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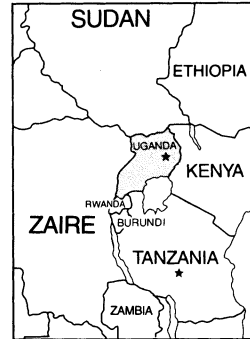
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INTIMATE COLONIALISM: THE IMPERIAL PRODUCTION OF REPRODUCTION IN UGANDA, 1907–1925

CAROL SUMMERS



In 1924, the British recorded more births than deaths in Uganda for the first time since the foundation of the Uganda protectorate in 1900.¹ Civil war, smallpox, cholera, trypanosomiasis (sleeping sickness), bubonic plague, and other epidemics had combined to keep the recorded death rate above the recorded birth rate. But even as the high mortality of the trypanosomiasis epidemic fell, the population of this prize protectorate continued to decline. Protectorate officials and missionaries blamed the continued decline on sexually transmitted diseases (STDs), particularly syphilis.

In retrospect, their alarm may have been unwarranted. Researchers have since argued that syphilis was confused with endemic yaws and that infertility is a classic symptom of gonorrhea

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¹ *Annual Medical Report for the Year Ended 31 December 1924* (Entebbe: Government Printer, 1925), 8.

but not of syphilis.² Furthermore, the population statistics available for the protectorate were not necessarily accurate, though the time from the 1890s through the 1930s was, for much of Africa, one of the unhealthiest periods in history.³ Nevertheless, British officials and missionaries perceived a crisis and acted on the basis of that perception. The population appeared to be decreasing in the centralized kingdoms most crucial to the economic viability and social order of the protectorate: Buganda, Bunyoro, and Toro. A declining population meant a labor shortage capable of threatening the prosperity and viability of the protectorate. It might halt the development of labor-intensive export crops such as cotton, which were necessary to rationalize the expenses of the Uganda railroad and the new colonial administration. It might threaten the stability of the African oligarchs who performed the day-to-day work of ruling Uganda. Most certainly, it would be a sign to critics in Britain that the colony's centerpiece Buganda, so widely acclaimed in the late nineteenth century as an advanced African kingdom, was being hurt rather than helped by its colonial link.

British concern over the reproduction of the population and society of Uganda intensified from 1907 through 1924. Institutions and ideologies were developed to cope with an epidemic of STDs, to promote the family as a unit of reproduction, and to reform motherhood. The British colonizers and the African elite of Uganda built a population crisis from a collection of beliefs and data. The perceived severity of this crisis—and the response it evoked—changed over the years. That response began as a straightforward medical attempt to treat the ill. After the World War, though, “social hygiene” became an important therapeutic tool, and the administration worked to instill shame and to change the sexual behavior of individuals. At the end of the war, the administration medical service and its missionary allies promoted motherhood through the Maternity Training School (MTS) in an effort to make more women reproduce and to make them better mothers. And in the 1920s, the administration and the missions attempted to shape African family

² John Orley, “Indigenous Concepts of Disease and Their Interaction with Scientific Medicine,” in *Health in Tropical Africa during the Colonial Period*, ed. E. E. Sabben-Clare, D. J. Bradley, and K. Kirkwood (Oxford: Clarendon, 1980), 126–38.

³ The protectorate government believed the population of Uganda as a whole was decreasing at a rate of 20,000 per annum (CO536/24/19193, 1908, Colonial Office [CO], Public Records Office, Kew; and K. David Patterson and Gerald W. Hartwig, “The Disease Factor: An Introductory Overview,” in *Disease in African History*, ed. K. David Patterson and Gerald W. Hartwig [Durham, N.C.: Duke University Press, 1978], 4).

structures and private life by employing midwives trained by the MTS in health and education initiatives.

Medical intervention

From 1900 to 1920, between 250,000 and 330,000 people died of trypanosomiasis in Uganda in an epidemic that shocked the protectorate administration into action.⁴ The governor authorized forced removals to clear people away from the tsetse flies that carried the disease. A series of commissions came down from London to discover the cause of sleeping sickness, then to develop a means of controlling it, and finally to assess its impact upon the protectorate's economy and society. By 1905, few people were living in infected areas, and fewer were dying of trypanosomiasis.⁵ The crisis was over. Governor Hesketh Bell could argue that the administrative intervention had worked. The intervention left behind, however, not only a group of doctors and scientists familiar with conditions in Uganda but also a pattern for administrative intervention in the health and lives of the protectorate's people by a system of local administration that oversaw public health, and a pattern of visiting medical commissions that advocated advanced and coercive therapies and population management.

After the epidemic, though, the population continued to shrink, and the protectorate's administration turned its attention to the low birth rates reported by the most politically important regions of the protectorate, particularly Buganda, the protectorate's political, educational, and economic core. This low birth rate was blamed primarily on STDs, especially syphilis. So an investigating commission came to Uganda. It arrived in 1908 and set about requesting records on syphilis from the various doctors in the area. Doctor A. R. Cook of the Church Missionary Society's Mengo Hospital, the region's most prominent medical authority, forwarded statistics showing that syphilis and STDs in general were epidemic among the Baganda. Cook's statistics indicated that during the period 1904–6, syphilis cases constituted between 11 percent and 14 percent of patients at the mission hospital, and STD cases together

⁴ B. W. Langlands, "Sleeping Sickness in Uganda, 1900–1920," *Occasional Paper*, no. 1 (Makerere University College, Kampala, Uganda, 1967), 1; and D. J. Bradley, "The Situation and the Response," in Sabben-Clare, Bradley, and Kirkwood, eds., 6–12.

⁵ H. Hesketh Bell, *Report on the Measures Adopted for the Suppression of Sleeping Sickness in Uganda* (London: His Majesty's Stationery Office, 1909), 8.

