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OF POLITICS, PHILANTHROPY AND THE PROVISION OF MEDICAL SERVICES: GOVERNMENT HOSPITALS AND THE EXPANSION OF COLONIAL MEDICINE IN ZANZIBAR TOWN, 1896-1963

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Background: Biomedical Services in Colonial Zanzibar Town

By 1963, biomedical services had been extended in many parts of Zanzibar Town and had covered many people in the Town, which was estimated to be 60,000 persons. The 1960 Annual Report of the Director of Health Department showed that in that year, the number of people attending at the Hassanali Karimjee Jivanjee Hospital (HKJ) was 63,778 and it showed that in relation to the population of the Town that many people who could attend local dispensaries in the sub urban areas were also coming to the Town Hospital.¹ This was an illustration of how the biomedical services were extended in Zanzibar Town during the colonial period of nearly a century. This chapter examines the institutionalization of hospital care and also considers those people who attended these medical services between 1896 and 1963. The main argument is that the provision of biomedical services in colonial Zanzibar Town was the work of colonial administrators in collaboration with Indian philanthropists², and the local Zanzibari-born Arabs of Oman

¹ Zanzibar National Archives (ZNA), BA7/39 Annual Report of the Health Department for the Year 1960, p. 1.

² From the early nineteenth century, Indian traders flocked in Zanzibar Town. Indian merchants' dhows which traded in East African coast were under political support of the British under Bombay and later Indian colonial Government. Indian traders and the skilled and unskilled Indians who migrated to Zanzibar were referred to as the British-Indians while in Zanzibar. The opening of British Consulate in Zanzibar in 1841, which became a Political Agent of Bombay Government, reinforced the British support to Indian merchants, who became agents of industrial capital. Between 1862 and 1869 Indian traders disputed British jurisdiction over them and sought Sultan's support when Indians were not allowed to own slaves in Zanzibar. In 1883, the right of the jurisdiction over British- Indians in Zanzibar was transferred from the Bombay to the Government of India. From 1890, however, when Zanzibar became a British Protectorate, Indians in Zanzibar were reduced to a secondary position. Most of them had remained under Oman Arab's jurisdiction though retained relationship with India. For more information on British-Indians in Zanzibar and East Africa, refer to J.S. Mangat, *A History of the Asians in East Africa c. 1886 to 1945*, (Oxford: Clarendon Press, 1969); Robert G. Gregory, *India and East Africa, A History of Race Relations within the British Empire 1890-1939*, (Oxford: Clarendon Press, 1971); Robert G. Gregory, *The Rise and Fall of Philanthropy: Asian Contribution*, (New Brunswick, NJ: Transaction Publishers, 1992) Dana April Seidenberg, *Mercantile Adventurers, The World of East African Asians 1750-1985*, (New Delhi: New Age International (P) Limited Publishers, 1996)

origin. I challenge the argument that biomedical services in many colonial African countries were the work of missionaries and colonial state alone. This study shows that Indian philanthropists and the affluent Oman Arab plantation owners in Zanzibar played a major role in the establishment of hospitals and in educating their children in medical fields. They acted as intermediaries between the colonial administrators and their community members. Part of the task of this study is to look at the responses and accommodation of the Town people to western medicine. The majority Town's population acceptance of biomedical facilities came very late - in 1950s – the reasons for which will be explored in this chapter.

By the end of the British colonial period in Zanzibar in 1963, the biomedical facilities in Zanzibar Town included the General Hospital with sixteen clinics attached to it. They consisted of the Tuberculosis Clinic, the Venereal Disease Clinic, and the Schistosomiasis Clinic. Others were the Ante-Natal Clinic, the Genito-Urinary Clinic, a Women's and Child Welfare Clinic, a School Clinic, and the Rahaleo Clinic, which focused mainly on the health of women and children in the Town. Also, there were an Extract Clinic, a Dental Clinic, the General Out-patient Treatment Clinic, an Inoculation and Vaccination Clinic, an Eye Clinic, a Surgical Clinic, and an Orthopaedic Clinic. There were approximately ten government and private dispensaries, and other health posts.³ There were British, white South Africans and New Zealanders and local Zanzibari doctors, nurses and other auxiliary staffs like dispensers, orderlies and nursemaid (*ayahs*). This range of biomedical services represented sixty five years of state medical facilities in Zanzibar Town as the Department of Medicine was established in 1898, and built on the earlier work of individuals who, since 1887, had worked towards establishing a hospital.

³ ZNA, AJ18/14 Special Clinics, pp. 3-5

Formation of the Department of Medicine

The idea of founding government departments dealing with sanitation and medicine evolved after Zanzibar became a British Protectorate in 1890. Soon after the declaration of Protection, Sir Gerald Portal, who was the British Resident between 1891 and 1893 had arranged the administration of Zanzibar into various departments such as Public Works, Treasury, Army and Police, Customs and Port Office. Later other departments which dealt with Agriculture and Medicine and with Hospitals and Health were inaugurated. Between 1894 and 1945, all these departments were managed by the colonial state through the local funds.⁴

The Department of Sanitation, which was under the control of a British civil engineer, was established in 1894. It was concerned with Town sanitation services like sweeping and the clearing of garbage. By the end of 1894 the personnel of this department included one Goan clerk, two Indian sanitary inspectors, forty six sweepers and thirty two dustmen.⁵ Right from the beginning, the sanitation works involved the labour of experienced local-born Indian personnel. After the introduction of the Protectorate Government in Zanzibar in 1890, the colonial administrators depended on Indian staff since there were very few British officials in Zanzibar before the First World War.

In 1898, the Department of Hospital and Medicine was inaugurated. It was responsible for establishing and extending hospital facilities, though in fact the first Government Hospital had already been established in 1896. The idea of establishing the Department of Medicine arose in order to extend and maintain the hospitals. In addition to that, the Department of Health, which was involved in providing public health facilities such as smallpox vaccination and plague eradication campaigns, was formed in 1898. It was

⁴ By 1891, Gerald Porter began a wider programme for bringing Zanzibar's finances and administration under control. Sultan's expenditure was reduced in order to fund administrative works. Other financial reforms were provided for new schedules of duties for the utilization of an improved port system, and a tax upon stone houses in Zanzibar Town. All British officials and Indian administrators were paid their salary through local funds. For further information on British administrative policy after the declaration of Zanzibar Protectorate see the work of L. W. Hollingsworth, *Zanzibar under the Foreign Office 1890-1913*, especially on chapter four on 'Reorganization of the Administration by Sir Gerald Portal, 1891-1892.

⁵ L. W. Hollingsworth, *Zanzibar under the Foreign Office 1890-1913*, (London: Macmillan & Co. Ltd, 1953) p. 117, 191

established in order to contain epidemic diseases that occurred in the Town due the role Zanzibar Town played in the international commercial activities. As we saw in chapter two, from the early nineteenth century, Zanzibar Town had become an important commercial town in the East African coast. It became a trade exchange centre and a meeting point of both people and pathogens. In 1897, plague hit Bombay and other localities in India. It then spread to Mauritius, Madagascar, Durban, Delagoa Bay, Nairobi and Aden all of which had direct communication with Zanzibar. It was feared that the disease might reach Zanzibar. Also, in 1898, a smallpox epidemic coming with traders from the northern ports ravaged Zanzibar Town population.⁶ Subsequently, the Department of Health became involved in the establishment of an Infectious Diseases Hospital in 1900 and from 1910 in the management of the Leprosy Centre. In 1907, sanitation services were put under the Department of Medicine, which became the Department of Medicine and Sanitary Services (DMSS).⁷

The history of the Department of Public Health activities in Zanzibar Town will be discussed in greater detail in Chapter Six. This chapter focuses rather on the Department of Medicine and Sanitation Services. The formation of this department dealing with the health of the population became essential after the introduction of colonial rule in Africa. The political economic studies on health in colonial Africa showed that the provision of medical services in colonial Africa was determined within the context of expanding capitalist relations of production in Africa. However, as Ann Beck shows in her 1970s study, tracing the growth of medical services and colonial attempts to deal with diseases in colonial Tanganyika, "... although the medical department was essentially non-political, it was subjected to social, economic and political influences that determined its ability to deal with diseases."⁸ From its beginning the Department of Medicine and Sanitation Services was involved in supplying medical facilities which were related to the needs of the colonial state in Zanzibar. For instance, first priority was given to the European community and to the local soldiers in Zanzibar Town. This as will be

⁶ Robert Nunez Lyne, *Zanzibar in Contemporary Times: A Short History of the Southern East in the Nineteenth Century*, (London: Hurst and Blackett Limited, 1905) p. 279.

⁷ Hollingsworth, *Zanzibar under the Foreign Office 1890-1913*, pp. 117 and 191

⁸ Ann Beck, "Medicine and Society in Tanganyika, 1890-1930: A Historical Inquiry", *The American Philosophical Society*, 67:5-56, 1977, p. 5.

discussed later had influenced the provision of biomedical services in Zanzibar before 1900. Interestingly, before World War II, much of the works of the Department of Medicine and Sanitary Services was financed not by the British colonial office but through local funds and individual donations. This was typical to other British colonies in East Africa that Indian philanthropists had financed the provision of medical services in Tanzania, Kenya and Uganda during colonial period.⁹

Right from the beginning, there was confusion over the organization of departments dealing with health and medicine as there were significant areas of overlaps in their functions. There was often a mix up and repetition of the same work. For instance, both sanitation works and the programmes on disease prevention were performed by both departments. This could be seen from the early 1900s, with the incorporation of the Department of Hospital and Medicine together with the Department of Sanitation to form the Department of Medicine and Sanitation (DMSS). The Department of Health remained with the same duties. This was rectified in 1955 with the formation of the Health Department, which incorporated all works on hospital, disease and health matters.¹⁰

Moreover, in 1907, a Bacteriology Department was established under a British Medical Officer. It was involved in scientific investigations as well as routine clinical and pathological tests and post-mortem examination.¹¹ After its inception, the Department was under the in charge of Dr. A. G. Carment who had graduated from the University of Edinburgh in the 1890s. From 1920, he was assisted by the Indian laboratory assistant, Abdulghani Kark. The British colonial government depended on medical staff trained in India as very few local Zanzibari were trained in medicine before 1935. Kark was born in 1888 at Punjab, India and had studied at King Edward Medical College in Lahore, which had been established in the Punjab area in 1860. In Zanzibar, as the Senior Laboratory Assistant, he was responsible for all chemical and bacteriological tests. This involved clinical examination of faeces, blood, urine, sputa, milk and water from Bububu and

⁹ For Indian Philanthropist works in East Africa see Robert G. Gregory, *The Rise and Fall of Philanthropy: Asian Contribution*, (New Brunswick, NJ: Transaction Publishers, 1992)

¹⁰ The overlap between health and medical works could be seen in the Annual Reports of these Departments from 1906 to 1955.

¹¹ Hollingsworth, *Zanzibar under the Foreign Office 1890-1913*, pp. 191 and 194.

Welezo springs. Kark retired in 1938 at the age of 50.¹² As has been discussed in chapter two, the Bububu and Welezo springs were used to supply water in the Town from the late nineteenth century. The pipe water systems from Bububu spring was connected into the Town by Barghash bin Said, to replace local wells since the early 1880s.

