time. Askins was also a former Medical Officer of Health (MOH) for the city of Bristol. I use this case to illustrate the ways in which local colonial healthcare policies evolved in contexts of transfer of ideas within and across colonies and empires. That said, the article will also underscore the fact that individual colonial agents and their departments were responsible for pulling together all the disparate ideas and models into cohesive national colonial policies that were designed for the care and control of African society.

The article draws from a relatively rich body of archival evidence from the United Kingdom and Zimbabwe. Although there are regrettable gaps – especially in relation to Askins’s own personal papers – the accessible sources indicate convincingly that in formulating the medical units scheme, Askins was influenced by borrowed ideas and models pioneered in other dominions and colonies such as the Union of South Africa, French West Africa and the Belgian Congo. He was also apparently influenced by district health care delivery models that were being tried out in south-west England where he had spent much of his adult and professional life before coming to Southern Rhodesia in 1930.

Arguably, therefore, colonial healthcare concepts did not merely flow in bilateral circuits from metropole to colony in a linear fashion. Instead, they travelled along and across imperial and colonial networks that formed the main sinews of the colonial world. Among other things, this is underscored by the presence and open reference to French West African policies in Askins’s policy documents. The web of borrowings is what Samuel Coghe has referred to innovatively as “inter-imperial learning”.⁸

Historical assessments based on case studies of developments such as this one are called for because they illuminate the ways in which colonial policy formulation took place through individual and bureaucratic agency in an increasingly interconnected world of the twentieth century. In time, such cases studies can help to connect the dots that help to uncover the role played by ideas from the periphery in influencing key developments in the metropole.⁹ This article focuses on the policy formulation stages rather than on the actual implementation of the policy. Although the latter would shed light on how the scheme functioned in reality, the richness of that stage requires an entirely separate article.

Askins and healthcare reform since 1930

In 1929, when Southern Rhodesian government officials began to search for a new medical director to replace the colony’s inaugural incumbent, Andrew Milroy

8. S. Coghe, “Inter-imperial Learning and African Healthcare in Portuguese Angola in the Interwar Period’, *Social History of Medicine*, 28, 1 (2014), 134–154.

9. An example of historical work that adopts a global history approach to illustrate the influence of a peripheral region, see M. Espinosa, “Globalizing the History of Disease, Medicine, and Public Health in Latin America’, *Isis*, 104, 4 (2013), 798–806.

Fleming, who was retiring after 33 years at the helm, they cast the net wide. Although the colony had several senior contenders for the post, some of whom had acted as medical directors during Fleming's absences, an outsider, Robert A. Askins, landed the post. The then colonial secretary, William M. Leggate, was keen to appoint a candidate with new ideas on how to take the colony's health care sector forward. Leggate had tried unsuccessfully to encourage Fleming to work out a programme akin to a national health service that would encompass the entire colony.

Although he lacked colonial experience, Askins was not an inferior candidate. Born in 1880 in Clonmore, Ireland, he studied medicine at Trinity College, Dublin, where he graduated with first class Bachelor of Medicine and Surgery honours in 1907. Later, he earned a Cambridge Diploma in Public Health (1912) and the degrees of MA and MD (1913), again in Dublin.¹⁰ After a brief stint as assistant medical officer of health for Merthyr Tydfil, in 1909 he became assistant MOH to the Lancashire Education Committee – a position he held until 1914.¹¹ Thereafter, the Bristol Education Committee appointed him as the first substantive schools' medical officer, a position he held together with other key portfolios in the city's public health sector, until 1930. During World War I, he served as specialist sanitary officer. In 1917, he had also enrolled for law studies, and in 1920 was admitted to the Bar at Gray's Inn, a necessary qualification for someone with an interest in public health.¹²

In 1924, Askins was appointed to deputise for D.S. Davies, the MOH for both the city of Bristol and the county. Upon Davies' retirement in 1928, he was appointed unanimously to that top vacant position, which included being the medical officer of the port authority. In that same year, he was selected as lecturer-in-charge of teaching the discipline of Public Health at Bristol University.¹³ He also continued with his appointment as medical officer of schools. An active member of the British Medical Association and the Society for the Medical Officers of Health,¹⁴ Askins held all these demanding appointments simultaneously up to May 1930 when he left

10. "Obituary, R.A. Askins", *The British Medical Journal*, 21 December 1935, p 1235.

11. "Obituary, R.A. Askins", *British Medical Journal*, 21 December 1935, p 1235.

12. "A Passenger Missing", *The Times*, 5 September 1935, p 9; *The Times*, 2 November 1917, Digital Archive, 1785–1985, Accessed from Bristol Records Office, May 2010.

13. "A Passenger Missing", *The Times*, 5 September 1935, p 9.

14. In 1922, when the West of England branch of the Society of Medical Officers of Health formed a Schools' Medical sub-group, Askins agreed to act as temporary secretary. In October 1924, he was elected as president. In 1922, the branch had 78 members. See "Society of Medical Officers of Health, West of England Branch Meeting Report", *Public Health: The Journal of the Society of Medical Officers of Health*, 37, 3 (December 1924), p 95; Society of Medical Officers of Health, "Notes from Branches: West of England Branch", *Public Health: The Journal of the Society of Medical Officers of Health*, 36, 3 (December 1922), p 103.

Britain after accepting an appointment by Southern Rhodesia as the colony's chief medical bureaucrat.¹⁵

Askins distinguished himself quickly from his dithering predecessor, Fleming, making the control and eventual eradication of the colony's rural diseases a priority of his administration from the outset.¹⁶ This he sought to accomplish through the systematic establishment of hospitals and dispensaries countrywide and the deployment of hierarchies of trained medical staff in rural areas. He thus set out to initiate a rural medical service scheme organised around the innovative model of district medical units.¹⁷

Fleming had bequeathed to him only seven state-run venereal diseases dispensaries, one rural hospital for Africans, and five subsidised missionary dispensaries, for an estimated African population of 1 080 000.¹⁸ In 1930 state dispensaries had treated only 4 359 patients, mainly for venereal diseases.¹⁹ Recognising the inadequacy of these services, on 8 September 1930 (that is, just over a month after his assumption of duty) Askins produced the first draft of his ideas on rural healthcare, spelling out how he planned to proceed. Entitled "Preliminary Report on the Treatment of Natives",²⁰ the draft dealt extensively with this challenging subject, one which was occupying the energies of interwar reformers across the continent.

Making a case for reform, Askins argued – perhaps very much in common with other colonial officials – that the colony was threatened by the many diseases that occurred in endemic and epidemic forms among African communities. In his view, these diseases had to be controlled because of their "liability to spread to Europeans" and the "unnecessary destruction of life and lowering of health" experienced by Africans as a result of these menacing maladies.²¹ He emphasised the danger of such infection being "conveyed to European households by natives who had the disease

15. Bristol Records Office, City and County of Bristol, *Annual Report of the Medical Officer of Health for the Year Ended 31 December 1930*, p 5.

16. National Archives of Zimbabwe (hereafter NAZ), Southern Rhodesia, *Report on the Public Health for the Year 1930* (Government Printer, Salisbury, 1931), p 19.

17. NAZ, S1173/336, Scheme for the Medical Treatment of Natives, Training of Native Orderlies, R.A. Askins, "Preliminary Report on the Treatment of Natives", 8 September 1930.

18. This number was based on estimates because the first African census was only conducted in 1962. See R. Marindo, "Death Colonised: Historical Adult Mortality in Rhodesia", *Zambezia*, 26, 2 (1999), p 148.

19. NAZ, Southern Rhodesia, *Report on the Public Health for the Year 1930*, p 20; Editorial, "Medical Services for Natives: Dr Askins' Views", *Journal of Medical Association of South Africa*, 11 (April 1931), p 224.