(including syphilis, gonorrhoea, and yaws) constituted between 18 percent and 20 percent of inpatients. Furthermore, 22 percent of outpatient cases were seeking treatment for STDs. While these statistics were not unusually high, particularly given confusion between syphilis and yaws, Cook suggested a crisis by estimating that 70 percent of pregnancies among the Baganda ended in miscarriage, stillbirth, or infant death within the first week after birth, attributable to congenital syphilis.⁶ James Will, of the administration's medical service, charged Cook with exaggeration, but the commission believed in an epidemic and Cook's statistics, gradually exaggerated, became the basis of all future statements about the syphilis epidemic in Uganda.⁷

After the massive response to the trypanosomiasis epidemic, medical activism seemed appropriate. F. J. Lambkin, the head of the investigating commission, emphasized that syphilis was just as important as sleeping sickness, because before trypanosomiasis,

another malady of an even more serious nature had begun to sap the life-blood of the tribes. Syphilis was very prevalent in the protectorate, but the researches connected with sleeping sickness overshadowed all attention to the syphilitic outbreak, attracted to itself all interest, and set back all investigations with regard to syphilis in that part of the world. The consequence was that syphilitic disease gained a firm footing in the protectorate, and, being left to itself, caused devastation everywhere among the inhabitants. . . . In fact, as things stand at present, owing to the presence of syphilis, the entire population stands a good chance of being exterminated in a very few years, or left a degenerate race fit for nothing.⁸

⁶ A. R. Cook, "VD Statistics for Col. Lambkin," December 14, 1907, in box: "Incoming General Correspondence, 1899, 1902-9," Albert Cook Library, Mulago Medical School, Makerere University, Uganda (hereafter referred to as ARCLM). A. R. Cook and his brother J. H. Cook were doctors with the CMS. Katherine Timpson came to Uganda as a nurse, married A. R. Cook, and became matron of Mengo Hospital.

⁷ J. Will to A. R. Cook, September 25, 1908; Will to J. H. Cook, January 1 1909, both in ARCLM. Lambkin repeated the statistics (F. J. Lambkin, "An Outbreak of Syphilis in a Virgin Soil: Notes on Syphilis in the Uganda Protectorate," in *A System of Syphilis*, ed. D'Arcy Power and J. Keogh Murphy [London: Oxford University Press, 1908], 2:339). The governor repeated them (H. Hesketh Bell, *Glimpses of a Governor's Life* [London: Sampson Low, Marston, 1946], 171-72), missionary literature used them in fund raising, and medical officers in Uganda used them to extract funding from the colonial office.

⁸ F. J. Lambkin, "An Outbreak of Syphilis in a Virgin Soil," 339.

His alarm was not ignored. Before he left Uganda, Lambkin instructed doctors in the intramuscular injection of mercury, which he claimed would facilitate mass treatment and mass cures. Other doctors with experience in the region were skeptical. Doctor Will asserted that when he had tried intramuscular injections twenty years before, the pain was so severe that he was unable to convince anyone to come back for a second shot and was left with an oversupply of an expensive medicine that no one would take.⁹ Doctors A. R. and J. H. Cook also had their doubts about an extensive STD treatment scheme. They stalled, agreeing to cooperate only years later, after the administration's assurances that examination and treatment would be voluntary and that the administration would provide the technicians and drugs.¹⁰

Despite this local opposition, the administration, accustomed to the idea of massive medical intervention, saw the antisypphilis campaign as a real possibility. Previously, treatment of syphilis had been haphazard at best. Before the development of 606 (marketed in the United States as Salvarsan), mercury was the most effective treatment available for patients with syphilis.¹¹ It could cure the disease if both doctor and patient had the patience to endure treatment until the cure was permanent, but patients hated its side effects.¹² The Lambkin method of intramuscular injection offered a new opportunity. The intramuscular injections did not require patients to take pills at specified times; they put the administration of medication directly under the control of the medical practitioner.

Lambkin argued that medical intervention against syphilis was necessary, feasible, and potentially cost-effective. Too many actively infectious cases in young, productive adults had caused substantial debility to an already depleted work force.¹³ All the commission was asking for, Lambkin emphasized, was a bit of money and some state help in convincing Africans to attend clinics. Given that, Lambkin's assistant assured the Colonial Office that in

⁹ Will to A. R. Cook, September 25, 1908, ARCLM.

¹⁰ A. R. Cook to Major Keane, "Memo on discussion at the medical subconference," December 7, 1921, ARCLM.

¹¹ The name 606 was the original one for the syphilis cure developed in 1908. It has also been called Salvarsan, Neo-Kharsivan, Sulfarsenol, NAB, arsphenamine, and Neo-Salvarsan (Keane, "Annual Report on VD Measures for 1921," in *Annual Medical and Sanitary Report for Year Ended 31 December, 1921, Uganda Protectorate*, ed. C. A. Wiggins, Chief Medical Officer [Entebbe: Government Printer, 1922], 66).

¹² Lambkin, "The Treatment of Syphilis," in Power and Murphy, eds., 260, 261, 283, 296.

¹³ Lambkin and Keane, November 21, 1910, CO536/38 (n. 3 above).

six months he could have “dealt with and cured most of the syphilitic sick in this country.”¹⁴

Lambkin’s investigation and initiatives focused on Buganda, the political, economic, and religious center of the protectorate. Before the establishment of the protectorate, Buganda had been the most powerful and influential state in the region, and it retained that status in the twentieth century through an adroit alliance with British imperial power. Should Ganda power be threatened by depopulation, the protectorate’s administration feared regional destabilization. The British public, educated by missionary propaganda, travelers’ tales, and the debate over the Uganda railroad, saw Buganda as a valuable colonial possession and syphilis as a disease imported by the colonial expansion, so there was a substantial British lobby for an antisiphilis campaign.¹⁵ The colonial office responded to pressure from the protectorate’s administration and the Uganda lobby in Britain and requested 2,000 pounds sterling each year to fight in Buganda the disease that had been introduced “as one of the blessings of European Civilization.”¹⁶

Within Buganda, the Lukiko (the Ganda Council that headed the Native Government of Buganda) had proved its willingness to legislate on health matters by enforcing compulsory smallpox vaccination. Hesketh Bell, who had authorized the radical intervention of the trypanosomiasis removals, agreed to begin the Lambkin initiative in Buganda, where he believed the Native Government would be willing and able to perform the necessary coercion.¹⁷ The Native Government’s cooperation, though, proved difficult to enlist. Lambkin’s original scheme faltered after eighteen months when two of the three medical officers involved left the protectorate, complaining that they could not enforce notification and treatment without more help than they were receiving from the

¹⁴ G. Keane, November 21, 1910, CO536/37837. Keane’s statement proved ludicrously optimistic.