As already noted the Bacteriology Department was formed in order to control epidemic diseases, which increasingly devastated the Town population, due to migration and trading activities with Asian and European traders from the early nineteenth century. This was a relatively new medical and scientific speciality: only in 1898, was a course on bacteriology training was introduced at King's College Medical School, London, but it rapidly became compulsory for the British medical officers who wanted to work in Africa. They joined the course in order to qualify for a Diploma in Tropical Medicine. By 1900, the training in bacteriology was covered in many British Medical Schools.¹³ Furthermore, the study of bacteria was given impetus in Britain after the establishment of School of Tropical Diseases and Hygiene of Liverpool and London in 1899 and 1900 respectively. John Farley demonstrated that "the declaration of war against tropical diseases coincided also with the acquisition of new tropical territories by the British...This acquisition of African territories acted as the major stimulus for the colonial office's war against tropical disease. British tropical medicine was thus "colonial medicine."¹⁴ Therefore, the introduction of the Bacteriology Department was regarded as being important so as to control the health of the Town population and European community in Zanzibar.

Before the World War II, as we had mentioned earlier, the biomedical services in colonial Zanzibar were financed through local funds. For various reasons the British colonial state was unable to finance medical services in its colonies, though an attempt was made since 1913 to rectify the situation. This became a British policy throughout its East African colonies that health services were financed through local funds. For instance, in 1914, Sir William Simpson, a British physician and pioneer in tropical medicine, who worked as

¹² ZNA, AJ 27/35 Abdulghani Kark Laboratory Assistant

¹³ John Farley, *Bilharzia: A History of Imperial Tropical Medicine*, (Cambridge: Cambridge University Press, 1991), pp. 27-28.

¹⁴ Farley, *Bilharzia: A History of Imperial Tropical Medicine*, p. 15.

health officer for Calcutta, India in 1890s, had visited East Africa employed by the colonial office in London to investigate health condition in its colonies in East Africa. He visited Kenya, Uganda and Zanzibar and proposed measures to be taken to improve health condition of the “native” population, (Indians, Arabs and Africans). He pointed out that lack of personnel, the paucity of funds, poor economic condition, a poor system of communications, sanitation in East Africa could not progress. He also showed that although the health departments were aware of the needs could not help since it lacked personnel.¹⁵

The British colonial state was, however, unable to spearhead any developments in its colonies in Africa in general and in East Africa in particular, due to economic crisis which faced Britain aftermath the World War I. Ann Beck demonstrated that “the economic crisis in Britain from 1919 to 1922 compelled the postwar government to adopt drastic steps to fight against inflation and unemployment in order to avoid the lingering threat of the radicalization of masses. Plans for the development in eastern Africa were, therefore, subordinated to Britain’s all-out effort to overcome serious problems facing home society and politics.”¹⁶ Another attempt was made in 1929, to introduce development plans in order to boost the economic and social developments to its colonies in East Africa including Tanganyika, a former German colony in East Africa put under the mandate of Britain following the defeat of Germany in World War I. However, the colonial development scheme in East African colonies delayed due to onset of the world depression in 1929 which caused economic stagnation in many countries in the world. Also, World War II reduced the British government’s efforts towards economic and social developments in East Africa.¹⁷

Generally, before 1945, the colonial government in Zanzibar had depended on its local revenue to finance health sector. For instance, in 1927, “the total expenditure on Medical and Sanitary services was £47,719 being 8.83 per cent of £540,345, the actual revenue of

¹⁵ W. J. Simpson, Report on Sanitary Matters in East African Protectorate, Uganda and Zanzibar, Colonial Office, London, 1915, pp 4-5

¹⁶ Ann Beck, *Medicine, Tradition, and Development in Kenya and Tanzania, 1920-1970*, (Massachusetts: Crossroads Press, 1981) p. 2

¹⁷ Beck, *Medicine, Tradition, and Development in Kenya and Tanzania, 1920-1970*, p. vii

the Protectorate for the year.”¹⁸ Also, between 1931 and 1934 the financial expenditure Medical and Sanitary services ranged between 10 and 11 percent of the actual revenue of the colonial government in Zanzibar.¹⁹ However, these budgets were not enough to cover all medical works in two islands. For instance, the training of local Zanzibari in medical field had not yet started before 1934 waiting for funds. Also, rural biomedical facilities were very slow to expand due to lack of medical personnel.²⁰ After World War II, the British colonial state began to put money to finance economic and social developments including health sector in colonial Zanzibar. However, as we shall see later, the Indian philanthropists and local born-Zanzibari Oman Arabs had played a major role in the expansion of medical facilities before and even after the World War II. The next section attempts to show the role played by the colonial state, the philanthropists and local born Arabs in the extension of medical services in colonial Zanzibar Town and the way the Town people accommodated to biomedical services.

Hospitals, Patients and Biomedical Services

As we have seen in chapter three, the institutionalization of biomedical care in Zanzibar Town had started from the mid nineteenth century. The French, the British and the German Missionaries established several hospitals in the Town. From the late 1880s, the German and later the British colonial administrators inaugurated the establishment of the hospital services in the Town. The inauguration of government hospital works came after several efforts made by Indian community in Zanzibar to open hospitals to treat the Town population.²¹

¹⁸ ZNA, BA 7/9 Annual Report Medical and Sanitation Department, 1927, p. 2.

¹⁹ ZNA, BA 7/16 Annual Medical and Sanitary Report for the Year ended 31st December, 1934, p.5.

²⁰ Joop Garssen, *Policies and Practices in Pre- and Post- independence Health Care: The Case of Zanzibar*, Population Centre, (Faculty of Spatial Sciences, University of Groningen, The Netherlands, 1993) p. 31.

²¹ See, for example, effort made by Tharia Topan, the leading wealthier Indian merchant who built the Tharia Topan Hospital or ‘Jubilee Hospital’, in 1887 to serve Indians, Arabs and Africans in Zanzibar Town. Unfortunately, Tharia died in 1891 before the completion of the hospital. His will was, however, disputed by his heirs and the building was sold off to Nasur Nur Mohamed, another wealthier Indian who converted the ground floor into a dispensary to serve only Ithnasheri Indians and leased the upper floor as apartments. The construction and history of Tharia Topan Hospital has been explained in detail by Steve Battle, “The Old Dispensary: An Apogee of Zanzibari Architecture.” *The History & Conservation of Zanzibar Stone Town*, Abdul Sheriff (ed.) (London: James Currey, 1995) pp 91- 99

The Government Hospitals in Zanzibar Town were established by the German Imperial Company and later the British colonial administrators from the late 1880s. Initially, these government hospitals were constructed to treat only Zanzibari local soldiers as the European soldiers and administrators were treated at ‘The Lutheran Berlin III Hospital’, ‘The UMCA Hospital’ and at ‘The French Mission Hospital’. It was the “native” army and soldiers who served the colonial state during the conquest period, who were given first priority in the provision of medical services in comparison with other local people in colonial Africa and India. This is reminiscent of what David Arnold has explained with regard to colonial India. Arnold has demonstrated that the British colonial officers initially had restricted areas of concerns and limited financial and administration commitments that could only be address those areas of immediate importance such as jails and the army. It was a hallmark of British imperialism that the local people bear part of the cost of their medical services.²²

The German East Africa Imperial Company (IBEACo), which was involved in the conquest of Tanganyika, built a military hospital in Zanzibar Town in 1889. It was established when Khalifa b. Said, who ruled Zanzibar in 1888 after the death of Barghash was forced to submit East African coastal control starting from Warsheikh, Somalia up to the Ruvuma River in Tanganyika, to the British and German colonial states. The ten miles inland strip from northern Somalia to the southern Tanganyika had been under the control of Oman Arab rulers in Zanzibar since the late eighteenth century. From 1886, the ten miles inland strip was given to Germany and Britain under the Anglo-German Treaty or Delimitation Treaty.²³

The ‘German Military Hospital’ in Zanzibar was named the ‘Wissmann Hospital’ after Hermann von Wissmann, an Imperial German officer who was sent by the German state to subdue coastal resistances in Tanganyika. Wissmann’s force comprised 850 Africans, 50 to 80 NCOs and German officers. The ‘Wissmann Unit’ was kept in Zanzibar Town

²² David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century in India*, (Berkeley and Los Angeles: University of California Press, 1993) p. 269.

²³ Norman R. Bennett, *A History of the Arab State of Zanzibar*, (London: Methuen & Co Ltd, 1978) pp 131-132; Hollingsworth, *Zanzibar under the Foreign Office 1890-1913*, p. 20.

and had seven naval bases all in Zanzibar Town. It launched an attack on the mainland of Tanganyika in 1889. Later, in 1899, Chancellor Otto von Bismarck of Germany organized parliamentary authorization for 2,000,000 Marks to finance further German military expedition in East Africa. Norman Bennett comments that: “Wissmann’s appointment signalled the beginning of the end of the German East African Company’s role as an instrument of German imperial policy in East Africa.”²⁴ ‘The German Military Hospital’ played a major role in treating the soldiers who were sent to the mainland during this expansion period. Zanzibar Town became a centre of German conquest activities through its Consulate that was stationed in Zanzibar Town under Gerhard Rholfs from 1884.

Among the German military doctors who worked at the ‘Wissmann Hospital’ was Dr. A. Becker who later became the Principal Medical Officer of Health Services when Tanganyika became a German colony from 1890 to 1918. During the whole period of German rule in Tanganyika, military as well as civilian doctors were used in the provision of medical services, though the military doctors had dominated the provision of health services. The military doctors formed two-thirds of all doctors in Tanganyika before the outbreak of World War I.²⁵ While discussing the history of German medical services in colonial Tanganyika Juhani Koponen had commented that: “reflecting the military origins of the colonial state, the medical infrastructure was, in the common colonial fashion, firmly based on military doctors (“Stabsarzt”- staff surgeon corresponding to major) and medical NCOs of the colonial forces.”²⁶

²⁴ Bennett, *A History of the Arab State of Zanzibar*, pp 151-152, and 154; Helmut Stoecker (ed.) *German Imperialism in Africa*, London: C. Hurst & Co., 1986) pp 29; For further history of German’s occupation and local resistances in Tanganyika, see the work of Robert D. Jackson, ‘Resistance to the German Invasion of the Tanganyikan Coast, 1888- 1891’, *Protest and Power in Black Africa*, Robert I. Rotberg and Ali A. Mazrui, eds. (New York: Oxford University Press, 1970) pp 37-79; Jonathon Glassman, *Feasts and Riot: Revelry, Rebellion, and Popular Consciousness on the Swahili Coast, 1856-1888* (Portsmouth, N.H.: Heinemann, 1995) and Juhani Koponen, *Development for Exploitation, German Colonial Policies in Mainland Tanzania, 1884-1914*, (Helsinki: Finnish Historical Society, 1994)

²⁵ Koponen, *Development for Exploitation, German Colonial Policies in Mainland Tanzania, 1884-1914*, p. 464.

²⁶ Alexander Becker, A New Sultan Succeeds to the Throne in Zanzibar: Our Special Audience with Him, *Tanganyika Notes and Records*, No. 61, 1963 (1911) pp 147, 147-154; Helmut Stoecker (ed.) *German Imperialism in Africa*, (London: C. Hurst & Co., 1986) pp 99; Juhani Koponen, *Development for Exploitation, German Colonial Policies in Mainland Tanzania, 1884-1914*, p. 464.