20. NAZ, S1173/336, Askins, "Preliminary Report on the Treatment of Natives", 8 September 1930.

21. NAZ, S1173/336, Askins, "Preliminary Report on the Treatment of Natives", p 1.

and carrying the infection, though to all outward appearances perfectly well'.²² This line of thought was elaborated in his first substantive *Annual Report* as the colony's chief medical officer, in which he asserted that:

The native is the reservoir of infective tropical disease, from which the European and his family is subject to invasion. Unfortunately the native carrier is commonly a perfectly healthy looking individual, so that the European may not have the opportunity of realising until too late the danger to which he is being subjected.²³

Askins listed and discussed a list of diseases that he considered to be a threat to the colony. With regard to syphilis, a highly dreaded disease that fuelled discourses of Black Peril,²⁴ Askins averred that although it was spread "almost entirely through the medium of sexual intercourse", it was nonetheless "undesirable from an aesthetic point of view that there should be the risk of native boys being in European houses whilst they are suffering from this disease".²⁵ In addition to syphilis, he also blamed malaria for a "large amount of death, and a lowering of health amongst the European population in the rural districts".²⁶ He condemned Africans for spreading this disease to the white population, maintaining that "malaria is a disease which is largely carrier borne by natives who are apparently healthy".²⁷

Moreover, he noted that African "carriers" also transmitted amoebic and bacillary dysentery, both of which were, in his opinion, "endemic amongst the natives of Southern Rhodesia", to the "unsuspecting" European "victims".²⁸ Extending his list of the menacing "native" diseases, he listed bilharzia (which he said infected six per cent of European children), cerebro-spinal meningitis, and sleeping sickness as some of the endemic diseases that were frequently transmitted to Europeans by Africans. Curiously, Askins disputed the emerging view that big game was to blame for the spread of sleeping sickness. Instead, he blamed Africans for being the "cause of the [sleeping sickness] disease that remained endemic in the colony".²⁹ As he warned in his official *Annual Report* for 1930, this danger tended to increase because the colony was "becoming more closely settled by Europeans".³⁰ In addition, he argued, "all our dysentery comes from native carriers".³¹

22. NAZ, S1173/336, Askins, "Preliminary Report on the Treatment of Natives", p 1.

23. Southern Rhodesia, *Report on the Public Health for the Year 1930*, p 19.

24. For more on this, see J. McCulloch, *Black Peril, White Virtue: Sexual Crime in Southern Rhodesia, 1902–1935* (Indiana University Press, Bloomington, 2000).

25. NAZ, S1173/336, Askins, "Preliminary Report on the Treatment of Natives", p 3.

26. NAZ, S1173/336, Askins, "Preliminary Report on the Treatment of Natives", p 3.

27. NAZ, S1173/336, Askins, "Preliminary Report on the Treatment of Natives", p 3.

28. NAZ, S1173/336, Askins, "Preliminary Report on the Treatment of Natives", p 3.

29. NAZ, S1173/336, Askins, "Preliminary Report on the Treatment of Natives", p 3.

30. Southern Rhodesia, *Report on the Public Health for the Year 1931*, p 19.

31. Editorial, "Jottings from the Recent Sitting of the Advisory Board of Native Development", *Native Mirror*, 1 January 1931, p 23.

Clearly, Askins's ideas were based on the prejudicial perceptions and faulty knowledge of the time. The renewed focus on the rural epidemiological arena was premised on the faulty reasoning that civilisation had driven diseases away from urban areas and that most of the remaining scourges were rural and, by extension, African.³² To buttress his ideas he cited evidence produced by the London School of Hygiene and Tropical Medicine field researchers who had been doing their work in the colony from 1925.³³ However, he also relied on his own observations and the opinions of other (mainly white) observers he met during his initial tour of the colony.³⁴ Askins was concerned that the colony's healthcare infrastructure was virtually non-existent in rural areas, a situation that created dangerous social and geographical inequalities in health and healthcare provision.

While acknowledging that Africans in townships and mining compounds had "ample" access to medical facilities, and that subsidised mission medical stations and a few state-owned dispensaries catered for some rural areas, he did not consider this nearly enough. In his own words, "excellent as the above institutions are, a careful examination of the position makes it clear that only a small proportion of the native population are at present receiving medical treatment, and that the great majority are devoid of such care".³⁵ He therefore wanted more to be done, and his reference to the excellence of these services could have been out of respect for his associates.

He also viewed the existing approach to rural health care as being narrow in the sense that there was too much focus on a single disease, mainly syphilis. His alternative view was that the health of Africans had to be "considered as a whole, and that establishing separate clinics for individual ailments, such as venereal diseases, should be avoided".³⁶ He proposed the adoption of systematic planning and the comprehensive development of rural medical services. As he said in a note to E.G. Howman, the superintendent of "natives" in the Fort Victoria district, "I feel that some kind of definite policy is essential ... a common policy [should be] worked out for the entire country".³⁷

Moreover, he emphasised that it was "most essential that a policy be framed and adopted which will have in view the definite object of reducing, and ultimately eradicating these diseases which are endemic among the native population".³⁸ He also registered his strong feeling that the health needs of the Africans should be dealt with, "not haphazardly but by a comprehensive scheme for the entire colony",³⁹ since

32. Southern Rhodesia, *Report on the Public Health for the Year 1932*, p 8.

33. NAZ, S1173/336, Askins, "Preliminary Report on the Treatment of Natives", p 3.

34. Editorial, "Jottings from the Recent Sitting of the Advisory Board of Native Development", *Native Mirror*, 1 January 1931, p 23.

35. Southern Rhodesia, *Report on the Public Health for the Year 1931*, p 19.

36. Southern Rhodesia, *Report on the Public Health for the Year 1931*, p 20.

37. NAZ, S1173/336, Medical Treatment Scheme for Natives, 1930–1931, R.A. Askins to E.G. Howman, 15 September 1930.

38. Southern Rhodesia, *Report on the Public Health for the Year 1930*, p 19.

39. NAZ, S1173/336, Askins, "Preliminary Report on the Treatment of Natives", p 3.

there was “no reason whatsoever why malaria, dysentery, pneumonia and everything else should not be treated together”.⁴⁰ For him, therefore, whatever method of medical care was adopted, the health of the African was to be considered in its entirety and not piecemeal.

The thrust of his new policy approach was encapsulated in his eight-point proposal, which stated that:

1. The health of the African people and the many diseases from which they suffered “should be considered as a whole” and that the establishment of clinics for individual diseases “should be avoided”.
2. The country should be mapped out into sizeable districts and medical units should be established in these districts gradually and as circumstances (financial and logistical) of the colony permitted.
3. Each medical unit should consist of a central hospital “of the simplest possible type”, with African patients dwelling “as far as is possible” in huts and under conditions resembling their home life “as closely as is consistent with efficiency”. To such a hospital a European government medical officer should be appointed, with a small cohort of European nursing staff, but the greater part of the nursing was to be carried out by trained African orderlies.
4. Up to six dispensaries should be “attached” to each central hospital. They were to be positioned at a maximum distance of fifty miles by road from the hospital. Like the main hospital, these dispensaries were also to be of simple construction, and to be staffed by trained African nursing staff and directly supervised and visited by the central hospital medical officer at regular intervals, once every week or every ten days.
5. African men and women should be trained as orderlies and midwives in government hospitals before being deployed to serve in these medical units. They were to be Africans of “known character”, with an education of up to Standard VI or as close to that benchmark as possible. These African medical aids were to complete a course in hygiene as part of their instruction, and would be expected to visit rural homesteads as part of their duties.
6. The new scheme should take advantage of existing hospitals and use them as springboards for beginning such work in the districts where they were found.
7. The scheme should be managed in close cooperation with the Native Affairs Department and other departments dealing with Africans.
8. Wherever possible, the African concerned should bear the cost of his/her medical care.⁴¹

40. Editorial, “Jottings from the Recent Sitting of the Advisory Board of Native Development”, *Native Mirror*, 1 January 1931, p 23.