¹⁵ See D. A. Low, *Buganda in Modern History* (London: Weidenfeld & Nicolson, 1971), 228–29, for a discussion of Anglo-Ganda cooperation. See *ibid.*, 62–73, for a discussion of Buganda’s exceptional prominence in Britain. The entire concept of “virgin soil” epidemic syphilis was predicated on the contemporary belief that Uganda had not previously been exposed to syphilis. See, e.g., Lambkin, “An Outbreak of Syphilis in a Virgin Soil,” 339–55.

¹⁶ Lord Crewe to Lloyd George, July 23, 1908, CO536/24. See also Comments by the Secretary of State, 1910, CO536/24; and Governor Hesketh Bell, April 17, 1908, CO536/19.

¹⁷ Governor Hesketh Bell, April 17, 1908, CO536/19.

Native Government.¹⁸ In 1913, protectorate officials complained that “the Natives were not playing up well” to the antisyphilis initiatives.¹⁹

Despite these setbacks, the remaining medical officer, George Keane, remained optimistic, and in 1913 he sought to begin the treatment program again, backed up by new laws and more cooperation from the Native Government.²⁰ The protectorate administration had declared syphilis a “Dangerous Disease” under the Dangerous Diseases Ordinance of 1909, and in 1913 it went further, suggesting that new legislation should be initiated in the Lukiko, and then strengthened by protectorate ordinance.²¹ These “Townships (Venereal Diseases) Rules, 1913” were recognizably coercive. Baganda could be physically forced to undergo examination, and when evidence of any STD was found, they were legally required to undergo treatment. If they stopped coming for their weekly syphilis shots or daily gonorrhoea treatments, their local chief was authorized to have them hauled in for treatment. These laws were modeled on the controversial Contagious Diseases Acts of England and, like them, were enforced only selectively. Officials in Uganda nevertheless demanded the authority to impose medical treatment on the willing and unwilling alike. “Drastic laws,” the governor argued, “are our only chance of dealing satisfactorily with what is now the most serious medical problem in Uganda.”²²

Moral intervention

But syphilis was not merely a medical problem. As Africans were diagnosed with syphilis, a disease reaching epidemic proportions through nonmonogamous sex, they also were diagnosed as immoral. This linkage between syphilis and immorality was present in missionary publications from the earliest observations of syphilis in Uganda, despite the frequent confusion of syphilis with yaws, a related disease transmitted by casual contact. European observers

¹⁸ Principal Medical Officer to Secretary of State for Colonies, May 27, 1913, CO536/60/22767.

¹⁹ Colonial Office Discussion of the Medical Report of 1912, July 4, 1913, CO536/60.

²⁰ The increase in Ganda cooperation was reported by Keane, November 24, 1913, CO536/66/43579.

²¹ Colonial Office Discussion of the Medical Report of 1912, July 4, 1913, CO536/53; Discussion of antisyphilis legislation, CO536/60/22767.

²² Governor [F. J. Jackson] to CO, June 2, 1913, CO536/60.

in 1882 already had proclaimed syphilis widespread, fertility low, and promiscuity common.²³ Imperial observers, especially nondoctors, also disparaged Ganda morality. The women of Buganda, declared one imperial agent, were dissolute and poor breeders; he argued that the nation could be saved only through the influence of Christianity.²⁴

The earliest administrative attempts to cope with syphilis, though, were not laden with moral condemnation, but patterned on the public health measures that had attended trypanosomiasis and other diseases which lacked obvious moral implications. The protectorate's administration deleted clauses of moral condemnation from the Lukiko's version of the Venereal Diseases Legislation of 1913. Initially, the administration put forth its plan as merely another public health initiative.

The missionaries, however, never took that position. They argued that penalties for spreading disease were too light under the new legislation.²⁵ In 1908, even as Lambkin and the administration's medical officers were coming up with carefully nonjudgmental plans, A. R. Cook requested funds from the medical missionary auxiliary to build an isolation hospital primarily for the treatment of syphilis, a disease too embarrassing even to name in a mission publication. Innocent victims existed, he emphasized, particularly as the Baganda did not understand the mode of transmission. But for most sufferers, he would allow no excuses: "The immense majority have fallen ill through immorality." This did not mean that sufferers from syphilis should not be treated. Cook, too, emphasized the danger of the nation's dying out unless its disease, however ill-gotten, was treated. Besides, he argued, treatment provided an important opportunity for evangelization and "remembrance of the enormous influence of the evil surrounding them from birth, backed up by an hereditary tendency to do evil—for until Christianity was introduced, purity of home life was unknown—will prevent our passing a harsh judgement on the sinner, whatever we may think of the sin."²⁶

As late as the end of 1914, George Keane, the administration's doctor in charge of STD programs, continued to provide relatively optimistic reports concerning the progress of antisiphilic efforts.

²³ C. T. Wilson and R. W. Felkin, *Uganda and the Egyptian Soudan*, vol. 1, *Uganda* (London: Sampson Low, Marston, Searle, & Rivington, 1882), 150–51, 183, 186–87.

²⁴ H. Harry Johnston, *The Uganda Protectorate* (London: Hutchinson, 1902), 2:642.

²⁵ From the governor [Jackson], June 2, 1913, CO536/60/22767.

²⁶ A. R. Cook, "An Urgent Need in Uganda," *Mercy and Truth* 12 (1908): 44–50.