Also, E. Steudel who became a surgeon of the German forces in Tanganyika in 1900 initially was employed to work at the ‘Wissmann Hospital’ at Zanzibar Town. In addition, the German nursing sisters sponsored by the Women’s Association for Care of the Sick in the Colonies, a non-governmental organization for female colonial enthusiasts, had assisted the German medical services in East Africa, perhaps including Zanzibar.²⁷ Beyond this information, the extent of German medical services in Zanzibar Town is unclear. However, we do know that by March 1890, ‘The German Military Hospital’ or ‘Wissmann Hospital’ was closed and moved to Bagamoyo, Tanganyika. This was the time when Zanzibar was put under British colonial rule, though the German East Africa Company (DOAG) kept its headquarters in Zanzibar until 1905.²⁸

After the removal of German Military Hospital, a Khoja Indian, Sivji Bhai Haji Paru popularly known as Sewa Haji²⁹, was requested by the British colonial administration in Zanzibar to donate money for the building of another hospital in Town in 1894, primarily for the use of the army. This came into being as the Tharia Topan’s Hospital, which was started to be constructed in 1887 by Tharia, another wealthier Indian merchant, had never come up as it was plan before. Sewa Haji donated Rs. 12,400 to the colonial state in Zanzibar for the founding of a hospital. The government hospital had also intended to treat Africans, Arabs and Asians living in Zanzibar Town.³⁰

²⁷ Koponen, *Development for Exploitation, German Colonial Policies in Mainland Tanzania, 1884-1914*, p 465

²⁸ Koponen, *Development for Exploitation, German Colonial Policies in Mainland Tanzania, 1884-1914*, p 187, 465; Sigvard von Sicard, ‘The Lutheran Church on the Coast of Tanzania 1887-1914, with Special Reference to the Evangelical Lutheran Church in Tanzania Synod of Uzaramo-Uluguru,’ *Studia Missionalia Upsaliensia XII*, (Uppsala: Almqvist & Wiksells, 1970) p 71

²⁹ Sewa Haji was a Bohora Indian trader born in Zanzibar in 1860s from the trading family. He was involved in lucrative trade in clothes from India to Zanzibar. From the early twentieth century, many Indian traders in Zanzibar including Sewa Haji moved to Tanganyika looking for more profitable new opportunities following the decline of Zanzibar as the great East African entrepot after 1905. The German colonial government requested Sewa Haji, to donate money in the building of hospitals in Tanga, Bagamoyo and Dar es Salaam in Tanganyika from the early twentieth century.

³⁰ ZNA, AB 2/150, Hassanali Karimjee Jivanjee Hospital Naming of Hospital Blocks after the Names of the Various Donors; ZNA NW14/1 *Samachar* 1929, *Samachar* was one among the private newspapers that were founded by various ethnic communities in Zanzibar Town from the late nineteenth century. It was founded by Fazal Jan Mohamed Master who was born in 1873 at Hyderabad in Sindh, India. He came to Zanzibar in 1890. It was established in 1901 and it was written in Gujerati and English. It involved in writing for public welfare and for the uplift of the population with special attention to Islamic matters and more specifically to those relating to his community, the Shia Ithnasheri.

The first government hospital in the Town was called ‘The Native and Subordinate Hospital of the Government’ (NSHG). It was located in the Old Barrack area at Mnazimmoja. Between 1896 and 1900, this hospital was known as the ‘Military Hospital’ as it treated mainly the local police and army, since few local people attended this hospital. Many Town people had resorted to the use of their eastern medicine and African. As we noted in chapter two, the Town population employed Islamic, Hindu-Ayurvedic and African therapy techniques and medicine in treating many diseases. This was even the same to the late nineteenth century colonial India. David Arnold pointed out that “the active survival of indigenous medicine, ranging from various forms of folk practice to the complex system of Ayuverda and Yunani, restricted the demand for Western medicine and limited the scope for a rival medical profession.”³¹

The provision of medical services to military staffs became important in order to monitor the health of military servants. A history of military services in Zanzibar goes back as far as 1876 during the suppression of the slave trade. The British Royal Navy had been involved in seizing slave dhows which smuggled slaves to Arabia, Zanzibar, Mombasa and Lamu after the proclamation of decree to end slave trade in Zanzibar in 1873. In 1875, Sir John Kirk, the then British Consul between 1868 and 1887, suggested that a small army should be raised and placed under the Command of a British Officer to watch the movement of illegal slave trading activities.³²

As discussed in Chapter Two, these slave trade route areas were the transmission routes of many diseases due to the long established contact with the coast. Traders from the coast imported cholera and prompted the eruption of smallpox epidemics throughout the trading posts during the nineteenth century. Cholera, which was imported to Zanzibar from Asia, spread inland through the slave trade routes areas. From the coast, cholera

³¹ David Arnold, “Crisis and Contradiction in India’s Public Health,” *The History of Public Health and Modern State*, Dorothy Porter (ed.) (Editions Rodopi B. V., Amsterdam- Atlanta, 1994) p. 339

³² Hollingsworth, *Zanzibar under the Foreign Office 1890-1913*, p 15-16; For the history of Abolition of Slave Trade and Slavery in Zanzibar see, Basil Cave ‘The End of Slavery in Zanzibar and British East Africa’, *Journal of African Society*; G. L. Sullivan, *Dhow Chasing in Zanzibar Water, Slave Catching in the Indian Ocean*, (London Gilbert and Rivington, Printers, St. John’s Square, 1871) Henry Stanley Newman, *Banani: The Transition from Slavery to Freedom in Zanzibar and Pemba*, (New York: Negro Universities Press, 1898)

reached up to the Buganda area. By the mid- nineteenth century, five major epidemics had hit the East African coast and Zanzibar through the incoming traders from the Red Sea ports and Persian Gulf areas. In addition, venereal diseases were common around the trade routes areas and were introduced at an earlier date to the coastal cities by sailors, traders, and merchants from other Indian Ocean ports and Europe. These diseases affected the mainland trading post areas throughout the nineteenth century.³³

The Hospital came to be known as the ‘Native and Subordinate Hospital of the Government’ reflecting the colonial government’s emphasis on dividing the people according to their social and economic status and ethnic background. After the abolition of slavery in 1897 in Zanzibar, the economic divisions between the Arabs and Indians grew as many Arab landlords were indebted to Indians due to the decline of clove production. The Arabs formed the Arab Association in 1900 in an attempt to maintain the economic prosperity. The Indians, on the other hand, formed ‘The Indian Merchants’ Association’ in 1905 and later Indian National Association (INA) in 1910 to support their commercial domination. The British colonial state intervened by supporting the Arabs who were given priority in the government as junior administrators and as clerks. The British considered Zanzibar as an “Arab state.” Indians were also employed in the colonial government in junior positions though most of them were involved in their private businesses.³⁴

Ethnic division in Zanzibar became further entrenched from 1927 after the introduction of the Legislative Council with representatives from several ethnic groups living in Zanzibar. Initially, only the Arab and Indian representatives were allowed to join the

³³D. E. Ferguson, ‘The Political Economy of Health and Medicine in Colonial Tanganyika’ p 308; For more information on cholera epidemics in East Africa see James Christie. *Cholera Epidemics in East Africa*, (London: Macmillan, 1876); for the history of the coastal traders and spread of disease inland see: Hartwig, G. W, “Social Consequences of Epidemic Diseases: the Nineteenth Century in Eastern Africa” in G. W. Hartwig and K. D. Patterson (eds.) *Disease in African History: an Introductory Survey and Case Studies*, (Durham, N. C: Duke University Press, 1978); Charles Good, “Salt, Trade, and Disease: Aspects of Development in Africa’s Northern Great Lakes Region”, *The International Journal of African Historical Studies*, (1972:5, 4) pp. Richard F. Burton. *Zanzibar; City, Island, and Coast* (London: Tinsley Brothers, 18, Catherine St., Strand, 1872, Vol. 1 & 2)

³⁴ Michael Lofchie, *Zanzibar: Background to Revolution*, (Princeton: Princeton University Press, 1965); Norman R. Bennett, *A History of the Arab State of Zanzibar*, (London: Methuen & Co Ltd, 1978)

Legislative Council. African's representation in the Legislative Council started after World War II, when the British extended the local political representation in many colonized African countries. Also, ethnicity was intensified during World War II with the introduction of food rationing in which high priority was given to Arabs and Indians and lastly to Africans.³⁵ Tapio Nisula has pointed out that "(t)his division is an illuminating example of the way health services were associated with the alleged needs of diverse races and offered according to medical standards created for racial categories in accordance with colonial thinking."³⁶ The British administrators in Zanzibar allocated biomedical facilities according to belief about "race" and social and economic position by which the Europeans were given extensive medical services, to be followed by the rich Arabs and Indians and lastly to poor Indians, Arabs and Africans.

In most cases, the poor Indians were also benefited in these biomedical facilities as many of them were assisted through their charity institutions. There were dispensaries for Khojas, Ithnasheri and Hindus in Zanzibar Town. Also, there were dozens of charity houses and sick rooms for helping poor Indians. Many of these Indian dispensaries were run by qualified medical doctors graduated in Indian Universities. For instance, Nasur Lilan, the owner of the Ithnasheri dispensary and the one who built one of the Indian 'Daram Salah' employed qualified Khoja doctor in his dispensary.³⁷ Much is unknown of the medical history in these charity houses, but there was a possibility that Western medicine was employed to treat these Indians.

Besides that, the colonial government in Zanzibar maintained European Hospital through its local funds from the government revenue. The Zanzibar Government Hospital, intended only for Europeans, was opened in 1913. It was built when the administration of the Foreign Office was passed to the Colonial Office. From 1914 onwards, all the

³⁵ Laura Fair, *Pastimes and Politics : Culture, Community, and Identity in Post- Abolition Urban Zanzibar, 1890-1945*, (Ohio: Ohio University Press, 2001) pp 41-42; Bennett, *A History of the Arab State of Zanzibar*, p 174; Lofchie, *Zanzibar: Background to Revolution*, pp 41-42

³⁶ Nisula Tapio, *Everyday Spirits and Medical Interventions, Ethnographic and Historical Notes on Therapeutic Conventions in Zanzibar Town*, (Transactions of the Finnish Anthropological Society, NRO, XLIII, 1999) p 235

³⁷ Zanzibar Gazette October 25, 1893

administrative affairs of Zanzibar were under British authority.³⁸ The European Hospital was opened at Mambomsiige, which was originally built by an Oman Arab landlord, Bushir b. Harthy as his apartment in 1850. It was purchased by the British Government to be used as the British Consulate in the late 1850s and occupied temporarily by the UMCA from 1864 up to 1877. Up to 1912 the only Hospital which admitted Europeans was that maintained by the French Mission. It was closed in that year and the government established a hospital of its own. It was physically, distant from the Native and Subordinate Hospital of the Government so there were problems in the use of nurses, supplies, dispensary, and compounder. It had four first class furnished rooms and a special maternity room and operating room.³⁹

This European Hospital was located at Shangani point near the sea beaches for two purposes. One, the building was the property of the British colonial government bought by their Consulate, so it became easier for the colonial administrator to use the building without using more funds in constructing a new hospital building. Two, it became suitable to be used as a hospital for Europeans as it was near the sea. From the late nineteenth century, most hospital buildings for Europeans in colonial African countries were established in the hilly areas or near the sea beaches in order to catch the supposedly health breeze. Another aspect of hospital design for Europeans, were the gardens where the patients could have rest for the betterment of their health. In Zanzibar, the idea for selecting a place for building of hospitals for Europeans was influenced by the idea of racial residential segregation which was based upon the discoveries of Ronald Ross of Indian Medical Services (IMS) that *anopheles* mosquitoes were the vector for malaria. Therefore the separation of residential zones and hospital buildings for Europeans became important in order to protect the health of Europeans.⁴⁰ The early 1900s were a

³⁸ Ingram, W. H., *Zanzibar: Its History and Its People*, (London: Frank Cass & Co. Ltd. 1967, 1931) pp 176-7

³⁹ ZNA, Report on the Zanzibar Protectorate from 1911-1923 by John H. Sinclair, British Resident, 1924, p 69, ZNA, BA7/4 Report on the Medical Division for the Year 1915

⁴⁰ For the history of British and French soldiers' mortality in Tropical Africa during the imperial conquest of Africa and the choice for best areas to contain Tropical diseases, see for example, Philip D. Curtin, *Death by Migration Europe's Encounter with the Tropical World in the Nineteenth Century*, (Cambridge: Cambridge University Press, 1989); Philip D. Curtin, *Disease and Empire the Health of European Troops in the Conquest of Africa*, (Cambridge: Cambridge University Press, 1998)

crucial stage for the development of racial segregation as a whole and in the building of hospitals.