41. NAZ, S1173/336, Askins, “Preliminary Report on the Treatment of Natives”, p 3.

Although not the first proposal on rural healthcare, this plan – which became known as the “medical units scheme” – was the first comprehensive initiative for the development of rural district medical system for Africans to be made by a medical bureaucrat in the colony. At the dawn of the second decade of the century, Fleming’s dithering administration had been forced to come up with a rural dispensaries initiative. These dispensaries were not replicated or expanded across the colony. The reasons for this failure included, among other things, the fact that it was dependent on the patronage and enthusiasm of the native commissioners, the rural civil administrative arm of the state, and not health professionals in the Public Health Department.⁴² It appears at times that Fleming felt Africans were still too primitive to appreciate the benefits of medical care.

Although building on earlier work, Askins’s scheme was a departure from the norm. Its declared objectives included addressing the disparities in healthcare; the reduction and ultimate eradication of endemic diseases among rural Africans; the prevention of disease through early treatment; the safeguarding of whites against infectious “native” diseases; the promotion of biomedical precepts among Africans; and the securing of colonial development in general.⁴³ The initiative was to be tried initially by means of a pilot scheme before being replicated across the colony.

Generally speaking, the colonial officials welcomed the scheme. The chief native commissioner at the time, Col. Clive Lancaster Carbutt, was positive about the proposition and the difference it might make. At a Native Affairs Conference held in Victoria Falls in June 1931, and attended by officials from Southern Rhodesia’s neighbouring colonies, Carbutt noted:

There has not been, until recently, any defined policy for the development of medical services for Natives; but within the last two years the Medical Director [Askins] for the colony has evolved a definite scheme of development which will result in the gradual establishment of a chain of Native Hospitals throughout the colony, with a number of clinics attached to each hospital.⁴⁴

An earlier sitting of the Advisory Board of Native Development passed a resolution that:

This Advisory Board, having heard with great pleasure and satisfaction the suggestions for the formulation of a definite scheme for medical services for the Natives of this country laid before it by the Medical Director, signifies its whole

42. For more on these early efforts, see G. Ncube, “‘The Problem of the Health of the Native’: Colonial Rule and the Rural African Healthcare Question in Zimbabwe, 1890s to 1930”, *South African Historical Journal*, 64, 4 (2012), pp 807–826.

43. NAZ, S1173/336, Askins, “Preliminary Report on the Treatment of Natives”, pp 1–3; Southern Rhodesia, *Report on the Public Health for the Year 1930*, p 19.

44. UK National Archives (hereafter UKNA), DO 35/389/10, Minutes of the Natives Affairs Conference, Victoria Falls, June 1931.

hearted approval of such a scheme which it feels can but greatly benefit both black and white races alike.⁴⁵

The scheme was not only potentially transformative because it set out, for the first time, to provide rural medical services in a systematic way, but also because it sought to transfer the actual running of the few existing makeshift rural dispensaries from the firm grip of the Native Affairs Department officials to a district healthcare team consisting of a medical officer and medical assistants.⁴⁶ However, the free assistance of Native Affairs officials was still desperately required in the rolling out of such a medical service, especially with regard to the mapping of districts and making arrangements for initial construction. Although initially some native commissioners protested against the scheme because the status quo had offered them opportunities for wider social control of their districts, the matter was resolved when the chief native commissioner instructed them to cooperate “in every way which will lead to the Natives gaining the benefit of qualified and skilled treatment”.⁴⁷

As a new model for delivering rural medical services, the advent of the medical units scheme was indicative of several things. Firstly, Askins’s arrival signalled the beginning of a new focus on the district as the primary zone for rural public health intervention, and hierarchical regionalism would be the new focus henceforth. Secondly, there was a discernible shift of focus from individual maladies to a group of endemic rural diseases. Thirdly, the concept received inspiration from emerging British and other colonial African models of health care delivery. Thus, as elaborated below, Askins’s 1930 reforms should be understood as a local adaptation of a cluster of circulating ideas and models of healthcare that were generally characteristic of developments in the interwar years.

Reform as individual initiative in a broader context

Given the fact that different sections of colonial society had been advocating for the extension of medical services in rural areas as illustrated elsewhere,⁴⁸ it is possible to view this new policy thrust as a direct outcome of such internal advocacy. Moreover, because during his initial tour of the colony as the medical director, Askins had been requested, primarily by white settlers, to set up clinics for the control of venereal diseases, Askins’s initiative can be seen in that context as an answer to these internal anxieties and appeals.

45. Editorial, “Jottings from the Recent Sitting of the Advisory Board of Native Development”, *Native Mirror*, 1 January 1931, p 23.

46. Southern Rhodesia, *Report on the Public Health for the Year 1930*, p 20.

47. NAZ, S138/56, Native Dispensaries, 1924–1933, Medical Director to Acting Native Commissioner, Bikita, 2 April 1933; Medical Director to Chief Native Commissioner, 5 May 1933; Chief Native Commissioner to Superintendent of Natives, Fort Victoria, 30 May 1933.

48. Ncube, “The Problem of the Health of the Native”.

Indeed, there was continuing direct pressure from missionaries and the Advisory Board of Native Development, which comprised missionaries, native affairs officials, and such individuals as the “outspoken negrophile”, F.L. Hadfield, the founder of the *Native Mirror* – an African-oriented newspaper run by white liberals.⁴⁹ Some of the Advisory Board’s members went to the extent of encouraging Askins to motivate for the establishment of a separate division of African medical services, which would be a sub-department of the main department, and through which efforts focused on African healthcare could be orchestrated and channelled.⁵⁰ In addition, Leggate had communicated government readiness to reform healthcare as early as 1929, so it can be assumed that Askins was just tapping into these ripe conditions.

However, looking at Askins’s new policy thrust from this angle alone is rather limiting because it gives only a partial picture of the issues involved. Firstly, as will be elaborated a little later in the article, there are very strong indications that Askins was personally interested in such reform because it was an issue of international and broader colonial concern. Even if we allow for differences in leadership between him and his predecessor, had Askins not been personally interested in such reform, the existing pressure for change would not have produced positive results within such a short space of time. Secondly, by September 1930 when Askins proposed his reforms, the colony’s political economy had changed radically because of the Great Depression. The depression had led to a precipitous decline in national income, thrown many white settlers out of employment, condemned many into virtual indigents and caused serious agitation over the “tepid” Moffat government’s uninspiring handling of the crisis.⁵¹ In addition to postponing the planned “native development” projects, the colonial Treasury was looking for ways of balancing its books on the backs of African commodity producers and taxpayers, hence the introduction of new levies and control laws (such as the Maize Control Act) and the surreptitious debiting of the Native Development account.⁵²

The implication was that although Leggate had indicated the availability of funds for healthcare development in 1929, by mid-1930 the position had altered markedly. Arguably, Askins’s emphasis on what appeared to be a simple – and therefore cheap – scheme to address some important and urgent programmes was a

49. L. Gann, quoted in T. Ranger, *Bulawayo Burning: The Social History of a Southern African City, 1893–1960* (James Currey and Weaver Press, Suffolk and Harare, 2010), p 109; Editorial, “Jottings from the Recent Sitting of the Advisory Board of Native Development”, *Native Mirror*, 1 January 1931, p 23.

50. Editorial, ‘Jottings from the Recent Sitting of the Advisory Board of Native Development’, *Native Mirror*, 1 January 1931, p 23.

51. I. Phimister, *An Economic and Social History of Zimbabwe, 1890–1948: Capital Accumulation and Class Struggle* (Longman, London and New York, 1988), pp 171–173.