But despite the restriction of the campaign to Buganda rather than Uganda as a whole, even within Buganda there were more potential patients than could be treated.²⁷ Keane emphasized that the STD program was uninterested in treating cases of syphilis that had proceeded beyond the actively infectious stage to the point at which infectiousness declines but the most painful symptoms began to appear. Nevertheless, 76–87 percent of the cases his team encountered were contagious.²⁸ And estimates of the proportion of the total population affected by some form of syphilis ran as high as 80 percent.²⁹ By 1915, the discussion of STD in Uganda had built to a crescendo, and then it stopped. The problem was enormous, but its very magnitude had pushed it back to the position of STD treatment before the Lambkin investigation—that is, STD treatment was deemed important but impractical given the limited reach of the colonial state and the high demands of the available medical technology. To reach even those in Buganda who needed treatment, and to force them to accept painful and expensive treatment against their will, would require a stronger state and a more extensive medical system than Britain had transferred to Uganda. The resources necessary to make the treatment scheme credible were simply not available.

During the First World War, Uganda was hit by epidemics of small-pox, dysentery, cerebro-spinal meningitis, and bubonic plague, followed after the war by influenza.³⁰ This high morbidity and mortality produced acute concern in both Britain and Uganda over the vitality and survival of the population. As early as May 1917, the Colonial Office discussed the possibility of resuming anti-STD efforts in Uganda as soon as staff could be released from wartime work.³¹ But when STD work resumed, its character changed. It was no longer a medical response to an epidemic. It became a moral crusade.³²

Some new medical resources for treating syphilis became available after the war as limited supplies of 606—expensive, but more

²⁷ G. Keane, "Venereal Disease," November 24, 1913, CO536/66/43579; "Venereal Disease," November 11, 1912, CO536/53.

²⁸ Lambkin and Keane, November 21, 1910, CO536/38.

²⁹ Bell, *Glimpses of a Governor's Life* (n. 7 above), 171–72.

³⁰ A. G. Stanley-Smith, "Sir Albert Cook's Legacy," 1967, ARCLM (n. 6 above).

³¹ "Antivenereal Work," May 17, 1917, CO536/98.

³² Within Britain itself, concern over the demographic implications of changing patterns of motherhood and fertility also intensified during this period. Many of the programs developed for Uganda were implicitly or explicitly modeled on the various initiatives that Jane Lewis and Anna Davin have described as "imperial motherhood" (see Jane Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900–1939* [London: Croom Helm, 1980]; and Anna Davin, "Imperialism and Motherhood," *History Workshop*, no. 5 [Spring 1978], 9–65).

effective and with fewer side effects than mercury—arrived in Uganda. But with the failure of the prewar campaign, and the disappointing accomplishments of the Native Government, even Keane, the head of the prewar treatment scheme, advocated a new strategy. The postwar approach was to have three parts: a coercive anti-STD campaign similar to the one before the war; a propaganda campaign to educate the Baganda in the dangers of immorality; and a motherhood campaign to train midwives and, through them, mothers, in an effort to lower the infant mortality rate. This was no mere public health initiative. It was a complex response to the depopulation of Uganda. It mobilized new forces in both Uganda and Britain in an attempt to inspire and institutionalize a new morality.

The administration allowed the missionaries to take the lead in the new campaign and, in paying for the missionary-administered social purity campaign and maternal health programs, it provided missionaries with a highly visible platform from which to speak. Even before the war, missionary rhetoric on the subjects of population and motherhood in Uganda had been highly judgmental. A. R. Cook and Katherine Timpson Cook of the CMS's Mengo Hospital had been the primary spokespersons. They emphasized that the Baganda acted immorally because they had never been taught sexual morality. A. R. Cook decried "the entire absence of a national conscience against sins of immorality" and argued that, without education in sexual self-control, the colonial abolition of harsh, deterrent responses to adultery or illicit sex—such as enslavement or death—left the Baganda confused amid moral anarchy.³³ Before the war, the Cooks had attempted to address this perceived lack of conscience by preaching to the ill in the isolation hospital. They apparently had some success, as A. R. Cook declared this to be rewarding work.³⁴

The Cooks' approach to patient selection differed from the state-medicine perspective the administration endorsed. The administration treated cases of primary and secondary syphilis that were actively contagious and present in relatively young, otherwise healthy men and women. The Cooks treated "human wreckage . . . those whom even their not over-scrupulous heathen friends refuse to receive into their huts."³⁵ This emphasis on treating those who would be most transformed by the experience, rather than those viewed as most useful to society, exemplified the Mengo approach

³³ A. R. Cook, "An Urgent Need in Uganda" (n. 26 above), 44–50.

³⁴ A. R. Cook, "News from Mengo," *Mercy and Truth* 13 (1909): 9–13.

³⁵ A. R. Cook, "The Opening of the Roosevelt Block, Mengo Hospital," *Mercy and Truth* 14 (1910): 76–79.

to STDs. Doctor J. H. Cook, writing in 1910, commended the administration's treatment centers as the only approach that the state could take, but asserted that the missions could do more: "I cannot help feeling that this . . . is yet tackling the problem from the wrong end. I believe that it would be more scientific to tackle the cause, the moral cause, rather than the physical result."³⁶

The administration reinstated its treatment program under Keane, but its medical achievements were limited. Drugs were scarce. From April through August 1921, the administration's medical team had no 606, which remained the most efficient treatment for syphilis, yaws, and plague. Even when 606 was available, it was, at six shillings a dose, extremely expensive. Patients were most often treated instead with inefficient and painful mercury injections. Doses of both mercury and 606 were frequently halved on the assumption that Africans were more sensitive to drugs than Europeans, leading to patient complaints that they were forced to attend clinics for months because "the injections are not strong enough."³⁷ Furthermore, coercion was becoming increasingly difficult. Women were shielded by their relatives, who objected when women were taken away from their work and families.³⁸ Many outpatients ceased to report for weekly treatments as soon as their immediate symptoms subsided, but before they were cured.³⁹ And, in addition to this Ugandan resistance, the administration began to receive protests from women's groups in Britain objecting to compulsory examination.⁴⁰ The original public health strategy was obviously not going to work.