By 1921, the European Hospital was too large for a tiny European population in the Town which was estimated to comprise a mere 2% of the Town population as a whole. Its 25 to 30 beds laid empty in most of the year treating few Europeans in the Town and sailors who came to the Town for temporary visits. The presence of few Europeans in the hospital could be associated with low cases of malaria among Europeans. The European staffs in the Town were normally used anti-malaria measures. These measures resulted into low death rate and illness among them. It was reported in the 1913 Public Health Report that “efforts are made to try and induce all officials to take quinine regularly during the unhealthy months. During March, April, May, June and July quinine is distributed gratis to all Government officials.”⁴¹

Due to the low number of European patients in the wards, the only work that was done by the “ward boys” was to polish the brass, swept the floor and dusted furniture. In 1923, the Principal Medical Officer, showed that the European Hospital Building was not actually suitable as a hospital since the building had not been intended for that purpose. He also showed that the sum of the money used for the maintenance of the European Hospital building by the Public Works Department (PWD) for four years would have “amply justified the building of properly designed permanent hospital”. The following year, the ‘European Hospital’ with seven private wards was opened in the compound of the Native and Subordinate Hospital of the Government.⁴² From 1960 onwards, the European Hospital was named the ‘West Wing’ of the Government Hospital and it began to receive the Oman Arab Royal family members.⁴³ This was a time near to the independence of Zanzibar. The colonial state was prepared to give back the country to the Omani regime. Generally, the European community received extensive and a wider range of facilities which are especially striking when we note the small population, while the larger

⁴¹ ZNA, BA 7/2 Public Health Report for the Year 1913, p. 43.

⁴² ZNA, AB 2/131 Government Hospitals Fees For Private Patients

⁴³ ZNA, AJ15/319 Medical Attention for Members of the Royal Family

population in Zanzibar Town of Arabs, Indians and Africans received very limited and generally insufficient medical services.

E. D. Ferguson has compared the medical facilities in colonial Tanganyika of Europeans on the one hand and those of the Arabs, Indians and Africans on the other, by showing that the European Hospital at Dar es salaam had extensive facilities which included a well-fitted X-ray room and a photographic dark room and room for the examination of ophthalmic cases, a spacious an operating theatre, and an outpatient department which was large in relation to the small European community. Above all the Hospital faced the Indian Ocean and received the benefit of the sea breeze. In contrast, the Sewa Haji Hospital at Dar es salaam was built near the Gerezani Creek and was a curious rambling collection of buildings. Generally, the capacity of Sewa Haji Hospital beds was insufficient for the needs of the population of the Town. The ratio of beds to population served was approximately 1: 400-500 for the Sewa Haji Hospital and 1:10 for the European Hospital.⁴⁴

Throughout the 1930s, there was the demand for a larger hospital in Zanzibar Town. In 1935, the Indian National Association approached the government for the construction of Asiatic wing of the hospital to accommodate more Indians in the Town. In 1946, the Asiatic wing was opened through the funds donated by another Indian philanthropist, Sir Tayabali Hassanali Karimjee.⁴⁵ The complaints of insufficient space for Asiatic patients in the Government Hospital were in part the consequence of the familiarity Indians had with- and their acceptance of biomedical facilities in India from the late- nineteenth

⁴⁴ D. E. Ferguson, 'The Political Economy of Health and Medicine in Colonial Tanganyika', *Tanzania under Colonial Rule*, M. H. Y. Kaniki (ed.) (London: Longman Group Limited, 1980) pp 326

⁴⁵ ZNA NW14/1 *Samachar* 1929, the history of Karimjee family in Zanzibar started from the early nineteenth century when Jivanjee Budhabhoy, a founder of merchant enterprise arrived penniless in East Africa. He was a survivor of a storm-wrecked dhow and able to swim ashore and found a trading dynasty in 1819. In 1825, Budhabhoy established a small trading firm at Zanzibar under his own name. He began to work as a small trader, *dukanwallah* exchanging American and Indian textiles for Zanzibar's traditional spices and agricultural products as well as more lucrative standard items from the mainland. As he was the only one of many Indian traders who had come to try their luck at Zanzibar, competition was stiff and expansion slow. Budhabhoy died in 1861 leaving three sons: Pirbhoy, Karimjee, and Esmailjee doing separate business. The most famous was Karimjee Jivanjee who established Karimjee Jivanjee and Company. Karimjee Jivanjee's three grandsons, Hassanali, Mohamedali and Yusufali inherited the family business after the death of Karimjee Jivanjee in 1898 when he was 72. p 45,

century and also with similar private medical facilities Indians had in Zanzibar Town. However, the construction of Asiatic wing did not satisfy the need of expanding Town community.

Again in 1952, Mr. Tayabali Karimjee informed the colonial government of his intention to assist in the extension and construction of a new hospital in Zanzibar Town. He intended to donate between £10,000 – £20,000 for the building of the Zenubbai Karimjee Hospital, which was a T B Sanatorium and for the expansion of the Native and Subordinate Hospital of the Government.’⁴⁶ This was done in order to absorb the expanding Town community of all groups. Accordingly, on 28 July 1955, the Hassanali Karimjee Jivanjee Hospital (HKJ) was opened. It was a communal hospital with different wards for different “races.” It had four storeys and had accommodation for 214 patients. It provided both free and paying wards. It had a well-designed theater unit on the third floor with twin theatres and a small orthopaedic theatre adjoining.⁴⁷ The cost of the hospital was £152,982 of which £90,000 was donated by Her Majesty’s British Government and some £62,000, which was addition of £50,000 that was promised earlier by Sir Tayabali Hassanali Karimjee, was donated by him. The Hospital was named after his father.⁴⁸

In general, the Indian philanthropists contributed significantly to the establishment of hospitals in colonial Zanzibar from 1896 onwards during the inception of the first Government Hospital. Robert G. Gregory has discussed in length the Indian charity activities in East Africa by showing that Indians had pioneered the expansion of not only medical facilities, but also they contributed in the establishment of education and social welfare facilities in Kenya, Uganda and Tanzania. They constructed hospitals and dispensaries for the use of the non-European communities in these countries during the colonial period. He showed that the motives behind Asian philanthropically works in East

⁴⁶ZNA, AJ 4/70 Donation for the Construction of New Hospital Zanzibar 60,000/, 1,200,000/ and New T.B. Sanatorium Dole 5,000/, 100,000/ by Mr. Tayabali Karimjee.

⁴⁷ Report for Zanzibar for the Year, 1957; ZNA, AB 2/151 Hassanali Karimjee Jivanjee Hospital Opening; ZNA, AB 2/1, Annual Report of the Medical Department 1954 & 1955, p 4; ZNA, AJ18/11 Hassanali Karimjee Jivanjee Hospital

⁴⁸ ZNA, BA7/46 Health Department Annual Report 1955, p. 2.

Africa was to demonstrate the community's loyalty to the colonial rule. Another was associated with the injunction to perform charitable deeds found in all the great Asian religions.⁴⁹

Gregory acknowledged that the major impetus to philanthropic activities of Indians was lack of services available specifically to Asians. He sees this as an outcome of "the peculiar character of the British colonial environment which had to be compensated for by "models of benevolence" resulting in part from Indian's modernization and that African modernization or European presence had very little to do with Asian philanthropy in East Africa.⁵⁰ However, other scholars had different opinion concerning the Indian philanthropic works in East Africa. Michael Brett observed that several rich Indians had used charitable organizations to secure themselves socially and politically in order to flourish economically. He also pointed out that the essence of Indian prosperity was through the exploitation of local resources. Indians as minorities in East Africa with economy in their hand led to African and Arab popular resentment against them.⁵¹ David Arnold assessed the contribution of local Indians in the construction of hospitals in colonial India as a way to cement a close and beneficial relationship between the ruling power and the local Indian group. He showed that "medical philanthropist was strategically adopted by influential Indian traders in order to buy influence, prestige and political recognition from the British colonial authority."⁵² What ever the case may be for the benefit of our discussion, the Indians' contributions in health services in colonial Zanzibar has changed the scholarly debate on the role of the colonial state in the provision of health services. The rest of the discussion will consider the accommodation of the Town population to the biomedical care and facilities.

⁴⁹ Gregory, *The Rise and Fall of Philanthropy: Asian Contribution*, p. 9

⁵⁰ Gregory, *The Rise and Fall of Philanthropy: Asian Contribution*, p. 9.

⁵¹ Michael Brett, *Colonialism and Underdevelopment in East Africa*, (Cambridge: Cambridge University Press, 1980) p. 21

⁵² Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century in India*, p. 270.

Who were the patients? 1896-1930

When the Government Hospital was opened in 1896, very few patients made use of its services. Until the 1930s biomedical services were perceived to be “alien” by the majority of the Town’s population. By and large, it was soldiers, a few government employees who worked in colonial government services, such as in government departments already established; the Indian, Arab and tiny African elite; and school children who voluntarily utilized the services. These local Town population attended the Government Hospital (GHNS) for the treatment of cases of illness especially malaria, which was endemic in Zanzibar. Other diseases which were common treated in the Government Hospital were rheumatism, V.D, ulcers and “cold in the chest.”⁵³ The legs, skin and feet ulcers “emerged after years of dormancy following the sufferer’s experience with other infections such as yaws, smallpox, or the exotic jiggers. Poor nutrition increased the risks of complications from ulcers.”⁵⁴

Wounds and war injuries were also treated. We see this for instance when, in 1896, the Sultan’s Palace was bombarded by the British fleet when one of the Sultan’s brothers usurped the throne. Most of the wounded local soldiers (who were mainly Arab, Persian, Baloochi, Comorian, few local African-born Zanzibari and free slaves) were treated at the GHNS. What is noteworthy, however, is that the British army officers were not treated at the Government Hospital, but instead were sent to the missionary hospital of the UMCA and to the French Mission Hospital. These were the two hospitals which mainly treated the European community in Zanzibar Town at that time.⁵⁵ This suggests that the medical services in the Government Hospital were poor and only meant for treating local Zanzibari soldiers. Thus, it would seem evident that segregation and racism dominated the provision of health services right from the beginning.