52. Phimister, *An Economic and Social History of Zimbabwe*, pp 183–184; C.F. Keyter, *Maize Control in Southern Rhodesia, 1931–1941: The African Contribution to White Survival* (Central Africa Historical Association, Salisbury, 1978).

necessary strategy if he entertained any hope of being listened to by a government that was presiding over what was its worst economic crisis to date. There is no indication in the available sources that there were any funding streams from the metropole to make his proposition possible. In his meeting with the Advisory Board of Native Development, Askins admitted: “If we are going to extend the system at the moment, we come up against the question of finance”.⁵³ Therefore, although the longstanding internal interest in reform certainly provided the necessary logic for his proposal, that alone was inadequate.

It is, therefore, necessary to reflect on the broader context within which Askins acted, and the individual agency he brought to bear on the issue as he familiarised himself with changes in colonial healthcare policy and practice. This perspective is necessary because it helps us to understand why Fleming and Askins dealt with the same problem differently. Clearly, Askins read the situation quite differently from Fleming, perhaps because of his broader outlook. For Askins, reform was an urgent local (colonial), international and personal issue that required a new, concerted approach, even in the midst of an economic depression.

Notably, Askins framed his ideas with developments in other colonies in mind. His reforms came in the context of similar developments that were emerging in other African colonies during the interwar years. Such schemes, which included the establishment of rural dispensaries, the commencement of training schemes for healthcare workers and the adoption of other special initiatives such as maternity work, have been widely discussed in the burgeoning historical literature focusing on different regions of colonial Africa.⁵⁴

These essentially simultaneous, overlapping and cross-pollinating⁵⁵ developments indicated the gradual acceptance by colonial governments of the

53. Editorial, “Jottings from the Recent Sitting of the Advisory Board of Native Development”, *Native Mirror*, 1 January 1931, p 23.

54. M.H. Dawson, “The 1920s Anti-Yaws Campaigns and Colonial Medical Policy in Kenya”, *The International Journal of African Historical Studies*, 20, 3 (1987), pp 417–35; Iliffe, *East African Doctors*; A. Crozier, *Practicing Colonial Medicine: The Colonial Medical Service in British East Africa* (I.B. Tauris, London and New York, 2007); M.S. Kiwanuka, “Colonial Policies and Administrations in Africa: The Myth of Contrasts”, *African Historical Studies*, 3, 2 (1970), pp 295–315; J. Turriffin, “Colonial Midwives and Modernising Childbirth in French West Africa”, in J. Allman, S. Geiger and N. Musisi, N. (eds), *Women in African Colonial Histories* (Indiana University Press, Bloomington and Indianapolis, 2002); N. Rose Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization and Mobility in the Congo* (Duke University Press, Durham and London, 1999); K.A. Shapiro, “Doctors or Medical Aids: The Debate over the Training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 1930s”, *Journal of Southern African Studies*, 13, 2 (January 1987).

55. For instance, South African public health officials admitted they had been inspired by the French model of African medical auxiliaries. See, National Archives, Pretoria,

responsibility to provide medical care as a national service for one reason or another. Askins proved himself a person of wider outlook than his predecessor because he was quick to notice that Southern Rhodesia was already lagging behind in the area of rural healthcare. It was therefore imperative that a scheme be formulated so that the colony could catch up with her peers. In prefatory remarks on his new scheme, he showed awareness of this fact and brought it to the attention of the other Southern Rhodesian officials, noting:

The treatment of natives is a matter which has long received the attention of the authorities of the French African colonies and of the Congo. The matter has more recently received much consideration in Uganda and Nyasaland, and schemes are now under review in Northern Rhodesia and the Union of South Africa.⁵⁶

Further arguing his case, he indicated that while many aspects of colonial African life were still open to “doubt and discussion”, it had become clear that there was “unanimity of opinion in regard to the need and desirability of the provision of medical treatment for their more urgent wants”.⁵⁷ He cited this as one of the major highlights of the conference of the South African Medical Association held in Durban in 1930 where, he learned, there was “complete agreement as regards the necessity, though there were wide differences of opinion as regards the correct method, for securing medical treatment of natives”.⁵⁸ Clearly, Askins had taken time to familiarise himself with developments in other parts of the colonial world by, among other things, following and reading periodical reports and other key policy documents from these colonies. This knowledge was used jointly with local realities and appeals, to justify reform.

It is also possible that he became aware of the fact that comparing Southern Rhodesia with other colonies that had programmes in place was a useful strategy in a colony that, because of its peculiar position as a non-dominion settler territory, was always conscious of how it was perceived within the family of British colonies. Officials took care to be seen as doing better than other colonies in terms of their “native policy”, in order to avoid any embarrassing opprobrium from the British metropole.⁵⁹ Officials in Southern Rhodesia were thus quick to tout the progressive nature of their “native policy”.

Unions of South Africa (hereafter UG), 25-1927, *Report of the Hospital Survey Committee*, p 9; League of Nations Health Organisation, “Report of the Pan-African Health Conference held at Johannesburg, November 20–30, 1935”, *League of Nations Quarterly Bulletin of the Health Organisation*, 6, 1 (March, 1936), p 201.

56. NAZ, S1173/239 Natives (Medical Attention), 1925-31, Askins to Colonial Secretary, 19 July 1931.

57. NAZ, Southern Rhodesia, *Report on the Public Health for the Year 1930*, p 19.

58. NAZ, Southern Rhodesia, *Report on the Public Health for the Year 1930*, p 19.

59. C. Summers, *From Civilization to Segregation: Social Ideals and Social Control in Southern Rhodesia, 1890–1934* (Ohio University Press, Athens: OH, 1994), p 171; M.C.

But why would reform be such an urgent matter for Askins personally? Together with urban planning⁶⁰ – perhaps an interest which he developed because of the nature of his previous preoccupation with urban-focused public health work in Bristol – the development of new medical services in the underserved rural areas was a domain where he could achieve distinction as a new colonial public health bureaucrat. His predecessor had pioneered legacy initiatives in other areas, including the initiation of a schools, medical services for white children and the setting up of a London School of Hygiene and Tropical Medicine Field Station within the colony.⁶¹

Seen in the wider context of colonial civilisation, it is reasonable to argue that the provision of a rural medical service provided Askins with an underdeveloped area where he could carve his own niche as a transformer of so-called “backward” Africa. Indeed, as noted earlier, similar developments elsewhere on the continent also provided the necessary impetus and models. However, the urgency he showed also said something about him as a public health professional, a man who had recently arrived from a region of imperial Britain that was undergoing major reform in healthcare provision. There are strong indications that he brought some of the reform momentum from his previous duty station, Bristol. Peering into his previous experience could therefore yield further insights into some enduring influences that might have played an important role in his determination to reform Southern Rhodesia’s medical system.

While doing that, it may also be helpful to keep in mind Lenore Manderson’s perceptive observation that *some* public health programmes were merely implemented in colonies “soon after they were introduced in the centre, and reflected not government understanding of colonial needs, but rather contemporary changing ideas and practices in public health occurring within the United Kingdom”.⁶²

Askins left England at a time when social reform schemes, of which public health was an integral part, were engaging the attention of the British society at large. There were emerging concerns about the health of the nation and Jane Lewis suggests that this was a result of eugenicist and imperial ideas, especially following the Anglo-Boer War, which exposed the extremely poor quality of health of British army

Steele, “The Foundations of a ‘Native’ Policy: Southern Rhodesia, 1923–1933”, DPhil thesis, Simon Fraser University, 1972), p 24.