But Keane remained hopeful, announcing triumphantly in his 1921 report that "it is a tribute to the efficiency of anti-venereal disease measures that at length an awakening of a sense of social

³⁶ J. H. Cook, "The Highest Work of Medical Missions," *Mercy and Truth* 14 (1910): 310–11.

³⁷ Apolo Kagwa [reporting complaints] to Provincial Commissioner, December 19, 1921, CO536/120/conf. August 26, 1922, "Venereal Disease." The expense of 606 or even mercury provided an additional motive for lowering dosages for Africans (see the casebooks of Mengo Hospital [ARCLM]).

³⁸ Women were reportedly more difficult to compel to treatment because their work and domestic responsibilities were more demanding than those of male outpatients (Keane, "Annual Report on VD Measures for 1921" [n. 11 above]).

³⁹ This had always been a problem. See, e.g., Keane, November 21, 1910, CO536/38/37837, and "Annual Report on VD Measures for 1921." Over the years, though, the population of partially cured—chronic—cases accumulated.

⁴⁰ Governor Coryndon to Secretary of State, CO536/120/conf. August 26, 1922, "Venereal Disease." This file also contains letters and reports from the Young Baganda Association, and Drs. A. R. Cook, J. H. Cook, G. J. Keane, and J. Hope Reford (acting principle medical officer, Uganda) responding to these attacks by defending the treatment program.

shame has begun to appear.”⁴¹ While still maintaining his ambivalence about the quality of treatment in the mission hospitals, Keane had come around to the Cooks’ point of view: that the Baganda could best be saved through the dissemination of “ideas of domesticated existence and family life.”⁴²

Keane convinced the administration and the colonial office that shame, created by the education and propaganda of the Cooks’ Social Purity Campaign, was the most efficient means of addressing the problem of STDs. Some officials opposed this change in strategy, arguing that the state was being railroaded into paying for missionary expenses. But despite this lack of enthusiasm, the Colonial Office saw the missionaries as necessary. “In view of the widespread incidence of VD,” stated one doubter, “I am afraid that little progress will be made unless the assistance of the missionary societies can be enlisted.”⁴³ The administration saw shame as a tool, but it did not view Buganda in strictly moralistic terms.

The missionaries, in a mirror image of the administration’s position, viewed the situation as a moral crisis, and spoke the rhetoric of development and demography instrumentally. They sought to change the “callous indifference” Baganda showed toward the “ravages” of syphilis.⁴⁴ In missionary publications, A. R. Cook described his social purity speech as a set of descriptions, parables, and analyses that “tracked back the evil to its underlying moral causes. . . . Above all, these diseases differed from others in affecting the soul as well as the body.”⁴⁵

The English-language draft of the speech, however, was remarkably nonjudgmental. It had a moral content, and the missionaries delivering it certainly saw the morality of the Baganda as an issue. But the speech emphasized public policy and put forth patriotic and rational, rather than ethical or religious, arguments. It appealed to ethnic pride and notions of progress: “The glory of a nation is its people. A strong prosperous nation is a land where there are numerous healthy families, in which the population is growing year by year, and where the births greatly exceed the deaths. If Uganda is to be judged by these standards it is a dying nation.” The speech’s

⁴¹ Keane, “Annual Report on VD Measures for 1921.”

⁴² *Ibid.*

⁴³ O. A. G. Jarvis, “Anti-Venereal Campaign,” January 5, 1922, CO536/118/6.

⁴⁴ A. R. Cook to International Women’s Suffrage Association, August 26, 1922, CO536/120. To an extent, they may have succeeded. Note the letter from Nuwa Sematiba, secretary of the Young Baganda Association, in the same CO file, who wrote, “No matter if roads, houses, factories and railways are constructed, it will all be of no use if the population is disappearing.”

⁴⁵ A. R. Cook, “A Social Purity Campaign in Uganda,” *Mercy and Truth* 25 (1921): 271–98.

exhortations to reform did not condemn past morals so much as outline the steps necessary for survival. The Cooks told the Baganda to discourage excessive schooling in favor of early marriage, to spread knowledge of how STDs were transmitted, and to accept treatment. The only explicit attempt to remake Ganda sexual mores was the speech's conclusion that "self-control of the young man or woman is the essence of the whole matter, and this can only be secured by parental example, by careful training from childhood, and by the growth of a healthy public spirit."⁴⁶

Institutional intervention

The STD treatment program and the social purity campaign were designed to reach the sexually active individual, making him or her healthier and more fertile. But the state did not confine its intervention to individuals. Instead, through motherhood programs and girls' education, it attempted to reshape families.

The Maternity Training School (MTS), founded in 1918, grew from the complex and sometimes contradictory attitudes of the white community of the protectorate. Funded by the administration as a public health measure, run by the Church Missionary Society (CMS) for evangelical and humanitarian purposes, and initially governed by a board with representatives from the CMS, Catholics, and the administration, the MTS was intended to train teenage girls from all over Uganda as midwives and send them to care for women and their babies. The MTS was, however, rooted in a more profound European desire to transform African society than the public health efforts that responded to trypanosomiasis or STDs. From the beginning of the twentieth century, Europeans perceived Ugandan mothers as incompetent. As Katherine Timpson Cook wrote, "Many of our dear Christian women who are quite intelligent about reading are quite ignorant about caring for their little ones. A great number of the new-born babies die at once, or a few days after, and no wonder when we remember the treatment they receive at birth. The little mite is dashed all over with cold water, not dried, placed on a large banana leaf quite naked, to finish off any life that may remain after the cold water and night air. . . . It is a case of 'the survival of the fittest' in Uganda."⁴⁷

⁴⁶ A. R. Cook (and possibly Katherine Timpson Cook), English-language draft of Social Purity Campaign Speech, for delivery in Luganda, 1921, ARCLM.

⁴⁷ Katherine Timpson (later Cook), "Mothers in Mengo," *Mercy and Truth* 4 (1900): 219.