⁵³ ZNA, BA 83/1 Zanzibar Government, The Annual Report, 1902; ZNA, BA 109/3 A Handbook of Zanzibar 1912, p 10

⁵⁴ Charles Good, *The Steamer Parish, The Rise and Fall of Missionary Medicine on an African Frontier*, (Chicago and London: The University of Chicago Press, 2004) p. 283.

⁵⁵ ZNA, BA 109/3 A Handbook of Zanzibar 1912, p 10; ZNA BA 109/7, Zanzibar Protectorate Annual Report 1913, p 32; A Guide To Zanzibar 1939, ZNA, BA 104/5, The Gazette of Zanzibar, 9/9/1896, It was established in 1892 by Messrs. Forwood Bros. & Co. It was called ‘The Gazette for Zanzibar and East Africa’ intended to give commercial report. The first issue was on 1/2/1892. On 17/10/1894 it was sold and managed by the Zanzibar Government and it changed its name to ‘Zanzibar Gazette’. Dr. Sullivan Beard the then British Vice Consul became the first editor.

In 1906, a dispensary for treating the army and their families was established at Ziwani, further south of Zanzibar Town. This dispensary was also treated local soldiers. Most of the European army officers were treated at the Missionary Hospitals and later at the 'European Hospital', which was established by the colonial government in Zanzibar in 1913 exclusively for the European community in the Town and later in the early 1960s the Royal family members were attended at the European Hospital. The Annual Report of the Medical Division for the Year 1915 showed that in 1914, 91 men out of 122 inpatients who were treated at the European Hospital came from the ships of Her British Majesty's Navy in Zanzibar. Many of them suffered wounds from shelling in the campaign to defeat the military forces of German East Africa. Chronic cases and some convalescents were shipped to Simon's Town, a British naval base near Cape Town in South Africa.⁵⁶ This implies that even the nominally better facilities for the European community was not very good

Besides treating land and naval troops, and police, a small percentage of the Town population was also treated at the Government Hospital from 1900. This was the time when western medical facilities were very limited to tiny population in the Town as we have mentioned earlier. However, the small number of patients choosing to attend the Government Hospital was a major setback for the British colonial administrators in the early period of the establishment of the Government Hospital. It was reported in the Annual Report of Zanzibar Government in 1902 that the outpatients treated among the soldiers and the other Town population was 3,624; or a daily average of 10 new cases compared to the situation in 1901 when the clinic had received 1,267 cases. In other words, it was gradually that new patients attended the hospital every year but this attendance was very small to compare with the population of the Town during that time.⁵⁷ It should be noted, however, that despite this apparent increase, the annual attendance of the Town population in the Government Hospital was very low in proportion to the number of people in the Town. The estimated population figure of Zanzibar Town showed that in 1895 the Town had 60,000 people. There were no official

⁵⁶ZNA, BA 7/4 Report on the Medical Division for the Year 1915, p 70-73

⁵⁷ ZNA, BA 83/1 Zanzibar Government, The Annual Report, 1902

registration records of births and deaths in Zanzibar at that time, but from the available records, it can be estimated that the total attendance of the Town population at the Government Hospital was only 6 percent of the total Town's population.

By 1906, the services had still catered to a low percentage of the Town population. In that year it was reported in the Zanzibar Medical and Sanitary Progress Report that, the physicians were rarely consulted by the local population in the Town. It was reported that "it is impossible to give any statistics under this heading (natives) as the majority of the natives prefer to employ their own medicine men... practically only those in the employment of Europeans seek the advice of qualified men as they are compelled to do so." As in the past, those who attended the Hospital as out-patients were the government employees, the majority of whom were soldiers, *askaris* and their families and inmates in jails.⁵⁸ Also, there was a decline in the number of patients attending the Government Hospital during 1909. It was reported that "Outpatients were 6108 which is a decrease of 981 of 1908 and in excess of the number of in-patients for 1907 by 365. The total number of inpatients was 1050, a decrease of 249 from the total for 1908 and in excess of the number of in-patients for 1907 only by 48."⁵⁹ The reasons for this as stated by the colonial government in Zanzibar were that:

"We fear that the present wide-spread discontent amongst natives and their dislike for anything connected with 'Zirkal' (government) is a much more potent factor, as is also the rule brought into force in the middle of the year by which government employees are fined so long as they are off duty from venereal diseases."⁶⁰

Furthermore, it was reported that "Death amongst in patients numbered 58, a mortality of 5.5 % of patient admitted, the corresponding mortality was 3.1 for 1908 and 2.09 for 1907. The number of mortality is high because of paupers who were sent by the police in a dying condition. And by large number of children who were brought from King's African Rifles admitted with Pneumonia, Bronchitis, and Fever."⁶¹ Obviously, this figure

⁵⁸ Report by Medical Officer, 1906, p. 7; ZNA NW 4/1 Al-Falaq (The Dawn) 10/9/1938. This was a newspaper that was introduced by the Arab community in Zanzibar in 1927. It was started as a mouthpiece organ for Arab clove planters who were indebted to Indian traders from the early twentieth century. By 1950, the newspaper was radicalized when Ahmed Lemky, a radical Arab Nationalist became an editor. The newspaper then became anti-colonialist and involved in nationalist activities.

⁵⁹ ZNA, BA 83/3 Annual Reports for 1909 and 1910, p 40

⁶⁰ ZNA, BA 83/3 Annual Reports for 1909 & 1910, p 40

⁶¹ ZNA, BA 83/3 Annual Reports for 1909 & 1910, p. 41.

is low in comparison to the Town population at that time. The 1910 Census Report showed that the total number of the Town population was 35,204, which means that about 9 percent of the population attended the Hospital.

Apart from the army and police, the prisoners – who presumably had little choice in the matter – also were brought within the ambit of western biomedicine as they attended a hospital and a dispensary that had been built at the Central Prison, at Kilimani near the Ziwani area. After the abolition of slavery in 1897, prisons were refurbished while others were constructed to lock those were labeled by the British colonial administrators to be vagrant.⁶² For instance, the former old Arab fort was transformed into a jail in 1897. Later, by the early twentieth century, the ‘Native and Indian Jail’ was put near the Old Barracks. The first blocks of the Kilimani Gaol were built in 1917 to accommodate European, Indian, Arab and African prisoners.

The provision of biomedical services to the prisoners began around this period. The 1927 Annual Report of the Medical, Sanitary and Biological Division showed that the most diseases that infected the prisoners the most were malaria, ankylostomiasis, respiratory, digestive and skin diseases.⁶³ By 1934, efforts at reform were made by the Medical Officers, in which a detailed medical examination of all prisoners was begun. Many of the prisoners were said to show sign associated with congenital, secondary and tertiary syphilis. It was noted by the Medical Officer in charge of the prison dispensary and hospital that some of these causes were associated with yaws. Moreover, patients were diagnosed with vitamin deficiency. The prison diet which was different for European, Indian, Arab, and African prisoners led to more suffering to African prisoners. This was the case throughout colonial Africa. By 1955, the health of inmates in the prison was said by the Medical Officer to be satisfactory due to the increase hygiene and construction of a new prison building. However, up to the late colonial period in Zanzibar, the number of inmates who suffered hookworm, schistosomiasis and malaria was still high despite the

⁶² ZNA, AC 2/24 “Inward and Outward Letters 1897”

⁶³ ZNA, BA 7/4 The Annual Report of Medical, Sanitary and Biological Division of 1927, p. 47.

measures taken.⁶⁴ This shows that, despite of the extension of medical services in the jails but the health of the African inmates was poor due to anaemia caused by hookworms

Some historians have seen medicine and the state working together to ‘survey and discipline subjects’. There was relationship between state and medicine, and oppression or “civilization.” From 1870s, school medical facilities were introduced in Britain in order to monitor and control the health of its subjects. Medical examinations were done to the school children and buildings were supervised to ensure its safeness.⁶⁵ Like the other health policies in colonized African countries, British colonial administrators introduced school medical facilities in Zanzibar from the early decade of the twentieth century. The School Medical clinic was established in Zanzibar Town in 1913, seven years after the introduction of Government education and Zanzibar became a first British colony in Africa to start the services. Like the early established biomedical services in colonial Zanzibar Town, the School Medical clinic’s building was erected at a cost of Rs. 15,000 from the *Wakf* (endowment) Funds derived from the Arab and African Muslim *Wakf* estates.⁶⁶

The aim of introducing the medical services to the school children in the Town was made clear by the Director of the Medical Services. In 1924 he reported that: “first it is intended to familiarize the rising generation of the population with European medicine. Second, a certain amount of information is collected, which had an anthropometric (the measurement of a person for the purposes of understanding human physical variation) importance. Thirdly, it aimed to be an aid to hygienic and discipline instruction.”⁶⁷ The school children became a focus of western medicine, as they were considered as the future labour of Zanzibar. This was also reported in the 1924 Medical and Sanitary Report.

⁶⁴ ZNA, BA 7/11 The Annual Report of Medical, Sanitary and Biological Division of 1934, pp 34- 35; ZNA, BA 7/22 The Annual Report of Medical, Sanitary and Biological Division of 1955, p 177; ZNA BA 7/38 The Annual Report of Medical, Sanitary and Biological Division of 1961, pp 35- 36

⁶⁵ George Rosen, *History of Public Health*, (Johns Hopkins University Press, 1993)

⁶⁶ ZNA, AJ18/28 School Clinic; The endowments of Muslim properties are known under Islamic law as *Wakf*. Rents or produce generated by *Wakf* property, such as land or houses could be used to endow a mosque or any other public building like a school or dispensary for the use of Muslim community.

⁶⁷ ZNA, BA7/5 Annual Report on the Medical and Public Health Department for the Year 1924

By 1924, the Director of Medical Services apparently considered the local African students as the “cleanest, sturdiest and generally the fittest.” Indians came next and the Arabs were observed as anemic and of poor physique. It was reported that most of these Arabs came from Pemba and *shamba* (rural) and were thoroughly infected with malaria and Ankylostomiasis which retarded their physical condition.⁶⁸ These observations are related to actual living conditions and had nothing to do with supposed “race.” Most of the Indians in the Town lived in crowded conditions, with little ventilation or space in their houses. This obviously negatively affected their health condition as is reflected in the table reproduced in Figure.