60. Askins was also chairperson of the Southern Rhodesia Town Planning Board. See *The Herald*, 6 September 1935, p 3.

61. NAZ, S881/446, “London School of Hygiene and Tropical Medicine in Southern Rhodesia”, Newton to R.W. Harris, 21 January 1925; Central Statistical Office, *Official Yearbook of the Colony of Southern Rhodesia for 1932* (Rhodesian Printing & Publishing Co., Salisbury, 1932), pp 644-50.

62. L. Manderson, *Sickness and the State: Health and Illness in Colonial Malaya, 1870–1940*, (Cambridge University Press, Cambridge, 1996), p 11.

recruits.⁶³ This realisation increased the focus on personal healthcare services and produced an associated push for the state to take a leading role in the provision of such services.⁶⁴ The 1906 assumption of power by the Liberal Party created an enabling environment for the rising tidal wave of social reform, especially those driven by the “radical reforming politician”, Lloyd George,⁶⁵ leading, *inter alia*, to the introduction of the National Health Insurance scheme in 1911.⁶⁶

Further reforms were introduced soon after World War I, including the establishment of a Health Ministry in 1919 and the publication, in 1920, of the Dawson Report which advocated the setting up of health centres and the increased availability of health services.⁶⁷ This report’s publication coincided with the formulation of pioneering schemes such as the Gloucestershire Extension of Medical Services Scheme (GEMSS) whose *raison d’être* was also the extension of personal health services through a locally coordinated healthcare delivery system.⁶⁸ Other pioneering experiments emerged in the 1920s, notably the Peckham Health Centre which sought to combine primary health care with recreation to foster “a sense of community” with positive health outcomes.⁶⁹

In all this push for reform, some historians have argued, medical officers of health played crucial roles as both originators and implementers of such policies.⁷⁰ Indeed, some of them, such as Arthur Newsholme, have attracted a great deal of

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63. J. Lewis, “Health and Health Care in the Progressive Era”, in R. Cooter and J. Pickstone (eds), *Medicine in the Twentieth Century* (Harwood Academic Publishers, Amsterdam 2000), pp 84–85.
64. J. Lewis, “Providers, ‘Consumers’, the State and the Deliverers of Health-Care Services in Twentieth Century Britain”, in A. Wear (ed.), *Medicine in Society: Historical Essays* (Cambridge University Press, Cambridge, 1994), p 318.
65. D. Porter, *Health, Civilisation and the State: A History of Public Health from Ancient to Modern Times* (Routledge, London and New York, 1999), p 206.
66. Lewis, “Providers, ‘Consumers’, the State and the Deliverers of Health-Care Services in Twentieth Century Britain”, p 318.
67. G.C. Gosling, “‘Co-operate, Co-ordinate, Unify!’ The 1920 Proposal to Amalgamate the Medical Charities of Bristol”, *Southern History: A Review of the History of Southern England*, 29 (2007), p 84; Lewis, “Providers, ‘Consumers’, the State and the Deliverers of Health-Care Services in Twentieth Century Britain”, pp 331–332.
68. M. Gorsky, “The Gloucestershire Extension of Medical Services Scheme: An Experiment in the Integration of Health Services in Britain before the NHS”, *Medical History*, 50 (2006).
69. J. Lewis and B. Brookes, “A Reassessment of the Work of the Peckham Health Centre, 1926–1951”, *The Milbank Memorial Fund Quarterly: Health and Society*, 61, 2 (1983), p 308.
70. M. Gorsky, “Local Leadership in Public Health: The Role of the Medical Officer in Britain, 1872–1974”, *Journal of Epidemiology and Community Health*, 61, 6 (2007), pp 468–72.

scholarly attention because of the legacies of their ideas.⁷¹ Going into detail about these interesting developments is outside the scope of this article; suffice to say that medical officers of health were responsible for originating programmes designed to make a radical improvement of access to medical services. In addition, personal health services expanded significantly under their initiative as they oversaw the development of numerous welfare schemes in the early twentieth century.⁷² Askins was one of those medical officers of health who was in the forefront of the implementation of new schemes, an experience he arguably carried over to the less developed colony of Southern Rhodesia.

Askins's association with the aspirations to extend medical services to previously ignored risk groups had its beginnings in 1914, when the Bristol Education Committee appointed him as the inaugural head of the Schools' Medical Service. Accordingly, it is important to recount his story briefly from this point onwards, and to clarify the argument that his work in Bristol influenced his approach when he became Southern Rhodesia's chief medical officer.

Initiated by the British parliament in 1908,⁷³ the schools' medical service constituted one of the new areas for widened medical coverage in early twentieth-century Britain. Working within that context in a leadership position placed Askins on the cutting edge of ideas that related children's health to national success and progress.

In 1915, Askins went on war duty to France and returned to Bristol after demobilisation with increased confidence about the subject of youth health and national well-being. For instance, in his 1919 Annual Report of the Schools' Medical Officer, he spoke about how the war had made him realise "the large amount of physical unfitness in adults due to want of care and treatment during childhood".⁷⁴ This realisation, he revealed, gave him a "powerful incentive" to enlarge and improve the schools' medical work, with the objective of improving the standard of health of those children "who are to form the future of the race".⁷⁵ He was certainly not the only one to realise this, but he worked within an enabling wave of reformative ideas which he became increasingly passionate about. During that period, systematic

71. J.M. Eyler, "The Sick Poor and the State: Arthur Newsholme on Poverty, Disease and Responsibility", in D. Porter and R. Porter (eds), *Politics and Society: Historical Essays* (Rodopi, Amsterdam and Atlanta: GA, 1993), Chapter 7.

72. Gorsky, "Local Leadership in Public Health", pp 468–470.

73. Anonymous, "School Medical Service and the Ministry of Health", *Public Health*, 35, 4 (1922), p 99.

74. Bristol Records Office, Bristol Education Committee, *Annual Report of the School Medical Officer for Year ended 31 December 1919*, p 5.

75. Bristol Education Committee, *Annual Report of the School Medical Officer for Year ended 31 December 1919*, p 5.

treatment as an important preventive tool was becoming an area of increasing emphasis,⁷⁶ an issue he pursued vigorously in his school medical work.

In 1924, Askins was appointed Deputy Medical Officer of Health of Bristol, and in 1928, he succeeded Dr Davies as Bristol's MOH. This put him in complete charge of an area of strategic significance, not only in terms of south-west England, but also nationally. As a port city, Bristol occupied an important position in the country's defence against imported diseases. In addition to coordinating the public health activities of the port authority in general, he was also solely responsible for the direct supervision of inspection of foreign immigrants.

With this background in mind, there is reasonable ground to view his advocacy for coordinated rural medical services in Southern Rhodesia as a continuation of his Bristol initiatives, but in a different context. Although the rhetoric and language of justification differed between colony and metropole, in essence, in both instances the aim of safeguarding the health of the elite from infection and ensuring a healthy nation were high on the agenda. Moreover, in drawing up his medical units scheme for rural Southern Rhodesia, Askins was inspired by very specific healthcare delivery models that were being tried out in some English counties in the 1920s. For instance, there were notable similarities between his scheme and John Middleton Martin's GEMSS scheme, which suggests strongly that Askins drew some lessons from the GEMSS.

The influence of the Gloucestershire scheme

The idea of the district being the focal point for organised medical care may have had other colonial origins, but its featuring in Askins's medical units scheme had observable roots in the English county of Gloucestershire. In parts of Britain the idea of organising health services on a district basis emerged strongly during the early twentieth century as a result of concerns about the fragmentation of existing health care services.⁷⁷ Coordination schemes such as the regional hospital trusts had their origin in such concerns. As N.T.A. Oswald put it, the thinking behind these hospital trusts was that:

If the whole population is to have access, when necessary, to highly specialized services which cannot, by definition, be provided at all locations, then there must

76. In her book, *Marketing Health* Virginia Berridge talks about this trend, which was an outcome of germ revolution which led to shifts in the basic approach of public health. As Berridge argues, although disease co-evolved with poverty, officials responded by expanding the range of personal treatment within the health services. See V. Berridge, *Marketing Health: Smoking and the Discourse of Public Health in Britain, 1945–2000* (Oxford University Press, Oxford, 2007), p 9.