Cook's agenda as a missionary was not merely to teach women, but to make nurturers of these savage mothers. Some missionaries compared African women to animals—and found the animals superior: “I suppose there is none other stronger than the mother-instinct in animals and birds,” one missionary wrote, “Yet a heathen African mother is willing, nay, is anxious, to destroy her new-born baby. . . . Her superstitious dread . . . is stronger than her human mother-instinct.”⁴⁸ African women, the missionaries believed, behaved as though less than fully human. And colonial officials and their wives concurred, perceiving them as clumsier, stupider, and dirtier than African men.⁴⁹

This image of African women as less than fully human facilitated the STD compulsory examination and treatment programs, justifying coercive legislation of a type opposed in Britain itself by those who had prompted repeal of the Contagious Diseases Acts on the grounds that the forced examinations dehumanized women. The image also slowed the development of maternal health programs for Ganda women. Initially, attempts to cope with a declining population had focused on STD treatment rather than maternal health, partially because though the local customs concerning childbirth and infant care were considered harmful, they were also considered “more difficult to overcome than any others.”⁵⁰

Yet the administration acknowledged that if it was to give serious attention to the problem of STD and the declining population, it needed to intervene in the private sphere of pregnancy, birth, and infant care. This intervention was highly problematic. Many European observers believed that outside intervention had corrupted African women. Syphilis itself was said to have arrived in Buganda through increased contact with the east, and Lambkin argued that Christianity transformed it into an epidemic by setting women free and abolishing deterrent punishments for adultery.⁵¹

The official medical service, despite its experience in dealing with epidemics, had little success in reaching women as a category

⁴⁸ R. Y. Stones, “Medical Education in Africa,” *Mission Hospital* 30 (1926): 81–84.

⁴⁹ E. F. Kennedy, “Life Was Seldom Dull: The Experiences of a Woman in Equatorial Africa,” Rhodes House, Oxford MSS.Afr.s.514.

⁵⁰ Colonial Office Discussion of the Medical Report of 1912, July 4, 1913, CO536/60.

⁵¹ Lambkin, “An Outbreak of Syphilis in a Virgin Soil” (n. 7 above), 343–44. Buganda's contacts with the outside world had expanded radically during the nineteenth century through interactions with Swahili traders from the east coast, military forces from the Anglo-Egyptian Sudan, railway workers from as far away as India, and European imperial agents, adventurers, traders, and missionaries.

of patients with special needs. Women's relatives shielded them from the compulsory examination, notification, and treatment programs. Even when found, women were difficult to treat. Because they had more domestic responsibilities than men, their absence from home during inpatient treatment caused serious domestic problems.⁵²

Male doctors and their male assistants ran the STD programs, and their control made the work morally suspect. African women avoided the programs and British women deplored them. Some British women's organizations and many Baganda saw them as treating women like prostitutes. Regardless of how women actually were treated, this image exacerbated the unwillingness of Baganda women to go to the centers for treatment and suggested to some Europeans that intervention might be undermining the morals of African women.⁵³ The CMS medical subconference sent Keane a list of treatment guidelines that emphasized propriety. Missionaries were not to examine anyone except with consent, and women were to be examined by a female inspector. The resignation of the administration's only female doctor, Margaret Lamont, sparked off protests from English groups that had fought against the English Contagious Diseases Acts in the 1870s and 1880s.⁵⁴

The missionaries' role as intermediaries between the European community and women with babies quieted this type of criticism. And the missionaries had powerful motivations for stepping into this role. Philosophically, they approved of programs designed to help Africans and serve the African as "an end in himself."⁵⁵ Missionaries observed that "the mothers are really attached to their little ones, and their grief is very touching when they die, and yet

⁵² Keane, "Annual Report on VD Measures for 1921" (n. 11 above), 67–68.

⁵³ Unlike contagious diseases programs in England (see Judith Walkowitz, *Prostitution and Victorian Society* [Cambridge: Cambridge University Press, 1980]), India (see Kenneth Ballhatchet, *Race, Sex, and Class under the Raj* [New York: St. Martin's, 1980]), and South Africa (see Charles van Onselen, "Prostitutes and Proletarians, 1886–1914," in *Studies in the Social and Economic History of the Witwatersrand, 1886–1914* [New York: Longman, 1982], 103–62), the Ugandan program was not aimed specifically at prostitution. More men than women were examined, and the emphasis was on safeguarding fertility rather than on policing loose women. See, for discussions of this policy, "Venereal Diseases" file, August 26, 1922, CO536/120/conf.

⁵⁴ A. R. Cook to Keane, "Memo on discussion at the medical subconference," December 7, 1921, ARCLM (n. 6 above); "Venereal Disease," August 26, 1922, CO536/120/47470/conf.; and Walkowitz.

⁵⁵ J. H. Oldham, "The Population Question in Africa" (1926), 33–34, in box 206, Documents of the Conference of the British Mission Societies/International Missionary Council (CBMS/IMC), School of Oriental and African Studies, London.

the infant mortality is so high.”⁵⁶ The Maternity Training School trained midwives to help individual women bear and keep alive the children they desperately wanted. By decreasing maternal mortality and increasing women’s chances of having nonsyphilitic children, the MTS was working to prevent suffering. Furthermore, women had long been an important part of the missionary program. Women missionaries participated in medicine and evangelism even before trained nurses arrived in 1897, and their presence calmed fears about the moral difficulties of treating women who suffered from STDs. These women argued that action was necessary, but that “it is useless tackling the problem merely from the men’s point of view. The women must be taught and helped.”⁵⁷

The missionaries’ push for a maternal health program in Uganda was also highly practical. The CMS maternity program mobilized new financial resources for medical missionary work during a period of fiscal crisis. Women and children were perceived as worthy of help, and individuals, organizations, and governments both within Uganda and beyond contributed to fund the MTS.⁵⁸ In the larger community of colonial Africa, the MTS trained the initial faculty of Lady Griggs’s Maternity Training School in Kenya, and visiting commissions praised the MTS program enthusiastically.⁵⁹ This widespread support translated into funding from both official and private sources, part of which helped finance the rest of the medical mission’s programs.⁶⁰

This support meant more than just money. It also gave missionaries a privileged niche within the increasingly secular and formal colonial power structure of Uganda. In providing the mission with a medical specialty that the state found difficult to manage, the maternity program prevented the medical aspect of missionary work from becoming redundant as state-sponsored medical services

⁵⁶ A. Bond, “Toro Hospital and the Work There,” *Mercy and Truth* 19 (1915): 397–406. Grief from infant mortality and childlessness is a major theme of the medical literature. There is no evidence of married women choosing contraception, abortion, or infanticide.