The Medical Examination of School Children in Zanzibar Town in 1924

	Indians	Arabs	Swahilis and others
1. Lack of cleanliness	12%	11.5%	2%
2. Defective teeth	21%	23%	9%
3. Enlarged tonsils	21%	9%	5%
4. Defective vision	42%	23%	24%
5. Enlarged spleen	33%	37%	28%
6. Parasitemia	3%	6.8%	10%

Source: BA7/5 Annual Report on the Medical and Public Health Department for the Year 1924

By 1930, it was noticed that the commonest problems among the school pupils in the Town were undernourishment, enlargement of spleen and skin diseases. Paludrine, (an anti- malaria tablets), cod liver oil and iron were given to the children regularly.⁶⁹ In order, to up grade the health of school children, the school vegetable gardens were introduced in 1940. But they became abandoned after few years because of limited time the children had in school. Moreover, by the mid - 1930s, the school medical services became popular in the Town and it became a focus of parents’ discontent when the clinic building was used as laboratory. For instance, in 1935 the Arab Association wrote to the Secretary of the *Wakf* Commission concerning the school clinic building. The

⁶⁸ZNA BA7/5 Annual Report on the Medical and Public Health Department for the Year 1924

⁶⁹ ZNA AJ18/28, School Clinic, p 63

Association was concerned about the health of their children who now had to go to the former T B Clinic for their medical examination.⁷⁰ This marked the shift the Town people began to make towards the acceptance of western medicine. Part of the reason was concerned with the idea of modernization and the importance on the use of the biomedical services emanated among the Oman Arab elites. These elites, who many of them were the leader of the Arab Association, persuaded their community members in the importance of the use of Western medicine.

Western medicine had, however, not become hegemonic for the Town population during the thirty early years of the introduction of biomedicine in colonial Zanzibar. The government servants, the prisoners, elites (mainly the Arabs, Indians and the Swahili), and the school children used the facilities as they were under the direct control of the colonial state. Most interesting is that most of the Indian and Arab elites had direct connection with colonial governments as administrators and in business activities and a large number of Indian elite had access to medical services in India. However, these elites represented a small percentage of the Town population as a whole. The medical services therefore, covered only a small amount of the Town population by this period. The African population, which formed 70 percent of the Town population, was represented only by school children, police and prisoners. From the early 1940s, there were patients' increases in the Government Hospitals and its clinics. The next section will examine reasons for the increase patient's attendances in the hospital.

Who were the patients? 1940-1963

From 1940, progress was made in the attendance and acceptance of biomedical services by the Town people. There were various factors for this including: the extension of services for women's health; the construction of new clinics and dispensaries; and the introduction of local medical staff in the Towns hospitals increased the attention and awareness of local Town population of the beneficial use of western medicine. This went together with the reduction of hospital fees to attract many Town people, especially poor

⁷⁰ ZN, AJ18/28, School Clinic, p 63

Africans. For instance, although women medical services in Zanzibar Town had started in 1909, but it was only really in the late 1930s that the Town's women responded positively to them. The first of these services was the "Women Outpatients' building which was established in 1909 at the GHNS's compound. However, the attendance of women patients at the Government Hospital remained very low up to the mid 1930s. It was reported by the Director of the Medical Services in the 1937 Annual Medical Report that by 1900, the medical services offered to the Women's Outpatients Department were used by Indian and Goan women, but very few Swahili women from affluent families and the wives of the local soldiers attended the services.⁷¹ The Director of the Medical Services was comparing the attendance of women in the Government Hospital from the early twentieth century by showing that slow progress was made on the women's side.

The services expanded again in 1936 after the first female doctor was appointed to work in the Women's Outpatients Clinic, and in the Maternity and Child Welfare Clinic, in Government Hospital for Natives and Subordinates in Zanzibar (GHNS). In 1937, the medical staff in these Women's clinics included: the Indian Women's Medical Assistant or Sub Assistant Surgeon (SAS) in charge; a "European" nursing sister who had a health visitor's qualification; a dispenser from South Africa; a Goan midwife; an assistant-in-training; a clerk and an African *ayah*. They dealt with 7,310 new cases and 45,306 attendances during the year. In Zanzibar, this rose from 22% of women's attendances in 1935 to 40% in 1936 when the clinic started and to 59% in 1937. In Pemba where there was no female doctor, therefore, the attendance was 23%.⁷² The efforts towards the expansion of women's medical services in the Government Hospital were praised by the Arab Association members. The wrote that: "the appointment of a lady medical officer is more praiseworthy, it dispel the belief in witchcraft and other local pedantries which were rooted in minds of women folk who use hundred of rupees in devil dance."⁷³ This comment represented one side of the view of the problem. I think that the Town women ignored the western medical services, as they saw them as being in opposition to their cultural norms. It was uncommon at that time for Muslim women, to be under the care of

⁷¹ ZNA, NW 4/1, Al-Falaq (The Dawn), 18/8/1938, Vol. 6, p. 2

⁷² ZNA, NW 4/1, Al-Falaq (The Dawn), 18/8/1938, Vol. 6, p. 1-2

⁷³ ZNA, AB 2/128, Medical Facilities Government Hospital Charges, pp 1-2

a male other than the family members. The public life of the Town during that time was “genderized.” For instance, there were separate schools for girls and a separate space for women in many public areas and buildings. These cultural norms were, however, perpetuated by the male patriarchy, such as fathers, brothers and husbands in the families. It was unfamiliar for a female patient to be examined by male doctors. The colonial administrators were aware of the problem. The situation was eventually adjusted by the introduction of female staff to treat the Town’s women.

The appointment of a female Sub-Assistant Surgeon from India was approved by the colonial state in Zanzibar in 1936. By 1937, the SAS officers attended and were in charge of several clinics concerned with “women’s diseases” and reproductive health in the Town. These included the Ante-Natal Clinic, the Genito-Urinary Clinic, and the General Women’s Clinic. As the workload in government medical services increased and as the numbers of female patients increased more female SAS officers were needed. Several applications were received by the government from India for the post but they were withdrawn during a time of political and economic friction which led to propaganda being circulated in India relating to the “clove controversy” between Zanzibar and India.⁷⁴ It was reported in the administrative reports of the Department of Medicine and Sanitary that in 1940, the posts of female SAS were advertised again in four leading newspapers in India such as: *The Times of India*, Bombay, *The Madras Mail*, Madras, *The Statesman*, Calcutta and *The Pioneer*, Allahabad. Also, the advertisement was forwarded to the Principal, Women’s Christian Medical College, at Ludhiana.⁷⁵ However, the posts were to remain vacant until after WW II.

In 1945, Mrs. V. R. Sholapurkar, a female Sub Assistant Surgeon was employed in the Government services in Zanzibar released from the Hindu Free Dispensary, owing to the

⁷⁴ ZNA, AB 2/44 Sub Assistant Surgeons; In 1934, the British colonial state in Zanzibar had passed ‘the Clove Exporters Decree’ in which the Clove Growers Association, under the monopoly of the colonial state in Zanzibar became a sole exporter of cloves. This demoralized the Indian clove merchant’s whose survival besides retail business depended on clove exportation to India. For more information on clove controversy in Zanzibar between 1930s and 1940s refer to J. R. Mlahagwa & A. J. Temu, “The Decline of the Landlords, 1873-1963”, *Zanzibar under Colonial Rule*, A. Sheriff (ed.) (London: James Currey, 1991) pp 158-9

⁷⁵ ZNA, AB 2/44 Sub Assistant Surgeons

arrival of Mrs. Noronha from India to work in the Hindu Free Dispensary. Mrs. Sholapurkar was a resident of India and her husband was employed to work in Education Department in Zanzibar. In 1951, when Mrs. V. R. Sholapurkar was on leave, Dr. Talati who had graduated in Medicine at Bombay University and returned to Zanzibar in that year was employed as a female Sub -Assistant Surgeon in the Government Hospital.⁷⁶ Generally, the provision of medical services for the women in Zanzibar Town had to depend on female medical officers from India up to the late 1940s. From the early 1950s, more female nurses were trained locally in Zanzibar. This increased the confidence of the Town women on biomedical services. Also, Beside the British colonial nurses, the archival sources on colonial medical history in Zanzibar are silent on the presence of any female British medical doctors operated in Zanzibar.

Although the training of local nurses had started in 1927 at GHNS, by 1940, very few local Zanzibari nurses had already been trained. This was due to the lack of sufficient qualified teaching staff and the resistance towards the job itself. More qualified teaching staff began to train local nurses in Zanzibar Town, when the salary of the East African nurses was revised in 1945 so as to attract British nurses to work in East Africa.⁷⁷ Furthermore, between 1927 and 1945, the nursing services in Zanzibar were mostly dominated by Zanzibaris- born of slave descendants, who received their education at the St. Monica School and the St. Joseph Convent, maintained by Anglican Church of UMCA and the French Catholics in Zanzibar respectively. In 1945, the Senior Medical Officer approached Sk. Mohamed Nassor Lemky, one among the influential educated Oman Arab-Zanzibari and a Secretary of the Arab Association on the Government's intention to teach the educated Arab girls as nurses and sisters. It had been reported that in the past every effort to enroll educated Arab women in nursing had failed.⁷⁸

Many Arab girls associated the work of nursing with slave work which hindered their involvement in the field. Also, it was noted that very early marriage for the Arab girls

⁷⁶ ZNA, AB 2/44 Sub Assistant Surgeons; ZNA AB 86/69 Mrs. V. R. Sholapurkar Lady Assistant Medical Officer

⁷⁷ ZNA, AB 2/25 Medical Department- Nursing Staff; ZNA AB 2/13 Regulations for Nursing Sisters 1938-1946; ZNA, AB 2/37 Salaries and Conditions of Service of Nurses and Midwives (Europeans)

⁷⁸ ZNA AJ 25/8a Zanzibar Native Medical Service Training, Syllabus and Examination Results

caused the problem. It became very difficult for a married woman to be involved in anything other than domestic affairs.⁷⁹ It has been reported that “Arab girls are not interested as Hospital Ayahs. They associate the work with menial task of slavery. The small number of African Mission girls is literate. Obstacle is that Arab girls are in *purdah* (seclusion). They are not allowed to work in male ward or night shifts. But they are needed especially those who have finished in the Government schools. Most are absorbed in teaching.”⁸⁰

The Arab Association in Zanzibar became involved in the training of Arab girls as nurses by convincing the Arab parents of the importance of training of their daughters as nurses. It can be generally argued that these ethnic associations played a major role in making their ethnic group members to accommodate with western medicine. The history of Arab’s involvement with the modernization activities started from the early twentieth century. Two important factors could be related. First, the Egyptian transformation into capitalism and the influence of modernization from the late nineteenth century was a reason. Second, the Islamic reform movements in Egypt in the same period attracted many Zanzibari Omani Arab landowning class. From the early twentieth century many of them began to send their children to Egypt to join secular education.⁸¹ Most of the educated Oman Arabs from Egypt began to transform social and political life of Zanzibar from the mid- twentieth century during the struggle for independence of Zanzibar.