77. Examples include, Gosling, "Co-operate, Co-ordinate, Unify!"; and N.T.A. Oswald, "A Social Service without Social Doctors", *Social History of Medicine*, 4, 2 (1991), pp 295–315.

be a formal referral system between hospitals from a wide area to a centre where skills and resources are concentrated.⁷⁸

This may have been the influence behind Askins's proposed arrangement that there be a district hospital where the skills of the government medical officer would be accessed through a referral system of patients from the outlying dispensaries, and through the medical officer's regular visits to such outlying dispensaries.

However, as already noted, the British health service coordination and extension scheme that appears to have had the most direct influence on Askins's medical units scheme was the GEMSS, the Gloucestershire County Council's public health project, whose boundaries overlapped with Askins's Bristol and county public health boundaries. The GEMSS was commenced in 1920 headed by John Middleton Martin, the MOH of that county, as an experiment in both the extension and coordination of rural medical services.⁷⁹ George C. Gosling suggests that in similar spirit with the recommendations of the Dawson Report of 1920, the GEMSS's aim was to deliver "a network of local health centres as a means to bring about a co-ordinated regional health service".⁸⁰

The aim of the model was to set up a scheme that would deal effectively with the many common maladies found in the county, namely, defects in schoolchildren, maternity and child welfare cases, tuberculosis, venereal diseases, and orthopaedic cases.⁸¹ The scheme sought to use the county's existing infrastructure and personnel, including hospitals, hospital staff, general practitioners, and district nursing groups to operate in a coordinated system with a number of out-stations that pivoted around central hospitals, to create an elaborate district health system. Martin Gorsky offers the best description of the main features of the scheme:

[I]ts innovative feature was the provision of "out-stations" in the rural parts of the county. These were small-scale health centres, either purpose built or situated in existing cottage hospitals, Poor Law institutions or tuberculosis dispensaries, and staffed by GPs paid on a contractual basis. Gloucestershire was divided into administrative areas (Bristol, Gloucester and Cheltenham), each with its general hospital, to which the out-stations were affiliated for patient referrals, and with its specialist institutions such as tuberculosis sanatoria.⁸²

Although Middleton Martin's original desire for the GEMSS to be a well-functioning regional service offering both curative and preventive services was never fully

78. Oswald, "A Social Service without Social Doctors", p 300.

79. Gorsky, "The Gloucestershire Extension of Medical Services Scheme"; Gosling, "Co-operate, Co-ordinate, Unify!"

80. Gosling, "Co-operate, Co-ordinate, Unify!", p 84.

81. UKNA, Mh66/90, A.C. Parsons, "Administrative County of Gloucester, Report on a Survey of Public Health Services, 1932", p 90.

82. Gorsky, "The Gloucestershire Extension of Medical Services Scheme", p 494.

realised, a report compiled in the early 1930s praised the scheme for its full exploitation of local resources.⁸³ Each of the district hospitals had its allocated part of the county, and the allocation of personnel was arranged in such a way that consultants left their hospital bases and visited patients at their nearest out-stations, whereas in most counties patients were obliged to travel to see consultants.⁸⁴ Middleton Martin's goal was to develop the scheme to the extent that there would be an out-station within three miles of every section of the county, to be achieved on the basis of the rational usage of the county's available health resources.⁸⁵

The Gloucestershire scheme is so closely echoed in Askins's scheme that it is not far-fetched to argue that Askins's medical units scheme was a direct adaptation of the GEMSS. Firstly, the proposed division of Southern Rhodesia into "medical districts" or medical units mirrored the division of Gloucestershire into three health districts, namely those of Bristol, Gloucester and Cheltenham, in which there were designated out-stations connected to the big hospitals or centres of specialisation. Secondly, the idea of mobile consultants is replicated in the Askins scheme, with each medical unit being run through the services of an itinerant medical officer who visited out-stations located at certain pre-determined distances from the district hospital. These were to be supported by a sedentary African auxiliary and white nursing staff. Thirdly, the use of "existing agents" and institutions by the Gloucestershire scheme found its way into the Askins proposal of taking advantage of existing government infrastructure in launching the programme of medical units. In both schemes, the new institutions had to be purpose-built, mainly to economise on resources, although Askins also rationalised his idea by saying that he required medical stations that were familiar to Africans.

The Gloucestershire scheme was certainly more elaborate and complex because it was grafted on a better-developed foundation. In contrast, the Askins scheme was concerned mainly with inaugurating services in areas where they were virtually non-existent. In addition, the Askins scheme had to negotiate a complex set of racial relations in addition to the professional and resource issues the Gloucestershire scheme had to handle. Nevertheless, the two schemes shared some profound similarities. Gorsky suggests that public health's affinity for well-planned and coordinated services during the period under review may have emerged as a result of the influence of notions of "rationalization" and "scientific management" spawned by the Taylorist management system pioneered in the American factories by Frederick W. Taylor.⁸⁶

83. UKNA, Mh66/90, Parsons, "Administrative County of Gloucester, Report on a Survey of Public Health Services, 1932", p 91.

84. UKNA, Mh66/90, Parsons, "Administrative County of Gloucester, Report on a Survey of Public Health Services, 1932", p 92.

85. J. Middleton Martin, "Gloucestershire Scheme for Extension of Medical Services", *British Medical Journal*, 2, 3128 (December 1920), p 916.

86. Gorsky, "The Gloucestershire Extension of Medical Services Scheme", p 493.

Although the Gloucestershire scheme had its detractors, it had such widespread appeal that renowned advocates of social medicine, public health reformists and intellectuals such as Professor Charles-Edward Winslow of Yale University travelled to Gloucester in August 1932 to study the system of medical out-stations.⁸⁷ Within the United Kingdom, it was cited as one of the preeminent pioneering experiments in organised medicine.⁸⁸ As contemporaries, Askins and Martin interacted in various forums, including the West of England branch of the Society of Medical Officers of Health, of which Askins was elected president in October 1924.⁸⁹ Society meetings offered members opportunities to discuss new schemes in their districts and many of those schemes were selected for publication in the society's official journal. This fostered exchange of ideas, and their adaptation in different areas.

Furthermore, Gloucester was Askins's preferred leisure retreat and it was said of him that "he was extremely fond of simple rural life, and whenever his duties permitted he sought the company of the Somerset and Gloucester Hills".⁹⁰ If he had no experience in rural healthcare delivery, he had experience of rural life, and he apparently also had a valuable template from the Gloucester public health scheme on which to formulate his own ideas.

The reforms as colonial biomedical power

Yet, Askins's reforms were as colonial, as they were innovative. Indeed, as David Arnold famously writes:

There is indeed a sense in which all modern medicine is engaged in a colonizing process.... It can be seen in the increasing professionalization of medicine and the exclusion of "folk" practitioners, in the close and often symbiotic relationship between medicine and the modern state, in the far-reaching claims made by medical science for its ability to prevent, control, and even eradicate human diseases.⁹¹

Anna Crozier adds that one of the defining features of colonial medicine in British Africa was the continued "sensationalisation" of the African as inherently pathological, and the valorisation and celebration of the colonial doctor as the hero

87. UKNA, Mh66/90, Parsons, "Administrative County of Gloucester, Report on a Survey of Public Health Services, 1932", p 90.

88. "Obituary, John Middleton Martin", *The British Medical Journal*, 1, 4123 (13 January 1940), p 74.

89. Society of Medical Officers of Health, "West of England Branch Meeting Report", *Public Health: The Journal of the Society of Medical Officers of Health*, 37, 3 (December 1924), p 95.