⁵⁷ “The Lady Coryndon Maternity Training School” (1925?) Box 206, CBMS/IMC.

⁵⁸ Testimonials to MTS (1920?), box: “Incoming General Correspondence (Including MTS), 1919–21, 1925–30,” ARCLM.

⁵⁹ The MTS received approval from, among others, the East Africa Commission and the various Phelps-Stokes Commissions (minutes, July 6, 1925, “Minute book of the Lady Coryndon Maternity Training School Committee,” vol. 2, 1923–54 [A. R. Cook, Secretary], ARCLM).

⁶⁰ See, e.g., J. H. Cook to A. R. Cook, May 22, 1925, box: “Mengo Hospital Incoming Correspondence from CMS London, October 1919–32,” ARCLM.

expanded. The mission acquired an official role as the only trainer of midwife candidates for the administration's certifying exam.⁶¹ The CMS supervisors in London applauded this as a master stroke, ensuring missionaries access to Africans even as the administrative structure was secularized.⁶² And later in the midwives' careers, the mission, as their sponsor, could instruct state officials on how these women were to be managed and their practices promoted.⁶³

The maternal health program of Uganda was a joint venture between the state and its missionary subcontractor, two groups with different agendas but overlapping interests. The program was designed to suit everyone involved. For the administration, it was a bureaucratic response to high rates of maternal and infant mortality. The mission-run maternity system was to consist of a school for the training of African midwives (the MTS) and the maternity centers throughout the country, to which trained and certified midwives would be sent. An inspector from the MTS would supervise standards of technique, hygiene, and morals in the outlying centers. Ideally, the centers were to be supported by the patient fees, though midwives were guaranteed a salary from either the administration or the sponsoring mission. The midwives within the centers would provide prenatal care, deliver the babies, and teach new mothers how to care for their infants.

The missionaries wanted to do more than stabilize the population by facilitating live births. Hoping to produce salvation as well as treatment, they emphasized the Christian education of midwives and mothers and cultivated the role of the midwife as a moral exemplar for her community. Midwives were to live the propaganda that the social purity campaign delivered as rhetoric. Katherine Timpson Cook and A. R. Cook saw each midwife as a potential light shining in the wilderness, delivering medical, moral, and religious enlightenment to her flock. The Catholic missions were so impressed by the evangelical potential of the idea that by 1924 they withdrew their support from the CMS maternity program and began one of their own at Nsambya, headed by Mother Kevin.⁶⁴

⁶¹ "Constitution of the Maternity Training School," July 1920, box: "Incoming General Correspondence (Including MTS) 1919–21, 1925–30," ARCLM.

⁶² H. D. Hooper to Katherine Cook, April 22, 1930, ARCLM.

⁶³ Form letters: A. R. Cook to Police Commissioners; A. R. Cook to Ssaza chiefs (English translation), both in box: "Incoming General Correspondence (Including MTS), 1919–21, 1925–30," ARCLM.

⁶⁴ Mother Kevin, "Report of MTS, 1924, Nsambya," in *Annual Medical Report for the Year Ending 31 December 1924* (n. 1 above), 21–22.

Back in England, the maternity program was an enormous public relations success. The MTS published progress reports with touching stories about the happy mothers who survived childbirth and whose babies lived, saved by the midwives' care. Pictures showed midwives lined up, clean and smiling in their uniforms. And by 1924, the recorded birth rate did surpass the recorded death rate in most regions of the protectorate, including Buganda.

Privately, however, the midwives' sponsors were more ambivalent. The tiny excess of births over deaths was not necessarily the result of STD treatment or midwives' care. In 1926, despite the rapid expansion of midwife training, only about 2,000 of 16,000 live births registered in Buganda were attended by certified midwives.⁶⁵ In the protectorate as a whole, MTS-trained midwives were even scarcer, and sometimes deliberately avoided by potential patients.⁶⁶ Furthermore, the moral and social agenda of the maternity programs encountered significant problems. The midwives were young women who were given an education, selected to play a leadership role, and then sent into communities where their new education isolated them. The missionaries, and even the more sympathetic MTS committee, were appalled whenever a midwife stepped beyond her sermonizing role and attempted to establish either equality with the European missionaries in whose stations she worked or membership in a local community through a liaison with a local man. Both responses constituted rejections of the MTS's emphasis on deference and Christian morality.

The relationship between the midwives and their European sponsors was complex and contradictory. Propaganda disseminated in England lauded midwives as potential saviors of their race. They were portrayed as prototypes for a new African womanhood, one "doing yeoman service to their country women and children," as each maternity center became "a potential centre of light and learning."⁶⁷ These new women saved infants, rather than merely watching them die. Privately, however, within Uganda, this praise

⁶⁵ Minutes, February 8, 1926, "Minute book of the Lady Coryndon Maternity Training School Committee," vol. 2, 1923–54 (A. R. Cook, Secretary), ARCLM.

⁶⁶ Isabel Servin to Katherine Cook, August 12, 1920, box: "Incoming General Correspondence (Including MTS), 1919–21, 1925–30," ARCLM. Neither Servin nor the others reporting problems explain why some women chose to avoid midwives. Possible explanations include expense, fear of moral condemnation, and distrust of colonial innovations.