The local nurses’ services had extended from 1950 when the School of Nursing was established in that year. Between 1941 and 1951, 66 students qualified, of whom 45 were males and 21 were females.⁸² In 1955, 23 nurses sat for the Junior Hospital Examination for Nurses, 6 were female and 17 were male. The entrance was Std. 8 for males and std. 6

⁷⁹ ZNA AB 2/242 Nursing Education

⁸⁰ ZNA AB 2/53 Training of Natives for Zanzibar Native Medical Service

⁸¹ Egypt transformation into capitalism and modernity started in the mid- eighteenth century under Ali Bey (1760-72). More transformation took place from the early nineteenth century under Muhammad Ali (1805-48). During that time Egypt was wide to European economic penetration. Also, Muhammad Abduh (1849-1905), a Muslim reformer and an Al – Azhar intellectual wanted Muslim to harmonize with science and technology. See M. Rifaat Bey, *The Awakening of Modern Egypt*, (London & Toronto: Longmans, Green & Company, 1946; Also, John Iliffe, *Africans: The History of a Continent*, (Cambridge: Cambridge University Press, 1995) p. 163- 4

⁸² ZNA, AB 2/242 Nursing Education

for females. Both were selected by an examination in arithmetic, English and general knowledge. The course took place for three years. The nurses' examination involved a general nursing paper, a surgical nursing paper, and a medical nursing and materia medica, practical and oral examination. From, 1956 the Director of Medical Services decided not to dismiss those nurses who failed in their junior examination but to divide the Female Assistant Nurses into Grade I composed of assistant nurses who failed the examination and grade II were those who passed the exam. It was also decided that the Grade II Assistant Nurses were suitable for "chaperoning", while the Grade I Assistant Nurses were suitable to be in charge of the ward. Those who failed the final examination at the second attempt usually remain in the services as unqualified orderlies or as 'Ayahs'.⁸³ Generally the training of local nurses attracted more patients in Government Hospital. Many of the female nurses were allocated in female wards to treat female patients.

By the end of colonial period in Zanzibar, there were about ten qualified nurses who were trained outside Zanzibar. One among them was Sister Afiya Himid who qualified as nursing sister at St. Thomas' Hospital, Haverford West, Pembrokeshire, in 1961.⁸⁴ There was also an Arab girl who had qualified in Cairo and who was engaged in the government services by the early 1960s. Another nursing sister was Miss F. Hassanali who passed her entrance examination of the Government Girls Secondary School in 1950s. She joined Zanzibar Government Hospital in 1954 and proceeded to England to study nursing at Radcliffe Infirmary in the late 1950s.⁸⁵ The most successful of local Zanzibari Nursing Sister was Sister Khadija Salum Mecca, a staff nurse who received the Order of the Brilliant Star 4th class from the Sultanate government. She was the first woman in Zanzibar except for members of the Royal family to receive this decoration. Khadija Salum Mecca, who became in-charge of theatre in 1960, was further trained in England for the Ward Sisters' Course in the early 1960s. Also, at the same time, Mr. Masoud Ibrahim, a hospital assistant was sent to England on TB nurses' courses in 1960.

⁸³ ZNA, AJ 25/8b Zanzibar Native Medical Service Training, p 6; BA7/46 Health Department Annual Report 1955

⁸⁴ ZNA, AJ 27/47 Miss Afiya H. Yahya, Nursing Sister

⁸⁵ ZNA, AB2/244 Nursing Education for Miss F. Hassanali

Generally, by the end of colonial period, abroad there were 24 Nursing sisters, SRN, SCM, and 1 mental nurse students.⁸⁶

In what seems to have been a determined effort to make biomedical facilities attractive to Town's women no charges were levied for attendances at the Women's Clinic. Indeed, from 1936, the majority African population in the Town was exempted from paying the hospital and clinic fees as most of them were below in the economic ranks to be compared with Indians and Arabs. This was revealed in the 1948 Social Survey conducted by the colonial officials in Zanzibar. The Survey showed that the Indians were in the upper economic ranks followed by the Arabs, and lastly by the Africans.⁸⁷ Also, in 1936, a schedule of fees had drawn up for the government employees in which, lowest fees were charged to Africans, higher fees to Arabs, Comorians and Indians and highest fees to Europeans.⁸⁸ The hospital services were ranked accordingly. Africans were receiving lowest food rations.

In 1935, the Arab Association, however, made a statement at the Legislative Council about the charges imposed by the government at its hospitals. It was reported that the Association

“feared that the charges will avert public to its old habit of going to *Mwalims* and *Mgangs* or witchcraft men (sic) and that Africans will entitled free treatment and Indians had their own private hospital so the remaining are the Arabs. They are concerned with their financial position which has dropped down due to clove prices decline. They prefer the prices charged at the UMCA hospital of one rupee per patient on the first visit and exemption in other visits.”⁸⁹

In the same year, the government pensioners and the Indian Nationalist Association (INA) also sent a petition to the government about the medical charges. They were concerned with the economic depression, which was then hitting the world economy. Indian

⁸⁶ ZNA, BA7/39 Annual Report of the Health Department for the Year 1960

⁸⁷ ZNA, BA 28/11, Edward Batson, “Personal Socio- Economic Rank”, *The Social Survey of Zanzibar, Laboratory Tables and Reports*, (Cape Town: University of Cape Town Press, Vol., 12, 1962)

⁸⁸ ZNA AB 2/122 Medical Standing Orders – 1935-1956

⁸⁹ ZNA, AB 2/128 Medical Facilities Government Hospital Charges; ZNA AB 2/131 Government Hospitals Fees For Private Patients

businessmen were concerned over the collapse of their businesses.⁹⁰ However, up to the end of the colonial period in Zanzibar, Indians and the Arabs paid the hospital fees. The colonial state considered the individual cases among poor Indians and Arabs whenever the need arose. This gives us a different picture to what the Zanzibar Revolutionary leaders later said about the colonial medical services. They argued that the majority poor Africans were completely deprived of medical services in colonial Zanzibar.⁹¹ Indeed, Joop Garssen in assessing the pre- and post- independence biomedical services in Zanzibar has commented that: “To dismiss pre-independence health care as all bad therefore does not only do great injustice to many colonial health workers but also misses out on the opportunity to take advantage of earlier experiences.”⁹²

Meanwhile, the introduction of several government, private and charity dispensaries and clinics gradually attracted more Town people. Before 1940, there were only three dispensaries and two clinics in the Town. Besides the Ziwani, and the Central Gaol dispensary for the police and inmates in the jail, there was the Mwembeladu dispensary at the Gulioni area, which was opened in 1927 to cater for those people who were familiar with the services. The area was preferred as it accommodated the former French Missionary Hospital, built in 1888 for treating the African population. It had been closed in 1900 since few people made use of the services.⁹³ In addition to that, there were the Home Treatment Services which were introduced by the medical administrators in Zanzibar Town in 1922. The Zanzibari-African dispensers who were undergoing training as part of their training visited any African patients unable to attend either the Town dispensary or outpatient services.⁹⁴ The motive behind the establishment of the Home Treatment Services was to familiarize the Town population to use the biomedical services.

⁹⁰ZNA, AB 2/128 Medical Facilities Government Hospital Charges; ZNA AB 2/131 Government Hospitals Fees For Private Patients; ZNA AJ15/319 Medical Attention for Members of the Royal Family

⁹¹ This statement was revealed after the 1964 Zanzibar Revolution that the majority African population had no access to medical services during colonial period so as to bless the Revolution activities. It was followed by the introduction of free health services by the government after the 1964. However, it can be explained that the intention of British administration in colonial Zanzibar was that the provision of health services to the local people was important whether employed by the government or not.

⁹² Joop Garssen, Policies and Practices in Pre- and Post- Independence Health Care, The Case of Zanzibar, p. 70.

⁹³ZNA, BA 7/8 Annual Report on the Medical and Public Health Department for the Year 1927, p 42

⁹⁴ ZNA, BA7/10 Annual Reports Medical and Public Health Department for the Year 1931, p 40

There was also, the Nasur Nur Mohamed Dispensary, and the “Free Hindu Dispensary” which were established in 1900 and 1920 respectively for the Ithnasheri and Hindu communities in the Town. They had also women’s services.⁹⁵

The number of clinics and dispensaries was increased after 1940 for many reasons. First, more funds were made available by Indian philanthropists in establishing these clinics. For instance, in 1952, a T. B Sanatorium was built by Sir Tayabali Hassanali Karimjee and it was named the Zenubbai Karimjee Hospital, after the donor’s mother. Second, government began to provide more funds for the establishment of hospital, clinics and dispensaries after 1945. Third, the political parties in Zanzibar began to provide health services to their member from the early 1960s.

For instance, the Rahaleo clinic was opened by the colonial government in the centre of the Ng’ambo area in 1940 and was extended after the inauguration of ‘Ten Years Development Plan’, which started after WW II, in which more funds were provided for the development of African community.⁹⁶ In the midst of WW II, a project of reconstructing Ng’ambo was inaugurated by C. S. Eric Dutton, a British planner at the Colonial office in London, under 1946-1955 Development Plan. This occurred across British ruled Africa⁹⁷ Also, the increased attendance at the Rahaleo Clinic was due to the establishment of the Rahaleo Civic Social Hall, which was built in 1948 by the colonial state in Zanzibar, near to the Rahaleo Clinic. Movies on health propaganda were shown to illustrate the importance of attending to these hospitals. The role of cinema on health services will be discussed in detail in the next chapter, which deals with the history of the Public Health activities in Zanzibar Town. In addition to that, the Social Welfare activities were centred at Rahaleo for Ng’ambo women at this time, whereby the question of raising standard of local African community through the use of health and biomedical services was in operation. In addition, by the 1940s, there were seven first aid posts in the

⁹⁵ ZNA, BA7/46 Health Department Annual Report 1955, p 7; ZNA AB 2/1, Annual Report of the Medical Department 1954, 1955, p 10

⁹⁶ ZNA, AB 2/34 Postings of Medical Officers;

⁹⁷ Garth A. Myers, *Reconstructing Ng’ambo: Town Planning on the Other Side of Zanzibar*, (PhD Dissertation, University of California, Los Angeles, 1993) p 224,

Town, mainly in the charge of private doctors. By 1957, when the Town had expanded substantially, the government established treatment centres in the commercial and industrial areas which were established far from the HKJ Hospital.⁹⁸

By the mid 1950s, the formation of political parties had started in Zanzibar. After the 1957 General Election with the majority win for the Afro-Shirazi Party, (ASP), which was supported mainly by the Africans in Zanzibar, the political and ethnic tensions had began to intensify. Most of the African squatters were evicted and their plants were uprooted from the Arab plantations. The Arabs were the majority supporters of the Zanzibar Nationalist Party (ZNP). The tension increased in the 1961 June Election when fighting broke up between the ZNP and the ASP members. About 68 people were injured and 8 were killed. It was then that the ZNP opened its dispensary, - the ZNP Welfare Dispensary - at Darajani in Zanzibar Town. It was opened at that height of political conflicts in Zanzibar as many members were injured due to political chaos in the Town. It was explained by one of the ZNP executive members that the dispensary was intended for poor persons in the Town, to be free of charges and it intended to treat all patients regardless of political party.⁹⁹ However, there were no members of the ASP who were ready to avail themselves of these services due to political frictions at that time. Instead the ASP established their own health services at Miembeni at their party headquarters through members' contributions.

Generally, the involvement of political parties in opening biomedical services in Zanzibar Town was influenced by middle- class nationalist press for free and extensive medical services from the government. As we had noted earlier the educated Oman Arab elites were the one who spearheaded nationalist movements in colonial Zanzibar. The African accommodation to the opening of the biomedical services was because of popularity western medicine did have in the Town during that time and it was also due to the question of ethnicity and political frictions that we have explained them previously. Africans and the members of the ASP saw the need of opening their own health facilities

⁹⁸ZNA, AJ 19/32 Town Dispensaries

⁹⁹ ZNA, AJ 15/313 Establishment of the New Dispensary by the ZNP in their Headquarter at Darajani

so that its members could use the facilities. Health services then became a political agenda during that period.