90. "Obituary, R.A. Askins", *British Medical Journal*, 21 December 1935, p 1235.

91. D. Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India* (University of California Press, Los Angeles and London, 1993), pp 9–10.

who selflessly served the primitive African patients at great personal risk.⁹² There was a tendency among many colonial medical officials to be unquestioning of their own self-proclaimed superiority and essentialist moral obligations.⁹³ These insights aptly summarise some of the inner essences of Askins's reforms.

Firstly, in formulating his ideas Askins did not jettison the infamous colonial practice of framing Africans as reservoirs of infective disease. By resorting to the "reservoir of disease" stereotype, Askins consolidated a prejudiced image that Africans had endured since the pre-reform era. Such views underpinned repressive disease control measures. A good example of this sensationalist view related to the syphilis scare, a disease that, because of its closer connections with inter-racial sexual relations, endured the most widespread, elaborate and lingering attention of the colonists from the turn of the century onwards.⁹⁴

Lynette A. Jackson remarks that a "striking characteristic of the public health files on colonial Zimbabwe (Southern Rhodesia) is the frequency with which one encounters references to African women as disease *hosts* or *agents*" (emphasis added).⁹⁵ According to Jackson, at a conference held in 1928 to consider some new strategies against syphilis, Fleming indicted what he called the many "stray [African] women", "girls on the move" and "travelling prostitutes", as the most significant agents responsible for "spreading disease all over the country".⁹⁶ Such women were forced to submit to compulsory examination which they remembered as *chibeura* (to turn upside down).

But were Askins's reforms solely driven by self-serving, racist public health attitudes? Were they only about averting the spill-over effects of poor health among the Africans? There is no single answer to this question. In December 1930, when he addressed the Advisory Board of Native Development, he told those present that "we doctors feel the humane side", but that "the purely selfish side is also of practical importance ... because it will obviously commend public sympathy".⁹⁷ Was this a well-

92. A. Crozier, "Sensationalising Africa: British Medical Impressions of Sub-Saharan Africa, 1890–1939", *The Journal of Imperial and Commonwealth History*, 35, 3 (September 2007), pp 393–415. A good example of this celebratory hagiography is Oliver Ransford's *Bid the Sickness Cease: Disease in the History of Black Africa* (John Murray, London, 1983), p 5.

93. Manderson, *Sickness and the State*, p 6.

94. For more information, see McCulloch, *Black Peril, White Virtue*, Chapter 9.

95. L.A. Jackson, "'Stray Women' and 'Girls on the Move': Gender, Space and Disease in Colonial and Post-Colonial Zimbabwe", in P.T. Zeleza and E. Kalipeni (eds), *Sacred Spaces and Public Quarrels: African Cultural and Economic Landscapes* (Africa World Press, Trent: NJ and Asmara, 1999), p 149.

96. Jackson, "'Stray Women' and 'Girls on the Move'", p 150.

97. Editorial, "Jottings from the Recent Sitting of the Advisory Board of Native Development", *Native Mirror*, 1 January 1931, p 23.

crafted remark meant to pre-empt any form of alarm from this missionary dominated group?

The well-informed German medical historian, Walter Bruchhausen has argued compellingly that not all colonial healthcare officials should be accused of “lacking a genuine sympathy for the sick and a wish to relieve their suffering”.⁹⁸ Indeed, Askins was concerned that the various diseases that occurred in endemic and epidemic forms in the colony were of importance both because of the likelihood that they would spread to Europeans and because of the unnecessary destruction of life and erosion of health which resulted among the Africans.⁹⁹ The latter reason clearly stemmed from a form of medical humanitarianism.

Arguably, sometimes invoking such popular, sensationalist images was an important strategy used by reform-minded officials to get the buy-in of colonial legislatures and frugal treasury officials who held the keys to funding. Askins had dealt with complex funding issues during his time in Bristol, and was therefore aware of the difficulties involved in fundraising for new projects. For instance, in 1925, he had a long list of items for which he required funds, including hospital treatment for children suffering from crippling conditions, operative treatment of enlarged tonsils and adenoids, increasing dental staff and the provision of open-air hospitals and schools accommodation.¹⁰⁰ In anticipation of official outrage at the funds that were required, he tactfully pre-empted criticism by noting that “the treatment of illness in its commencing stages in childhood, is the most remunerative investment which the state can make”.¹⁰¹

If it was a challenge to convince the authorities in richer England, Southern Rhodesia was an even tougher terrain for him, given the complex, racialized structures of development, as well as the immense impact of the worldwide depression on colonial coffers. However, as Bruchhausen also admits, in our efforts to understand the nature of colonial healthcare institutions and policies, we should look for answers beyond “just the personal” and “moral” feelings of the key players.¹⁰² Even if we accept Askins’s explanation that he emphasised self-interest for pragmatic reasons, his entire framing of the issue cannot escape critical assessment from many other angles. Firstly, in mimicking the popular stereotype of the African as a “reservoir of disease”, Askins fortified prejudice and tainted his own motives.

98. W. Bruchhausen, “Public and Child Health in German East Africa and Tanganyika Territory, 1900–1960”, *Dynamis*, 23 (2003), p 87, at <http://ddd.uab.cat/pub/dynamis/02119536v23p85.pdf> Accessed 25 October 2010.

99. NAZ, S1173/336, Askins, “Preliminary Report on the Treatment of Natives”, p 1.

100. Bristol Records Office, City and County of Bristol Education Committee, *Report of the Schools’ Medical Officer for the Year Ended 31 December 1925*, pp 7–8.

101. City and County of Bristol Education Committee, *Report of the Schools’ Medical Officer for the Year Ended 31 December 1925*, p 8.

102. Bruchhausen, “Public and Child Health in German East Africa and Tanganyika Territory”, p 87.

In his *Mimesis and Alterity*, Michael Taussig argues perceptively that the “wonder of mimesis lies in the copy drawing on the character and power of the original, to the point whereby the representation may even assume that character and that power. In older language, this is ‘sympathetic magic’”.¹⁰³ Askins’s approach, as much as it was partly sympathetic, did exactly what is suggested by Taussig. That said, there is no compelling evidence to suggest that he did not believe these stereotypes himself.

Secondly, in his policy proposal Askins revealed that one of his reasons for developing rural medical services was to eradicate the influence of indigenous healers, of whose medical work he disparagingly remarked, it “must frankly be described as being of the most primitive character”.¹⁰⁴ Trained as he was in metropolitan biomedicine, he took aim particularly at indigenous midwifery, charging that there was a great deal of “folly and superstition”, and a “considerable admixture of cruelty” that entailed the extreme suffering of African women in childbirth.¹⁰⁵ Indeed, Askins was keen to supplant African forms of healing and to impose Western biomedical institutions and practices. In January 1931, writing to the Chief Native Commissioner who had sought his opinion on the subject of doctoring by Africans, Askins showed that he looked forward to the eradication of this colonially maligned practice “as soon as the government is able to substitute a scheme for the treatment of natives by a duly qualified medical practitioner”.¹⁰⁶

In June 1931, Molala Milasi, described in the scant records as an African “doctor”, applied through the Native Affairs Department to try an experimental cure for leprosy, or alternatively for a permit to cure patients on his own. The response from Askins response was: “we cannot grant this native a room in which to experiment on leprosy. Neither will it be possible to issue him with a permit to ‘doctor’ the sick”.¹⁰⁷ He added that if the African in question cared to “send in samples of his medicines and tell us his methods in using them, the government analyst has promised to experiment with the samples”¹⁰⁸ It is not clear whether this leeway was an open-minded gesture or a ploy to take the medication in question stealthily and apply the methods of its usage under the cover of scientific analysis. Indeed, other biomedical practitioners would have rejected the request unequivocally.