⁶⁷ "Report of the Lady Coryndon Maternity Training School" in "CMS Medical Missions in Uganda, 1920," PPR/COO/L11, Contemporary Medical Archives (CMA), Wellcome Institute, London.

was qualified. Missionaries and officials alike saw midwives not as rational adults, but as fragile, morally suspect, impractical girls. Katherine Timpson Cook habitually censored the mail of student midwives at the MTS, weeding any letter she saw as a “direct incitement to immorality.” Sexual activity, or pregnancy, abruptly ended “many promising careers,” as it was evidence for expulsion on the grounds of “moral lapses.”⁶⁸

This close supervision did not end with certification. Midwives continued to be treated as minors even after graduation. Katherine Timpson Cook and her successors inspected each Maternity Center on a regular basis. These inspectors mothered the midwives sternly, attempting to provide emotional support and to ensure that moral standards and medical practice were up to expectations. The mission also asked the Native Government to provide midwives with male guardians who were to protect them and to collect fees from patients, providing a monthly accounting to the MTS committee.⁶⁹ And midwives were supposed to defer to European missionaries. Too much pride or independence was considered dangerous. Missionaries complained when the midwives proved difficult to dominate, requesting official MTS scoldings for the offenders.⁷⁰

More than just scolding midwives for alleged disrespect, moral lapses, or laziness, the MTS committee could ask the administration to take them off the list of registered midwives. Katherine Timpson Cook and A. R. Cook came to the defense of one of the school’s brightest students, who was accused of insubordination, and noted that her censure had been arbitrary and that her side of the story had been ignored.⁷¹ Yet censure and subsequent expulsion were the most powerful tools available to the MTS in its attempts to ensure that its midwives continued not merely as competent medical practitioners but also as moral models. After several disputed cases of moral lapses, the committee stated as policy that, following a conviction, the midwife would either lose her professional

⁶⁸ From Katherine Cook, Letter, December 23, 1929; J. H. Cook to A. R. Cook, June 30, 1921, both in box “A: Copy Letters from AR Cook, B: Cook family letters,” ARCLM. For a sample of officials’ opinions, see the discussion of the Midwives Ordinance of 1922, April 27, 1922, CO536/118/230.

⁶⁹ Form Letter, A. R. Cook to Ssaza chiefs (English Translation), box: “Incoming General Correspondence (Including MTS), 1919–21, 1925–30,” ARCLM.

⁷⁰ Pilgrim to Katherine Cook, June 20, 1921, box: “Incoming General Correspondence (Including MTS), 1919–21, 1925–30,” ARCLM.

⁷¹ Minutes, April 7, 1923, “Minute book of the MTS Committee,” vol. 2, 1923–54 (A. R. Cook, Secretary), ARCLM.

status or, if suitably repentant, be suspended for a year, retrained at the MTS, and reassigned with a lower salary.⁷²

The minute book of the MTS committee relates a history of struggle and conflict over the independence of the midwives from the authority of school, mission, or state and over prescribed moral and sexual behavior. When midwives talked back to missionaries, took vacations from their stations, or married according to customary practice, they were seen as rejecting the tight, narrowly prescribed role of the deferential, self-denying professional imagined by the program's sponsors. As long as the midwives were competent, this independence did not threaten their medical function. But independence challenged the social agenda of the maternity program. Midwives with moral lapses might be able to treat syphilis and deliver babies, but if they did not act as agents of imperial morality, they would be no more than a partial success for their sponsors. Midwives were trained, but they proved to be active mediators between their home cultures and the culture they had been taught rather than passive mouthpieces for the gospels of morality and motherhood. This annoyed their sponsors. As one complained, "The best scholars [midwives] did not always possess the most stable moral characters. Many of them came from homes of doubtful virtue. The anxious question was not so much 'would some fall' as 'would any stand.'" ⁷³ The midwives proved too indirect and weak a tool for social transformation.

Social engineering

The British tended to view women as the spiritual, moral, and reproductive centers of families. As faith, morality, and fertility became important to colonial policy, officials, missionaries, and medical practitioners began to address women's health and education seriously. In the early stages of the colonial encounter, women had been deemed irrelevant to knowledge, production, and war—the issues that concerned early explorers and exploiters. But by the 1920s, in the midst of an underpopulation crisis, reproduction and families were vital to colonial policy. From attempts to treat the undifferentiated mass of the sick, efforts to ensure the reproduction and survival of the Baganda grew into major initiatives in social

⁷² Minutes, January 10, 1924, "Minute book of the MTS Committee," vol. 2, 1923–54 (A. R. Cook, Secretary), ARCLM.

⁷³ A. R. Cook, "Report of LCMTS, 1925," in *Annual Medical and Sanitary Report for the Year Ending 31 December 1925* (Entebbe: Government Printer, 1926), 24–27.

engineering. Officials and missionaries became increasingly intrusive as they examined bodies for lesions, condemned the moral state of sufferers and demanded repentance, and then combined bodily care and reproductive evangelism in the maternity program.

The emphasis remained upon the public issues of the protectorate's political, social, and economic viability. But the treatment of STDs, the social purity campaign, and subsequent maternity programs explicitly turned what had been private concerns regarding health, morality, and fertility into matters of public policy and public responsibility. In Uganda, the state bypassed African families, aimed treatment and propaganda at individuals, and worked to create new, colonial families from the building blocks of mothers and children produced by the midwife and joined together through a moral education. These new families were designed specifically for the reproduction of an imperial structure threatened by reproductive failure. They were agencies of the state, cultivated for their effects on political stability and economic development. In attempting to seize this control over reproduction, the colonial state was in some sense proposing to reconstruct this African society from the individual upward through a policy that was social engineering incarnate, the antithesis of its explicit ideology of Indirect Rule. By promoting fertility, the administration sought to acquire taxpaying subjects and a labor force. By promoting a new motherhood and attempting to reinforce social ties threatened through economic and political change, it endeavored to make itself self-perpetuating. Through this paternalistic program that integrated biomedical and ideological initiatives into an attempted comprehensive reconstruction of the African population, the administration sought to sustain the Ganda oligarchy and avoid labor shortages, internal dissention, or open rebellion by Africans faced with impending physical or sociocultural extinction. The social programs of the protectorate were not mere sideshows to the public politics and economic maneuvering of imperialism. They were integral to the holding of power.

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