Significantly more local Town people became interested in the biomedicine when local Zanzibari doctors were employed in the provision of such medical services. These local medical doctors were familiar to the Town people. In 1924, Makerere College in Uganda was opened, and was shortly followed by the establishment of Mulago Medical School in 1927, which was designed for the use of the whole of East African countries with an academic component but a hospital- based practical bias. East African students- including Zanzibari-born Arabs, Comorian, Indians and Africans were trained to become Senior Native African Medical Assistants (SNAMAs) and later Senior African Medical Assistants (SAMAs). The medical training for Zanzibaris to serve in as the qualified medical services in the Zanzibar Government Hospital had started in the early 1930s. By the end of 1936, of the 34 students who graduated at Makerere, two came from Zanzibar.¹⁰⁰ This was the first batch of the Zanzibari Medical Assistants. These Zanzibari students were trained in the medical field as a cheaper substitute for male Indian Sub-Assistant Surgeons (SAS) who were claimed by the British administrators to show little consideration to the local people in Zanzibar Town, though the female SAS were encouraged to work in Zanzibar for the rest of colonial period.

The first Makerere Zanzibari graduated students were Said Mahfudh Bingurnah and Said Aboud, who both of them were Zanzibari-born Arabs. They studied medicine and surgery. Said Mahfudh Bingurnah was born in 1909 in Zanzibar. He studied at Zanzibar Central School, and Teacher Training's College before admitted to Makerere. He was trained by the colonial state to be a teacher after completing his teacher's training courses but the demand for trained local medical doctors forced the government to sponsor him in his medical studies.¹⁰¹

¹⁰⁰ John Iliffe, *East African Doctors: A History of the Modern Profession* (Fountain Publishers: 2002) p 2, 61

¹⁰¹ ZNA, AB 86/63 Dr. Said Mahfudh Bingurnah Assistant Medical Officer

In 1940, the government's medical students were still in a secondary school in Zanzibar Town. They were Kingwaba Hassan, and Ahmed Said el-Riyami. The colonial government in Zanzibar decided to look on the progress of the well performing students while in secondary schools so that they could be given government scholarships in medical training after finishing their secondary education. By 1948, seven Zanzibari students were at Makerere.¹⁰² However, as British medical education in Zanzibar did not offer place for women to be trained as doctors so there were very few Zanzibari women medical doctors throughout the colonial period except for the nurses. All Makerere Zanzibari medical students were males and no female Zanzibari woman was qualified for the medical training there. At the same time, other Zanzibari students were trained abroad. By 1960, 11 students were in India and Pakistan and 26 in United Kingdom.¹⁰³

Beside Kingwaba Hassan, who was an African-born Zanzibari and Ramaniklal Shah, an Indian-born Zanzibari, the rest of the Zanzibari medical students at Makerere College between 1935 and 1962 were Arab-born Zanzibaris.¹⁰⁴ Generally, there were more Arab-born Zanzibaris in medical training at Makerere College in comparison to the Zanzibari Africans and Indians for several reasons. Firstly, most of the qualified Arab doctors came from the rich landowning class and wealthier Arabs who started to educate their children in Egypt before the inception of government schools in 1907. The remaining were sent in government schools in Zanzibar and got an opportunity to be trained by the colonial government. As already noted in this chapter, there was a great effort made by the colonial government to ensure that the Arabs were given preferences in junior positions of administration compare with Indians and Africans. This gave them advantage compared to Africans, who were given lower priority in the job market. Many Indians preferred to be involved in private business activities after finishing their studies while most of the Zanzibari-Indian doctors were trained in Indian Universities.

¹⁰² ZNA, AJ 25/5 Zanzibar Medical Students Employment Of; ZNA BA 7/46 Health Department Annual Report 1955

¹⁰³ ZNA, AJ 25/8a Zanzibar Native Medical Service Training, Syllabus and Examination Results

¹⁰⁴ ZNA, AJ25/5 Zanzibar Medical Students Employment Of

Secondly, the percentage of Africans who joined and finished in government schools before 1960 was lower in comparison with the Arabs, Indians and Comorians. Also, Indians owned about ten community schools in Zanzibar Town up to 1963. For instance, in 1948, 50 Arab students completed Standard 12 in which 40 were males and 10 were females. Also, 40 Indian students completed Standard 12 in which 30 were male and 10 were female. Only 20 male Comorians reached Standard 12 in 1948, and no African who reached at that level.¹⁰⁵ Many Zanzibari- Africans reached in Standard 12 only in the late colonial period as the British were ready to leave Zanzibar. Most of these Zanzibari-Africans, through the Afro-Shirazi Party, began to study medicine from the early 1960s and were sponsored by Socialist countries like Russia, China and Cuba, which assisted the nationalist struggles in Zanzibar.

Besides these factors, the other affluent Zanzibari parents (mostly of Omani origin) sent their children, both male and female in England and Egypt to receive medical training. For instance, in 1947, Dr. Zakiya Salim was ready to take her appointment as medical officer at the GHNS, after completing her medical education at Faculty of Medicine, Fuad I University, Cairo, in 1943.¹⁰⁶ She became one of the first female qualified doctors in colonial Zanzibar. In addition, Dr. Fatma Ali Rashid El-Lemky had completed her studies in Midwifery and Gynaecology and Preventive Medicine in 1949 in Cairo. In 1955, she proceeded to London to be qualified as a registered midwife. She was admitted at the West London Hospital Medical School. In 1958, she was appointed as House Officer, Gynaecology at the King Edward Memorial Hospital, Ealing. Later, she obtained an appointment as House Physician in Solihull Hospital, Warwickshire. In 1960, she returned to Zanzibar and worked at Hassanali Karimjee Jivanjee Hospital as paediatrician.¹⁰⁷ This female medical doctor supplemented the services of the female Indian SAS.

¹⁰⁵ ZNA BA 28/7, Edward Batson, "Schooling", *The Social Survey of Zanzibar, Laboratory Tables and Reports*, (Cape Town: University of Cape Town Press, Vol., 10, 1961)

¹⁰⁶ ZNA AJ25/5 Zanzibar Medical Students Employment of

¹⁰⁷ ZNA, AB 86/71 Dr. Fatma Ali Rashid El-Lemky- Woman Assistant Medical Officer

In addition, the Government Hospital at its clinics and dispensary had depended on the services of auxiliaries, dispensers, ayahs and orderlies. By 1940, the services were mostly carried out by the African population in the Town. As had been noted earlier, many Africans of the slave descendants had filled the posts since the late nineteenth century. They received their education at St. Monica and St. Paul; the two UMCA Missionary schools established from 1870s and at St. Joseph Convent established for the African girls by French Roman Catholic Church in 1880. Most of these students were absorbed as Catechists in the mainland of East Africa when most of the missionary works were extended in those areas after 1900. John Iliffe demonstrated that between the 1870s and 1920 very few local Africans were trained as auxiliaries in hospitals in East Africa. Most were allocated purely menial functions and learned by practical apprenticeship. The earliest were freed slaves and greater majority were of low social status.¹⁰⁸

Despite the increasing of number of the patients and the extension of biomedical facilities in colonial Zanzibar, malnutrition continued to affect the health of the Town population. Diseases such as malaria, anemia, yaws, ankylostomiasis, and tropical ulcers became a problem towards the end of the British colonial rule.¹⁰⁹ There was an Ankylostomiasis clinic and malaria was fought through the assistance from the World Health Organization (WHO) from 1955, but anaemia became a major problem. The situation became significant due to the fact that most of the African population- who formed the 70 percent of the Town population- remained poor up to the end of colonial rule in comparison with the Arabs, Indians, and Comorians. Although most of the poor Africans were given free access in government hospitals and its dispensary and clinics their economic power was still limited up to the late colonial period. I can here argue that despite the extension of biomedical facilities in colonial Zanzibar Town, the British policies of categorizing the people according to their race had antagonized local people and prejudiced their good intentions in the provision of biomedical services.

¹⁰⁸ J. Iliffe, *East African Doctors: A History of the Modern Profession*, p 2

¹⁰⁹ZNA, BA7/39 Annual Report of The Health Department for the Year 1960, p 19

Conclusions

Antonio Gramsci, in *Prison Notebooks* has used the term 'hegemony' as permeation throughout society of an entire system of values, attitudes, beliefs and morality which support status quo in power relations. Hegemony is an organizing principle diffused by the process of socialization into every area of daily life.¹¹⁰ By looking at the history of hospitals in Zanzibar, I can argue that in the early years of the colonial period, culture was not given an important place by the colonial administration. This is why, by and large, the biomedical facilities were ignored and it did not become hegemonic. Before 1937, for instance, indigenous women's prejudice towards western medicine was strong. It was only after the introduction of female doctors, assistance and nurses that many Town women had began to accommodate with the services. These women's services helped in removing many health problems that the women faced.

Apart from that, not all the Town population became familiar with biomedical services in the early period of colonial medical services due to the fact the services were dispensed by those people who had direct connection with the colonial administrators either in business activities, in jails, in schools or in offices. The other Town people could not accommodate themselves easily as they were not part of the colonial administration. This is significant as far as the historiography of colonial medicine in Africa is concerned. In many colonized African countries, western medicine was directed towards educated elite who were involved with the colonial government activities in urban areas. It was mostly the Missionaries who spread western medicine in rural areas before 1930. However, the missionary medical services did not absorb the majority Muslim population in Zanzibar. By 1900, most of Missionary medical services were shifted to the mainland of Tanganyika where the Christian populations were established there.

The most important aspect of western medicine in colonial Zanzibar was the contribution made by individual Indians in providing biomedical services. Indians' wealth was used in building hospitals and clinics for the Town community in general and for their community in general. This became possible due to the role Indians played in charity

¹¹⁰ Antonio Gramsci, *Selections from Prison Notebooks*, (London: Lawrence and Wishart, 1971) p. 27.

activities not only in medical field but also in other social welfare activities. For instance, in 1947, the Indian Community through Indian National Association (INA) contributed to the formation of Voluntary Social Welfare Association with heavy Indian donations. This organisation helped poor people in the Town by providing them with handicraft instruments to become self employers, the opportunity that the colonial government did not offer.

Apart from that, the Oman Arab elite played a major role in the transformation of political life in Zanzibar especially from 1940s. The Arab Association's newspaper, Al-Falaq (The Dawn) became a strong political organ for Omani Arabs when Ahmed Lemky, a young graduate from Egypt who involved in Egyptian nationalist struggle by that time, became an editor. Lemky changed the old fashion outlook of many conservative Oman Arab landlords. He mobilized the older section of the leadership to demand their political right from the British colonial state. It was during that time that health agendas became political agendas. Also, economic frictions between Indians and Arabs, which led to the down fall of Oman Arab prosperity and the rise of Indian merchants who control the economy of Zanzibar, caused hatreds to grow between Arabs and Indians. The Arabs saw the need of having extended health services to both Arabs and Africans against extended Indians health facilities. The contribution of local individuals in western medicine during colonial period is the new historiography that challenged the former ideas that the introduction of western medicine was the only work of colonial administrators and missionaries. The history of western medicine in colonial Zanzibar therefore offers us a new outlook on the contribution of local individuals in the provision of western medicine.