103. M. Taussig, *Mimesis and Alterity: A Particular History of the Senses* (Routledge, New York and London, 1993), p xiii.

104. Medical Association of South Africa, “Medical Services for Natives: Dr Askins’ Views”, *Journal of the Medical Association of South Africa*, 11 (April 1931), p 223.

105. Medical Association of SA, “Medical Services for Natives: Dr Askins’ Views”, p 223.

106. NAZ, S1173/329, Natives (Medical Attention), 1925–1931, Askins to Chief Native Commissioner, 29 January 1931.

107. NAZ, S1173/329, Natives (Medical Attention), 1925–1931, G.A. Taylor (for Medical Director) to Chief Native Commissioner, 10 June 1931.

108. NAZ, S1173/329, Taylor to Chief Native Commissioner, 10 June 1931.

However, what was unfortunate, although not surprising, was that Askins suffocated this budding therapeutic pluralism at a time when biomedicine was still itself faced with pharmacological and epidemiological challenges in respect of African healthcare, some notable progress in other areas notwithstanding. Some medicines used by doctors were not any safer. For instance, between 1930 and 1932, a venturesome use of vermifuges such as carbon tetrachloride, together with a purgative to cure hookworm and endemic helminthic disease, caused a scare when patients vomited and became ill; a woman so treated miscarried and six Africans died on the Rand, and one in Salisbury.¹⁰⁹

Thirdly, Askins also fortified racial privilege by pivoting the medical units scheme around European medical officers when he formulated the structure of the district health team. In his policy documents he referred specifically to the marginalised South African Loram Committee Report, which had recommended, *inter alia*, the training of Africans as doctors to work in rural areas, but stated emphatically that he would not recommend the scheme in Southern Rhodesia.¹¹⁰ In his own words, Askins said:

I do not think the problem of Southern Rhodesia is a very difficult one. It is perfectly obvious that we want trained Native Orderlies and Native Midwives ... I think there is no doubt we do not want to fall in with Rockefeller's suggestion in regard to the Johannesburg University. I do not think it would be wise to adopt the proposition of Rockefeller for trained Native Doctors. Therefore, we go back to this, that we have got to have white doctors with Native orderlies and Native nurses to assist them.¹¹¹

For him, therefore, the correct course for Southern Rhodesia was the modification of the much-vaunted French West African system whereby Africans were trained and deployed to work under the supervision of a white doctor.¹¹² Perhaps what Askins wanted to be modified in the case of Southern Rhodesia was that, according to M.S. Kiwanuka, the French gave some of their best African medical assistants a chance to practise medicine privately.¹¹³ The system of medical orderlies supervised by white

109. Steele, "The Foundations of a 'Native' Policy", p 289.

110. NAZ, S1173/336, Askins, "Preliminary Report on the Treatment of Natives", p 4.

111. Editorial, "Jottings from the Recent Sitting of the Advisory Board of Native Development", *Native Mirror*, 1 January 1931, p 23.

112. Lord Hailey praised the French scheme in his *African Survey* as being "the most successful and certainly the largest effort in Africa to provide a colonial medical education with an acknowledged standard of efficiency". See W.M. Hailey, *An African Survey: A Study of Problems Arising in Africa South of the Sahara*, (Oxford University Press, London, 1938).

113. Editorial, "Jottings from the Recent Sitting of the Advisory Board of Native Development", *Native Mirror*, 1 January 1931, p 23; Kiwanuka, "Colonial Policies and Administrations in Africa", p 308.

doctors also commended itself to him because the cost “would be low per capita”.¹¹⁴ In thinking about these issues he drew on the South African case where the liberal recommendations of the Loram Committee Report came under immense criticism by medical conservatives.¹¹⁵ By dint of this, Askins’s otherwise reformative scheme took on a conservative, colonial nature. Therefore, as he sought to extend the benefits of biomedicine to the rural Africans, he also promoted white privilege at the expense of the indigenous peoples.

Conclusion

The research and findings presented in this article suggest that studies of colonial healthcare should give careful attention to how colonial officials adapted broader ideas and models in their framing of policy documents that undergirded the development of colonial social services. The scheme interrogated here confirms Coghe’s notion of inter-imperial learning as an important feature of colonial healthcare policymaking and practice. However, what happened to the different schemes that emerged from the ideas circulating through these networks depended very much on local circumstances.

The initiative proposed by Askins began gradually in 1931 with a pilot scheme in Ndanga, a sprawling rural district on the south-eastern corner of the colony. Subsequently the plan was to extend the model across the entire colony, subject to resource availability. However, the rollout of the scheme suffered an early setback due to Askins’s tragic death in 1935. It was reported that he drowned at sea while travelling to Britain.¹¹⁶ Thereafter, the pioneer Ndanga Medical Unit developed in tandem with the enthusiasm and character of the presiding medical officer, Dr James Kennedy who had been appointed by his fellow Irishman, Askins, to spearhead the development of the model unit.

Although Askins’s successor as MOH, A.P. Martin, virtually abandoned the rural medical units scheme in favour of a centrifugal clinic system whose

114. Editorial, ‘Jottings from the Recent Sitting of the Advisory Board of Native Development’, *Native Mirror*, 1 January 1931, p 23.

115. NAZ, S1173/336, Askins, “Preliminary Report on the Treatment of Natives”, p 4. For more on the South African debate, see Shapiro, “Doctors or Medical Aids”; Digby, “Visions and Vested Interests”; and A. Digby, *Diversity and Division: Healthcare in South Africa from the 1800s* (Peter Lang, Oxford, 2006), pp 191–198. As the main gateway into landlocked Southern Rhodesia during the age of ship transportation, South Africa was Askins’s main source of comparative policy documents. This regional metropole also possessed a better-organised professional medical service that dominated debates and the dissemination of information about healthcare reform nationally and regionally.

116. “Obituary R.A. Askins”, *British Medical Journal*, 21 December 1935, p 1235.

development moved outwards from the core areas of European settlement,¹¹⁷ during the 1940s, the Ndanga Unit catered for more patients than any other district healthcare system in the colony.¹¹⁸ Martin also abandoned Askins's modest building plans of grass-thatch clinics when prefabricated materials and building funds became easily available. However, the Ndanga Medical Unit continued with its grass-thatch structures until the 1960s as a relic of the Dr Kennedy and Askins era. Dr Kennedy retired from Ndanga in 1959. If Askins's modest building plans were rapidly overtaken by time, the hierarchical regionalism of healthcare delivery became the norm since his time. Indeed, at a later stage Martin's clinics were gradually reshaped into a tiered district healthcare system that survives to date.

This model of service provision was as Rhodesian as it was international. Indeed, Askins came into the colonial African scene at a time when reformist ideas were floating across metropolitan and imperial borders, and so it would be a mistake to treat Southern Rhodesia as an isolated case. As has been demonstrated in this article, the Southern Rhodesian version of rural healthcare reform was influenced by developments elsewhere. By pushing to bring healthcare services to rural areas, the reforms were progressive when measured against colonial standards. However, these good intentions were bound up with numerous prejudices, including ethnocentrism and the entrenchment of racial privilege. This was perhaps indicative of the multiple, and often incompatible aims and operations of colonial biomedicine. In the interstices of these impulses were tensions between race, public health and colonial progress. And, as this article has shown, these impulses had histories beyond the local and the colonial.

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117. C.J. Valentine, "Settler Visions of Health: Healthcare Provision in the Central African Federation, 1953–1963", MA thesis, Portland State University, 2017, p 41.

118. For more on how the scheme unfolded, see G. Ncube, "The Making of Rural Healthcare in Colonial Zimbabwe: A History of the Ndanga Medical Unit, 1930–1960s", PhD thesis, University of Cape Town, 2012.

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